WSR 07-10-012
PROPOSED RULES
DEPARTMENT OF LICENSING
[Filed April 19, 2007, 3:43 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-13-098.

Title of Rule and Other Identifying Information: Chapter 308-20 WAC, Cosmetology, barber, manicurists, and estheticians, amending WAC 308-20-110 Minimum safety and sanitation standards for schools, cosmetologists, manicurists, estheticians, barbers, instructors, salon/shops, mobile units and personal services and 308-20-550 Posting of required licenses, registrations, permits and notice to consumers; and repealing WAC 308-20-600 Disinfecting and sterilizing of tools and other implements and 308-20-610 Chemical use and storage.

Hearing Location(s): Pellegrino's, Tyee Event Center & Pellegrino's Tyee Grill, 5757 Littlerock Road S.W., Tumwater, WA 98512, on June 11, 2007, at 9:30 a.m.

Date of Intended Adoption: June 12, 2007.

Submit Written Comments to: Sandra Gonzales, Department of Licensing, Cosmetology Program, P.O. Box 9026, Olympia, WA 98507, e-mail sgonzales@dol.wa.gov, fax (360) 664-2550, by June 7, 2007.

Assistance for Persons with Disabilities: Contact Sandra Gonzales by June 7, 2007, TTY (360) 664-8885 or (360) 664-6649.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose is to clarify and improve the safety and sanitation standards. In summary, the proposed rules include standards and guidelines for the following:

- Chemical use and storage.
- Sanitation and disinfection of tools and implements.
- Use of "prescriptive" medical devices.
- Personal cleanliness.
- Refuse and waste material.
- Cleaning and disinfecting foot spas.
- Storage of tools and implements.
- Prohibited instruments.
- Blood spills.
- Posting of current inspection report.

Reasons Supporting Proposal: Changes to the safety and sanitation standards will be clearer and more in line with today's industry standards and improve the health, safety, and welfare of licensees and consumers.

Statutory Authority for Adoption: RCW 18.16.030, 43.24.023.

Statute Being Implemented: RCW 18.16.030.

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

Name of Proponent: Department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Trudie Touchette, 405 Black Lake Boulevard S.W., (360) 664-6649; and Enforcement: Susan Colard, 405 Black Lake Boulevard S.W., (360) 664-6649.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules will have minor impact to businesses in the industry.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to this rule revision. Washington state department of licensing is not a named agency, therefore, exempt from this provision.

April 19, 2007
Trudie Touchette
Administrator

AMENDATORY SECTION (Amending WSR 04-05-005, filed 2/6/04, effective 3/8/04)

WAC 308-20-110 Minimum safety and sanitation standards for schools, cosmetologists, manicurists, estheticians, barbers, instructors, salons/shops, mobile units and personal services. ((~~In addition to the requirements of RCW 18.16.175,~~)) Every licensee shall maintain the following safety and sanitation standards. In addition, school instructors and apprentice trainers must assure persons training in a school or apprentice salon/shop will adhere to the following safety and sanitation standards:

(((~~(1) **Safety shall be maintained as follows:**~~

~~(a) A separate area with hot and cold running water shall be designated for use in dispensing and mixing chemicals and disinfecting supplies, tools, equipment, and other materials;~~

~~(b) All containers must be clearly labeled;~~

~~(c) All chemicals must be stored and labeled according to manufacturer's instructions;~~

~~(d) Disinfected supplies, tools, equipment and other material shall be stored separately from those that have been used;~~

~~(e) First-aid supplies shall be available;~~

~~(f) Licensees shall not work on clients with parasites, open wounds, or signs of infection; and~~

~~(g) School instructors and apprentice trainers shall not allow persons training in a school or apprentice salon/shop to work on clients with parasites, open wounds, or signs of infection.~~

~~(2) **Sanitation shall be maintained as follows:**~~

~~(a) Floors, walls, fixtures, work stations and ceilings shall be clean and free from dust, dirt and hair;~~

~~(b) Hair shall be removed from the floor after each service; and~~

~~(c) Waste receptacles shall be emptied and disinfected daily.~~

~~(d) Disposable products shall be placed in a waste receptacle;~~

~~(e) Creams and lotions shall be dispensed using a disposable, or sanitized applicator, and fluids shall be dispensed with a squeeze bottle or pump;~~

~~(f) Use clean towel, new neck strip and other sanitized supplies for each client;~~

~~(g) Clean reusable supplies and implements with a disinfectant after each use; and~~

~~(h) Wash hands with single-use soap and disposable hand-drying towels after toilet use and before providing service to each client.~~)) (1) **Requirements and standards.**

(a) All locations must have a dispensing sink with hot and cold running water. Dispensing sinks are used for mixing chemicals, and disinfecting supplies, tools, equipment, and other materials. Dispensing sinks must be labeled "not for public use."

(b) On-site laundry facilities must be maintained in a sanitary condition.

(c) Single-use hand soap and disposable or single use hand-drying towels for customers must be provided.

(d) Use of bar soap or a common towel is prohibited.

(e) Licensees must not work on clients with visible parasites, open wounds, or signs of infection.

(f) Licensees must sanitize and disinfect affected work area if visible parasites, open wounds, or signs of infection are found on a client.

(g) Creams and lotions must be dispensed using a disposable, or sanitized and disinfected applicator, and liquids must be dispensed with a squeeze bottle or pump.

(h) Wash hands with single-use soap and/or hand sanitizer and disposable or single use hand-drying towels after restroom use and before providing service to each client.

(i) Waste containers must be emptied, sanitized and disinfected daily.

(j) After service on each client, hair and nail clippings must immediately be placed in a closed covered container.

(2) **Personal cleanliness.**

(a) A licensee must thoroughly wash his or her hands with soap and warm water or any equally effective cleansing agent immediately before providing services to each client, before checking a student's work on a client, or after smoking, eating or using the restroom.

(b) A client's skin upon which services will be performed must be washed with soap and warm water or wiped with disinfectant or waterless hand cleanser approved for use on skin before a service on the hands and feet.

(c) A licensee who has a contagious disease, visible parasite, or open wound of a nature that may be transmitted, must not perform services on a client until the licensee takes medically approved measures to prevent transmission of the disease.

(3) **Articles in contact with a client.**

(a) A neck strip or towel must be placed around the client's neck to prevent direct contact between a multiple use haircloth or cape and the client's skin, and must be in place during entire service.

(b) All items, which come in direct contact with the client's skin that do not require disinfecting, must be sanitized; to include reusable gloves.

(c) All articles, which come in direct contact with the client's skin that cannot be sanitized and disinfected, must be disposed of in a waste receptacle immediately after service on each client.

(d) Disposable protective gloves must be disposed of after service on each client.

(4) **Materials in contact with a client.**

(a) All chemical substances, including paraffin wax must be dispensed from containers in a manner to prevent contamination of the unused portion.

(b) Any part of the body being immersed in paraffin wax must be sanitized with soap and water or sanitizing solution.

(c) Paraffin wax must be covered when not in use, and maintained at a temperature specified by the manufacturer's instructions.

(5) **Chemical use and storage.**

(a) When administering services to a client that involve the use of chemicals or chemical compounds, all licensees must follow safety procedures, which prevent injury to the client's person or clothing.

(b) Licensees using chemicals or chemical compounds in providing services to clients must store the chemicals so as to prevent fire, explosion, or bodily harm.

(i) Flammable chemicals must be stored away from potential sources of ignition.

(ii) Chemicals which could interact in a hazardous manner such as oxidizers, catalysts, and solvents, must be stored per manufacturer's instruction.

(iii) All chemicals must be stored in accordance with the manufacturer's directions.

(6) **Refuse and waste material.**

(a) All chemical, flammable, toxic or otherwise harmful waste material must be deposited in a closed container at the conclusion of each service on a client and removed from the premises to a fire-retardant container at the close of each business day.

(b) All nonchemical waste related to the performance of services must be deposited in a covered container to avoid the potential for cross contamination through release of or exposure to infectious waste materials.

(c) All waste unrelated to the performance of services must be deposited in a covered waste disposal container. Containers located in the reception or office area, which do not contain waste relating to the performance of services, are exempt from having covers.

(d) Outer surfaces of waste disposal containers must be kept clean.

(e) Any disposable sharp objects that come in contact with blood or other body fluids must be disposed of in a sealable rigid (puncture proof) labeled container that is strong enough to protect the licensee, client and others from accidental cuts or puncture wounds that could happen during the disposal process.

(f) Licensees must have both sealable plastic bags and sealable rigid containers available for use at all times services are being performed.

(7) **Sanitation/disinfecting.**

(a) All tools and implements, including; reusable skin cleaning sponges and skin care bowls, must be sanitized and disinfected or disposed of after service on each client.

(b) When used according to the manufacturer's instructions, each of the following is an approved method of disinfecting tools and implements after they are cleaned of debris:

(i) Complete immersion or spray with an EPA-registered hospital grade disinfectant solution of the object(s) or portion(s) thereof to be disinfected; or

(ii) Steam sterilizer, registered and listed with the U.S. Food and Drug Administration; or

(iii) Dry heat sterilizer, registered and listed with the U.S. Food and Drug Administration, or Canadian certification.

(c) All sanitized and disinfected tools and implements must be kept in a sanitizer or closed nonairtight container.

(d) All disinfecting solutions and/or agents must be kept at manufacturer recommended strengths to maintain effectiveness, be free from foreign material and be available for immediate use at all times the location is open for business.

(e) Nail files, cosmetic make-up sponges, buffer blocks, sanding bands, toe separators or sleeves, orangewood sticks, and disposable nail bits which have not been approved for disinfection and reuse, must be given to the client or discarded after service on each client. Presence of these articles in the work area will be prima facie evidence of reuse.

(8) **Disinfecting nonelectrical tools and implements.**

(a) All tools and implements used within a field of practice must be disinfected after service on each client in the following order:

(i) Remove all hair and/or foreign material;

(ii) Clean thoroughly with soap or detergent and water;

(iii) Rinse thoroughly with clear, clean water; and

(iv) Disinfect with an EPA-registered hospital grade disinfectant with demonstrated bactericidal, fungicidal, and virucidal activity, and use according to manufacturer's instructions.

(b) Tools and implements without sharp edges or points, including but not limited to combs, brushes, rollers, rods, etc., must be totally immersed according to manufacturer's instructions.

(c) Clips or other tools and instruments must not be placed in mouths, pockets or unsanitized holders.

(d) A client's personal tools and instruments must not be used in the establishment except when prescribed by a physician.

(9) **Disinfecting electrical tools and implements.** Electrical tools and implements must be disinfected after service on each client in the following order:

(a) Remove hair and/or foreign matter;

(b) Disinfect with an EPA hospital grade disinfectant specifically made for electrical tools and implements.

(10) **Storage of tools and implements.**

(a) New and/or sanitized and disinfected tools and implements must be stored separately from all others.

(b) Roller storage receptacles and contents must be sanitized and disinfected and free of foreign material.

(c) Storage cabinets, work stations and storage drawers for sanitized and disinfected tools and implements must be clean, free of debris and used only for sanitized and disinfected tools and implements.

(d) Storage of used tools and implements that are not in a labeled drawer or container is prohibited at the workstation.

(11) **Cleaning and disinfecting footspas.**

(a) As used in this section, "footspa" or "spa" is defined as any basin using circulating water.

(b) After service upon each client, each footspa must be cleaned and disinfected in the following order:

(i) All water must be drained and all debris must be removed from the spa basin.

(ii) The spa basin must be cleaned with soap or detergent and water.

(iii) The spa basin must be disinfected with an EPA-registered hospital grade disinfectant with demonstrated bactericidal, fungicidal, and virucidal activity, which must be used according to manufacturer's instructions.

(iv) The spa basin must be wiped dry with a clean towel.

(c) At the end of each day, each footspa must be cleaned and disinfected in the following order:

(i) The screen must be removed, all debris trapped behind the screen must be removed, and the screen and the inlet must be washed with soap or detergent and water.

(ii) Before replacing the screen, the screen must be totally immersed in an EPA-registered hospital grade disinfectant with demonstrated bactericidal, fungicidal, and virucidal activity, which must be used according to the manufacturer's instructions.

(iii) The spa system must be flushed with low sudsing soap and warm water for at least ten minutes, after which the spa must be rinsed and drained.

(d) Every other week (biweekly), after cleaning and disinfecting as provided in (c) of this subsection, each footspa must be cleaned and disinfected in the following order:

(i) The spa basin must be filled completely with water and one teaspoon of 5.25% bleach for each one gallon of water, or a solution of sodium hypochlorite of approximately 50 ppm used according to manufacturer's instructions.

(ii) The spa system must be flushed with the bleach and water solution, or sodium hypochlorite solution, for five to ten minutes and allowed to sit for six to ten hours.

(iii) The spa system must be drained and flushed with water before service upon a client.

(e) A record must be made of the date and time of each cleaning and disinfecting as required by (c) and (d) of this subsection, and indicate whether the cleaning was a daily or biweekly cleaning. This record must be made at the time of cleaning and disinfecting. Cleaning and disinfecting records must be made available upon request by either a client or a department representative.

(12) **Headrests and treatment tables.**

(a) The headrest of chairs must be sanitized, disinfected and covered with a clean towel or paper sheet after service on each client.

(b) Shampoo trays and bowls must be sanitized and disinfected after each shampoo, kept in good repair and in a sanitary condition at all times.

(c) All treatment tables must be sanitized, disinfected and covered with sanitary linens or examination paper, which must be changed after each service on a client.

(13) **Walls and ceilings.** Walls and ceilings must be clean and free of excessive spots, mildew, condensation, or peeling paint.

(14) **Liquids, creams, powders and cosmetics.**

(a) All liquids, creams, and other cosmetic preparations must be kept in clean and closed containers.

(b) All bottles and containers must be distinctly and correctly labeled to disclose their contents. All bottles and containers containing poisonous substances must be additionally and distinctly marked as such.

(c) When only a portion of a cosmetic preparation is to be used on a client, it must be removed from the container in such a way as not to contaminate the remaining portion.

(d) Pencil cosmetics must be sharpened before each use. Sanitize and disinfect or dispose of the sharpener after service on each client.

(15) **Towels or linens.** Clean towels or linens must be used for each client in cosmetology, esthetics, manicuring and barbering services. Towels and linens must be sanitized and disinfected with a product that is labeled 10% bleach solution or the equivalent.

(16) **Prohibited hazardous substances—Use of products.** No establishment or school may have on the premises cosmetic products containing hazardous substances which have been banned by the U.S. Food and Drug Administration for use in cosmetic products. Use of 100% liquid methyl methacrylate monomer and methylene chloride products are prohibited. No product must be used in a manner that is disapproved by the U.S. Food and Drug Administration.

(17) **Prohibited instruments or practices.**

(a) Any razor-edged tool, which is designed to remove calluses.

(b) Neck and nail dusters to remove debris from client.

(18) **Blood spills.** If there is a blood spill or exposure to other body fluids during a service, licensees and students must stop and proceed in the following order:

(a) Put on gloves;

(b) Clean the wound with an antiseptic solution;

(c) Cover the wound with a sterile bandage;

(d) If the wound is on a licensee hand in an area that can be covered by a glove or finger cover, the licensee must wear a clean, fluid proof protective glove or finger cover. If the wound is on the client, the licensee providing service to the client must wear gloves on both hands.

All equipment, tools and instruments that have come into contact with blood or other body fluids must be sanitized and disinfected or discarded. Blood-contaminated tissue or cotton or other blood-contaminated material must be placed in a sealed, labeled plastic bag and that plastic bag must be placed into another plastic bag (double bagged), and discarded. Licensees must wear gloves if there is contact with blood or other body fluids, and must sanitize and disinfect or discard gloves and wash hands.

(19) **First aid kit.** The establishment must have a first aid kit that contains at a minimum: Small bandages, gauze, antiseptic, and a blood spill kit that contains disposable bags, gloves and hazardous waste stickers.

(20) **Medical devices.** Any medical device listed with the U.S. Food and Drug Administration as a "prescriptive device" must be under the delegation and supervision of a licensed physician or physician's assistant or an advanced registered nurse practitioner (ARNP) as defined under chapters 18.71, 18.57, 18.71A, and 18.57A RCW, and RCW 18.79.050.

(21) **Restroom.**

(a) All locations must have a restroom available. The restroom must be located on the premises or in adjoining premises, which is reasonably accessible.

(b) All restrooms located on the premises must be kept clean, sanitary and in proper working order at all times.

AMENDATORY SECTION (Amending WSR 04-05-005, filed 2/6/04, effective 3/8/04)

WAC 308-20-550 Posting of required licenses, registrations, permits, ((~~and~~)) notice to consumers, and current inspection form. (1) Licenses, the consumer notice required by chapter 18.16 RCW, ((~~and~~)) the apprentice salon/shop notice as defined in WAC 308-20-555, and the most current inspection form shall be posted in direct public view.

(2) Original operator licenses with an attached current photograph shall be posted in clear view of clients in the operator's work station.

(3) School, instructor, salon/shop, and mobile unit licenses shall be displayed in the reception area.

(4) Personal services shall display their licenses and consumer notice in direct view of their client.

(5) A pocket identification card may not be used in lieu of an original license.

(6) No license which has expired or become invalid for any reason shall be displayed by any operator, instructor, or business in connection with the practice of cosmetology, barbering, esthetics, or manicuring. Any license so displayed shall be surrendered to a department representative upon its request.

(7) Licenses issued by another state, territory, or foreign country shall not be displayed in any salon/shop.

(8) A receipt, issued by the department of licensing, showing the application for a duplicate license may be used if the original has been lost, stolen, or otherwise destroyed until the duplicate license is received.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 308-20-600	Disinfecting and sterilizing of tools and other implements.
WAC 308-20-610	Chemical use and storage.

WSR 07-10-027
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed April 23, 2007, 2:39 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-06-079.

Title of Rule and Other Identifying Information: Chapter 392-144 WAC, School bus driver qualifications.

Hearing Location(s): Brouillet Conference Room, Office of Superintendent of Public Instruction, 600 South Washington Street, Olympia, WA 98504-7200, on June 6, 2007, at 9:00 a.m.

Date of Intended Adoption: June 7, 2007.

Submit Written Comments to: Allan J. Jones, Director, Pupil Transportation and Traffic Safety Education, P.O. Box 47200, Olympia, WA 98504-7200, e-mail allan.jones @k12.wa.us, fax (360) 586-6124, by May 31, 2007.

Assistance for Persons with Disabilities: Contact Penny Coker by May 31, 2007, TTY (360) 664-3631.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Clarification needs to be added to chapter 392-144 WAC informing school districts they are required to obtain an original, current, and complete school bus driving record from the department of licensing.

Statutory Authority for Adoption: RCW 28A.160.20 [28A.160.210].

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: Clarification needs to be added to chapter 392-144 WAC informing school districts they are required to obtain an original, current, and complete school bus driving record from the department of licensing.

Name of Proponent: Office of superintendent of public instruction, governmental.

Name of Agency Personnel Responsible for Drafting: Charlie Schreck, Office of Superintendent of Public Instruction, (360) 725-6136; Implementation: Martin Mueller, Office of Superintendent of Public Instruction, (360) 725-5175; and Enforcement: Allan J. Jones, Office of Superintendent of Public Instruction, (360) 725-6120.

No small business economic impact statement has been prepared under chapter 19.85 RCW. This revision is only applicable to public school districts.

A cost-benefit analysis is not required under RCW 34.05.328.

April 23, 2007
Terry Bergeson

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-110 Temporary authorizations—Requirements and issuing procedures. (1) A temporary school bus driver authorization may be issued by the superintendent of public instruction upon application by an authorized representative of the employing school district when the following has been provided:

(a) Verification of successful completion of the school bus driver training course.

(b) Verification that it has on file a copy of a current and valid medical examiner's certificate.

(c) Verification that it has on file ((~~a~~)) an original, current ((~~five-year~~)) and complete school bus driver's abstract, including departmental actions, of the applicant's employment and nonemployment driving record ((~~issued by~~)) obtained from the department of licensing verifying compliance with all provisions of this chapter. The issue date of this abstract must be within sixty calendar days prior to the date the application is being submitted for temporary authorization.

(d) Verification that it has on file a disclosure statement in compliance with preemployment inquiry regulations in WAC 162-12-140, signed by the applicant, specifying all convictions which relate to fitness to perform the job of a school bus driver under WAC 392-144-103 and all crimes against children or other persons, that meets the requirements of RCW 43.43.834(2).

(e) Verification that it has requested a criminal record check as required under chapter 28A.400 RCW and the date of such request.

(f) Verification that it has on file an applicant's disclosure of all serious behavioral problems which explains the nature of all such problems and/or conditions, a listing of the names, addresses, and telephone numbers of all doctors, psychologists, psychiatrists, counselors, therapists, or other health care practitioners of any kind or hospitals, clinics, or other facilities who have examined and/or treated the applicant for such problems and/or conditions and dates of examinations, therapy, or treatment and the school district has determined that any reported serious behavioral problem does not endanger the education welfare or personal safety of students, teachers, bus drivers, or other colleagues.

(g) Verification that the applicant complies with all of the requirements for authorized school bus drivers set forth in this chapter except for a first-aid card and/or the results of a criminal record check.

(2) Upon approval of the temporary authorization, notice will be provided to the employing school district.

(3) The temporary authorization shall be valid for a period of sixty calendar days. The temporary authorization may be renewed by approval of the regional transportation coordinator when the results of the criminal background check have not been received.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-120 School bus driver authorization—Requirements and issuing procedures. A school bus driver authorization may be issued by the superintendent of public instruction upon application by an authorized representative of the employing school district subject to compliance with the following provisions:

(1) The employing school district shall forward to the superintendent of public instruction the following verifications relating to the applicant:

(a) Verification of successful completion of the school bus driver training course taught by an authorized school bus driver instructor.

(b) Verification that it has on file a copy of a current and valid medical examiner's certificate.

(c) Verification that it has on file ((~~a~~)) an original, current ((~~five-year~~)) and complete school bus driver's abstract, including departmental actions, of the applicant's employment and nonemployment driving record ((~~issued by~~)) obtained from the department of licensing verifying compliance with all provisions of this chapter. The issue date of this abstract must be within sixty calendar days prior to the date an application was submitted for temporary authorization. If no request for a temporary school bus authorization was sub-

mitted, the issue date must be within sixty calendar days prior to the date of application of the school bus driver authorization.

(d) Verification that the applicant has a current and valid first-aid card.

(e) Verification that it has on file a disclosure statement in compliance with preemployment inquiry regulations in WAC 162-12-140, signed by the applicant, specifying all convictions which relate to fitness to perform the job of a school bus driver under WAC 392-144-103 and all crimes against children or other persons, that meets the requirements of RCW 43.43.834(2).

(f) Verification that it has on file the results of a criminal record check as required under chapter 28A.400 RCW and that such results establish that the applicant has not committed any offense which constitutes grounds for denying, suspending, or revoking an authorization under this chapter and the date of such request.

(g) Verification that it has on file an applicant's disclosure of all serious behavioral problems which explains the nature of all such problems and/or conditions, a listing of the names, addresses, and telephone numbers of all doctors, psychologists, psychiatrists, counselors, therapists, or other health care practitioners of any kind or hospitals, clinics, or other facilities who have examined and/or treated the applicant for such problems and/or conditions and dates of examinations, therapy, or treatment and the school district has determined that any reported serious behavioral problem does not endanger the educational welfare or personal safety of students, teachers, school bus drivers, or other colleagues.

(h) Verification that the applicant complies with all of the requirements for authorized school bus drivers set forth in this chapter.

(2) Upon approval of an application, the superintendent of public instruction shall issue a notice of school bus driver authorization to the employing school district.

(3) Subsequent authorizations for an individual driver with new or additional employing school districts must be issued from the superintendent of public instruction to such districts prior to the operation of any motor vehicle for the transportation of children.

(4) The superintendent of public instruction will provide each school district with a list of their authorized school bus drivers and each authorized school bus driver's status.

AMENDATORY SECTION (Amending WSR 06-15-010, filed 7/6/06, effective 8/6/06)

WAC 392-144-160 School district—Verification of driver's continuing compliance. (1) Every school district shall evaluate each authorized school bus driver for continuing compliance with the provisions of this chapter annually. The results of this evaluation of all drivers shall be forwarded to the superintendent of public instruction on SPI Form 1799, Verification Statement and Confirmation of Updated Records, no later than November 15th of each year.

(2) This report shall verify that each authorized school bus driver's medical examination certificate expiration date, first-aid expiration date, driver's license expiration date and most recent school bus driver in-service training date has been updated in compliance with OSPI procedures.

(3) This report shall verify that each authorized school bus driver has made an updated disclosure in writing and signed and sworn under penalty of perjury which updates the disclosure required in WAC 392-144-102(4).

(4) This report shall verify that a current and original school bus driver's abstract has been obtained from the department of licensing on each authorized school bus driver((~~'s five-year~~)) and the driving record is in compliance with WAC 392-144-103.

(5) This report shall verify that each authorized school bus driver remains in compliance with the physical requirements of WAC 392-144-102(5).

(6) This report shall be a written verification that the evaluation has been conducted in accordance with the requirements of this chapter and that all drivers are in compliance, or if all drivers are not in compliance, a list of drivers who are out of compliance and the reason for noncompliance shall be provided.

WSR 07-10-035
PROPOSED RULES
DEPARTMENT OF LICENSING
[Filed April 24, 2007, 1:58 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-02-008.

Title of Rule and Other Identifying Information: WAC 308-124A-450 Real estate licensing examination procedures.

Hearing Location(s): Department of Licensing, 2nd Floor Conference Room, 2000 4th Avenue West, Olympia, WA, on June 8, 2007, at 10:00 a.m.

Date of Intended Adoption: June 8, 2007, or after.

Submit Written Comments to: Jerry McDonald, P.O. Box 2445, Olympia, WA 98507, e-mail jmcdonald@dol.wa.gov, fax (360) 570-7051, by June 1, 2007.

Assistance for Persons with Disabilities: Contact Marjorie Hatfield by June 1, 2007, TTY (360) 664-8885 or (360) 664-6426.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To ensure the security of real estate examinations.

Reasons Supporting Proposal: To clarify procedures for security breaches and disruptive behavior at testing sites by applicants.

Statutory Authority for Adoption: RCW 18.85.040(1).

Statute Being Implemented: RCW 18.85.090, 18.85.095, and 18.85.130.

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

Name of Proponent: Real estate program, business and professions division, department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Jerry McDonald, 2000 4th Avenue West, Olympia, WA, (360) 664-6524.

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

enterprises - only affects individual applicants for licensure as real estate salespersons or real estate brokers.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed changes have no financial impact on the department.

April 24, 2007
Jerry McDonald
Assistant Administrator

AMENDATORY SECTION (Amending WSR 93-24-096, filed 11/30/93, effective 1/1/94)

WAC 308-124A-450 Examination procedures. (1) Each applicant will be required to present one piece of positive identification which bears a photograph of the applicant. ((~~In the event the applicant has no photo identification, the applicant will be required to make prior arrangements with the department not later than ten working days prior to the examination.~~)) Failure to produce the required identification will result in the applicant being refused admission to the examination.

(2) Applicants will be required to refrain from:

(a) Talking to other examinees during the examination unless specifically directed or permitted to do so by a test monitor. ((~~Any applicant observed talking or attempting to give or receive information; using unauthorized materials during any portion of the examination; or removing test materials and/or notes from the testing room will be subject to denial of a license.~~))

(b) Attempting to communicate or record any information.

(c) Using unauthorized materials during any portion of the examination.

(d) Removing test materials and/or notes from the testing room.

(e) Disruptive behavior.

(3) Applicants who participate in ((~~disruptive behavior during the examination~~)) any activity listed in subsection (2) of this section will be required to turn in their test materials to the test monitor and leave the examination site. Their opportunity to sit for the examination will be forfeited. Their answer sheet will be voided. A voided answer sheet will not be scored and the examination fee will not be refunded. A candidate must then reapply to take the examination.

(4) Any applicant who was removed from the testing site for any of the reasons listed in subsection (2) of this section will be required to submit a letter to the department requesting permission to retest and stating the circumstances of the event. After receipt of the applicant's letter, the department will review the proctor's report and the applicant's letter and may deny testing for up to one year.

WSR 07-10-036
PROPOSED RULES
GAMBLING COMMISSION
[Filed April 24, 2007, 2:39 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-03-167.

Title of Rule and Other Identifying Information: New chapter 230-13 WAC, Amusement games.

Hearing Location(s): La Quinta Inn and Suites, 1425 East 27th Street, Tacoma, WA 98421, (253) 383-0146, on July 13, 2007, at 9:30 a.m.

Date of Intended Adoption: July 13, 2007.

Submit Written Comments to: Susan Arland, P.O. Box 42400, Olympia, WA 98504-2400, e-mail Susan2@wsgc.wa.gov, fax (360) 486-3625, by July 1, 2007.

Assistance for Persons with Disabilities: Contact Shirley Corbett, Executive Assistant, by July 1, 2007, TTY (360) 486-3637 or (360) 486-3447.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The gambling commission is rewriting its rules manual using plain English techniques. We anticipate the project will be completed by January 1, 2008. The rules manual is being broken into sections and rewritten a section at a time. This filing is to provide notification that rules regarding amusement games are under review and are not being rewritten in plain English.

Overview of chapter 230-13 WAC, Amusement game rules changes.

INDIVIDUAL RULE CHANGES:

Post-January 1, 2008, WAC 230-13-001 Defining "operator." We added a definition of "operator" to the post-January 1, 2008, amusement games rules to clearly define whom we are referring to when we use the word "operator" in the amusement game rules. Using "operator" is a way of avoiding repeating "licensees or unlicensed organizations" in each rule we have written. Unlicensed organizations are allowed by RCW 9.46.0321 to have limited gambling activities without obtaining a license as long as their gross gambling receipts are below $5000. Amusement games are one of their permitted activities.

Post-January 1, 2008, WAC 230-13-010 Time and place of public meetings. In the post-January 1, 2008, WAC 230-13-010, the director grants approval for new amusement games. The pre-January 1, 2008, WAC Authorized amusement games—Types, standards and classifications, states, "Operators may introduce new games…without prior approval of the commission." We have reevaluated this rule with Director Day and are making a policy recommendation that the current rule means "commission" as in "commission staff"; and not as "commissioners." Therefore, Director Day will stand in for the commissioners in approving new amusement games.

We also eliminated the "twelve-month test period" for new amusement games in the post-January 1, 2008, WAC. Staff is certain that this was a temporary measure added during the time when crane games were being introduced into the state and are now concerned that the "test period" would allow a number of unauthorized games to be placed for public use without our having a chance to inspect and approve them.

Post-January 1, 2008, WAC 230-13-040 Group 6—Strength test amusement game standards. The language in the pre-January 1, 2008, WAC 230-20-508 Authorized amusement games—Types, standards and classifications,

uses the verb "may" to indicate how the game should operate, as in "This may include hand, arm, or whole body strength and may also require the player to use a tool or instrument to strike an object or target, which may cause the object to be propelled…"

We changed that language in the post-January 1, 2008, WAC to "must" because we feel that the more stringent language was intended in the rule, but the writer used the more permissive sounding language by mistake. We do not believe we will be limiting the way this group of games is played by making the language more restrictive. There are few of these games and all of them require the actions described, though the pre-January 1, 2008, WAC states that they "may" be operated in this way; "must" fits the way the requirements are enforced in the field.

Post-January 1, 2008, WAC 230-13-060 Group 10—Shooting amusement game standards. This post-January 1, 2008 rule, combines two rules pre-January 1, 2008, WAC 230-20-508, which became effective January 6, 1994, and pre-January 1, 2008, WAC 230-20-660, which was filed June 25, 1976. Neither has been revised since then, and it is likely that the game they were written to enforce is no longer being offered or played.

We removed the use of a "combined score" to determine winners mentioned in pre-January 1, 2008, WAC 230-20-508 Authorized amusement games—Types, standards and classifications, subsection (7)(j)(iii)(D) because we know of no instances where a combined score is or could be used in a shooting game.

Post-January 1, 2008, WAC 230-13-090 Adult supervision of unattended amusement games. This pre-January 1, 2008, WAC 230-20-680 Commercial amusement games—Operation restrictions, like several others, references a list of locations included in another rule—pre-January 1, 2008, WAC 230-04-138 Commercial amusement games—Authorized locations, which duplicates a good deal of the language contained in RCW 9.46.0331. We wish to remove this sort of cross-referencing to other WACs and instead have operators refer to the RCW covering amusement games.

We added a definition of "unattended amusement game" to this post-January 1, 2008 rule. We also removed the percentage operators must pay to charitable or nonprofit organizations that was listed in the pre-January 1, 2008, WAC because the requirement already exists in post-January 1, 2008 rule, WAC 230-13-160 Basing rent on a percentage of gross receipts.

Lastly, we took out requirements about areas where school age minors must not play amusement games because they are already listed in RCW 9.46.0331 Amusement games authorized—Minimum rules.

Post-January 1, 2008, WAC 230-13-105 Attended amusement game requirements. We removed the pre-January 1, 2008, WAC 230-20-510 Attended amusement games—Operational restrictions,reference to following the RCW and WAC because this requirement is duplicative of post-January 1, 2008, WAC 230-13-085 Control and maintenance of amusement games.

Post-January 1, 2008, WAC 230-13-145 Marking the difference between objects thrown in multiple amusement games on the same premises. We removed the requirement in the first sentence of the pre-January 1, 2008, WAC 230-20-620 Amusement games—Objects to be thrown to be uniform—Similar games not to use different objects unless designated, "No person licensed to conduct amusement games shall conduct any such game within the state of Washington wherein the winning of a prize depends upon the player's ability to throw or project an object unless all such objects available to any player in said game are uniform in size and weight" because it is already explained in the post-January 1, 2008, standards for groups of amusement games that require something to be thrown.

Post-January 1, 2008, WAC 230-13-150 Amusement game locations. We removed the redundant requirement in pre-January 1, 2008, WAC 230-04-138 Commercial amusement games—Authorized locations about the rental amount paid to charitable or nonprofit organizations, because post-January 1, 2008, WAC 230-13-160 Basing rent on a percentage of gross receipts, explains the requirement for rents.

We also propose removing the repetitive list of locations where operators may place amusement games in pre-January 1, 2008, WAC 230-04-138 Commercial amusement games—Authorized locations about the rental amount paid to charitable or nonprofit organizations, because they are already spelled out in RCW 9.46.0331.

Post-January 1, 2008, WAC 230-13-175 Recordkeeping for unlicensed charitable and nonprofit amusement games. We removed the requirement in pre-January 1, 2008, WAC 230-08-060 Commercial amusement game records, that records in commercial amusement games include proving that prizes were awarded to winners. This requirement doesn't seem necessary since the records of the prizes bought and the prizes awarded are already required.

Reasons Supporting Proposal: To make our rules manual more user friendly. To make rules easier to find and understand.

Statutory Authority for Adoption: RCW 9.46.070.

Statute Being Implemented: Not applicable.

Name of Proponent: Washington state gambling commission, governmental.

Name of Agency Personnel Responsible for Drafting: Susan Arland, Rules Coordinator, Lacey, (360) 486-3466; Implementation: Rick Day, Director, Lacey, (360) 486-3446; and Enforcement: Mark Harris, Assistant Director, Lacey, (360) 486-3579.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement has not been prepared pursuant to RCW 19.85.025 and/or the proposed rule change clarifies language or rules without changing the effect.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state gambling commission is not an agency that is statutorily required to prepare a cost-benefit analysis under RCW 34.05.328.

April 24, 2007

Susan Arland

Rules Coordinator

Chapter 230-13 WAC

AMUSEMENT GAME RULES

NEW SECTION

WAC 230-13-001 Defining "operator." In this chapter, "operator" means the licensee or unlicensed charitable or nonprofit organization operating the amusement game.

NEW SECTION

WAC 230-13-005 Amusement games authorized. (1) We authorize the eleven groups of amusement games set forth in this chapter. Operators must only operate amusement games that meet the standards of at least one of the authorized groups.

(2) Commercial businesses or nonprofit or charitable organizations may apply for licenses for amusement games.

(3) Charitable or nonprofit organizations also may conduct amusement games without a license when authorized to do so under RCW 9.46.0321 and 9.46.0331.

(4) Operators must operate amusement games as either:

(a) An attended amusement game.

(i) An "attended amusement game" means an amusement game that requires the presence or assistance of a person (attendant) in the regular operation of the game; and

(ii) These games must award a merchandise prize to players if players achieve the objective with one cost of play; or

(b) A coin or token activated amusement game.

(i) A "coin or token activated amusement game" means an amusement game that uses a mechanical, electronic, or electro-mechanical machine to allow the player to activate the game by inserting coins or tokens; and

(ii) These games may dispense merchandise prizes, or coupons, tickets, or tokens redeemable for merchandise prizes.

(5) Amusement games must not award additional plays as prizes.

NEW SECTION

WAC 230-13-010 Approval of new amusement games. (1) Operators may introduce new games that meet the standards of an authorized group without approval of the director as long as they provide the director or his or her designee with a description, the rules of play, and the group number of the game with an explanation of why that group was chosen at least sixty days before introducing the game.

(2) If the director notifies the operator that the proposed game does not meet the standards or otherwise violates the gambling laws or rules, the operator:

(a) May not introduce the game; and

(b) If already introduced, must remove it from play until the operator brings it into compliance with the authorized group.

NEW SECTION

WAC 230-13-015 Group 1—Ball toss or kick amusement game standards. In Group 1 games, players throw or kick balls to win prizes.

(1) In ball toss or kick amusement games:

(a) All balls for each game must be uniform in size and weight; and

(b) All targets for each game must be the same size and weight or the operator must color code the target and advise the players of the difference in targets if the difference is not visible to players; and

(c) Target weight must not exceed seven and one-half pounds; and

(d) A target must not have a loose or floating weight.

(2) If the goal of the game requires estimating the speed of the ball thrown or kicked, operators must offer the player at least three balls to practice estimating the speed and one ball for the actual throw or kick.

(3) If operators use a ping pong or similar light weight ball in games requiring players to toss the ball into a dish, saucer, cup, or similar container, they must place water in the bottom of each container.

NEW SECTION

WAC 230-13-020 Group 2—Dart amusement game standards. In Group 2 games, players throw darts into a target area to win prizes. If players achieve the predetermined score or pattern, pierce or break a target, or just stick the dart in the target, the player wins a prize.

(1) In dart amusement games:

(a) All darts must be uniform in size and unaltered with the point sharp, or functional if suction-cup darts, and all feathers or tail sections intact; and

(b) The target area for all dart games must be of a material capable of being penetrated and retaining a metal tip dart, or holding a suction-cup dart; and

(c) The target area must be in the rear of the stand and must be at least three feet but not more than fifteen feet from a foul line.

(2) In "add 'em up games," where players must achieve a predetermined score, all darts stuck on the lines of the target must result in another throw by the player. Players have the right to add up the score of the darts thrown.

NEW SECTION

WAC 230-13-025 Group 3—Hoop or ring toss amusement game standards. In Group 3 games, players toss one or more hoops or rings over one or more targets which may consist of bottles, pegs, blocks, prizes, or any item capable of having a ring or hoop tossed over it to win prizes. In hoop or ring toss amusement games:

(1) The operator must advise the player as to the degree that the hoop(s) or ring(s) must go over the target; and

(2) Hoops or rings for each game must be uniform in size and shape and must be capable of going over the target; and

(3) Targets used at an individual stand must be the same size. If not, the operator must post signs or use color codes to point out the different sizes.

NEW SECTION

WAC 230-13-030 Group 4—Coin or token toss amusement game standards. In Group 4 games, players toss one or more coins or tokens onto a surface or into a target area to win a prize. In coin or token toss amusement games:

(1) The game must have a clear and unobstructed thirty-six inch vertical airspace above the target area or surface; and

(2) The target or surface must be level and not altered to give an advantage to the operator; and

(3) Any game which has a target area of four square inches or less must award a prize if any part of the coin or token is within the target area.

NEW SECTION

WAC 230-13-035 Group 5—Hand/eye coordination amusement game standards. In Group 5 games, players perform task(s) using hand and eye coordination to win a prize.

(1) Hand and eye coordination amusement games must include one or more of the following:

(a) Striking a moving or fixed object or target including a sequence of moving or fixed objects or targets; or

(b) Launching object(s) at target(s) from a mechanism. Players must aim object(s) so they may land in, on, or go through a target(s), including catching the target(s) or having the object(s) caught in the target(s). In games where players launch, toss, or catapult objects at target(s), the launching machine must respond in an identical manner on repetitive uses when the player applies or selects an equal amount of force; or

(c) Dropping object(s) onto target area(s) or surface(s), including covering the area(s), or surface(s) with the object(s). If a player must cover a spot or specific target area, then the target area must be a circular spot and:

(i) The player must receive at least five circular discs to drop on the target or target area; and

(ii) The diameter of the circular discs used to cover the target or target area must be at least sixty-four percent of the diameter of the target spot or area; and

(iii) The target spot or area must be permanently affixed to a solid surface; or

(d) Capturing, lassoing, hooking, or getting a hold of an object(s) and causing them to move or change position; or

(e) Guiding object(s) or images through a pattern, maze, or task; or

(f) Climbing on, over, through, or around object(s); or

(g) Similar tasks.

(2) For any game requiring a player to perform a task normally associated with playing billiards or pool, operators must allow players to use a regulation billiard table, balls, and cue.

NEW SECTION

WAC 230-13-040 Group 6—Strength test amusement game standards. In Group 6 games, players test their strength by performing task(s) for a predetermined number of times or length of time to win a prize. The tasks must do one or more of the following:

(1) Test hand, arm, or whole body strength; or

(2) Require the player to use a tool to strike an object or target, and cause the object to travel a specific distance; or

(3) Require the object(s) to strike another object(s) to achieve the goal of the game.

NEW SECTION

WAC 230-13-045 Group 7—Crane amusement game standards. In Group 7 games, players maneuver a crane or claw mechanism to attempt to retrieve a prize. All crane amusement games must:

(1) Allow at least twenty seconds playing time per operation; and

(2) Have a crane or claw capable of reaching, picking up, and dispensing all prizes in the machine; and

(3) Have the machine controls clearly labeled as to their function; and

(4) Have prizes loose and not packed, arranged, lodged, or intertwined in the machine in any way that would prevent the crane or claw from picking up and dispensing the prize.

NEW SECTION

WAC 230-13-050 Group 8—Penny fall amusement game standards. In Group 8 games, players insert coins or tokens (coins) into a chute and aim the chute to win a prize. The coins land on a flat surface(s) which has sweeper and/or pusher arm(s) moving across the surface(s). Carefully aimed coins may cause coins on the flat surface(s) to be pushed or swept into holes or chutes which dispense tokens or tickets to the player.

(1) Coin fall games must:

(a) Have level surfaces and contain similar coins; and

(b) Have the outcome of the game determined by player's skill.

(2) Coin fall games may contain obstacles which if properly passed or struck by a coin, award additional tickets.

(3) If coin fall games have obstacles, operators must:

(a) Turn on the obstacles before the player inserts the coin; and

(b) Keep them on long enough to allow the player to attempt to strike or pass the obstacles.

(4) Operators may set merchandise prizes on the coins, tokens, or other surfaces in the game and if the prize is pushed into a hole or chute, then it is awarded to the player. All prizes must fit down the hole or chute.

NEW SECTION

WAC 230-13-055 Group 9—Ball roll amusement game standards. In Group 9 games, players roll balls to a target area to win a prize. Ball roll amusement games may be either:

(1) One player:

(a) Attempting to score a predetermined number of points by landing in a target area; or

(b) Striking and/or knocking down target(s); or

(2) More than one player:

(a) Attempting to score a predetermined number of points; or

(b) Striking and/or knocking down target(s); or

(c) Landing in a target area. The first player to achieve the goal wins a prize.

NEW SECTION

WAC 230-13-060 Group 10—Shooting amusement game standards. In Group 10 games, players use a mechanism to fire projectile(s) to hit target(s) to win prizes. In shooting amusement games:

(1) The game may require a player to:

(a) Destroy or obliterate all or part of the target; or

(b) Hit the target or specific portion of it; or

(c) Hold an electronic beam, light beam, or water stream on the target or portion of it to achieve a specific result.

(2) The projectiles may include pellets, BBs, corks, water, electronic beams, light beams, balls, or suction-cup darts.

(3) The targets may be stationary or mobile.

(4) Operators and players must comply with all safety requirements of the local city or county ordinances.

(5) A short range shooting gallery must give players, at least:

(a) Four shots to shoot out a target which has a diameter of one-quarter inch or less; or

(b) One shot at each target which they must strike. Targets must be at least one-half inch square and may include a bulls-eye section which players must shoot out without touching the outside of the target.

(6) "Shoot-out-the-star" games must give players at least one hundred projectiles in an automatic mechanism to shoot out a star which is no more than one and one-quarter inch from point to point.

(7) Operators may determine a winner and award a prize based on the number of players participating.

(8) If suction-cup darts are used in the game, players must receive another turn if the dart does not stick to the target area.

(9) If targets must be knocked over or off of a shelf, then the bases of the targets must be uniformly shaped front and rear.

(10) If players must destroy or obliterate all or part of a target to win, then the players must have the right to have the target brought to them and to visually inspect it at any time during the game or at the conclusion of the game.

NEW SECTION

WAC 230-13-065 Group 11—Cake walk and fish pond amusement game standards. Group 11 games are:

(1) Cake walk amusement games where players walk on a numbered or color-coded circle while music is played. When the music stops, a player wins a prize depending on the number or color of the portion of the circle the player is standing on; and

(2) Fish pond amusement games where players receive a prize each time they play by:

(a) Either hooking or capturing a fake fish floating in water or similar object with a number or symbol on the bottom. The number or symbol of the fish or object corresponds to a prize; or

(b) Having the operator place a prize directly onto the "line" or catching device of the player from behind a curtain or similar obstruction.

OPERATING AMUSEMENT GAMES

NEW SECTION

WAC 230-13-070 Notifying local law enforcement of amusement game operation. (1) Amusement game operators must notify the local law enforcement agency in writing at least ten days before operating amusement games at any location. The chief officer of the local law enforcement agency may reduce this time limit. The notice must include, at least:

(a) The name and address of the operator; and

(b) The name and address of the person managing the games at the location; and

(c) The date(s) and the location where the operator will conduct the amusement games.

(2) Operators must have all amusement game equipment available for inspection by local law enforcement or us at least the two hours before operating.

(3) Operators may place individual amusement games at locations where amusement games already exist without renotifying local law enforcement.

NEW SECTION

WAC 230-13-075 Assigning and reporting group numbers of authorized amusement games. Amusement game licensees must determine the authorized group number of each game and prepare a list of all games they plan to operate during each license year. They must submit this list to us with their activity report. The list must contain, at least, the name and group number of each game.

NEW SECTION

WAC 230-13-080 Operating coin or token activated amusement games. (1) Coin or token activated amusement games must have nonresetting coin-in meters, certified as accurate to within plus or minus one coin or token in one thousand plays, which stop play of the machine if the meter is removed or disconnected when operating at:

(a) Amusement parks; or

(b) Regional shopping malls; or

(c) Movie theaters; or

(d) Bowling alleys; and

(e) Miniature golf course facilities; and

(f) Skating facilities; and

(g) Amusement centers. "Amusement center" means a permanent location whose primary source of income is from the operation of ten or more amusement devices; and

(h) Restaurants; and

(i) Grocery or department stores. A "department or grocery store" means a business that offers the retail sale of a full line of clothing, accessories, and household goods, or a full line of dry grocery, canned goods, or nonfood items plus some perishable items, or a combination of these. A department or grocery store must have more than ten thousand

square feet of retail and support space, not including the parking areas; and

(j) Any premises that a charitable or nonprofit organization currently licensed to operate punch boards, pull-tabs, or bingo controls or operates.

(2) All coin or token activated amusement games must have a coin acceptor capable of taking money for one play and may have an additional acceptor to include paper money.

(3) Operators using amusement games that do not return change must have a change-making bill acceptor or the ability to get change in the immediate vicinity of such games. All amusement games using paper money acceptors must either:

(a) Return change; or

(b) Clearly disclose to the player before play that change is not returned and tell them where at the location they may get change.

NEW SECTION

WAC 230-13-085 Control and maintenance of amusement games. Amusement game operators must:

(1) Closely monitor and control all games to ensure they are operated according to all provisions of Title 230 WAC and chapter 9.46 RCW; and

(2) Protect players from fraud and game manipulation; and

(3) Maintain all games or machines in proper condition to ensure they comply with their authorized amusement game group.

NEW SECTION

WAC 230-13-090 Adult supervision of unattended amusement games. (1) Operators must provide adult supervision at all locations where school-aged minors are allowed to play amusement games during all hours of operation.

(a) "School aged minors" means anyone at least six, but not yet eighteen years old.

(b) An "unattended amusement game" means a game that does not require the player to interact with an attendant, for example, a coin activated game.

(2) An adult supervisor must ensure that school-age minors:

(a) Do not enter or play amusement games during school hours at regional shopping centers; and

(b) Do not enter or play amusement games during school hours at and after 10:00 p.m. on any day at any location mentioned in RCW 9.46.0331.

NEW SECTION

WAC 230-13-100 Material degree of skill required in amusement games. Amusement game operators must conduct games in which the outcome depends to a material degree on the skill of the player. We consider a "material degree of skill" to be present when both of these requirements are met:

(1) The player's physical or mental abilities play an important and integral role in determining the outcome of the game; and

(2) The success rate of the average player would improve with repeated play or practice.

NEW SECTION

WAC 230-13-105 Attended amusement game requirements. (1) Attendants of amusement games must, at least:

(a) Collect payment from the player(s); and

(b) Give equipment or components to the player(s) to participate in the game; and

(c) Award merchandise prize(s) to any winners.

(2) Attendants must not:

(a) Materially assist players; or

(b) Participate in the game.

NEW SECTION

WAC 230-13-110 Charitable or nonprofit amusement game operation and management. (1) Charitable and nonprofit organizations must closely supervise all persons operating their gambling activities according to all provisions of Title 230 WAC and chapter 9.46 RCW.

(2) Only full and regular members of charitable or nonprofit organizations may supervise or manage amusement games.

(3) Organizations may use nonmembers for positions that are not of a supervisory or management nature if the nonmembers are:

(a) Employees of the organization, hired on a regular or part-time basis, and employed primarily for purposes other than to conduct the activities; or

(b) Volunteers under the supervision of a member and not directly or indirectly compensated for their work.

NEW SECTION

WAC 230-13-115 "Limited location" license requirements. Amusement game licensees operating under a "limited location" license must assign each game a number and keep a list of all games and their booth numbers available in the operator's on-site office.

NEW SECTION

WAC 230-13-120 Posting amusement game rules. (1) Amusement game operators must fully inform players of game rules. They must prominently post a sign made of permanent material printed in lettering at least one and one-half inches in height that includes, at least:

(a) Fees charged for play; and

(b) Rules of play; and

(c) Prizes or number of tickets to be won; and

(d) Any variation in the size or weight of objects used in the game which is not readily visible to the player; and

(e) Name of the operator; and

(f) Booth number, if applicable; and

(g) Amusement game group number.

(2) For coin or token activated games, if all aspects of the activity are within four feet of the player, operators may use lettering smaller than one and one-half inches in height as

long as they prominently post the sign and make it legible to players. The operator must ensure that the manufacturer either:

(a) Preprints the sign and information on the machine; or

(b) Attaches it to the machine.

NEW SECTION

WAC 230-13-125 Factors affecting skill readily visible for amusement games. If there are physical limitations which affect the degree of skill needed to win a prize, the amusement game operator must make these factors readily visible to the player. For example, if a target, basket, or hoop used in the amusement game has a limiting feature, such as shape or size, the operator must prominently post a duplicate of the target, basket, or hoop which shows the limitation.

NEW SECTION

WAC 230-13-130 Display and exchange of amusement game prizes. (1) Amusement game operators must prominently display a sample of each type of prize available.

(2) Operators must only award prizes that are posted. However, after a player has won two or more prizes, operators may offer that player the opportunity to exchange those prizes for one or more other prizes, but only if that prize was on display during the play of the game.

(3) Operators must not allow winners to forfeit previously won prize(s) in exchange for another play.

(4) Operators may give winners tickets which winners may combine with other tickets won and redeem for a merchandise prize.

NEW SECTION

WAC 230-13-135 Maximum wagers and prize limitations at certain amusement game locations. The maximum wager is fifty cents and the maximum cost for a prize is two hundred fifty dollars if school-aged minors are allowed to play amusement games at the following locations:

(1) Regional shopping centers; and

(2) Movie theaters; and

(3) Bowling alleys; and

(4) Miniature golf course facilities; and

(5) Skating facilities; and

(6) Amusement centers; and

(7) Department or grocery stores within a regional shopping center as defined in WAC 230-13-090 (2)(b); and

(8) Any business whose primary activity is to provide food service for on premises consumption.

NEW SECTION

WAC 230-13-140 Price to play amusement games must be paid in cash or check. (1) Amusement game operators must charge cash or check for playing.

(2) Operators may accept tokens, scrip, or tickets, but only if:

(a) The equivalent value in cash for each token, scrip, or ticket is printed on the token, ticket, or scrip; and

(b) Tokens, tickets or scrip are not redeemable for cash; and

(c) Tickets or scrip show the name of the operator or sponsor.

NEW SECTION

WAC 230-13-145 Marking the difference between objects thrown in multiple amusement games on the same premises. Amusement game operators must not operate more than one game of a similar type on the same premises using similar objects of a different size or weight unless the difference in each game's objects is readily apparent.

AUTHORIZED LOCATIONS AND RENTAL OF AMUSEMENT GAMES OR PREMISES

NEW SECTION

WAC 230-13-150 Amusement game locations. (1) Amusement game operators must obtain written permission to operate at any location from the person or organization owning the premises or sponsoring the event where the operator will hold the activity.

(2) Operators may only conduct commercial amusement games at locations set out in RCW 9.46.0331.

(3) Operators must conduct amusement games in conformance with local zoning, fire, health, and similar regulations.

NEW SECTION

WAC 230-13-155 Contracts for commercial amusement games. (1) Operators must ensure that all contracts are written and specific in terms, setting out the term of the contract, amount of rent or consideration, rent due dates, and all expenses each party must pay.

(2) All contracts become part of the operator's license file. If commercial amusement game operators violate any terms of a contract, it may be grounds for suspension or revocation of their license.

(3) Class B or above licensees may enter into contracts with business owners of any of the following locations to operate amusement games on their premises:

(a) Amusement parks; or

(b) Regional shopping centers; or

(c) Any location that possesses a valid license from the Washington state liquor control board and prohibits minors on their premises; or

(d) Movie theaters; or

(e) Bowling alleys; or

(f) Miniature golf course facilities; or

(g) Skating facilities; or

(h) Amusement centers; or

(i) Department or grocery stores having more than ten thousand square feet of retail and support space, not including the parking areas; or

(j) Charitable or nonprofit organizations with a premises licensed for Class A amusement games; or

(k) Any commercial business that provides food service for on premises consumption as its primary activity.

(4) Operators must not place amusement games at a location which does not have a valid license.

NEW SECTION

WAC 230-13-160 Basing rent on a percentage of gross receipts. Class B or above amusement game operators:

(1) May base the rent or consideration paid to a Class A commercial amusement game location on a percentage of revenue the activity generates if the method of distribution is specific.

(2) May not base the rent or consideration paid to a charitable or nonprofit organization on a percentage of revenue the activity generates unless the amount returned to the organization is equal to or exceeds twenty-two percent of the gross gambling receipts. Operators must pay the organization at least once a month.

(3) If located at regional shopping centers, may use a percentage of receipts to pay rental leases. They are also exempt from the profits restrictions of RCW 9.46.120(2).

NEW SECTION

WAC 230-13-165 Charitable or nonprofit organizations renting amusement game equipment. Charitable or nonprofit organizations may rent or otherwise obtain amusement game equipment as long as the amount paid is:

(1) A reasonable price for the gambling equipment or for use of the gambling equipment; and

(2) A lump sum or hourly rate established in the competitive market; and

(3) Not based on a percentage of the gross receipts, income, or profit.

RECORDKEEPING FOR AMUSEMENT GAMES

NEW SECTION

WAC 230-13-170 Recordkeeping for commercial amusement games. (1) Amusement game licensees must prepare a detailed record for each location where they operate games. They must retain the records for at least three years. The records must include details necessary to determine:

(a) Gross gambling receipts received from players; and

(b) Value of prizes awarded to winners.

(2) Records must include, at least:

(a) The gross gambling receipts collected from amusement games at each location, with receipting records; and

(b) An entry for each withdrawal of receipts from the games. Coin or token activated amusement games only require an entry of the ending meter reading, the number of plays, and gross gambling receipts at the end of each month; and

(c) A summary of the operation of the activity. This includes, at least, coin-in meter readings and gross gambling receipts. Operators must provide these coin-in meter readings and gross gambling receipts to charitable or nonprofit organizations each time they service a game or disburse money.

(3) Licensees must report at least monthly the number and actual cost of merchandise prizes awarded for each location.

(4) For amusement games that issue tickets for the redemption of prizes, licensees must at least log the beginning and ending nonresettable ticket out meters or ticket numbers during each collection of funds from each game.

(5) Licensees must provide the full details for all amusement game operating expenses.

NEW SECTION

WAC 230-13-175 Recordkeeping for unlicensed charitable and nonprofit amusement games. (1) Unlicensed charitable or nonprofit organizations must keep records according to WAC 230-07-125 which will allow us to:

(a) Determine the amount of gross gambling receipts received from amusement games; and

(b) Identify individuals responsible for receiving and controlling them.

(2) Records must include, at least, the full names, addresses, and phone numbers of employees and members involved in the activity.

WSR 07-10-037

PROPOSED RULES

GAMBLING COMMISSION

[Filed April 24, 2007, 2:39 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-04-057.

Title of Rule and Other Identifying Information: New chapter 230-13 WAC, Amusement games [chapter 230-01 WAC, About the commission].

Hearing Location(s): La Quinta Inn and Suites, 1425 East 27th Street, Tacoma, WA 98421, (253) 383-0146, on July 13, 2007, at 9:30 a.m.

Date of Intended Adoption: July 13, 2007.

Submit Written Comments to: Susan Arland, P.O. Box 42400, Olympia, WA 98504-2400, e-mail Susan2@wsgc.wa.gov, fax (360) 486-3625, by July 1, 2007.

Assistance for Persons with Disabilities: Contact Shirley Corbett, Executive Assistant, by July 1, 2007, TTY (360) 486-3637 or (360) 486-3447.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The gambling commission is rewriting its rules manual using plain English techniques. We anticipate the project will be completed by January 1, 2008. The rules manual is being broken into sections and rewritten a section at a time. This filing is to provide notification that rules regarding the commission in general are under review and are now being rewritten in plain English.

Overview of chapter 230-01 WAC, About the commission changes

INDIVIDUAL RULE CHANGES:

Pre-January 1, 2008, WAC 230-02-010 Washington state gambling commission—Purpose and organization and 230-12-900 Deputy director. These pre-January 1, 2008 rules were originally written in 1973 to describe the newly formed commission; they gave a lot of detail about term limits and information that is contained in the Gambling Act at RCW 9.46.040 and 9.46.050. Because the RCW is so specific, we feel that these WAC rules can be removed.

Post-January 1, 2008 WAC 230-01-001 Time and place of public meetings. Chapter 34.05 RCW, the Administrative Procedure Act (APA), states requirements for public agencies to give proper notice of their public meetings. In our pre-January 1, 2008, WAC 230-02-020 Time and place of meetings, states, "giving at least two weeks advance notice, we normally hold regular public meetings monthly."

We propose dropping this "two week advance notice" language because we normally file all our meeting dates in December for the upcoming year, so we are exceeding what is called for by the APA.

Reasons Supporting Proposal: To make our rules manual more user friendly. To make rules easier to find and understand.

Statutory Authority for Adoption: RCW 9.46.070.

Statute Being Implemented: Not applicable.

Name of Proponent: Washington state gambling commission, governmental.

Name of Agency Personnel Responsible for Drafting: Susan Arland, Rules Coordinator, Lacey, (360) 486-3466; Implementation: Rick Day, Director, Lacey, (360) 486-3446; and Enforcement: Mark Harris, Assistant Director, Lacey, (360) 486-3579.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement has not been prepared pursuant to RCW 19.85.025 and/or the proposed rule change clarifies language of rules without changing the effect.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state gambling commission is not an agency that is statutorily required to prepare a cost-benefit analysis under RCW 34.05.328.

April 24, 2007
Susan Arland
Rules Coordinator

Chapter 230-01 WAC

ABOUT THE COMMISSION

NEW SECTION

WAC 230-01-001 Time and place of public meetings. (1) We normally file a schedule of meetings in January of each year with the code reviser's office.

(2) We hold montyly two-day meetings beginning on the second Thursday and Friday of the month at a time and place we set.

(3) We may call additional public meetings as necessary to accomplish our business.

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

NEW SECTION

WAC 230-01-005 Address and hours of administrative offices. (1) Our administrative office is located in Lacey, Washington.

Mailing Address	Location Address
Washington State Gambling Commission P.O. Box 42400 Olympia, WA 98504-2400	Washington State Gambling Commission 4565 7th Avenue S.E. Lacey, WA 98503

(2) Normal business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays.

(3) Services available are:

(a) Administration;

(b) Information;

(c) Licensing;

(d) Investigation;

(e) Activity report processing; and

(f) Public records.

(4) Address applications for licenses, required license materials, or requests for notices, information, or other inquiries to our mailing address.

NEW SECTION

WAC 230-01-010 Field offices and operations. Direct regulatory and operational questions to our field offices, located at:

City	Telephone Number
Eastern Region North 901 Monroe Room 240 Spokane, WA 99201	509-325-7900
1703 Creekside Loop Suite 120 Yakima, WA 98902	509-575-2820
Northwest Region 3501 Colby Avenue Suite 102 Everett, WA 98201	425-304-6300
451 Southwest 10th Street Plaza 451 Building Suite 218 Renton, WA 98057	425-277-7014
Southwest Region Tacoma Mall Office Building 4301 South Pine Street Suite 307 Tacoma, WA 98409	253-671-6280

NEW SECTION

WAC 230-01-015 Effective dates for rule-making orders. (1) Rules adopted December through May become effective July 1.

(2) Rules adopted June through November become effective January 1.

(3) The commission may specify earlier or later effective dates. The earliest a rule may become effective is thirty-one days after filing with the code reviser's office as explained in RCW 34.05.380(3).

(4) Rules adopted under emergency rule making must specify an effective date as explained in RCW 34.05.350.

NEW SECTION

WAC 230-01-020 Commission activities exempt from State Environmental Protection Act. The commission has reviewed its authorized activities and has found them to be exempt pursuant to WAC 197-10-040(2), 197-10-150 through 197-10-190 and the State Environmental Policy Act, chapter 43.21C RCW.

NEW SECTION

WAC 230-01-025 Definitions used in Title 230. Words and terms used in these rules have the same meaning as they have in chapter 9.46 RCW, unless otherwise provided in these rules.

WSR 07-10-040
PROPOSED RULES
COMMISSION ON JUDICIAL CONDUCT

[Filed April 25, 2007, 10:36 a.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: CJCRP - Terminology and Rule 11 - Confidentiality, adds definition of "Court Personnel" and significantly reduces what could be construed as overly broad prohibitions on free speech upon those not involved with the court system while retaining the prohibitions on and protections of court employees.

Hearing Location(s): Evergreen Room, Holiday Inn Express Hotel & Suites, 19621 International Boulevard, SeaTac, WA 98188, on June 8, 2007, at 11:00 a.m.

Date of Intended Adoption: June 8, 2007.

Submit Written Comments to: J. Reiko Callner, P.O. Box 1817, Olympia, WA 98507, e-mail rcallner@cjc.state.wa.us, fax (360) 586-2918, by June 1, 2007.

Assistance for Persons with Disabilities: Contact Kathy Sullivan by June 1, 2007, TTY (360) 753-4585.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: CJCRP - Terminology and Rule 11 - Confidentiality, adds definition of "Court Personnel" and significantly reduces what could be construed as overly broad prohibitions on free speech upon those not involved with the court system while retaining the prohibitions on and protections of court employees. The existing rule restrains all parties outside the commission from disclosing the existence of a pending investigation. This amendment narrows the prohibition to apply only to those who work within the court system. It more narrowly tailors the confidentiality rule to its dual purposes of (1) safeguarding judicial independence against dissemination of frivolous or unsubstantiated complaints, while (2) maintaining judicial integrity, and offering protection to court personnel who cooperate with the commission from the potential for retaliation.

Statutory Authority for Adoption: WA Const. Art IV. Sec. 31.

Statute Being Implemented: Chapter 2.64 RCW.

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: Clarifies Rule 11; no significant fiscal impact beyond minor printing costs.

Name of Proponent: Commission on judicial conduct, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: J. Reiko Callner, 210 11th Avenue S.W., #400, Olympia, WA 98501, (360) 753-4585.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No small business impact statement is required for this proposal by chapter 19.85 RCW. The rules are procedural in nature.

A cost-benefit analysis is not required under RCW 34.05.328. Does not apply. No significant fiscal impact.

April 25, 2007
J. Reiko Callner
Executive Director

AMENDATORY SECTION (Amending 06-01 filed 4/9/07)

TERMINOLOGY

"Court Personnel" means employees of the court, including judges, administrators, independently contracted court staff, regular court staff; county clerks and clerk employees; and attorneys.

RULE 11. CONFIDENTIALITY

(a) Investigative and initial proceedings.

(1) Before the commission files a statement of charges alleging misconduct by or incapacity of a judge, all proceedings, including commission deliberations, investigative files, records, papers and matters submitted to the commission, shall be held confidential by the commission, disciplinary counsel, investigative officers, and staff except as follows:

(A) With the approval of the commission, the investigative officer may notify respondent that a complaint has been received and may disclose the name of the person making the complaint to respondent pursuant to Rule 17(e).

(B) The commission may inform a complainant or potential witness of the date when respondent is first notified that a complaint alleging misconduct or incapacity has been filed

with the commission. The name of the respondent, in the discretion of the commission, may not be used in written communications to the complainant.

(C) The commission may disclose information upon a waiver in writing by respondent when:

(i) Public statements that charges are pending before the commission are substantially unfair to respondent; or

(ii) Respondent is publicly accused or alleged to have engaged in misconduct or with having a disability, and the commission, after a preliminary investigation, has determined that no basis exists to warrant further proceedings or a recommendation of discipline or retirement.

(D) The commission has determined that there is a need to notify another person or agency in order to protect the public or the administration of justice.

(2) The commission and court personnel shall keep the fact that a complaint has been made, or that a statement has been given to the commission, ~~shall be~~ confidential during the investigation and initial proceeding except as provided under Rule 11.

(3) No person providing information to the commission shall disclose information they have obtained from the commission concerning the investigation, including the fact that an investigation is being conducted, until the commission files a statement of charges, dismisses the complaint, or otherwise concludes the investigation or initial proceeding.

(b) Hearings on statement of charges.

(1) After the filing of a statement of charges, all subsequent proceedings shall be public, except as may be provided by protective order.

(2) The statement of charges alleging misconduct or incapacity shall be available for public inspection. Investigative files and records shall not be disclosed unless they formed the basis for probable cause. Those records of the initial proceeding that were the basis of a finding of probable cause shall become public as of the date of the fact-finding hearing.

(3) Disciplinary counsel's work product shall be confidential.

(c) Commission deliberations. All deliberations of the commission in reaching a decision on the statement of charges shall be confidential.

~~**(d) General Exceptions.**~~

~~(1) A complainant may inform any third party, or the public generally, of the factual basis of his or her complaint.~~

~~(2) Any person, other than a complainant, who gives a statement to the commission, may inform any third party, or the public generally, of the factual basis of such statement.~~

~~(e)~~ (d) General Applicability.

(1) No person shall disclose information obtained from commission proceedings or papers filed with the commission, except that information obtained from documents disclosed to the public by the commission pursuant to Rule 11 and all information disclosed at public hearings conducted by the commission are not deemed confidential under Rule 11.

(2) Any person violating Rule 11 may be subject to a proceeding for contempt in superior court.

(3) A judge shall not intimidate, coerce, or otherwise attempt to induce any person to disclose, conceal or alter records, papers, or information in violation of Rule 11. Violation of Rule 11 ~~(e)~~(d)(3) may be charged as a separate violation of the Code of Judicial Conduct.

(4) If the commission or its staff initiates a complaint under Rule 17 (b)(1), then Rule 11 (a)(1) as it applies to the commission~~, rather than those applicable to complainants,~~ shall govern the commission and its staff.

(5) These confidentiality rules also apply to former commission members, disciplinary counsel, investigative counsel and staff with regard to information they had access to while serving the commission.

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Commission on Judicial Conduct and appear in the Register pursuant to the requirements of RCW 34.08.040.

WSR 07-10-045
PROPOSED RULES
WHATCOM COMMUNITY COLLEGE

[Filed April 26, 2007, 8:47 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-06-087.

Title of Rule and Other Identifying Information: Chapter 132U-03 WAC, Organization; chapter 132U-104 WAC, Board of trustees—Bylaws—Meetings; and chapter 132U-280 WAC, Family Educational Rights and Privacy Act (FERPA).

Hearing Location(s): Whatcom Community College, Laidlaw Center Boardroom, 237 West Kellogg Road, Bellingham, WA 98226, on Thursday, June 28, 2007, at 3:00 p.m.

Date of Intended Adoption: July 11, 2007.

Submit Written Comments to: Bets Nelson, 237 West Kellogg Road, Bellingham, WA 98226, e-mail bnelson@whatcom.ctc.edu, fax (360) 676-2171, by June 18, 2007.

Assistance for Persons with Disabilities: Contact Bill Culwell, Disabilities Support Director, by June 18, 2007, TTY (360) 647-3279 or (360) 676-2170 ext. 3320.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To revise location of campus operations; add reference to web site for information; change board of trustees' meetings; update FERPA.

Reasons Supporting Proposal: New buildings on the WCC campus require changes to locations of operations; new technology, specifically a web site is a new source of public information; a new board of trustees has changed the day they will meet; technology and college practices require revisions to the FERPA chapter.

Statutory Authority for Adoption: RCW 28B.50.130 and 28B.50.140.

Rule is necessary because of federal law, Family Educational Rights and Privacy Act.

Name of Proponent: Whatcom Community College, governmental.

Name of Agency Personnel Responsible for Drafting: Bets Nelson, 237 West Kellogg Road, Bellingham, WA 98226, (360) 676-2170 ext. 3275; Implementation and Enforcement: Patricia Onion, 237 West Kellogg Road, Bellingham, WA 98226, (360) 676-2170 ext. 3276.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No monetary implications are attached to this policy. No costs imposed on small business through adoption of these rule amendments.

A cost-benefit analysis is not required under RCW 34.05.328. No economic impact. Rules relate to internal college operations.

April 25, 2007
Patricia Onion
Vice President for
Educational Services

AMENDATORY SECTION (Amending WSR 90-05-043, filed 2/15/90, effective 3/18/90)

WAC 132U-03-020 Organization—Operation—Information. (1) Organization. Whatcom Community College is established in Title 28B RCW as a public institution of higher education. The institution is governed by a five-member board of trustees, appointed by the governor. The board employs a president, who acts as the chief executive officer of the institution. The president establishes the structure of the administration.

(2) Operation. The administrative office of Whatcom Community College is at the following address:

237 West Kellogg Road
Bellingham, Washington 98226

The office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, except legal holidays. ((~~Educational operations are also located at the following addresses~~))

((~~245 Marine Drive~~))
((~~Blaine, Washington 98230~~))

((~~1600 Grover Street~~))
((~~Lynden, Washington 98264~~))

(3) Information. Additional and detailed information concerning the educational offerings may be obtained from the College website or catalog, copies of which are available at the following address:

((~~Admissions Office~~))
Entry and Advising Center
Whatcom Community College
237 West Kellogg Road
Bellingham, Washington 98226

AMENDATORY SECTION (Amending WSR 90-05-043, filed 2/15/90, effective 3/18/90)

WAC 132U-03-030 Rules coordinator. The rules coordinator for this institution shall have an office located at the office of the ((~~president~~)) Vice President for Educational Services, with the following mailing address:

((~~Office of the President~~))
Educational Services Office
Whatcom Community College
237 West Kellogg Road
Bellingham, WA 98226

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-104-030 Meetings of the board of trustees. The board customarily holds monthly meetings on the second ((~~Tuesday~~)) Wednesday of each month at such place as it may designate. Notices of the time and place of all regular and special meetings shall be governed by the requirements of chapter 42.30 RCW Open Public Meetings Act.

Chapter 132U-280 WAC

FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT Last Update: 7/8/88 WAC

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

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-010 ((~~Confidentiality of student records~~)) Purpose. The college continually receives requests from outside sources for information about students, both past and present. ((~~The staff and faculty of the college are reminded that~~)) Under the authority of 20 U.S.C. 1232(g), the Family Educational Rights and Privacy Act (FERPA) of 1974, as amended, directs the college to adopt a policy on student education records to insure that information contained in such records is treated in a responsible manner with due regard to the personal nature of the information contained in those records. ((~~In order to prevent embarrassment or possible legal involvement of the college and its employees because of improper disclosure of information, it is important that college policy be implemented in the release of such information.~~)) The college shall annually notify students currently in attendance of their rights under this Act.

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-015 Definitions. ((~~of a student. A~~)) (1)(a) The term "education records" shall mean those records that are directly related to a student and maintained by the college.

(b) The term "education records" does not mean:

(i) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.

(ii) Records related to a person who is employed by the college, are made and maintained in the normal course of

business, relate exclusively to such person in that person's capacity as an employee, and are not available for any other use.

(iii) Records on a student which are created or maintained by a physician, psychiatrist, psychologist or other recognized professional or paraprofessional acting in his or her professional capacity, or assisting in a paraprofessional capacity and which are created, maintained or used only in connection with the treatment of the student, and are not available to anyone other than persons providing such treatment; provided, however, that such records can be personally reviewed by a physician or other appropriate professional of the student's choice. For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are part of the program of instruction at the college.

(iv) Records that only contain information about an individual after he or she is no longer a student.

(v) The college does not maintain confidential educational records regarding student political or ideological beliefs or associations.

(c) "Student" is defined as any person who is or has been officially registered at Whatcom Community College ((~~and with respect to~~)) for whom the college maintains education records or personally identifiable information.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-020 ((~~Education records —~~))Student's right to inspect and review records. (1) A student has the right to inspect and review his or her education records.

(((~~(a) For purposes of this section the term "education records" means those records, files, documents, and other materials which contain information directly related to a student.~~

~~(b) The term "education records" does not include:~~

~~(i) Records of instructional, supervisory and administrative personnel which exist solely for the use of the maker and which are not accessible or revealed to any other person except a substitute.~~

~~(ii) In the case of persons who are employed by an educational institution but who are not attending that institution, records made and maintained in the normal course of business which relate exclusively to such person in that person's capacity as an employee and are not available for any other use.~~

~~(iii) Records on a student which are created or maintained by a physician, psychiatrist, psychologist or other recognized professional or paraprofessional acting in his or her professional or paraprofessional capacity, or assisting in that capacity and which are created, maintained or used only in connection with the treatment of the student, and are not available to anyone other than persons providing such treatment; provided, however, that such records can be personally reviewed by a physician or other appropriate professional of the student's choice.~~

~~(2)(a) Recommendations, evaluations or comments concerning a student that are provided in confidence, either expressed or implied, as between the author and the recipient, shall be made available to the student, except as provided in (b), (c), and (d) of this subsection.~~

~~(b) The student may specifically release his right to review where the information consists only of confidential recommendations respecting:~~

~~(i) Admission to any educational institution; or~~

~~(ii) An application for employment; or~~

~~(iii) Receipt of an honor or honorary recognition.~~

~~(c) A student's waiver of his or her right of access to confidential statements shall apply only if:~~

~~(i) The student is, upon request, notified of the names of all persons making confidential statements concerning him, and~~

~~(ii) Such confidential statements are used solely for the purpose for which they were originally intended, and~~

~~(iii) Such waivers are not required as a condition for admission to, receipt of financial aid from, or receipt of any other services or benefits from the college.~~

~~(d) Recommendations, evaluations or comments concerning a student that have been provided in confidence, either expressed or implied, as between the author and the recipient, prior to January 1, 1975, shall not be subject to release under (a) of this subsection. Such records shall remain confidential and shall be released only with the consent of the author. Such records shall be used by the institution only for the purpose for which they were originally intended.~~

~~(3) Where requested records or data include information on more than one student, the student shall be entitled to receive or be informed of only that part of the record or data that pertains to the student.~~))

(((~~(4)~~))) (2) ((~~Students have the right to obtain~~)) If circumstances prevent the student from inspecting and reviewing his or her records, the college shall provide copies of the((~~ir~~)) education records. Charges for the copies shall not exceed the cost normally charged by the college (except in cases where charges have previously been approved by the boards of trustees' action for certain specified services((~~, such as~~)); e.g. official transcripts. ((~~and grade sheets).~~))

(((~~(5) The college registrar is the official custodian of academic records and therefore is the only official who may issue a transcript of the student's official academic record.~~))

(3) Limitations on right to inspect and review records.

(a) If the education records of a student contain information on more than one student, the student may inspect and review or be informed of only the specific information about that student.

(b) The college does not have to permit a student to inspect and review education records that are:

(i) Financial records, including any information those records contain about a student's parents.

(ii) Confidential letters and confidential statements of recommendation placed in the student's education records, if:

(1) The student has waived his or her right to inspect and review those letters and statements; and

(2) Those letters and statements are related to the students admission to an education institution, application for employment, or receipt of an honor or honorary recognition.

(c) A waiver under paragraph (b)(ii) of this section is valid only if:

(i) The college does not require the waiver as a condition for admission to or receipt of a service or benefit from the agency or institution; and

(ii) The waiver is made in writing and signed by the student, regardless of age.

(d) If a student has waived his or her rights under paragraph (b)(ii)(2) of this section, the college shall:

(i) Give the student, on request, the names of the individuals who provided the letters and statements of recommendation; and

(ii) Use the letters and statements of recommendation only for the purpose for which they were intended.

(e) A waiver under paragraph (b)(ii)(2) of this section may be revoked, in writing, with respect to any actions occurring after the revocation.

((~~(6)~~)) (4) Student education records may be destroyed in accordance with ((~~a department's~~)) the college's routine retention schedule. However, in no case will any record which ((~~is requested~~)) exists at the time the request is made by a student for review in accordance with this section and WAC 132U-280-025 be removed or destroyed prior to providing the student access.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-025 Request((~~s and~~)) to amend education records - appeal procedure((~~s~~)). (1) A request by a student ((~~for review of information~~)) to amend an education record should be made in writing to the college individual ((~~or office~~)) who created the record or, if no longer employed by the college, the department having custody of the ((~~particular~~)) record.

(2) An individual or ((~~office~~)) department must respond to a request ((~~for~~)) to amend education records within a reasonable period of time, but in no case more than ((~~thirty~~)) forty five days after the request has been made. A college individual or ((~~office which is unable to comply with~~)) department that denies a student's request or is unable to comply with the request within the above-state time period shall inform the student of that fact and the reasons in writing.

(3)(a) A student who feels that his or her request has not been properly answered by a particular individual or ((~~office~~)) department or who feels that the information contained in those records is incorrect should contact the appropriate ((~~dean~~)) supervisor responsible for the individual or ((~~office~~)) department for mediation.

(b) In cases where a student remains dissatisfied after consulting with the appropriate ((~~dean~~)) supervisor, the student may then request a hearing by the appropriate vice president or his or her designee(s). If the vice president is also the supervisor who handled the matter in (3)(a), it will be referred to another vice president who does not have a direct interest in the outcome of the hearing. Following the hearing, the hearing officer shall render his or her decision, in writing, within a reasonable period of time. In all cases, the decision of the hearing officer shall be final.

(c) In no case shall any ((~~request for review~~)) appeal by a student be considered by the college which has not been filed with that body in writing within ninety days from the date of the initial request to the custodian of the record.

(d) The college shall not review any matter regarding the appropriateness of official academic grades or disciplinary records beyond that provided for in WAC 132U-120-2100, et seq.

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-030 Release of ((~~personally identifiable~~)) education records. (1) The college shall not permit access to or ((~~the~~)) release of education records or personally identifiable information contained therein, ((~~other than "directory information"~~)) without the written consent of the student, to any party other than the ((~~following~~)) student.

(2) The college may permit access or release of education records, without student consent, under the following conditions:

(a) College ((~~staff, faculty and students when officially appointed to a faculty council or administrative committee,~~)) officials, when the information is required for a legitimate educational interest within the performance of their responsibilities to the college, with the understanding that its use will be strictly limited to the performance of those responsibilities. College officials will be defined by college policy and made public through the college's annual Notification of Student Rights under FERPA, which will be published in the college catalog and on the college's public website.

(b) Federal and state officials requiring access to education records in connection with the audit and evaluation or a federally or state-supported education program or in connection with the enforcement of the federal or state legal requirements which relate to such programs. In such cases the information required shall be protected by the federal or state official in a manner which will not permit the personal identification of students and their parents to other than those officials and such personally identifiable data shall be destroyed when no longer needed for such audit, evaluation or enforcement of legal requirements.

(c) ((~~Agencies or individuals~~)) Agency officials requesting information in connection with a student's application for, or receipt of financial aid((~~.~~)), if the information is necessary to determine eligibility, amount or conditions of aid, or to enforce the terms and conditions of aid.

(d) Organizations conducting studies for or on behalf of the college for purposes of developing, validating or administering predictive tests, administering student aid programs, and improving instruction, if such studies are conducted in such a manner as will not permit the personal identification of students by persons other than representatives of such organizations, and such information will be destroyed when no longer needed for the purposes for which it was provided.

(e) Accrediting organizations in order to carry out their accrediting functions.

(f) Any person or entity designated by judicial order or lawfully issued subpoena or court order, upon condition that the student is notified of all such ((~~orders or~~)) subpoenas or court orders in advance of the compliance therewith((~~.~~)); except for subpoenas or court orders that specifically direct the college not to disclose the existence or contents of the subpoena or court order. Any college individual(s) or ((~~office~~)) department(s) receiving a subpoena or ((~~judicial~~)) court order for education records should immediately notify the ((~~attorney general~~)) college registrar who will contact the college's assigned attorney general for assistance.

(g) Certain items of personally identifiable information, commonly referred to as "directory" information, to parties who demonstrate a legitimate educational interest, as determined by the college. Directory information will be defined by college policy and made public through the college's annual Notification of Student Rights under FERPA, which will be published in the college catalog and on the college's public website.

(h) Officials from the U.S. Department of Defense for the purpose of military recruiting, as authorized under 32 CFR Part 216 (Solomon Amendment), which requires the college to provide "student recruitment directory information" regarding students at least 17 years of age who are registered for at least one credit. Students who have formally requested the college withhold "directory information" are excluded.

(i) Any other officials with legitimate educational interest as authorized under CFR 99.31 and identified via the annual Notification of Student Rights under FERPA, which is published in the college catalog and on the college public website.

(3) In cases where records are made available without student release as permitted by subsection ((~~(1)~~)) (2)(b), (c), (d), (e), ((~~and~~)) (f) and (i) of this section, the college shall maintain a record kept with the education record released which will indicate the parties which have requested or obtained access to a student's records maintained by the college and which will indicate the legitimate interest of the investigating party. Releases in accordance with subsection ((~~(1)~~)) (2)(a) (g) and (h) of this section need not be recorded.

((~~(2)~~)) (4) Where the consent of a student is obtained for the release of education records, it shall be in writing, signed and dated by the ((~~person~~)) student giving such consent, and shall include:

(a) A specification of the records to be released;

(b) The reasons for such release; and

(c) The names of the parties to whom such records will be released.

((~~(4)~~)) (5) Personally identifiable education records released to third parties, with or without student consent, shall be accompanied by a written statement indicating that the information cannot be subsequently released in a personally identifiable form to any other parties without obtaining consent of the student.

(((5) ~~The term "directory information" used in subsection (1) of this section is defined as student's name, address, telephone number, dates of attendance, and degrees and awards received. Students may request that the college withhold directory information except through written notice to the registration office.~~))

(6) Students may direct the college to withhold "directory" information, referred to in (2)(g) and (h), through written notification to the college registrar at any time throughout the student's enrollment at the college.

((~~(6)~~)) (7) Information from education records may be released by a college official to appropriate persons in connection with an emergency if the knowledge of such information is necessary to protect the health or safety of a student or other person(s).

(8) The college registrar is the official custodian of education records and is the only official who can issue an official transcript of the student's academic record.

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

AMENDATORY SECTION (Amending WSR 88-15-005, filed 7/8/88)

WAC 132U-280-035 College ((~~records~~)) compliance. ((~~All~~)) The college ((~~individuals or offices having custody of education records~~)) will develop policies and procedures ((~~in accord with WAC 132U-280-010 through 132U-280-040.~~)) to implement WAC 132U-280 and all college individuals or offices having custody of education records will comply with those policies and procedures. ((~~Any supplementary regulations found necessary by departments will be filed with~~)) The college ((~~which~~)) will be responsible for periodic review of all related polic((~~y~~))ies and procedures.

((~~No records shall be kept that reflect a student's political or ideological beliefs or associations.~~))

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

WSR 07-10-072

WITHDRAWAL OF PROPOSED RULES

DEPARTMENT OF LICENSING

(By the Code Reviser's Office)

[Filed May 1, 2007, 9:29 a.m.]

WAC 308-13-230, proposed by the department of licensing in WSR 06-21-061 appearing in issue 06-21 of the State Register, which was distributed on November 1, 2006, is withdrawn by the code reviser's office 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 07-10-073
WITHDRAWAL OF PROPOSED RULES
DEPARTMENT OF HEALTH
(By the Code Reviser's Office)
[Filed May 1, 2007, 9:29 a.m.]

WAC 246-817-450 and 246-817-460, proposed by the department of health in WSR 06-21-105 appearing in issue 06-21 of the State Register, which was distributed on November 1, 2006, is withdrawn by the code reviser's office 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 07-10-074
WITHDRAWAL OF PROPOSED RULES
DEPARTMENT OF LICENSING
(By the Code Reviser's Office)
[Filed May 1, 2007, 9:29 a.m.]

WAC 308-12-230, proposed by the department of licensing in WSR 06-21-109 appearing in issue 06-21 of the State Register, which was distributed on November 1, 2006, is withdrawn by the code reviser's office 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 07-10-077
PROPOSED RULES
BOARD OF ACCOUNTANCY
[Filed May 1, 2007, 11:22 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-05-076.

Title of Rule and Other Identifying Information: WAC 4-25-510 What is the board's meeting schedule and how are officers elected?

Hearing Location(s): Hilton Seattle Airport & Conference Center, 17620 Pacific Highway South, SeaTac, WA, on June 15, 2007, at 8:00 a.m.

Date of Intended Adoption: June 15, 2007.

Submit Written Comments to: Richard C. Sweeney, Executive Director, P.O. Box 9131, Olympia, WA 98507-9131, e-mail webmaster@cpaboard.wa.gov, fax (360) 664-9190, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Cheryl Sexton by June 4, 2007, TTY (800) 833-6384 or (360) 664-9194.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The board proposes adding some flexibility to the rule to allow the board to schedule meetings on dates other than the last Friday of the months of January, April, July, and October.

Reasons Supporting Proposal: The annual meeting of the National Association of State Boards of Accountancy (NASBA) often falls within days of the board's annual meeting in October creating scheduling conflicts for board members and staff.

Statutory Authority for Adoption: RCW 18.04.055, 42.30.070.

Statute Being Implemented: RCW 18.04.055, 42.30.070.

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

Name of Proponent: Primarily the Washington state board of accountancy, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Richard C. Sweeney, CPA, Olympia, Washington, (360) 586-0163.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule(s) will not have more than minor economic impact on business.

A cost-benefit analysis is not required under RCW 34.05.328. The board of accountancy is not one of the agencies required to submit to the requirements of RCW 34.05.328.

May 1, 2007
Richard C. Sweeney, CPA
Executive Director

AMENDATORY SECTION (Amending WSR 05-01-137, filed 12/16/04, effective 1/31/05)

WAC 4-25-510 What is the board's meeting schedule and how are officers elected? Regular board meetings begin at 9:00 a.m. on the last Friday of the month in the months of January, April and July or a otherwise determined by the board. The board holds an annual meeting beginning at 9:00 a.m. on the last Friday of October or a otherwise determined by the board.

The board consists of nine members. At the annual meeting the board elects the chair, vice-chair, and secretary from its members. The newly elected officers assume the duties of their offices on January 1 following the annual board meeting. Officers serve a term of one year and can be reelected for one additional term.

Either the chair or a quorum of the board has the authority to call meetings of the board. The chair presides at all meetings. In the event of the chair's absence or inability to act, the vice-chair presides. The board determines other duties of the officers.

The board's meetings are open public meetings conducted pursuant to chapter 42.30 RCW. WAC 4-25-521 provides information on how to contact the board's office for meeting times and locations or additional information regarding the board's activities.

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

WSR 07-10-078
PROPOSED RULES
BOARD OF ACCOUNTANCY
[Filed May 1, 2007, 11:23 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-05-005 [07-03-088].

Title of Rule and Other Identifying Information: WAC 4-25-530 Fees.

Hearing Location(s): Hilton Seattle Airport & Conference Center, 17620 Pacific Highway South, SeaTac, WA, on June 15, 2007, at 8:00 a.m.

Date of Intended Adoption: June 15, 2007.

Submit Written Comments to: Richard C. Sweeney, Executive Director, P.O. Box 9131, Olympia, WA 98507-9131, e-mail webmaster@cpaboard.wa.gov, fax (360) 664-9190, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Cheryl Sexton by June 4, 2007, TTY (800) 833-6384 or (360) 664-9194.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To increase the section fees charged to candidates applying to take the uniform certified public accountant (CPA) examination and eliminate the fee charges to transfer grades to another jurisdiction.

Reasons Supporting Proposal: The CPA examination providers, the American Institution of Certified Public Accountants (AICPA), the National Association of State Boards of Accountancy (NASBA), and Prometric, the testing centers used to administer the computer-based CPA exam have notified the board of a forthcoming increase of all CPA exam fees:

AICPA - $80.00 per section (increase from the current $65.00 per section).

NASBA - $18.00 per section (increase from the current $15.00).

Prometric - $23.85 per test hour (increase from current $23.11 per test hour), plus $4.00 per section (increase from current $3.00 per section).

These fee increases will become effective with ATTs (Authorizations to Test) submitted August 18, 2007. The board must therefore increase the fees it charges for the administration of the CPA examination to adequately pay all costs.

Additionally, the board is proposing to eliminate the fee the board charges to process transfer of grades. This fee has caused confusion and therefore additional staff time to process requests for exchange of information between jurisdictions. The cost outweighs the benefit.

Statutory Authority for Adoption: RCW 18.04.065, 18.04.105(3).

Statute Being Implemented: RCW 18.04.065, 18.04.105 (3).

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

Name of Proponent: Washington state board of accountancy, government; AICPA, private; NASBA, private; Prometric, private.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Richard C. Sweeney, P.O. Box 9131, Olympia, WA 98507-9131, (360) 586-0163.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule will not have more than minor economic impact on business.

A cost-benefit analysis is not required under RCW 34.05.328. The board of accountancy is not one of the agencies required to submit to the requirements of RCW 34.05.-328.

May 1, 2007
Richard C. Sweeney
Executive Director

AMENDATORY SECTION (Amending WSR 06-14-030, filed 6/27/06, effective 8/1/06)

WAC 4-25-530 Fees. The board shall charge the following fees:

(1)	Initial application for individual license, practice privilege, individual license through reciprocity, CPA firm license (sole proprietorships with no employees are exempt from the fee), or registration as a resident nonlicensee firm owner	$330
(2)	Renewal of individual license, CPA-Inactive certificate, practice privilege, CPA firm license (sole proprietorships with no employees are exempt from the fee), or registration as a resident nonlicensee firm owner	$230
(3)	Application for CPA-Inactive certificateholder to convert to a license	$0
(4)	Application for reinstatement of license, practice privilege, CPA-Inactive certificate, or registration as a resident nonlicensee owner	$480
(5)	Quality assurance review (QAR) program fee (includes monitoring reviews for up to two years)	
	Firm submits reports for review	$400
	Firm submits a peer review report for review	$60
	Firm is exempted from the QAR program because the firm did not issue attest reports	$0
(6)	Late fee	$100
(7)	Amendment to firm license except for a change of firm address (there is no fee for filing a change of address)	$35

(8)	Copies of records, per page exceeding fifty pages	$0.15
(9)	Computer diskette listing of licensees, CPA-Inactive certificateholders, grants of practice privilege, registered resident nonlicensee firm owners, or firms	$75
(10)	Replacement CPA wall document	$50
(11)	~~Process transfer of grades~~	~~$35~~
~~(12)~~	Dishonored check fee (including, but not limited to, insufficient funds or closed accounts)	$35
(12~~3~~)	CPA examination. Exam fees are comprised of section fees plus administrative fees. **The total fee is contingent upon which section(s) is/are being applied for and the number of sections being applied for at the same time.** The total fee is the section fee(s) for each section(s) applied for added to the administrative fee for the number of section(s) applied for.	
(a)	Section fees:	
(i)	Auditing and attestation	$~~187.00~~ 209.33
(ii)	Financial accounting and reporting	$~~175.44~~ 197.40
(iii)	Regulation	$~~152.33~~ 173.55
(iv)	Business environment and concepts	$~~140.78~~ 161.63

		1/1/04 - 12/31/06	**After 1/1/07**
(b)	Administrative fees:		
(i)	First-time candidate - Four sections	$124.50	$132.95
(ii)	First-time candidate - Three sections	$111.00	$119.10
(iii)	First-time candidate - Two sections	$97.00	$104.70
(iv)	First-time candidate - One section	$83.00	$90.30
(v)	Reexam candidate - Four sections	$122.50	$130.75
(vi)	Reexam candidate - Three sections	$104.00	$111.40
(vii)	Reexam candidate - Two sections	$85.00	$91.50
(viii)	Reexam candidate - One section	$66.00	$71.60
	National Association of State Boards of Accountancy candidate data base investigation fee for exam applications submitted without the applicant's Social Security number	$70	$70

Note: The board may waive late filing fees for individual hardship including, but not limited to, financial hardship, critical illness, or active military deployment.

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

WSR 07-10-079
PROPOSED RULES
BOARD OF ACCOUNTANCY

[Filed May 1, 2007, 11:31 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-17-014.

Title of Rule and Other Identifying Information: WAC 4-25-820 What are the requirements for participating in quality assurance review (QAR)?

Hearing Location(s): Hilton Seattle Airport & Conference Center, 17620 Pacific Highway South, SeaTac, WA, on June 15, 2007, at 8:00 a.m.

Date of Intended Adoption: June 15, 2007.

Submit Written Comments to: Richard C. Sweeney, Executive Director, P.O. Box 9131, Olympia, WA 98507-9131, e-mail webmaster@cpaboard.wa.gov, fax (360) 664-9190, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Cheryl Sexton by June 4, 2007, TTY (800) 833-6384 or (360) 664-9194.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The current rule refers to attest standards but limits the QAR program to review of only reports and historical financial statement presentations (audit, review, or compilation) in accordance with generally accepted accounting principles (GAAP) or an other comprehensive basis of accounting (OCBOA). This excludes the review of reports by certified public accountants (CPAs) on internal controls, performance audits, forecasts, projections, and agreed upon procedures covered by the attestation standards. These types of reports are routinely issued by CPA firms. The proposed amendment clarifies that the statute and board rules cover all reports by licensees on information produced by management and expands the QAR review to cover more than reports on historical statements.

Reasons Supporting Proposal: The board is charged with protection of the public interest and ensuring the integrity and dependability of financial information as it relates to the licensure of CPAs and CPA firms used for guidance in financial transactions or for accounting for or assessing the status or performance of commercial and noncommercial enterprises, whether public, private or governmental. The purpose of the QAR program is to monitor licensees' compliance with attest standards.

Statutory Authority for Adoption: RCW 18.04.055(9).

Statute Being Implemented: RCW 18.04.055(9).

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: The expanded review of all attest services will become effective with the 2008 QAR cycle.

Name of Proponent: Primarily the Washington state board of accountancy, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Richard C. Sweeney, CPA, Olympia, Washington, (360) 586-0163.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule(s) will not have more than minor economic impact on business.

A cost-benefit analysis is not required under RCW 34.05.328. The board of accountancy is not one of the agencies required to submit to the requirements of RCW 34.05.-328.

May 1, 2007
Richard C. Sweeney, CPA
Executive Director

AMENDATORY SECTION (Amending WSR 05-01-135, filed 12/16/04, effective 1/31/05)

WAC 4-25-820 What are the requirements for participating in quality assurance review (QAR)? (1) **Purpose.** The Washington state board of accountancy is charged with protection of the public interest and ensuring the ~~integrity~~ dependability of ~~financial~~ information ~~as it relates to the licensure of CPAs and CPA firms~~ used for guidance in financial transactions or for accounting for or assessing the status or performance of commercial and noncommercial enterprises, whether public, private or governmental. The purpose of the QAR program is to monitor licensees' compliance with attest standards.

(2) **Structure and implementation.**

(a) The board will annually appoint a quality assurance review committee to perform the following functions:

(i) Review of financial statements and the reports of licensees thereon to assess their compliance with applicable professional standards;

(ii) Review of licensees' attestation reports and information covered by those reports for conformity with applicable professional standards;

(iii) Improvement of reporting practices of licensees through education and rehabilitative measures; and

~~(iii) Referral of cases requiring further investigation to the board; and~~

(iv) Such other functions as the board may assign to the committee.

(b) Once every three years the board will require each licensed firm to participate in the board's quality assurance review program. Participating firms will be notified by the board in January of the reporting requirement, and participating firms will be required to submit a quality assurance review status form, along with the appropriate fee, by the following April 30th. Failure to submit a complete quality assurance review status form postmarked by the April 30th due date, will result in the assessment of late fees. The board may waive late fees based on individual hardship including, but not limited to, financial hardship, critical illness, or active military deployment.

(c) Each participating firm shall submit, for each of its offices, one licensee report and the information covered by that report, for each of the following types of service or any other service the Board determines:

• ~~a c~~Compilation report on historical financial statements,

• ~~a r~~Review report on historical financial statements, ~~and~~

• ~~an a~~Audit report on historical financial statements,

• Agreed-upon procedures

• Forecasts

• Internal controls

• Performance audits, and

• Projections.

A firm shall select these reports from all reports prepared during the twelve months preceding the date of board request or, if no reports have been issued within the last twelve months, from all reports during the preceding three years.

If reports issued by all offices of a firm are reviewed and issued in a controlled, centralized process, only one ~~of~~ each of the type of licensee reports, including the information covered by the reports, specified above need be submitted by the firm as a whole.

(d) The board may exempt from the requirement of (c) of this subsection any firm ~~which~~ that has participated in a board-approved peer review program within the three years immediately preceding the date of board request.

(e)Firms requesting exemption must submit a copy of an unmodified report, letter of comments, response to letter of comments, if applicable, and letter of acceptance from the reviewing organization. Firms that receive modified peer review reports may request exemption, but must submit copies of such reports and related correspondence, at the discretion of the board, for consideration on an individual basis.

~~(e)~~ (f) Any documents submitted in accordance with (c) of this subsection may have the name of the client, the client's address, and other identifying factors omitted, provided that the omission does not render the type or nature of the entity undeterminable. Dates may not be omitted.

~~(f)~~ (g) Reports submitted to the committee pursuant to (c) of this subsection and comments of reviewers, the committee and the board on such reports or workpapers relating thereto, shall also be preserved in confidence except to the extent that they are communicated by the board to the licensees who issued the reports or disclosure is required under administrative procedure rules or by direction of a court of law.

~~(g)~~ (h) The committee's review of ~~financial statements and~~ the licensee reports ~~of the licensees~~ and other information covered by those reports ~~thereon~~ shall be directed toward the following:

(i) Presentation of the financial statements covered by the licensee reports and/or other information covered by those reports in conformity with ~~generally accepted accounting principles or other comprehensive basis of accounting, if~~ applicable professional standards for presentation and disclosure;

(ii) Compliance by licensees with ~~generally accepted auditing standards~~ applicable attestation standards; and

(iii) ~~Compliance by licensees with other professional standards; and~~

~~(iv)~~ Compliance by licensees with the rules of the board and other regulations relating to the practice of public accounting.

~~(h)~~ (i) If the board determines that a report and/or other information covered by the report referred to the board by the committee is substandard or seriously questionable with respect to applicable professional standards, the board may take one or more of the following actions:

(i) Send the licensee a letter of comment detailing the perceived deficiencies and require the licensee to develop quality control procedures to ensure that similar occurrences will not occur in the future;

(ii) Require any licensee who had responsibility for issuance of a report, or who substantially participated in preparation of the report and/or related workpapers, to successfully complete specific courses or types of continuing education as specified by the board;

(iii) Require that the licensee responsible for a substandard report submit all or specified categories of its reports to a preissuance review in a manner and for a duration prescribed by the board. The cost of the preissuance review will be at the firm's expense;

(iv) Require the licensee responsible for a substandard report to submit to a peer review conducted in accordance with standards acceptable to the board. The cost of the peer review will be at the licensee's expense;

(v) Require the licensee responsible for substandard work to submit to on-site field review or other investigative procedures of work product and practices by board representatives in order to assess the degree or pervasiveness of substandard work. The board may assess the costs of such field review or procedures to the licensee if the results of such investigative efforts substantiate the existence of substandard work product;

(vi) Initiate an investigation pursuant to RCW 18.04.295, 18.04.305, and/or 18.04.320.

~~(i)~~ (j) The board may solicit and review licensee reports ~~financial statements~~ and/or other information covered by the reports ~~related reports of licensees~~ from clients, public agencies, banks, and other users of ~~financial statements~~ such information. ~~In gathering information about the attest work of licensees, the board may make use of investigators.~~

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

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

WSR 07-10-080
PROPOSED RULES
BOARD OF PILOTAGE COMMISSIONERS

[Filed May 1, 2007, 12:16 p.m.]

Original Notice.

Exempt from preproposal statement of inquiry under RCW 34.05.310(4).

Title of Rule and Other Identifying Information: WAC 363-116-185 Tariffs, and pilotage rates for the Grays Harbor pilotage district.

Hearing Location(s): 2901 Third Avenue, 4th Floor, Rainier Conference Room, Seattle, WA 98121, on June 14, 2007, at 9:30 a.m.

Date of Intended Adoption: June 14, 2007.

Submit Written Comments to: Captain Harry Dudley, Chairman, 2901 Third Avenue, Suite 500, Seattle, WA 98121, e-mail larsonp@wsdot.wa.gov, fax (206) 515-3906, by June 7, 2007.

Assistance for Persons with Disabilities: Contact Judy Bell by June 11, 2007, (206) 515-3647.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposal is to establish a 2007-2008 Grays Harbor pilotage district annual tariff.

The proposed rule reflects a 3% increase in all tariff categories except the *Pension Charge* and *Travel Allowance*.

Pension Charge: It is proposed that the charge per pilotage assignment, including cancellations, be increased $3.00.

Travel Allowance: It is proposed that the transportation fee per assignment remain at $55.00.

Reasons Supporting Proposal: RCW 88.16.035 requires that a tariff be set annually.

Statutory Authority for Adoption: RCW 88.16.035.

Statute Being Implemented: Chapter 88.16 RCW.

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: Current rates for the Grays Harbor pilotage district expire on July 31, 2007. New rates must be set accordingly.

All requirements necessary to amend the existing Grays Harbor pilotage district tariff as set forth in chapter 53.08 RCW have been met.

The board may adopt a rule that varies from the proposed rule upon consideration of presentations and written comments from the public and any other interested parties.

Name of Proponent: Port of Grays Harbor, public.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Board of Pilotage Commissioners, 2901 Third Avenue, Seattle, WA 98121, (206) 515-3904.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule is being considered in the context of the required annual revision to the rates charged for pilotage services. The application of the proposed increase is clear in the description of the proposal and its anticipated effects as well as the attached proposed tariff.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to this rule adoption. The Washington state board of pilotage commissioners is not a listed agency in RCW 34.05.328 (5)(a)(i).

May 1, 2007
Peggy Larson
Administrator

AMENDATORY SECTION (Amending WSR 06-13-057, filed 6/16/06, effective 8/1/06)

WAC 363-116-185 Pilotage rates for the Grays Harbor pilotage district. Effective 0001 hours August 1, ((~~2006~~)) 2007, through 2400 hours July 31, ((~~2007~~)) 2008.

CLASSIFICATION	RATE
Fees for piloting of vessels in the inland waters and tributaries of Grays Harbor shall consist of the following:	
Draft and Tonnage Fees:	
Each vessel shall be charged according to its draft and tonnage for each vessel movement inbound to the Grays Harbor pilotage district, and for each movement outbound from the district.	
Draft	$((~~92.70~~)) 95.48 per meter or $((~~28.25~~)) 29.10 per foot
Tonnage	$((~~0.266~~)) 0.274 per net registered ton
Minimum Net Registered Tonnage	$((~~930.00~~)) 958.00
Extra Vessel (in case of tow)	$((~~520.00~~)) 536.00
Provided that, due to unique circumstances in the Grays Harbor pilotage district, vessels that call, and load or discharge cargo, at Port of Grays Harbor Terminal No. 2 shall be charged $((~~5,150.00~~)) 5,305.00 per movement for each vessel movement inbound to the district for vessels that go directly to Terminal No. 2, or that go to anchor and then go directly to Terminal No. 2, or because Terminal No. 2 is not available upon arrival that go to layberth at Terminal No. 4 (without loading or discharging cargo) and then go directly to Terminal No. 2, and for each vessel movement outbound from the district from Terminal No. 2, and that this charge shall be in lieu of only the draft and tonnage fees listed above.	
Boarding Fee:	
Per each boarding/deboarding from a boat or helicopter	$((~~1,000.00~~)) 1,030.00
Harbor Shifts:	
For each shift from dock to dock, dock to anchorage, anchorage to dock, or anchorage to anchorage	$((~~647.88~~)) 667.00
Delays per hour	$((~~154.49~~)) 159.00
Cancellation charge (pilot only)	$((~~258.22~~)) 266.00
Cancellation charge (boat or helicopter only)	$((~~774.69~~)) 798.00
Pension Charge:	
Charge per pilotage assignment, including cancellations	$((~~171.00~~)) 174.00
Travel Allowance:	
Transportation fee per assignment	$55.00
Pilot when traveling to an outlying port to join a vessel or returning through an outlying port from a vessel which has been piloted to sea shall be paid $((~~903.82~~)) 931.00 for each day or fraction thereof, and the travel expense incurred.	
Bridge Transit:	
Charge for each bridge transited	$((~~283.61~~)) 292.00
Additional surcharge for each bridge transited for vessels in excess of 27.5 meters in beam	$((~~785.22~~)) 809.00
Miscellaneous:	
The balance of amounts due for pilotage rates not paid within 30 days of invoice will be assessed at 1 1/2% per month late charge.	

WSR 07-10-084
PROPOSED RULES
DEPARTMENT OF AGRICULTURE
[Filed May 1, 2007, 2:08 p.m.]

Continuance of WSR 07-08-018.

Preproposal statement of inquiry was filed as WSR 06-16-090.

Title of Rule and Other Identifying Information: Chapter 16-610 WAC, Livestock inspection and identification.

Hearing Location(s): WSU - Mount Vernon Northwestern Washington Research & Extension Center, 16650 State Route 536, Mount Vernon, WA 98273-4768, on June 12, 2007, at 5:00 p.m.; and at the Moses Lake Fire Department,

701 East Third Avenue, Moses Lake, WA 98837, on June 14, 2007, at 5:00 p.m.

Date of Intended Adoption: June 28, 2007.

Submit Written Comments to: Dannie McQueen, 1111 Washington Street S.E., Olympia, WA 98504, e-mail WSDARulesComments@agr.wa.gov, fax (360) 902-2092, by 5:00 p.m., June 15, 2007.

Assistance for Persons with Disabilities: Contact WSDA Receptionist by June 4, 2007, TTY (360) 902-1996 or (360) 902-1976.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend chapter 16-610 WAC to clarify and consolidate requirements, to make the language clear and usable, to amend fees for livestock brand inspection, to include rules for open consignment horse sales, and to include a penalty schedule for notices of infraction.

Reasons Supporting Proposal: The proposal to amend chapter 16-610 WAC is in response to a change in state law enacted by the legislature (ESB 6376). The proposal will amend fees for livestock brand inspections so that they match those set in statute, and will provide for the self-inspection of up to twenty-five head of cattle. On the advice of the assistant attorney general and the officer of the courts, we propose to include a civil infraction schedule for violations of chapter 16.57 RCW in order to allow the department to pursue penalties for illegal actions. In addition, rules regarding open consignment horse sales are needed to specify when and where these types of sales can be held.

Statutory Authority for Adoption: Chapters 16.57, 16.58, 16.65, and 34.05 RCW.

Statute Being Implemented: Chapters 16.57, 16.58, and 16.65 RCW.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Leslie Alexander, Pasco, (509) 543-7383.

No small business economic impact statement has been prepared under chapter 19.85 RCW. There is no significant economic impact associated with these rules.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state department of agriculture is not a listed agency in RCW 34.05.328 (5)(a)(i).

May 1, 2007
Leonard E. Eldridge, DVM
State Veterinarian

WSR 07-10-085
PROPOSED RULES
DEPARTMENT OF AGRICULTURE
[Filed May 1, 2007, 2:10 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-07-039.

Title of Rule and Other Identifying Information: WAC 16-54-190 Animal health documentation requirements for intrastate movement of livestock.

Hearing Location(s): WSU - Mount Vernon Northwestern Washington Research & Extension Center, 16650 State Route 536, Mount Vernon, WA 98273-4768, on June 12, 2007, at 5:00 p.m.; and at the Moses Lake Fire Department, 701 East Third Avenue, Moses Lake, WA 98837, on June 14, 2007, at 5:00 p.m.

Date of Intended Adoption: June 28, 2007.

Submit Written Comments to: Dannie McQueen, 1111 Washington Street S.E., Olympia, WA 98504-2560, e-mail WSDARulesComments@agr.wa.gov, fax (360) 902-1809, by 5:00 p.m., June 15, 2007.

Assistance for Persons with Disabilities: Contact WSDA receptionist by June 4, 2007, TTY (360) 902-1996 or (360) 902-1976.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: For movement of livestock within the state of Washington, there are no animal health documentation requirements if there is no change of ownership. At the request of stakeholders, the Washington state department of agriculture (WSDA) is proposing rules that state this position.

Reasons Supporting Proposal: These amendments will clarify the requirements for movement of livestock within the state of Washington when there is a change of ownership.

Statutory Authority for Adoption: Chapters 16.36 and 34.05 RCW.

Statute Being Implemented: Chapter 16.36 RCW.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Leonard Eldridge, DVM, Olympia, (360) 902-1881.

No small business economic impact statement has been prepared under chapter 19.85 RCW. There is no economic impact associated with these rules.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state department of agriculture is not a named agency in RCW 34.05.328 (5)(a)(i).

May 1, 2007
Leonard E. Eldridge, DVM
State Veterinarian

NEW SECTION

WAC 16-54-190 Animal health documentation requirements for intrastate movement of livestock. (1) Livestock moving within the state of Washington and without change of ownership may be transported without animal health documentation unless required by the management of specific events, such as livestock shows or fairs.

(2) Livestock transported to or from a place of sale or otherwise during change of ownership must be transported with animal health documentation or other evidence that the livestock meet applicable animal health requirements.

(3) During emergency disease outbreaks, the director may require that livestock moving within Washington are transported with animal health documentation or other evidence that the livestock meet animal health requirements.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state department of agriculture is not a listed agency in RCW 34.05.328 (5)(a)(i).

May 1, 2007
Leonard E. Eldridge, DVM
State Veterinarian

WSR 07-10-088
PROPOSED RULES
DEPARTMENT OF AGRICULTURE
[Filed May 1, 2007, 2:22 p.m.]

Supplemental Notice to WSR 07-09-010.

Preproposal statement of inquiry was filed as WSR 06-11-071.

Title of Rule and Other Identifying Information: Chapter 16-54 WAC, Animal importation.

Hearing Location(s): WSU - Mount Vernon Northwestern Washington Research & Extension Center, 16650 State Route 536, Mount Vernon, WA 98273-4768, on June 12, 2007, at 5:00 p.m.; and at the Moses Lake Fire Department, 701 East Third Avenue, Moses Lake, WA 98837, on June 14, 2007, at 5:00 p.m.

Date of Intended Adoption: June 28, 2007.

Submit Written Comments to: Dannie McQueen, 1111 Washington Street S.E., Olympia, WA 98504, e-mail WSDARulesComments@agr.wa.gov, fax (360) 902-2092, by 5:00 p.m., June 15, 2007.

Assistance for Persons with Disabilities: Contact WSDA Receptionist by June 4, 2007, TTY (360) 902-1996 or (360) 902-1976.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend chapter 16-54 WAC by reorganizing and rewriting the chapter for clarity, to update requirements for bringing animals into the state in order to help prevent the entry and spread of infectious and contagious animal diseases, and to correct out-dated information.

Reasons Supporting Proposal: The amendments help safeguard the health, safety and welfare of the state's livestock populations and the livestock industry, and will help the state maintain its disease-free certifications. In addition, these proposed amendments will help prevent the introduction and spread of zoonotic diseases, thereby assisting in safeguarding the health, safety, and welfare of the citizens of Washington state.

Statutory Authority for Adoption: Chapters 16.36 and 34.05 RCW.

Statute Being Implemented: Chapter 16.36 RCW.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Leonard Eldridge, DVM, Olympia, (360) 902-1881.

No small business economic impact statement has been prepared under chapter 19.85 RCW. There is no significant economic impact associated with these rules.

AMENDATORY SECTION (Amending WSR 99-09-023, filed 4/15/99, effective 5/16/99)

WAC 16-54-010 Definitions. ((~~For purposes of this chapter:~~

~~(1) "Director" means the director of agriculture of the state of Washington or his duly authorized representative.~~

~~(2) "Breeding cattle" shall be those females and bulls not consigned to a federally inspected slaughter establishment, a restricted feedlot, or other authorized slaughter only channel.~~

~~(3) "Official brucellosis test" means blood samples are to be tested only by cooperating state-federal laboratories or by such persons as may be authorized by state of origin animal health officials to conduct the standard agglutination tests or the card test. All samples initially tested at other than cooperating state-federal laboratories shall be promptly submitted and confirmed at the cooperating state-federal laboratory.~~

~~(4) "Official brucellosis vaccinate" means a female bovine animal vaccinated between the ages of four and twelve months (one hundred twenty days to three hundred sixty-five days) with an approved brucella vaccine such as strain 19 vaccine or RB-51 vaccine or any other legal brucellosis vaccination administered in accordance with the laws and regulations of a state or country.~~

~~(5) "Class free and Class A, B, and C states" means states as classified by the current federal brucellosis eradication uniform methods and rules.~~

~~(6) "Stage I, II, III, IV, or V Pseudorabies state" means states as classified by the current federal pseudorabies eradication Uniform Methods and Rules.~~

~~(7) "Official health certificate" means a legible certificate of veterinary inspection executed on an official form of the state of origin or of the Animal and Plant Inspection Service (APHIS), United States Department of Agriculture (USDA), by a licensed and accredited veterinarian or a veterinarian approved by the proper official of APHIS, USDA.~~

~~(8) "Animal" means any animal species except fish and insects.~~

~~(9) "Domestic animal" means any farm animal raised for the production of food and fiber or companion animal or both.~~

~~(10) "Farm animal" means any species which have normally and historically been kept and raised on farms in Washington, the United States, or elsewhere or used or intended for use as food, fiber, breeding, or draft and which may be legally kept for such use in Washington and are not those animals classified as wildlife or deleterious exotic wildlife under Title 77 RCW.~~)) In addition to the definitions found in RCW 16.36.005, the following definitions apply to this chapter:

"Accredited free state or zone" means a state, or a zone that is part of a state, that has been determined by United States Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS) to have a zero prevalence

of cattle and bison herds affected with bovine tuberculosis as listed in Title 9 CFR Part 77.79 (January 1, 2006).

"Approved veterinary laboratory" means a laboratory that has been approved by National Veterinary Services Laboratories.

"Certificate of veterinary inspection" means a legible veterinary health inspection certificate on an official form (electronic or paper) from the state of origin or from APHIS, USDA executed by a licensed and accredited veterinarian or a veterinarian approved by APHIS, USDA. The certificate of veterinary inspection is also known as an "official health certificate."

"Department" means the Washington state department of agriculture (WSDA).

"Director" means the director of WSDA or the director's authorized representative.

"Domestic bovine" means domesticated cattle, including bison.

"Domestic equine" means horses, donkeys, mules, ponies, and other animals in the *Equidae* family.

"Entry permit" means prior written permission issued by the director to admit or import animals or animal reproductive products into Washington state.

"Exotic animal" means species of animals that are not native to Washington state but exist elsewhere in the world in the wild state.

"Immediate slaughter" means livestock will be delivered to a federally inspected slaughter plant within three days of entry into Washington state.

"Mature vaccinate" means a female bovine over the age of twelve months that has been vaccinated, under directions issued by the state of origin, with a mature dose of brucellosis vaccine.

"Modified accredited state or zone" means a state, or a zone that is part of a state, that has been determined by USDA, APHIS to have a prevalence of bovine tuberculosis of less than 0.1 percent of the total number of herds of cattle and bison as listed in Title 9 CFR Part 77.11 (January 1, 2006).

"Movement permit" means an entry permit that is valid for six months and permits the entry of domestic equine into Washington state.

"NPIP" means the National Poultry Improvement Plan.

"Official brucellosis test" means the official test defined by Title 9 CFR Part 78.1 (January 1, 2006).

"Official brucellosis vaccinate" means an official adult vaccinate or official calfhood vaccinate as defined by Title 9 CFR Part 78.1 (January 1, 2006).

"Poultry" means chickens, turkeys, ratites, waterfowl, game birds, pigeons, doves, and other domestic fowl designated by statute. Poultry does not mean free ranging birds defined as wildlife in RCW 77.08.010(16).

"Restricted feedlot" means a feedlot holding a permit issued under chapter 16-30 WAC.

"USDA, APHIS" means the United States Department of Agriculture Animal and Plant Health Inspection Service.

"Wild animals" is defined in RCW 77.08.010(17).

GENERAL IMPORTATION REQUIREMENTS

NEW SECTION

WAC 16-54-025 Transporting livestock—Sanitary requirements. All trucks, railway cars, and other conveyances used for the transportation of livestock must be maintained in a sanitary condition and cleaned and disinfected when required by the director in order to prevent the spread of disease.

NEW SECTION

WAC 16-54-028 Testing procedure requirements. (1) An accredited veterinarian or a veterinary technician under the direct supervision of an accredited veterinarian must collect and submit all test specimens.

(2) All livestock regulatory tests must be performed by a laboratory approved by the National Veterinary Services Laboratories.

(a) Official tuberculosis tests must be conducted by a licensed accredited veterinarian.

(b) Technicians employed and approved by state, federal, or tribal government and directly or indirectly supervised by state, federal, or tribal animal health veterinarians may conduct routine surveillance tests.

AMENDATORY SECTION (Amending WSR 99-09-023, filed 4/15/99, effective 5/16/99)

WAC 16-54-030 ((~~Health~~)) Certificate of veterinary inspection, and entry permit requirements. (((~~(1) All animals entering Washington shall be accompanied by an official health certificate except:~~

~~(a) Dogs and cats originating in Washington and visiting Canada for thirty days or less.~~

~~(b) Dogs, cats and ferrets that are family pets traveling by private automobile with their owners who possess a current rabies certificate for the animals. This exemption does not apply to dogs, cats or ferrets imported for sale or puppies, kittens, or kits too young to vaccinate.~~

~~(c) Horses traveling into Washington with their Oregon or Idaho owners in personal vehicles for round-trip visits of not more than ninety-six hours duration. This exemption does not apply during emergency disease conditions declared by the state veterinarian or extend to any required testing.~~

~~(d) Llamas and alpacas traveling into Washington with their Oregon or Idaho owners in personal vehicles for round-trip visits of not more than ninety-six hours duration. This exemption does not apply during emergency disease conditions declared by the state veterinarian.~~

~~(e) Sheep traveling into Washington with their Oregon or Idaho owners in personal vehicles for round-trip visits of not more than ninety-six hours duration. This exemption does not apply during emergency disease conditions declared by the state veterinarian or extend to any animals entering for breeding purposes.~~

~~(f) Those classes of animals specifically exempted in laws or regulations of this state.~~

~~(2) Official health certificate shall contain the following information:~~

~~(a) Date of inspection. All health certificates void after thirty days, except breeding cattle forty-five days from date of issue. The director may give special exemption for show animals.~~

~~(b) Names and addresses of the consignor and consignee.~~

~~(c) Certification that the animals are apparently free from evidence of infectious and communicable disease.~~

~~(d) Test or vaccination status when required.~~

~~(e) Description of each animal to include species, breed, age, sex, tag or tattoo and for cattle, only an official ear tag will be accepted or if registered, the registry name, number and tattoo for individual identification except one brand or other owner identified animals, all of the same description, for which tests are not required.~~

~~(f) Certification of disinfection of cars and trucks when required.~~

~~(g) An owner/agent statement which says "the animals in this shipment are those certified to and listed on this certificate" and is signed and dated by the owner, agent, or veterinarian.~~

~~(3) All health certificates shall be reviewed by the livestock sanitary official of the state of origin and a copy shall be forwarded immediately to the department of agriculture, Olympia, Washington.~~)) (1) **Certificate of veterinary inspection:**

(a) A certificate of veterinary inspection must accompany all animals entering Washington state, except where specifically exempted in this chapter.

(b) The certificate of veterinary inspection must show that all livestock listed have been examined and found in compliance with vaccination, testing, and Washington animal identification requirements found in chapter 16-610 WAC.

(c) Any exemption to the requirement for a certificate of veterinary inspection may be suspended during an emergency disease condition declared by the director.

(2) **Entry permit:** An entry permit is required on:

(a) All domestic bovine (including Mexican cattle, Canadian cattle, and bison);

(b) Swine;

(c) Rams;

(d) Equine identified on a certificate similar to the Washington Equine Certificate of Veterinary Inspection and Movement Permit (form AGR-3027);

(e) Equine from states or countries where the diseases listed in WAC 16-54-071 have been diagnosed;

(f) Intact male equine that test positive to equine viral arteritis; and

(g) Equine reproductive products from donors that test positive to equine viral arteritis.

(3) Entry permits are granted at the discretion of the director and may be obtained from:

Washington State Department of Agriculture
Animal Services Division
1111 Washington Street S.E.
P.O. Box 42577
Olympia, Washington 98504-2577
360-902-1878.

NEW SECTION

WAC 16-54-032 Certificate of veterinary inspection—Required information. (1) A certificate of veterinary inspection must contain the following information:

(a) An entry permit, when required;

(b) Date of inspection;

(c) Names and addresses of the consignor and consignee;

(d) Shipment information, including:

(i) Origin of shipment;

(ii) Anticipated shipment date; and

(iii) Number of animals in the shipment;

(e) Certification that the animals are free from clinical signs or known exposure to any infectious or communicable disease;

(f) Test or vaccination status, when required;

(g) Description of each animal by:

(i) Identifying species;

(ii) Breed;

(iii) Age;

(iv) Sex of the animal;

(v) Color; and

(vi) Tag, tattoo, microchip, USDA-approved RFID (radio frequency identification device) ear tag, or other official method of identification, including ownership brands.

(2) All certificates of veterinary inspection must be reviewed by the animal health official of the state of origin and a copy must be immediately forwarded to:

Washington State Department of Agriculture
Animal Services Division
1111 Washington Street S.E.
P.O. Box 42577
Olympia, Washington 98504-2577.

AMENDATORY SECTION (Amending Order 1172, filed 12/15/70)

WAC 16-54-060 Quarantine. ((~~Domestic animals entering the state without proper health certificate or official permission, or not meeting the health requirements of the state of Washington, shall be held in quarantine at the owner's expense and be subject to any required tests, inspection, vaccination at owner's expense until released from quarantine by the director.~~)) Any animal entering Washington state without a required certificate of veterinary inspection, or required entry permit, or that does not meet the requirements of this chapter shall be quarantined at the owner's expense and subject to any required test, inspection, or vaccination at the owner's expense until released from quarantine by the director.

IMPORTATION RESTRICTIONS

NEW SECTION

WAC 16-54-065 Prohibited entries. (1) Any animal that is infected with or exposed to any infectious or communicable disease is prohibited from entering Washington state.

(2) Livestock susceptible to vesicular stomatitis that have been located within the past thirty days within ten miles

of any premises under quarantine for vesicular stomatitis are prohibited from entering Washington state.

(3) The following animals are prohibited from entering Washington state for any purpose:

(a) Cattle originating from Mexican dairies;

(b) Feral swine;

(c) Domestic swine from herds where brucellosis is known to exist;

(d) Deleterious exotic wildlife, as defined by RCW 77.08.010 and designated at WAC 232-12-017, except as provided in WAC 232-12-017.

(4) The Washington state department of health under WAC 246-100-191 (Animals, birds, pets—Measures to prevent human disease) prohibits certain animals including bats, skunks, foxes, raccoons, and coyotes from being imported into Washington state except for exhibition by bona fide public or private zoological parks.

(5) Entry permits allowing bona fide public or private zoological parks to import bats, skunks, foxes, raccoons, and coyotes may be issued by the director in consultation with the secretary of the Washington state department of health.

Exemptions:

(6) Infected or exposed animals destined for immediate slaughter, or with an entry permit to a research facility, or with an entry permit to a veterinary facility for treatment may enter at the discretion of the director.

NEW SECTION

WAC 16-54-068 Restrictions. (1) It is a violation to import animals into Washington state that do not comply with the requirements of this chapter or any other Washington state regulation relating to animal health and care, or to the importation and movement of poultry, hatching eggs, and wildlife.

(2) All animals entering Washington state must comply with the requirements of USDA, APHIS regulations found at Title 9 CFR for movement or importation from foreign countries.

(3)(a) Livestock entering Washington state from a state where a reportable disease listed in WAC 16-70-010 has been diagnosed within the past thirty days must be accompanied by a valid entry permit and a certificate of veterinary inspection.

(b) The certificate of veterinary inspection shall also include written verification that the animals have not been exposed to any reportable disease nor located within ten miles of an area where such a disease has been diagnosed.

(c) In the case of a state where vesicular stomatitis has been diagnosed, the certificate of veterinary inspection must be issued within twenty-four hours of shipment to Washington state and must contain:

(i) The temperature reading of each animal at the time of inspection; and

(ii) The following statement written by an accredited veterinarian:

"All animals identified on this certificate have been examined and found to be free from clinical signs of vesicular stomatitis. During the past thirty days, these animals have not been exposed to vesicular stomatitis or located within ten miles of an area where vesicular stomatitis has been diagnosed."

(d) Cattle entering Washington state from a state or a foreign state or province where vesicular stomatitis has been diagnosed must be held at their destination separate and apart from all other cattle for a period of seven days and reexamined by an accredited veterinarian at the end of that period.

(4) Dogs, cats, and ferrets must be accompanied by an entry permit and proof of current rabies vaccination if they originate from a rabies quarantined area or an area where the state or country of origin has designated terrestrial rabies as endemic.

HORSES, DONKEYS, MULES AND OTHER DOMESTIC EQUINE AND EQUINE REPRODUCTIVE PRODUCTS

AMENDATORY SECTION (Amending WSR 99-09-023, filed 4/15/99, effective 5/16/99)

WAC 16-54-071 Domestic equine and equine reproductive products—Importation requirements. ((~~(1) Domestic equine animals shall be accompanied by an official health certificate stating that they are free from clinical symptoms of infectious and communicable disease. All equine over six months of age must have a record of a negative test for the diagnosis of equine infectious anemia made within six months prior to entry. Horses moving to Washington from Oregon or Idaho may be excluded from test requirements when reciprocal.~~

~~(2) Breeding stallions or their semen shall be tested negative for equine viral arteritis (EVA) within ninety days of import. Positive stallions or semen may be imported with a certifying statement on the health certificate that the consignee has been advised and consents to the shipment. All positive stallions or semen entering Washington shall be moved on a permit issued by the office of the state veterinarian and may be subject to quarantine.~~

~~(3) Washington horses may reenter Washington when returning from shows, rides or other events from states that will accept travel to that state with a current "equine certificate of veterinary inspection and interstate movement permit" without additional animal health certifications. Within fourteen days of the return to Washington an "itinerary of interstate travel" must be filed with the state veterinarian's office. Likewise horses from the western state of Oregon, California, Idaho, Nevada, Utah, Arizona, Montana, Wyoming, Colorado, or New Mexico may enter the state of Washington for shows, rides or other events and return with documents similar to the above named documents under a state system of equine health certification acceptable to the Washington state veterinarian and the state origin by written agreement. In any case, travel under this alternative to normal thirty-day health certification will be limited to not more than ninety days duration for any one excursion and the movement permit shall expire in six months from the date of the certificate.~~)) **Import health requirements.**

(1)(a) In addition to the other requirements of this chapter, all horses, donkeys, mules, and other domestic equine and equine reproductive products entering Washington state

must be accompanied by a certificate of veterinary inspection.

(b) Equine vaccinated against equine viral arteritis (EVA) must be accompanied by a vaccination certificate.

(c) Reproductive products from donors that test positive for EVA must be accompanied by an application and entry permit.

(d) Domestic equine from the western states of Oregon, Idaho, California, Nevada, Utah, Arizona, Montana, Wyoming, Colorado, and New Mexico may enter Washington state for shows, rides, or other events either with a certificate of veterinary inspection or with a document similar to the Equine Certificate of Veterinary Inspection and Movement Permit. Individual trips cannot exceed ninety days.

(e) An itinerary of interstate travel must be filed with the department within fourteen days of the expiration of the movement permit.

(2) All certificates and forms may be obtained from and sent to:

Washington State Department of Agriculture
Animal Services Division
1111 Washington Street S.E.
P.O. Box 42577
Olympia, Washington 98504-2577

Exemptions to import health requirements.

(3) Horses traveling into Washington state with their Oregon or Idaho owners in private conveyance for round-trip visits of not more than four days duration for purposes other than breeding are exempt from the certificate of veterinary inspection.

Import test requirements.

Equine infectious anemia (EIA).

(4) All domestic equine, except foals under six months of age accompanying their negative tested dams, must have a negative test for equine infectious anemia (EIA) within six months before entering Washington state.

Exemptions to EIA test requirements.

(5) Domestic equine moving to Washington from Oregon are excluded from EIA test requirements.

Equine viral arteritis (EVA).

(6) Intact males over six months of age must test antibody negative for EVA within thirty days before entry into Washington state or have proof of vaccination.

(7) Vaccinated equine that test antibody positive for EVA must be accompanied by a certificate of veterinary inspection that provides proof of:

(a) A prevaccination negative antibody blood test;

(b) Vaccination within ten days of the prevaccination blood test; and

(c) Approved method of animal identification. Approved methods of identification are:

(i) Photograph or clearly drawn picture of the animal (both sides and front);

(ii) Brand (hot iron or freeze brand);

(iii) Microchip; and/or

(iv) Lip tattoo.

(8) Intact males over six months of age and equine reproductive products from donors that test positive for EVA may enter Washington state only if accompanied by an entry permit and a statement on the certificate of veterinary inspection verifying that the consignee:

(a) Has been advised of the positive antibody test results and the associated risks of EVA infection;

(b) Agrees to follow the recommendations of the Office International des Epizooties of the World Organization of Animal Health regarding EVA and USDA recommendations found in the *Equine Viral Arteritis Uniform Methods and Rules*, effective April 19, 2004; and

(c) Consents to the shipment.

(9) Intact males that test antibody positive for EVA are required to have an entry permit and may be subject to quarantine.

(10) Equine semen and embryos must originate from donors that have proof of vaccination or a negative antibody test for EVA during the current breeding season.

(11) Equine semen and embryos from antibody positive donors must be used or implanted only in vaccinated or seropositive mares. These mares must be isolated for twenty-one days following insemination or implantation.

(12) Additional testing for EVA may be required during emergency disease conditions declared by the director.

Piroplasmosis.

(13) Any equine that has ever tested positive for piroplasmosis may not enter Washington state.

(14) Any equine that has originated from a country or state where piroplasmosis is endemic must be negative to a C-ELISA test within thirty days before entry into Washington state, and must be quarantined upon arrival and retested within sixty to ninety days. Horses that test positive on the post-arrival C-ELISA test are not permitted to remain in the state and must be removed.

CATTLE, BISON, AND OTHER DOMESTIC BOVINE

AMENDATORY SECTION (Amending WSR 05-14-019, filed 6/24/05, effective 7/25/05)

WAC 16-54-082 Domestic bovine animals—Importation requirements. ((~~All domestic bovine animals (including bison) entering Washington shall be moved on a permit issued by the office of the state veterinarian. All domestic bovine animals (including bison) shall meet the following requirements:~~

~~(1) Tuberculosis. All beef and dairy cattle must originate from herds not under quarantine in a not less than modified accredited area. The state veterinarian may require a negative tuberculosis test within thirty days of import for cattle (including bison) from the states classified as modified accredited or accredited free if Mycobacterium bovis (M. bovis) has been cultured from a herd in that state within the previous twelve months. All Mexican cattle imported from Mexico within three years of date of importation to Washington must show proof of a tuberculosis retest at least one hundred twenty days after import to the United States. Such cattle without proof of retest must be held on the premises of destination under Hold Order/Quarantine in Washington and kept separate from all other cattle for not less than one hundred twenty nor more than one hundred eighty days from the

~~date of entry and retested for tuberculosis during the one hundred twenty to one hundred eighty-day period.~~

~~All dairy cows and bulls six months of age or older must test negative for bovine tuberculosis within sixty days prior to entering Washington. These dairy cattle must be identified with a USDA silver identification ear tag or a RFID (Radio Frequency Identification) tag. Dairy heifers and bull calves under six months of age entering Washington must obtain a permit and upon entry will be issued a hold order/quarantine requiring the animals to proceed directly to a premise or designated facility and to be held separate from all other cattle until they test negative for bovine tuberculosis after six months of age. Dairy heifers and bull calves under six months of age must be identified with a USDA silver identification ear tag or a RFID (Radio Frequency Identification) tag. Dairy cattle that originate in an accredited tuberculosis free herd as defined by USDA in 9 CFR Chapter 1, Part 77 (January 1, 2005) and for which both an accredited herd number and date of last tuberculosis test are shown on the official interstate health certificate or certificate of veterinary inspection, dairy steers and spayed heifers being imported to restricted feedlots to be fed for slaughter, dairy cattle consigned to federally inspected slaughter plants for immediate slaughter, and dairy cattle consigned to a state federally approved livestock market to be sold directly to slaughter only are exempt from bovine tuberculosis testing under this section.~~

~~(2) Brucellosis health certificate requirements. All domestic bovine animals (including bison), except those consigned to restricted feedlots, to federally inspected slaughter plants for immediate slaughter, or beef breed cattle, slaughter only dairy breed cattle, or dairy breed cattle from Oregon, Montana, and Idaho consigned to a state-federal approved livestock market, shall be accompanied by an official interstate health certificate and shall meet the following requirements:~~

~~(a) Brucellosis test.~~

~~(i) Cattle from class free and A states.~~

~~(A) Sexually intact heifers from brucellosis quarantined herds in class free and A states shall not be imported into the state of Washington except for immediate slaughter at a federally inspected slaughter plant.~~

~~(B) Cattle other than those referred to in (a)(i)(A) of this subsection from class free or A states which are test eligible, unless destined for a restricted feedlot or for immediate slaughter at a federally inspected slaughter establishment, must be negative to an official brucellosis test conducted within thirty days prior to date of entry. Cattle not considered test eligible include:~~

~~(I) Calves under six months of age.~~

~~(II) Steers and spayed heifers.~~

~~(III) Officially vaccinated dairy cattle under twenty months of age and officially vaccinated beef cattle under twenty-four months of age.~~

~~(IV) Cattle from a certified brucellosis free herd.~~

~~(V) Cattle from selected brucellosis free states designated by the Washington state veterinarian.~~

~~(ii) Cattle from Class B or C states.~~

~~(A) Sexually intact females from other than certified brucellosis free herds in states classified B or C by the USDA shall not be imported into the state of Washington except for immediate slaughter at a federally inspected slaughter establishment.~~

~~(B) Sexually intact males from Class B states which are test eligible, unless destined for a restricted feedlot or for immediate slaughter at a federally inspected slaughter establishment, must be negative to an official brucellosis test conducted within thirty days prior to date of entry and held on the premises of destination and kept separate from all other cattle for retest not less than forty-five nor more than one hundred twenty days from the date of the preentry test. Cattle not considered test eligible include:~~

~~(I) Calves under six months of age.~~

~~(II) Steers and spayed heifers.~~

~~(III) Cattle from a certified brucellosis free herd.~~

~~(C) Sexually intact males from Class C states which are test eligible must be negative to two official brucellosis tests conducted prior to entry at least sixty days apart, the second test to be conducted within thirty days of entry. Those cattle shall be held on the premises of destination and kept separate from all other cattle for retest not less than forty-five nor more than one hundred twenty days from the date of the second negative preentry test. Cattle not considered test eligible include:~~

~~(I) Calves under six months of age.~~

~~(II) Steers and spayed heifers.~~

~~(III) Cattle from a certified brucellosis free herd.~~

~~(iii) Beef cattle eligible for brucellosis testing coming from class free or A states or dairy cattle coming from Idaho, Montana, or Oregon may be moved to state-federal approved livestock markets in Washington to meet entry health requirements.~~

~~(iv) Should brucellosis infection occur in the state of Washington as a result of importation of infected animals, all future importations from the state of origin shall be required to meet import regulations of the next lower classification. State regulatory officials of that state shall be notified and the lower classification entry requirement will be in effect for twelve months following notification to the state of origin.~~

~~(b) Brucellosis vaccinates female dairy cattle. All female dairy cattle must be identified as official brucellosis vaccinates before entry into a dairy cow breeding herd. Except the following classes of cattle are exempt from this requirement:~~

~~(i) Calves under four months of age.~~

~~(ii) Those cattle consigned directly to a restricted feedlot.~~

~~(iii) Spayed heifers.~~

~~(c) Brucellosis vaccinates female beef cattle. All female beef breed cattle must be identified as official brucellosis vaccinates before entry into a beef cow breeding herd, except the following classes of cattle are exempt from this requirement:~~

~~(i) Calves under four months of age.~~

~~(ii) Cattle sold or consigned to a restricted feedlot.~~

~~(iii) Spayed heifers.~~

~~(d) Cattle from a certified brucellosis free country may be imported if the state veterinarian, upon being assured that to allow such cattle to enter would not create any jeopardy to the livestock industry of the state of Washington, issues a special permit for such entry.~~

~~(3) Scabies. The office of the state veterinarian may require that any cattle from a known infected area be dipped at an official dipping facility within ten days of entry and, except those consigned to a federally inspected slaughter plant for immediate slaughter within fourteen days, be accompanied by an official interstate health certificate. Ivermectin may be used as an alternative to the dipping procedure for beef and nonlactating dairy animals.~~

~~(4) Vesicular stomatitis. The office of the state veterinarian may require that:~~

~~(a) Any cattle be accompanied by an official interstate health certificate except those consigned to a federally inspected slaughter plant for immediate slaughter within fourteen days;~~

~~(b) Dairy breed cattle be held separate and apart from all other cattle for a period of seven days at the point of destination and rechecked by an accredited veterinarian at the end of that period; except that dairy breed cattle from known infected areas shall not be allowed entry into the state; and~~

~~(c) Beef breed cattle from known infected areas be held separate and apart from all other cattle for a period of thirty days either prior to entry or at the point of destination or both.~~

~~(5) Temporary grazing permits. Herd owners desiring to move cattle into Washington for temporary grazing purposes must obtain a prior permit from the office of the state veterinarian. The state veterinarian may, if deemed necessary, require a brucellosis herd test and/or an official health certificate for any cattle entering the state for grazing purposes. Applicants must also file an approved herd plan with the office of the state veterinarian to phase out all brucellosis nonvaccinates in the herd prior to January 1, 1988. Grazing permits shall be for one specified season only and shall be valid for movement to only that destination declared on the permit. A copy of the permit shall accompany any vehicle transporting cattle into the state for such temporary grazing purposes.~~)) **Import health requirements.**

(1) Domestic bovine entering Washington state must have a certificate of veterinary inspection and an entry permit issued by the office of the state veterinarian prior to entry. Entry permits are required on all feeder cattle entering restricted feedlots and are to be obtained by the brand inspector of the state of origin and recorded on the brand document.

Exemptions to import health requirements.

(2) A certificate of veterinary inspection is not required for domestic bovine that are:

(a) Consigned to federally inspected slaughter plants for immediate slaughter; or

(b) Consigned to state-federal approved livestock markets for sale for immediate slaughter only; or

(c) Consigned to specifically approved livestock markets or restricted holding facilities where import requirements can be met; or

(d) Consigned to a restricted feedlot.

NEW SECTION

WAC 16-54-083 Domestic and foreign bovine brucellosis requirements. (1) Female cattle, domestic and foreign, must have an official calfhood brucellosis vaccination and legible vaccination tattoo before entry into Washington state.

(a) Cattle vaccinated with strain 19 vaccine must be permanently identified with a tattoo in the right ear that must bear the USDA registered V shield preceded by a number indicating the quarter of the year in which they were vaccinated, followed by the last digit of the year of vaccination.

(b) Cattle vaccinated with RB-51 strain of vaccine must be permanently identified with a tattoo in the right ear that must bear the USDA registered V shield preceded by the letter R followed by the last digit of the year of vaccination.

(c) Brucellosis vaccinated cattle from foreign countries must present original vaccination certificates. On arrival, the cattle must be tattooed with the USDA V shield and the year indicated on the vaccination certificate.

(2) Mature vaccinated domestic bovine that are identified by a legible vaccination tattoo and USDA vaccination and USDA identification tags will be allowed entry into Washington state if the state of origin allows mature vaccination and is of the same brucellosis class or higher.

(3)(a) Test eligible dairy cattle from all states and all cattle from Class A states must be tested negative for bovine brucellosis within thirty days before entry.

(b) Beef cattle from selected brucellosis free states designated by the director may be required to have a negative test thirty days before entry.

(c) Test eligible bovine are bulls over six months of age, brucellosis vaccinated dairy females over twenty months of age, and brucellosis vaccinated beef breed females over twenty-four months of age.

(4) All animals must be identified by USDA approved official identification.

Exemptions to domestic bovine brucellosis test and vaccination requirements.

(5) Domestic bovine that are exempt from brucellosis testing and vaccination requirements are:

(a) Those cattle from a class free state consigned to restricted feedlots;

(b) Those consigned to federally inspected slaughter plants for immediate slaughter;

(c) Heifer calves less than four months of age;

(d) Slaughter only dairy breed cattle from Oregon, Idaho, and Montana that are consigned to a state-federal approved livestock market;

(e) Bull calves less than six months of age;

(f) Steers and spayed heifers;

(g) Official brucellosis vaccinated dairy cattle less than twenty months of age;

(h) Official brucellosis vaccinated beef cattle less than twenty-four months of age;

(i) Cattle from a certified brucellosis free herd, as defined by Title 9 CFR Part 78.1; and

(j) Test eligible beef breed cattle and dairy cattle that are consigned to a state or federally approved livestock market to meet entry testing requirements. Heifer calves between four and twelve months of age may be consigned to a state-federal approved sale yard where they will remain until meeting vaccination requirements.

NEW SECTION

WAC 16-54-085 Domestic bovine tuberculosis requirements. (1) All domestic bovine from a modified accredited advanced or lower state or zone must have a negative TB test within sixty days before entry into Washington state. Domestic bovine from a modified accredited or lower state or zone shall be held separate and apart from native cattle for sixty days and retested negative at least sixty days after entry into Washington state.

(2) **Dairy cattle six months of age or older** must:

(a) Test negative for bovine tuberculosis within sixty days before entering Washington state; and

(b) Be identified with a USDA silver identification ear tag, or a USDA-approved RFID tag, or an orange brucellosis vaccination tag.

(3) **Dairy heifers and bull calves less than six months of age** must:

(a) Be issued a hold order or a quarantine order that requires the animals to be taken directly to a designated premises or facility;

(b) Be held separate and apart from all other domestic bovine until they test negative for bovine tuberculosis after six months of age; and

(c) Be identified with a USDA silver identification ear tag, or a USDA-approved RFID tag, or an orange brucellosis vaccination tag.

(4) **Mexican cattle -** All cattle imported from Mexico that enter Washington, including those imported for rodeo or recreation purposes, must be sexually neutered and must bear official Mexican identification and brand before entry.

(a) All Mexican cattle must be accompanied by proof of two negative bovine tuberculosis tests conducted in the United States after entry from Mexico. The second negative test must be a minimum of sixty days after the first test and within thirty days before entry into Washington state.

(b) All Mexican cattle that remain in the state of Washington shall be tested annually for tuberculosis.

(c) If Mexican cattle entering Washington state are not accompanied by proof of two negative bovine tuberculosis tests prior to entry, they will be issued a hold order or a quarantine order that requires the animals to be taken directly to a designated premises or facility and kept separate and apart from Washington cattle until the completion of required tests.

(d) Sexually intact Mexican beef cattle may enter only with a prior entry permit and at the discretion of the director.

Exemptions to domestic bovine tuberculosis test requirements.

(5) **Dairy cattle** are exempt from bovine tuberculosis testing requirements if they:

(a) Originate from an accredited bovine tuberculosis-free herd, as defined by USDA, APHIS in Title 9 CFR Chapter 1 Part 77 (January 1, 2006), and if an accredited herd number and the date of the last bovine tuberculosis test are shown on the certificate of veterinary inspection;

(b) Are consigned to federally inspected slaughter plants for immediate slaughter; or

(c) Are consigned to slaughter through state and federally approved sale yards and remain in slaughter channels.

(6) **Adult dairy cows from Oregon and Idaho** that have not met the department's brucellosis and tuberculosis requirements may enter a WSDA approved brucellosis/tuberculosis holding facility in Washington state until testing requirements have been met.

(7) **Dairy steers and spayed heifers** are exempt from bovine tuberculosis testing requirements before entry into Washington state if they are entering restricted feedlots to be fed for slaughter.

(8) **Mexican cattle** are exempt from the second bovine tuberculosis test and isolation requirements if their official Mexican identification remains intact and they are consigned to a federally inspected slaughter plant for immediate slaughter.

NEW SECTION

WAC 16-54-088 Temporary grazing permits. Cattle moving interstate on grazing permits are exempt from a certificate of veterinary inspection and testing requirements.

(1)(a) Persons desiring to move cattle into Washington state for temporary grazing purposes must complete a temporary grazing application approved by both states. After approval, a permit number will be issued.

(b) Temporary grazing permits are valid for a period not to exceed six months and are valid only for movement to the destination specified on the permit and return to the location of origin.

(c) A copy of the approved application must accompany any vehicle transporting cattle into Washington state for temporary grazing purposes.

(d) Temporary grazing permits will be issued only for cattle entering from states that share common borders with the state of Washington.

(e) If cattle have been commingled with other herds or additional cattle have been added to the original grazing herd, they must have a certificate of veterinary inspection and entry permit in order to return to Washington.

(2) Permits are granted based on current disease conditions in both states. The director may specify conditions on the permit to prevent or control disease.

GOATS

AMENDATORY SECTION (Amending WSR 92-21-039, filed 10/15/92, effective 11/15/92)

WAC 16-54-090 Goats—Importation and testing requirements. ((~~Goats except those for immediate slaughter, shall be accompanied by a health certificate stating they are clinically free from infectious and communicable disease. Dairy goats shall be tested negative for brucellosis within thirty days prior to date of entry. Goats under six months of age are exempt from brucellosis test requirement.~~)) **Import health requirements.**

(1) All goats entering Washington state must be accompanied by a certificate of veterinary inspection. The certificate of veterinary inspection must state that the animals are free from clinical signs or known exposure to any infectious or communicable disease.

(2) Female dairy goats six months of age or older must test negative for brucellosis and tuberculosis within thirty days before they enter Washington state.

(3) Sexually intact goats must have official USDA scrapie identification.

Exemption to import health requirements.

(4) Goats traveling into Washington state with their Oregon and Idaho owners in private conveyance for round-trip visits of not more than four days duration for purposes other than breeding are exempt from the certificate of veterinary inspection.

SHEEP

AMENDATORY SECTION (Amending WSR 99-09-023, filed 4/15/99, effective 5/16/99)

WAC 16-54-101 Sheep—Importation and testing requirements. ((~~Sheep except those for immediate slaughter, shall be accompanied by a health certificate stating they are clinically free from infectious and communicable disease and in addition shall comply with the following requirements which shall be stated on the health certificate:~~

~~(1) Originate from a flock in which no scrapie has existed for five years or is from a flock enrolled in the USDA Voluntary Scrapie Flock Certification Program.~~

~~(2) All breeding rams six months of age and over must have a negative ELISA test for brucella ovis within thirty days prior to entry into Washington and be palpated and certified free of brucella ovis or be from a brucella free flock. Each ram must be individually identified with an individual yardage or registration tattoo. This number, along with the test results and date of test, must be entered on the health certificate which must accompany the animal(s).~~

~~(3) All blackface rams imported into Washington state for the purpose of breeding must be determined by genetic testing to be QR or RR at the 171 codon.~~

~~(4) All blackface breeding rams shall be moved on a permit issued by the office of the state veterinarian.~~)) **Import health requirements.**

(1) A certificate of veterinary inspection must accompany all sheep entering Washington state. The certificate of veterinary inspection must state that the sheep:

(a) Are clinically free from the signs of infectious diseases, including footrot, sore mouth, and caseous lymphadenitis; and

(b) Originated from a flock in which scrapie has not been diagnosed in the past five years or are from a flock enrolled in the USDA Voluntary Scrapie Flock Certification Program described in Title 9 CFR Part 54 (January 1, 2006).

(c) Are officially identified with official USDA scrapie program identification. Sheep required to be officially identified include:

(i) All breeding sheep;

(ii) All sexually intact sheep imported for exhibition;

(iii) All sheep over eighteen months of age.

Import test requirements.

(2) All breeding rams over six months of age require an entry permit.

(3) The certificate of veterinary inspection must state that the rams:

(a) Tested negative on an ELISA test for *Brucella ovis* within thirty days before entering Washington state; and

(b) Are palpated and certified free of any evidence of epiditymitis; and

(c) Are individually identified with an official USDA scrapie program identification. Each ram's identification number, test results, and the date of the test must be entered on the certificate of veterinary inspection accompanying the animal.

(4) Any purebred rams of Suffolk, Hampshire, Shropshire, or Montadale descent, or cross thereof; any nonpurebred rams known to have Suffolk, Hampshire, Shropshire, or Montadale ancestors; and any nonpurebred rams of unknown ancestry with a black face, except for hair sheep, may enter Washington state for breeding purposes if they are determined by genetic testing before entry to be QR or RR at the 171 codon. Hair sheep known to have Suffolk, Hampshire, Shropshire, or Montadale ancestors are considered blackface sheep.

Exemptions to import health and test requirements.

(5) Sheep traveling into Washington state with their Oregon and Idaho owners in private conveyance for round-trip visits of not more than four days duration for purposes other than breeding are exempt from the certificate of veterinary inspection.

(6) Sheep entering Washington state for immediate slaughter at a USDA inspected slaughter plant are exempt from the certificate of veterinary inspection and testing requirements.

(7) Official USDA approved scrapie identification is not required on slaughter sheep less than eighteen months of age.

LLAMAS AND ALPACAS

NEW SECTION

WAC 16-54-105 Llamas and alpacas. Import health requirements.

(1) All llamas and alpacas imported into Washington state shall be accompanied by a health certificate stating that the animals are free from signs of or exposure to infectious or communicable disease.

Exemptions to import health requirements.

(2) Llamas and alpacas traveling into Washington state with their Oregon and Idaho owners in private conveyance for round-trip visits of not more than four days duration for purposes other than breeding are exempt from the certificate of veterinary inspection.

SWINE

AMENDATORY SECTION (Amending WSR 92-21-039, filed 10/15/92, effective 11/15/92)

WAC 16-54-111 Swine—Importation and testing requirements. (((~~(1) Slaughter swine. Swine not known to be affected with or exposed to infectious or communicable diseases may be moved into the state without health certificate to a federally inspected slaughter establishment or public livestock market specifically approved under Part 76, Title 9, Code of Federal Regulations for immediate slaughter and shall not be diverted enroute for any purpose. The waybills or certificates for movement must state "for immediate slaugh-~~

~~ter." Saleyards receiving for slaughter only swine may not offer such swine for sale for any other purpose without meeting all health certificate and test requirements and receive a permit from the state veterinarian.~~

~~(2) Feeder and breeder swine.~~

~~(a) Swine must be accompanied by a permit issued by the department of agriculture state veterinarian, or the state veterinarian's representative, and an official health certificate stating they are clinically free from infectious and contagious disease or exposure thereto. The consignor and consignee will be properly listed with exact mailing address and destination clearly shown. The name and address of the consignee for pet swine shipments will be verified prior to issuance of the permit to import and a written quarantine will be issued pending post entry pseudorabies testing.~~

~~(b) Swine brucellosis. All swine imported for breeding purposes over six months of age entering the state of Washington must be tested and found negative to brucellosis within thirty days prior to entry or originate in a validated brucellosis free herd or state or area. Swine from herds where brucellosis is known to exist will not be admitted.~~

~~(c) Swine pseudorabies. All swine being imported into the state of Washington must be:~~

~~(i) Tested and found negative to pseudorabies within thirty days prior to the date of importation, and~~

~~(ii) Isolated and held in quarantine at the point of final destination until retested and found negative to pseudorabies at least thirty days and not more than sixty days after the date of importation.~~

~~(d) The following classes of swine are exempt from these pseudorabies test requirements:~~

~~(i) Swine originating from a pseudorabies qualified negative herd where the qualifying test has been conducted within sixty days of shipment and all new additions since the test have been tested negative.~~

~~(ii) Swine being shipped directly to a federally inspected slaughter establishment for immediate slaughter.~~

~~(iii) Direct shipment from a stage IV or V state/area.~~

~~(iv) Swine from a country determined to be free of pseudorabies.~~)) **Import health requirements.**

(1) All swine entering Washington state must be accompanied by an entry permit, a certificate of veterinary inspection, and official USDA approved identification. Feral swine are prohibited in Washington state.

Import test requirements.

(2) **Brucellosis.** All intact male and intact female swine more than six months of age must be tested negative for brucellosis within thirty days before entering Washington state or must originate from a USDA validated brucellosis free herd or state (Swine Brucellosis Control/Eradication State-Federal-Industry Uniform Methods and Rules, April, 1998).

(3) **Pseudorabies.** No test is required from states recognized as Stage IV or Stage V by Pseudorabies Eradication State-Federal-Industry Program Standards, November 1, 2003.

(4) A negative pseudorabies test within thirty days before entry is required for swine from any state or area that loses Stage IV or Stage V status.

Exemptions to import test requirements.

(5) Swine shipped directly to a federally inspected slaughter plant for immediate slaughter are exempt from testing requirements.

Swine semen and embryos.

(6)(a) Swine semen and swine embryos entering Washington state for insemination of swine or implantation into swine shall be accompanied by a certificate of veterinary inspection issued by an accredited veterinarian stating that the donor swine are not known to be infected with or exposed to pseudorabies, were negative to an official pseudorabies serologic test within thirty days prior to the collection of the semen or embryos or were members of a qualified pseudorabies negative herd, and had not been exposed to pseudorabies within thirty days prior to the collection of the semen or embryos.

(b) Brucellosis testing is not required on donor swine from brucellosis validated free states.

(c) Pseudorabies testing is not required on donor swine from pseudorabies Stage IV or Stage V states.

AVIAN SPECIES

AMENDATORY SECTION (Amending WSR 94-23-121, filed 11/22/94, effective 12/23/94)

WAC 16-54-145 ((~~Ratites.~~)) Poultry, including ratites—Importation and testing requirements. ((~~All ratites imported into Washington shall be accompanied by a permit number and a health certificate or certificate of veterinary inspection unless otherwise exempted, stating that the birds are free from signs or exposure to infectious disease. Ratites as defined in chapter 16.57 RCW and/or their eggs or parent flock must be tested negative for the following diseases: Salmonella pullorum typhoid enteriditis [enteritis]. Health requirements for ratites also appears in chapter 16-59 WAC.~~)) **Import health requirements.**

(1) All poultry, including ratites, imported into Washington state must be accompanied by a certificate of veterinary inspection.

(a) USDA VS form 17-6 (Certificate for Poultry or Hatching Eggs for Export) will be accepted in lieu of the certificate of veterinary inspection.

(b) For hatching eggs and baby poultry, a USDA NPIP VS form 9-3 (Report of Sales of Hatching Eggs, Chicks, and Poults) may be used in lieu of the certificate of veterinary inspection.

(c) The certificate of veterinary inspection must include either the NPIP number or negative results of the required tests.

(2) Poultry or hatching eggs must originate from flocks or areas not under state or federal restriction.

(3) Each ratite entering Washington state must be permanently identified with USDA approved identification. The type of identification must be listed on the certificate of veterinary inspection.

Import test requirements.

(4) Poultry must:

(a) Originate from an NPIP participant flock that has met classification requirements for pullorum-typhoid, *Salmonella* enteriditis, and avian influenza; or

(b) Test negative within thirty days before entering Washington for pullorum-typhoid, *S.* enteriditis, and avian influenza.

(5) Hatching eggs must originate from an NPIP participant flock that has met classification requirements for the diseases listed in subsection (4)(a) of this section. If the parent breeder flock is not an NPIP participant, the parent birds must be tested for the above diseases within thirty days before entry.

(6) Turkeys, their poults, and eggs must originate from a producer who is participating in the mycoplasmosis control phase of the NPIP or must have been tested serologically negative for *M. gallisepticum* and *M. synoviae* within thirty days of entry.

Exemptions to import health requirements.

(7) Doves, pigeons, and poultry destined for immediate slaughter are exempt from the certificate of veterinary inspection and testing requirements.

NEW SECTION

WAC 16-54-160 Birds other than poultry—Importation and testing requirements. Import health requirements.

(1) Birds entering Washington state require a certificate of veterinary inspection that contains the following statement:

"To my knowledge, the birds listed on this certificate are free from clinical signs of or known exposure to infectious or communicable disease during the past thirty days."

(2) All birds must be individually identified in a manner appropriate to the species.

Exemptions to import health requirements.

(3) Family pet birds are exempt from the certificate of veterinary inspection.

SMALL ANIMALS

NEW SECTION

WAC 16-54-170 Dogs, cats, and ferrets—Importation and testing requirements. Import health requirements.

(1) Dogs, cats, or ferrets entering Washington state require a certificate of veterinary inspection.

(2) The certificate of veterinary inspection for dogs, cats, or ferrets must identify each animal and certify that each animal at the time of entry is current on rabies vaccination according to the manufacturer's label, and does not originate from an area under quarantine for rabies.

Exemptions to import health requirements.

(3) Dogs, cats, or ferrets less than ninety days of age do not require a rabies vaccination.

(4) Dogs and cats that originate in Washington state and visit Canada for thirty days or less are exempt from a certificate of veterinary inspection.

(5) Dogs, cats, or ferrets that are family pets and have current rabies vaccination certificates and are traveling by private conveyance with their owners are exempt from a certificate of veterinary inspection.

Import test requirements.

(6) The director may require dogs six months of age or older to be tested negative for heartworm.

Exemptions to import test requirements.

(7) Dogs and cats that are family pets, have been owned more than one month, are not going to be sold or have a change of ownership, and are traveling by private conveyance with their owner or handler are exempt from the heartworm test requirement.

WILD AND EXOTIC ANIMALS AND BIRDS, INCLUDING ZOO ANIMALS

NEW SECTION

WAC 16-54-180 Wild and exotic animals and birds—Importation and testing requirements. Import health requirements.

(1) Wild and exotic animals and birds entering Washington state must be accompanied by a certificate of veterinary inspection issued by an accredited veterinarian licensed in the state of origin, or accompanied by an international certificate of health.

(2) All wild and exotic animals must be accompanied by an entry permit.

Import test requirements.

(3) **Brucellosis:** Within thirty days before entering Washington state, negative serologic testing must be conducted on the following categories of captive wild or exotic animals that are more than six months of age:

Table 1.
Wild and exotic animals that must be tested for brucellosis

Tested For	Species Scientific Name	Common Name Examples
Brucella abortus	*Camelidae*	• Vicuna • Guanaco
	Cervidae	• Elk • Caribou • Moose • Reindeer • Deer
	Giraffidae	• Giraffe • Okapi
	Bovidae	• Antelope • Wild cattle (gaur, banteng, kaupre, yak) • Bison (American bison, European bison)

Table 1.
Wild and exotic animals that must be tested for brucellosis

Tested For	Species Scientific Name	Common Name Examples
		• Buffalo (Asian water buffalo, tamaraw, lowland anoa, mountain anoa, African buffalo)
	Ovidae, Capridae	• Wild sheep (bighorn sheep, dalls sheep, mouflon, argoli, uriol, blue sheep, barbary sheep, red sheep) • Wild goats (Rocky Mountain goat, ibex, walia ibex, west caucasion tur, east caucasion tur, Spanish ibex, markhor)
Brucella suis	*Suidae*	• Wild swine (European wild boar, bearded pig, Jovan pig, pygmy hog, wart hog, giant forest pig, East Indian swine or Babirusa, African bush pig, peccaries)
Brucella suis biovar 4	*Cervidae*	• Caribou • Reindeer
Brucella ovis	*Ovidae, Capridae*	• All wild sheep and goats must be tested and found negative to *Brucella ovis* within thirty days before entering Washington state

(4) **Tuberculosis** (*Mycobacterium bovis* and *Mycobacterium tuberculosis*):

(a) Animals less than six months of age that are nursing negative tested dams may be excluded from tuberculosis test requirements.

(b) Within thirty days before entering Washington state, the animals listed in the following table must test negative for *M. bovis* and *M. tuberculosis* by a skin test or other approved test that follows federal tuberculosis protocols:

Table 2.
Wild and exotic animals that must be tested for tuberculosis

Species Scientific Name	Common Name Examples
Ceropithecidae	• Old world primates
Hylobotidae	• Gibbons • Lessor apes
Pongidae	• Great apes
Bovidae	• Antelope • Wild cattle
Ovidae, Capridae	• Wild sheep • Wild goats
Cervidae, Giraffidae	• Elk • Caribou • Moose • Reindeer • Deer • Giraffe • Okapi

(c) *Cervidae*, such as elk, deer, caribou, moose, and reindeer and *Giraffidae*, such as giraffe and okapi, must be from herds not known to be infected with, exposed to, or affected by tuberculosis. They must also test negative for *M. bovis* using the testing requirements defined in Title 9 CFR Part 77.33 (January 1, 2006).

(d) For all captive wild or exotic animals not listed in Table 2 in subsection (2)(b) of this section, the following statement signed by the animal's owner or agent must be placed on the official certificate of veterinary inspection:

"To my knowledge, the animals listed on this certificate are not infected with tuberculosis and have not been exposed to animals infected with tuberculosis during the past twelve months."

(5) **Pseudorabies:** All wild swine imported for zoos, exhibitions or to a research facility must test negative for pseudorabies no more than thirty days before entry into Washington state and must be held in quarantine for thirty to sixty days pending a postentry retest.

(6) **Equine infectious anemia:** All wild horses, donkeys, and hybrids of the family *Equidae* must test negative on an approved test for equine infectious anemia no more than six months before entry into Washington state.

(7) **Elaphostrongylinae** (*Parelophostrongylus tenvis* (meningeal worm) and *Elaphostrongylus cervis* (muscle worm)): Before entering Washington state, all *Cervidae* must be examined for *Elaphostrongylinae* infection in the absence of anthelminthic treatment that could mask detection of the parasite.

(a) **All *Cervidae* residing for at least six months** west of a line through the eastern boundaries of North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, and Texas must have a negative fecal exam for dorsal-spined larvae made by an approved laboratory using the Baermann technique and be certified that they have not been treated with or exposed to anthelminthics for at least thirty days before testing.

(b) **All *Cervidae* residing for less than six months** west of a line through the eastern boundaries of North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, and Texas must be held in a preentry quarantine for thirty to sixty days and have two fecal tests for dorsal-spined larvae made by an approved laboratory using the Baermann technique.

(i) The first test must be conducted at least thirty days and not more than forty days before the second test.

(ii) Fecal samples of at least thirty grams per sample are to be collected by an accredited veterinarian from the animal's rectum and identified by the animal's official identification number.

(iii) During the thirty-day testing period, test animals must be held in quarantine and isolated from all other *Cervidae* not included in the shipment.

(iv) If any animal tests positive to either of the two fecal tests, neither that animal nor any other animal held in quarantine with the infected animal may be imported into Washington state.

(c) All imported *Cervidae* must be held for one hundred eighty days in an onsite quarantine and be available for inspection by the director during this time.

(d) Every thirty, sixty, ninety, one hundred twenty, one hundred fifty, and one hundred eighty days after arrival, fecal samples from the animals must be tested by the Baermann technique in an approved laboratory and be found negative for dorsal-spined larvae. Animals that test positive for dorsal-spined larvae must either be removed from Washington state or destroyed.

(e) To prevent the presence of the gastropod intermediate hosts of *Elaphostrongylinae* larvae, the quarantine site must be prepared and inspected before the imported animals enter. Preparation includes:

(i) Providing a hard surface, such as asphalt or concrete, on which to keep the animals;

(ii) Spraying the quarantine area with an EPA-registered molluscicide; and

(iii) Spraying a four-meter wide tract around the perimeter of the holding compound with an EPA-registered molluscicide. This perimeter tract must be treated once every five days and within twenty-four hours of precipitation (10 mm or more) to ensure that the gastropod population is kept to zero within the compound.

(8) **Rabies:** Any carnivorous mammal taken from the wild is prohibited from entering Washington state if rabies has been diagnosed in the state of origin during the past twelve months.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 16-54-018	Official brucellosis vaccinates.
WAC 16-54-020	Illegal importation.
WAC 16-54-035	Certification of health—Wild and exotic animals.
WAC 16-54-040	Immediate slaughter cattle and horses.
WAC 16-54-050	Vehicles.
WAC 16-54-120	Dogs and cats.
WAC 16-54-125	Species prohibited by state health department.
WAC 16-54-135	Llamas and alpacas.
WAC 16-54-155	Exotic Newcastle Disease (END) quarantine.

WSR 07-10-092
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed May 1, 2007, 3:39 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-13-076.

Title of Rule and Other Identifying Information: Amending WAC 388-550-6000 Outpatient hospital services—Conditions of payment and reimbursement, 388-550-6350 Outpatient sleep apnea/sleep study programs, 388-550-6500 Blood and blood products, 388-550-7000 Outpatient prospective payment system (OPPS)—General, 388-550-7050 OPPS—Definitions, 388-550-7100 OPPS—Exempt hospitals, 388-550-7200 OPPS—Payment method, 388-550-7300 OPPS—Payment limitations, 388-550-7400 OPPS APC relative weights, 388-550-7500 OPPS APC conversion factor, and 388-550-7600 OPPS payment calculation.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend sections in chapter 388-550 WAC relating to outpatient prospective payment system (OPPS), outpatient sleep apnea/sleep study programs, blood and blood components, and conditions of payment and payment methods for outpatient hospital services. These amendments change verbiage from "medical assistance administration (MAA)" to "the department," replace "ambulatory payment classification (APC) conversion factor" with "OPPS conversion fac-

tor," add the definition for "national payment rate," and clarify and update existing language.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Cynthia Smith, P.O. Box 45502, Olympia, WA 98504-5510, (360) 725-1839.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The department has determined that the proposed rule does not meet the definition of "significant legislative rule" under RCW 34.05.328, and therefore a cost-benefit analysis is not required.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 04-20-060, filed 10/1/04, effective 11/1/04)

WAC 388-550-6000 Outpatient hospital services—Conditions of payment and ((~~reimbursement~~)) payment methods. (1) The ((~~medical assistance administration (MAA)~~)) department pays hospitals for covered outpatient hospital services provided to eligible clients when the services meet the provisions in WAC 388-550-1700. All professional medical services must be billed according to chapter 388-531 WAC.

(2) To be paid for covered outpatient hospital services, a hospital provider must:

(a) Have a current core provider agreement with ((~~MAA~~)) the department;

(b) Bill ((~~MAA~~)) the department according to the conditions of payment under WAC 388-502-0100;

(c) Bill ((~~MAA~~)) the department according to the time limits under WAC 388-502-0150; and

(d) Meet program requirements in other applicable WAC and ((~~MAA~~)) the department's published issuances.

(3) ((~~MAA~~)) The department does not pay separately for any services:

(a) Included in a hospital's room charges;

(b) Included as covered under ((~~MAA's~~)) the department's definition of room and board (e.g., nursing services). See WAC 388-550-1050; or

(c) Related to an inpatient hospital admission and provided within one calendar day of a client's inpatient admission.

(4) ((~~MAA~~)) The department does not pay:

(a) A hospital for outpatient hospital services when a managed care plan is contracted with ((~~MAA~~)) the department to cover these services;

(b) More than the "acquisition cost" ("A.C.") for HCPCS (Healthcare Common Procedure Coding System) codes noted in the outpatient fee schedule ((~~as paid "A.C."~~)); or

(c) For cast room, emergency room, labor room, observation room, treatment room, and other room charges in combination when billing periods for these charges overlap.

(5) ((~~MAA~~)) The department uses the outpatient departmental weighted costs-to-charges (ODWCC) rate to pay for covered outpatient services provided in a critical access hospital (CAH). See WAC 388-550-2598.

(6) ((~~MAA~~)) The department uses the maximum allowable fee schedule to pay non-OPPS hospitals and non-CAH hospitals for the following types of covered outpatient hospital services listed in ((~~MAA's~~)) the department's current published outpatient hospital fee schedule and billing instructions:

(a) ((~~Laboratory services~~)) EKG/ECG/EEG and other diagnostics;

(b) Imaging services;

(c) ((~~EKG/ECG/EEG and other diagnostics~~)) Immunizations;

(d) ((~~Physical therapy~~)) Laboratory services;

(e) ((~~Speech/language~~)) Occupational therapy;

(f) ((~~Synagis~~)) Physical therapy;

(g) Sleep studies; ((~~and~~))

(h) Speech/language therapy;

(i) Synagis; and

(j) Other hospital services identified and published by the department.

(7) ((~~MAA~~)) The department uses the hospital outpatient rate as described in WAC 388-550-4500 to pay for covered outpatient hospital services when:

(a) A hospital provider is a non-OPPS or a non-CAH provider; and

(b) The services are not included in subsection (6) of this section.

(8) Hospitals must provide documentation as required and/or requested by ((~~MAA~~)) the department.

(9) All hospital providers must present final charges to the department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department ((~~shall~~)) pays for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department ((~~shall~~)) pays for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the ((~~medical assistance adminis-~~

~~tration (MAA)~~)) the department as centers of excellence for sleep apnea/sleep study programs.

(3) The department ((~~shall~~)) does not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals ((~~shall~~)) must bill the department for sleep studies using current procedural terminology codes. The department ((~~shall~~)) does not ((~~reimburse~~)) pay hospitals for these services when billed under revenue codes alone.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-6500 Blood and blood ((~~products~~)) components. (1) The department ((~~shall limit Medicaid reimbursement to a hospital for blood derivatives to~~)) pays a hospital only for:

(a) Blood bank service charges for processing ((~~the~~)) and storage of blood and blood ((~~products~~)) components; and

(b) Blood administration charges.

(2) ((~~Other than payment of blood bank service charges,~~)) The department ((~~shall~~)) does not pay for blood and blood ((~~derivatives~~)) components.

(3) The department ((~~shall~~)) does not pay a hospital separately ((~~reimburse blood bank service charges for handling and processing blood and blood derivatives provided to an individual who is hospitalized when the hospital is reimbursed under~~)) for the services identified in subsection (1) when these services are included and paid using the diagnosis-related group (DRG) ((~~system~~)), per diem, or per case rate payment rates. ((~~The department shall bundle these service charges into the total DRG payment.~~))

(4) The department ((~~shall reimburse a hospital, which is~~)) pays a hospital no more than the hospital's cost, as determined by the department, for the services identified in subsection (1) when the hospital is paid ((~~under~~)) using the ratio of costs-to-charges (RCC) or departmental weighted costs-to-charges (DWCC) payment method((~~, separately for processing blood and blood products~~)).

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7000 Outpatient prospective payment system (OPPS)—General. (1) The ((~~medical assistance administration's (MAA's)~~)) department's outpatient prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement methodology as its primary reimbursement method. ((~~MAA~~)) The department is basing its OPPS on the centers for medicare and medicaid services (CMS) prospective payment system for hospital outpatient department services.

(2) For a complete description of the CMS outpatient hospital prospective payment system, including the assignment of status indicators (SIs), see 42 CFR, Chapter IV, Part 419. The Code of Federal Regulations (CFR) is available from the CFR web site and the Government Printing Office, Seattle office. The document is also available for public inspection at the Washington state library (a copy of the document may be obtained upon request, subject to any pertinent charge).

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7050 OPPS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the ((~~medical assistance administration's (MAA's)~~)) department's outpatient prospective payment system (OPPS):

((~~**"Alternative outpatient payment"** means a payment calculated using a method other than the ambulatory payment classification (APC) method, such as the outpatient hospital rate or the fee schedule.~~))

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

((~~**"Ambulatory payment classification (APC) weight"** means the relative value assigned to each APC.~~

~~**"Ambulatory payment classification (APC) conversion factor"** means a dollar amount that is one of the components of the APC payment calculation.~~))

"Budget target" means the amount of money appropriated by the legislature or through ((~~MAA's~~)) the department's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means the ((~~MAA~~)) department specific multiplier applied to all payable ambulatory payment classifications (APCs) to allow ((~~MAA~~)) the department to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"Modifier" means 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 hospital 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.

"National payment rate" means a rate for a given procedure code, published by the centers for medicare and medicaid (CMS), that does not include a state or location specific adjustment.

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program published by 3M Health Information Systems that ((~~MAA~~)) the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS.

"Outpatient prospective payment system (OPPS)" means the payment system used by ((~~MAA~~)) the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system conversion factor" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for medicare and medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a one-digit identifier assigned to each service by the outpatient code editor (OCE) software.

"SI" see **"status indicator."**

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7100 OPPS—Exempt hospitals. The ((~~medical assistance administration (MAA)~~)) department exempts the following hospitals from the initial implementation of ((~~MAA's~~)) department's outpatient prospective payment system (OPPS). (Refer to other sections in chapter 388-550 WAC for outpatient payment methods ((~~MAA~~)) the department uses to pay hospital providers that are exempt from ((~~MAA's~~)) the department's OPPS.)

(1) Cancer hospitals;

(2) Critical access hospitals;

(3) Free-standing psychiatric hospitals;

(4) ((~~Out-of-state hospitals (Bordering-city hospitals are considered in-state hospitals. See WAC 388-550-1050.);~~

~~(5)~~)) Pediatric hospitals;

(((~~6~~))) (5) Peer group A hospitals;

(((~~7~~))) (6) Rehabilitation hospitals; and

(((~~8~~))) (7) Veterans' and military hospitals.

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7200 OPPS—Payment method. (1) This section describes the payment methods the ((~~medical assistance administration (MAA)~~)) department uses to pay for covered outpatient hospital services provided by hospitals not exempted from the outpatient prospective payment system (OPPS).

AMBULATORY PAYMENT CLASSIFICATION (APC) METHOD

(2) ((~~MAA~~)) The department uses the APC method when the centers for medicare and medicaid services (CMS) has established ((~~either an APC weight or~~)) a national payment rate to pay for covered services. The APC method is the primary payment methodology for OPPS. Examples of services paid by the APC methodology include, but are not limited to:

(a) Ancillary services;

(b) Medical visits;

(((~~b~~))) (c) Nonpass-through drugs or devices;

(d) Observation services;

(e) Packaged services subject to separate payment when criteria are met;

(f) Pass-through drugs;

(g) Significant procedures that are not subject to multiple procedure discounting (except for dental-related services);

(((~~c~~))) (h) Significant procedures that are subject to multiple procedure discounting; and

(((~~(d) Nonpass-through drugs or devices;~~

~~(e) Observation services; and~~

~~(f) Ancillary services~~)) (i) Other services as identified by the department.

OPPS MAXIMUM ALLOWABLE FEE SCHEDULE

(3) ((~~MAA~~)) The department uses the ((~~OPPS~~)) outpatient fee schedule published in the ((~~OPPS section of MAA's~~)) the department's billing instructions to pay for covered:

(a) Services that are exempted from the APC payment methodology or services for which there are no established weight(s);

(b) Procedures that are on the CMS inpatient only list;

(c) Items, codes, and services that are not covered by medicare;

(d) Corneal tissue acquisition;

(e) ((~~Drugs or biologicals that are pass-throughs; and~~

~~(f)~~)) Devices that are pass-throughs (see WAC 388-550-7050 for definition of pass-throughs); and

(f) Dental clinic services.

HOSPITAL OUTPATIENT RATE

(4) ((~~MAA~~)) The department uses the hospital outpatient rate described in WAC 388-550-3900 and 388-550-4500 to pay for the services listed in subsection (3) of this section for which ((~~MAA~~)) the department has not established a maximum allowable fee.

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7300 OPPS—Payment limitations. (1) The ((~~medical assistance administration (MAA)~~)) department limits payment for covered outpatient hospital services to the current published maximum allowable units of services listed in the outpatient ((~~prospective payment system (OPPS)~~)) fee schedule and published in the ((~~OPPS section of MAA's~~)) department's hospital billing instructions, subject to the following:

(a) When a unit limit for services is not stated in the ((~~OPPS~~)) outpatient fee schedule, ((~~MAA~~)) department pays for services according to the program's unit limits stated in applicable WAC and published issuances.

(b) Because multiple units for services may be factored into the ambulatory payment classification (APC) weight, ((~~MAA~~)) department pays for services according to the unit limit stated in the ((~~OPPS~~)) outpatient fee schedule when the limit is not the same as the program's unit limit stated in applicable WAC and published issuances.

(2) ((~~MAA~~)) The department does not pay separately for covered services that are packaged into the APC rates. These services are paid through the APC rates.

(3) The department:

(a) Limits surgical dental services payment to the ambulatory surgical services fee schedule and pays:

(i) The first surgical procedure at the applicable ambulatory surgery center group rate; and

(ii) The second surgical procedure at fifty percent of the ambulatory surgery center group rate.

(b) Considers all surgical procedures not identified in subsection (a) to be bundled.

(4) The department limits outpatient services billing to one claim per episode of care. If there are late charges, or if any line of the claim is denied, the department requires the entire claim to be adjusted.

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7400 OPPS APC relative weights. The ((~~medical assistance administration (MAA)~~)) department uses the ambulatory payment classification (APC) relative weights established by the centers for medicare and medicaid services (CMS) at the time the budget target adjustor is established. ((~~MAA updates the APC relative weights at least quarterly in conjunction with the outpatient code editor (OCE) updates~~)) See WAC 388-550-7050 for the definition of budget target adjustor.

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7500 OPPS ((~~APC~~)) conversion factor. The ((~~medical assistance administration (MAA) uses the ambulatory payment classification (APC) conversion factors established by the Centers for Medicare and Medicaid Services (CMS) and in effect on November 1, 2004, as MAA's initial APC conversion factors. MAA updates its APC conversion factors at least biannually~~)) department calculates the outpatient prospective payment system (OPPS) conversion factors by modeling, using the centers for medicare and medicaid services (CMS) addendum B and wage index information available and published at the time the OPPS conversion factors are set for the upcoming year.

AMENDATORY SECTION (Amending WSR 04-20-061, filed 10/1/04, effective 11/1/04)

WAC 388-550-7600 OPPS payment calculation. (1) The ((~~medical assistance administration (MAA)~~)) department follows the discounting and modifier policies of the centers for medicare and medicaid services (CMS). ((~~MAA~~)) The department calculates the ambulatory payment classification (APC) payment as follows:

APC payment =
((~~APC relative weight x APC conversion factor x~~)) National payment rate x Hospital OPPS conversion factor x
Discount factor (if applicable) x Units of service (if applicable) x Budget target adjustor

(2) The total OPPS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

(3) The department pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

(a) Billed amount minus the third-party payment amount; or

(b) Allowed amount minus the third-party payment amount.

WSR 07-10-093
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:41 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-17-136.

Title of Rule and Other Identifying Information: Amending WAC 388-550-1100 Hospital coverage, 388-550-2600 Inpatient psychiatric services, and 388-550-2650 Base community psychiatric hospitalization payment method for Medicaid and non-Medicaid clients.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules update and clarify information regarding the department's inpatient psychiatric services coverage (including adding applicable definitions), payment policy, and general policy for hospital care. The proposed rules also clarify how the department pays a hospital for covered dental-related services that are provided in the hospital's operating room. Also, effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for Medicaid and state children's health insurance program (SCHIP) clients and non-Medicaid and non-SCHIP clients is no longer used. (A "non-Medicaid or non-SCHIP client" is defined as a client eligible under the general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psy-

chiatric indigent inpatient (PII) program, or other state-administered program, as determined by the department.)

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 01-16-142, filed 7/31/01, effective 8/31/01)

WAC 388-550-1100 Hospital ((~~coverage~~)) care — General. (1) The ((~~medical assistance administration (MAA) covers~~)) department:

(a) Pays for the admission of an eligible medical assistance client to a hospital only when the client's attending physician orders admission and when the admission and treatment provided ((~~meet the requirements of~~)):

(i) Are covered according to WAC 388-501-0050, 388-501-0060 and 388-501-0065;

(ii) Are medically necessary as defined in WAC 388-500-0005;

(iii) Are determined according to WAC 388-501-0165 when prior authorization is required;

(iv) Are authorized when required under this chapter; and

(v) Meet applicable state and federal requirements.

(b) For ((~~nonemergent~~)) hospital admissions, defines "attending physician" ((~~means~~)) as the client's primary care provider, or the primary provider of care to the client at the time of ((~~hospitalization. For emergent admissions, "attending physician" means the staff member who has hospital admitting privileges and evaluates the client's medical condition upon the client's arrival at the hospital~~)) admission.

(2) Medical record documentation of hospital services must meet the requirements in WAC 388-502-0020((~~(1), Records and reports—Medical record system~~)).

(3) ((~~In areas where the choice of hospitals is limited by managed care or selective contracting, the department is not responsible for payment under fee-for-service for hospital care and/or services:~~

~~(a) Provided to clients enrolled in an MAA managed care plan, unless the services are excluded from the health carrier's capitation contract with MAA and are covered under the medical assistance program; or~~)) The department:

(a) Pays for a hospital covered service provided to an eligible medical assistance client enrolled in a department managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the department and meets prior authorization requirements. (See WAC 388-550-2600 for inpatient psychiatric services.)

(b) ((~~Received by a Medicaid-eligible~~)) Does not pay for nonemergency services provided to a medical assistance client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 388-550-4600 and 388-550-4700 apply. The department's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The department ((~~provides chemical-dependent pregnant Medicaid-eligible clients~~)) pays up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment ((~~when:~~

~~(a) An alcoholism, drug addiction and treatment support act ADATSA assessment center verifies the need for the inpatient care; and~~

~~(b) The hospital chemical dependency treatment unit is certified by the division of alcohol and substance abuse~~)) for chemical dependent pregnant clients eligible under the chemical-using pregnant (CUP) women program.

See ((~~WAC 388-550-6250 for outpatient hospital services for chemical-dependent pregnant Medicaid clients~~)) WAC 388-533-0701 through 0730.

(5) The department ((~~covers~~)) pays for inpatient hospital detoxification of acute alcohol or other drug intoxication ((~~only in a hospital having a detoxification provider agreement with MAA to perform these services~~)) when the services are provided to an eligible client:

(a) In a detoxification unit in a hospital that has a detoxification provider agreement with the department to perform these services and the services are approved by the division of alcohol and substance abuse (DASA); or

(b) In an acute hospital and all of the following criteria are met:

(i) The hospital does not have a detoxification specific provider agreement with DASA;

(ii) The hospital provides the care in a medical unit;

(iii) Non-hospital based detoxification is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from a regional support network (RSN) or a mental health division (MHD) designee as an inpatient stay;

(v) The client's stay qualifies as an inpatient stay;

(vi) The client is not participating in the department's chemical-using pregnant (CUP) women program; and

(vii) The client's principal diagnosis meets the department's medical inpatient detoxification criteria listed in the department's published billing instructions.

(6) The department covers medically necessary dental-related services provided to an eligible client((~~s~~)) in a ((~~hospital setting for the care or treatment of teeth, jaws, or structures directly supporting the teeth:~~

~~(a) If the procedure requires hospitalization; and~~

~~(b) A physician or dentist provides or directly supervises such services~~)) hospital-based dental clinic when the services:

(a) Are provided in accordance with chapter 388-535 WAC; and

(b) Are billed on the American Dental Association (ADA) or health care financing administration (HCFA) claim form.

(7) The department pays a hospital((~~s~~)) for covered dental-related services ((~~provided in special care units when the provisions in WAC 388-550-2900(13) are met~~)), including oral and maxillofacial surgeries, that are provided in the hospital's operating room, when:

(a) The covered dental-related services are medically necessary and provided in accordance with chapter 388-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least on of the following is true:

(i) The dental-related service(s) is provided to an eligible medical assistance client on an emergency basis;

(ii) The client is eligible under the division of developmental disability program;

(iii) The client is age eight or younger; or

(iv) The dental service is prior authorized by the department.

(8) ((~~All services are subject to review and approval as stated in WAC 388-501-0050.~~

~~(9)~~)) For inpatient voluntary or involuntary psychiatric admissions, see WAC 388-550-2600 ((~~and chapter 246-318 WAC~~)).

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-2600 Inpatient psychiatric services. ((~~For psychiatric hospitalizations, including involuntary admissions, see chapter 246-318 [246-320] WAC~~)) (1) The department, on behalf of the mental health division (MHD), regional support networks (RSNs) and prepaid inpatient health plans (PIHPs), pays for covered inpatient psychiatric services for a voluntary or involuntary inpatient psychiatric admission of an eligible medical assistance client, subject to the limitation and restrictions in this section and other published rules.

(2) The following definitions and abbreviations and those found in WAC 388-550-0005 and 388-550-1050 apply to this section (where there is any discrepancy, this section prevails):

(a) "Authorization number" refers to a number that is required on a claim in order for a provider to be paid for providing psychiatric inpatient services to a medical assistance client. An authorization number:

(i) Is assigned when the certification process and administrative prior authorization process has occurred;

(ii) Identifies a specific request for the provision of psychiatric inpatient services to a medical assistance client;

(iii) Verifies when prior or retrospective authorization has occurred;

(iv) Will not be rescinded once assigned; and

(v) Does not guarantee payment.

(b) "Certification" means a clinical determination by a MHD designee that a client's need for a voluntary or involuntary inpatient psychiatric admission, length of stay extension, or transfer has been reviewed and, based on the information provided, meets the requirements for medical necessity for inpatient psychiatric care. The certification process occurs concurrently with the administrative prior authorization process.

(c) "I.D." See "Institution for Mental Diseases."

(d) "Institution for Mental Diseases (I.D.)" means a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The MHD designates whether a facility meets the definition for an I.D.

(e) "Involuntary admission" refer to chapters 71.05 and 71.34 RCW.

(f) "Mental health division (MHD)" is the unit within the department of social and health services (DSHS) authorized to contract for and monitor delivery of mental health programs. MHD is also known as the state mental health authority.

(g) "Mental health division designee" or "MHD designee" means a professional contact person authorized by MHD, who operates under the direction of a regional support network (RSN) or a prepaid inpatient health plan (PIHP).

(h) "PIHP" see "Prepaid inpatient health plan."

(i) "Prepaid inpatient health plan (PIHP)" see WAC 388-865-0300.

(j) "Prior authorization" means an administrative process by which hospital provides must obtain a MHD designee's certification for a client's inpatient psychiatric admission, length of stay extension, or transfer. The administrative prior authorization process occurs concurrently with the certification process.

(k) "Regional support network (RSN)" see WAC 388-865-0200.

(l) "Retrospective authorization" means a process by which hospital providers and hospital unit providers must obtain a MHD designee's certification after services have been initiated for a medical assistance client. This process is allowed only when circumstances beyond the control of the hospital or hospital unit provider prevented a prior authorization request.

(m) "RSN" see "regional support network."

(n) "Voluntary admission" refer to chapters 71.05 and 71.34 RCW.

(3) The following department of health (DOH)-licensed hospitals and hospital units are eligible to be paid for provid-

ing inpatient psychiatric services to eligible medical assistance clients, subject to the limitations listed:

(a) Medicare-certified distinct part psychiatric units;

(b) State-designated pediatric psychiatric units;

(c) Hospitals that provide active psychiatric treatment outside of a medicare-certified or state-designated psychiatric unit, under the supervision of a physician; and

(d) Free-standing psychiatric hospitals approved as an institution for mental diseases (I.D.).

(4) To be paid for a voluntary inpatient psychiatric admission:

(a) The hospital provider or hospital unit provider must meet the applicable general conditions of payment criteria in WAC 388-502-0100; and

(b) The voluntary inpatient psychiatric admission must meet the following:

(i) For a client eligible for medical assistance, the admission to voluntary inpatient psychiatric care must:

(A) Be medically necessary as defined in WAC 388-500-0005;

(B) Be ordered by an agent of the hospital who has the clinical or administrative authority to approve an admission;

(C) Be prior authorized and meet certification and prior authorization requirements as defined in subsection (2) of this section. See subsection (7) of this section for a voluntary inpatient psychiatric admission that was not prior authorized and requires retrospective authorization by the client's MHD designee; and

(D) Be verified by receipt of a certification form dated and signed by an MHD designee (see subsection (2) of this section). The form must document at least the following:

(I) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(II) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(III) The inpatient services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning;

(IV) The client has been diagnosed as having an emotional or behavioral disorder, or both, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; and

(V) For admission to long term inpatient psychiatric care, the client has been diagnosed with a severe psychiatric disorder that warrants extended care in the most intensive, restrictive setting.

(ii) For a client eligible for both medicare and a medical assistance program, the department pays secondary to medicare.

(iii) For a client eligible for both medicare and a medical assistance program and who has not exhausted medicare lifetime benefits, the hospital provider or hospital unit provider must notify the MHD designee of the client's admission if the dual eligibility status is known. The admission:

(A) Does not require prior authorization by a MHD designee; and

(B) Must be in accordance with medicare standards.

(iv) For a client eligible for both medicare and a medical assistance program who has exhausted medicare lifetime benefits, the admission must have prior authorization by a MHD designee.

(v) When a liable third party is identified (other than medicare) for a client eligible for a medical assistance program, the hospital provider or hospital unit provider must obtain a MHD designee's authorization for the admission.

(5) To be paid for an involuntary inpatient psychiatric admission:

(a) The involuntary inpatient psychiatric admission must be in accordance with the admission criteria specified in chapters 71.05 and 71.34 RCW; and

(b) The hospital provider or hospital unit provider:

(i) Must be certified by the MHD in accordance with chapter 388-865 WAC;

(ii) Must meet the applicable general conditions of payment criteria in WAC 388-502-0100; and

(iii) When submitting a claim, must include a completed and signed copy of Involuntary Treatment Act Patient Claim Information form (DSHS 13-628).

(6) To be paid for providing continued inpatient psychiatric services to a medical assistance client who has already been admitted, the hospital provider or hospital unit provider must request from a MHD designee within the time frames specified, certification and authorization as defined in subsection (2) of this section for any of the following circumstances:

(a) If the client converts from involuntary (legal) status to voluntary status, or from voluntary to involuntary (legal) status as described in chapter 71.05 or 71.34 RCW, the hospital provider or hospital unit provider must notify the MHD designee prior to the change of status;

(b) If an application is made for determination of a patient's medical assistance eligibility, the request for certification and prior authorization must be submitted by the close of the next business day;

(c) If there is a change in the client's principal ICD9-CM diagnosis to a mental disorder, the request for certification and prior authorization must be submitted within two business days of the change;

(d) If there is a request for a length of stay extension for the client, the request for certification and prior authorization must be submitted prior to the end of the initial allowed days of services (see subsections (10) and (11) of this section for payment methodology and payment limitations); and

(e) If the client is to be transferred from one community hospital to another community hospital for continued inpatient psychiatric care, the request for certification and prior authorization must be submitted prior to the transfer.

(7) A MHD designee has the authority to approve or deny a request for retrospective certification for a client's voluntary inpatient psychiatric admission, length of stay extension, or transfer that was not prior authorized. The MHD designee responds to the hospital unit within three working days of the request, in accordance with the requirements of this section, and bases an approval or denial:

(a) On the client's condition at the time of admission to the hospital or hospital unit if the request is for retrospective authorization of admission; or

(b) On the client's condition at the time of the end of the allowable day of service in that hospital or hospital unit if the

request is for retrospective authorization for a length of stay extension or for a transfer.

(8) To be paid for a psychiatric inpatient admission of an eligible medical assistance client, the hospital provider or hospital unit provider must submit on the claim form the authorization (see subsection (2)(a) for definition of prior authorization and retrospective authorization).

(9) The department uses the payment methods described in WAC 388-550-2650 through 388-550-5600, as appropriate, to pay a hospital and hospital unit for providing psychiatric services to medical assistance clients, unless otherwise specified in this section.

(10) Covered days for a voluntary psychiatric admission are determined by a MHD designee utilizing MHD approved utilization review criteria.

(11) The number of paid days authorized for an involuntary psychiatric admission is limited to twenty days. If the length of stay exceeds twenty days, the hospital provider or hospital unit provider must request a length of stay extension prior to the twentieth day of service.

(12) The department pays the administrative day rate for any authorized days of voluntary inpatient psychiatric stay that meet the administrative day definition in WAC 388-550-1050.

(13) In order for a MHD designee to implement and participate in a medical assistance client's plan of care, a hospital provider or hospital unit provider must provide any clinical and cost of care information to the MHD designee upon request. This requirement applies to all medical assistance clients admitted for:

(a) Voluntary inpatient psychiatric services; and

(b) Involuntary inpatient psychiatric services, regardless of payment source.

(14) If the number of days billed exceeds the number of days authorized by the MHD designee for any claims paid, the department will recover any unauthorized days paid.

AMENDATORY SECTION (Amending WSR 07-06-043, filed 3/1/07, effective 4/1/07)

WAC 388-550-2650 Base community psychiatric hospitalization payment method for medicaid and SCHIP clients and non-medicaid and non-SCHIP clients. (1) Effective for dates of admission from July 1, 2005 through June 30, 2007, and in accordance with legislative directive, the department implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and SCHIP clients and one for non-medicaid and non-SCHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and SCHIP clients and non-medicaid and non-SCHIP clients is no longer used. (For the purpose of this section, a "non-medicaid or non-SCHIP client" is defined as a client eligible under the general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered program, as determined by the department.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and SCHIP covered patients, paid to hospitals that accept commitments under the involuntary treatment act (ITA).

(b) The non-medicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC 388-500-0005. In addition, the department considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The department does not consider detoxification to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate mental health division (MHD) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC 388-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a MHD designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC 388-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act patient claim information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the county involuntary treatment office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and department-covered services.

(6) The medicaid base community psychiatric hospitalization payment rate applies only to a medicaid or SCHIP client admitted to a non-state-owned free-standing psychiatric hospital located in Washington state.

(7) The non-medicaid base community psychiatric hospitalization payment rate applies only to a non-medicaid or SCHIP client admitted to a hospital:

(a) Designated by the department as an ITA-certified hospital; or

(b) That has a department-certified ITA bed that was used to provide ITA services at the time of the non-medicaid or non-SCHIP admission.

(8) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the department pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the department-specific non-diagnosis related group (DRG) payment method.

(ii) For non-medicaid and non-SCHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-((~~only~~))administered program DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system.

(ii) For non-medicaid and SCHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-((~~only~~))administered program DRG allowable (including the high cost outlier allowable, if applicable), or the department-specified non-DRG payment method if no relative weight exists for the DRG in the department's payment system; or

(B) The non-medicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A non-state-owned free-standing psychiatric hospital as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For non-medicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and SCHIP clients, except the base community inpatient psychiatric hospital payment rate is the non-medicaid rate, and the RCC allowable is the state-((~~only~~))administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650.

(ii) For non-medicaid and non-SCHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC 388-550-4650 in conjunction with the non-medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For medicaid and SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

(ii) For non-medicaid non-SCHIP clients, inpatient hospital psychiatric services are paid using the department-specified non-DRG payment method.

WSR 07-10-094
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:42 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: Amending WAC 388-550-2598 Critical access hospital (CAH) program.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane behind Goodyear Tire. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The health and recovery services administration (HRSA) is amending this rule to add language to update and clarify the department's critical access hospital (CAH) policy and processes for rate-setting, claim payment, etc. The proposed rule incorporates into rule that for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

Reasons Supporting Proposal: See purpose statement above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45510, Olympia, WA 98504-5510, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has analyzed the proposed rule and concluded that no new costs will be imposed on businesses affected by them. The preparation of a comprehensive small business economic impact statement is not required.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45510, Health and Recovery Services Administration, Olympia, WA 98504-5510, phone (360) 725-1856, fax (360) 743-9152 [753-9152], e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-03-077, filed 1/17/07, effective 2/17/07)

WAC 388-550-2598 Critical access hospitals (CAHs). (1) ((~~The department reimburses department of health (DOH)-approved critical access hospitals (CAHs) for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis, using departmental weighted costs-to-charges (DWCC) ratios and a retrospective cost settlement process. The department pays CAH fee-for-service hospital claims subject to retrospective cost settlement, adjustments such as a third party payment amount, and any client responsibility amount.~~

~~(2) For inpatient and outpatient hospital services provided to clients enrolled in a managed care plan, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care Healthy Options DWCC payment rates to be cost. Cost settlements are not performed by the department for managed care claims.~~

~~(3) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this section:~~

~~(a) "CAH," see "critical access hospital."~~

~~(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with use of the CAH's final settled Medicare cost report (Form 2552-96) after the end of the CAH's HFY.~~

~~(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.~~

~~(d) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (8) for how the department calculates a DWCC rate.~~

~~(e) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."~~

~~(f) "HFY" see "hospital fiscal year."~~

~~(g) "Hospital fiscal year" means each individual hospital's fiscal year.~~

~~(h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for services provided during its current hospital fiscal year, using the appropriate DWCC rate, as determined by the department.~~

~~(i) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue and procedure codes that are grouped to each hospital's Medicare Cost Report in reported cost centers.~~

~~(4) To be reimbursed as a CAH by the department, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the department upon request. CAHs reimbursed under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.~~

~~(5) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.~~

~~(6) To ensure quality of care:~~

~~(a) A CAH is responsible to investigate any reports of substandard care or violations of the facility's medical staff bylaws; and~~

~~(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:~~

~~(i) Department of health (DOH); or~~

~~(ii) Other agencies with review authority for department programs.~~

~~(7) The department may conduct a postpay or on-site review of any CAH.~~

~~(8) The department prospectively calculates fee-for-service and managed care inpatient and outpatient DWCC rates separately for each CAH. To calculate prospective interim inpatient and outpatient DWCC rates for each hospital currently in the CAH program, the department:~~

~~(a) Obtains from each CAH its estimated aggregate charge master change for its next HFY;~~

~~(b) Obtains from each CAH the costs-to-charges ratio of each respective cost center the "as filed" version of the Medicare cost report the CAH initially submits for cost settlement of its most recently completed HFY;~~

~~(c) Obtains from each CAH the revenue codes and procedure codes to cost centers crosswalk related to the Medicare cost report used for cost settlement. Each CAH must indicate any differences between the revenue codes and procedure codes to cost centers crosswalk and the standard groupings of revenue codes and procedure codes to cost cen-~~

ters crosswalk statistics the department provides to the hospital from the department's CAH DWCC rate calculation model. (Example: A CAH reports to the department that for its DWCC rate calculation, the Anesthesia Cost Center, Revenue Code 370, should be grouped to the Surgery Cost Center, Revenue Code 360.)

(d) Obtains from the Medicaid management information system (MMIS) the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (b) of this subsection:

(i) Medical assistance program codes;

(ii) Inpatient and outpatient claim types;

(iii) Procedure codes, revenue codes, or diagnosis-related group (DRG) codes;

(iv) Allowed charges and third party liability/client and department paid amounts; and

(v) Units of service.

(e) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified in (b) of this section:

(i) Medical assistance program codes;

(ii) Inpatient and outpatient claim types;

(iii) Procedure codes, revenue codes, or diagnosis-related group (DRG) codes; and

(iv) Allowed charges.

(f) Separates the inpatient claims data and outpatient claims data;

(g) Obtains the cost center allowed charges by classifying inpatient and outpatient allowed charges from (d) and (e) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" Medicare cost report the CAH initially submits to the department. The department:

(i) Uses the claims classifications and cost center combinations as defined in the department's CAH DWCC rate calculation model;

(ii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(iii) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been submitted and a cost center average is being used; and

(iv) Does not allow an unbundling of cost centers.

(h) Determines the departmental-weighted costs for each cost center by multiplying the cost center's allowed charges from (d) and (e) of this subsection for the appropriate inpatient or outpatient claim type by the related service cost center ratio;

(i) Sums all allowed charges from (d) and (e) of this subsection;

(j) Sums all departmental-weighted costs for inpatient and outpatient claims from (h) of this subsection;

(k) Multiplies each hospital's total departmental-weighted costs from (j) of this subsection by the Medicare market basket inflation rate. The Medicare market basket inflation rate is published and updated periodically by the centers for Medicare and Medicaid services (CMS);

(l) Multiplies each hospital's total allowed charges from (i) of this subsection by the CAH estimated charge master change from (a) of this subsection. If the charge master change factor is not available from the hospital, the department will apply a reasonable alternative factor; and

(m) Determines the DWCC inpatient and outpatient rates by dividing the calculation result from (k) of this section by the calculation result from (l) of this subsection.

(9) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective DWCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" Medicare cost report, and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) Managed care clients is:

(i) The hospital's most recent "as filed" Medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(10) For a newly licensed hospital that is also a CAH, the department uses the current statewide average DWCC rates for the initial prospective DWCC rates.

(11) For a CAH that comes under new ownership, the department uses the prior owner's DWCC rates.

(12) In addition to the prospective managed care inpatient and outpatient DWCC rates, the department:

(a) Incorporates the DWCC rates into the calculations for the managed care capitated premiums that will be paid to the managed care plans; and

(b) Requires all managed care plans having contract relationships with CAHs to pay the inpatient and outpatient DWCC rates applicable to managed care claims. For purposes of this section, the department considers the DWCC rates used to reimburse CAHs for care given to clients enrolled in a managed care plan to be cost. Cost settlements are not performed for managed care claims.

(13) For fee-for-service claims only, the department uses the same methodology as outlined in subsection (8) to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" Medicare cost report data, the revenue codes and procedure codes to cost centers crosswalk provided by the CAH, and claims data from the fee-for-service claims. Specifically, the department:

(a) Compares actual department total interim CAH payments to the departmental weighted CAH fee for service costs for the period being cost settled; and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The department recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(14) The department performs finalized cost settlements using the same methodology as outlined in subsection (13) of this section, except that the department uses the hospital's final settled Medicare cost report instead of the initial "as filed" Medicare cost report. The CAH must submit its final settled Medicare cost report to the department by the sixtieth day of receiving its Medicare cost report that has been settled

~~by the Medicare fiscal intermediary. The department will use the final settled Medicare cost report for a final cost settlement~~)) The following definitions and abbreviations and those found in WAC 388-500-0005 and 388-550-1050 apply to this section:

(a) "CAH," see "critical access hospital."

(b) "Cost settlement" means a reconciliation of the fee-for-service interim CAH payments with a CAH's actual costs determined in conjunction with the use of the CAH's final settled medicare cost report (Form 2552-96) after the end of the CAH's HFY.

(c) "Critical access hospital (CAH)" means a hospital that is approved by the department of health (DOH) for inclusion in DOH's critical access hospital program.

(d) "Departmental weighted costs-to-charges (DWCC) rate" means a rate the department uses to determine a CAH payment. See subsection (5) of this section for how the department calculates a DWCC rate.

(e) "DWCC rate" see "departmental weighted costs-to-charges (DWCC) rate."

(f) "HFY" see "Hospital fiscal year."

(g) "Hospital fiscal year" means each individual hospital's medicare cost report fiscal year.

(h) "Interim CAH payment" means the actual payment the department makes for claims submitted by a CAH for service provided during its current HFY, using the appropriate DWCC rate, as determined by the department.

(i) "Revenue codes and procedure codes to cost centers crosswalk" means a document that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in each hospital's medicare cost report.

(2) To be paid as a CAH by the department, a hospital must be approved by the department of health (DOH) for inclusion in DOH's critical access hospital program. The hospital must provide proof of CAH status to the department upon request. A CAH paid under the CAH program must meet the general applicable requirements in chapter 388-502 WAC. For information on audits and the audit appeal process, see WAC 388-502-0240.

(3) The department pays an eligible CAH for inpatient and outpatient hospital services provided to fee-for-service medical assistance clients on a cost basis (except when services are provided in a distinct psychiatric unit, a distinct rehabilitation unit, or detoxification unit), using departmental weighted costs-to-charges (DWCC) rates and a retrospective cost settlement process. The department pays CAH fee-for-service claims subject to retrospective cost settlement, adjustments such as a third party payment amount, any client responsibility amount, etc.

(4) For inpatient and outpatient hospital services provided to clients enrolled in a managed care organization (MCO) plan, DWCC rates for each CAH are incorporated into the calculations for the managed care capitated premiums. The department considers managed care Health Options and MHD designee DWCC payment rates to be cost. Cost settlements are not performed by the department for managed care claims.

(5) The department prospectively calculates fee-for-service and managed care inpatient and outpatient DWCC rates separately for each CAH.

(a) Prior to the department's calculation of the prospective interim inpatient DWCC and outpatient DWCC rates for each hospital participating in the CAH program, the CAH must timely submit the following to the department:

(i) Within twenty working days of receiving the request from the department, the CAH's estimated aggregate charge master change for its next HFY;

(ii) At the time that the "as filed" version of the medicare cost report the CAH initially submits to the medicare fiscal intermediary for the cost settlement of its most recently completed HFY, a copy of that same medicare cost report;

(iii) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, the CAH's corresponding revenue codes and procedure codes to cost centers crosswalk that indicates the revenue codes and procedure codes that are assigned by each hospital to a specific cost center in the hospital's medicare cost report;

(iv) At the same time that the "as filed" version of the medicare cost report the CAH has submitted to the medicare fiscal intermediary for cost settlement of its most recently completed HFY, a document indicating any differences between the CAH's revenue codes and procedure codes to cost centers crosswalk and the standard revenue codes and procedure codes to cost centers crosswalk that the department provides to the CAH from the department's CAH DWCC rate calculation model. (For example, a CAH hospital might indicate when it submits its crosswalk to the department, that a difference exists in the CAH's placement of statistics for the anesthesia revenue code normally identified to the anesthesia cost center in the department's CAH DWCC rate calculation model, but identified to the surgery cost center in the CAH's submitted medicare cost report.)

(b) The department:

(i) Determines if differences between the CAH's crosswalk and the crosswalk in the CAH DWCC rate calculation model will be allowed when the CAH timely submits the document identified in (a)(iii) and (a)(iv) of this subsection. If the CAH does not timely submit the document, the department may use the CAH DWCC rate calculation model without considering the differences.

(ii) Does not allow unbundling or merging of the standard cost centers identified in the CAH DWCC rate calculation model when the department calculates the DWCC rates. This is a standard the department follows during the rate calculation process even though the CAH hospital may have in contrast to the CAH DWCC rate calculation model indicated multiple cost centers, or merged into fewer costs centers, when reporting in the medicare cost report. (For example, a CAH reports to the department that in the department's standard radiology cost center grouping in the CAH DWCC rate calculation model, the hospital has established three costs centers in the medicare cost report, which are radioisotopes, radiology therapeutic, and radiology diagnostic. During the rate calculation process, the department combines these three cost centers under the standard radiology cost center group-

ing. No unbundling of the standard cost center grouping is allowed.)

(c) The department:

(i) Obtains from its medicaid management information system (MMIS), the following fee-for-service summary claims data submitted by each CAH for services provided during the same HFY identified in (a)(ii) of this subsection:

(A) Medical assistance program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DRG) codes (for inpatient claims only);

(D) Claim allowed charges, third party liability, client paid amounts, and department paid amounts; and

(E) Units of service.

(ii) Obtains Level III trauma payment data from the department of health (DOH).

(iii) Obtains the costs-to-charges ration (CCR) of each respective cost center from the "as filed" version of the medicare cost report identified in (a)(ii) of this subsection, supplemented by any crosswalk information as described in (a)(iii) and (a)(iv) of this subsection.

(iv) Obtains from the managed care encounter data the following data submitted by each CAH for services provided during the same HFY identified:

(A) Medical assistance program codes;

(B) Inpatient and outpatient hospital claim types;

(C) Procedure codes (for outpatient hospital claims only), revenue codes, and diagnosis related group (DGR) codes (for inpatient claims only); and

(D) Claim allowed charges.

(v) Separates the inpatient claims data and outpatient hospital claims data;

(vi) Obtains the cost center claim allowed charges by classifying inpatient and outpatient hospital claim allowed charges from (c)(i) and (c)(iv) of this subsection billed by a CAH (using any one of, or a combination of, procedure codes, revenue codes, or DRG codes) into the related cost center in the CAH's "as filed" medicare cost report the CAH initially submits to the department.

(vii) Uses the claims classifications and cost center combinations as defined in the department's CAH DWCC rate calculation model;

(viii) Assigns a CAH that does not have a cost center ratio that CAH's cost center average;

(ix) Allows changes only if a revenue codes and procedure codes to cost centers crosswalk has been timely submitted (see (a)(iii), (a)(iv), and (b)(i) of this subsection) and a cost center average is being used;

(x) Does not allow an unbundling of cost centers (see (b)(ii) of this subsection);

(xi) Determines the departmental-weighted costs for each cost center by multiplying the cost center's claim allowed charges from (c)(i) and (c)(iv) of this subsection for the appropriate inpatient or outpatient claim type by the related service costs center ratio;

(xii) Sums all:

(A) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for inpatient hospital claims.

(B) Claim allowed charges from (c)(i) and (c)(iv) of this subsection separately for outpatient hospital claims.

(xiii) Sums all:

(A) Departmental-weighted costs from (c)(xi) of this subsection separately for inpatient hospital claims.

(B) Departmental-weighted costs from (c)(xi) of this subsection separately for outpatient hospital claims.

(xiv) Multiplies each hospital's total departmental-weighted costs from (c)(xiii) of this subsection by the centers for medicare and medicaid services (CMS) medicare market basket inflation rate to update costs from the HFY to the rate setting period. The medicare market basket inflation rate is published and updated by CMS periodically;

(xv) Multiplies each hospital's total claim allowed charges from (c)(xii) of this subsection by the CAH estimated charge master change from (a)(i) of this subsection. If the charge master change factor is not submitted timely by the hospital (see (a)(i) of this subsection), the department will apply a reasonable alternative factor; and

(xvi) Determines:

(A) The inpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(B) The outpatient DWCC rates by dividing the calculation result from (c)(xiv) of this subsection by the calculation result from (c)(xv) of this subsection.

(6) For a currently enrolled hospital provider that is new to the CAH program, the basis for calculating initial prospective DWCC rates for inpatient and outpatient hospital claims for:

(a) Fee-for-service clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate MMIS summary claims data for that HFY.

(b) MCO clients is:

(i) The hospital's most recent "as filed" medicare cost report; and

(ii) The appropriate managed care encounter data for that HFY.

(7) For a newly licensed hospital that is also a CAH, the department uses the current statewide average DWCC rates for the initial prospective DWCC rates.

(8) For a CAH that comes under new ownership, the department uses the prior owner's DWCC rates until:

(a) The new owner submits its first "as filed" medicare cost report to the medicare fiscal intermediary, and at the same time to the department, the documents identified in (5)(a)(i) through (a)(iv) of this section; and

(b) The department has calculated new DWCC rates based on the new owner's "as filed" medicare cost report and other timely submitted documents.

(9) In addition to the prospective managed care inpatient and outpatient DWCC rates, the department:

(a) Incorporates the DWCC rates into the calculations for the department's MCO capitated premium that will be paid to the MCO plan; and

(b) Requires all MCO plans having contract relationships with CAHs to pay inpatient and outpatient DWCC rates applicable to managed care claims. For purposes of this sec-

tion, the department considers the DWCC rates used to pay CAHs for care given to clients enrolled in an MCO plan to be cost. Cost settlements are not performed for claims that are submitted to the MCO plans.

(10) For fee-for-service claims only, the department uses the same methodology as outlined in subsection (5) of this section to perform an interim retrospective cost settlement for each CAH after the end of the CAH's HFY, using "as filed" medicare cost report data from that HFY that is being cost settled, the other documents identified in subsection (5)(a)(i), (a)(iii) and (a)(iv) of this section, when data from the MMIS related to fee-for-service claims. Specifically, the department:

(a) Compares actual department total interim CAH payments to the departmental-weighted CAH fee-for-service costs for the period being cost settled. (Interim payments are the sum of third party liability/client payments, department claim payments, and Level III trauma payments); and

(b) Pays the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to exceed the total interim CAH payments for that period. The department recoups from the hospital the difference between CAH costs and interim CAH payments if actual CAH costs are determined to be less than total interim CAH payments.

(11) The department performs finalized cost settlements using the same methodology as outlined in subsection (10) of this section, except that the department uses the hospital's "final settled" medicare cost report instead of the initial "as filed" medicare cost report for the HFY being cost settled. The "final settled" medicare cost report received from the medicare fiscal intermediary must be submitted by the CAH to the department by the sixtieth day of the hospital's receipt of that medicare cost report.

(12) A CAH must have and follow written procedures that provide a resolution to complaints and grievances.

(13) To ensure quality of care:

(a) A CAH is responsible to investigate any reports of substandard care or violations of the hospital's medical staff bylaws; and

(b) A complaint or grievance regarding substandard conditions or care may be investigated by any one or more of the following:

(i) Department of health (DOH); or

(ii) Other agencies with review authority for department programs.

(14) The department pays detoxification units, distinct psychiatric units, and distinct rehabilitation units operated by CAH hospitals using inpatient payment methods other than DWCC rates and cost settlement.

(a) For dates of admission before August 1, 2007, the department uses the RCW payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units. The exception is for state-administered programs' psychiatric claims, which are paid using:

(i) The DRG payment method for claims grouped to stable DRG relative weights (unless the claim has an HIV-related diagnosis), and in conjunction with the base community psychiatric hospitalization payment method; or

(ii) The RCW payment method for other psychiatric claims (except for DRGs 469 and 470), in conjunction with the base community psychiatric hospitalization payment method.

(b) For dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay for services provided in detoxification units, distinct psychiatric units, and distinct rehabilitation units.

(15) The department may conduct a post pay or on-site review of any CAH.

WSR 07-10-095
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:44 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 1 of 6;** new WAC 388-550-3010 Payment method—Per diem payment and 388-550-3020 Payment method—Bariatric surgery—Per case payment; and amending WAC 388-550-3100 Calculating DRG relative weights, 388-550-3150 Base period costs and claims data, and 388-550-3250 Indirect medical education costs.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amended rules and new rules describe policy regarding the department's hospital services coverage, rate-setting methods, and payment methods, based on recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rules replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090, recommended that a study be done by navigant to look at the department's inpatient payment system and include recommendations on the design. These rules are written to incorporate into rule the results of the navigant study, and to update information on the department's hospital coverage, rate-set-

ting, and payment processes. At the same time and for the same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

NEW SECTION

WAC 388-550-3010 Payment method—Per diem payment. (1) Effective for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay some covered inpatient hospital services as specified in this section and WAC 388-550-4300, 388-550-4400, and 388-550-3460. The per diem payment method for long term acute care (LTAC), administrative day, and swing bed is effective for dates of admission before, and on and after, August 1, 2007.

(2) The department uses the all-patient diagnosis related group (AP-DRG) grouper software to assign a DRG classification to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG grouper software to use and updates the grouper version. This update is normally completed once every three years during inpatient payment system rebasing.

(3) A per diem payment includes, but is not limited to:

(a) A hospital covered service(s) provided to a client during the client's inpatient hospital stay.

(b) An outpatient hospital covered service(s), including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department establishes the average length of stay (ALOS) for each DRG classification during the rebasing process. If a client's actual length of stay (LOS) exceeds the ALOS for the DRG classification, the department may retrospectively review the appropriateness of the LOS for payment.

(a) For hospital admissions that require prior authorization, the department determines the allowed amount for the per diem payment by multiplying the assigned per diem rate by the LOS authorized by the department or department's designee, or the actual number of days if the actual LOS is less than the approved LOS.

(b) For hospital admissions that do not require authorization, the department determines the allowed amount for the per diem payment by multiplying the assigned per diem rate by the actual LOS. If the actual LOS exceeds the ALOS, the department may perform a retrospective review to determine the appropriate payment.

(c) The department adds to the allowed amount any high outlier amount determined by the department for those per diem paid claims in a DRG classification that is in a non-specialty service category. See WAC 388-550-3000, 388-550-3460, and 388-550-3700.

(5) The department's per diem payments to hospitals may be adjusted when one or more of the following occur:

(a) A claim qualifies as a per diem high outlier claim (see WAC 388-550-3700). The outlier provision does not include a claim grouped to a DRG classification in a specialty service category. The specialty services categories include psychiatric, rehabilitation, detoxification, and CUP program services. Long term acute care (LTAC), administrative days and swing bed days do not qualify for high outlier payment;

(b) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay;

(c) A client has third party liability coverage at the time of admission to the hospital or distinct unit;

(d) A client is eligible for medicare, and medicare has made a payment for the hospital charges; or

(e) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital or a different hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which, if any, inpatient hospital stay(s) qualify for payment. An outlier payment may be made if the department determines the claim for the com-

bined hospital stays qualifies as a high outlier. (See WAC 388-550-3700 for high outliers.)

(6) The department does not pay for a client's day(s) of absence from the hospital.

(7) The department pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(8) The department applies all applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to the payment.

NEW SECTION

WAC 388-550-3020 Payment method—Bariatric surgery —Per case payment. (1) The department pays designated department-approved hospitals for prior authorized bariatric surgery when the criteria in WAC 388-550-2301 are met. Claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) do not qualify for outlier payments.

(2) For dates of admission before and on and after August 1, 2007, the department pays for claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) using a per case rate. See WAC 388-550-3470.

(3) The department applies all applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to the payment.

AMENDATORY SECTION (Amending WSR 04-13-048, filed 6/10/04, effective 7/11/04)

WAC 388-550-3100 Calculating DRG relative weights. (1) This section describes how the ((~~medical assistance administration (MAA)~~)) department calculates Washington diagnostic-related group (DRG) relative weights((~~, MAA~~)). The department:

(a) Classifies the Washington hospital admissions data using the all-patient ((~~grouper~~)) diagnosis related group (AP-DRG).

(b) Statistically tests each DRG for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) Establishes a single set of medicaid-specific relative weights from Washington hospital admissions data. For dates of admission before August 1, 2007, the relative weights are based on claim charges. The department identifies these relative weights ((~~may be~~)) as stable or unstable.

(d) Tests the stability of the relative weights from subsection (1)(c) of this section using a reasonable statistical test to determine if the weights are stable. ((~~MAA~~)) The department accepts as stable and adopts those relative weights that pass the reasonable statistical test.

(e) For dates of admission before August 1, 2007, may compare the medicaid-specific relative weights to non-medicaid relative weights. ((~~MAA~~)) The department:

(i) May combine the medicaid-specific relative weights with the non-medicaid relative weights if the non-medicaid relative weights are statistically comparable to the medicaid-specific weights; or

(ii) Uses only the medicaid-specific relative weights if the non-medicaid relative weights are not statistically comparable to the medicaid-specific relative weights.

(f) For dates of admission before August 1, 2007, uses the ratio of costs-to-charges (RCC) payment method to pay for hospital stays that have unstable DRG relative weights.

(2) When using ratios with a DRG relative weight as base, ((~~MAA~~)) the department adjusts all stable relative weights so that the average weight of the case mix population equals 1.0.

(3) For dates of admission on and after August 1, 2007, the department:

(a) Bases the relative weights on the estimated wage adjusted cost of the claims in each stable DRG classification. the operating and capital component costs were used for this process. To calculate relative weights, the department divides the average cost per discharge for each stable AP-DRG classification by the average cost per discharge for all stable AP-DRG classifications combined. For purposes of these calculations, the department uses the two most current years of medicaid inpatient hospital paid claims data available at the time of relative weight calibration.

(i) The department uses a combination of medicaid fee-for-service and healthy options (HO) managed care organization (MCO) data from the two most current years of fully adjudicated paid claims data available at the time of relative weight calibration.

(ii) The department removes:

(A) Claims that represent statistical outliers from the dataset prior to calculating relative weights, based on the assumption that these claims are likely to be paid under an alternative outlier payment methodology. The department identifies statistical outliers as those claims with estimated costs that exceed three standard deviations of the mean cost of all claims in each AP-DRG classification;

(B) Claims to be paid by alternative methods, including psychiatric, rehabilitation, detoxification, CUP woman program, bariatric surgery cases, and organ transplant claims;

(C) Transfer-out claims;

(D) Same day discharges;

(E) Claims that were either ungroupable or had invalid diagnosis for AP-DRG classification purposes; and

(F) Claims related to state-administered programs where the payment calculations are based on reduced state-administered program payment rates.

(b) Uses the term "unstable" generically to describe an AP-DRG classification that has fewer than ten occurrences, or that is unstable based on the statistical stability test indicated below. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the populations's estimated standard deviation.

The Formula is:

$N = (Z^2 * S^2)/R^2$, where

• The Z statistic for 90 percent confidence is 1.64;

• S = the standard deviation for the AP-DRG classification; and

• R = acceptable error range, per sampling unit

(c) Uses:

(i) The per diem payment method to pay for hospital stays that group to an unstable DRG relative weight, some long term acute care (LTAC) services, and other specialty service and low volume services groups identified in WAC 388-550-3460.

(ii) One of the other non-DRG payment methods (e.g., RCC, per case rate, etc.) to pay for claims paid using other non-DRG payment methods (e.g., some transplants, the high outlier portion of high outlier claims, non-per diem portion of LTAC claims, bariatric surgery, etc.).

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-3150 Base period costs and claims data. (1) The department ((~~shall~~)) sets a hospital's cost-based conversion factor for dates of admission before August 1, 2007, using base period cost data from its medicare cost report (Form ((~~HCFA~~)) CMS 2552) for its fiscal year corresponding with the base period.

(2) The department ((~~shall~~)) may use in rate-setting ((~~only~~)), "as filed" base period cost data, or "final settled" medicare cost report base period cost data that have been desk reviewed and/or field audited by the medicare intermediary.

(3) The department ((~~shall~~)), to the extent feasible, factors out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600((~~(1)~~)) before calculating the hospital's conversion factor.

(4) For dates of admission before August 1, 2007, the department ((~~shall~~)) uses the figures for total costs, capital costs, and direct medical education costs from a hospital's ((~~HCFA 2552 report~~)) medicare cost report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize medicaid claims.

(5) For dates of admission before August 1, 2007, the department ((~~shall~~)) uses nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

(a) Routine;
(b) Intensive care;
(c) Intensive care-psychiatric;
(d) Coronary care;
(e) Nursery;
(f) Neonatal intensive care unit;
(g) Alcohol/substance abuse;
(h) Psychiatric; and
(i) Oncology.

(6) For dates of admission before August 1, 2007, the department ((~~shall~~)) uses twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

(a) Operating room;
(b) Recovery room;
(c) Delivery/labor room;
(d) Anesthesiology;
(e) Radiology-diagnostic;
(f) Radiology-therapeutic;
(g) Radioisotope;
(h) Laboratory;
(i) Blood storage;
(j) Intravenous therapy;
(k) Respiratory therapy;
(l) Physical therapy;
(m) Occupational therapy;
(n) Speech pathology;
(o) Electrocardiography;
(p) Electroencephalography;
(q) Medical supplies;
(r) Drugs;
(s) Renal dialysis;
(t) Ancillary oncology;
(u) Cardiology;
(v) Ambulatory surgery;
(w) Computerized tomography scan/magnetic resonance imaging;
(x) Clinic;
(y) Emergency;
(z) Ultrasound;
(aa) Neonatal intensive care unit transportation;
(bb) Gastrointestinal laboratory; and
(cc) Miscellaneous.

(7) The department shall:

(a) Extracts from the medicaid management information system all medicaid and SCHIP paid claims data for each hospital's base year;

(b) Assigns line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Uses the cost center categories to apportion medicaid and SCHIP costs.

(8) For dates of admission on and after August 1, 2007, the department rebased the hospital inpatient payment system and used claim and estimated cost data to estimate costs for the system development.

(a) Claim data used for rebasing process. The department uses the following claim data resources considered the most complete and available at the time the system is developed for the rebase:

(i) From the department's medicaid management information system (MMIS) database, two years of fee-for-service paid claim data, excluding claims related to state programs and paid at the Title XIX reduced rates;

(ii) From the comprehensive hospital abstract reporting system (CHARS) dataset that is maintained by the department of health (DOH), two years of sample claims representing healthy options (HO) services that are identified from the CHARS dataset based on the medicaid HO eligibility data files; and

(iii) From the healthcare cost report information system (HCRIS) that is maintained by the centers for medicare and medicaid (CMS), the hospital's most current medicare cost report data. If the hospital's medicare cost report from the HCRIS system is not available, the department uses the medicare cost report provided by the hospital.

(b) Claim data used to estimate costs. The department uses:

(i) The fee-for-service and HO claims for two fiscal years to calculate diagnosis related group (DRG) relative weights.

(ii) The fee-for-service and HO claims for the most current single fiscal year to calculate conversion factors, per diem rates, and per case rates.

(iii) The payments from fee-for-service only claims for a single year to model the fiscal impacts to the department and individual hospitals that result from the implementation of the payment methodology.

(c) Estimated costs of claims. The department:

(i) Identifies the operating (routine and ancillary), capital (routine and ancillary), and direct medical education (routine and ancillary) cost components from different worksheets from the hospital's medicare cost report;

(ii) estimates costs for each separate component identified in (c)(i) of this subsection for each fee-for-service and HO claim in the dataset by:

(A) Calculating the operating, capital, and direct medical education routine costs for each fee-for-service and HO claim by multiplying the average hospital cost per day reported in the medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service.

(B) Calculating the operating, capital, and direct medical education ancillary costs for each fee-for-service and HO claim by multiplying the ration of costs-to-charges (RCC) reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, clinic) by the allowed charges reported at the claim line level by type of service.

(d) Routine and ancillary cost components. For purposes of estimating costs consistently for all hospitals' claims, the department uses standard routine and ancillary cost components. The standard cost components used for estimating costs of claims are:

(i) Routine cost components:
(A) Routine care;
(B) Intensive care;
(C) Intensive care-psychiatric;
(D) Coronary care;
(E) Nursery;
(F) Neonatal ICU;
(G) Alcohol/Substance abuse;
(H) Psychiatric;
(I) Oncology; and
(J) Rehabilitation.

(ii) Ancillary cost components:
(A) Operating room;
(B) Recovery room;
(C) Deliver/labor room;
(D) Anesthesiology;
(E) Radio, diagnostic;
(F) Radio, therapeutic;
(G) Radioisotope;
(H) Laboratory;
(I) Blood administration;
(J) Intravenous therapy;
(K) Respiratory therapy;
(L) Physical therapy;
(M) Occupational therapy;
(N) Speech pathology;
(O) Electrocardiography;
(P) Electroencephalography;
(Q) Medical supplies;
(R) Drugs;
(S) Renal dialysis/home dialysis;
(T) Ancillary oncology;
(U) Cardiology;
(V) Ambulatory surgery;
(W) CT scan/MRI;
(X) Clinic;
(Y) Emergency;
(Z) Ultrasound;
(AA) NICU transportation;
(BB) GI laboratory;
(CC) Miscellaneous; and
(DD) Observation beds.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-3250 Indirect medical education costs—Conversion factors, per diem rates, and per case rates. (1) For ((~~a~~)) dates of admission before August 1, 2007, for each hospital with a graduate medical education program, the department ((~~shall~~)) removes indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap for conversion factor rebasing.

(2) For dates of admission before August 1, 2007, to arrive at indirect medical education costs for each component, the department ((~~shall~~)):

(a) ((~~Multiply~~)) Multiplies medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) ((~~Multiply~~)) Multiplies the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) For dates of admission before August 1, 2007, after the peer group's cost cap has been calculated, the department ((~~shall~~)) adds back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450(((~~6~~))).

(4) For dates of admission on and after August 1, 2007, the department:

(a) Uses the indirect medical costs in the calculation of the hospital DRG conversion factor, per diem rates, and per case rates.

(b) Uses the medicare's indirect medical education factor matching the same period of the hospital medicare cost report used in calculating the hospital cost to estimate the hospital aggregate operating and capital costs. The indirect medical education costs were removed from the hospital aggregate operating and capital costs in determination of statewide standardized average operating and capital cost per discharge, per day, and per case amounts.

(c) To calculate the hospital-specific DRG conversion factor, per diem rates, and per case rates, adjusts the hospital's indirect medical education costs to the statewide standardized average operating and capital costs. The hospital's indirect medical education factor is the most current factor from the inpatient medicare pricer that is available from CMS's website at the time the rate calculations are made.

WSR 07-10-096
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:45 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 2 of 6;** amending WAC 388-550-3450 Payment method for calculating CBCF rates; and new WAC 388-550-3460 Payment method—Per diem rate and 388-550-3470 Payment method—Bariatric surgery—Per case rate.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amended rules and new rules describe policy regarding the department's hospital services coverage, rate-setting methods, and payment methods, based on recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rules replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090 recommended that a study be done by navigant to look at the department's inpatient payment system and include recommendations on the design. These rules are written to incorporate into rule the results of the navigant study, and to update information on the department's hospital coverage, rate-setting, and payment processes. At the same time and for the same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 99-14-027, filed 6/28/99, effective 7/1/99)

WAC 388-550-3450 Payment method for calculating ((~~CBCF~~)) medicaid DRG conversion factor rates. (1) For medicaid and SCHIP accommodation costs, ((~~MAA~~)) the department:

(a) Uses each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the ((~~nine~~)) accommodation categories described in WAC 388-550-3150((~~(5)~~)); then

(b) Divides those costs per category by total hospital days per category to arrive at a per day accommodation cost; then

(c) Multiplies the per day accommodation cost for each category by the total medicaid and SCHIP days to arrive at total medicaid accommodation costs per category for the three components.

(2) For ancillary costs ((~~MAA~~)) the department:

(a) Uses the base period cost data to calculate total operating, capital, and direct medical education costs for each of the hospital's ((~~twenty-nine~~)) ancillary categories described in WAC 388-550-3150; then

(b) Divides these costs by total charges per category to arrive at a ratio of costs-to-charges (RCC) per ancillary category; then

(c) Multiplies these RCCs by medicaid and SCHIP charges per category, as tracked by the medicaid management information system (MMIS), to arrive at total medicaid and SCHIP ancillary costs per category for the three components (operating, capital, and medical education).

(3) ((~~MAA~~)) The department:

(a) Combines medicaid and SCHIP accommodation and ancillary costs to derive the hospital's total costs for operating, capital, and direct medical education components for the base year; then

(b) Divides the hospital's combined total cost by the number of medicaid and SCHIP cases during the base year to arrive at an average medicaid and SCHIP cost per ((~~DRG admission~~)) discharge; then

(c) For dates of admission before August 1, 2007, adjusts, for hospitals with a fiscal year ending different than the common fiscal year end, the medicaid and SCHIP average cost by a factor determined by ((~~MAA~~)) the department to standardize hospital costs to the common fiscal year end. ((~~MAA~~)) The department adjust the hospital's medicaid and SCHIP average cost by the hospital's specific case mix index.

(4) ((~~MAA~~)) For dates of admission before August 1, 2007, the department caps the medicaid and SCHIP average cost per case for peer groups B and C at seventy percent of the peer group average. In calculation of the peer group cap, ((~~MAA~~)) the department removes the indirect medical education and outlier costs from the Medicaid average cost per admission.

(a) For hospitals in ((~~MAA~~)) department peer groups B or C, ((~~MAA~~)) the department determines aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap; then

(b) To whichever is less, the hospital-specific aggregate cost or the peer group cost cap determined in subsection (4) of this section, ((~~MAA~~)) the department adds:

(i) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(ii) An outlier cost adjustment in accordance with WAC 388-550-3350((~~(2)~~)).

(5) For dates of admission before August 1, 2007, for an inflation adjustment ((~~MAA~~)) and outlier set-aside adjustment, the department may:

(a) Multiply the sum obtained in subsection (4) of this section by an inflation factor as determined by the legislature for the period January 1 of the year after the base year through October 31 of the rebase year; ((~~then~~))

(b) Reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted CBCF((~~; then~~

~~(c) Multiply the hospital's adjusted CBCF by the applicable DRG relative weight to calculate the DRG payment for each admission~~)).

(6) For dates of admission on and after August 1, 2007, the department establishes medicaid DRG conversion factors for calculation of the medicaid and SCHIP DRG payments.

(a) The department determines DRG conversion factors based on the estimated hospital operating, capital, and direct medical education costs from medicaid and SCHIP fee-for-services and Health Option claims data for the most current state fiscal year, or "base year claims data." The claims data is designated by the department as the "base year claims data" used for the DRG conversion factor calculation process. The "base year claims data" consists of medicaid and SCHIP fee-for-service and health options claims data for the most current state fiscal year (at the time the rebasing process takes place) from instate acute care hospitals that are not a critical access hospital (CAH) or a long term acute care (LTAC) hospital. The detailed cost calculation is described in WAC 388-550-3150. Only base year claims grouped to a DRG classification that has a stable DRG relative weight are included in the DRG conversion factor calculation. Stable relative weight DRGs are defined in WAC 388-550-3100.

(b) The department calculates and adjusts hospital-specific operating, capital and direct medical education costs as follows:

(i) For hospital-specific operating costs, the department divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index; then divides the result by (1.0 plus the hospital-specific medicare operating indirect medical education factor); then divides that result by the hospital-specific medicaid case-mix index; then

(ii) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides that result by the hospital-specific medicaid case-mix; then

(iii) For hospital-specific direct medical education costs, the department divides hospital-specific direct medical education costs by the hospital-specific medicaid case-mix; then

(iv) To make adjustments to hospital-specific costs derived in subsections (i) through (iii) of this subsection, the department uses:

(A) The medicare wage indices and indirect medical education factors in effect for the medicare inpatient prospective payment system (PPS) federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations; and

(B) The medicaid case mix indices based on the recalibrated DRG relative weights applied to the base year claims data. Medicaid case mix index is described in WAC 388-550-3400.

(c) Calculates statewide operating and capital standardized amounts to adjust hospital-specific operating and capital costs as follows. The department:

(i) Divides the statewide aggregate adjusted operating costs by the statewide aggregate number of discharges in the base year claims data (cost and discharges are described in subsection (a) and (b) of this subsection); and

(ii) Divides the statewide aggregate adjusted capital costs by the statewide aggregate number of discharges in the base year claims data (costs and discharges described in subsection (a) and (b) of this section.

(d) The department makes hospital-specific adjustments to the statewide operating and capital standardized amounts as follows:

(i) Operating standardized amount is multiplied by the most currently available (in the medicare final rule) hospital-specific medicare wage index, and the resulting product is multiplied by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor in the medicare final rule). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(ii) Capital standardized amount is multiplied by (1.0 plus the most current available hospital-specific medicare capital indirect medical education factor that has been published at the point the rate setting calculation takes place during the rebasing process).

(e) To determine hospital-specific DRG conversion factors, the department sums for each hospital:

(i) The adjusted operating standardized amount;

(ii) The adjusted capital standardized amount; and

(iii) The direct medical education cost per discharge adjusted for hospital-specific case-mix index.

(f) The department adjusts the hospital-specific DRG conversion factors for inflation based on the CMS PPS input price index. The adjustment is to reflect the increases in price index levels between the base year data and the rebased inpatient payment system implementation year.

(g) The department may adust the hospital-specific DRG conversion factors by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services for the rebasing implementation year.

(h) The department may make other necessary adjustments as directed by the legislature.

(i) The hospital's specific DRG conversion factor may not be changed unless the inpatient payment system is rebased or the legislature authorized the changes.

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

NEW SECTION

WAC 388-550-3460 Payment method—Per diem rate. (1) For dates of admission before August 1, 2007 the department established per diem rates for:

(a) Inpatient chronic pain management as indicated in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as indicated in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as indicated in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as indicated in WAC 388-550-4500.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diems for the services identified in subsection (1), except for the community psychiatric hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of psychiatric services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates statewide standardized per diem rates for the following categories:

(i) Rehabilitation services—Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services—Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services—Chemically using pregnant (CUP) women program services are identified as any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the new system. These claims include any statistical outliers. These statewide standardized amounts serve as the basis for calculating per diem rates for each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs. Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index; then divides the result by (1.0 plus the hospital-specific medicare operating indirect medical education factor); then divides that result by the hospital-specific medicaid case-mix index; then

(B) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides the result by the hospital-specific medicaid case-mix; then

(iii) The department then sums the costs and days for all included hospitals for each service, and calculates each services' statewide standardized weighted average cost per day amounts, weighted based on number of days.

(d) Once the department establishes the statewide standardized amounts, hospital-specific per diem rates for each specialty service are calculated.

(i) Starting with the statewide standardized operating amount, the department multiplies the labor portion of the amount times the most currently available hospital-specific wage index, as published by medicare. This adjustment is made to reflect wage differences incurred by hospitals in different regions of the state.

(ii) The department also adjusts the operating and capital amounts to reflect the indirect costs associated with approved teaching programs. The department adjusts for the indirect costs by multiplying the operating and capital amounts by (1.0 plus the most currently available hospital-specific medicare indirect medical education factor in the medicare final

rule for the operating and capital components). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(iii) The department then adds to the operating and capital amounts the hospital-specific direct medical education cost per day (hospital-specific direct medical education cost per day adjusted for hospital-specific case-mix index).

(iv) Finally, the department adjusts the facility-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(e) Specialty service claims are not eligible for high outlier payments. See WAC 388-550-3700.

(4) For dates of admission on and after August 1, 2007, the department establishes hospital-specific per diem rates for psychiatric services provided by instate non-critical access hospitals that are free-standing psychiatric hospitals, acute care hospitals with psychiatric distinct part units, or other acute care hospitals with more than two hundred medicaid fee-for-service and healthy options psychiatric patient days in the base year.

(a) The department identifies psychiatric claims for hospitals meeting the criteria in this subsection as all claims from free-standing psychiatric hospitals, and all claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at the acute care hospitals. The department includes all claims from freestanding psychiatric hospitals, regardless of AP-DRG assignment.

(b) To determine facility-specific cost per day amounts for psychiatric services, the department uses the estimated costs of the psychiatric claims in the base year claims dataset. These claims include any statistical outliers.

(c) The department calculates average cost per day amounts for each hospital and then makes adjustments to the average cost per day amounts to reflect changes in the indirect medical education factor and hospital-specific wage index between the base year and the implementation year.

(d) Finally, the department adjusts the hospital-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(5) For dates of admission on and after August 1, 2007, for hospitals not meeting the criteria in subsection (4), the department calculates per diem rates using the same method used for rehabilitation, detoxification and CUP women program payments described in this section, except that the department uses only the psychiatric claims from those facilities identified as qualifying for hospital-specific rates.

(6) For dates of admission on and after August 1, 2007, for freestanding rehabilitation facilities, the department uses the per diem rate established for rehabilitative services rather than a facility-specific rate.

(7) For dates of admission on and after August 1, 2007, for claims that are classified into AP-DRG classifications that do not have enough claims volume to establish stable relative weights, and that are not specialty claims as described in this section, the department also uses a per diem rate.

(a) These types of claims are less homogeneous than the specialty claims described in this section, and the costs of these claims are more variable than the costs of those that are included under the DRG payment method. The department conducts significant analyses to establish per diem rates based on groupings that would distinguish between higher cost per day claims and lower cost per day claims. As part of this analysis, the department analyzes costs per day based on the following criteria for groupings, which are not mutually exclusive:

(i) Neonatal claims, based on assignment to Major Diagnostic Category (MDC) 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures;

(iv) AP-DRG assignments that include primarily surgical procedures;

(v) Cranial procedure claims, based on specific cranial procedure AP-DRG classifications, and

(vi) MDC assignment.

(b) Based on the analyses of cost per day amounts for each grouping criteria identified in subsection (7)(a), the department identified four non-specialty service groupings appropriate for establishing per diem payments. These are:

(i) Neonatal claims, based on assignment to MDC 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified in this subsection; and

(iv) AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified in this subsection.

(c) For each service group, except for burn cases, the department calculates a per diem rate for each hospital based on the aggregate statewide weighted average cost per day for the service after adjusting costs for regional wage differences and differences in graduate medical education program costs. Unstable burn claim per diem rates are based on the average cost per day of unstable burn claims at Harborview Medical Center, which treats the vast majority of burn cases in the state.

(d) The per diem calculations are based on the estimated costs of the claims for each service group in the base year, including both fee-for-service and healthy options claims data. After determining the statewide weighted average cost per day after these adjustments, the department calculates the per diem rate for each hospital for each service group by adjusting the statewide weighted average cost per day amount for each hospital based on its hospital-specific wage index and medical education program costs.

(e) Because of the variability of the cost of claims in unstable AP-DRG classifications, the department developed an outlier policy for these per diem payments, similar to the

outlier methodology recommended for the DRG payment method.

(f) Claims that are not in the specialty service groupings indicated in subsection (3)(a) and (b), may qualify for a high outlier payment if the claim qualifies under the high outlier criteria. See WAC 388-550-3700.

NEW SECTION

WAC 388-550-3470 Payment method—Bariatric surgery—Per case rate. (1) The department:

(a) Pays for bariatric surgery provided in designated department-approved hospitals when all criteria established in WAC 388-550-2301 and 388-550-3020 are met;

(b) Requires qualification and prior authorization of the provider before bariatric surgery related services are provided (see WAC 388-550-2301); and

(c) Uses a per case rate to pay for bariatric surgery.

(2) For dates of admission before August 1, 2007, the department determines the per case rate by using a hospital-specific medicare fee schedule rate the department used to pay for bariatric surgery.

(3) For dates of admission on and after August 1, 2007, the department determines the per case rate by using the bariatric per case rate calculation method described in this subsection and established by the department's new inpatient payment system implemented on August 1, 2007.

(a) To adjust hospital-specific operating, capital, and direct medical education costs, the department:

(i) Inflates the hospital-specific operating, capital, and direct medical education routine costs from the hospital's medicare cost report fiscal year to the mid-point of the state fiscal year.

(ii) Divides the labor portion of the hospital-specific operating costs by the hospital-specific medicare wage index in effect for the medicare inpatient prospective payment system federal fiscal year that most closely matches the time period covered by the medicare cost report used for these calculations.

(b) To determine the statewide standardized weighted average cost per case by using the adjusted hospital-specific operating and capital costs derived in (a) of this subsection, the department:

(i) Adjusts the hospital-specific operating and capital costs to remove the indirect costs associated with approved medical education programs; then

(ii) Calculates the operating standardized amount by dividing statewide aggregate adjusted operating costs by the statewide aggregate number cases in the base year claims data; then

(iii) Calculates the capital standardized amount by dividing statewide aggregate adjusted capital costs by the statewide aggregate number of cases in the base year claims data.

(c) To make hospital-specific adjustments to the statewide operating and capital standardized amounts, the department:

(i) Defines the adjusted operating standardized amount for bariatric services as the average of all instate hospitals operating standardized amount after making adjustments for the wage index and the indirect medical education. The department:

(A) Multiplies the labor portion of the operating standardized amount by (1.0 plus the most currently available hospital-specific medicare wage index); then

(B) Adds the non-labor portion of the operating standardized amount to the labor portion derived in (c)(i)(A) of this subsection; then

(C) Multiplies the amount derived in (c)(i)(B) of this subsection by 1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor to derive the operating standardized amount for bariatric services; then

(D) Adjusts the hospital-specific operating standardized amount for bariatric services for inflation based on the CMS PPS Input Price Index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(E) Calculates the statewide bariatric operating payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(i)(D) of this subsection for each hospital approved by the department to provide bariatric services; and

(II) Dividing the results in (E)(I) of this subsection by the number of instate hospitals approved by the department to provide bariatric services.

(ii) Defines the adjusted capital standardized amount for bariatric services as the average of all instate hospitals capital standardized amount after adjusting for the indirect medical education. The department:

(A) Multiplies the amount derived in (b)(iii) of this subsection by (1.0 plus the most currently available hospital-specific medicare capital indirect medical education factor) to derive the adjusted indirect medical education capital standardized amount for bariatric services.

(B) Adjusts the hospital-specific capital standardized amount for bariatric services for inflation based on the CMS PPS Input Price Index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year.

(C) Calculates the statewide bariatric capital payment per case amount by:

(I) Totaling the hospital-specific amounts derived in (c)(ii)(B) of this subsection for each hospital approved by the department to provide bariatric services; and

(II) Dividing the results derived in (C)(I) of this subsection by the number of instate hospitals approved by the department to provide bariatric services.

(iii) Defines the direct medical education standardized amount for bariatric services as the instate hospitals hospital-specific direct medical education weighted cost per case multiplied by the CMS PPS Input Price Index. The adjustment is to reflect the increases in price index levels between the base year data and the payment system implementation year. The department calculates the statewide bariatric direct medical education standardized payment per case by:

(A) Multiplying the hospital-specific direct medical education weighted cost per case for each hospital approved by the department to provide bariatric services by the CMS PPS Input Price Index; then

(B) Totaling the hospital-specific amounts derived in (iii)(A) of this subsection for each hospital approved by the department to provide bariatric services.

(d) To determine hospital-specific bariatric payment per case amount, the department sums for each hospital the instate statewide bariatric operating payment per case, the instate statewide bariatric capital payment per case, and the hospital-specific direct medical education payment per case. (For critical border hospitals, the direct medical education payment per case is limited at the highest direct medical education payment per case amount for the instate hospitals approved by the department to provide bariatric services.)

(e) The department adjusts the hospital-specific bariatric payment per case amount by a factor to achieve budget neutrality for the state's aggregate inpatient payments for all hospital inpatient services.

(f) The department may make other necessary adjustments as directed by the legislature (i.e., rate rebasing and other changes as directed by the legislature).

WSR 07-10-097
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:47 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 3 of 6;** amending WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers, 388-550-3800 Rebasing and recalibration, 388-550-3900 Payment method—Border area hospitals, 388-550-4000 Out-of-state hospitals, 388-550-4100 Payment method—New hospitals, 388-550-4200 Change in hospital ownership, and 388-550-4300 Hospitals and units exempt from the DRG payment method.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules describe policy regarding the department's hospital services coverage, rate-setting methods, and payment methods, based on recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rules replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090 recommended that a study be done by navigant to look at the department's inpatient payment system and include recommendations on the design. These rules are written to incorporate into rule the results of the navigant study, and to update information on the department's hospital coverage, rate-setting, and payment processes. At the same time and for the same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 01-16-142, filed 7/31/01, effective 8/31/01)

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. The department applies the following payment rules when ((~~a~~)) an eligible client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit:

(1) The department does not ((~~reimburse~~)) pay a hospital for a ((~~nonemergent~~)) nonemergency case when the hospital transfers the client to another hospital.

(2) The department pays a hospital that transfers ((~~emergent~~)) emergency cases to another hospital, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment; or

(b) For dates of admission:

(i) Before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average length of stay.

(ii) On or after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem rate by dividing the hospital's DRG allowed amount for payment for the appropriate DRG by that DRG's statewide average length of stay for the AP-DRG classification as determined by the department.

(3) The department uses:

(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and

(b) ((~~MAA's~~)) The department's length of stay data to determine the number of medically necessary days for a client's hospital stay.

(4) The department:

(a) Pays the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment; and

(b) Applies the outlier payment methodology if a transfer case qualifies:

(i) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(ii) For dates of admission on or after August 1, 2007, as a high outlier.

(5) The department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(a) The department's maximum payment to the discharging hospital is the full DRG payment.

(b) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (2) of this section.

(6) The department makes all applicable claim payment adjustments to claims for client responsibility, third party liability, medicare, etc.

AMENDATORY SECTION (Amending WSR 05-06-044, filed 2/25/05, effective 7/1/05)

WAC 388-550-3800 Rebasing and recalibration. (1) The ((~~medical assistance administration (MAA)~~)) department rebases most of the rates used in the medicaid inpatient payment system ((~~periodically using each hospital's cost report for its fiscal year that ends during the calendar year designated by MAA to be used for each update~~)) once every three years. Changes to the inpatient hospital rate calculations and rate-setting methods involved in this rebasing process are implemented pursuant to the rebasing of the rate system

(a) To determine costs for that rebasing process, the department uses:

(i) Each instate hospital's medicare cost report for the hospital fiscal year that ends during the calendar year that the rebasing base year designated by the department begins; and

(ii) Inpatient medicaid and SCHIP claims data for the twelve-month period designated by the department as the rebasing base year.

(b) The rebasing process updates rates for the diagnosis related group (DRG), per diem, and per case rate payment methods.

(c) Other inpatient payment system rates (e.g., the ratio of costs-to-charges (RCC) rates, departmental weighted costs-to-charges (DWCC) rates, administrative day rate, and swing bed rate) are rebased on an annual basis.

(d) The department increases inpatient hospital rates only when mandated by the state legislature. These increases are implemented according to the base methodology in effect, unless otherwise directed by the legislature.

(2) ((~~MAA~~)) The department periodically recalibrates diagnosis-related group (DRG) relative weights ((~~periodically~~)), as described in WAC 388-550-3100, but no less frequently than each time the rate rebasing ((~~is conducted~~)) process described in subsection (1) takes place. The department makes recalibrated relative weights effective on the ((~~rate~~)) rebasing implementation date, which can change with each rebasing process.

(3) When recalibrating DRG relative weights without rebasing, ((~~MAA~~)) the department may apply a budget neutrality factor (BNF) to hospitals' ((~~cost based~~)) conversion factors to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total ((~~reimbursement~~)) aggregate payments calculated under a new payment system to total ((~~reimbursement~~)) aggregate payments calculated under the prior payment system.

AMENDATORY SECTION (Amending WSR 99-14-027, filed 6/28/99, effective 7/1/99)

WAC 388-550-3900 Payment method—Bordering city ((~~area~~)) hospitals and critical border hospitals. (1) For dates of admission before August 1, 2007, under the diagnosis-related group (DRG) payment method:

(a) ((~~MAA~~)) The department calculates the cost-based conversion factor (CBCF) of a bordering city ((~~area~~)) hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(b) For a bordering city ((~~area~~)) hospital with no ((~~HCFA~~)) medicare cost report (Form 2552-96) for the rebasing year, ((~~MAA~~)) the department assigns the ((~~MAA~~)) department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(2) ((~~MAA~~)) For dates of admission before August 1, 2007, the department calculates:

(a) The ratio of costs-to-charges (RCC) in accordance with WAC 388-550-4500.

(b) For a bordering city ((~~area~~)) hospital with no ((~~HCFA 2552~~)) medicare cost report submitted to the department, its RCC is based on the Washington in-state average RCC ((~~ratios~~)).

(3) For dates of admission before August 1, 2007, the department pays a bordering city hospital using the same payment methods as for an instate hospital for allowed cov-

ered charges related to medically necessary services identified on an outpatient hospital claim.

(4) For dates of admission on and after August 1, 2007, with the exception of hospitals previously paid under the outpatient prospective payment system (OPPS) methodology and critical border hospitals located in bordering cities, the department pays bordering city hospitals for allowed covered charges related to medically necessary services based on the inpatient and outpatient hospital rates and payment methods used to pay out-of-state hospitals. See WAC 388-550-4000.

(5) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an inpatient hospital claim:

(a) Under one of the inpatient DRG, RCC, per diem, or per case rate payment methods that are similar to the methods used to pay instate hospitals, whether the hospital does, or does not have a medicare cost report (Form 2552-96) for the rebasing year;

(b) Using a DRG conversion factor, per diem, or per case rate based on the statewide standardized average that will result in payment that does not exceed the payment that would be made to any instate hospital for the same service, including medical education components of payments; and

(c) Using a hospital's specific RCC rate based on the hospital's annual medicare cost report information for the applicable period. For a critical border hospital that does not submit a medicare cost report to the department, the department determines which instate hospital has the lowest RCC rate and uses that rate as the critical border hospital's RCC rate.

(6) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. Those rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital. Bordering city hospitals' base period claims data is analyzed during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies as a critical border hospital.

(7) For dates of admission on and after August 1, 2007, the department pays a critical border hospital for allowed covered charges related to medically necessary services identified on an outpatient hospital claim using the outpatient hospital payment methods and payment criteria identified in WAC 388-550-6000 and 388-550-7200.

(8) The department makes applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to claim payments.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-4000 Payment method—Emergency services—Out-of-state hospitals ((~~payment method~~)). The department pays for emergency services that are covered by the department and provided to eligible medical assistance clients as follows:

(1) For dates of admission before August 1, 2007, the department ((~~shall~~)) pays:

(a) Inpatient hospital claims for emergency services provided in out-of-state hospitals, the lesser of:

(i) Billed charges; or

(ii) ((~~the amount calculated using~~)) The weighted average of ratio of cost-to-charge (RCC) ratios for in-state ((~~Washington~~)) hospitals multiplied by the allowed covered charges for medically necessary services.

(b) Outpatient hospital claims for emergency services provided in out-of-state hospitals, the lesser of:

(i) Billed charges; or

(ii) The weighted average of outpatient hospital rates for instate hospitals multiplied by the allowed covered charges for medically necessary services.

(2) For dates of admission on and after August 1, 2007, the department pays:

(a) Inpatient hospital claims for emergency services provided in out-of-state hospitals under the inpatient diagnostic related group (DRG), ration of costs-to-charges (RCC), per diem, and per case rate payment methods, whether or not the hospital has submitted a medicare cost report (Form 2552-96) to the department for the rebasing year. The department:

(i) Pays an out-of-state hospital and bordering city hospital that is not a critical border hospital, using the lowest of the instate inpatient hospital rates, and excludes payment for medical education (out-of-state hospitals are not eligible to receive payment for medical education.). This rate is the same rate calculated for all rural hospitals in Washington for the same service (excluding DWCC rates that are paid to instate critical access hospitals).

(ii) Pays a department designated critical border hospital according to WAC 388-550-3900.

(b) Pays outpatient hospital claims for emergency services provided in out-of-state hospitals that are:

(i) Bordering city hospitals, including critical border hospitals previously paid under the outpatient prospective payment system (OPPS) methodology for dates of admission before August 1, 2007, in accordance with WAC 388-550-7200; and

(ii) Out-of-state hospitals, including bordering city hospitals not previously paid under the OPPS methodology, the lesser of:

(A) Billed charges; or

(B) The weighted average of outpatient hospital rates for instate hospitals times the allowed covered charges for medically necessary services.

(3) The department does not pay for nonemergency hospital services provided to medical assistance clients in out-of-state hospitals unless the facility is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

(i) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

(ii) Authorized services are paid according to subsections (1) and (2) of this section.

(4) The department makes all applicable claim payment adjustments for clients responsibility, third party liability, medicare, etc., to claim payments.

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

AMENDATORY SECTION (Amending WSR 99-14-027, filed 6/28/99, effective 7/1/99)

WAC 388-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, ((~~MAA~~)) the department considers as new:

(a) A hospital which began services after the most recent rebased cost-based conversion factors (CBCFs) conversion factors, RCC rates, per diem rates, per case rates, etc.((~~,~~)) ; or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) ((~~MAA~~)) The department determines a new hospital's:

(a) CBCF as the average of the CBCF of all hospitals within the same ((~~MAA~~)) department peer group for dates of admission before August 1, 2007.

(b) Conversion factor, per diem rate, or per case rate, to be the statewide average rate for the conversion factor, category of per diem rate, or per case rate, for dates of admission on and after August 1, 2007, adjusted by the geographically appropriate hospital specific medicare wage index.

(3) ((~~MAA~~)) The department determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC rate for all current Washington in-state hospitals.

(4) ((~~MAA~~)) The department considers that a change in hospital ownership does not constitute a new hospital.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-4200 Change in hospital ownership. (1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital ((~~shall~~)) must notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department ((~~shall~~)) sets the new provider's cost-based conversion factor (CBCF), conversion factor, per diem rates, per case rate, at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department ((~~shall~~)) sets for a hospital formed as a result of a merger:

(a) A blended CBCF, conversion factor, per diem rate, per case rate, based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500. Partial year cost reports will not be used for this purpose.

(5) The department ((~~shall~~)) recaptures depreciation and acquisition costs as required by section 1861 (V)(1)(0) of the Social Security Act.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are ((~~reimbursed~~)) paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) For dates of admission before August 1, 2007, subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to medicaid-eligible clients:

(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are ((~~reimbursed~~)) paid through the DRG payment method (see WAC 388-550-4400):

(i) General assistance programs; and

(ii) Other state((~~-only~~)) administered programs.

(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.

(c) Peer group F hospitals (critical access hospitals).

(d) Rehabilitation units when the services are provided in department-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.

The department uses the same criteria as the medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. ((~~Exception:~~)) Inpatient rehabilitation services provided to clients eligible under the following programs are covered and ((~~reimbursed~~)) paid through the DRG payment method (see WAC 388-550-4400 for exceptions):

(i) General assistance programs; and

(ii) Other state-only administered programs.

(e) Out-of-state hospitals excluding hospitals located in designated bordering cities as described in WAC 388-501-0175. Inpatient services provided in out-of-state hospitals to clients eligible under the following programs are not covered or ((~~reimbursed~~)) paid by the department:

(i) General assistance programs; and

(ii) Other state((~~-only~~)) administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) A negotiated per diem rate; or

(ii) DRG.

(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with medicare certified distinct psychiatric units. The department uses the same criteria as the medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.

(i) Inpatient psychiatric services provided to clients eligible under the following programs are ((~~reimbursed~~)) paid through the DRG payment method:

(A) General assistance programs; and

(B) Other state((~~-only~~)) administered programs.

(ii) ((~~Regional support networks (RSNs)~~)) Mental health division (MHD) designees that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through ((~~an RSN~~)) a MHD are paid through the department's payment system.

(3) The department limits inpatient hospital stays for dates of admission before August 1, 2007 that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, "*Length of Stay by Diagnosis and Operation, Western Region*," unless the stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by the regional support network (RSN);

(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(4) If subsection (3)(c) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

(5) For dates of admission on and after August 1, 2007, the department exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to medicaid-eligible clients:

(a) Peer group E hospitals as described in WAC 388-550-3300(2), i.e., hospitals participating in the department's certified public expenditure (CPE) payment program. See WAC 388-550-4650.

(b) Peer group F hospitals, i.e., critical access hospitals. See WAC 388-550-2598.

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. Inpatient psychiatric services, involuntary treatment act services, and detoxification services provided in out-of-state hospitals are not covered or paid by the department or a MHD designee. The department does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:

(i) General assistance programs; and

(ii) Other state-administered programs.

(f) Military hospitals when no other specific arrangements have been made with the department. The department, or the military hospital, may elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) Per diem payment method; or

(ii) DRG payment method.

(g) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (b), (c), and (f) of this subsection. See WAC 388-550-3010. A MHD designee that arranges to pay a hospital and/or a designated distinct psychiatric unit of a hospital directly, may use the department's payment methods or contract with the hospitals to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(6) The department limits all inpatient hospital stays exempt from the DRG payment method, for dates of admission on and after August 1, 2007, that have not received a length of stay extension from the department, to the average length of stay calculated for the specific DRG classification in the inpatient payment system effective August 1, 2007. Exceptions to this standard exist as follows. The inpatient stay is:

(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by a MHD designee;

(b) For chemical dependency treatment, which is subject to WAC 388-550-1100; or

(c) For detoxification of acute alcohol or other drug intoxication.

(7) If subsection (6)(c) of this section applies to an eligible client, the department will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:

(i) Petition for commitment to chemical dependency treatment; or

(ii) Temporary order for chemical dependency treatment.

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

WSR 07-10-098
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:48 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 4 of 6;** amending WAC 388-550-3700 DRG high-cost and low-cost outliers.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule describes how the department pays inpatient hospital claims for dates of admission on and after August 1, 2007. The proposed rule reflects recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rules replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090 recommended that a study be done by navigant to look at the department's inpatient hospital payment system and include recommendations on the design. This rule is written to incorporate the results of the navigant study into rule, and to update information on the department's hospital coverage, rate-setting, and payment processes. At the same time and for the same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-13-053, filed 6/12/03, effective 7/13/03)

WAC 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers. This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under per diem payment methodology.

(1) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date January 1, 2001 or after.

(3) For dates of admission before August 1, 2007, the department determines payment for medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and in-state children's hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) In-state children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Three examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after, and before August 1, 2007).

Examples for DRG high-cost outlier claim qualification and payment calculation (admission dates are January 1, 2001, or after).

Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > $33,000?	Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
$17,000	$5,000	$15,000	No	Yes	N/A	64%
*33,500	5,000	15,000	Yes	Yes	**$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Nonin-state children's hospital (RCC is 64%)
*$33,500	Allowed charges
- $33,000 $ 500	The greater amount of 3 x app. DRG pymt ($15,000) or $33,000
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/nonin-state children's) (75% x 64% = 48%)
$ 240	Outlier portion
+ $ 5,000	Applicable DRG payment
**$ 5,240	Outlier payment

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) ((~~A~~)) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a Medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007 the department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of

days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for day outlier claims is the applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department determined estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.

(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection (16) of this section.

The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission. To qualify as a high outlier claim, when a claim is grouped to medical, surgical, burn, or neonatal DRG service category, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable per diem base allowed amount for payment.

The department performs retrospective prepay utilization review on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.

Specifically, this formula is:

$N=(Z^2 * S^2)/R^2$, where

• The Z statistic for 90 percent confidence is 1.64

• S=the standard deviation for the AP-DRG classification, and

• R=acceptable error range, per sampling unit

If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classification during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.

The DRG classification assigned to the per diem payment method, that are in one of the following major services categories in subsection (16)(a) through (d) of this section, qualify for determination to ascertain if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of a AP-DRG relative weight. A claim in a DRB classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:

(a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;

(b) Burn claims based on assignment to MDC 22;

(c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and

(d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.

(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the medicaid or SCHIP DRG paid and per diem paid claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for medicaid or SCHIP DRG paid and per diem paid claims is as follows:

(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the noncovered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.

(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:

(i) For DRG paid claims grouped to non-neonatal or non-pediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For non-specialty service category per diem paid claims grouped to non-neonatal and non-pediatric DRG classifications, and for non-specialty service category per diem paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment allowed amount; and

(iv) For non-specialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all non-specialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Reduced as indicated in WAC 388-550-4800 for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

DRG high outlier

Three examples for medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges minus Noncovered Charges	Base DRG Payment Allowed Amount[1]	175% of Base DRG Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base DRG Payment Allowed Amount?	Total DRG High Outlier Claim Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$95,600	$28,837	$50,465	Yes	Yes	$38,761	65%
$64,500	$28,837	$50,465	No	Yes	$28,837	65%
$77,000	$28,837	$50,465	Yes	No	$28,837	65%

All examples represent a claim that is a non-psychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight= Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$95,600 x 65% = $62,140 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria (in this example $50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

$62,140 - $50,465 = $11,675 x 85% = $9,924 = High outlier portion allowed amount

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$28,837 + $9,924 = $38,761

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight= Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 65% = $41,925 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($41,925 - $50,465 = ($8,540)) x 85% = ($7,259), which is converted to $0. Also, $41,925 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$77,000 x 65% = $50,050 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii))= high outlier portion allowed amount, if greater than $0, otherwise $0.

($50,050 - $50,465 = ($415)) x 85% = ($353), which is converted to $0. Also, $50,050 is greater than $50,000, but not greater than $50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Per Diem High Outlier

Three examples for medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Less Total Noncovered Charges	Base Per Diem Payment Allowed Amount[1]	175% of Base Per Diem Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount?	Total Per Diem High Outlier Claim's Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$100,000	$25,000	$43,750	Yes	Yes	$47,313	70%
$64,000	$25,000	$43,750	No	Yes	$25,000	70%
$75,000	$35,000	$61,250	Yes	No	$35,000	70%

All examples represent a claim that is a non-psychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 (rate) x 25 (days) = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$100,000 x 70% = $70,000 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($70,000 - $43,750 = $26,250) x 85% = $22,313 = High outlier portion allowed amount

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$25,000 + $22,313 = $47,313

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 25 = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 70% = $45,150 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($45,150 - $43,750 = $1,400), but $45,150 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$25,000 + $0 = $25,000

Example three: (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 35 = $35,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$75,000 x 70% = $52,500 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater tan $0, otherwise $0.

($52,500 - $61,250 = (8,750)) x 85% = ($7,438), which is converted to $0. Also, $52,500 is greater than $50,000, but not greater than $61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$35,000 + $0 = $35,000

(18) The department makes all applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to the payment.

WSR 07-10-099
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:49 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 5 of 6;** amending WAC 388-550-4400 Services—Exempt from DRG payment, 388-550-4500 Payment method—Inpatient RCC and administrative day rate and outpatient rate, and 388-550-6700 Hospital services provided out-of-state.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules describe policy regarding the department's hospital services coverage, rate-setting methods, and payment methods, based on recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rules replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090, recommended that a study be done by navigant to look at the department's inpatient payment system and include recommendations on the design. These rules are written to incorporate into rule the results of the navigant study, and to update information on the department's hospital coverage, rate-setting, and payment processes. At the same time and for the

same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-12-022, filed 5/20/05, effective 6/20/05)

WAC 388-550-4400 Services—Exempt from DRG payment. (1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are ((~~reimbursed by the~~)) paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.

(2) Subject to the restrictions and limitations in this section, for dates of admission before August 1, 2007, the department exempts the following services for medicaid clients from the DRG payment method:

(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state((~~-only~~)) administered program.

(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state((~~-only~~)) administered program.

(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. These are medicaid program services and are not funded by the department ((~~through~~)) for the general assistance programs or any other state((~~-only~~)) administered program.

(e) Acute physical medicine and rehabilitation services provided in ((~~MAA~~)) department-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. See WAC 388-550-4300 (2)(d). Rehabilitation services provided to clients under the general assistance programs and any other state-only administered program are also reimbursed through the RCC payment method.

(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals. Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:

(i) General assistance programs; and

(ii) Other state administered programs.

(g) Chronic pain management treatment provided in department-approved pain treatment facilities.

(h) Administrative day services. The department ((~~reimburses~~)) pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.

(i) Inpatient services recorded on a claim that is grouped by ((~~MAA~~)) the department to a DRG for which ((~~MAA~~)) the department has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid through the general assistance programs and any other state((~~-only~~)) administered program.

(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, pancreas, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by ((~~MAA~~)) the department through the general assistance programs and any other state((~~-only~~)) administered program.

(k) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. ((~~MAA~~)) The department pays hospitals for bariatric surgery on a ((~~single~~)) per case rate basis. See WAC 388-550-3470.

(3) Inpatient services provided through a managed care plan contract are ((~~reimbursed~~)) paid by the managed care plan.

(4) Subject to the restrictions and limitations in this section, for dates of admission on and after August 1, 2007, the department exempts the following services for medicaid and SCHIP clients from the DRG payment method. This policy also applies to covered services paid through the general

assistance programs and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services.

(b) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically-using pregnant (CUP) women program by a certified hospital. These are medicaid program services and are not covered or funded by the department through the general assistance programs or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. A mental health division (MHD) designee that arranges to pay a hospital directly for psychiatric services, may use the department's payment methods or contract with the hospital to pay using different methods. Claims not paid directly through a MHD designee are paid through the department's payment system.

(e) Chronic pain management treatment provided in a hospital approved by the department to provide that service.

(f) Administrative day services. The department pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. A hospital must request an administrative day designation on a case-by-case basis. The department may designate part of a client's stay to be paid an administrative day rate upon review of the claim and/or client's medical record.

(g) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG (AP DRG) relative weight. Claims grouped to DRG 469 or DRG 470 will be denied payment.

(h) Organ transplants that involve heart, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The department pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method.

(i) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3020 and 388-550-3470.

(j) Services provided by a critical access hospital (CAH).

(k) Services provided by a hospital participating in the certified public expenditure (CPE) payment program. The CPE "hold harmless" provision allows a reconciliation that is described in WAC 388-550-4670.

(l) Services provided by a long term acute care (LTAC) hospital.

AMENDATORY SECTION (Amending WSR 03-13-055, filed 6/12/03, effective 7/13/03)

WAC 388-550-4500 Payment method—Inpatient RCC ((~~and~~)) rate, administrative day rate ((~~and~~)), hospital outpatient rate, and swing bed rate. (1) The inpatient ratio of costs-to-charges (RCC) ((~~payment~~)) allowed amount is the hospital's ((~~allowable~~)) covered charges on a claim multiplied by the hospital's inpatient RCC rate. The department limits this RCC allowed amount for payment to the hospital's allowable usual and customary charges.

(a) The ((~~medical assistance administration (MAA)~~)) department calculates a hospital's RCC rate by dividing allowable ((~~operating~~)) costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) ((~~MAA~~)) The department bases ((~~these figures~~)) the RCC rate calculation on data from the hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(c) ((~~MAA~~)) The department updates a hospital's inpatient RCC rate annually ((~~with~~)) after the ((~~submittal of new CMS 2552~~)) hospital sends its "as filed" hospital fiscal year medicare cost report ((~~data~~)) to the centers for medicare and medicaid services (CMS) and to the department.

(i) In situations where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the RCC rate based on a department-determined method.

(ii) Prior to ((~~computing the ratio, MAA~~)) calculating the RCC rate, the department excludes ((~~increases in operating~~)) department nonallowed costs ((~~or total rate-setting revenue~~)) and nonallowable revenues. Costs and revenues attributable to a change in ownership are one example of what the department does not allow in the calculation process.

(2) The department limits a hospital's RCC payment to one hundred percent of its ((~~allowable~~)) allowed covered charges.

(3) The department establishes the basic inpatient hospital RCC ((~~payment~~)) allowed amount by multiplying the hospital's assigned RCC rate by the allowed covered charges for medically necessary services. ((~~MAA~~)) The department deducts client responsibility (((~~spend-down~~))) and third-party liability (TPL) ((~~from~~)), and makes other applicable payment program adjustments to the basic ((~~payment~~)) allowed amount to determine the actual payment due.

(4) For dates of admission:

(a) Before August 1, 2007, the department uses the RCC payment method to ((~~reimburse~~)) pay:

(((~~a~~))) (i) DRG-exempt hospitals ((~~as provided~~)) identified in WAC 388-550-4300; and

(((~~b~~))) (ii) Any hospital for DRG-exempt services ((~~described~~)) identified in WAC 388-550-4400. See the services identified in WAC 388-550-4400 (2)(g), (h), and (k) for an exception to this policy.

(b) For dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay:

(i) Transplant services identified in WAC 388-550-4400;

(ii) DRG and per diem payment method high outlier payments;

(iii) Long term acute care (LTAC) hospital services not covered under the LTAC per diem rate; and

(iv) Other services specified by the department.

(5) ((~~In-state and border area~~)) For dates of admission before August 1, 2007, the department pays instate and bordering city hospitals that lack sufficient ((~~CMS 2552~~)) medi-

care cost report data to establish a hospital specific RCC ((~~are reimbursed~~)), using the weighted average in-state:

(a) RCC rate for applicable inpatient services ((~~as provided~~)) identified in WAC 388-550-4300 and 388-550-4400; and

(b) Outpatient rate as provided in WAC 388-550-6000.

(6) The department pays out-of-state hospitals ((~~are also reimbursed for the respective~~)) for covered services ((~~using the weighted average in-state:~~

~~(a) RCC rate for inpatient services as provided in WAC 388-550-4300 and 388-550-4400; and~~

~~(b) Outpatient rate for outpatient hospital services as provided in WAC 388-550-6000~~)) as described in WAC 388-550-4000.

(7) ((~~MAA~~)) The department identifies all in-state hospitals that have hospital specific RCC rates, and calculates the weighted average in-state RCC rate annually by dividing the department-determined total allowable ((~~operating~~)) costs of these hospitals by the department-determined total ((~~respective~~)) patient-related revenues associated with those costs.

(8) The department ((~~pays~~)) allows hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client ((~~no longer needs an~~)) does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(a) ((~~MAA sets payment for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate is adjusted annually~~)) Upon request, the department's nursing facility rate-setting staff provides the department's hospital rate-setting staff with the statewide weighted average nursing facility medicaid payment rate each year to update the all-inclusive administrative day rate on November 1.

(b) The department does not pay for ancillary services provided during administrative days ((~~are not reimbursed~~)).

(c) The department identifies administrative days ((~~for a DRG exempt case~~)) during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital ((~~at~~)) the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate subacute placement can be made.

(9) ((~~MAA~~)) The department calculates the weighted average in-state hospital outpatient rate annually by multiplying the weighted average in-state RCC rate by the outpatient adjustment factor.

(10) For hospitals that have their own hospital specific inpatient RCC rate, ((~~MAA~~)) the department calculates the hospital's specific hospital outpatient rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor.

(11) The outpatient adjustment factor:

(a) Must not exceed 1.0; and

(b) Is updated annually. ((~~This update causes an additional update of~~)) At the time the outpatient adjustment factor is updated, the hospital outpatient rate for ((~~each~~)) the hospital is adjusted.

(12) ((~~MAA~~)) The department establishes the basic hospital outpatient ((~~payment~~)) allowed amount for a claim as provided in WAC 388-550-6000 and 388-550-7200. ((~~MAA~~)) The department deducts any client responsibility (((~~spend-down~~))) and any third-party liability (TPL) ((~~from~~)), and makes any other applicable payment program adjustments to the ((~~basic payment~~)) allowed amount to determine the actual payment due.

(13) The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The department does not allow payment for acute inpatient level of care for swing bed days when a client is receiving department-approved nursing service level of care in a swing bed.

(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200, and may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

AMENDATORY SECTION (Amending WSR 01-02-075, filed 12/29/00, effective 1/29/01)

WAC 388-550-6700 Hospital services provided out-of-state. (1) The department ((~~shall reimburse~~)) pays:

(a) For dates of admission before August 1, 2007 for only emergency care for an eligible medicaid and SCHIP client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(b) For dates of admission on and after August 1, 2007, for both emergency and nonemergency out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, for eligible medicaid and SCHIP clients based on the medical necessity and utilization review standards and limits established by the department.

(i) Prior authorization by the department is required for the nonemergency out-of-state hospital medical care provided to medicaid and SCHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As instate hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. Department designated critical border hospitals are paid as instate hospitals. See WAC 388-550-3900 and 388-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible medicaid and SCHIP clients based on authorization by a mental health division designee.

(d) Based on the department's limitations on hospital coverage under WAC 388-550-1100 and 388-550-1200 and other applicable rules.

(2) The department ((~~shall~~)) authorizes and ((~~provide~~)) pays for comparable ((~~medical care~~)) hospital services ((~~to~~)) for a medicaid and SCHIP client who is temporarily outside the state to the same extent that such ((~~medical care~~)) services are furnished to an eligible medicaid client in the state, subject to the exceptions and limitations in this section. See WAC 388-550-3900 and 388-550-4000.

(3) The department ((~~shall not authorize payment for out-of-state medical care furnished to state-funded clients (medically indigent/medical care services), but may authorize medical services in designated bordering cities~~)) limits out-of-state hospital coverage for clients eligible under state-administered programs as follows:

(a) For a client eligible under the psychiatric indigent inpatient (PII) program or who receives services under the Involuntary Treatment Act (ITA), the department does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(b) For a client eligible under a department's general assistance program, the department pays only for hospital services covered under the client's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The department does not pay for hospital services provided to clients eligible under a general assistance program in other hospitals located outside the state of Washington. The department or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC 388-550-1200.

(4) The department ((~~shall~~)) covers hospital care provided to medicaid or SCHIP clients in areas of Canada as described in WAC 388-501-0180, and based on the limitations described in the state plan.

(5) The department ((~~shall~~)) may review all cases involving out-of-state ((~~medical care~~)) hospital services, including those provided in bordering city hospitals and critical border hospitals, to determine whether the services are within the scope of the client's medical assistance program.

(6)(((~~(a)~~))) If the client can claim deductible or coinsurance portions of medicare, the provider ((~~shall~~)) must submit the claim to the intermediary or carrier in the provider's own state on the appropriate medicare billing form.

(((~~(b)~~))) If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For ((~~reimbursement~~)) payment for out-of-state inpatient hospital services, see WAC 388-550-3900 and 388-550-4000.

(8) ((~~The department shall reimburse out-of-state outpatient hospital services billed under the physician's current procedural terminology codes at an amount that is the lower of:~~

~~(a) The billed amount; or~~

~~(b) The rate paid by the Washington state Title XIX Medicaid program.~~

~~(9)~~)) Out-of-state providers ((~~shall~~)), including bordering city hospitals and critical border hospitals, must present final charges to ((~~MAA~~)) the department within three hundred sixty-five days of the ((~~date of service~~)) "statement covers period from date" shown on the claim. ((~~In no case shall~~)) The state of Washington ((~~be~~)) is not liable for payment of charges received beyond ((~~one year~~)) three hundred sixty-five days from the ((~~date services were rendered~~)) "statement covers period from date" shown on the claim.

WSR 07-10-100
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:50 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 6 of 6;** amending WAC 388-550-4800 Hospital payment methods—State administered programs.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule describes policy regarding the department's hospital services coverage, rate-setting methods, and payment methods, based on recommendations made in the navigant study and supported by the state legislature. In addition, the proposed rule replace "medical assistance administration (MAA)" with "the department," and update and clarify other language.

Reasons Supporting Proposal: In 2005, ESSB 6090, recommended that a study be done by navigant to look at the department's inpatient payment system and include recommendations on the design. This rule is written to incorporate into rule the results of the navigant study, and to update information on the department's hospital coverage, rate-setting, and payment processes. At the same time and for the same reasons, the department is proposing rule making to reflect changes and new sections in chapter 388-550 WAC.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 753-9152, e-mail linnld@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-12-132, filed 6/1/05, effective 7/1/05)

WAC 388-550-4800 Hospital payment methods—State administered programs. Subsections (1) through (11) of this section apply to hospital payment methods for state administered programs for dates of admission before August 1, 2007. Subsections (12) through (19) of this section apply to hospital payment methods for state administered programs for dates of admission on and after August 1, 2007.

(1) Except as provided in subsection (2) of this section, the ((~~medical assistance administration (MAA)~~)) department uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to ((~~reimburse~~)) pay hospitals at reduced rates for covered services provided to a client who is not eligible under ((~~any~~)) a medicaid program, the SCHIP program, or alien emergency medical (AEM) program and:

(a) Who qualifies for the general assistance unemployable (GAU) program; or

(b) Is involuntarily detained under the Involuntary Treatment Act (ITA).

(2) ((~~MAA~~)) The department exempts the following services from the state-administered programs' payment methods and/or reduced rates:

(a) Detoxification services when the services are provided under ((~~an MAA~~)) a department-assigned provider number starting with "thirty-six." (((~~MAA reimburses~~)) The department pays these services using the Title XIX medicaid RCC payment method.)

(b) Program services provided by ((~~MAA~~)) department-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (((~~MAA reimburses~~)) The department pays these services through cost settlement as described in WAC 388-550-2598.)

(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (((~~MAA reimburses~~)) The department these services through the "full cost" public hospital certified public expenditure (CPE) payment program (see WAC 388-550-4650)).

(3) ((~~MAA~~)) The department determines:

(a) A state-administered program RCC payment by reducing a hospital's Title XIX medicaid RCC rate using the hospital's ratable.

(b) A state-administered program DRG payment by reducing a hospital's Title XIX medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).

(4) ((~~MAA~~)) The department determines:

(a) The RCC rate for the state-administered programs mathematically as follows:

State-administered programs' RCC rate = current Title XIX medicaid RCC rate x (one minus the current hospital ratable)

(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:

State-administered programs' DRG CF = current Title XIX medicaid DRG CBCF x (one minus the current hospital ratable) x EF

(5) ((~~MAA~~)) The department determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:

(a) Under the RCC payment method:

State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges

(b) Under the DRG payment method:

State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative weight (See subsection (6) of this section for how ((~~MAA~~)) the department determines payment for state-administered program claims that qualify as DRG high-cost outliers.)

(6) For state-administered program claims that qualify as DRG high-cost outliers, ((~~MAA~~)) the department determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

High-cost Outlier Calculations for Qualifying Claims State-administered Programs (for admission dates January 1, 2001 and after)														
In-state Children's Hospitals Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	85%	(=)	Outlier Add-on Amount	(+)	*DRG Allowed Amount
Psychiatric DRGs 424-432 Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	100%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
All other qualifying claims Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	60%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount														

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8) ((~~MAA~~)) The department determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9) To calculate a hospital's ratable that is applied to both the Title XIX medicaid RCC rate and the Title XIX medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, ((~~MAA~~)) the department:

(a) Adds the hospital's medicaid revenue (medicaid revenue as reported by department of health (DOH) includes all medicaid revenue and all other medical assistance revenue) and medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 medicare cost report received by ((~~MAA~~)) the department at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital-medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital-specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital-specific final ratable factors for the year; then

(i) Calculates an instate-average ratable and an instate-average ratable factor used for new hospitals with no prior year history.

(10) ((~~MAA~~)) The department updates each hospital's ratable annually on August 1.

(11) ((~~MAA~~)) The department:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX Medicaid DRG CBCF x (one minus the prior ratable)

(12) For dates of admission on and after August 1, 2007, the department pays for services provided to a client eligible for a state administered program based on state-administered program rates. The state administered program rates are established independently from the process used in setting the medicaid payment rates. The state administered program rates may not be changed unless the legislature authorizes the changes. The department uses the ratable factor and equiva-

lency factor to keep the state administered program payment rates at the same level they were at before the state medicaid rates are rebased.

(13) The table in this subsection shows a comparison of the payment policy for the department's inpatient payment system for dates of admission before August 1, 2007, and the inpatient payment system effective for dates of admission on and after August 1, 2007. Under this inpatient payment system effective August 1, 2007, the per diem rates are used to pay for many services previously paid using the RCC payment method.

The following table indicates differences in policy for the two inpatient payment systems:

Inpatient payment system for dates of admission before August 1, 2007	Inpatient payment system for dates of admission on and after August 1, 1007
DRG Grouper, version 14.1	DRG Grouper, version 23.0
RCC Rate:	Per Diem Rate:
- Psych	-Psych
-Rehab	-Rehab
-Detox	-Detox
-Neonate	-CUP
-Transplant	-Burns
-HIV	-Medical
-Low volume services	-Surgical
-Military hospitals	-Neonate and pediatric
Per Diem Rate:	-Chronic pain management
-Chronic pain management	
Per Case Rate:	Per Case Rate:
-Bariatric surgery	-Bariatric surgery
	RCC Rate:
	-Transplant services
	-Military hospitals

See specific sections in the chapter 388-550 WAC to determine how the department pays hospitals participating in the critical access hospital (CAH) program, the long term acute care (LTAC) program, and the certified public expenditure (CPE) payment program.

(14) Due to changes in payment methodologies established for the inpatient payment system effective August 1, 2007, the department has established the following state administered program rates used for dates of admission on and after August 1, 2007:

(a) State administered program DRG conversion factor for claims grouped under stable DRG classifications services.

(b) State administered program per diem rates for claims grouped under the following specialty service categories:

(i) CUP;

(ii) Detoxification; and

(iii) Physical medicine and rehabilitation.

(c) State administered program per diem rates for the claims grouped to unstable DRG classifications under the following non-specialty service categories:

(i) Surgical;

(ii) Medical;

(iii) Burns; and

(iv) Neonate and pediatric.

(d) State administered program per diem rates for claims grouped under psychiatric services.

(e) State administered program per case rate for claims grouped under bariatric services.

(f) State administered program RCC rates for claims grouped under transplant services.

(15) This subsection describes the state administered program (DRG) conversion factor and payment calculation processes used by the department to pay claims paid using the DRG payment method. The department pays for services grouped to a stable DRG classification that are provided to clients eligible for a state administered program based on use of a DRG conversion factor and a DRG relative weight. This process is similar to the payment method used to pay for medicaid and SCHIP services that are grouped to a stable DRG classification.

(a) The department's state administered program DRG conversion factor calculation process is as follows:

(i) For instate and critical border hospitals, the hospital's specific DRG conversion factor that is used to calculate payment for a state administered program claim, is based on the medicaid conversion factor adjusted by the most available ratable factor and the applicable equivalency factor. Mathematically the calculation is:

State administered program DRG CF =

((Medicaid DRG CF x applicable Equivalency Factor) x most available ratable factor)

(ii) For instate and critical border hospitals that do not have a current state administered program DRG conversion factor, the state administered program conversion factor is the hospital's specific proposed medicaid conversion factor multiplied by the average applicable equivalent factor and average applicable ratable.

(iii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program DRG conversion factor is the lowest instate medicaid DRG conversion factor multiplied by the average ratable and equivalency factor.

(b) The department's state administered program DRG equivalency factor calculation process is as follows:

(i) The equivalency factor is a factor used to hold the hospital's specific state administered program DRG conversion factor or rates at the same level before and after the medicaid DRG rate is rebased. Mathematically the calculation is:

Equivalency factor = (State administered program DRG CF/(Medicaid DRG CF x ratable))

(ii) The department may make an adjustment to the equivalency factor to address the differences in the relative weight values of the two DRG grouper versions due to the recalibration of the weights.

(iii) Refer to the to the ratable and ratable factor definition and calculation for the ratable factor determination.

(c) The department's DRG payment calculation process for DRG classifications grouped to stable DRG relative weights is as follows:

(i) The department determines the allowed amount for the inlier portion of the state-administered program DRG payment calculation. Mathematically the calculation is:

State administered program DRG inlier portion allowed amount of the payment = (State administered program DRG CF x DRG relative weight)

(ii) The department determines the high outlier claim calculation for the state administered program DRG payment. See WAC 388-550-3700 for more information about high outlier qualification and calculation processes. Mathematically the calculation is:

State-administered program DRG inlier and outlier portion allowed amount of the payment = (State-administered program DRG CF x DRG relative weight) + outlier adjustment

(iii) The outlier payment adjustment calculation for a state administered program claim is different than the outlier payment calculation for a medicaid claim. The outlier adjustment for a state administered program claim is adjusted by the ratable factor.

(iv) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to non-neonatal DRGs and non-pediatric DRGs, equals one hundred seventy-five percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment in hospitals other than Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center.

(v) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to neonatal DRGs, pediatric DRGs, equals one hundred fifty percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment when the claim is from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

(vi) The outlier transfer provision is applied for the calculation of services paid under the state administered program DRG payments.

(vii) Refer to the medicaid percent of outlier adjustment factor described in WAC 388-550-3700 for the percent of outlier adjustment factor.

(d) The department determines the outlier portion allowed amount calculation for the state-administered program high outlier claim DRG payment as follows. Mathematically the calculation is:

State administered program outlier portion allowed amount of claim = ((Covered charges x RCC) - outlier threshold) x (Percent of outlier adjustment factor x ratable factor)

(i) A claim is an outlier claim when the claim cost (covered charges x RCC) is greater than both the fixed loss amount of fifty thousand dollars and one hundred seventy-five percent(one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(ii) The outlier threshold used in calculation of the outlier payment adjustment will always be one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.

(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.

(16) This subsection describes the state-administered program per diem rate and payment calculation for the following specialty service categories and unstable DRG non-specialty service categories.

(a) The per diem rate is separately established for each of the following services:

(i) CUP;

(ii) Detoxification;

(iii) Physical medicine and rehabilitation;

(iv) Surgical;

(v) Medical;

(vi) Burns; and

(v) Neonate and pediatric.

(b) The per diem rate calculation process for CUP, detoxification, physical medicine and rehabilitation, surgical, medical, burns, and neonate and pediatric services is, for instate and critical border hospitals, the hospital's specific state administered program per diem rate is based on the Title XIX medicaid rates multiplied by the most available ratable factor and the equivalency factor. Mathematically the calculation is:

State administered program per diem rate =

((Hospital's specific medicaid per diem x ratable factor) x Equivalency factor)

(c) The per diem equivalency factor calculation process is as follows:

(i) The per diem equivalency factor is a factor used to hold the aggregate payment for all non-medicaid claims grouped under per diem payment method at the same level before and after the per diem medicaid rate is rebased. The equivalency factor is the calculated based on the estimate non-medicaid per diem, the medicaid per diem, and the hospital's specific ratable factor. Mathematically the calculation is:

Equivalency factor =

(Estimated state administered program per diem rate/ (Medicaid per diem rate x ratable))

(ii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program per diem rate is the lowest instate medicaid per diem rate multiplied by the average ratable and equivalency factor.

(iii) The state administered program per diem rate is an estimate based on the actual payment per day. The actual payment per day equals the aggregate payment amount (inflated from the base year to the implementation year) divided by the number of days associated with the aggregate costs.

(iv) For a hospital with more than twenty state administered program claims that grouped in the base year data to DRG classifications that are paid using the per diem payment method, a hospital's specific equivalency factor is established based on the hospital's data.

(v) For a hospital with less than twenty state administered program claims that grouped in the base year data to DRG classifications are paid using the per diem payment method, an average equivalency factor is established based on the hospital database of all hospitals.

(d) The state administered program per diem allowed amount of payment calculation process for CUP, detoxification, and physical medicine and rehabilitation services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

The high outlier and transfer policy is not applied to payment calculations for CUP, detoxification, and physical medicine and rehabilitation services.

(e) The state administered program per diem allowed amount of payment calculation process for surgical, medical, burns, and neonate services is as follows. Mathematically the calculation is:

Per diem payment =

Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment

(i) The outlier policy is applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services (see WAC 388-550-3700). Refer to the state administered program outlier DRG adjustment payment calculation for the outlier calculation.

(ii) The transfer policy is not applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services.

(17) The state administered program per diem rate and payment calculation for psychiatric services is as follows:

(a) The department uses a payment method similar to the method used to pay for medicaid psychiatric services, for state administered program psychiatric services provided to clients eligible for those services. Psychiatric services provided to state administered program clients are paid using a psychiatric per diem rate. The per diem rate calculation process for state administered program psychiatric services is as follows:

(i) For instate hospitals, the hospital's specific state administered program psychiatric per diem rate used to calculate the allowed amount for payment is based on the Title XIX medicaid rate adjusted by a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem. Mathematically the calculation is:

State administered program psychiatric per diem rate =

Medicaid psychiatric per diem x a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem.

(ii) For hospitals located outside the state of Washington, including bordering city hospitals, critical border hospitals, and other out-of-state hospitals, psychiatric services and involuntary treatment act (ITA) services are not covered or paid by the department.

(b) The per diem payment calculation process for state-administered program psychiatric services is as follows. Mathematically the calculation is:

Psychiatric payment =

State administered program hospital's specific per diem rate x patient stay LOS recognized by the department's MHD designee for payment

(i) Outlier payment and transfer policies are not applied to state administered program psychiatric claims.

(ii) The ratable factor was provided to the department by the legislature.

(18) This subsection describes the state administered program per case rate and payment processes for bariatric surgery services.

(a) The department limits provision of bariatric surgery services to medical assistance clients to hospitals that are approved by the department to provide those services. Bariatric surgery services provided to a medical assistance client by an approved hospital must also be prior authorized by the department for the hospital to receive payment from the department for those services. Effective August 1, 2007, the department approved bariatric surgery services programs at the Sacred Heart Medical Center, the University of Washington Medical Center, and the Oregon Health Science University. The department may approve other programs based on department discretion.

(b) The department calculates the state administered program per case rate for bariatric surgery services by multiplying the hospital's specific medicaid per case rate for bariatric surgery services by the hospital's specific ratable factor and DRG-equivalency factor. Mathematically the calculation is:

State administered program per case rate =

Medicaid per case rate x hospital's specific ratable factor x DRG equivalency factor

The per case payment rate for bariatric surgery services is an all-inclusive rate. No outlier provision is applied to the per case rate.

(19) This subsection describes the state administered program RCC rates and payment calculation processes for transplant services and other RCC paid services. Transplant services provided to a client eligible for those services through a state administered program are paid using the RCC payment method. There are some other services that may be paid using the RCC payment method, e.g., services provided by military hospitals when no other payment method is agreed upon by the department and the hospital. The state administered program RCC rate is calculated by multiplying the medicaid RCC rate by the ratable factor. Mathematically the calculation is:

State administered program RCC rate = medicaid RCC x ratable factor

WSR 07-10-101
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:52 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 1 of 3;** new WAC 388-550-5410 Medicaid cost report schedules; and amending WAC 388-550-5400 Payment method—

PHDSH, 388-550-5425 Upper payment limit (UPL) payments for inpatient hospital services, and 388-550-5450 Supplemental distributions to approved trauma service centers.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing new rules and amendments to existing rules to ensure clear and consistent policies for hospital reimbursement and to ensure compliance with federal and state guidelines. The proposed rules add new sections to ensure all disproportionate share hospital (DSH) programs are identified in rule and ensure that sufficient program detail is provided; amend sections pertaining to DSH requirements to ensure consistency with federal guidelines; describe how hospitals qualify for DSH payments; add definitions that apply to DSH payments; amend sections pertaining to the certified public expenditure (CPE) payment program to clarify CPE payment program policies and ensure consistency with federal guidelines embodied in the state plan; and amend sections pertaining to supplemental distributions to approved trauma centers in response to hospital provider input to the department; and incorporate into rule that the department is terminating the upper payment limit (UPL) program.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Ayuni Wimpee, P.O. Box 45510, Olympia, WA 98504-5510, (360) 725-1835.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Ayuni Wimpee, P.O. Box 45510, Olympia, WA 98504-5510, phone (360) 725-1835, fax (360) 753-9152, e-mail wimpeah@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5400 Payment method—Public hospital disproportionate share hospital (PHDSH). (1) The department's public hospital disproportionate share hospital (PHDSH) program is a public hospital program for:

(a) Public hospitals located in the state of Washington that are:

(i) Owned by a public hospital district((~~s~~)); and

(ii) Not certified by the department of health (DOH) as a critical access hospital;

(b) Harborview Medical Center; and

(c) University of Washington Medical Center.

(2) The ((~~department pays~~)) PHDSH payments to a hospital((~~s~~)) eligible under this program ((~~a payment equal to~~)) may not exceed the hospital's ((~~individual~~)) disproportionate share hospital (DSH) ((~~payment limit~~)) cap calculated according to WAC 388-550-4900. The ((~~resulting amount is multiplied by~~)) hospital receives only the federal matching assistance percentage ((~~in effect for Washington State at the time of the payment. This amount is sent to the hospital~~)) of the total computable payment amount.

(3) Hospitals receiving payment under ((~~this DSH~~)) the PHDSH program must ((~~certify that funds have been spent on uncompensated care at the hospital equal to or in excess of the payment amount before applying the federal matching assistance percentage~~)) provide the local match for the federal funds through certified public expenditures (CPE). Payments are limited to costs incurred by the participating hospitals.

(4) A hospital receiving payment under the PHDSH program must submit to the department federally required medicaid cost report schedules apportioning inpatient and outpatient costs, beginning with the services provided during the state fiscal year 2006. See WAC 388-550-5410.

(5) PHDSH payments are subject to the availability of DSH funds under the statewide DSH cap. If the statewide DSH cap is exceeded, the department will recoup PHDSH payments first, but only from hospitals that received total inpatient and DSH payments above the hold harmless level, and only to the extent of the excess amount above the hold harmless level. See WAC 388-550-4900 (13) and (14), and WAC 388-550-4670.

NEW SECTION

WAC 388-550-5410 Medicaid cost report schedules. (1) A certified public expenditure (CPE) hospital must annually submit to the department federally required medicaid cost report schedules, using schedules approved by the centers for medicare and medicaid services (CMS), that apportion inpatient and outpatient costs to medicaid clients and uninsured patients for the service year, as follows:

(a) Title XIX fee-for-service claims;

(b) Medicaid managed care organization (MCO) plan claims;

(c) Uninsured patients (individuals who are not covered under any health care insurance plan for the hospital service provided). The cost report schedules for uninsured patients must not include the cost of services that medicaid would not have paid for had the patients been medicaid eligible; and

(d) State-administered program patients. State-administered program patients are reported separately and are not to be included on the Uninsured patient cost report schedule. The department will provide Provider Statistics and Reimbursements (PS&R) reports for the state-administered program claims.

(2) The department requires each CPE hospital to submit medicaid cost report schedules to the department for services provided to patients discharged on or after July 1, 2005.

(3) A CPE hospital must:

(a) Use the information on individualized PS&R reports provided by the department when completing the medicaid cost report schedules. The department provides the hospital with the PS&R reports at least thirty days prior to the appropriate deadline.

(i) For state fiscal year (SFY) 2006, the deadline for all CPE hospitals to submit the federally required medicaid cost report schedules is June 30, 2007.

(ii) For SFY 2007 and thereafter, each CPE hospital is required to submit the medicaid cost report schedules to the department within thirty days after the medicare cost report is due to its medicare fiscal intermediary.

(iii) For hospitals with a December 31 year end, partial year medicaid cost report schedules for the period July 1, 2005 through December 31, 2005 must be submitted to the department by August 31, 2007.

(b) Complete the cost report schedules for medicaid MCO plan and the uninsured patients using the hospital provider's records.

(c) Comply with the department's instructions regarding how to complete the required cost report schedules.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5425 Upper payment limit (UPL) payments for inpatient hospital services. (1) ((~~Each state fiscal year, in accordance with legislative direction and established prospective payment methods, the department creates an upper payment limit (UPL) payment pool that provides supplemental payments for inpatient hospital services to a hospital provider of Title XIX Medicaid services that is classified as either a:~~

~~(a) Washington state-owned or state-operated hospital; or~~

~~(b) Nonstate government-owned hospital.~~

~~(2) UPL payments for inpatient hospital services are subject to:~~

~~(a) Federal approval for federal matching funds; and~~

~~(b) A department analysis of the Medicare UPL for hospital payment.~~

~~(3) The department determines each payment year's UPL payment for inpatient hospital services by:~~

~~(a) Using the charge and payment data from the department's payment system for inpatient hospital services for the base year; and~~

~~(b) Calculating the cumulative difference between Medicare payments and Title XIX payments, including third party liability payment for all eligible hospitals during the most recent state fiscal year.~~

~~(4) UPL payments for inpatient hospital services:~~

~~(a) Are determined for participating eligible hospitals during each federal fiscal year;~~

~~(b) Are paid by the department on a periodic basis to one or more of the participating eligible hospitals; and~~

~~(c) Must be used by the receiving hospital(s) to improve health care services to low income patients~~)) The upper payment limit (UPL) program is terminated effective July 1, 2007. The department will not make UPL payments after June 30, 2007.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5450 Supplemental distributions to approved trauma service centers. (1) The ((~~department's~~)) trauma care fund (TCF) is an amount legislatively appropriated to ((~~DSHS~~)) the department each biennium, at the legislature's sole discretion, for the purpose of supplementing the department's payments to eligible trauma service centers for providing qualified trauma services to eligible medicaid fee-for-service clients. Claims for trauma care provided to clients enrolled in the department's managed care programs are not eligible for supplemental distributions from the TCF.

(2) Beginning with trauma services provided after June 30, 2003, the department makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section and subject to legislative action.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable WAC;

(c) Meet the billing requirements in this section and other applicable WAC;

(d) Submit all information the department requires to ensure services are being provided; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) ((~~For qualified hospitals, determined as a percentage of a fixed amount per quarter. Each eligible hospital's share per quarter is based on the amount paid by the department to that hospital for inpatient and outpatient trauma care the hospital provides to Medicaid clients during that quarter, expressed as a percentage of the following total~~)) Allocated into five fixed payment pools of equal amounts. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals

are determined by first summing each eligible hospital's qualifying payments since the beginning of the service year and expressing this amount as a percentage of total payments to all eligible hospitals for qualifying services provided during the service year to date. Each hospital's payment percentage is multiplied by the available amount in the current period pool to determine the portion of the pool to be paid to each qualifying hospital. Eligible hospitals and qualifying payments are described in (i) through (iii) of this subsection:

(i) Qualifying payments are the department's payments to Level 1, Level 2, and Level 3 trauma service centers for qualified medicaid trauma cases ((~~in that quarter~~)) since the beginning of the service year. The department determines the countable payment ((~~per quarter~~)) for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The department's payments to Level 1, Level 2, and Level 3 hospitals for trauma cases transferred in ((~~during that quarter~~)) since the beginning of the service year. A Level 1, Level 2, or Level 3 hospital that receives a transferred trauma case from any lower level hospital is eligible for the enhanced payment, regardless of the client's Injury Severity Score (ISS). An ISS is a summary rating system for traumatic anatomic injuries; and

(iii) The department's payments to Level 2 and Level 3 hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in subsection (4)(b) of this section) that ((~~are~~)) these hospitals transferred to a higher level designated trauma service center ((~~during that quarter~~)) since the beginning of the service year.

(b) Paid only for a medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of subsection (4)(c).

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level 1, Level 2, or Level 3 adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) It is designated or recognized by DOH as an approved Level 2 or Level 3 adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (b)(ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level 4 or Level 5 trauma service center does not qualify for supplemental distributions for ((~~transferred~~)) trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in subsection (4)(b) of this section.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the department to:

(i) Trauma service centers designated or recognized as Level 4 or Level 5;

(ii) Critical access hospitals (CAHs), except when the CAH is also a Level 3 trauma service center. Beginning with qualifying trauma services provided in state fiscal year (SFY) 2007, the department allows a hospital with this dual status to receive distributions from the TCF; or

(iii) Any hospital for follow-up surgical services related to the qualifying trauma incident but provided to the client after the client has been discharged for the initial qualifying injury.

(5) Distributions for an SFY are divided into five "quarters" and paid as follows:

(a) Each quarterly distribution paid by the department from the TCF totals twenty percent of the amount designated by the department for that SFY;

(b) The first quarterly supplemental distribution from the TCF is made six months after the SFY begins;

(c) Subsequent quarterly payments are made approximately every four months after the first quarterly payment is made, except as described in subsection (d);

(d) The "fifth quarter" final distribution from the TCF for the same SFY is:

(i) Made one year after the end of the SFY;

(ii) Based on the SFY that the TCF designated amount relates to; and

(iii) Distributed based on each eligible hospital's percentage of the total payments made by the department to all designated trauma service centers for qualified trauma cases during the relevant fiscal year.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) The department may consider a request for a claim adjustment submitted by a provider only if the request is received by the department within one year from the date of the initial trauma service;

(b) The department does not allow any carryover of liabilities for a supplemental distribution from the TCF ((~~after a date specified by the department as the last date to make~~)) beyond three hundred sixty-five calendar days from the date of discharge (inpatient) or date of service (outpatient). The deadline for making adjustments to a trauma claim ((~~for an SFY~~)) is the same as the deadline for submitting the initial claim to the department. WAC 388-502-0150(7) does not apply to TCF claims;

(c) All claims and claim adjustments are subject to federal and state audit and review requirements; and

(d) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the department in any biennium cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

WSR 07-10-102
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed May 1, 2007, 3:53 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 2 of 3;** amending WAC 388-550-4670 CPE payment program—"Hold harmless" provision and 388-550-4900 Disproportionate share payments.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing new rules and amendments to existing rules to ensure clear and consistent policies for hospital reimbursement and to ensure compliance with federal and state guidelines. The proposed rules add new sections to ensure all disproportionate share hospital (DSH) programs are identified in rule and ensure that sufficient program detail is provided; amend sections pertaining to DSH requirements to ensure consistency with federal guidelines; describe how hospitals qualify for DSH payments; add definitions that apply to DSH payments; amend sections pertaining to the certified public expenditure (CPE) payment program to clarify CPE payment program policies and ensure consistency with federal guidelines embodied in the state plan; and amend sections pertaining to supplemental distributions to approved trauma centers in response to hospital provider input to the department; and incorporate into rule that the department is terminating the upper payment limit (UPL) program.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Ayuni Wimpee, P.O. Box 45502 [45510], Olympia, WA 98504-5510, (360) 725-1835.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Ayuni Wimpee, P.O. Box 45510, Olympia, WA 98504-5510, phone (360) 725-1835, fax (360) 753-9152, e-mail wimpeah@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-11-100, filed 5/17/06, effective 6/17/06)

WAC 388-550-4670 CPE payment program—"Hold harmless" provision. ((~~(1)~~)) To meet legislative requirements, the department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure (CPE) payment program. Under the ((~~"~~))hold harmless((~~"~~)) provision, hospitals eligible for payments under the CPE payment program will receive no less in combined state and federal payments than they would have received under the methodologies otherwise in effect ((~~during state fiscal year (SFY) 2005~~)) as described in this section.

(((~~(2) As part of the "hold harmless" payment calculation, the department reprices inpatient hospital claims paid during the service year, beginning with service year SFY 2006, to determine how these claims would have been paid under the payment methodologies in effect during SFY 2005.~~

~~(3) The department makes the final "hold harmless" calculation after the department receives the hospital's final audited Medicare cost report and audited financial statements for the service year. The department calculates the federally required prospective cost settlement at the same time. Any adjustments to state grants payments due to the cost settlement calculations will be made as payment adjustments to the next year's state grants~~)) (1) For each state fiscal year, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the state fiscal year (SFY) as the sum of:

(a) The total payments for inpatient claims for patients admitted during the fiscal year, calculated by repricing the claims using:

(i) For SFYs 2006 and 2007, the inpatient payment method in effect during SFY 2005;

(ii) For SFYs 2008 and beyond, the payment method that would otherwise be in effect during the CPE payment program year if the CPE payment program had not been enacted; and

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(2) For each SFY, the department determines total payments made under the program during the fiscal year, including the allowable federal portion of inpatient claims and disproportionate share hospital (DSH) payments, and the state

and federal shares of any supplemental upper payment limit payments.

(3) The amount determined in subsection (2) of this section is subtracted from the amount calculated in subsection (1) of this section to determine the gross state grant amount necessary to hold the hospital harmless. Prepaid hold harmless grants prepaid for the same SFY referred to in subsection (2) of this section are deducted from the gross hold harmless amount to determine the net amount due to or from the hospital.

(a) The department calculates an interim hold harmless grant amount approximately ten months after the SFY to include the paid claims for the same SFY admissions. Claims are subject to utilization review prior to the interim hold harmless calculation.

(b) The department calculates the final hold harmless grant amount at such time as the final allowable federal portions of program payments are determined. The procedure is the same as the interim grant calculation but it includes all additional claims that have been paid or adjusted since the interim hold harmless calculation. Claims are subject to utilization review prior to the final calculation of the hold harmless amount due to or from the hospital.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by section 1902 (a)(13)(A) of the Social Security Act((~~, the department gives consideration to hospitals that serve a disproportionate number of low-income clients with special needs by making a payment adjustment to eligible hospitals in accordance with legislative direction and established prospective payment methods. The department considers this adjustment a disproportionate share hospital (DSH) payment.~~

~~(1) To qualify for a DSH payment for each state fiscal year (SFY), an instate or bordering city hospital provider must submit to the department, the hospital's completed and final DSH application by the due date specified in that year's application letter.~~

~~(2) A hospital is a disproportionate share hospital eligible for the low-income disproportionate share hospital (LIDSH) program for a specific SFY if the hospital submits a DSH application for that specific year in compliance with subsection (1) and if both the following apply:~~

~~(a) The hospital's Medicaid inpatient utilization rate (MIPUR) is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or the hospital's low-income utilization rate (LIUR) exceeds twenty-five percent; and~~

~~(b) At least two obstetricians who have staff privileges at the hospital have agreed to provide obstetric services to eligible individuals at the hospital. For the purpose of establishing DSH eligibility, "obstetric services" is defined as routine nonemergency delivery of babies. This requirement for two obstetricians with staff privileges does not apply to a hospital:~~

~~(i) That provides inpatient services predominantly to individuals under eighteen years of age; or~~

~~(ii) That did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.~~

~~(3) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.~~

~~(4) The department may consider a hospital a disproportionate share hospital for programs other than the LIDSH program if the hospital submits a DSH application for the specific year and meets the following criteria for the year specified in the application:~~

~~(a) The hospital has a MIPUR of not less than one percent; and~~

~~(b) The hospital meets the requirement of subsection (2)(b) of this section.~~

~~(5) To determine a hospital's eligibility for any DSH program, the department uses the criteria in this section and the information derived from the DSH application submitted by the hospital, subject to the following:~~

~~(a) Charity care. If the hospital's DSH application and audited financial statement for the relevant fiscal year do not agree on the amount for charity care, the department uses the lower amount claimed.~~

~~(b) Bad debt. If the hospital's DSH application does not allocate bad debt between insured and uninsured patients, the department assigns the entire amount of bad debt to insured patients.~~

~~(c) Total inpatient hospital days. If the hospital's DSH application lists a total number of inpatient hospital days that is lower than the total number in the hospital's Medicare cost report, the department uses the higher number to determine the hospital's MIPUR. The department may use the lower number to determine the hospital's MIPUR if, within ten business days of the department's written notification to the hospital of the discrepancy, the hospital submits documentation that supports the lower number of inpatient hospital days listed on the DSH application. Acceptable documentation includes, but is not limited to, a revised cost report submitted to Medicare that shows the correct data.~~

~~(6) Hospitals must submit annually to the department a copy of the hospital's charity and bad debt policy as part of the individual hospital's DSH application.~~

~~(7) The department administers the low-income disproportionate share hospital (LIDSH) program and may administer any of the following DSH programs:~~

~~(a) General assistance unemployable disproportionate share hospital (GAUDSH);~~

~~(b) Small rural hospital assistance program disproportionate share hospital (SRHAPDSH);~~

~~(c) Small rural hospital indigent assistance program disproportionate share hospital (SRHIAPDSH);~~

~~(d) Nonrural hospital indigent assistance program disproportionate share hospital (NRHIAPDSH);~~

~~(e) Public hospital disproportionate share hospital (PHDSH); and~~

~~(f) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).~~

~~(8) The department allows a hospital to receive any one or all of the DSH payment adjustments discussed in subsection (7) of this section when the hospital:~~

~~(a) Meets the requirements in subsection (4) of this section; and~~

~~(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.~~

~~(9) The department ensures each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as:~~

~~(a) The cost to the hospital of providing services to Medicaid clients, including clients served under Medicaid managed care programs;~~

~~(b) Less the amount paid by the state under the non-DSH payment provision of the state plan;~~

~~(c) Plus the cost to the hospital of providing services to uninsured patients;~~

~~(d) Less any cash payments made by uninsured clients; and~~

~~(e) Plus any adjustments required and/or authorized by federal regulation.~~

~~(10) The department's total annual DSH payments cannot exceed the state's DSH allotment for the federal fiscal year.~~

~~If the department's statewide allotment is exceeded, the department may adjust future DSH payments to each hospital to compensate for the amount overpaid. Adjustments will be made in the following program order:~~

~~(a) PHDSH;~~

~~(b) SRHAPDSH;~~

~~(c) NRHAPDSH;~~

~~(d) SRHAPDSH;~~

~~(e) GAUDSH;~~

~~(f) PHDSH; and~~

~~(g) LIDSH~~)) (42 USC 1396 (a)(13)(A)) and RCW 74.09.730, the department makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. &A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 USC 1396r-4;

(b) It satisfies all the requirements of department rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the hospital fiscal year that ended during the calendar year immediately preceding the year in which the state fiscal year for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the state fiscal year (SFY) two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "Disproportionate share hospital (DSH) cap" means the maximum amount per state fiscal year that the state can distribute in DSH payments to hospitals (statewide DSH cap), or the maximum amount of DSH payments a hospital may receive during a state fiscal year (hospital-specific DSH cap).

(e) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the department which the department uses to verify medicaid patient eligibility and patient days.

(f) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the department during a state fiscal year. For a critical access hospital (CAH), the DSH cap is based strictly on the net cost to the hospital of providing services to uninsured patients.

(g) "Low income utilization rate (LIUR)" means the sum of these two percentages: (1) the ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care) and state-administered programs, plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus (2) the ratio of inpatient charges (excluding contractual allowances), divided by total billed charges for inpatient services. The department uses LIUR as one criterion to determine a hospital's eligibility for the low income disproportionate share hospital (LIDSH) program. To qualify for LIDSH, a hospital's LIUR must be greater than twenty-five percent.

(h) "Medicaid inpatient utilization rate (MIPUR)" means the number of inpatient days of service provided by a hospital to medicaid clients during its hospital fiscal year, divided by the number of inpatient days of service provided by that hospital to all patients during the same period.

(i) "Nonrural hospital" means a hospital that is not a peer group E hospital or a small rural hospital and is located inside the state of Washington or in a designated bordering city. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.

(j) "Obstetric services" means routine, nonemergency delivery of babies.

(k) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or the state fiscal year.

(l) "Small rural hospital" means a hospital that is not a peer group E hospital, has fewer than seventy-five acute licensed beds, is located inside the state of Washington, and is located in a city or town with a nonstudent population of no more than seventeen thousand one hundred fifteen in calendar year 2006 as determined by the Washington State office of financial management estimate. The nonstudent population ceiling increases cumulatively by two percent each succeeding state fiscal year.

(m) "Uninsured patient" means an individual who does not have health insurance that would apply to the hospital service the individual sought and received. An individual who did have health insurance that applied to the hospital service

the individual sought and received, is considered an insured individual for DSH program purposes, even if the insurer did not pay the full charges for the services. When determining the cost of a hospital service provided to an uninsured patient, the department uses as a guide whether the service would have been covered under medicaid and how much the department would have paid for the service had the patient been eligible for medicaid.

(4) To be considered for a DSH payment for each SFY, a hospital located in the state of Washington or in a designated bordering city must submit to the department a completed and final DSH application by the due date. The due date will be posted on the department's website. The department will also send notice, by electronic mail, of the DSH application due date to all hospitals that applied for or received DSH payments in the previous SFY.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital submits a completed DSH application for that specific year, if it satisfies the utilization rate requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a medicaid inpatient utilization rate (MIPUR) greater than one percent; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's eligibility for any DSH program, the department uses the criteria in this section and the information obtained from the DSH application submitted by the hospital, subject to the following:

(a) Charity care. If the hospital's DSH application and audited financial statements for the relevant fiscal year do not agree on the amount for charity care, the department uses the lower amount listed. For purposes of calculating a hospital's LIUR, the department allows a hospital to claim charity care amounts related to inpatient services only. A hospital must submit a copy of its charity care policy for the relevant fiscal year as part of the hospital's DSH application.

(b) Total inpatient hospital days. If the hospital's DSH application and its medicare cost report do not agree on the number of total inpatient hospital days, the department uses the higher number listed to determine the hospital's MIPUR. Labor and delivery days count towards total inpatient hospital days. Nursing facility and swing bed days do not count towards total inpatient hospital days.

(7) The department administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH);

(c) General assistance-unemployable disproportionate share hospital (GAUDSH);

(d) Small rural disproportionate share hospital (SRDSH);

(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(g) Public hospital disproportionate share hospital (PHDSH); and

(h) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) Except for IMDDSH, the department allows a hospital to receive any one or all of the DSH payment adjustments it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section). See WAC 388-550-5130 regarding IMDDSH. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the department calculates DSH payments due an eligible hospital using data from the hospital's base year. The department does not use base year data for GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The department's total DSH payments to a hospital for any given SFY cannot exceed the individual hospital's annual DSH limit (also known as the hospital-specific DSH cap) for that SFY. Except for critical access hospitals (CAHs), the department determines a hospital's DSH cap as follows:

(a) The cost to the hospital of providing services to medicaid clients, including clients served under medicaid managed care organization (MCO) plans;

(b) Less the amount paid by the state under the non-DSH payment provision of the medicaid state plan;

(c) Plus the cost to the hospital of providing services to uninsured patients;

(d) Less any cash payments made by or on behalf of uninsured patients; and

(e) Plus any adjustments required and/or authorized by federal regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to uninsured patients. In calculating a CAH's DSH cap, the department deducts payments received by the hospital from and on behalf of the uninsured patients from the hospital's costs of services for the uninsured patients.

(12) In any given federal fiscal year, the total of the department's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the department's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the department will adjust DSH payments to each hospital to account

for the amount overpaid. The department makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) NRIADSH;

(e) GAUDSH;

(f) PIIDSH;

(g) IMDDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the department will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program WACs for description of how amounts to be recouped are determined.

(15) The total amount the department may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed pools. Any changes in payment amount to a hospital in a particular DSH pool means a redistribution of payments within that DSH pool. When necessary, the department will recoup from hospitals to make additional payments to other hospitals within that DSH pool.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the department will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH pool. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH pool.

(b) If an individual hospital has been underpaid by a specified amount, the department will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH pool. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH pool.

(17) All information submitted by a hospital related to its DSH application is subject to audit. The department may audit any, none, or all DSH applications for a given state fiscal year. The department determines the extent and timing of the audits. For example, the department may choose to do a desk review upon receipt of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the department will recoup the overpayment amount, with interest, in accordance with the provisions of RCW 74.09.220 and RCW 43.20B.695.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific state fiscal year. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full state fiscal year in which the rules are adopted.

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

WSR 07-10-103
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:54 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 3 of 3;** amending WAC 388-550-5000 Payment method—LIDSH, 388-550-5125 Payment method—PIIDSH, 388-550-5150 Payment method—GAUDSH, 388-550-5200 Payment method—SRDSH, 388-550-5210 Payment method—SRIADSH, and 388-550-5220 Payment method—NRHIAPDSH; and new WAC 388-550-4925 Eligibility for DSH programs—New hospital providers, 388-550-4935 DSH eligibility—Change in hospital ownership, and 388-550-5130 Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH).

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing new rules and amendments to existing rules to ensure clear and consistent policies for hospital reimbursement and to ensure compliance with federal and state guidelines. The proposed rules add new sections to ensure all disproportionate share hospital (DSH) programs are identified in rule and ensure that sufficient program detail is provided; amend sections pertaining to DSH requirements to ensure consistency with federal guidelines; describe how hospitals qualify for DSH payments; add definitions that apply to DSH payments; amend sections pertaining to the certified public expenditure (CPE) payment program to clarify CPE payment program policies and ensure consistency with federal guidelines embodied in the state plan; and amend sections pertaining to supplemental distributions to approved trauma centers in response to hospital provider input to the department; and

incorporate into rule that the department is terminating the upper payment limit (UPL) program.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Ayuni Wimpee, P.O. Box 45510, Olympia, WA 98504-5510, (360) 725-1835.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Ayuni Wimpee, P.O. Box 45502 [45510], Olympia, WA 98504-5510, phone (360) 725-1835, fax (360) 753-9152, e-mail wimpeah@dshs.wa.gov.

April 26, 2007
Stephanie E. Schiller
Rules Coordinator

NEW SECTION

WAC 388-550-4925 Eligibility for DSH programs—New hospital providers. To be eligible for disproportionate share hospital (DSH) payments, a new hospital provider must have claims data, audited financial statements, and an "as filed" or finalized medicare cost report for the hospital base year used by the department in calculating DSH payments for the state fiscal year (SFY) for which the hospital provider is applying. See WAC 388-550-4900(9).

NEW SECTION

WAC 388-550-4935 DSH eligibility—Change in hospital ownership. (1) For purposes of eligibility for disproportionate share hospital (DSH) payments, a change in hospital ownership has occurred if any of the criteria in WAC 388-550-4200(1) is met.

(2) To be considered eligible for DSH, a hospital whose ownership has changed must notify the department in writing no later than thirty days after the change in ownership becomes final. The notice must include the new entity's fiscal year end.

(3) A hospital that did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted, and changes ownership after that date is not eligible for DSH unless it meets the obstetric services requirement. See WAC 388-550-4900 (5)(b). The hospital must also meet the utilization rate requirement. See WAC 388-550-4900 (5)(a).

(4) If the fiscal year reported on a hospital's medicare cost report does not exactly match the fiscal year reported on the hospital's DSH application to the department, and if therefore the utilization data reported to the department do not agree, the department will use as the data source the document that gives the higher number of total inpatient hospital days for purposes of calculating the hospital's medicaid inpatient utilization rate (MIPUR). See WAC 388-550-4900 (6)(b).

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5000 Payment method—Low income disproportionate share hospital (LIDSH). (1) A hospital that is not a peer group E hospital but serves the department's clients is eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900 ((~~(1) through (3)~~)) (5).

(2) Hospitals considered eligible under the criteria in subsection (1) of this section receive LIDSH payments. The total LIDSH payment amounts equal the funding set by the state's appropriations act for LIDSH. The amount that the state appropriates for LIDSH may vary from year to year.

(3) The department ((~~distributes~~)) determines LIDSH payments to each LIDSH eligible hospital using ((~~a prospective payment method. The department determines the standardized Medicaid inpatient utilization rate (MIPUR) by~~)) three factors:

(a) ((~~Dividing~~)) The hospital's ((~~MIPUR by the average MIPUR of all LIDSH-eligible hospitals~~)) medicaid inpatient utilization rate (MIPUR); ((~~then~~))

(b) ((~~Multiplying~~)) The hospital's medicaid case mix index (CMI) as determined by the department; and

(c) The hospital's Title XIX medicaid discharges for the applicable hospital fiscal year.

(4) The department calculates the LIDSH payment to an eligible hospital as follows. The department:

(a) Divides the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals; then

(b) Multiplies the ((~~hospital's standardized MIPUR~~)) result derived in subsection (a) by the hospital's most recent DRG payment method ((~~rebased~~)) medicaid case mix index, and then by the hospital's ((~~most recent fiscal~~)) base year Title XIX ((~~admissions~~)) discharges; then

(c) ((~~Multiplying the product by an initial random base amount~~)) Converts the product to a percentage of the sum of all such products for individual hospitals; and ((~~then~~))

(d) ((~~Comparing the sum of all annual LIDSH payments to the appropriated amount. If the amounts differ, the department progressively selects a new base amount by successive approximation until the sum of the LIDSH payments to hospitals equals~~)) Multiplies this percentage by the legislatively appropriated amount for LIDSH.

(((~~(4)~~)) (5) For DSH program purposes, a hospital's medicaid CMI is the average diagnosis related group (DRG) weight for all of the hospital's medicaid DRG-paid claims during the state fiscal year used as the base year for the DSH application. It is possible that the CMI the department uses

for DSH calculations will not be the same as the CMI the department uses in other hospital rate calculations.

(6) After each applicable state fiscal year has ended, the department will not make changes to the LIDSH payment distribution that has resulted from calculations identified in subsection ((~~(3)~~)) (4) of this section. ((~~However, hospitals may still submit corrected DSH application data to the department after June 15 and prior to July 1 of the applicable state fiscal year to correct calculation of the MIPUR or low income utilization rate (LIUR) for historical record keeping. See WAC 388-550-5550 for rules regarding public notice for changes in Medicaid payment rates for hospital services~~)) The department will recalculate the LIDSH payment distribution only when the applicable state fiscal year has not yet ended at the time the alleged need for an LIDSH adjustment is identified, and if the department considers the recalculation necessary and appropriate under its regulations.

(7) Consistent with the provisions of subsection (6) of this section, the department applies any adjustments to the DSH payment distribution required by legislative, administrative, or other state action, to other DSH programs in accordance with the provisions of WAC 388-550-4900 (13) through (16).

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5125 Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH). (1) Effective for dates of admission on and after July 1, 2003, a hospital is eligible for the psychiatric indigent inpatient disproportionate share hospital (PIIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 ((~~(2)(b) through (4)(a)~~)) (5);

(b) Is ((~~an in-state or bordering city hospital~~)) not designated an institution for mental diseases (IMD);

(c) Provides services to clients eligible under the psychiatric indigent inpatient (PII) program. See WAC 388-865-0217 for more information regarding the PII program; and

(d) ((~~Qualifies under Section 1923(d) of the Social Security Act~~)) Is located within the state of Washington. A hospital located out-of-state, including a hospital located in a designated bordering city, is not eligible to receive PIIDSH payments.

(2) PIIDSH is available only for emergency, voluntary inpatient psychiatric care. PIIDSH is not available for charges for nonhospital services associated with the inpatient psychiatric care.

(3) The department ((~~determines the~~)) makes PIIDSH ((~~payment for each eligible hospital using a prospective payment method, in accordance with WAC 388-550-4800~~)) payments to a hospital on a claim-specific basis.

NEW SECTION

WAC 388-550-5130 Payment method—Institution for mental diseases disproportionate share hospital (IMDDSH). (1) A mental hospital owned by the state of Washington is eligible to receive payments under the institution for mental diseases disproportionate share hospital (IMDDSH) program.

(2) A free-standing psychiatric facility, regardless of location, is not eligible to receive:

(a) IMDDSH payments; or

(b) Any other disproportionate share hospital (DSH) payment from the department.

(3) A free-standing psychiatric facility within the state of Washington is eligible to receive a state grant amount from the department if the legislature appropriates general funds—state for IMDs. An out-of-state IMD, including an IMD located in a designated bordering city, is not eligible to receive a state grant amount.

(4) Under federal law, 42 USC 1396r-4 (h)(2), the state's annual IMDDSH expenditures are capped at thirty-three percent of the state's annual statewide DSH cap. This amount represents the maximum that the state can spend in any given fiscal year on IMDDSH, but the state is under no obligation to actually spend that amount.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH). (1) A hospital is eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 ((~~(2)(b) through (4)(a)~~));

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a ((~~low-income utilization rate (LIUR)~~)) medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The department determines the GAUDSH payment for each eligible hospital((~~, using a prospective payment method,~~)) in accordance with WAC 388-550-4800((~~, except that the payment is not reduced by the additional three percent specified in WAC 388-550-4800(4)~~)).

(3) The department makes GAUDSH payments to a hospital on a claim-specific basis.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5200 Payment method—((~~SRHAP-DSH~~))Small rural disproportionate share hospital (SRDSH). (1) The department makes small rural ((~~hospital assistance program~~)) disproportionate share hospital (((~~SRHAPDSH~~))) (SRDSH) payments to qualifying small rural hospitals ((~~through the disproportionate share hospital (DSH) program.~~

~~(2)~~)). To qualify for ((~~a SRHAPDSH~~)) an SRDSH payment, a hospital must:

(a) Not be a peer group E hospital;

(b) Meet the criteria in WAC 388-550-4900 ((~~(2)(b) through (4)(a)~~)) (5);

(c) Have fewer than seventy-five acute licensed beds; and

(d) Be an in-state hospital. A hospital located out-of-state, or in a designated bordering city is not eligible to receive SRDSH payments;

(((d) Be a small rural hospital with fewer than seventy-five acute licensed beds; and

(e))) (2) In addition, for the ((SRHIAPDSH)) SRDSH program ((year)) to be implemented for state fiscal year (SFY) ((beginning)) 2008, which begins on July 1, ((2002)) 2007, the city or town must have a nonstudent population of ((fifteen)) no more than seventeen thousand ((five)) one hundred ((or less)) fifteen in calendar year 2006, as determined by the Washington State office of financial management estimate.

For each subsequent SFY, the nonstudent population ((requirement)) ceiling is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for ((SRHIAPDSH)) SRDSH payments from a legislatively appropriated pool. The department determines each hospital's individual ((SRHIAPDSH)) SRDSH payment from the total dollars in the pool using percentages established ((through the following prospective payment method)) as follows:

(a) At the time the ((SRHIAPDSH)) SRDSH payment is to be made, the department calculates each hospital's profitability margin based on ((the most recent, completed year-end)) the hospital's base year data ((using)) and audited financial statements ((from the hospital)).

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies the medicaid payment amounts made by the department to the individual hospital(('s most recent, completed SFY Medicaid reimbursement amounts)) during the SFY two years prior to the current SFY for which DSH application is being made. These medicaid payment amounts are based on historical data considered to be complete; then

(ii) Multiplies the total medicaid ((reimbursement)) payment amount determined in subsection (i) by the individual hospital's assigned profit factor (1.1 or 1.0) to identify a revised medicaid ((reimbursement)) payment amount; ((then)) and

(iii) Divides the revised medicaid ((reimbursement)) payment amount for the individual hospital by the sum of the revised medicaid ((reimbursement)) payment amounts for all qualifying hospitals during the same period.

(4) The department's ((SRHIAPDSH)) SRDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured ((indigent)) patients for that hospital unless an exception is ((identified)) required by federal statute or regulation.

(5) The department reallocates dollars as defined in the state plan.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5210 Payment method—((SRHIAPDSH)) Small rural indigent assistance disproportionate share hospital (SRIADSH) program. (1) The department makes small rural ((hospital)) indigent assistance ((program)) disproportionate share hospital (((SRHIAPDSH))) (SRIADSH) program payments to qualifying small rural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an ((SRHIAPDSH)) SRIADSH payment, a hospital must:

(a) Not be a peer group E hospital;

(b) Meet the criteria in WAC 388-550-4900 (((2)(b) through (4)(a))) (5);

(c) Have fewer than seventy-five acute licensed beds; and

(d) Be an in-state hospital that provided charity services to clients during the ((most recent, completed fiscal)) base year. A hospital located out-of-state or in a designated bordering city is not eligible to receive SRIADSH payments; and

(((d) Be a small rural hospital with fewer than seventy-five acute licensed beds; and))

(e) ((For state fiscal year (SFY) beginning July 1, 2003,)) Be located in a city or town ((that has)) with a nonstudent population of ((fifteen)) no more than seventeen thousand ((eight)) one hundred ((ten or less)) fifteen in calendar year 2006, as determined by the Washington State office of financial management estimate. This estimated nonstudent population ceiling is used for SFY 2008, which begins July 1, 2007. For each subsequent SFY, the nonstudent population ((requirement)) ceiling is increased cumulatively by two percent.

(3) The department pays hospitals qualifying for ((SRHIAPDSH)) SRIADSH payments from a legislatively appropriated pool. The department determines each hospital's individual SRHIAPDSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the ((SRHIAPDSH)) SRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the ((most recent, completed year-end)) hospital's base year data ((using)) and audited financial statements ((from the hospital)).

(b) The department determines the average profitability margin for ((the qualifying)) all hospitals qualifying for SRIADSH.

(c) Any qualifying hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other qualifying hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of revised costs by dividing its revised cost amount by the sum of the revised charity cost amounts for all qualifying hospitals during the same period.

(4) The department's ((~~SRHIAPDSH~~)) SRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for that hospital unless an exception is ((~~identified~~)) required by federal regulation. The department reallocates dollars as defined in the state plan.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-5220 Payment method—((~~NRHIAPDSH~~))Nonrural indigent assistance disproportionate share hospital (NRIADSH). (1) The department makes nonrural ((~~hospital~~)) indigent assistance ((~~program~~)) disproportionate share hospital (((~~NRHIAPDSH~~))) (NRIADSH) payments to qualifying nonrural hospitals through the disproportionate share hospital (DSH) program.

(2) To qualify for an ((~~NRHIAPDSH~~)) NRIADSH payment, a hospital must:

(a) Not be a peer group E hospital;

(b) Meet the criteria in WAC 388-550-4900 (((~~(2)(b) through (4)(a)~~))) (5);

(c) Be an in-state or bordering city hospital that provided charity services to clients during the ((~~most recent, completed fiscal~~)) base year; and

(d) Be a hospital that does not qualify as a small rural hospital as defined in WAC 388-550-5210.

(3) The department pays hospitals qualifying for ((~~NRHIAPDSH~~)) NRIADSH payments from a legislatively appropriated pool. The department determines each hospital's individual ((~~NRHIAPDSH~~)) NRIADSH payment from the total dollars in the pool using percentages established through the following prospective payment method:

(a) At the time the ((~~NRHIAPDSH~~)) NRIADSH payment is to be made, the department calculates each hospital's profitability margin based on the ((~~most recent, completed year-end~~)) hospital's base year data ((~~using~~)) and audited financial statements ((~~from the hospital~~)).

(b) The department determines the average profitability margin for the qualifying hospitals.

(c) Any hospital with a profitability margin of less than one hundred ten percent of the average profitability margin for qualifying hospitals receives a profit factor of 1.1. All other hospitals receive a profit factor of 1.0.

(d) The department:

(i) Identifies from historical data considered to be complete, each individual qualifying hospital's allowed charity charges; then

(ii) Multiplies the total allowed charity charges by the hospital's ratio of costs-to-charges (RCC), limiting the RCC to a value of 1, to determine the hospital's charity costs; then

(iii) Multiplies the hospital's charity costs by the hospital's profit factor assigned in (c) of this subsection to identify a revised cost amount; then

(iv) Determines the hospital's percentage of the ((~~NRHIAPDSH~~)) NRIADSH revised costs by dividing the hospital's revised cost amount by the total revised charity costs for all qualifying hospitals during the same period.

(4) The department's ((~~NRHIAPDSH~~)) NRIADSH payments to a hospital may not exceed one hundred percent of the projected cost of care for medicaid clients and uninsured indigent patients for the hospital unless an exception is ((~~identified~~)) required by federal statute or regulation. The department reallocates dollars as defined in the state plan.

WSR 07-10-104
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 3:56 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 1 of 3;** amending WAC 388-550-1200 Restrictions on hospital coverage, 388-550-1300 Revenue code categories and subcategories, 388-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals, and 388-550-1400 Covered and noncovered revenue code categories and subcategories for inpatient hospital services.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend sections in chapter 388-550 WAC relating to restrictions on hospital coverage, revenue code categories and subcategories for outpatient hospitals and inpatient hospital services for dates of admission before August 1, 2007, and on and after August 1, 2007. The department is also amending these sections in order to change verbiage from "medical assistance administration (MAA)" to "the department," change verbiage from "facility" to "hospital" and to update and clarify other language.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The department has determined that the proposed rule does not meet the definition of "significant legislative rule" under RCW 34.05.328, and therefore a cost-benefit analysis is not required.

April 27, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 99-06-046, filed 2/26/99, effective 3/29/99)

WAC 388-550-1200 ((~~Limitations~~)) Restrictions on hospital coverage. A hospital ((~~coverage~~)) covered service provided to a client eligible under ((~~the~~)) a medical assistance ((~~fee for service~~)) program ((~~is limited for certain eligible clients~~)) that is paid by the department's fee-for-services payment system must be within the scope of the client's medical assistance program. ((~~This~~)) Coverage restriction includes, but is not limited to the following:

(1) ((~~Medical care~~)) Clients enrolled with the department's ((~~healthy options carriers~~)) managed care organization (MCO) plans are subject to the respective ((~~carrier's~~)) plan's policies and procedures for coverage of hospital services;

(2) ((~~Medical care~~)) Clients covered by primary care case management are subject to the clients' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for clients described in subsections (1) and (2) ((~~and (3)~~)) of this section, see WAC 388-538-100.

(4) Coverage for ((~~medically~~)) psychiatric indigent (((~~MI~~))) inpatient (PII) clients is limited to ((~~emergent~~)) voluntary inpatient psychiatric hospital services, subject to the conditions and limitations of WAC ((~~388-521-2140, 388-529-2950,~~)) 388-865-0217 and this chapter:

(a) Out-of-state ((~~care,~~)) healthcare ((~~hospital or other medical,~~)) is not covered for clients under the ((~~MI~~)) PII program; and

(b) Bordering city hospitals and critical border hospitals ((~~areas~~)) are not considered ((~~in-state~~)) instate hospitals for PII program claims.

(5) ((~~Out-of-state medical care is~~)) Healthcare services provided by a hospital located out-of-state are:

(a) Not covered for clients eligible under the medical care services (MCS) program. However, clients eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and SCHIP clients without prior authorization, based on the medical necessity and utilization review standards and limits established by the department.

(ii) Nonemergency out-of-state care for medicaid and SCHIP clients when prior authorized by the department based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC 388-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and SCHIP clients based on authorization by a mental health division (MHD) designee.

(6) See WAC 388-550-1100(((~~(3)~~))) for ((~~chemical dependent pregnant clients~~)) hospital services for chemical-using pregnant (CUP) women.

(7) ((~~Only Medicaid categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older may receive care in a state mental institution or approved psychiatric facility~~)) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a MHD designee. See WAC 388-550-2600.

(8)(((~~(a)~~))) For clients eligible for both medicare and medicaid ((~~hospitalization~~)) (dual eligibles), ((~~MAA~~)) the department pays deductibles and coinsurance, unless the client has exhausted his or her medicare Part A benefits.

(~~((i) MAA payment is limited in amount so that when added to the Medicare payment, the total amount is no more than what the department pays for the same service when provided to a Medicaid eligible, non-Medicare client.~~

~~(ii) Providers must accept the total Medicare/Medicaid amount as payment in full.~~

~~(iii) Beneficiaries are not liable for any additional charges billed by providers or by a managed care entity.~~

~~(iv) Providers or managed care entities that charge beneficiaries excess amounts are subject to sanctions.~~

~~(b)~~)) If ((~~such~~)) medicare benefits are exhausted, the department pays for hospitalization for such clients subject to ((~~MAA~~)) department rules. See also chapter 388-502 WAC.

(9) The department does not pay for covered inpatient hospital services for a medical assistance client:

(a) Who is discharged from a hospital by a physician because the client no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(10) If the hospital's utilization review committee determines the client's stay is beyond the period of medical necessity, as described in subsection (9) of this section, the hospital must:

(a) Inform the client in a written notice that the department is not responsible for payment (42 CFR 456);

(b) Comply with the requirements in WAC 388-502-0160 in order to bill the client for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the department.

(11) Other coverage restrictions, as determined by the department.

AMENDATORY SECTION (Amending WSR 03-19-044, filed 9/10/03, effective 10/11/03)

WAC 388-550-1300 Revenue code categories and subcategories. (1) Revenue code categories and subcategories listed in this chapter are published in the UB-92 and/or UB-04 National Uniform Billing Data Element Specifications Manual.

(2) The ((~~medical assistance administration (MAA)~~)) department requires a hospital provider to report and bill all hospital services provided to medical assistance clients using the appropriate revenue codes published in the manual referenced in subsection (1) of this section.

AMENDATORY SECTION (Amending WSR 03-19-044, filed 9/10/03, effective 10/11/03)

WAC 388-550-1350 Revenue code categories and subcategories—CPT and HCPCS reporting requirements for outpatient hospitals. (1) The ((~~medical assistance administration (MAA)~~)) department requires an outpatient hospital provider to report the appropriate current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) codes in addition to the required revenue codes on an outpatient claim line ((~~with~~)) when using any of the following revenue code categories and subcategories:

(a) "IV therapy," only ((~~subcategory~~)) subcategories "general classification" and "infusion pump";

(b) "Medical/surgical supplies and devices," only subcategory ((~~"prosthetic/orthotic devices"~~)) "other supplies/devices";

(c) "Oncology";

(d) "Laboratory";

(((~~d~~))) (e) "Laboratory pathological";

(((~~e~~))) (f) "Radiology - diagnostic";

(((~~f~~))) (g) "Radiology - therapeutic and/or chemotherapy administration";

(((~~g~~))) (h) "Nuclear medicine";

(((~~h~~))) (i) "CT scan";

(((~~i~~))) (j) "Operating room services," only subcategories "general classification" and "minor surgery";

(((~~j~~))) (k) "Blood and blood components";

(l) Administration, processing, and storage((~~,~~)) for blood components" ((~~only subcategory "administration (e.g., transfusions)"~~));

(((~~k~~))) (m) "Other imaging services";

(((~~l~~))) (n) "Respiratory services";

(((~~m~~))) (o) "Physical therapy";

(((~~n~~))) (p) "Occupational therapy";

(((~~o~~))) (q) "Speech therapy - language pathology";

(((~~p~~))) (r) "Emergency room," only subcategories "general classification" and "urgent care";

(((~~q~~))) (s) "Pulmonary function";

(((~~r~~))) (t) "Audiology";

(((~~s~~))) (u) "Cardiology";

(((~~t~~))) (v) "Ambulatory surgical care";

((~~(u) "Outpatient services";~~

~~(v)~~)) (w) "Clinic," only subcategories "general classification((~~,~~))" ((~~"dental clinic,"~~)) and "other clinic";

(((~~w~~))) (x) "Magnetic resonance technology (MRT)";

(((~~x~~))) (y) "Medical/surgical supplies - extension," only subcategory "surgical dressings";

(((~~y~~))) (z) "Pharmacy - extension" subcategories "Erythropoietin (EPO) less than ten thousand units," "Erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(((~~z~~))) (aa) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(((~~aa~~))) (bb) "EKG/ECG (electrocardiogram)";

(((~~bb~~))) (cc) "EEG (electroencephalogram)";

(((~~cc~~))) (dd) "Gastro-intestinal services";

(((~~dd~~))) (ee) "Specialty room - treatment/observation room," subcategory "treatment room and observation room";

((~~(ee) "Lithotripsy";~~))

(ff) "Telemedicine," only subcategory "other telemedicine";

(gg) "Extra-corporeal shock wave therapy (formerly lithotripsy)";

(hh) "Acquisition of body components," only subcategories "((~~living donor~~)) general classification" and "cadaver donor";

(((~~gg~~))) (ii) "Hemodialysis - outpatient or home," only subcategory "general classification";

(((~~hh~~))) (jj) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(((~~ii~~))) (kk) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," only subcategory "general classification";

(((~~jj~~))) (ll) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(((~~kk~~))) (mm) "Miscellaneous dialysis," only subcategories "general classification" and "ultrafiltration";

(nn) "Behavioral health treatments/services," only subcategory "electroshock therapy";

~~((ll) "Psychiatric/psychological treatments," only subcategory "electroshock therapy";~~

~~(mm)~~)) (oo) "Other diagnostic services";

(((~~nn~~))) (pp) "Other therapeutic services," only ((~~subcategory~~)) subcategories "general classification," "cardiac rehabilitation," and "other therapeutic service"; and

(((~~oo~~))) (qq) Other revenue code categories and subcategories identified and published by the department.

(2) For an outpatient claim line requiring a CPT or HCPCS code(s), the department denies payment if the required code is not reported on the line.

AMENDATORY SECTION (Amending WSR 03-19-045, filed 9/10/03, effective 10/11/03)

WAC 388-550-1400 Covered and noncovered revenue codes categories and subcategories for inpatient hospital services. Subject to the limitations and restrictions listed, this section identifies covered and noncovered revenue

code categories and subcategories for inpatient hospital services.

(1) The department ((~~covers~~)) pays for an inpatient hospital covered service in the following revenue code categories and subcategories ((~~for inpatient hospital services~~)) when the hospital provider accurately bills:

(a) "Room & board - private (one bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(b) "Room & board - semi-private (two bed)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(c) "Room & board - semi-private - (three and four beds)," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(d) "Room & board - deluxe private (((~~deluxe~~)))," only subcategories "general classification," "medical/surgical/gyn," "OB," "pediatric," and "oncology";

(e) "Nursery," only subcategories "general classification," "newborn - level I," "newborn - level II," "newborn - level III," and "newborn - level IV";

(f) "Intensive care unit," only subcategories "general classification," "surgical," "medical," "pediatric," "intermediate ICU," "burn care," and "trauma";

(g) "Coronary care unit," only subcategories "general classification," "myocardial infarction," "pulmonary care," and "intermediate CCU";

(h) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(i) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery" and "IV therapy/supplies";

(j) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant";

(k) "Oncology," only subcategory "general classification";

(l) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "nonroutine dialysis," "hematology," "bacteriology & microbiology," and "urology";

(m) "Laboratory ((~~pathological~~)) pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(n) "Radiology - diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X ray";

(o) "Radiology - therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy administration - injected," "chemotherapy administration - oral," "radiation therapy," and "chemotherapy administration - IV";

(p) "Nuclear medicine," only subcategories "general classification," "diagnostic," ((~~and~~)) "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(q) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(r) "Operating room services," only subcategories "general classification" and "minor surgery";

(s) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(t) "((~~Blood and blood component~~)) Administration, processing and storage for blood and blood component," only subcategories "general classification" and "administration (((~~e.g., transfusions~~)))";

(u) "Other imaging services," only subcategories "general classification," "diagnostic mammography," "ultrasound," and "positron emission tomography";

(v) "Respiratory services," only subcategories "general classification," "inhalation services" and "hyper baric oxygen therapy";

(w) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(x) "Speech therapy-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(y) "Emergency room," only subcategories "general, urgent care classification" and "urgent care";

(z) "Pulmonary function," only subcategory "general classification";

(aa) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(bb) "Ambulatory surgical care," only subcategory "general classification";

(cc) "Outpatient services," only subcategory "general classification";

(dd) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," ((~~and~~)) "MRA - lower extremities," and "MRA-other";

(ee) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(ff) "Pharmacy-extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(gg) "Cast room," only subcategory "general classification";

(hh) "Recovery room," only subcategory "general classification";

(ii) "Labor room/delivery," only subcategory "general classification," "labor," "delivery," and "birthing center";

(jj) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(kk) "EEG (Electroencephalogram)," only subcategory "general classification";

(ll) "Gastro-intestinal services," only subcategory "general classification";

(mm) "Treatment/observation room," only subcategories "general classification," "treatment room," and "observation room";

(nn) ((~~"Lithotripsy," only subcategory "general classification"~~)) "Extra-corporeal shock wave therapy (formerly lithotripsy)," only subcategory "general classification";

(oo) "Inpatient renal dialysis," only subcategories "general classification," "inpatient hemodialysis," "inpatient peritoneal (non-CAPD)," "inpatient continuous ambulatory peritoneal dialysis (CAPD)," and "inpatient continuous cycling peritoneal dialysis (CCPD)";

(pp) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(qq) "Miscellaneous dialysis," only subcategory "ultra filtration((~~,~~))" ((~~and~~));

(rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascularlab," "electromyelogram," and "pregnancy test((~~,~~))"; and

(ss) "Other therapeutic services," only subcategory "general classification".

(2) The department ((~~covers~~)) pays for an inpatient hospital covered service in the following revenue code subcategories ((~~for inpatient hospital services~~)) only when the hospital provider is approved by the department to provide the specific service((~~(s)~~)):

(a) "All inclusive rate," only subcategory "all-inclusive room & board plus ancillary";

(b) "Room & board - private (one bed)," only subcategory "psychiatric";

(c) "Room & board - semi-private (two beds)," only subcategories "psychiatric," "detoxification," "rehabilitation," and "other";

(d) "Room & board - semi-private three and four beds," only subcategories "psychiatric" and "detoxification";

(e) "Room & board - deluxe private (((~~deluxe~~))," only subcategory "psychiatric";

(f) "Room & board - ward," only subcategories "general classification" and "detoxification";

(g) "Room & board - other," only subcategories "general classification" and "other";

(h) "Intensive care unit," only subcategory "psychiatric";

(i) "Coronary care unit," only subcategory "heart transplant";

(j) "Operating room services," only subcategories "organ transplant-other than kidney" and "kidney transplant";

(k) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate" and "evaluation or reevaluation";

(l) "Clinic," only subcategory "chronic pain clinic";

(m) "Ambulance," only subcategory "neonatal ambulance services";

(n) "((~~Psychiatric/psychological treatments~~)) Behavioral health treatment/services," only subcategory "electroshock treatment"; and

(o) "((~~Psychiatric/psychological~~)) Behavioral health treatment/services - extension," only subcategory "rehabilitation."

(3) The department ((~~covers~~)) pays revenue code category "occupational therapy," subcategories "general classification, "visit charge, "hourly charge," "group rate," and "evaluation or reevaluation" when:

(a) A client is in an acute PM&R facility;

(b) A client is age twenty or younger; or

(c) The diagnosis code is listed in the ((~~medical assistance administration's (MAA's)~~)) department's published billing instructions.

(4) The department does not ((~~cover~~)) pay for inpatient hospital services in the following revenue code categories and subcategories ((~~for inpatient hospital services~~)):

(a) "All inclusive rate," subcategory "all-inclusive room and board";

(b) "Room & board - private (one bed)" subcategories "hospice," "detoxification," "rehabilitation," and "other";

(c) "Room & board - semi-private (two bed)," subcategory "hospice";

(d) "Room & board - semi-private - (three and four beds)," subcategories "hospice," "rehabilitation," and "other";

(e) "Room & board - deluxe private (((~~deluxe~~)))," subcategories "hospice," "detoxification," "rehabilitation," and "other";

(f) "Room & board - ward," subcategories "medical/surgical/gyn," "OB," "pediatric," "psychiatric," "hospice," "oncology," "rehabilitation," and "other";

(g) "Room & board - other," subcategories "sterile environment," and "self care";

(h) "Nursery," subcategory "other nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit," subcategory "other intensive care";

(l) "Coronary care unit," subcategory "other coronary care";

(m) "Special charges";

(n) "Incremental nursing charge ((~~rate~~))";

(o) "All inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotics devices," "oxygen - take home," and "other supplies/devices";

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)";

(u) "Laboratory," subcategories "renal patient (home)," and "other laboratory";

(v) "Laboratory ((~~pathological~~)) pathology," subcategory "other laboratory - pathological";

(w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - therapeutic," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategory "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture," and "other anesthesia";

(cc) "Blood and blood components";

(dd) "((~~Blood and blood component~~)) Administration, processing and storage for blood and blood components," subcategory "other processing and storage";

(ee) "Other imaging services," subcategories "screening mammography," and "other imaging services";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy," subcategory "other physical therapy";

(hh) "Occupational therapy," subcategory "other occupational therapy";

(ii) "Speech therapy-language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening," and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient services," subcategory "other outpatient service";

(pp) "Clinic," subcategories "general classification," "dental clinic," "psychiatric clinic," "OB-gyn clinic," "pediatric clinic," "urgent care clinic," "family practice clinic," and "other clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance," subcategories "general classification," "supplies," "medical transport," "heart mobile," "oxygen," "air ambulance," "pharmacy," "telephone transmission EKG," and "other ambulance";

(tt) "Home health (HH) skilled nursing";

(uu) "Home health (HH) medical social services";

(vv) "Home health (HH) - ((~~home health~~)) aide";

(ww) "Home health (HH) - other visits";

(xx) "Home health (HH) - units of service";

(yy) "Home health (HH) - oxygen";

(zz) "Magnetic resonance technology (MRT)," ((~~subcategories "MRA other" and~~)) subcategory "other MRT";

(aaa) "Medical" "medical/surgical supplies - extension," subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Specialty room - treatment/observation room," subcategory "other ((~~treatment/observation room~~)) speciality rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine";

(ppp) "((~~Lithotripsy," subcategory "other lithotripsy"~~)) Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis," subcategory "other inpatient dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - outpatient or home";

(ttt) "Peritoneal dialysis - outpatient or home";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home";

(www) "Miscellaneous dialysis," subcategories "general classification," "home dialysis aid visit," and "other miscellaneous dialysis";

(xxx) ((~~"Psychiatric/psychological treatments,"~~)) Behavioral health treatments/services, subcategories "general classification," "milieu therapy," "play therapy," "activity therapy," ((~~and "other psychiatric/psychological treatment"~~)) "intensive outpatient services - psychiatric," "intensive outpatient services - chemical dependency," "community behavioral health program (day treatment)";

(yyy) ((~~"Psychiatric/psychological services,"~~)) Behavioral health treatment/services - (extension), subcategories "((~~general classification~~)) rehabilitation," "partial hospitalization - less intensive," "partial hospitalization - intensive," "individual therapy," "group therapy," "family therapy," "bio feedback," "testing," and "other ((~~psychiatric/psychological service~~)) behavioral health treatment/services";

(zzz) "Other diagnostic services," subcategories "general classification," "pap smear," "allergy test," and "other diagnostic service";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services," subcategories "recreational therapy," "cardiac rehabilitation," "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," and "other therapeutic services";

(cccc) "Other therapeutic services - extension," subcategories "athletic training" and "kinesiotherapy";

(dddd) "Professional fees";

((~~(dddd)~~)) (eeee) "Patient convenience items"; and

((~~(eeee)~~)) (ffff) Revenue code categories and subcategories that are not identified in this section.

WSR 07-10-105
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed May 1, 2007, 3:58 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 2 of 3;** amending WAC 388-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services, 388-550-1600 Specific items/services not covered, 388-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services, 388-550-1800 Hospital speciality services not requiring prior authorization, and 388-550-1900 Transplant coverage.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend sections in chapter 388-550 WAC relating to covered and noncovered outpatient revenue code categories and subcategories; specific noncovered services; authorization and utilization review of hospital services; specialty services not requiring prior authorization; and transplant coverage in order to change verbiage from "medical assistance administration (MAA)" to "the department," change verbiage from "facility" to "hospital." The proposed rules amend sections for dates of admission before August 1, 2007, and on and after August 1, 2007.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The department has determined that the proposed rule does not meet the definition of "significant legislative rule" under RCW 34.05.328, and therefore a cost-benefit analysis is not required.

April 27, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-19-046, filed 9/10/03, effective 10/11/03)

WAC 388-550-1500 Covered and noncovered revenue code categories and subcategories for outpatient hospital services. (1) The department ((~~covers~~)) pays for an outpatient hospital covered service in the following revenue code categories and subcategories ((~~for outpatient hospital services~~)) when the hospital provider accurately bills (((~~see subsection (2) of this section for revenue code subcategories covered only when the department approves the hospital provider to provide the specific service(s)~~))):

(a) "Pharmacy," only subcategories "general classification," "generic drugs," "nongeneric drugs," "drugs incident to other diagnostic services," "drugs incident to radiology," "nonprescription," and "IV solutions";

(b) "IV therapy," only subcategories "general classification," "infusion pump," "IV therapy/pharmacy services," "IV therapy/drug/supply delivery," and "IV therapy/supplies";

(c) "Medical/surgical supplies and devices," only subcategories "general classification," "nonsterile supply," "sterile supply," "pacemaker," "intraocular lens," and "other implant," and "other supplies/devices";

(d) "Oncology," only subcategory "general classification";

(e) "Durable medical equipment (other than renal)," only subcategory "general classification";

(f) "Laboratory," only subcategories "general classification," "chemistry," "immunology," "renal patient (home)," "nonroutine dialysis," "hematology," "bacteriology and microbiology," and "urology";

(((~~f~~))) (g) "Laboratory ((~~pathological~~)) pathology," only subcategories "general classification," "cytology," "histology," and "biopsy";

(((~~g~~))) (h) "Radiology - diagnostic," only subcategories "general classification," "angiocardiography," "arthrography," "arteriography," and "chest X ray";

(((~~h~~))) (i) "Radiology - therapeutic and/or chemotherapy administration," only subcategories "general classification," "chemotherapy - injected," "chemotherapy - oral," "radiation therapy," and "chemotherapy - IV";

(((~~i~~))) (j) "Nuclear medicine," only subcategories "general classification," "diagnostic," and "therapeutic," "diagnostic radiopharmaceuticals," and "therapeutic radiopharmaceuticals";

(((~~j~~))) (k) "CT scan," only subcategories "general classification," "head scan," and "body scan";

(((~~k~~))) (l) "Operating room services," only subcategories "general classification" and "minor surgery";

(((l))) (m) "Anesthesia," only subcategories "general classification," "anesthesia incident to radiology," and "anesthesia incident to other diagnostic services";

(((m))) (n) "((Blood and blood component)) Administration, processing and storage for blood and blood components," only subcategories "general classification" and "administration (((e.g., transfusions)))";

(((n))) (o) "Other imaging," only subcategories "general classification," "diagnostic mammography," "ultrasound," "screening mammography," and "positron emission tomography";

(((o))) (p) "Respiratory services," only subcategories "general classification," "inhalation services," and "hyper baric oxygen therapy";

(((p))) (q) "Physical therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(((q))) (r) "Occupational therapy," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(((r))) (s) "Speech therapy-language pathology," only subcategories "general classification," "visit charge," "hourly charge," "group rate," and "evaluation or reevaluation";

(((s))) (t) "Emergency room," only subcategories "general classification" and "urgent care";

(((t))) (u) "Pulmonary function," only subcategory "general classification";

(((u))) (v) "Audiology," only subcategories "general classification," "diagnostic," and "treatment";

(((v))) (w) "Cardiology," only subcategories "general classification," "cardiac cath lab," "stress test," and "echocardiology";

(((w))) (x) "Ambulatory surgical care," only subcategory "general classification";

(((x) "Outpatient services," only subcategory "general classification";))

(y) "Magnetic resonance technology (MRT)," only subcategories "general classification," "MRI - brain (including brainstem)," "MRI - spinal cord (including spine)," "MRI - other," "MRA - head and neck," ((and)) "MRA - lower extremities" and "MRA-other";

(z) "Medical/surgical supplies - extension," only subcategories "supplies incident to radiology," "supplies incident to other diagnostic services," and "surgical dressings";

(aa) "Pharmacy - extension," only subcategories "single source drug," "multiple source drug," "restrictive prescription," "erythropoietin (EPO) less than ten thousand units," "erythropoietin (EPO) ten thousand or more units," "drugs requiring detailed coding," and "self-administrable drugs";

(bb) "Cast room," only subcategory "general classification";

(cc) "Recovery room," only subcategory "general classification";

(dd) "Labor room/delivery," only subcategories "general classification," "labor," "delivery," and "birthing center";

(ee) "EKG/ECG (Electrocardiogram)," only subcategories "general classification," "holter monitor," and "telemetry";

(ff) "EEG (Electroencephalogram)," only subcategory "general classification";

(gg) "Gastro-intestinal services," only subcategory "general classification";

(hh) "Specialty room - treatment/observation room," only subcategories (("general classification,")) "treatment room," and "observation room";

(ii) "((Lithotripsy," only subcategory "general classification")) Telemedicine," only subcategory "other telemedicine";

(jj) "Extra-corporeal shock wave therapy (formerly lithotripsy)," subcategory "general classification";

(((jj))) (kk) "Acquisition of body components," only subcategories "general classification," "living donor," and "cadaver donor";

(((kk))) (ll) "Hemodialysis - outpatient or home," only subcategory "general classification";

(((ll))) (mm) "Peritoneal dialysis - outpatient or home," only subcategory "general classification";

(((mm))) (nn) "Continuous ambulatory peritoneal dialysis (CAPD - outpatient or home," only subcategory "general classification";

(((nn))) (oo) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," only subcategory "general classification";

(((oo))) (pp) "Miscellaneous dialysis," only subcategories "general classification," and "ultra filtration";

(((pp) "Psychiatric/psychological treatments)) (qq) "Behavioral health treatments/services," only subcategory "electroshock treatment"; and

(((qq))) (rr) "Other diagnostic services," only subcategories "general classification," "peripheral vascular lab," "electromyelogram," "pap smear," (("allergy test,")) and "pregnancy test."

(2) The department ((covers)) pays for an outpatient hospital covered service in the following revenue code subcategories only when the outpatient hospital provider is approved by the department to provide the specific service(s):

(a) "Clinic," subcategories "general classification," "dental clinic," and "other clinic"; and

(b) "Other therapeutic services((- extension))," subcategories, "general classification," "education/training," "cardiac rehabilitation," and "other therapeutic service."

(3) The department does not ((cover)) pay for outpatient hospital services in the following revenue code categories and subcategories ((for outpatient hospital services)):

(a) "All inclusive rate";

(b) "Room & board - private (one bed)";

(c) "Room & board - semi-private (two beds)";

(d) "Room & board - semi-private (three and four beds)";

(e) "Room & board - deluxe private (((deluxe)))";

(f) "Room & board - ward";

(g) "Room & board - other";

(h) "Nursery";

(i) "Leave of absence";

(j) "Subacute care";

(k) "Intensive care unit";

(l) "Coronary care unit";

(m) "Special charges";

(n) "Incremental nursing charge rate";

(o) "All inclusive ancillary";

(p) "Pharmacy," subcategories "take home drugs," "experimental drugs," and "other pharmacy";

(q) "IV therapy," subcategory "other IV therapy";

(r) "Medical/surgical supplies and devices," subcategories "take home supplies," "prosthetic/orthotic devices," and "oxygen - take home((,))" ((~~and "other supplies/devices"~~));

(s) "Oncology," subcategory "other oncology";

(t) "Durable medical equipment (other than renal)," subcategories "rental," "purchase of new DME," "purchase of used DME," "supplies/drugs for DME effectiveness (home health agency only)," and "other equipment";

(u) "Laboratory," subcategory "other laboratory";

(v) "Laboratory ((~~pathological~~)) pathology," subcategory "other laboratory pathological";

(w) "Radiology - diagnostic," subcategory "other radiology - diagnostic";

(x) "Radiology - therapeutic and/or chemotherapy administration," subcategory "other radiology - therapeutic";

(y) "Nuclear medicine," subcategory "other nuclear medicine";

(z) "CT scan," subcategory "other CT scan";

(aa) "Operating room services," subcategories "organ transplant - other than kidney," "kidney transplant," and "other operating room services";

(bb) "Anesthesia," subcategories "acupuncture" and "other anesthesia";

(cc) "Blood and blood components";

(dd) "((~~Blood and blood component~~)) Administration, processing and storage for blood and blood component," subcategory "other processing and storage";

(ee) "Other imaging," subcategory "other imaging service";

(ff) "Respiratory services," subcategory "other respiratory services";

(gg) "Physical therapy services," subcategory "other physical therapy";

(hh) "Occupational therapy services," subcategory "other occupational therapy";

(ii) "Speech therapy-language pathology," subcategory "other speech-language pathology";

(jj) "Emergency room," subcategories "EMTALA emergency medical screening services," "ER beyond EMTALA screening" and "other emergency room";

(kk) "Pulmonary function," subcategory "other pulmonary function";

(ll) "Audiology," subcategory "other audiology";

(mm) "Cardiology," subcategory "other cardiology";

(nn) "Ambulatory surgical care," subcategory "other ambulatory surgical care";

(oo) "Outpatient Services((,))" ((~~subcategory "other outpatient service"~~));

(pp) "Clinic," subcategories "chronic pain center," "psychiatric clinic," "OB-GYN clinic," "pediatric clinic," "urgent care clinic," and "family practice clinic";

(qq) "Free-standing clinic";

(rr) "Osteopathic services";

(ss) "Ambulance";

(tt) "Home health (HH) - skilled nursing";

(uu) "Home health (HH) - medical social services";

(vv) "Home health (HH) - ((~~home health~~)) aide";

(ww) "Home health (HH) - other visits";

(xx) "Home health (HH) - units of service";

(yy) "Home health (HH) - oxygen";

(zz) "Magnetic resonance technology(MRT)," ((~~subcategories "MRA - other" and~~)) subcategory "other MRT";

(aaa) "Medical/surgical supplies - extension," only subcategory "FDA investigational devices";

(bbb) "Home IV therapy services";

(ccc) "Hospice services";

(ddd) "Respite care";

(eee) "Outpatient special residence charges";

(fff) "Trauma response";

(ggg) "Cast room," subcategory "other cast room";

(hhh) "Recovery room," subcategory "other recovery room";

(iii) "Labor room/delivery," subcategories "circumcision" and "other labor room/delivery";

(jjj) "EKG/ECG (Electrocardiogram)," subcategory "other EKG/ECG";

(kkk) "EEG (Electroencephalogram)," subcategory "other EEG";

(lll) "Gastro-intestinal services," subcategory "other gastro-intestinal";

(mmm) "Speciality room - treatment/observation room," ((~~subcategory~~)) subcategories "general classification" and "other ((~~treatment/observation room~~)) speciality rooms";

(nnn) "Preventive care services";

(ooo) "Telemedicine," subcategory "general classification;

(ppp) "((~~Lithotripsy," subcategory "other lithotripsy"~~)) Extra-corporal shock wave therapy (formerly lithotripsy)," subcategory "other ESWT";

(qqq) "Inpatient renal dialysis";

(rrr) "Acquisition of body components," subcategories "unknown donor," "unsuccessful organ search - donor bank charges," and "other donor";

(sss) "Hemodialysis - outpatient or home," subcategories "hemodialysis/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)," "support services (home)," and "other outpatient hemodialysis (home)";

(ttt) "Peritoneal dialysis - outpatient or home," subcategories "peritoneal/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)" "support services (home)," and "other outpatient peritoneal dialysis (home)";

(uuu) "Continuous ambulatory peritoneal dialysis (CAPD) - outpatient or home," subcategories "CAPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home)" "support services (home)," and "other outpatient CAPD (home)";

(vvv) "Continuous cycling peritoneal dialysis (CCPD) - outpatient or home," subcategories "CCPD/composite or other rate," "home supplies," "home equipment," "maintenance one hundred percent (home), "support services (home)," and "other outpatient CCPD (home)";

(www) "Miscellaneous dialysis," subcategories "home dialysis aid visit" and "other miscellaneous dialysis";

(xxx) "((~~Psychiatric/psychological~~)) Behavioral health treatments/services," subcategories "general classification,"

"milieu therapy," "play therapy," "activity therapy," ((~~and "other psychiatric/psychological treatment"~~)) "intensive outpatient services - psychiatric," "intensive outpatient services - chemical dependency," and "community behavioral health program (day treatment)";

(yyy) "((~~Psychiatric/psychological services~~)) Behavioral health treatment/services (extension)";

(zzz) "Other diagnostic services," subcategories "((~~general classification~~)) allergy test" and "other diagnostic services";

(aaaa) "Medical rehabilitation day program";

(bbbb) "Other therapeutic services - extension," subcategories ((~~"general classification,"~~)) "recreational therapy," ((~~"cardiac rehabilitation,"~~)) "drug rehabilitation," "alcohol rehabilitation," "complex medical equipment - routine," "complex medical equipment - ancillary," "athletic training," and "kinesiotherapy";

(cccc) "Professional fees";

(dddd) "Patient convenience items"; and

(eeee) Revenue code categories and subcategories that are not identified in this section.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-1600 Specific items/services not covered. The department ((~~shall~~)) does not ((~~cover certain hospital items/services for any hospital stay including,~~)) pay for an inpatient or outpatient hospital service, treatment, equipment, drug or supply that is not listed or referred to as a covered service in this chapter. The following list of noncovered items and services is not intended to be all inclusive. Noncovered items and services include, but are not limited to((~~, the following~~)):

(1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;

(2) Telephone/telegraph services or television/radio rentals;

(3) Medical photographic or audio/videotape records;

(4) Crisis counseling;

(5) Psychiatric day care;

(6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;

(7) Standby personnel and travel time;

(8) Routine hospital medical supplies and equipment such as bed scales;

(9) Handling fees and portable X-ray charges;

(10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;

(11) Cafeteria charges; and

(12) Services and supplies provided to nonpatients, such as meals and "father packs"((~~; and~~

~~(13) Standing orders. The department shall cover routine tests and procedures only if the department determines such services are medically necessary, according to the following criteria. The procedure or test:~~

~~(a) Is specifically ordered by the admitting physician or, in the absence of the admitting physician, the hospital staff having responsibility for the client (e.g., physician, advanced registered nurse practitioner, or physician assistant);~~

~~(b) Is for the diagnosis or treatment of the individual's condition; and~~

~~(c) Does not unnecessarily duplicate a test available or made known to the hospital which is performed on an outpatient basis prior to admission; or~~

~~(d) Is performed in connection with a recent admission~~)).

AMENDATORY SECTION (Amending WSR 04-20-058, filed 10/1/04, effective 11/1/04)

WAC 388-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services. (1) This section applies to the department's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to medical assistance clients receiving services through the fee-for-service program. For clients ((~~receiving services through other~~)) eligible under other medical assistance programs, see chapter 388-538 WAC ((~~(Managed care program)~~)) for managed care organizations, chapters 388-800 and 388-810 WAC ((~~(.)~~)) for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), and chapter 388-865 WAC ((~~(.)~~)) for mental health treatment programs coordinated through the mental health division or its designee). See chapter 388-546 WAC for transportation services.

(2) ((~~The medical assistance administration (MAA) may perform one or more types of utilization reviews described in subsection (3)(b) of this section.~~

~~(3) MAA's utilization review~~)) All hospital services paid for by the department are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The department will deny, recover, or adjust hospital payments if the department or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The department may perform one or more types of UR described in subsection (6) of this section.

(6) The department's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review" — an evaluation performed by ((~~MAA~~)) the department or its designee during a client's course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review" — an evaluation performed by ((~~MAA~~)) the department or its designee prior to the provision of healthcare services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review" — an evaluation performed by ((~~MAA~~)) the department or its designee following the provision of healthcare services that includes both a post-payment retrospective ((~~utilization review~~)) UR (performed ((~~by MAA~~)) after healthcare services are provided and ((~~reimbursed~~)) paid), and a prepayment retrospective ((~~utilization review~~)) UR (performed ((~~by MAA~~)) after healthcare services are provided but prior to ((~~reimbursement~~)) payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the department or its designee notifies the appropriate oversight entity if either of the following is identified:

(a) A quality of care concern; or

(b) Fraudulent conduct.

(((~~(4) Covered inpatient and outpatient hospital services must:~~

~~(a) Be medically necessary as defined in WAC 388-500-0005;~~

~~(b) Be provided at the appropriate level of care as defined in WAC 388-550-1050; and~~

~~(c) Meet all authorization and program requirements in WAC and MAA published issuances.~~

~~(5) Authorization for inpatient and outpatient hospital services is valid only if the client is eligible for covered services on the date of service. Authorization does not guarantee payment.~~))

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-1800 ((~~Services—Contract facilities~~)) Hospital specialty services not requiring prior authorization. The department ((~~shall reimburse~~)) pays for certain specialty services without requiring prior authorization when such services are provided ((~~in medical assistance administration (MAA)-approved contract facilities~~)) consistent with department medical necessity and utilization review standards. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2) under the conditions established in WAC 388-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-1900 Transplant coverage. (1) The department ((~~shall~~)) pays for medically necessary transplant procedures only for eligible medical assistance clients who((~~:~~

~~(a) Meet the criteria in WAC 388-550-2000; and~~

~~(b)~~)) are not otherwise subject to a managed care organization (MCO) plan. Clients eligible under the alien emergency medical (AEM) program are not eligible for transplant coverage.

(2) The department ((~~shall~~)) covers the following transplant procedures when the transplant procedures are performed in a hospital designated by the department as a "center of excellence" for transplant procedures and meet that hospital's criteria for establishing appropriateness and the medical necessity of the procedures:

(a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas and small bowel;

(b) Bone marrow and peripheral stem cell (PSC);

(c) Skin grafts; and

(d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department ((~~shall~~)) pays facility charges only to those ((~~medical centers~~)) hospitals that meet the standards and conditions:

(a) Established by the department; and

(b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department ((~~shall~~)) pays ((~~facility charges~~)) for skin grafts and corneal transplants to any qualified ((~~medical facility~~)) hospital, subject to the limitations in this chapter.

(5) The department ((~~shall~~)) deems organ procurement fees as being included in the ((~~reimbursement~~)) payment to the transplant ((~~facility~~)) hospital. The department may make an exception to this policy and ((~~reimburse~~)) pay these fees separately to a transplant ((~~facility~~)) hospital when an eligible medical ((~~care~~)) medical client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department ((~~shall~~)), without requiring prior authorization, pays for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department ((~~shall~~)) requires prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department ((~~shall~~)) does not pay for experimental transplant procedures. In addition, the department ((~~shall~~)) considers as experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department ((~~shall~~)) pays for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay.

(9) The department ((~~shall cover~~)) pays for bone marrow, PSC, skin grafts and corneal transplants ((~~whenever~~)) when medically necessary.

(((~~(9) In reviewing coverage for transplant services, the department shall consider cost benefit analyses on a case-by-~~

~~case basis~~)) (10) The department may conduct a post-payment retrospective utilization review as described in WAC 388-550-1700, and may adjust the payment if the department determines the criteria in this section are not met.

WSR 07-10-106
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 4:00 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: **Part 3 of 3;** amending WAC 388-550-2100 Requirements—Transplant hospitals, 388-550-2200 Transplant requirements—COE, 388-550-2301 Hospital and medical criteria requirements for bariatric surgery, 388-550-2400 Inpatient chronic pain management services, 388-550-2500 Inpatient hospice services, and 388-550-2800 Payment methods and limits—Inpatient hospital services for Medicaid and SCHIP clients.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend sections in chapter 388-550 WAC relating to hospital requirements for transplants and bariatric surgery, inpatient chronic pain management and hospice services, and payment methods for Medicaid and SCHIP clients in order to change verbiage from "medical assistance administration (MAA)" to "the department," change verbiage from "facility" to "hospital." The proposed changes also reflect updates for dates of admission before August 1, 2007, and on and after August 1, 2007.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is not required under RCW 34.05.328. The department has determined that the proposed rule does not meet the definition of "significant legislative rule" under RCW 34.05.328, and therefore a cost-benefit analysis is not required.

April 27, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-2100 Requirements—Transplant ((~~facilities~~)) hospitals. This section applies to requirements for hospitals that perform the department approved transplants described in WAC 388-550-1900(2).

(1) The department ((~~shall~~)) requires ((~~a~~)) instate transplant ((~~facility~~)) hospitals to meet the following requirements in order to be ((~~reimbursed~~)) paid for transplant services provided to medical ((~~care~~)) assistance clients. ((~~The facility shall~~)) A hospital must have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of transplant procedure(s) to be performed, except that ((~~MAA shall~~)) the department does not require CON approval for a hospital that provides peripheral stem cell (PSC), skin graft ((~~and~~)) or corneal transplant ((~~facilities~~)) services;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that ((~~MAA shall~~)) the department does not require UNOS approval for a hospital that provides PSC, skin graft ((~~and~~)) or corneal transplant ((~~facilities~~)) services; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the ((~~facility~~)) hospital proposes to perform.

(2) The department requires an out-of-state transplant center ((~~shall~~)), including bordering city and critical border hospitals, to be a Medicare-certified ((~~facility~~)) transplant center in a hospital participating in that state's Medicaid program. All out-of-state transplant services, excluding those provided in department approved centers of excellence (COE) in bordering city and critical border hospitals, must be prior authorized.

((~~(2)~~)) (3) The department ((~~shall~~)) considers a ((~~facility~~)) hospital for approval as a transplant center of excellence when the ((~~facility~~)) hospital submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members ((~~shall~~)) must be experienced and board-

certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department ((~~shall~~)) considers this requirement met when the ((~~facility~~)) hospital submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams ((~~shall~~)) must include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times; and

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients((~~;~~)).

((~~(iv)~~)) (c) Other resources that the transplant hospital must have include:

(i) Pathology resources for studying and reporting the pathological responses of transplantation;

((~~(v)~~)) (ii) Infectious disease services with both the professional skills and the laboratory resources needed to ((~~discover,~~)) identify((~~,~~)) and manage a whole range of organisms; and

((~~(vi)~~)) (iii) Social services resources.

((~~(c)~~)) (d) An organ procurement coordinator;

((~~(d)~~)) (e) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

((~~(e)~~)) (f) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

((~~(f)~~)) (g) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

((~~(g)~~)) (h) Extensive blood bank support;

((~~(h)~~)) (i) Patient management plans and protocols; and

((~~(i)~~)) (j) Written policies safeguarding the rights and privacy of patients((~~; and~~

~~(j) Satisfied~~)).

(4) In addition to the requirements of subsection (3) of this section, the transplant hospital must:

(a) Satisfy the annual volume and survival rates criteria for the particular transplant procedures performed at the ((~~facility~~)) hospital, as specified in WAC 388-550-2200(2).

((~~(3) In addition to the requirements of subsection (2) of this section, a facility being considered for approval as a transplant center of excellence shall~~)) (b) Submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the ((~~facility~~)) hospital:

((~~(a)~~)) (i) Participates in the national donor procurement program and network; and

((~~(b)~~)) (ii) Systematically collects and shares data on its transplant program(s) with the network.

((~~(4)~~)) (5) The department ((~~shall apply~~)) applies the following specific requirements to a PSC transplant ((~~facilities~~)) hospital:

(a) A PSC transplant ((~~facility may receive approval from the department to do~~)) hospital must be a department approved COE to perform any of the following PSC services:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; ((~~and/or~~)) and

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A PCS transplant hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

((~~(c)~~)) (6) The department ((~~shall~~)) does not ((~~reimburse~~)) pay a PSC transplant ((~~facility~~)) hospital for AABB inspection and certification fees related to PSC transplant services.

AMENDATORY SECTION (Amending WSR 01-02-075, filed 12/29/00, effective 1/29/01)

WAC 388-550-2200 Transplant requirements—COE. (1) The department ((~~shall~~)) measures the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department ((~~shall apply~~)) applies these criteria to a ((~~facility~~)) hospital during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE ((~~shall~~)) must meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant ((~~facility~~)) hospital within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for conditional approval as a transplant ((~~center of excellence~~)) COE. The department ((~~shall~~)) considers the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the ((~~state~~)) department of health (DOH).

(4) An in-state ((~~facility~~)) hospital granted conditional approval by the department as a transplant ((~~center of excellence shall~~)) COE must meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department ((~~shall~~)) must automatically revoke such conditional approval for any ((~~facility~~)) hospital which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The ((~~facility~~)) hospital submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence ((~~shall~~)) must meet Medicare's survival rate requirements for the transplant procedure(s) performed at the ((~~facility~~)) hospital.

(6) A transplant ((~~center of excellence shall~~)) COE must submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (((~~HCFA~~)) Form 2552-96 ((~~report~~))) documentation showing:

(a) The numbers of transplants performed at the ((~~facility~~)) hospital during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7)(((~~a~~))) Transplant ((~~facilities shall~~)) hospitals must:

(a) Submit to the department, within sixty days of the date of the ((~~facility's~~)) hospital's approval as a ((~~center of excellence~~)) COE, a complete set of the comprehensive patient selection criteria and treatment protocols used by the ((~~facility~~)) hospital for each transplant procedure it has been approved to perform.

(b) ((~~The facility shall~~)) Submit to the department annual updates to ((~~said~~)) the documents ((~~annually thereafter~~)) listed in subsection (a) of this section, or whenever the ((~~facility~~)) hospital makes a change to the criteria and/or protocols.

(c) Notify the department if no changes occurred during a reporting period ((~~the facility shall so notify the department to this effect~~)).

(8) The department ((~~shall~~)) evaluates compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by a transplant ((~~centers of excellence~~)) COE in accordance with subsection (7) of this section. The department ((~~shall~~)) terminates a ((~~facility's~~)) hospital's designation as a transplant ((~~center of excellence~~)) COE if a review or audit finds that ((~~facility~~)) hospital in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9)(((~~a~~))) The department ((~~shall~~)):

(a) Provides notification to a transplant ((~~centers of excellence~~)) COE it finds in noncompliance with subsection (8) of this section, and may allow from the date of notification sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) ((~~The department shall~~)) Does not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-502-0030;

(c) Requires, within six months of submitting a plan to correct a breach of compliance, a center ((~~shall~~)) to report ((~~to the department showing~~)) that:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance exists.

(10) The department ((~~shall~~)) periodically reviews the list of approved transplant ((~~centers of excellence~~)) COEs. The department may limit the number of ((~~facilities~~)) hospitals it designates as a transplant ((~~centers of excellence~~)) COE or contracts with to provide services to medical ((~~care~~)) assistance clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department ((~~shall reimburse~~)) pays a department-approved ((~~centers of excellence~~)) COE for covered transplant procedures using ((~~any of the~~)) methods identified in chapter 388-550 WAC.

AMENDATORY SECTION (Amending WSR 05-12-022, filed 5/20/05, effective 6/20/05)

WAC 388-550-2301 Hospital and medical criteria requirements for bariatric surgery. (1) The ((~~medical assistance administration (MAA)~~)) department pays a hospital for bariatric surgery and bariatric surgery-related services only when the surgery is provided in an inpatient hospital setting and only when:

(a) The client qualifies for bariatric surgery by successfully completing all requirements under WAC 388-531-1600;

(b) The client continues to meet the criteria to qualify for bariatric surgery under WAC 388-531-1600 up to the actual surgery date; ((~~and~~))

(c) The hospital providing the bariatric surgery and bariatric surgery-related services meets the requirements in this section and other applicable WAC; and

(d) The hospital receives prior authorization from the department prior to performing a bariatric surgery for a medical assistance client.

(2) A hospital must meet the following requirements in order to be ((~~reimbursed~~)) paid for bariatric surgery and bariatric surgery-related services provided to an eligible medical assistance client. The hospital must:

(a) Be approved by the department to provide bariatric surgery and bariatric surgery-related services and;

(i) For dates of admission on or after July 1, 2007, be located in Washington state or approved bordering cities (see WAC 388-501-0175) ((~~and have a current core provider agreement with MAA~~)).

(ii) For dates of admission on or after July 1, 2007, be located in Washington state, or be a department-designated critical border hospital.

(b) Have an established bariatric surgery program in operation under which at least one hundred bariatric surgery procedures have been performed. The program must have been in operation for at least five years and be under the

direction of an experienced board-certified surgeon. In addition, ((~~MAA~~)) department requires the bariatric surgery program to:

(i) Have a mortality rate of two percent or less;

(ii) Have a morbidity rate of fifteen percent or less;

(iii) Document patient follow-up for at least five years postsurgery;

(iv) Have an average loss of at least fifty percent of excess body weight achieved by patients at five years postsurgery; and

(v) Have a reoperation or revision rate of five percent or less.

(c) Submit documents to ((~~MAA's Division of Medical Management~~)) the department's division of healthcare services that verify the performance requirements listed in this section. ((~~The hospital must receive approval from MAA prior to performing a bariatric surgery for a medical assistance client.~~))

(3) ((~~MAA~~)) The department waives the program requirements listed in subsection (2)(b) of this section if the hospital participates in a statewide bariatric surgery quality assurance program such as the surgical Clinical Outcomes Assessment Program (COAP).

(4) See WAC 388-531-1600(13) for requirements for surgeons who perform bariatric surgery.

(5) Authorization does not guarantee payment. Authorization for bariatric surgery and bariatric surgery-related services is valid only if:

(a) The client is eligible on the date of admission and date of service; and

(b) The hospital and professional providers meets the criteria in this section and other applicable WAC to perform bariatric surgery and/or to provide bariatric surgery-related services.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-2400 Inpatient chronic pain management ((~~program~~)) services. (1)(((~~(a) The department shall cover inpatient chronic pain management training to assist eligible clients to manage chronic pain.~~

~~(b) The department shall pay for only one inpatient hospital stay, up to a maximum of twenty-one days, for chronic pain management training per eligible client's lifetime.~~

~~(c) Refer to WAC 388-550-1700 (2)(i) and 388-550-1800 for prior authorization.~~

~~(2) The department shall reimburse approved chronic pain management facilities an all-inclusive per diem facility fee under the revenue code published in the department's chronic pain management fee schedule. MAA shall reimburse professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.~~

~~(3) The department shall not reimburse a contract facility for unrelated services provided during the client's inpatient stay for chronic pain management, unless the facility requested and received prior approval from the department for those services~~)) The department pays a hospital that is specifically approved by the department to provide inpatient chronic pain management services, an all-inclusive per diem facility fee. The department pays professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(2) A client qualifies for inpatient chronic pain management services when all of the following apply:

(a) The client has had pain for at least three months and has not improved with conservative treatment, including tests and therapies;

(b) At least six months have passed since a previous surgical procedure was done in relation to the pain problem; and

(c) A client with active substance abuse must have completed a detoxification program, if appropriate, and must be free from drugs and/or alcohol for at least six months.

(3) The department:

(a) Covers inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) Pays for only one inpatient hospital stay, up to a maximum of twenty-one consecutive days, for chronic pain management training per a client's lifetime.

(c) Does not require prior authorization for chronic pain management services.

(d) Does not pay for services unrelated to the chronic pain management services that are provided during the client's inpatient stay, unless the hospital requests and receives prior authorization from the department

(4) All applicable claim payment adjustments for client responsibility, third party liability, medicare crossover, etc., apply to the department.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-2500 Inpatient hospice services. (1) The department ((~~shall reimburse~~)) pays hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies ((~~shall~~)) must bill the department for their services using revenue codes. The department ((~~shall reimburse~~)) pays hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department ((~~shall reimburse~~)) pays hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

AMENDATORY SECTION (Amending WSR 07-06-043, filed 3/1/07, effective 4/1/07)

WAC 388-550-2800 Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

Payment method used for Medicaid inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Diagnosis related group (DRG) negotiated conversion factor	Hospitals participating in the medicaid hospital selective contracting program under waiver from the federal government	Lesser of either the DRG billed amount minus the third-party payment and any client responsibility amount, or the allowable, minus the third-party payment amount and any client responsibility amount.
DRG cost-based conversion factor	Hospitals not participating in or exempt from the medicaid hospital selective contracting program	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowable, minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC)	((~~Hospitals or~~)) Some services exempt from DRG payment methods	The allowable minus the third-party payment amount and any client responsibility amount.
Costs-to-charges rate with a "hold harmless" settlement provision	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	The allowable minus the third-party payment amount and any client responsibility amount. The payment made is the federal share only.
Single case rate	Hospitals eligible to provide bariatric surgery to medical assistance clients	Single case rate minus the third-party payment amount and any client responsibility amount.
Fixed per diem rate	Long-term acute care (LTAC) hospitals	Per diem amount minus the third-party payment amount and any client responsibility amount.
Per diem rate	Some providers/services exempt from the DRG payment methods	Per diem amount, and for some services a high outlier amount, minus the third-party payer amount and any client responsibility amount.
Cost settlement	DOH-approved critical access hospitals (CAHs)	The allowable ((~~times the approved CAH rate~~)), subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.
Medicaid base community psychiatric hospitalization rate	Nonstate-owned free-standing psychiatric hospitals located in Washington state	Paid according to applicable payment method in WAC 388-550-2650 for medicaid and SCHIP clients, minus the third-party payment amount and any client responsibility amount.

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs.

(2) The department's annual aggregate medicaid and SCHIP payments to each hospital for inpatient hospital services provided to medicaid and SCHIP clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR Sec. 447.271). The department recoups annual aggregate medicaid and SCHIP payments that are in excess of the usual and customary charges.

(3) The department's annual aggregate payments for inpatient hospital services, including state-operated hospitals, will not exceed the estimated amounts that the department would have paid using medicare payment principles.

(4) When hospital ownership changes, the department's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(5) Hospitals participating in the department's medical assistance program must annually submit to the department:

(a) A copy of the hospital's CMS medicare cost report (form 2552-96) that is the official "as ((~~submitted~~)) filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 388-550-4900 for the requirement for a hospital to qualify for a DSH payment.

(6) Reports referred to in subsection (5) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the department.

(7) The department requires hospitals to follow generally accepted accounting principles.

(8) Participating hospitals must permit the department to conduct periodic audits of their financial records, statistical records, and any other records as determined by the department.

(9) The department limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(10) For a client's hospital stay that involves both regional support network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

(11) ((~~The department pays hospitals to cover the cost of certain newborn screening tests that are required under chapter 70.83 RCW (see also chapter 246-650 WAC). The flat fees that are not included in the DRG rate but are related to performing the newborn screening tests are added to the DRG payment. Hospitals are responsible to bill for all newborn screening fees when submitting any claims for newborn services to the department.~~

~~(12)~~)) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

WSR 07-10-107
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed May 1, 2007, 4:02 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-22-054.

Title of Rule and Other Identifying Information: Amending WAC 388-550-2900 Payment limits—Inpatient hospital services, 388-550-3000 Payment method—DRG, 388-550-3200 Medicaid cost proxies, 388-550-3300 Hospital peer groups and cost caps, 388-550-3350 Outlier costs, 388-550-3381 Payment methodology for acute PM&R services and administrative day services, 388-550-3400 Case mix index, and 388-550-3500 Hospital annual inflation adjustment determinations; and repealing WAC 388-550-2000 Medical criteria—Transplant services.

Hearing Location(s): Blake Office Park East, Rose Room, 4500 10th Avenue S.E., Lacey, WA 98503 (one block north of the intersection of Pacific Avenue S.E. and Alhadeff Lane. A map or directions are available at http://www1.dshs.wa.gov/msa/rpau/docket.html or by calling (360) 664-6097), on June 5, 2007, at 10:00 a.m.

Date of Intended Adoption: Not earlier than June 6, 2007.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, delivery 4500 10th Avenue S.E., Lacey, WA 98503, e-mail schilse@dshs.wa.gov, fax (360) 664-6185, by 5:00 p.m. on June 5, 2007.

Assistance for Persons with Disabilities: Contact Stephanie Schiller by June 1, 2007, TTY (360) 664-6178 or (360) 664-6097 or by e-mail at schilse@dshs.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend sections in chapter 388-550 WAC relating to hospital payment methodologies and limits in order to change verbiage from "medical assistance administration (MAA)" to "the department," change verbiage from "facility" to "hospital." In addition, the proposed changes reflect updates for dates of admission before August 1, 2007, and on and after August 1, 2007. The department is repealing WAC 388-550-2000.

Reasons Supporting Proposal: See above.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.500.

Statute Being Implemented: RCW 74.08.090 and 74.09.500.

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

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

Name of Agency Personnel Responsible for Drafting: Kathy Sayre, P.O. Box 45504, Olympia, WA 98504-5504, (360) 725-1342; Implementation and Enforcement: Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, (360) 725-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The department has determined that the proposed rule will not create more than minor costs for affected small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Larry Linn, P.O. Box 45502, Olympia, WA 98504-5502, phone (360) 725-1856, fax (360) 725-9152, e-mail linnld@dshs.wa.gov.

April 27, 2007
Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 04-20-058, filed 10/1/04, effective 11/1/04)

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) To ((~~receive reimbursement~~)) be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the department; and

(b) Be an in-state bordering city hospital, a critical border hospital, or a distinct unit of such a hospital, that meets the definition in RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act; or

(c) Be an out-of-state hospital that meets the conditions in WAC 388-550-6700.

(2) The department does not pay:

(a) A hospital or distinct unit for inpatient care and/or services provided to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) A hospital or distinct unit for care and/or services provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) ((~~Hospitals~~)) A hospital or distinct unit for ancillary services in addition to the ((~~diagnosis-related group (DRG) payment~~)):

(i) Diagnosis related group (DRG) payment, or per case rate payment on claims with dates of admission before August 1, 2007; or

(ii) DRG payment, per diem payment, or per case rate payment no claims with dates of admission on and after August 1, 2007.

(d) For additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established ((~~at the seventy-fifth percentile as published in the "*Length of Stay by Diagnosis and Operations, Western Region*"~~)) by the department or mental health division (MHD) designee (see WAC 388-550-2600), as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not requested and/or received approval for an extended length of stay (LOS) from the department or MHD designee as specified in WAC 388-550-4300(3). The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700, to evaluate an extended LOS. A MHD designee may also perform those utilization reviews to evaluate an extended LOS.

(e) For dates of admission before August 1, 2007, for elective or ((~~nonemergent~~)) nonemergency inpatient services provided in a nonparticipating hospital. A nonparticipating hospital is defined in WAC 388-550-1050. See also WAC 388-550-4600.

(f) For inpatient hospital services when the department determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The department may perform a retrospective utilization review as described in WAC 388-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(g) For two separate inpatient hospitalizations if a client is readmitted to the same or different hospital or distinct unit within seven calendar days of discharge, unless the readmission is due to conditions unrelated to the previous admission. The department:

(i) May perform a retrospective utilization review as described in WAC 388-550-1700 to determine the appropriate payment for the readmission.

(ii) Determines if the combined hospital stay for the admission qualifies to be paid as an outlier. See WAC 388-550-3700 for DRG high-cost outliers and per diem high outliers for dates of admission on and after August 1, 2007.

(h) For a client's day(s) of absence from the hospital or distinct unit.

(i) For an inappropriate or nonemergency transfer of a client from one acute care hospital or distinct unit to another. The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700 to determine if the admission to the second hospital or distinct unit qualifies for payment. See also WAC 388-550-3600 for hospital transfers.

(3) An interim billed inpatient hospital claim submitted for a client's continuous inpatient hospitalization of at least ninety calendar days, is considered for payment by the department only when the following occurs (this does not apply to interim billed hospital claims for which the department is not the primary payer (see (b) of this subsection), or to inpatient psychiatric admissions:

(a) Each interim billed hospital claim must:

(i) Be submitted in ninety calendar day intervals, unless the client is discharged prior to the next ninety calendar day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the department is not the primary payer, the department pays an interim billed hospital claim when the criteria in (a) of this subsection are met and:

(i) After ninety calendar days from the date the department becomes the primary payer; or

(ii) The date a client eligible for both medicare and medicaid has exhausted the medicare lifetime reserve days for inpatient hospital care.

(4) A hospital claim submitted for a client's continuous inpatient hospital admission of one hundred twenty calendar days or less is considered for payment by the department upon the client's discharge from the hospital or distinct unit. The department considers a client discharged from the hospital or distinct unit if one of the following occurs. The client:

(a) Obtains a formal release issued by the hospital or distinct unit;

(b) Dies in the hospital or distinct unit;

(c) Transfers from the hospital or distinct unit as an acute care transfer; or

(d) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitations unit or facility.

(5) To be eligible for payment, a hospital or distinct unit must bill an inpatient hospital claim:

(a) In accordance with the current national uniform billing date element specifications:

(i) Developed by the national uniform billing committee;

(ii) Approved and/or modified by the Washington State Payer Group or the department; and

(iii) In effect on the date of the client's admission.

(b) In accordance with the current published international classification of diseases clinical modification coding guidelines in effect on the date of the client's admission;

(c) Subject to the rules in this section and other applicable rules;

(d) In accordance with the department's current published billing instructions and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the department considers and pays an initial interim billed hospital claim and/or subsequent interim billed hospital claims; and

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim (i.e., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes.

(6) The department ((~~limits payment for private room accommodations to~~)) allows the semiprivate room rate for a client's room charges, even if a hospital bills the private room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by C.F.R. §447.271.

(7) For inpatient hospital claims, the department allows hospitals an all-inclusive administrative date rate, beginning on the client's admission date, for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(8) The department pays for observation services according to WAC 388-550-3000 (2)(b), 388-550-6000 (4)(c) and 388-550-7200 (2)(e) and other applicable rules.

(9) The department determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include, but are not limited to, any client responsibility, any third party liability amount, including medicare part A and part B, and any other adjustments as determined by the department.

(10) The department reduces payment rates to hospitals and distinct units for services provided to clients eligible under state-administered programs according to the hospital equivalency factor and/or ratable, or other department policy, as provided in WAC 388-550-4800.

(11) All hospital providers must present final charges to the department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

AMENDATORY SECTION (Amending WSR 05-11-077, filed 5/17/05, effective 6/17/05)

WAC 388-550-3000 Payment method—DRG. (1) The ((~~medical assistance administration (MAA)~~)) department uses the diagnosis-related group (DRG) payment method to ((~~reimburse~~)) pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) ((~~MAA~~)) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. ((~~MAA~~)) The department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not limited to:

(a) ((~~All covered hospital services provided to a client during the client's~~)) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, and observation services related to an inpatient hospital ((~~admission~~)) stay and provided within one calendar day of a client's inpatient hospital ((~~admission~~)) stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) ((~~MAA's~~)) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's conversion factor. The total allowed amount also includes any high outlier amount calculated for claims. See WAC 388-550-3450 and 388-550-4600(4).

(5) ((~~MAA's~~)) The department's DRG payment((~~s~~)) to a hospital((~~s~~)) may be adjusted when one or more of the following occur:

(a) For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007, a claim qualifies as a DRG high outlier (see WAC 388-550-3700);

(b) A client transfers from one acute care hospital or distinct unit to another acute care hospital or distinct unit (see WAC 388-550-3600);

(c) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay;

(d) A client has third party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare and medicare has made a payment for the Part B hospital charges; or

(((~~(e)~~))) (f) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient ((~~within seven days~~)) to the same hospital. ((~~MAA~~)) The department or its designee performs a retrospective utilization review (see WAC 388-550-1700 (((~~(3)(b)(iii)~~))) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment. Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high-cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.

(6) The department does not pay for a client's day(s) of absence from the hospital.

(7) The department pays an interim billed hospital claim or covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(8) The department applies all applicable claim payment adjustments for client responsibility, third party liability, medicare, etc., to the payment.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has medicaid and SCHIP charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its medicare cost report, the department ((~~shall~~)) establishes cost proxies to estimate ((~~such~~)) costs in order to ensure recognition of medicaid related costs.

(2) For the inpatient payment system effective for dates of admission before August 1, 2007, the department ((~~shall~~)) develops per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) For the inpatient payment system effective for dates of admission before August 1, 2007, the department ((~~shall~~)) also develops ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

(4) For the inpatient payment system effective for dates of admission on and after August 1, 2007, the department:

(a) Develops per diem proxies for accommodation cost centers using the hospital's per diem cost data within the affected same type of services; and

(b) Develops ratios of costs-to-charges (RCC) proxies for ancillary cost centers based on the hospital's aggregate ancillary costs to aggregate ancillary charges.

AMENDATORY SECTION (Amending WSR 06-08-046, filed 3/30/06, effective 4/30/06)

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes ((~~the department groups hospitals into peer groups and establishes cost caps for each peer group. The department sets hospital reimbursement rates at levels that recognize the costs of reasonable, efficient, and effective providers~~)), the department groups hospitals into peer groups.

(2) The six hospital peer groups are:

(a) Group A, rural hospitals;

(b) Group B, urban hospitals without medical education programs;

(c) Group C, urban hospitals with medical education program;

(d) Group D, specialty hospitals or other hospitals not easily assignable to the other five groups;

(e) Group E, public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) program; and

(f) Group F, ((~~critical access~~)) hospitals approved by the department of health (DOH) as critical access hospitals.

(3) For dates of admission before August 1, 2007, the department uses a cost cap at the seventieth percentile for hospitals in peer groups B and C for cost based conversion rate setting. All other peer groups are exempt from the cost caps for the following reasons:

(a) Peer group A hospitals because they are paid under the ratio of costs-to-charges (RCC) methodology for Medicaid claims.

(b) Peer group D hospitals because they are specialty hospitals without a common peer group on which to base comparisons.

(c) Peer group E hospitals because they are paid under the "full cost" public hospital certified public expenditure (CPE) program RCC methodology for inpatient claims.

(d) Peer group F hospitals because they are paid under the departmental weighted costs-to-charges (DWCC) methodology for ((~~Medicaid~~)) most hospital claims. See WAC 388-550-2598(14) for the payment methods for inpatient detoxification unit, distinct psychiatric unit, and distinct rehabilitation unit claims.

(4) For dates of admission before August 1, 2007, the department calculates cost caps for peer groups B and C for cost based conversion rate setting based on the hospitals' base period costs after subtracting:

(a) Indirect medical education costs, in accordance with WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5) For dates of admission before August 1, 2007, the department uses the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor. After the peer group cost cap is calculated, the department adds back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) For dates of admission before August 1, 2007, in cases where corrections or changes in an individual hospital's base-year cost or peer group assignment occur after peer group cost caps are calculated, the department updates the peer group cost caps involved only if the change in the individual hospital's base-year costs or peer group assignment will result in a five percent or greater change in the seventieth

percentile of costs calculated for either its previous peer group category, its new peer group category, or both.

(7) For dates of admission on and after August 1, 2007, the department continues to use the hospital peer groups in subsection (2) of this section to determine some rate setting and payment methods.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-3350 Outlier costs. (1) The information and processes described in subsections (1) through (5) of this section are applicable for claims with dates of admission before August 1, 2007.

(a) The department ((~~shall~~)) removes the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050((~~, Definitions~~)).

(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department ((~~shall~~)) adds the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department ((~~shall~~)) pays high-cost outlier claims from the outlier set-aside pool. The department ((~~shall~~)) calculates an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid Management Information System (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost diagnosis related group (DRG) outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department ((~~shall~~)) uses the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department ((~~shall~~)) funds the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements ((~~shall~~)) will be made to hospitals for outlier cases.

(6) For dates of admission on and after August 1, 2007, the department includes statistical outlier claims for calculation of the conversion factors, per diem rates, and per case rates, and does not establish an outlier set-aside pool. The department does not include statistical outlier claims for calibration of DRG relative weights.

AMENDATORY SECTION (Amending WSR 03-06-047, filed 2/28/03, effective 3/31/03)

WAC 388-550-3381 Payment methodology for acute PM&R services and administrative day services. The ((~~medical assistance administration's (MAA's)~~)) department's payment methodology for acute PM&R services provided by ((~~hospital-based~~)) acute PM&R ((~~facilities~~)) hospitals is described in this section.

(1) ((~~MAA~~)) For dates of admission before August 1, 2007, the department pays an acute PM&R rehabilitation ((~~facility~~)) hospital according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500((~~, Payment method—RCC~~)). For dates of admission on and after August 1, 2007, the department pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See WAC 388-550-3010 and 388-550-3460.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) Medical social services;

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When ((~~MAA~~)) the department authorizes administrative day(s) for a client as described in WAC 388-550-2561(8), ((~~MAA reimburses~~)) the department pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed in the client's use during the administrative portion of the client's stay.

(4) The department pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital((~~-based facility~~)) according to chapter 388-546 WAC.

AMENDATORY SECTION (Amending WSR 98-01-124, filed 12/18/97, effective 1/18/98)

WAC 388-550-3400 Case-mix index. (1)(((~~(a)~~))) The department ((~~shall~~)):

(a) Adjusts hospital costs ((~~for case mix under the diagnosis-related group (DRG) payment systems.~~)) used to calculate the conversion factor and per diem rates during the rebasing process by the hospital's case-mix index; and

(b) ((~~The department shall~~)) Calculates ((~~a~~)) the case-mix index (CMI) for each individual hospital to measure the relative cost for treating medicaid and SCHIP cases in a given hospital.

(2) The department ((~~shall~~)) calculates the CMI for each hospital using medicaid and SCHIP admissions data from the individual hospital and the hospital's base period cost report((~~, as described in~~)). See WAC 388-550-3150. The CMI is calculated for each hospital by summing all relative weights for all claims in the dataset, and dividing the sum of the relative weights by the number of claims. That amount represents the relative acuity of the claims. The hospital-specific CMI is calculated as follows:

(a) The department ((~~shall multiply~~)) multiplies the number of medicaid and SCHIP admissions to the hospital for a specific DRG classification by the relative weight for that DRG classification. The department ((~~shall~~)) repeats this process for each DRG billed by the hospital.

(b) The department ((~~shall~~)) adds together the products in (a) of this subsection for all of the medicaid and SCHIP admissions to the hospital in the base year.

(c) The department ((~~shall~~)) divides the sum obtained in (b) of this subsection by the corresponding number of medicaid and SCHIP hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRG((~~s~~)) classifications. A CMI of less than 1.0 indicates a mix of patients in the less costly DRG((~~s~~)) classifications.

(3) The department ((~~shall~~)) recalculates each hospital's case-mix index periodically, but no less frequently than each time rebasing is done.

AMENDATORY SECTION (Amending WSR 99-14-027, filed 6/28/99, effective 7/1/99)

WAC 388-550-3500 Hospital annual inflation adjustment determinations. (1) Effective ((~~on November 1 of~~)) each state fiscal year, ((~~MAA~~)) except rebase implementation years, the department may adjust all cost-based conversion factors (CBCF), per diem rates, and per case rates, by an inflation factor (vendor rate increase), as determined by the state legislature and ((~~as addressed in subsequent budget notes~~)) supported in the state's budget. ((~~MAA~~)) The department does not automatically give an inflation increase to negotiated conversion factors for contracted hospitals participating in the hospital selective contracting program.

(2) For dates of admission on and after August 1, 2007, except for rebase implementation years, the department makes adjustments to the hospital's DRG conversion factors, per diem rates, and per case rates, by an inflation factor (vendor rate increase), as authorized and determined by the legislature and supported in the state's budget.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-550-2000	Medical criteria—Transplant services.

WSR 07-10-109
PROPOSED RULES
DEPARTMENT OF AGRICULTURE

[Filed May 2, 2007, 8:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-03-139.

Title of Rule and Other Identifying Information: Chapter 16-623 WAC, Commission Merchant Act—Licensing fees, proof of payment, cargo manifests and registration of acreage commitments, the department is proposing to increase the license fees for commission merchants, dealers, limited dealers, brokers, cash buyers, and agents within the OFM fiscal growth factor for fiscal year 2008 (5.53%).

Hearing Location(s): Washington State Department of Agriculture, 21 North 1st Avenue, Conference Room 238, Yakima, WA 98902, on June 13, 2007, at 11:00 a.m.

Date of Intended Adoption: Not before June 20, 2007.

Submit Written Comments to: Henri Gonzales, P.O. Box 42560, Olympia, WA 98504-2560, e-mail hgonzales@agr.wa.gov, fax (360) 902-2094, by June 13, 2007.

Assistance for Persons with Disabilities: Contact Henri Gonzales by June 6, 2007, TTY (360) 902-1996 or (360) 902-2061.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule establishes the license fees charged by the commission merchants program for activities authorized in chapter 20.01 RCW. This proposal increases the license fees by no more than 5.53%, which is the OFM fiscal growth factor for fiscal year 2008. Current fees are not adequate to cover the costs of providing services; therefore, the proposed increase is necessary to ensure that the program will remain financially solvent. Chapter 20.01 RCW authorizes the director of the Washington state department of agriculture to adopt rules to enforce and carry out the provisions of this chapter.

Reasons Supporting Proposal: The commission merchant program enforces the Commission Merchants Act, licenses commission merchants, dealers, brokers and cash buyers, and investigates complaints. The program's revenue is derived almost solely from license fees. This increase in licensing fees would enable the program to cover the costs associated with operating the program.

Statutory Authority for Adoption: Chapters 20.01 and 34.05 RCW.

Statute Being Implemented: Chapter 20.01 RCW.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Kirk Robinson, 1111 Washington Street, Olympia, WA 98504-2560, (360) 902-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. RCW 19.85.030 (1)(a) requires that an agency must prepare a small business economic impact statement (SBEIS) for proposed rules that impose a more than minor cost on business in an industry. The department has analyzed the economic effects of the proposed revisions and has concluded that they do not impose a more than minor cost on small businesses in the regulated industry and, therefore, a formal SBEIS is not required.

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).

May 2, 2007

Mary A. Martin Toohey

Assistant Director

AMENDATORY SECTION (Amending WSR 05-09-094, filed 4/20/05, effective 5/21/05)

WAC 16-623-010 What requirements apply to licenses for commission merchants, dealers, brokers, cash buyers and agents? (1) The following table summarizes the license fee requirements for commission merchants, dealers, brokers, cash buyers, or agents:

License Class	License Fee	Annual Expiration Date	Annual Renewal Date	Penalty Amount for Not Renewing Before January 1
Commission merchant	$((~~450.00~~)) 474.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Dealer	$((~~450.00~~)) 474.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Limited dealer	$((~~250.00~~)) 263.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Broker	$((~~300.00~~)) 316.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Cash buyer	$((~~100.00~~)) 105.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Agent	$((~~50.00~~)) 52.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees
Additional license per class	$25.00	December 31	Before January 1	A late renewal penalty of twenty-five percent of the total fees

(2) A licensee can be licensed in more than one class for an additional fee of twenty-five dollars per class. The principal license must be in the class requiring the greatest fee and all requirements must be met for each class in which a license is being requested.

(3) All fees and penalties must be paid before the department issues a license.

(4) Applications for licenses are considered incomplete unless an effective bond or other acceptable form of security is also filed with the director.

(5) Licenses may be obtained by contacting the department's commission merchants program at 360-902-1854 or e-mail at: commerch@agr.wa.gov. Application forms, bond forms, and forms for securities in lieu of a surety bond are available on the department's web site at: ((~~http://www.agr.wa.gov/Inspection/CommissionMerchants/default.htm~~)) http://www.agr.wa.gov/Inspection/CommissionMerchants/default.asp.

WSR 07-10-110

PROPOSED RULES

DEPARTMENT OF AGRICULTURE

[Filed May 2, 2007, 8:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-03-140.

Title of Rule and Other Identifying Information: Chapter 16-675 WAC, Calibration services, special inspection and testing fees, the department is proposing to increase the fees charged by the metrology laboratory for inspection, tolerance testing and calibration services and the fees charged for request inspections and tests of weighing or measuring devices within the OFM fiscal growth factor for fiscal year 2008 (5.53%).

Hearing Location(s): Washington State Department of Agriculture, 1111 Washington Street S.E., Natural Resources Building, 2nd Floor, Conference Room 205, Olympia, WA 98504-2560, on June 7, 2007, at 10:00 a.m.

Date of Intended Adoption: Not before June 14, 2007.

Submit Written Comments to: Henri Gonzales, P.O. Box 42560, Olympia, WA 98504-2560, e-mail hgonzales@agr.wa.gov, fax (360) 902-2094, by June 7, 2007.

Assistance for Persons with Disabilities: Contact Henri Gonzales by May 31, 2007, TTY (360) 902-1996 or (360) 902-2061.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule establishes the fees charged by the weights and measures program for activities authorized in chapter 19.94 RCW. This proposal increases the fees charged by the metrology laboratory for inspection, tolerance testing and calibration of weighing and measuring standards and the fees charged for the inspection and testing of weighing or measuring devices when requested by the device owner within the OFM fiscal growth factor for fiscal year 2008 (5.53%). Current fees are not adequate to cover the costs of providing services; therefore, the proposed increase is necessary to ensure that the program will remain financially solvent. Chapter 19.94 RCW authorizes the department to adopt reasonable fees for the inspection and testing services performed by the weights and measures laboratory.

Reasons Supporting Proposal: The weights and measures program works to ensure the accuracy of weighing and measuring devices used in commerce in the state of Washington. The program's revenue is derived from both device registration and laboratory/request inspection fees. This increase in laboratory and request inspection fees would enable the program to cover the costs associated with performing these services.

Statutory Authority for Adoption: Chapters 19.94 and 34.05 RCW.

Statute Being Implemented: Chapter 19.94 RCW.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Kirk Robinson, 1111 Washington Street, Olympia, WA 98504-2560, (360) 902-1856.

No small business economic impact statement has been prepared under chapter 19.85 RCW. RCW 19.85.030 (1)(a) requires that an agency must prepare a small business economic impact statement (SBEIS) for proposed rules that impose a more than minor cost on business in an industry. The department has analyzed the economic effects of the proposed revisions and has concluded that they do not impose a more than minor cost on small businesses in the regulated industry and, therefore, a formal SBEIS is not required.

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).

May 2, 2007

Mary A. Martin Toohey

Assistant Director

AMENDATORY SECTION (Amending WSR 04-23-043, filed 11/10/04, effective 12/11/04)

WAC 16-675-045 What fees does the laboratory charge for the services it performs? The metrology laboratory charges the following fees for services performed:

Service Performed	Fee
Inspection, tolerance testing and calibration services performed at the metrology laboratory	$((~~100.00~~)) 105.50 per hour
Inspection, tolerance testing and calibration services performed at other than the metrology laboratory	$((~~100.00~~)) 105.50 per hour **plus** mileage and per diem at the rates established by the office of financial management (OFM) when the service is performed
Any service provided by the laboratory	**Minimum** one-half hour charge

AMENDATORY SECTION (Amending WSR 04-23-043, filed 11/10/04, effective 12/11/04)

WAC 16-675-055 What fees are charged when the inspecting and testing of a weighing or measuring device is specifically requested by the device's owner? The fees in the following table apply to inspecting and testing weighing or measuring devices when the inspection or test is:

(1) Specifically requested by the device's owner or his/her representative; or

(2) Performed on devices used by an agency or institution that receives money from the legislature or the federal government.

Weighing and Measuring Device	Inspection and/or Testing Fee
Small scales "zero to four hundred pounds capacity"	$((~~15.95~~)) 16.80 per scale
Intermediate scales "four hundred pounds to five thousand pounds capacity"	$((~~53.20~~)) 56.10 per scale
Large scales "over five thousand pounds capacity"	$((~~133.02~~)) 140.30 per scale
Large scales with supplemental devices	$((~~159.62~~)) 168.40 per scale
Railroad track scales	$((~~1,064.19~~)) 1,123.00 per scale
Liquid fuel meters with flows of less than twenty gallons per minute	$((~~15.95~~)) 16.80 per meter
Liquid fuel meters with flows of at least twenty but not more than one hundred fifty gallons per minute	$((~~53.20~~)) 56.10 per meter

Weighing and Measuring Device	Inspection and/or Testing Fee
Fuel meters with flows over one hundred fifty gallons per minute	$((~~159.62~~)) 168.40 per meter
Liquid petroleum gas meters with one-inch diameter or smaller dispensers	$((~~53.20~~)) 56.10 per meter
Liquid petroleum gas meters with greater than one-inch diameter dispensers	$((~~159.62~~)) 168.40 per meter
Inspection services not covered by the above special inspection fees	$((~~35.91~~)) 37.80 per hour for labor and travel time (minimum one hour charge)

WSR 07-10-113
PROPOSED RULES
DEPARTMENT OF AGRICULTURE

[Filed May 2, 2007, 9:04 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-06-046.

Title of Rule and Other Identifying Information: The department proposes to make amendments to chapter 16-390 WAC to increase the fee related to the fresh produce audit verification program and to make minor changes to increase its clarity. The sections to be amended are WAC 16-390-240 What is the fresh product audit verification program? and 16-390-242 What charges does the department assess for fruit and vegetable audit verification certificates issued under the fresh produce audit verification program?

Hearing Location(s): WSDA Yakima Office, 21 North First Avenue, Suite 226, Yakima, WA 98902, on Wednesday, June 27, 2007, at 1:00 p.m.; and at the Tree Fruit Research Center (Park on Western), 1100 North Western Avenue, Wenatchee, WA 98801, on Thursday, June 28, 2007, at 1:00 p.m.

Date of Intended Adoption: July 30, 2007.

Submit Written Comments to: Maryann Connell, Division Coordinator, Washington State Department of Agriculture, P.O. Box 42560, Olympia, WA 98504-2560, e-mail mconnell@agr.wa.gov, fax (360) 902-2085, by 5:00 p.m. on June 28, 2007.

Assistance for Persons with Disabilities: Contact Virginia Walsh by June 20, 2007, TTY (360) 902-1996 or (360) 902-1976.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments to chapter 16-390 WAC, WSDA fruit and vegetable inspection districts, inspection fees and other charges, will increase the hourly audit fees for good agricultural practices and good handling practices in excess of the office of financial management fiscal growth rate factor. WAC 16-390-240 will have a minor edit to more clearly define the fresh produce audit verification program and WAC 16-390-242 will be amended to increase the hourly rate from $49.00 to $75.00 per hour for audit-based services.

Reasons Supporting Proposal: United States Department of Agriculture, agricultural marketing service, fruit and vegetable programs, fresh products branch has added a good agricultural practices and good handling practices audit fee, changing the hourly service for GAP and GHP audits from $49.00 per hour to $75.00 per hour. The cooperative agreement between the United States Department of Agriculture, agricultural marketing service and Washington state department of agriculture states that WSDA will not charge less than USDA for the same services.

Statutory Authority for Adoption: Chapter 15.17 RCW, Standards of grades and packs and chapter 34.05 RCW, Administrative Procedure Act.

Statute Being Implemented: Chapter 15.17 RCW, Standards of grades and packs.

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

Name of Proponent: Washington state department of agriculture, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, Enforcement: Jim Quigley, Program Manager, P.O. Box 42560, Olympia, WA 98504-2560, (360) 902-1833.

No small business economic impact statement has been prepared under chapter 19.85 RCW. RCW 19.85.030 (1)(a) requires an agency to prepare a small business economic impact statement (SBEIS) for proposed rules that impose a more than minor cost on the business in an industry. The GAP and GHP audit fees under consideration are provided as a voluntary service to industry, so industry may decline a GAP or GHP audit or use other audit sources without paying the department's fee.

RCW 19.85.040(1) requires that an agency determine whether the proposed rule will have a disproportionate impact on small businesses by comparing the cost of compliance for small business with the cost of compliance for the ten percent of businesses that are the largest businesses required to comply. The GAP and GHP audit fees under consideration are provided as a voluntary service to industry, so industry may decline GAP or GHP audit or use other audit sources without paying the department's fee.

A cost-benefit analysis is not required under RCW 34.05.328. Washington state department of agriculture is not a named agency in RCW 34.05.328.

May 2, 2007
Dennis Hannapel
Assistant Director

AMENDATORY SECTION (Amending WSR 04-11-078, filed 5/18/04, effective 6/18/04)

WAC 16-390-240 What is the fresh produce audit verification program? The fresh produce audit verification program is a federal-state inspection service program that reviews and verifies a participating company's facility and agronomic practices, along with its documented procedures, to help determine if "good agricultural practices" and "good handling practices" are maintained.

AMENDATORY SECTION (Amending WSR 04-11-078, filed 5/18/04, effective 6/18/04)

WAC 16-390-242 What charges does the department assess for fruit and vegetable audit verification certificates issued under the fresh produce audit verification program? Charges assessed by the department for good agricultural practices (GAP) and good handling practices (GHP) audit verification certificates issued under the fresh produce audit verification program are as follows:

(1) The hourly rate for audit time, administration time and applicable travel time is ((~~charged at the hourly rate established by USDA/AMS/FPB/FVP the Schedule of Fees for Fresh Fruit and Vegetable Terminal Market Inspection Services, 7 CFR Part 51 Subpart 38, which became effective on January 15, 2004~~)) seventy-five dollars per audit hour.

(2) Mileage related to GAP and GHP audit services is charged at the rate established by the office of financial management (OFM) at the time the service was performed.

WSR 07-10-118
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed May 2, 2007, 9:33 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-06-029.

Title of Rule and Other Identifying Information: Chapter 246-254 WAC, Radiation protection fees.

Hearing Location(s): Department of Health Kent Offices, Marketing Center Creekside Three at CenterPoint, 20435 72nd Avenue South, Suite 200, Kent, WA 98032, on June 5, 2007, at 4:00 p.m.

Date of Intended Adoption: June 11, 2007.

Submit Written Comments to: Ellen Haars, Ph.D., X-ray Program, P.O. Box 47827, Olympia, WA 98504-7827, ellen.haars@doh.wa.gov, web site http://www3.doh.wa.gov/policyreview/, fax (360) 236-2255, by May 31, 2007.

Assistance for Persons with Disabilities: Contact Sharon Grundhoffer by May 31, 2007, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule simplifies the current X-ray registration fee structure so that the department can use the department of licensing's master license service. Changes are made in WAC 246-254-053 which specifies the various fee components and amounts. Other sections in chapter 246-254 WAC are amended to prescribe how and when to pay the fee, and change the basis for determining what constitutes a facility for purposes of registration.

Reasons Supporting Proposal: This rule change allows the department to participate in the governor's enterprise business portal and comply with RCW 19.02.050. The use of the master license service will save the department printing and mailing costs for annual fee bills and will allow registrants to pay by credit card if they choose.

Statutory Authority for Adoption: RCW 19.02.050, 43.20B.020, 43.70.110, 43.70.250, 70.98.080.

Statute Being Implemented: RCW 19.02.050, 43.20B.020, 43.70.110, 43.70.250, 70.98.080.

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

Name of Proponent: Washington state department of health, governmental.

Name of Agency Personnel Responsible for Drafting: Terry C. Frazee, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-3213; Implementation and Enforcement: Ellen Haars, Ph.D., 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-3231.

No small business economic impact statement has been prepared under chapter 19.85 RCW. Under RCW 19.85.025(3), rules that set or adjust fees pursuant to legislative standards are exempt from the requirement to prepare a small business [economic] impact statement.

A cost-benefit analysis is not required under RCW 34.05.328. Under RCW 34.05.328 (5)(b)(vi), rules that set or adjust fees pursuant to legislative standards are exempt from the requirement to prepare a cost-benefit analysis.

May 2, 2007
B. White
for M. C. Selecky
Secretary

AMENDATORY SECTION (Amending Order 208, filed 10/29/91, effective 11/29/91)

WAC 246-254-001 Purpose and scope. This chapter establishes fees charged for licensing, permitting, registration, and inspection services rendered by the ((~~division~~)) office of radiation protection as authorized under chapters 43.70, 70.98, and 70.121 RCW. These fees apply to owners and operators of radiation generating machines, users of radioactive material, operators of low-level radioactive waste disposal facilities, owners and operators of facilities emitting airborne radioactivity, and owners and operators of certain mineral processing and uranium or thorium milling operations and their associated tailings or waste.

AMENDATORY SECTION (Amending Order 208, filed 10/29/91, effective 11/29/91)

WAC 246-254-010 Definitions. As used in this chapter, the following definitions apply:

(1) "Application" means a completed RHF-1 or equivalent with supporting documentation requesting the department to grant authority to receive, possess, use, transfer, own or acquire radioactive material. For radiation machine facility registrations, "application" means the master business application and appropriate addenda used by the master license service of the department of licensing.

(2) "Compliance inspection" means a routinely scheduled visit to the licensee's facility and/or temporary job site(s) for the purpose of determining compliance with the radioactive material license and applicable regulations. This service is covered by the annual fee for the radioactive material license.

(3) "Department" means the department of health which has been designated as the state radiation control agency.

(4) "Direct staff time" means all work time directly applicable to or associated with a specific radioactive material licensee and includes license file review, inspection preparation, on-site visits, report writing, review and acknowledgement of correspondence, review of license applications, renewals and amendment requests, telephone contacts, and staff or management conferences specifically related to the license. Travel time is not considered direct staff time.

(5) "Emission unit" means the point of release of airborne emissions of radioactive material.

(6) "Environmental cleanup monitoring" means an on-site visit by the department to a licensee's facility or site of operation to determine the status of corrective actions to remove environmental radiation contamination resulting from the licensee's operation. Such a monitoring visit may include, but is not limited to, the review of the licensee's records pertaining to the environmental cleanup, observation of the licensee's cleanup work, sampling by the department for analysis, associated laboratory work, and the analysis of the information collected by the department.

(7) "Facility" means all buildings, structures and operations on one contiguous site using or identified by one physical location address designation.

(8) "Follow-up inspection" means an on-site visit to a licensee's facility to verify that prompt action was taken to correct significant items of noncompliance found by the department in a previous inspection. The first follow-up inspection is covered by the annual fee for the radioactive material license.

(9) "Inspection" means an official examination or observation by the department including but not limited to tests, surveys and monitoring to determine compliance with rules, regulations, orders, requirements and conditions of the department.

(10) "Investigation" means an on-site visit to a licensee's facility or site of operation when, in the department's judgment, it is required for the purpose of reviewing specific conditions, allegations, or other information regarding unusual conditions, operations, or practices. This service is covered by the annual fee for the radioactive material license.

(11) "License" means a license issued by the department in accordance with the regulations adopted by the department.

(12) "New license application" means a request to use radioactive material from a person not currently a licensee or from a current licensee requesting authorization to use radioactive material in a new way such that a change of fee category is required.

(13) "Perpetual care and maintenance" means further maintenance, surveillance or other care of milling or tailings impoundment sites after termination of the site operator's decommissioning responsibilities and license.

(14) "Registration" means registration with the department by any person possessing a source of ionizing radiation in accordance with regulations adopted by the department.

(15) "Sealed source and device evaluation" means a radiological safety evaluation performed by the department on the design, manufacture, and test data of any single sealed source and/or device model for the purpose of registering the sealed source or device with the United States Nuclear Regulatory Commission.

AMENDATORY SECTION (Amending Order 208, filed 10/29/91, effective 11/29/91)

WAC 246-254-020 Payment of fees. (1) Applicants, licensees, permittees, and registrants requesting or receiving licenses, permits, registrations, and actions or services by the department shall pay the applicable fee or fees for the license, permit, registration, and action or service provided by the department.

(2) The department shall charge a fee for each:

(a) Radiation machine facility registration, and radiation machine at the facility, if applicable;

(b) Radioactive material license;

(c) Service or action with respect to a radioactive material licensee not otherwise covered by fees;

(d) Cubic foot of low-level radioactive waste volume received at a commercial disposal site;

(e) Kilogram of uranium or thorium milled from ore; and

(f) Air emission permit.

(3) The department shall charge a fee for each radioactive material license based on the single highest fee category describing activities subject to the conditions of the license.

(4) The department shall charge the applicable license fee for each category when multiple licenses are required.

(5) The department may require multiple radioactive material licenses based upon:

(a) Physical separation of operations;

(b) Organizational separations within a licensee's operation;

(c) Complexity of uses of radioactive material such that two or more fee categories would apply to the operation.

(6) Each licensee, permittee, or registrant shall:

(a) Remit the full fee (i) at the fee rate established by rule at the time such fee is paid, and (ii) at least thirty days prior to the annual anniversary date for licensees or ((~~the biennial expiration date for registrants or~~)) (iii) on a payment schedule as provided in WAC 246-254-030 or other schedule as may be determined through partnership with the master license service of the department of licensing.

(b) Consider the annual anniversary to be the month and day of the expiration date of the existing radioactive material license, or other date as may be determined through partnership with the master license service of the department of licensing.

(7) The department shall refund one-half of the fee if an application is withdrawn prior to issuance of a radioactive material license.

(8) If there is a change by the applicant, licensee, permittee or registrant resulting in a higher fee category, the applicant, licensee, permittee, or registrant shall pay ((~~an additional fee~~)) a prorated fee for the remainder of the fee interval.

(9) Each licensee, permittee, or registrant shall remit the full amount of any quarterly billing or individual billing for licensing or compliance actions within thirty days of receipt of the bill.

(10) Fees due on or after the effective date of these regulations shall be at the rate prescribed in this chapter.

AMENDATORY SECTION (Amending Order 208, filed 10/29/91, effective 11/29/91)

WAC 246-254-050 Method of payment. (1) For radiation machine facility registration application and renewal fees, applicants and registrants shall submit payment to the master license service of the department of licensing.

(2) For all other fees and charges including shielding plan review and follow-up inspection fees, licensees, permittees and registrants shall:

((~~(1)~~)) (a) Submit fee payments by check, draft or money order made payable to the department of health; and

((~~(2)~~)) (b) Include fee payment with the application for license or submit the fee by mail, in person, or by courier to the address provided in the bill or bill correspondence.

AMENDATORY SECTION (Amending WSR 05-24-108, filed 12/7/05, effective 1/7/06)

WAC 246-254-053 Radiation machine facility registration fees. (1) Radiation machine facility fees apply to each person or facility owning, leasing ((~~and~~)) or using radiation-producing machines. The annual facility fee consists of the base registration fee and a per tube charge, where applicable.

((~~FEE TYPE~~ ~~FEE~~

~~(a) Annual Base Registration Fee~~ ~~$68~~

~~(b) Late registration or re-registration~~ ~~$68~~

~~(c) Tube Fees~~ ~~See Table 1~~

~~TABLE 1~~
~~Radiation Tube Fees~~

~~Group~~	~~First Tube~~	~~Each Additional Tube~~
~~(i) Group A: Dental, Podiatric, Veterinary, Bone Densitometers uses~~	~~$69~~	~~$35~~
~~(ii) Group B: Hospital, Medical, Chiropractic uses~~	~~$190~~	~~$100~~
~~(iii) Group C: Industrial, research, and other uses~~	~~$107~~	~~$35~~
~~(iv) Group D: Electron Microscopes, Mammographic X-ray Machines~~	~~NA~~	~~NA~~))

(a) **Radiation Machine Facility Fees**

Type of Facility		Facility Base Fee	Added Fee per Tube
(i)	Dental, podiatric, veterinary uses	$102	See following table
(ii)	Hospital, medical, chiropractic uses	$158	See following table
(iii)	Industrial, research, educational, security, or other facilities	$140	See following table
(iv)	Mammography only	$68	N/A
(v)	Bone densitometry only	$68	N/A
(vi)	Electron microscopes only	$68	N/A
(vii)	Bomb squad only	$68	N/A
(viii)	Radiation safety program as specified in subsection (3) of this section	$4,441	N/A

(b) **Radiation Machine Tube Fees**

Type of Tube		Added Fee per Tube
(i)	Dental (intraoral, panoramic, cephalometric, dental radiographic, and dental CT)	$35
(ii)	Veterinary (radiographic, fluoroscopic, portable, mobile)	$35
(iii)	Podiatric uses (radiographic, fluoroscopic)	$35
(iv)	Mammography	N/A
(v)	Bone densitometry	N/A
(vi)	Electron microscope	N/A
(vii)	Bomb squad	N/A
(viii)	Medical radiographic (includes R/F combinations, fixed, portable, mobile)	$100
(ix)	Medical fluoroscopic (includes R/F combinations, C-arm, Simulator, fixed, portable, mobile)	$100
(x)	Therapy (Grenz Ray, Orthovoltage, nonaccelerator)	$100

(b) **Radiation Machine Tube Fees**		
	Type of Tube	**Added Fee per Tube**
(xi)	Accelerators (therapy, other medical uses)	$100
(xii)	Computer tomography (CT, CAT scanner)	$100
(xiii)	Stereotactic (mammography)	$100
(xiv)	Industrial radiographic	$35
(xv)	Analytical, X-ray fluorescence	$35
(xvi)	Industrial accelerators	$35
(xvii)	Airport baggage	$35
(xviii)	Cabinet (industrial, security, mail, other)	$35
(xiv)	Other industrial uses (includes industrial fluoroscopic uses)	$35

(2) **X-ray shielding fees.**

(a) Facilities regulated under the shielding plan requirements of WAC 246-225-030 or 246-227-150 are subject to a $255 X-ray shielding review fee for each X-ray room plan submitted. A registrant may request an expedited plan review for an additional $500 for each X-ray room plan. Expedited plan means the department will complete the plan review within two business days of receiving all required information from the registrant.

(b) If a facility regulated under WAC 246-225-030 or 246-227-150 operates without submittal and departmental approval of X-ray shielding calculations and a floor plan it will be subject to a shielding design follow-up fee of $500.

(3) **Radiation safety fee.** If a facility or group of facilities under one administrative control employs two or more full-time individuals whose positions are entirely devoted to in-house radiation safety, the facility shall pay a flat, annual fee ((~~of $4,441~~)) as specified in subsection (1)(a)(viii) of this section.

(4) **Consolidation of registration.** Facilities may consolidate X-ray machine registrations into a single registration after notifying the department in writing and documenting that a single business license applies ((~~if the geographical location (parcel number) is the same~~)) to all buildings, structures and operations on one contiguous site using or identified by one physical address location designation.

(5) **Inspection fees.**

(a) The cost of routine, periodic inspections, including the initial inspection, are covered under the base fee and tube registration fees as described in subsection (1) of this section.

(b) Facilities requiring follow-up inspections due to uncorrected noncompliances must pay an inspection follow-up fee of $90.

(6) A facility's annual registration fee is valid for a specific geographical location and person only. It is not transferable to another geographical location or owner or user.

WSR 07-10-119
PROPOSED RULES
STATE BOARD OF HEALTH

[Filed May 2, 2007, 9:35 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-10-096.

Title of Rule and Other Identifying Information: Repeal existing WAC 246-203-120 Disposal of garbage, trash, rubbish, offal, dead animals, and manure, and adopt replacement and 246-203-121 Disposal of dead animals.

Hearing Location(s): Gladish Community & Cultural Center, 115 N.W. State Street, Pullman, WA 99163, on June 13, 2007, at 1:30 p.m.

Date of Intended Adoption: June 13, 2007.

Submit Written Comments to: Ned Therien, P.O. Box 47990, Olympia, WA 98504-7990, e-mail http://www3.doh.wa.gov/policyreview/, fax (360) 236-4088, by June 5, 2007.

Assistance for Persons with Disabilities: Contact Desiree Robinson by June 1, 2007, TTY (800) 833-6388 or (360) 236-4107.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposal would repeal WAC 246-203-120 Disposal of garbage, trash, rubbish, offal, dead animals, and manure, and adopt new WAC 246-203-121 Disposal of dead animals. The state board of health adopted WAC 246-203-120 in 1960, a decade before the legislature enacted chapter 70.95 RCW, Solid waste management. This rule revision would eliminate portions of the rule that duplicate or conflict with ecology's solid waste rules. It would add alternatives to those in existing WAC 246-203-120 for the disposal of dead animals. It would also clarify the relationship of the board's rule with RCW 16.36.092 Duty to bury carcass of diseased livestock, and the department of agriculture's new chapter 16-25 WAC, Disposal of dead livestock.

Reasons Supporting Proposal: This rule is needed to prevent the disposal of dead animals in a manner that causes a public health hazard or nuisance. The rule is needed for the disposal of animals not covered under the requirements of RCW 16.36.092 and chapter 16-25 WAC, which have applicability limited to diseased livestock. Public health hazards and nuisances could be caused by lack of proper disposal of the carcasses of other types of animals and nondiseased livestock.

Statutory Authority for Adoption: RCW 43.20.050(2).

Statute Being Implemented: RCW 43.20.050(2).

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: This rule would update and replace an existing board rule without adding a significant regulatory burden to the regulated community or for local health jurisdiction implementation. The department of health provides consultation to local health jurisdictions regarding enforcement of the existing board of health rule for dead animal disposal.

Name of Proponent: State board of health, governmental.

Name of Agency Personnel Responsible for Drafting: Ned Therien, State Board of Health, 101 Israel Road S.E., Tumwater, WA 98501, (360) 236-4103; Implementation and Enforcement: Dorothy Tibbets [Tibbetts], Department of Health, 243 Israel Road S.E., Tumwater, WA 98501, (360) 236-3361.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No additional costs are imposed on small businesses.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Ned Therien, P.O. Box 47990, Olympia, WA 98504-7990, phone (360) 236-4103, fax (360) 236-4088, e-mail ned.therien@doh.wa.[gov.]

April 30, 2007
Craig McLaughlin
Executive Director

NEW SECTION

WAC 246-203-121 Disposal of dead animals. (1) **Definitions.** For the purpose of this regulation the following definitions apply:

(a) "Burial" means completely covering with soil in a manner and location not requiring a permit for a landfill under chapter 70.95 RCW, Solid waste management—Reduction and recycling.

(b) "Composting" means a process of controlled aerobic decomposition in compliance with chapter 70.95 RCW, Solid waste management—Reduction and recycling.

(c) "Dead animal" means the carcass or tissue from an animal, large or small, except part of an animal used for food or other beneficial purpose in accordance with federal, state, and local laws and regulations. "Dead animal" does not mean a fish or other primarily aquatic animal.

(d) "Incineration" means controlled and monitored combustion for the purposes of volume reduction and pathogen destruction in an enclosed device approved by the department of ecology or the local air pollution control authority under chapter 70.94 RCW, Washington Clean Air Act, and chapter 70.95 RCW, Solid waste management—Reduction and recycling.

(e) "Landfilling" means a process of disposal at a permitted facility where solid waste is permanently placed in or on land in compliance with rules adopted by the department of ecology under chapter 70.95 RCW, Solid waste management—Reduction and recycling.

(f) "Livestock" means horses, mules, donkeys, cattle, bison, sheep, goats, swine, rabbits, llamas, alpacas, ratites, poultry, waterfowl, game birds, or other species according to RCW 16.36.005.

(g) "Natural decomposition" means natural decay on the surface of the ground without cover material.

(h) "Rendering" means heat processing according to requirements under chapter 16.68 RCW, Disposal of dead animals.

(2) **Disposal methods.**

(a) Within seventy-two hours after death or discovery, the owner of a dead animal or, if the owner of the animal cannot be identified, the owner of the property on which the animal is found must properly dispose of the dead animal. A dead animal must be covered or otherwise removed from public view immediately upon discovery by the person responsible for disposing of the dead animal.

(b) The person responsible for disposal of a dead animal must dispose of it in a manner so as not to become a public or common nuisance or cause pollution of surface or ground water.

(c) The person responsible for disposal of a dead animal must dispose of it by burial, landfilling, incineration, composting, rendering, or another method approved by the local health officer (such as natural decomposition) that is not otherwise prohibited by federal, state, or local law or regulation.

(d) A person disposing of a dead animal by burial must place it so that every part is covered by at least three feet of soil; at a location not less than one hundred feet from any well, spring, stream or other surface waters; not in a low-lying area subject to seasonal flooding or within a one hundred-year flood plain; and not in a manner likely to contaminate ground water.

(e) A person disposing of a dead animal must not bury or compost it within the sanitary control area of a public drinking water supply source as designated under chapter 246-290 WAC, Public water supplies, or chapter 246-291 WAC, Group B public water systems.

(f) The local health officer may specify the method of disposal for a dead animal if:

(i) The animal died with a communicable disease transmissible to humans; or

(ii) The local health officer considers a public health emergency to exist.

(g) The provisions of RCW 16.36.092 and chapter 16-25 WAC supersede the provisions of this regulation for the disposal of a livestock animal that has died because of disease or unknown cause.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 246-203-120	Disposal of garbage, trash, rubbish, offal, dead animals, and manure.

WSR 07-10-120
PROPOSED RULES
DEPARTMENT OF HEALTH
(Veterinary Board of Governors)
[Filed May 2, 2007, 9:36 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-24-113.

Title of Rule and Other Identifying Information: WAC 246-935-050 Animal health care tasks for veterinary technicians.

Hearing Location(s): Department of Health, Center Point Corporate Park, 20435 72nd Avenue South, Confer-

ence Room Two, Kent, WA 98032, on June 11, 2007, at 10:00 a.m.

Date of Intended Adoption: June 11, 2007.

Submit Written Comments to: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, web site http://www3.doh.wa.gov/policyreview/, fax (360) 586-4359, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Judy Haenke by June 4, 2007, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The amended rule will allow, but not require, a registered veterinary technician to close an incision or prepared wound as directed by a licensed veterinarian under direct supervision. By directing the veterinary technician to close an incision or prepared wound, the veterinarian can attend to other patients. It is anticipated that there will be more review and revision of this section in the future.

Reasons Supporting Proposal: The proposed amendment is the outcome of a rule-making petition from the Washington state association of veterinary technicians and consideration by the veterinary board of governors of standards necessary to protect the health of animal patients in Washington state. Initially, the board intended to review and update the entire section. At this time, in response to the petition, the board is moving forward only with the approval and definition of suturing. It is anticipated that the rule will be opened again at a later date under a separate CR-101 (preproposal notice) to complete the review.

Statutory Authority for Adoption: RCW 18.92.030.

Statute Being Implemented: RCW 18.92.030.

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

Name of Proponent: Department of health, veterinary board of governors, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, (360) 236-4947.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No small business economic impact statement has been prepared under RCW 19.85.030(1) because the proposed rule does not impose more than minor costs on businesses within the industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, phone (360) 236-4947, fax (360) 586-4359, e-mail judy.haenke@doh.wa.gov.

April 26, 2007
Lisa Salmi
Acting Executive Director

AMENDATORY SECTION (Amending WSR 02-02-046, filed 12/27/01, effective 1/27/02)

WAC 246-935-050 Animal health care tasks. (1) **Veterinary technicians.**

No individual, other than a registered veterinary technician, may advertise or offer her/his services in a manner calculated to lead others to believe that she/he is a trained or registered veterinary technician.

Veterinary technicians are prohibited from performing the following activities: Surgery except as outlined below; diagnosis and prognosis; prescribing drugs, medication or appliances; initiation of treatment without prior instruction by a veterinarian except as outlined under emergency animal care.

(a) Immediate supervision. A veterinary technician may perform the following tasks only under the immediate supervision of a veterinarian:

(i) Assist veterinarian in surgery by tissue handling;

(ii) Assist veterinarian in surgery by instrument handling;

(iii) Dental extractions.

(b) Direct supervision. A veterinary technician may perform the following tasks under the direct supervision of a veterinarian:

(i) Endotracheal intubation;

(ii) Blood administration;

(iii) Fluid aspiration, including cystocentesis;

(iv) Intraperitoneal injections;

(v) Monitoring of vital signs of anesthetized patient;

(vi) Application of splints;

(vii) Induce anesthesia by intravenous, intramuscular, or subcutaneous injection or by inhalation;

(viii) Administration of immunological agents including rabies vaccination;

(ix) Catheterization of the unobstructed bladder;

(x) Ophthalmological procedure including:

(A) Tear production testing

(B) Topical anesthetic application

(C) Fluorescein staining of the cornea

(D) Tonometry;

(xi) Teeth cleaning, provided an oral examination of the anesthetized patient has been conducted by the veterinarian;

(xii) Microchip implantation;

(xiii) Floating teeth;

(xiv) Removal of partially exposed foxtails and porcupine quills;

(xv) Provide massage;

(xvi) Suturing. The use of a needle, cutting or tapered, and suture material, staples, wound clips or tissue glue to close a skin or gingival incision or prepared wound as directed by the attending licensed veterinarian under direct supervision. Suturing may include the use of needle holders, thumb forceps, tissue forceps, retractors and comparable instruments for gentle handling of the tissues to be repaired/closed by such suturing. Suturing does not include the use of cutting instruments such as scalpels, scissors, electrosurgical equipment or other instruments to remove skin or other tissues from the animal patient.

(c) Indirect supervision. A veterinary technician may perform the following tasks under the indirect supervision of a veterinarian. If the animal is anesthetized, these tasks require the direct supervision of a veterinarian((-)):

(i) Enema;

(ii) Electrocardiography;

(iii) Application of bandages;

(iv) Gavage;

(v) Ear flush;
(vi) Radiology;
(A) Patient positioning;
(B) Operation of radiograph machines;
(C) Oral and rectal administration of radio-opaque materials;
(vii) Placement and securing of an intravenous catheter;
(viii) Injections of medications not otherwise prohibited:
(A) Intramuscular, excluding immunological agents
(B) Subcutaneous, excluding immunological agents
(C) Intravenous, including giving medication through an established intravenous catheter;
(ix) Oral medications;
(x) Topical medications;
(xi) Laboratory (specimen collections):
(A) Collection of tissue during or after a veterinarian has performed a necropsy
(B) Urine, except cystocentesis
(C) Blood
(D) Parasitology
(E) Exfoliative cytology
(F) Microbiology
(G) Fecal material
(xii) Laboratory (specimen testing):
(A) Urinalysis
(B) Hematology
(C) Serology
(D) Chemistries
(E) Endocrinology
(F) Parasitology
(G) Exfoliative cytology
(H) Microbiology
(I) Fecal analysis;
(xiii) Administration of preanesthetic drugs;
(xiv) Oxygen therapy;
(xv) Euthanasia in all circumstances as otherwise allowed by law;
(xvi) Removal of sutures;
(xvii) Indirect blood pressure measurement;
(xviii) Obtaining a general history from a client of a patient and the client's concerns regarding that patient;
(xix) Preliminary physical examination including temperature, pulse and respiration;
(xx) Behavioral consultation with clients;
(xxi) Dietary consultation with clients.
(2) **Unregistered assistants.**
Induction of anesthesia by any method is prohibited.
(a) Immediate supervision by veterinarian. An unregistered assistant may perform the following tasks only under the immediate supervision of a veterinarian:
(i) Assist veterinarian in surgery by tissue handling;
(ii) Assist veterinarian in surgery by instrument handling.
(b) Immediate supervision by veterinarian or veterinary technician. An unregistered assistant may perform the following tasks only under the immediate supervision of either a veterinarian or veterinary technician:
(i) Blood administration;
(ii) Laboratory (specimen collections):
(A) Hematology
(B) Exfoliative cytology, including skin scraping
(C) Microbiology
(D) Serology;
(iii) Placement and securing of an intravenous catheter.
(c) Direct supervision by veterinarian. An unregistered assistant may perform the following tasks only under the direct supervision of a veterinarian:
(i) Monitor vital signs of anesthetized patient;
(ii) Euthanasia in all circumstances as otherwise allowed by law;
(iii) Removal of sutures;
(iv) Teeth cleaning, provided an oral examination of the anesthetized patient has been conducted by the veterinarian;
(v) Provide massage;
(vi) Administration of immunological agents including rabies vaccination;
(vii) Microchip implantation;
(viii) Enema;
(ix) Removal of partially exposed foxtails and porcupine quills from skin and feet.
(d) Direct supervision by veterinarian or veterinary technician. An unregistered assistant may perform the following tasks under direct supervision of either a veterinarian or veterinary technician. If the animal is anesthetized, these tasks require immediate supervision of a veterinarian or a veterinary technician:
(i) Application of bandages;
(ii) Ear flush;
(iii) Electrocardiography;
(iv) Intramuscular or subcutaneous injections of medications not otherwise prohibited;
(v) Laboratory (test preparation, not evaluation):
(A) Parasitology
(B) Serology
(C) Urinalysis;
(vi) Preliminary physical examination including temperature, pulse and respiration;
(vii) Radiology:
(A) Patient positioning
(B) Operation of radiograph machines
(C) Rectal and oral administration of radio-opaque materials.
(e) Indirect supervision. An unregistered assistant may perform the following tasks under the indirect supervision of a veterinarian. If the animal is anesthetized, these tasks require the direct supervision of a veterinarian:
(i) Oral medications;
(ii) Topical medications;
(iii) Laboratory (specimen collection):
Collecting of voided urine and fecal material;
(iv) Oxygen therapy;
(v) Obtaining a general history from a client of a patient and the client's concerns;
(vi) Behavioral consultation with clients;
(vii) Dietary consultation with clients.
(3) **Emergency animal care.**
(a) Under conditions of an emergency, a veterinary technician and unregistered assistant may render certain life saving aid to an animal. A veterinary technician may:

(i) Apply tourniquets and/or pressure bandages to control hemorrhage;

(ii) Administer pharmacologic agents to prevent or control shock. Placement of an intravenous catheter and administering parenteral fluids, must only be performed after direct communication with a veterinarian, and only if the veterinarian is either present or immediately ((~~enroute~~)) en route to the location of the distressed animal;

(iii) Administer resuscitative oxygen procedures;

(iv) Establish open airways including the use of intubation appliances, but excluding surgery;

(v) Administer external cardiac resuscitation;

(vi) Apply temporary splints or bandages to prevent further injury to bones or soft tissues;

(vii) Apply appropriate wound dressings and external supportive treatment in severe burn cases;

(viii) Apply external supportive treatment to stabilize body temperature.

(b) An unregistered assistant may:

(i) Apply tourniquets and/or pressure bandages to control hemorrhage;

(ii) Administer resuscitative oxygen procedures;

(iii) Establish open airways including intubation appliances, but excluding surgery;

(iv) Apply external supportive treatment to stabilize body temperature.

WSR 07-10-121
PROPOSED RULES
DEPARTMENT OF HEALTH
(Veterinary Board of Governors)

[Filed May 2, 2007, 9:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-24-114.

Title of Rule and Other Identifying Information: WAC 246-933-230 Foreign trained veterinarians, 246-933-250 Examination requirement and procedures, 246-933-260 Frequency and location of examinations and 246-933-280 Examination review procedures; and new section WAC 246-933-265 Scope of Washington state jurisprudence examination.

Hearing Location(s): Department of Health, Center Point Corporate Park, 20435 72nd Avenue South, Conference Room Two, Kent, WA 98032, on June 11, 2007, at 10:00 a.m.

Date of Intended Adoption: June 11, 2007.

Submit Written Comments to: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, web site http://www3.doh.wa.gov/policyreview/, fax (360) 586-4359, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Judy Haenke by June 4, 2007, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposal accepts the program for assessment of veterinary education equivalence (PAVE) as an assessment of the educational equivalence of nonaccredited programs. The board currently accepts completion of the education commission for foreign veterinary graduates (ECFVG) program. As proposed, applicants may complete either PAVE or ECFVG. The proposed rules also update references to examination scoring and repeal outdated regulations related to examination administration and review procedures.

Reasons Supporting Proposal: Acceptance of the PAVE program provides an alternative way by which graduates of nonaccredited schools may demonstrate equivalent education. Candidates will have a better understanding of the application process through rules that have been updated for clarity and accuracy.

Statutory Authority for Adoption: RCW 18.92.030.

Statute Being Implemented: RCW 18.92.030, 18.92.-070.

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

Name of Proponent: Department of health, veterinary board of governors, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, (360) 236-4947.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No small business economic impact statement has been prepared under RCW 19.85.030(1) because the proposed rule does not impose more than minor costs on businesses within the industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, phone (360) 236-4947, fax (360) 586-4359, e-mail judy.haenke@doh.wa.gov.

April 26, 2007
Lisa Salmi
Acting Executive Director

AMENDATORY SECTION (Amending WSR 01-02-066, filed 12/29/00, effective 1/29/01)

WAC 246-933-250 Examination and licensure requirements ((~~and procedures~~)). ((~~In order to be licensed, any applicant for licensure must have successfully completed~~)) To qualify for licensure in this state, a candidate must:

(1) Successfully complete either the North American Veterinary Licensing Examination (NAVLE), or the National Board Examination for Veterinary Medical Licensing (NBE), ((~~and~~)) with the Clinical Competency Test (CCT)((~~. All applicants must also pass~~)); and

(2) Successfully complete the Washington state jurisprudence examination((~~. The Washington state examination shall consist of questions pertaining to laws regulating the practice of veterinary medicine in the state. The applicant may take the examinations up to six months prior to graduation from a course of instruction as described in WAC 246-933-220~~)); and

(3) Be a graduate of a program that is accredited by the American Veterinary Medical Association. A person who is

a graduate of a college of veterinary medicine not accredited by the American Veterinary Medical Association must:

(a) Successfully complete the American Veterinary Medical Association Education Commission for Foreign Veterinary Graduates (ECFVG); or

(b) Successfully complete the American Association of Veterinary State Board's Program for the Assessment of Veterinary Education Equivalence (PAVE); and

(4) Complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8.

NEW SECTION

WAC 246-933-265 Scope of Washington state jurisprudence examination. (1) The Washington state jurisprudence examination consists of multiple choice questions relating to state laws and administrative regulations in the practice of veterinary medicine.

(2) A candidate may take the Washington state jurisprudence examination up to six months prior to graduation from an approved course of study.

(3) The passing score on the examination is ninety percent.

(4) A candidate may retake the examination by submitting an application and fee to the department of health.

AMENDATORY SECTION (Amending WSR 01-02-066, filed 12/29/00, effective 1/29/01)

WAC 246-933-270 Examination results. (((~~(1) In order to pass the examination for licensure as a veterinarian, the applicant shall attain a grade that meets or exceeds the criterion-referenced passing score established by the National Board Examination Committee of the American Veterinary Medical Association for the North American Veterinary Licensing Examination (NAVLE). Additionally, the applicant must attain a minimum grade of ninety percent on the Washington state examination.~~

~~(2) An applicant who fails the North American Veterinary Licensing Examination (NAVLE), or the Washington state examination may retake the examination that he or she failed by completing an application and by submitting the reexamination fee to the Veterinary Board of Governors.~~)) The board accepts the following minimum passing score for licensure examinations.

(1) The minimum passing score for the North American Veterinary Licensing Examination (NAVLE) is the criterion-referenced passing score established by the National Board of Veterinary Medical Examiners.

(2) The minimum passing score before December 1982 for the National Board Examination for Veterinary Medical Licensing (NBE), and the Clinical Competency Test (CCT) is 1.5 standard deviation below the mean of the criterion population. From December 1992 through April 2000 the minimum passing score is the criterion referenced passing score required by the National Board of Veterinary Medical Examiners.

(3) The minimum passing score on the Washington state jurisprudence examination is ninety percent.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-933-230	Foreign trained veterinarians.
WAC 246-933-260	Frequency and location of examinations.
WAC 246-933-280	Examination review procedures.

WSR 07-10-122
PROPOSED RULES
DEPARTMENT OF HEALTH
(Veterinary Board of Governors)
[Filed May 2, 2007, 9:40 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 05-24-112.

Title of Rule and Other Identifying Information: Veterinary board of governors, WAC 246-933-401 Citation and purpose, 246-933-420 Basic requirement—Amount, 246-933-440 Exceptions, 246-933-450 Qualification of program for continuing education, 246-933-460 Programs approved by the veterinary board, and new section WAC 246-933-465 Self-study continuing veterinary medical education activities.

Hearing Location(s): Department of Health, Center Point Corporate Park, Conference Room Two, 20435 72nd Avenue South, Kent, WA 98032, on June 11, 2007, at 10:00 a.m.

Date of Intended Adoption: June 11, 2007.

Submit Written Comments to: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, web site http://www3.doh.wa.gov/policyreview/, fax (360) 586-4359, by June 4, 2007.

Assistance for Persons with Disabilities: Contact Judy Haenke by June 4, 2007, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules update and clarify existing continuing education rules, allow limited practice management courses and create a new section authorizing completion of self-study and electronically available courses. These rules do not propose an increase to the existing continuing education requirements or require that continuing education be earned in any specific category. The proposed rules expand the methods by which continuing education credits maybe earned by including methods that are often more accessible and less costly to complete.

Reasons Supporting Proposal: Currently, licensees are limited to earning continuing education credit only through attendance at a recognized program having a featured speaker. The proposed rules expand the methods by which continuing education credits may be earned by including self-study methods that are often more accessible and less costly to complete.

Statutory Authority for Adoption: RCW 18.92.030.

Statute Being Implemented: RCW 18.92.030.

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

Name of Proponent: Department of health, veterinary board of governors, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, (360) 236-4947.

No small business economic impact statement has been prepared under chapter 19.85 RCW. No small business economic impact statement has been prepared because, under RCW 19.85.030(1), the proposed rule does not impose more than minor costs on businesses within the industry.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Judy Haenke, Program Manager, P.O. Box 47868, Olympia, WA 98504-7868, phone (360) 236-4947, fax (360) 586-4359, e-mail judy.haenke@doh.wa.gov.

April 26, 2007
Lisa Salmi
Acting Executive Director

AMENDATORY SECTION (Amending Order 108B, filed 12/28/90, effective 1/31/91)

WAC 246-933-401 Citation and purpose. These rules may be cited ((~~and referred to~~)) as the "Veterinary continuing education rules." The purpose of these rules is to ((~~require licensed veterinarians to continue their professional educations as a condition of maintaining a license to practice veterinary medicine in this state~~)) establish standards of continuing veterinary medical education. The rules provide for qualifying training methods, designating approved continuing veterinary medical education providers and setting minimum continuing veterinary medical education credit requirements.

AMENDATORY SECTION (Amending WSR 98-05-060, filed 2/13/98, effective 3/16/98)

WAC 246-933-420 Basic requirement—Amount. Continuing veterinary medical education consists of programs of learning which contribute directly to the advancement or enhancement of skills in the practice of veterinary medicine, surgery and dentistry. Licensed veterinarians must complete thirty hours of continuing veterinary medical education every three years as required in chapter 246-12 WAC, Part 7. No more than ten hours can be earned in practice management courses in any three-year reporting period.

AMENDATORY SECTION (Amending Order 221B, filed 12/4/91, effective 1/4/92)

WAC 246-933-440 Exceptions. ((~~The following are exceptions from the continuing education requirements:~~

~~Upon a showing of good cause by a licensee to the board,~~)) The board may ((~~exempt such licensee from any, all, or part of the continuing education requirement. Good cause includes, but is not limited to:~~

~~(1) Illness;~~

~~(2) Hardship to practice~~)) excuse from or grant an extension of continuing veterinary medical education requirements to a licensee due to illness or other extenuating circumstances.

Licensees seeking an extension must petition the board, in writing, at least forty-five days prior to the end of the reporting period.

AMENDATORY SECTION (Amending Order 108B, filed 12/28/90, effective 1/31/91)

WAC 246-933-460 ((~~Programs~~)) Courses approved by the veterinary board. ((~~Completion of the following are deemed to qualify an individual for continuing education credit: Attendance at a recognized local, state, national, or international continuing education program having a featured speaker.~~)) Courses offered by the following organizations are presumed to qualify as continuing veterinary medical education courses without specific prior approval of the board.

(1) The American Association of Veterinary State Boards (AAVSB).

(2) The American Veterinary Medical Association (AVMA).

(3) The Washington State Veterinary Medical Association.

(4) Any board approved college or school of veterinary medicine.

(5) Any state or regional veterinary association which is recognized by the licensing authority of its state as a qualified professional association or educational organization.

(6) The American Animal Hospital Association.

(7) Veterinary specialty boards recognized by the American Veterinary Medical Association.

(8) Regional veterinary conferences and allied organizations recognized by AAVSB.

(9) The Registry of Approved Continuing Education (RACE)

(10) Other courses as approved by the board.

NEW SECTION

WAC 246-933-465 Self-study continuing veterinary medical education activities. The board may grant continuing veterinary medical education credit for participation in self-study educational activities. The board may grant a licensee a total of ten credit hours under this section for any three-year reporting period. Self-study educational activities may include:

(1) Credit for reports. The board may grant continuing education credit for reports on professional veterinary literature. Licensees must submit requests for credit at least sixty days prior to the end of the reporting period. The request must include a copy of the article, including publication source, date and author. The report must be typewritten and include at least ten descriptive statements about the article.

(a) Professional literature approved for these reports are peer reviewed veterinary medical journals.

(b) Each report qualifies for one credit hour. The board may grant a licensee up to five credit hours of continuing veterinary medical education under this subsection if the com-

bined total of ten hours for all types of self-study continuing veterinary medical education is not exceeded.

(2) Credit for preprogrammed educational materials. The board may grant a licensee continuing veterinary medical education credit for viewing and participating in board-approved formal preprogrammed veterinary educational materials. The preprogrammed materials must be approved by an organization listed in WAC 246-933-460, and must require successful completion of an examination. Preprogrammed educational materials include, but are not limited to:

(a) Correspondence courses offered through magazines or other sources;

(b) Cassettes;

(c) Videotapes;

(d) CD-ROM;

(e) Internet.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 246-933-450	Qualification of program for continuing education credit.

WSR 07-10-123
PROPOSED RULES
DEPARTMENT OF HEALTH
(Board of Pharmacy)
[Filed May 2, 2007, 9:45 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 04-18-091.

Title of Rule and Other Identifying Information: WAC 246-889-050 Suspicious transactions and reporting requirements, the proposed rule revises criteria for reporting sales of ephedrine, pseudoephedrine, and phenylpropanolamine products by wholesalers and manufacturers to retailers.

Hearing Location(s): Department of Health, Marketing Center Creekside Three at CenterPoint, 20435 72nd Avenue South, Room 1, Kent, WA 98032, on July 26, 2007, at 9:15 a.m.

Date of Intended Adoption: July 26, 2007.

Submit Written Comments to: Manet Wade, Department of Health, P.O. Box 47863, Olympia, WA 98504-7863, web site http://www3.doh.wa.gov/policyreview/, fax (360) 586-4359, by July 13, 2007.

Assistance for Persons with Disabilities: Contact Manet Wade by July 10, 2007, TTY (800) 833-6388 or 711.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The rule will implement 2004 legislation (ESHB [ESSB] 6478) chapter 52, Laws of 2004 codified as RCW 69.43.035 by amending WAC 246-889-050. The proposed rule requires wholesalers and manufacturers to report suspicious transactions of the sale of ephedrine, pseudoephedrine, and phenylpropanolamine products. It is expected that the reporting of suspicious transactions will deter the purchase of products used to manufacture methamphetamine.

Reasons Supporting Proposal: ESSB 6478 directs the board of pharmacy to adopt rules for reporting the suspicious transaction sales of ephedrine, pseudoephedrine, and phenylpropanolamine products.

Statutory Authority for Adoption: RCW 18.64.005.

Statute Being Implemented: RCW 69.43.035.

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

Name of Proponent: Washington state department of health, board of pharmacy, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Doll, 310 Israel Road S.E., Tumwater, WA, (360) 236-4833; Implementation and Enforcement: Lisa Salmi, 310 Israel Road S.E., Tumwater, WA, (360) 236-4828.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rule does not impose more than minor costs to businesses within the industry per RCW 19.85.030.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Manet Wade, Washington State Department of Health, Board of Pharmacy, P.O. Box 47863, Olympia, WA 98504, phone (360) 236-4838, fax (360) 586-4359, e-mail manet.wade@doh.wa.gov.

April 18, 2007
Lisa Salmi
Acting Executive Director

AMENDATORY SECTION (Amending WSR 03-13-027, filed 6/10/03, effective 7/11/03)

WAC 246-889-050 Suspicious transactions and reporting requirements. ((~~Any~~)) (1) A manufacturer or wholesaler who sells, transfers, or furnishes ((~~any substance specified in RCW 69.43.010(1) or WAC 246-889-020~~)) a regulated product to any ((~~person~~)) licensee shall report any suspicious transaction in writing to the state board of pharmacy.

(2) For the purpose of this rule, a regulated product is defined as a product specified in RCW 69.43.010(1) or WAC 246-889-020.

(3) For the purposes of this rule, a "suspicious transaction" is defined as any sale or transfer that meets any of the following criteria:

((~~(1)~~)) (a) Any sale or transfer that would lead a reasonable person to believe that the substance is likely to be used for the purpose of unlawfully manufacturing a controlled substance under chapter 69.50 RCW, based on such factors as:

((~~(a)~~)) (i) The amount of the substance involved;

((~~(b)~~)) (ii) The method of payment;

((~~(c)~~)) (iii) The method of delivery; or

((~~(d)~~)) (iv) Any past dealings with any participant in the transaction.

((~~(2) The transaction involves~~)) (b) Any sale or transfer involving payment for ((~~any substance specified in RCW 69.43.010(1) or WAC 246-889-020~~)) a regulated product in

cash or money orders in a total amount of more than two hundred dollars.

(((~~(3)~~))) (c) Any sale or transfer of ((~~any substance specified in RCW 69.43.010(1) or WAC 246-889-020~~)) a regulated product that meets the criteria identifying suspicious orders in ((~~Appendix A of~~)) the U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Program Report of the Suspicious Orders Task Force. Copies of the publication are available upon request from the ((~~state~~)) board of pharmacy.

(((~~(4) In addition to the above suspicious transaction criteria, the following requirements shall apply to over-the-counter wholesalers and full-line wholesalers:~~

~~(a) An over-the-counter wholesaler shall also use the following formula to identify a suspicious transaction:~~

~~(i) Any wholesaler whose individual sale or transfer of any product specified in RCW 69.43.010(1) or WAC 246-889-020 exceeds ten percent of the seller's distribution, during the same calendar month, shall be considered a suspicious transaction (e.g., if a wholesaler sells one thousand dollars' worth of pseudoephedrine tablets during a month in which less than ten thousand dollars of other goods are sold to its customers). In this case, the sales to each of the customers must be reported to the board.~~

~~(ii) Any time the value of a sale to a single customer of any product listed in RCW 69.43.010(1) or WAC 246-889-020 exceeds ten percent of the value of the full order shipped to the customer (e.g., if a wholesaler sells an order to a customer which contains one hundred dollars' worth of the pseudoephedrine tablets either alone or along with twenty-five dollars' worth of aspirin tablets).~~

~~(b) A full-line wholesaler shall also use the formula listed in Appendix E-3 of the U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Program Report of the Suspicious Orders Task Force to identify a suspicious transaction.~~)) (d) Any individual sale or transfer of a regulated product that exceeds ten percent of the nonprescription drugs contained in the order. (Example: If a wholesaler sells three thousand dollars worth of products to a shopkeeper and that order contains one thousand dollars worth of nonprescription drugs, the wholesaler must submit a suspicious transaction report if the order contains over one hundred dollars worth of regulated products.)

(e) Any order which contains regulated products and has no additional nonprescription drugs is considered a suspicious transaction.

(4) For the purposes of this rule, nonprescription drugs are defined as those drugs which may be sold at retail without a prescription for the diagnosis, treatment, cure or prevention of any disease that has been approved by the FDA and bears an appropriate label. An over-the-counter (OTC) drug is the same as a nonprescription drug.

The following are examples of products sold at retail which are not defined as OTC drugs:

(a) Cosmetics;

(b) Food, dietary, and vitamin supplements;

(c) Herbs;

(d) Products that carry the statements "this product is not intended to diagnose, treat, cure or prevent any disease" or "not evaluated by FDA."

(5) The written report of a suspicious transaction shall contain, at a minimum, the following information:

(a) Name, address and phone number of the manufacturer and/or wholesaler making the report;

(b) Washington state license number of the wholesaler;

(c) Washington state Unified Business Identifier (UBI) number of the recipient of the suspicious transaction;

(d) Trade/brand name of regulated product;

(e) Generic name of regulated product's active ingredients;

(f) Name ((~~and~~)), address and phone number of the ((~~person or firm receiving~~)) recipient of the suspicious transaction;

(((~~(e)~~))) (g) Quantity of substance purchased, transferred, or furnished, by number of units and doses per unit;

(((~~(d)~~))) (h) Date of purchase((~~,~~)) or transfer((~~, or furnish; and~~));

(((~~(e)~~))) (i) Method of payment of the substance;

(j) Lot number if available; and

(k) National Drug Code Number if available.

WSR 07-10-124
PROPOSED RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket PG-061027—Filed May 2, 2007, 10:00 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-15-124.

Title of Rule and Other Identifying Information: Chapter 480-93 WAC, Gas companies—Safety.

Hearing Location(s): WUTC Hearing Room 206, 2nd Floor, Chandler Plaza Building, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504-7250, on July 11, 2007, at 1:30 p.m.

Date of Intended Adoption: July 11, 2007.

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@wutc.wa.gov, fax (360) 586-1150, by June 1, 2007.

Assistance for Persons with Disabilities: Contact Mary DeYoung by July 9, 2007, TTY (800) 416-5289 or (360) 664-1133.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Since the rules in chapter 480-93 WAC, Gas companies—Safety, became effective June 2, 2005, stakeholders and agency staff have identified a variety of issues that suggest that the commission review certain rules relating to gas pipeline operations in chapter 480-93 WAC. This rule making would consider possible corrections, changes, and clarifications to WAC 480-93-005, 480-93-013, 480-93-015, 480-93-017, 480-93-018, 480-93-100, 480-93-124, 480-93-170, 480-93-180, 480-93-188, and 480-93-200 and add new WAC 480-93-250 Damage prevention, ensuring that pipeline operators comply with damage prevention requirements in chapter 19.122 RCW.

Reasons Supporting Proposal: The proposed changes will provide clarity in some areas of the rules, eliminate requirements that are no longer necessary and provide compliance with federal rules.

Statutory Authority for Adoption: RCW 80.01.040, 81.01.010, and 81.88.060.

Statute Being Implemented: Not applicable.

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: Sondra Walsh, Washington Utilities and Transportation Commission, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1286; Implementation and Enforcement: Carole J. Washburn, Washington Utilities and Transportation Commission, 1300 South Evergreen Park Drive S.W., Olympia, WA 98504, (360) 664-1174.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules will not result in or impose an increase in costs. Because there will not be any increase 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 rule is not a significant legislative rule as referenced in RCW 34.05.328(5).

May 2, 2007
Carole J. Washburn
Executive Secretary

AMENDATORY SECTION (Amending Docket No. PG-050933, General Order No. R-524, filed 11/23/05, effective 12/24/05)

WAC 480-93-005 Definitions. (1) **"Bar hole"** means a hole made in the soil or paving for the specific purpose of testing the subsurface atmosphere with a combustible gas indicator.

(2) **"Building"** means any structure that is normally or occasionally entered by humans for business, residential, or other purposes and where gas could accumulate.

(3) **"Business district"** means an area where the public regularly congregates or where the majority of the buildings on either side of the street are regularly utilized, for financial, commercial, industrial, religious, educational, health, or recreational purposes.

(4) **"CFR"** means the Code of Federal Regulations.

(5) **"Combustible gas indicator" (CGI)** means a device capable of detecting and measuring gas concentrations in air.

(6) **"Commission"** means the Washington utilities and transportation commission.

(7) **"Enclosed space"** means any subsurface structure of sufficient size that could accommodate a person and within which gas could accumulate, e.g., vaults, catch basins, and manholes.

(8) **"Follow-up inspection"** means an inspection performed after a repair has been completed in order to determine the effectiveness of the repair.

(9) **"Gas"** means natural gas, flammable gas, or gas that is toxic or corrosive.

(10) **"Gas associated substructures"** means those devices or facilities utilized by an operator which are not intended for storing, transporting, or distributing gas, such as valve boxes, vaults, test boxes, and vented casing pipe.

(11) **"Gas company"** means, as defined in RCW 80.04.010, every corporation, company, association, joint stock association, partnership and person, their lessees, trustees or receiver appointed by any court whatsoever, and every city or town, owning, controlling, operating or managing any gas plant within this state.

(12) **"High occupancy structure or area"** means a building or an outside area (such as a playground, recreation area, outdoor theater, or other place of public assembly) that is occupied by twenty or more persons on at least five days a week for ten weeks in any twelve-month period. (The days and weeks need not be consecutive.)

(13) **"Indication"** means a response indicated by a gas detection instrument that has not been verified as a reading.

(14) **"LEL"** means the lower explosive limit of the gas being transported.

(15) **"MAOP"** means maximum allowable operating pressure.

(16) **"Master meters system"** is defined as set forth in 49 CFR § 191.3.

(17) **"Operator":**

(a) For purposes of chapter 480-93 WAC, the term "operator" means:

(i) Every gas distribution company that has tariffs on file with the commission;

(ii) Every city or town that owns, controls, operates, or manages any gas plant in this state; and

(iii) Every other person or corporation transporting ((~~natural~~)) gas by pipeline, or having for one or more of its principal purposes the construction, maintenance, or operation of pipelines for transporting ((~~natural~~)) gas in this state; even though such person or corporation does not deliver, sell, or furnish any such gas to any person or corporation within this state. The terms "person" and "corporation" are defined in RCW 80.04.010. "Transporting ((~~natural~~)) gas by pipeline" means transmission or distribution of ((~~natural~~)) gas through a pipe.

(b) A single entity may qualify as an operator under one or more of the provisions of this subsection.

(c) The term "operator" includes operators of master meter systems, as ((~~that term is~~)) defined in ((~~WAC 480-93-005~~)) this section.

(18) **"Prompt action"** means to dispatch qualified personnel without undue delay.

(19) **"Psig"** means pounds per square inch gauge.

(20) **"Public service company"** is defined in RCW 80.04.010.

(21) **"Reading"** means a repeatable representation on a combustible gas indicator or equivalent instrument expressed in percent LEL or gas-air ratio.

(22) **"Record(s)"** means any electronic or paper document, map, data base, report or drawing created by or kept by an operator.

(23) **"Sniff test"** means a qualitative test utilizing both threshold and readily detectable methods for determining proper concentrations of odorant.

(((~~(23)~~))) (24) **"Transmission line"** means a gas pipeline as defined in 49 CFR § 192.3 on the date specified in WAC 480-93-999.

(((~~(24)~~))) (25) **"Weak link"** means a device or method used when pulling polyethylene pipe to ensure that damage will not occur to the pipeline by exceeding the maximum tensile stresses allowed.

(((~~(25)~~))) (26) Other terms that correspond to those used in 49 CFR Parts 191, 192 and 199 (Minimum Federal Safety Standards for Gas Pipelines) must be construed as used therein on the date specified in WAC 480-93-999.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-013 Covered tasks. (1) Background. 49 CFR §§ 192.803 through 192.809 prescribe the requirements associated with qualifications for operator personnel to perform "covered tasks." 49 CFR § 192.801 defines a "covered task." In WAC 480-93-999, the commission adopts 49 CFR §§ 192.801 through 192.809.

(2) In this section, the commission includes "new construction" in the definition of "covered task." Accordingly, for the purpose of this chapter, the commission defines a covered task that will be subject to the requirements of 49 CFR §§ 192.803 through 192.809 as an activity, identified by the operator, that:

(a) Is performed on a pipeline facility;

(b) Is an operations, maintenance, or new construction task;

(c) Is performed as a requirement of Part 192 CFR; and

(d) Affects the operation or integrity of the pipeline.

(3) In all other respects, the requirements of 49 CFR §§ 192.801 through 192.809 apply to this chapter.

(4) The equipment and facilities used for training and qualification must be similar to the equipment and facilities on which the employee will perform the covered task.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-015 Odorization of gas. (1) ((~~All natural~~)) Operators transporting gas ((~~that is transported~~)) by pipeline must ((~~be odorized~~)) odorize the gas at a concentration in air of at least one-fifth of the lower explosive limit, so that the gas is readily detectable by a person with a normal sense of smell.

(2) Operators must use an odorant testing ((~~instrumentation~~)) instrument when conducting sniff tests. Sniff tests must be performed at least once monthly. Master meter operators who comply with 49 CFR § 192.625(f) are exempt from this requirement.

(3) ((~~Instruments used to conduct odorant sniff tests must be maintained, tested for accuracy, calibrated, and operated in accordance with the~~)) Operators must take prompt action to investigate and remediate odorant concentrations that do not meet the minimum requirements of subsection (1) of this section.

(4) Operators must follow the instrument manufacturer's recommendations for maintaining, testing for accuracy, calibrating and operating odorant testing instruments. When ((~~there are no~~)) the manufacturer((~~'s~~)) does not provide a recommendation((~~s~~)), operators must conduct accuracy checks and calibrate instruments if outside specified tolerances, at least once annually.

(((~~(4)~~))) (5) Operators must keep all records of odorant usage, sniff tests performed, and ((~~equipment~~)) odorant testing instrument calibration for five years.

(6) Exception. This rule does not apply to pipelines that transport gas where the odorant would make the gas unfit for its intended purpose.

AMENDATORY SECTION (Amending Docket No. PG-050933, General Order No. R-524, filed 11/23/05, effective 12/24/05)

WAC 480-93-017 Filing requirements for design, specification, and construction procedures. (1) Any operator intending to construct or operate a gas pipeline facility in this state must file ((~~with the commission~~)) all applicable construction procedures, designs, and specifications used for each pipeline facility ((~~prior to operating the pipeline~~)) with the commission at least forty-five days prior to the initiation of construction activity. All procedures must detail the acceptable types of materials, fittings, and components for the different types of facilities in the operator's system.

(2) With the exception of emergency situations, any construction plans that do not conform with a gas company's existing and accepted construction procedures, designs, and specifications on file with the commission, must be submitted to the commission for review at least forty-five days prior to the initiation of construction activity.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-018 ((~~Maps, drawings, and records of gas facilities.~~)) Records. (1) ((~~In addition to any document required to be maintained by this chapter, each operator must also prepare, maintain, and make available to the commission, any record, map or written procedure required by federal law to be kept by an operator concerning the reporting of gas releases, and the design, construction, testing, or operation and maintenance of gas pipelines.~~

~~(2) Nothing in subsection (1) of this section limits the commission's right to inspect any other accounts, books, papers or documents of any public service company, pursuant to RCW 80.04.070.~~)) Operators must maintain records sufficient to demonstrate compliance with all requirements of 49 CFR §§ 191, 192 and chapter 480-93 WAC.

(2) Operators must give the commission access to records for review during an inspection and provide copies of requested records.

(3) Operators must maintain a list of forms and data bases, including examples where applicable, that specify what records the operator maintains. Operators must make this list available to the commission upon request.

(4) Operators must record and maintain records of the actual value of any required reads, tests, surveys or inspections performed. The records must include the name of the person who performed the work and the date the work was performed. The records must also contain information sufficient to determine the location and facilities involved. Examples of the values to be recorded include, but are not limited to, pipe to soil potential reads, rectifier reads, pressure test levels, and combustible gas indicator reads. A range of values may not be recorded unless the measuring device provides only a range of values.

(5) Operators must update records within six months of completion of any construction activity and make them available to appropriate company operations personnel.

(6) If an operator believes a record provided to the commission is confidential as that term is defined in WAC 480-07-160(2), the operator will follow the procedures in WAC 480-07-160 for designating and treating that record as confidential.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-100 Valves. (1) Each operator must have a written valve maintenance program detailing the valve selection process, inspection, maintenance, and operating procedures. The written program must detail which valves will be maintained under 49 CFR § 192.745, 49 CFR § 192.747, and this subsection. The written program must also outline how the operator will monitor and maintain valves during construction projects to ensure accessibility. The following criteria and locations must be ((~~considered when~~)) incorporated in the written program. The written program shall explain how each of the following are considered in selecting which valves require annual inspections and maintenance under 49 CFR § 192.747:

(a) Each pressure regulating station.

(b) Principal feeds into business districts.

(c) Geographical size of the area to be isolated.

(d) Number of potential customers affected.

(e) Pipeline size and operating pressures.

(f) Class locations.

(g) Potential threats including, but not limited to, earthquakes, floods, and landslides.

(h) Emergency response time.

(i) High occupancy structures or areas.

(j) Pipeline material: For example steel, polyethylene, or cast iron.

(2) Each operator must have a written service valve installation and maintenance program detailing the valve selection process, inspection, maintenance, and operating procedures. The written program must detail which new services will be required to have valves installed and maintained under this section. ((~~Preexisting services with valves already installed, and meeting the same inspection criteria established for new valve installation,~~)) Service valve installation requirements do not apply to existing services (they are not retroactive). Existing service valves that historically have not been maintained but are deemed necessary for maintenance by the written valve maintenance program must be maintained in accordance with subsection (3) of this section (service valve maintenance requirements are retroactive). ((~~The following criteria and/or locations must be considered when~~)) The written program shall explain how each of the following criteria and/or locations are considered in selecting which services will have valves installed and/or maintained under this section((~~.~~)):

(a) Services to churches, schools, hospitals.

(b) Service line length and size.

(c) Service line pressure.

(d) Services to buildings occupied by persons who are confined, are of impaired mobility, or would be difficult to evacuate.

(e) Services to commercial or industrial buildings or structures.

(f) Services to high occupancy structures or areas.

(3) All service valves selected for inspection in the program required in subsection (2) of this section must be operated and maintained at least once annually, but not to exceed fifteen months between operation and maintenance.

(4) Each operator must select which valves to inspect based on the unique operating conditions of the operator's pipeline system. The operator must install and maintain valves for the purpose of minimizing the hazards resulting from a gas pipeline emergency. When an operator determines the minimum number and spacing of valves, the operator's primary objective shall be the protection of life and property by reducing the amount of time that a pipeline has an uncontrolled release of gas. The operator must consider this objective in conjunction with the criteria listed in subsections (1) and (2) of this section. Operators must also incorporate their valve programs established in subsections (1) and (2) of this section into their emergency plan and other plans and procedures designed to protect life and property in the event of an emergency.

(5) Operators must fully implement the requirements of subsections (2) and (3) of this section within one year of the adoption date of this rule.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-124 Pipeline markers. (1) ((~~Operators must place pipeline markers at all railroad, road, irrigation, and drainage ditch crossings, and at all fence lines where a pipeline crosses private property, or where a pipeline or pipeline facility is exposed.~~

~~(2)(a) For buried pipelines, operators must place pipeline markers approximately five hundred yards apart, if practical, and at points of horizontal deflection of the pipeline.~~

~~(b) The following pipelines must have pipeline markers installed, not withstanding any exceptions in 49 CFR § 192.707(b):~~

~~(i)~~)) Pipeline markers must be placed at the following locations:

(a) Where practical, on ((~~all mains~~)) pipelines operating above two hundred fifty psig;

(((~~ii~~))) (b) On both sides of crossings of navigable waterways (custom signage may be required to ensure visibility);

(((~~iii~~))) (c) On both sides of river, creek, drainage ditch, or irrigation canal crossings where hydraulic scouring, dredging, or other activity could pose a risk to the pipeline (custom signage may be required to ensure visibility); ((~~and~~

~~(iv)~~)) (d) On both sides of railroad crossings;

(e) On above ground pipelines and pipeline facilities. Service risers and meter set assemblies, and operator owned piping downstream of the meter set assembly are exempt from this requirement;

(f) Over mains located in Class 1 and 2 locations;

(g) Over transmission lines in Class 1 and 2 locations, and where feasible, over transmission lines in Class 3 and 4 locations;

(h) At fence lines over mains crossing private property; and

(i) On both sides of interstate, U.S. and state route crossings.

(2) Where markers are required on buried pipelines, operators must, if practical, place them approximately five hundred yards apart and at points of horizontal deflection of the pipeline.

(3) Where gas pipelines are attached to bridges or otherwise span an area, operators must place pipeline markers at both ends of the suspended pipeline. ((~~Each~~)) Operators must conduct inspections at least annually, but not to exceed fifteen months between inspections, ((~~and maintain the markers~~)) to ensure that ((~~they~~)) markers are visible and legible.

(4) Operators must replace markers that are reported damaged or missing within forty-five days.

(5) Surveys of pipeline markers not associated with subsection (3) of this section must be conducted ((~~as frequently as necessary~~)) at least every five calendar years but not to exceed sixty-three months, to maintain the markers to ensure that they are visible and legible((~~, but at intervals not to exceed five years. The survey records must be kept for a minimum of ten years~~)).

(a) The operator must keep on file the last two surveys, or all surveys for the past five years, whichever number of surveys is greater.

(b) Survey records must include a description of the system and area surveyed.

(6) Operators must have maps, drawings or other sufficient records indicating class locations and other areas where pipeline markers are required.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-170 Tests and reports for pipelines. (1) Operators must notify the commission in writing at least ((~~two~~)) three business days prior to the commencement of any pressure test of a gas pipeline that will have a MAOP that produces a hoop stress of twenty percent or more of the specified minimum yield strength of the pipe used. Pressure test procedures must be on file with the commission or submitted at the time of notification.

(a) The pressure tests of any such gas pipeline built in Class 3 or Class 4 locations, as defined in 49 CFR § 192.5, or within one hundred yards of a building, must be at least eight hours in duration.

(b) When the test medium is to be a gas or compressible fluid, each operator must notify the appropriate public officials so that adequate public protection can be provided for during the test.

(c) In an emergency situation where it is necessary to maintain continuity of service, the requirements of subsection (1) of this section and subsection (1)(a) of this section may be waived by notifying the commission by telephone prior to performing the test.

(2) The minimum test pressure for any steel service line or main, regardless of the intended operating pressure, must be determined by multiplying the intended MAOP by a factor determined in accordance with the table located in 49 CFR § 192.619 (a)(2)(ii).

(3) Operators must perform pressure tests for all new or replacement pipeline installations.

(4) All service lines that are broken, pulled, or damaged, resulting in the interruption of gas supply to the customer, must be pressure tested from the point of damage to the service termination valve (generally the meter set) prior to being placed back into service.

(5) Operators may only use pretested pipe when it is not feasible to conduct a pressure test.

(6) Operators must perform soap tests at the tie-in joints at not less than the current operating pressure of the pipeline.

(7) Operators must keep records of all pressure tests performed for the life of the pipeline and must document the following information:

(a) Operator's name;

(b) Employee's name;

(c) Test medium used;

(d) Test pressure;

(e) Test duration;

(f) Pipe size and length;

(g) Dates and times; and

(h) Test results.

(8) Where feasible, operators must install and backfill plastic pipe prior to pressure testing to expose any potential damage that could have occurred during the installation and backfill process.

(9) Where multiple pressure tests are performed on a single installation, operators must maintain a record of each test. An example of a single installation with multiple tests would be any continuous on-going job or installation such as a new plat or long main installation where more than one pressure test was conducted during construction.

(10) Pressure testing equipment must be maintained, tested for accuracy, or calibrated, in accordance with the manufacturer's recommendations. When there are no manufacturer's recommendations, then pressure testing equipment

must be tested for accuracy at an appropriate schedule determined by the operator. Test equipment must be tagged with the calibration or accuracy check expiration date. The requirements of this section also apply to equipment such as pressure charts, gauges, dead weights or other devices used to test, monitor or check system pressures or set-points.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-180 ((~~Plan of operations and maintenance procedures; emergency policy; reporting requirements.~~)) Plans and procedures. (1) Each operator must have and follow a gas pipeline plan and procedure manual (manual) for operation, maintenance, inspection, and emergency response activities that is specific to the operator's system. ((~~The manual must comply with the provisions of the "Pipeline Safety Improvement Act of 2002."~~)) The manual must include plans and procedures for meeting all applicable requirements of 49 CFR §§ 191, 192 and chapter 480-93 WAC, and any plans or procedures used by an operator's associated contractors.

(2) ((~~Plans~~)) The manual must be filed with the commission ((~~as soon as practical for review and determination as to their adequacy, when properly executed, to achieve an acceptable level of safety~~)) forty-five days prior to the operation of any gas pipeline. Operators must file revisions to the manual with the commission annually. The commission may, after notice and opportunity for hearing, require that a manual be revised or amended. Applicable portions of the manual related to a procedure being performed on the pipeline must be retained on-site where the activity is being performed.

(3) The manual must be written in detail sufficient for a person with adequate training to perform the tasks described. For example, a manual should contain specific, detailed, step-by-step instructions on how to maintain a regulator or rectifier, conduct a leak survey or conduct a pressure test.

AMENDATORY SECTION (Amending Docket No. UG-011073, General Order No. R-520, filed 5/2/05, effective 6/2/05)

WAC 480-93-188 Gas leak surveys. (1) Operators must perform gas leak surveys using a gas detection instrument covering the following areas:

(a) Over all mains, services, and transmission lines including the testing of the atmosphere near other utility (gas, electric, telephone, sewer, or water) boxes or manholes, and other underground structures;

(b) Through cracks in paving and sidewalks;

(c) On all above ground piping (may be checked with either a gas detection instrument or with a soap solution);

(d) Where a gas service line exists, a survey must be conducted at the building wall at the point of entrance, using a bar hole if necessary; and

(e) Within all buildings where gas leakage has been detected at the outside wall, at locations where escaping gas could potentially migrate into and accumulate inside the building.

(2) Gas detection instruments must be maintained, tested for accuracy, calibrated, and operated in accordance with the manufacturer's recommendations. If there are no written manufacturer's recommendations or schedules, then instruments must be tested for accuracy at least monthly, but not to exceed forty-five days between testing, and include testing at least twelve times per year. Any instrument that fails its applicable tolerances must be calibrated or removed from service. Records of accuracy checks, calibration and other maintenance performed must be maintained for five years.

(3) Gas leak surveys must be conducted according to the following minimum frequencies:

(a) Business districts - at least once annually, but not to exceed fifteen months between surveys. All mains in the right of way adjoining a business district must be included in the survey;

(b) High occupancy structures or areas - at least once annually, but not to exceed fifteen months between surveys;

(c) ((~~Mains~~)) Pipelines operating at or above two hundred fifty psig - at least once annually, but not to exceed fifteen months between surveys; ((~~and~~))

(d) Where the gas system has cast iron, wrought iron, copper, or noncathodically protected steel - at least twice annually, but not to exceed seven and one-half months between surveys; and

(e) Unodorized pipelines - at least monthly.

(4) Special leak surveys must be conducted under the following circumstances:

(a) Prior to paving or resurfacing, following street alterations or repairs where gas facilities are under the area to be paved, and where damage could have occurred to gas facilities;

(b) In areas where substructure construction occurs adjacent to underground gas facilities, and damage could have occurred to the gas facilities, operators must perform a gas leak survey following the completion of construction, but prior to paving;

(c) Unstable soil areas where active gas lines could be affected;

(d) In areas and at times of unusual activity, such as earthquake, floods, and explosions; and

(e) After third-party excavation damage to services, operators must perform a gas leak survey from the point of damage to the service tie-in.

(5) Survey records must be kept for a minimum of five years. At a minimum, survey records must contain the following information:

(a) Description of the system and area surveyed (including maps and leak survey logs);

(b) Survey results;

(c) Survey method;

(d) Name of the employee who performed the survey;

(e) Survey dates; and

(f) Instrument tracking or identification number.

(6) Each operator must perform self audits of the effectiveness of its leak detection and recordkeeping programs. Operators must maintain records of the self audits for five years. Self audits must be performed as frequently as necessary, but not to exceed three years between audits. At a minimum, self audits should ensure that:

(a) Leak survey schedules meet the minimum federal and state safety requirements for gas pipelines;

(b) Consistent evaluations of leaks are being made throughout the system;

(c) Repairs are made within the time frame allowed;

(d) Repairs are effective; and

(e) Records are accurate and complete.

(((~~(7) Operators must fully implement subsection (3)(a) of this section within two years of the adoption of this rule.~~)))

AMENDATORY SECTION (Amending Docket No. PG-050933, General Order No. R-524, filed 11/23/05, effective 12/24/05)

WAC 480-93-200 Reporting requirements for operators of gas facilities. (1) Every operator must give notice to the commission by telephone within two hours of discovering an incident or hazardous condition arising out of its operations that:

(a) Results in a fatality or personal injury requiring hospitalization;

(b) Results in damage to the property of the operator and others of a combined total exceeding fifty thousand dollars;

(c) Results in the evacuation of a building, or a high occupancy structure((~~s~~)) or area((~~s~~));

(d) Results in the unintentional ignition of gas;

(e) Results in the unscheduled interruption of service furnished by any operator to twenty-five or more distribution customers;

(f) Results in a pipeline or system pressure exceeding the MAOP plus ten percent or the maximum pressure allowed by proximity considerations outlined in WAC 480-93-020;

(g) ((~~Is significant, in the judgment of the operator, even though it does not meet the criteria of (a) through (e) of this subsection; or~~)) Results in the news media reporting the occurrence; or

(h) ((~~Results in the news media reporting the occurrence~~)) Is significant, in the judgment of the operator, even though it does not meet the criteria of (a) through (((~~e~~))) (g) of this subsection.

(2) Operators must give notice to the commission by telephone within twenty-four hours of occurrence of every incident or hazardous condition arising out of its operations that results in:

(a) The uncontrolled release of gas for more than two hours;

(b) The taking of a high pressure supply or transmission pipeline or a major distribution supply pipeline out of service;

(c) A pipeline or system operating at low pressure dropping below the safe operating conditions of attached appliances and gas equipment; or

(d) A pipeline or system pressure exceeding the MAOP.

(3) Routine or planned maintenance and operational activities of the operator that result in operator-controlled plant and equipment shut downs, reduction in system pressures, flaring or venting of gas, and normal leak repairs are not reportable items under this section.

(4) Operators must provide to the commission a written report within thirty days of the initial telephonic report required under subsections (1) and (2) of this section. At a minimum, written reports must include the following:

(a) Name(s) and address(es) of any person or persons injured or killed, or whose property was damaged;

(b) The extent of such injuries and damage;

(c) A description of the incident or hazardous condition including the date, time, and place, and reason why the incident occurred. If more than one reportable condition arises from a single incident, each must be included in the report;

(d) A description of the gas facilities involved in the incident or hazardous condition, the system operating pressure at that time, and the MAOP of the facilities involved;

(e) The date and time the operator was first notified of the incident;

(f) The date and time the operators' first responders arrived on-site;

(g) The date and time the gas facility was made safe;

(((~~f~~))) (h) The date, time, and type of any temporary or permanent repair made; ((~~and~~

(~~g~~))) (i) The cost of the incident to the operator;

(j) Line type;

(k) City and county of incident; and

(l) Any other information deemed necessary by the commission.

(5) Operators must submit a supplemental report if required information becomes available after the thirty-day report is submitted.

(6) Operators must provide to the commission a ((~~written report within forty-five days of receiving the~~)) copy of each failure analysis ((~~of~~)) report completed or received by the operator, concerning any incident or hazardous condition ((~~that was~~)) due to construction defects or material failure within five days of completion or receipt of such report.

(((~~6~~))) (7) Operators must file with the commission the following annual reports no later than March 15 for the preceding calendar year:

(a) A copy of every Pipeline and Hazardous Materials Safety Administration (PHMSA) F-7100.1-1 and F-7100.2-1 annual report required by U.S. Department of Transportation, Office of Pipeline Safety.

(b) A report titled, "Damage Prevention Statistics." The Damage Prevention Statistics report must include in detail the following information:

(i) Number of gas-related one-call locate requests completed in the field;

(ii) Number of third-party damages incurred; and

(iii) Cause of damage, where cause of damage is classified as ((~~either~~)) one of the following:

(A) Inaccurate locate;

(B) Failure to use reasonable care; ((~~or~~))

(C) Excavated prior to a locate being conducted; or

(D) Excavator failed to call for a locate.

(c) A report detailing all construction defects and material failures resulting in leakage. Operators must categorize the different types of construction defects and material failures anticipated for their system. The report must include the following:

(i) Types and numbers of construction defects; and

(ii) Types and numbers of material failures.

(((~~(7)~~))) (8) Operators must file with the commission, and with appropriate officials of all municipalities where operators have facilities, the names, addresses, and telephone numbers of the responsible officials of the operator who may be contacted in the event of an emergency. In the event of any changes in operator personnel, the operator must notify immediately the commission and municipalities.

(((~~(8)~~))) (9) Operators must send to the commission, by e-mail, daily reports of construction and repair activities ((~~electronically to the commission. Operators may send reports either by facsimile or e-mail to the commission~~)). Reports may be faxed only if the operator does not have e-mail capability. ((~~The~~)) Reports must be received no later than 10:00 a.m. each day of the scheduled work, and must include both operator and contractor construction and repair activities. Report information must be broken down by individual crews and the scheduled work must be listed by address, as much as practical. To the extent possible the reports will only contain construction and repair activity scheduled for that day, but they may include a reasonable allowance for scheduling conflicts or disruptions.

(((~~(9)~~))) (10) When an operator is required to file a copy of a DOT Drug and Alcohol Testing Management Information System (MIS) Data Collection Form with the U.S. Department of Transportation, Office of Pipeline Safety, the operator must simultaneously submit a copy of the form to the commission.

NEW SECTION

WAC 480-93-250 Damage prevention. Each operator must comply with chapter 19.122 RCW, including:

(1) Subscribe to the appropriate one-number locator service;

(2) Provide, upon receipt of locate notice, reasonably accurate information as to its locatable underground facilities by surface-marking the location of the facilities;

(3) Respond with locate markings within two business days after receipt of the notice or within a time mutually agreed upon between the operator and the excavator requesting the utility locate information.

WSR 07-10-128
PROPOSED RULES
DEPARTMENT OF TRANSPORTATION

[Filed May 2, 2007, 10:29 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-24-119.

Title of Rule and Other Identifying Information: Setting toll amounts for toll facilities in Washington state.

Hearing Location(s): Gig Harbor Civic Center, 3510 Grandview Street, Gig Harbor, WA 98335, on June 5, 2007, at 1 p.m.

Date of Intended Adoption: June 5, 2007.

Submit Written Comments to: Reema Griffith, P.O. Box 47308, Olympia, WA 98504, e-mail griffir@wstc.wa.gov, fax (360) 705-6802, by June 5, 2007.

Assistance for Persons with Disabilities: Contact Reema Griffith by June 5, 2007, TTY (800) 833-6388 ask to be connected to (360) 705-7070.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Pursuant to RCW 47.56.030, 47.46.100 (Tacoma Narrows Bridge); and RCW 47.56.403 (SR 167 HOT lanes) this rule defines terms for toll facilities and establishes toll rates for the Tacoma Narrows Bridge. In addition, vehicles exempted from paying tolls are defined.

Reasons Supporting Proposal: The commission is required to establish toll rates for vehicles using the Tacoma Narrows Bridge that are adequate to cover the debt, operations and maintenance.

Statutory Authority for Adoption: RCW 47.56.030, 47.46.100.

Statute Being Implemented: RCW 47.56.030, 47.46.-100.

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

Name of Proponent: Washington state transportation commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Reema Griffith, P.O. Box 47308, Olympia, WA 98504, (360) 705-7070.

No small business economic impact statement has been prepared under chapter 19.85 RCW. The proposed rules do not apply to "businesses in an industry," as described in RCW 19.85.030 (1)(a) but rather the rules apply to ALL vehicles using the Tacoma Narrows Bridge, commercial or noncommercial vehicles alike.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state transportation commission is not a listed agency under RCW 34.05.328 (5)(a)(i).

May 2, 2007
Paul Parker
for Reema Griffith
Executive Director

Chapter 468-270 WAC

SETTING TOLL AMOUNTS FOR TOLL FACILITIES IN WASHINGTON STATE

NEW SECTION

WAC 468-270-010 Who sets the toll rates and exemptions? The Washington state transportation commission determines and establishes toll rates for toll facilities in Washington pursuant to RCW 47.56.030; 47.46.100 (Tacoma Narrows Bridge); and RCW 47.56.403 (SR 167 HOT lanes).

NEW SECTION

WAC 468-270-020 Who collects the tolls and how are they collected? The department is ultimately responsible for collecting tolls. However, the department may contract with one or more independent toll collection companies to manage the day-to-day toll collection activities at its various toll facil-

ities. All toll related revenues collected by any independent toll collection company through WSDOT are payable to the state of Washington.

NEW SECTION

WAC 468-270-030 Definitions. "Authorized emergency vehicle" includes but is not limited to a vehicle of any fire department, police department, sheriff's office, coroner, prosecuting attorney, Washington state patrol, ambulance service, public or private or any other emergency vehicle as defined in RCW 46.04.040.

"Bona fide emergency" occurs when an authorized emergency vehicle, as defined herein, responds to or returns from an emergency call.

"Cash customer" means a toll customer who is heading eastbound and is paying the toll in cash on a trip-by-trip basis.

"Cash lane" means a lane in use by a cash customer.

"Citizens advisory committee" means the citizens committee established by RCW 47.46.090 that advises the transportation commission on Tacoma Narrows Bridge toll rates.

"Department" means the Washington state department of transportation (WSDOT).

"Electronic toll collection (ETC) lane" means a lane in which the electronic toll collection system will read the transponder of each vehicle and automatically collect the toll without requiring the vehicle to slow its speed or stop.

"Good To Go!™" is the name of the department's electronic toll collection system.

""Good To Go!™" customer" means a toll customer who participates in the department's "Good To Go!™" toll collection system.

"High-occupancy toll (HOT) lanes" means one or more lanes of a highway that charges tolls as a means of regulating access to or the use of the lanes in order to maintain travel speed and reliability. HOT lane supporting facilities include, but are not limited to, approaches, enforcement areas, improvements, buildings, and equipment.

"Transponder" means a radio frequency identification (RFID) unit attached to a toll customer's vehicle that transmits a radio signal to a reader mounted in the toll facility. The purpose of the transponder is to automatically identify the toll customer's vehicle as it passes through the toll facility. You will receive a transponder when you open a "Good to Go!™" account.

"Transportation commission" means the Washington state transportation commission whose duties and composition are set out in chapter 47.01 RCW.

NEW SECTION

WAC 468-270-040 How are the tolls determined? In determining toll amounts, the transportation commission considers data and information provided by the department of transportation, public opinion and advice from any required citizen advisory committee. For the Tacoma Narrows Bridge only, in accordance with chapter 47.46 RCW, the commission must consider the toll rate advice of the citizen advisory committee and must set toll amounts that cover the debt and operations and maintenance until the indebtedness is repaid as required by law.

NEW SECTION

WAC 468-270-050 What toll facilities are currently subject to this chapter? Currently, the Tacoma Narrows Bridge and SR 167 HOT lanes are covered by this chapter.

NEW SECTION

WAC 468-270-060 How often will the toll rates for each toll facility be reviewed for potential change? The toll rates will be reviewed and subject to change at least annually and more often as necessary to ensure the toll revenue of each facility is meeting the payment requirements and/or traffic efficiency requirements for that facility.

NEW SECTION

WAC 468-270-070 What will the toll rates be?

Rate table $3.00 cash/$1.75
"Good to Go!™" (two axle vehicles)

Tacoma Narrows Bridge			
	Cash toll rate	"Good To Go!™" toll rates	
2 axle	$3.00	$1.75	
3 axle	$4.50	$2.65	(3)
4 axle	$6.00	$3.50	
5 axle	$7.50	$4.40	(3)
6 or more axles	$9.00	$5.25	

SR 167 HOT lanes	
To be determined	

Notes: (1) The base toll rate is the toll rate per axle. It is only used to calculate multi-axle rates, which are calculated as a multiplier of the base toll rate ($1.50 for cash and $0.875 for "Good to Go!™" toll rates).
(2) The "Good To Go!™" toll rates are in effect through June 30, 2008, or until changed by the commission. If no further action is taken by the commission, on July 1, 2008, the cash toll rate column becomes the toll rate for all vehicles.
(3) Rate rounded up to nearest five cents.

NEW SECTION

WAC 468-270-080 When are these toll rates in effect? The toll rates for each facility will take effect upon commencement of the tolling program on each new toll facility. Check the WSDOT web site at wsdot.wa.gov/goodtogo for updated information on the opening dates for the tolling programs.

(1) For the Tacoma Narrows Bridge toll rates will remain in effect until changed by the commission or removed due to final repayment of the project as provided by law.

(2) For the SR 167 HOT lanes, the tolls will remain in effect until changed by the commission.

NEW SECTION

WAC 468-270-090 What vehicles are exempt from paying tolls on the Tacoma Narrows Bridge? Except as provided herein, all vehicles crossing the Tacoma Narrows Bridge in an eastbound direction must pay the required toll. All vehicles that use the ETC lanes on the Tacoma Narrows Bridge must be equipped with a transponder. Emergency vehicles not equipped with transponders must pay cash.

(1) Only the following vehicles providing service directly to the Tacoma Narrows Bridge are exempt from paying tolls, but must be equipped with transponders:

(a) Washington state department of transportation (WSDOT) maintenance vehicles directly involved in bridge and roadway maintenance on the Tacoma Narrows Bridge;

(b) Washington state patrol vehicles directly providing service to the SR 16 corridor in the vicinity of the Tacoma Narrows Bridge;

(c) Vehicles under the Tacoma Narrows Bridge design build contract that must cross the bridge as part of their construction duties to complete the requirements of the design build contract. This exemption status will expire on July 1, 2008, or upon completion of their construction duties, whichever comes first.

(2) Authorized emergency vehicles on bona fide emergencies as defined herein may apply for credit for their emergency trips and for the return trip from an emergency call.

(a) To be eligible for a credit, an authorized emergency vehicle must be equipped with a transponder and have an authorized prepaid account.

(b) Emergency vehicles that use the ETC lanes on a bona fide emergency may apply for a credit for each emergency trip. The credit must be applied for within six months of the trip date. The department will establish and oversee the procedure for emergency vehicle toll credits.

NEW SECTION

WAC 468-270-100 What vehicles are exempt from paying tolls on the SR 167 HOT lanes? RCW 47.56.403 establishes an exempt category of vehicles. The transportation commission may include other exempt vehicles before tolling commences.

WSR 07-10-130
PROPOSED RULES
DEPARTMENT OF REVENUE

[Filed May 2, 2007, 11:16 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 07-06-078.

Title of Rule and Other Identifying Information: WAC 458-40-660 Timber excise tax—Stumpage value tables and 458-40-640 Timber excise tax—Stumpage value area (map).

Hearing Location(s): Fourth Floor L&P Large Conference Room, Capitol Plaza Building, 1025 Union Avenue S.E., Olympia, WA 98504, on June 13, 2007, at 10:00 a.m.

Date of Intended Adoption: June 26, 2007.

Submit Written Comments to: Mark Bohe, P.O. Box 47453, Olympia, WA 98504-7453, e-mail markbohe@dor.wa.gov, fax (360) 586-5543, by June 13, 2007.

Assistance for Persons with Disabilities: Contact Sandy Davis at (360) 725-7499 no later than ten days before the hearing date. Deaf and hard of hearing individuals may call 1-800-451-7985 (TTY users).

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: RCW 84.33.091 requires the department of revenue 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 department is proposing an amendment to WAC 458-40-660 to provide valuations for the second half of 2007. The stumpage value area (map) (WAC 458-40-640) establishes the stumpage value area and hauling distance zone map, which is part of this rule, that must be used to determine the proper stumpage value table and haul zone in calculating the taxable stumpage value of timber harvested from private land. The department proposes amending WAC 458-40-640 to revise the SVA 6 haul zones in this map due to mill closures in Yakima.

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

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 E. Bohe, 1025 Union Avenue S.E., Suite #544, Olympia, WA, (360) 570-6133; Implementation and Enforcement: Stuart Thronson, 1025 Union Avenue S.E., Suite #300, Olympia, WA, (360) 570-3230.

No small business economic impact statement has been prepared under chapter 19.85 RCW. A small business economic impact statement is not required when a legislative rule is being adopted under RCW 34.05.328.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Mark Bohe, P.O. Box 47453, Olympia, WA 98504-7453, e-mail markbohe@dor.wa.gov, fax (360) 586-5543. The proposed rules are significant legislative rules as defined by RCW 34.05.328.

May 2, 2007
Alan R. Lynn
Rules Coordinator

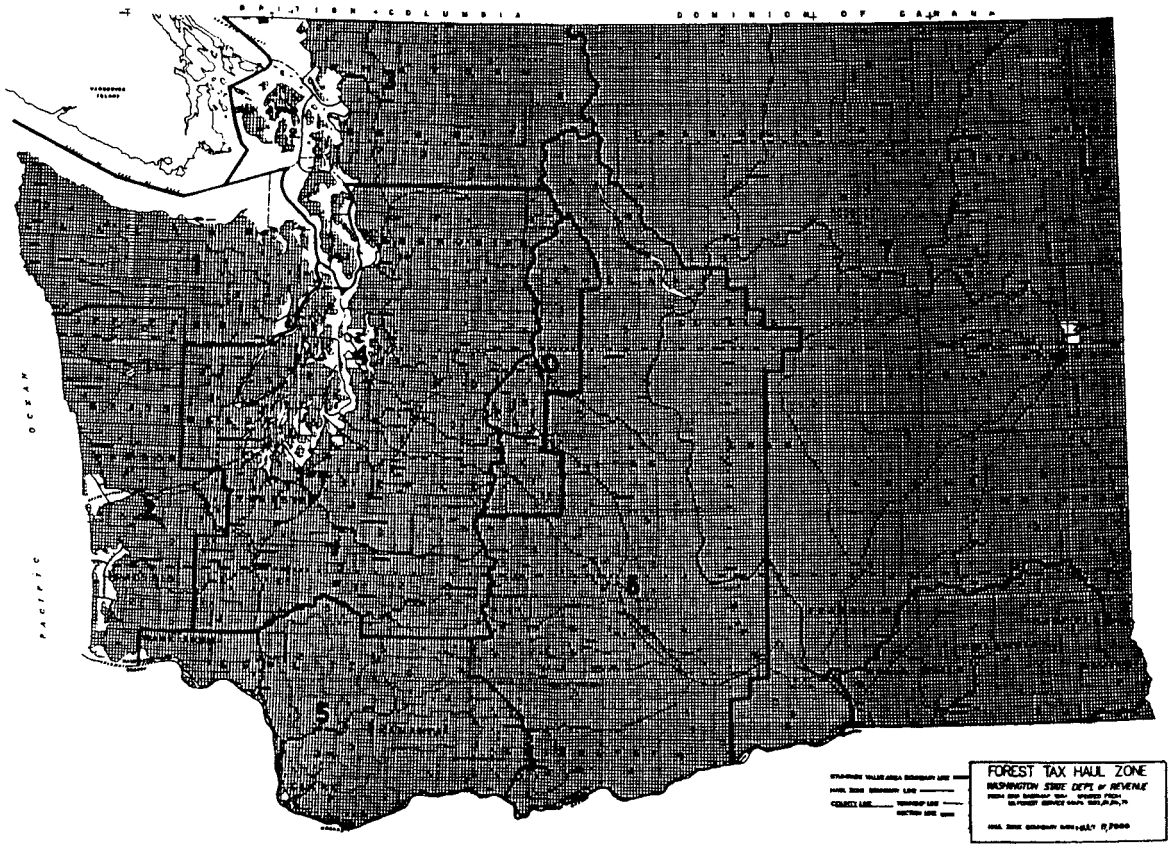
AMENDATORY SECTION (Amending WSR 04-14-032, filed 6/29/04, effective 7/30/04)

WAC 458-40-640 Timber excise tax—Stumpage value area (map). The stumpage value area and hauling distance zone map contained in this rule must be used to determine the proper stumpage value table and haul zone to be used in calculating the taxable stumpage value of timber harvested from private land.

WAC 458-40-640 Stumpage value area and hauling zone—Map

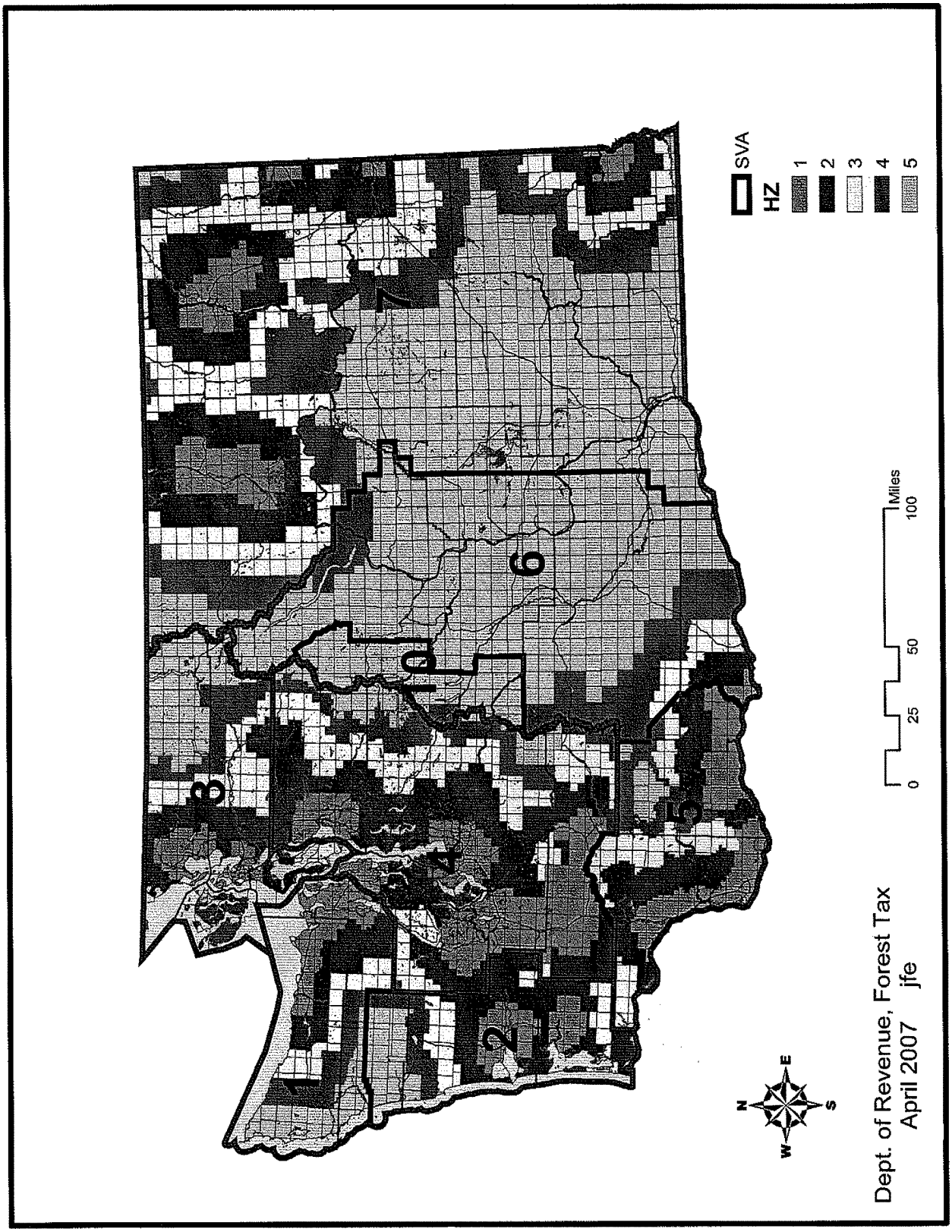
Harvesters may obtain a larger scale map by writing to the Washington State Department of Revenue, Special Programs Division, Forest Tax Section, Post Office Box 47472, Olympia, Washington 98504-7472; or by calling 1-800-548-8829.

((~~STRICKEN GRAPHIC~~



~~STRICKEN GRAPHIC~~))

Forest Tax SVA and Haul Zone Map



AMENDATORY SECTION (Amending WSR 07-02-039, filed 12/26/06, effective 1/1/07)

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 ((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2007:

((~~**TABLE 1 Proposed Stumpage Value Table**~~
~~**Stumpage Value Area 1**~~
~~January 1 through June 30, 2007~~

~~Stumpage Values per Thousand Board Feet Net Scribner Log Scale(1)~~

~~Species Name~~	~~Species Code~~	~~Timber Quality Code Number~~	~~Hauling Distance Zone Number~~				
			~~1~~	~~2~~	~~3~~	~~4~~	~~5~~
~~Douglas-Fir~~	~~DF~~	~~1~~	~~$612~~	~~$605~~	~~$598~~	~~$591~~	~~$584~~
		~~2~~	~~510~~	~~503~~	~~496~~	~~489~~	~~482~~
		~~3~~	~~473~~	~~466~~	~~459~~	~~452~~	~~445~~
		~~4~~	~~468~~	~~461~~	~~454~~	~~447~~	~~440~~
~~Western Redcedar(2)~~	~~RC~~	~~1~~	~~631~~	~~624~~	~~617~~	~~610~~	~~603~~
~~Western Hemlock(3)~~	~~WH~~	~~1~~	~~339~~	~~332~~	~~325~~	~~318~~	~~311~~
		~~2~~	~~330~~	~~323~~	~~316~~	~~309~~	~~302~~
		~~3~~	~~317~~	~~310~~	~~303~~	~~296~~	~~289~~
		~~4~~	~~315~~	~~308~~	~~301~~	~~294~~	~~287~~
~~Red Alder~~	~~RA~~	~~1~~	~~356~~	~~349~~	~~342~~	~~335~~	~~328~~
		~~2~~	~~211~~	~~204~~	~~197~~	~~190~~	~~183~~
~~Black Cottonwood~~	~~BC~~	~~1~~	~~69~~	~~62~~	~~55~~	~~48~~	~~41~~
~~Other Hardwood~~	~~OH~~	~~1~~	~~177~~	~~170~~	~~163~~	~~156~~	~~149~~
~~Douglas-Fir Poles & Piles~~	~~DFL~~	~~1~~	~~786~~	~~779~~	~~772~~	~~765~~	~~758~~
~~Western Redcedar Poles~~	~~RCL~~	~~1~~	~~1383~~	~~1376~~	~~1369~~	~~1362~~	~~1355~~
~~Chipwood(4)~~	~~CHW~~	~~1~~	~~1~~	~~1~~	~~1~~	~~1~~	~~1~~
~~RC Shake & Shingle Blocks(5)~~	~~RCS~~	~~1~~	~~164~~	~~157~~	~~150~~	~~143~~	~~136~~
~~RC & Other Posts(6)~~	~~RCP~~	~~1~~	~~0.45~~	~~0.45~~	~~0.45~~	~~0.45~~	~~0.45~~
~~DF Christmas Trees(7)~~	~~DFX~~	~~1~~	~~0.25~~	~~0.25~~	~~0.25~~	~~0.25~~	~~0.25~~
~~Other Christmas Trees(7)~~	~~TFX~~	~~1~~	~~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 Alaska-Cedar.~~

~~(3) Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."~~

~~(4) Stumpage value per ton.~~

~~(5) Stumpage value per cord.~~

~~(6) Stumpage value per 8 lineal feet or portion thereof.~~

~~(7) Stumpage value per lineal foot.~~

~~**TABLE 2 Proposed Stumpage Value Table**~~
~~**Stumpage Value Area 2**~~
~~January 1 through June 30, 2007~~

~~Stumpage Values per Thousand Board Feet Net Scribner Log Scale(1)~~

~~Species Name~~	~~Species Code~~	~~Timber Quality Code Number~~	~~Hauling Distance Zone Number~~				
			~~1~~	~~2~~	~~3~~	~~4~~	~~5~~
~~Douglas-Fir~~	~~DF~~	~~1~~	~~$612~~	~~$605~~	~~$598~~	~~$591~~	~~$584~~
		~~2~~	~~522~~	~~515~~	~~508~~	~~501~~	~~494~~
		~~3~~	~~502~~	~~495~~	~~488~~	~~481~~	~~474~~
		~~4~~	~~502~~	~~495~~	~~488~~	~~481~~	~~474~~
~~Western Redcedar(2)~~	~~RC~~	~~1~~	~~631~~	~~624~~	~~617~~	~~610~~	~~603~~
~~Western Hemlock(3)~~	~~WH~~	~~1~~	~~351~~	~~344~~	~~337~~	~~330~~	~~323~~
		~~2~~	~~351~~	~~344~~	~~337~~	~~330~~	~~323~~
		~~3~~	~~351~~	~~344~~	~~337~~	~~330~~	~~323~~
		~~4~~	~~335~~	~~328~~	~~321~~	~~314~~	~~307~~
~~Red Alder~~	~~RA~~	~~1~~	~~356~~	~~349~~	~~342~~	~~335~~	~~328~~
		~~2~~	~~211~~	~~204~~	~~197~~	~~190~~	~~183~~
~~Black Cottonwood~~	~~BC~~	~~1~~	~~69~~	~~62~~	~~55~~	~~48~~	~~41~~
~~Other Hardwood~~	~~OH~~	~~1~~	~~177~~	~~170~~	~~163~~	~~156~~	~~149~~
~~Douglas-Fir Poles & Piles~~	~~DFL~~	~~1~~	~~786~~	~~779~~	~~772~~	~~765~~	~~758~~
~~Western Redcedar Poles~~	~~RCL~~	~~1~~	~~1383~~	~~1376~~	~~1369~~	~~1362~~	~~1355~~
~~Chipwood(4)~~	~~CHW~~	~~1~~	~~1~~	~~1~~	~~1~~	~~1~~	~~1~~
~~RC Shake & Shingle Blocks(5)~~	~~RCS~~	~~1~~	~~164~~	~~157~~	~~150~~	~~143~~	~~136~~
~~RC & Other Posts(6)~~	~~RCP~~	~~1~~	~~0.45~~	~~0.45~~	~~0.45~~	~~0.45~~	~~0.45~~
~~DF Christmas Trees(7)~~	~~DFX~~	~~1~~	~~0.25~~	~~0.25~~	~~0.25~~	~~0.25~~	~~0.25~~
~~Other Christmas Trees(7)~~	~~TFX~~	~~1~~	~~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 Alaska-Cedar.~~

~~(3) Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."~~

~~(4) Stumpage value per ton.~~

~~(5) Stumpage value per cord.~~

~~(6) Stumpage value per 8 lineal feet or portion thereof.~~

~~(7) Stumpage value per lineal foot.~~

TABLE 3 Proposed Stumpage Value Table
Stumpage Value Area 3
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$612	$605	$598	$591	$584
		2	519	512	505	498	491
		3	489	482	475	468	461
		4	429	422	415	408	401
Western Redcedar[3]	RC	1	631	624	617	610	603
Western Hemlock and Other Conifer[4]	WH	1	346	339	332	325	318
		2	346	339	332	325	318
		3	346	339	332	325	318
		4	336	329	322	315	308
Red Alder	RA	1	356	349	342	335	328
		2	211	204	197	190	183
Black Cottonwood	BC	1	69	62	55	48	41
Other Hardwood	OH	1	177	170	163	156	149
Douglas-Fir Poles & Piles	DFL	1	786	779	772	765	758
Western Redcedar Poles	RCL	1	1383	1376	1369	1362	1355
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
(4) Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
(5) Stumpage value per ton.
(6) Stumpage value per cord.
(7) Stumpage value per 8 lineal feet or portion thereof.
(8) Stumpage value per lineal foot.

TABLE 4 Proposed Stumpage Value Table
Stumpage Value Area 4
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$612	$605	$598	$591	$584
		2	546	539	532	525	518
		3	502	495	488	481	474
		4	502	495	488	481	474
Lodgepole Pine	LP	1	208	201	194	187	180
Ponderosa Pine	PP	1	285	278	271	264	257
		2	204	197	190	183	176
Western Redcedar[3]	RC	1	631	624	617	610	603
Western Hemlock and Other Conifer[4]	WH	1	339	332	325	318	311
		2	338	331	324	317	310
		3	338	331	324	317	310
		4	336	329	322	315	308
Red Alder	RA	1	356	349	342	335	328
		2	211	204	197	190	183
Black Cottonwood	BC	1	69	62	55	48	41
Other Hardwood	OH	1	177	170	163	156	149
Douglas-Fir Poles & Piles	DFL	1	786	779	772	765	758
Western Redcedar Poles	RCL	1	1383	1376	1369	1362	1355
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
(4) Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
(5) Stumpage value per ton.
(6) Stumpage value per cord.
(7) Stumpage value per 8 lineal feet or portion thereof.
(8) Stumpage value per lineal foot.

TABLE 5 Proposed Stumpage Value Table
Stumpage Value Area 5
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$661	$654	$647	$640	$633
		2	513	506	499	492	485
		3	488	481	474	467	460
		4	488	481	474	467	460
Lodgepole Pine	LP	1	208	201	194	187	180
Ponderosa Pine	PP	1	285	278	271	264	257
		2	204	197	190	183	176
Western Redcedar[3]	RC	1	631	624	617	610	603
Western Hemlock and Other Conifer[4]	WH	1	339	332	325	318	311
		2	336	329	322	315	308
		3	336	329	322	315	308
		4	327	320	313	306	299
Red Alder	RA	1	356	349	342	335	328
		2	211	204	197	190	183
Black Cottonwood	BC	1	69	62	55	48	41
Other Hardwood	OH	1	177	170	163	156	149
Douglas-Fir Poles & Piles	DFL	1	786	779	772	765	758
Western Redcedar Poles	RCL	1	1383	1376	1369	1362	1355
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot.

TABLE 6 Proposed Stumpage Value Table
Stumpage Value Area 6
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$361	$354	$347	$340	$333
Lodgepole Pine	LP	1	208	201	194	187	180
Ponderosa Pine	PP	1	285	278	271	264	257
		2	204	197	190	183	176
Western Redcedar[3]	RC	1	489	482	475	468	461
True Firs and Spruce[4]	WH	1	239	232	225	218	211
Western White Pine	WP	1	281	274	267	260	253
Hardwoods	OH	1	50	43	36	29	22
Western Redcedar Poles	RCL	1	489	482	475	468	461
Small Logs[5]	SML	1	42	41	40	39	38
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCF	1	76	69	62	55	48
LP & Other Posts[7]	LPP	1	0.35	0.35	0.35	0.35	0.35
Pine Christmas Trees[8]	PX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[9]	DFX	1	0.25	0.25	0.25	0.25	0.25

[1] Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.
[2] Includes Western Larch.
[3] Includes Alaska-Cedar.
[4] Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot. Includes Ponderosa Pine, Western White Pine, and Lodgepole Pine.
[9] Stumpage value per lineal foot.

TABLE 7 Proposed Stumpage Value Table
Stumpage Value Area 7
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$400	$393	$386	$379	$372
Lodgepole Pine	LP	1	278	271	264	257	250
Ponderosa Pine	PP	1	285	278	271	264	257
		2	204	197	190	183	176
Western Redcedar[3]	RC	1	489	482	475	468	461
True Firs and Spruce[4]	WH	1	302	295	288	281	274
Western White Pine	WP	1	281	274	267	260	253
Hardwoods	OH	1	50	43	36	29	22
Western Redcedar Poles	RCL	1	489	482	475	468	461
Small Logs[5]	SML	1	36	35	34	33	32
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCF	1	76	69	62	55	48
LP & Other Posts[7]	LPP	1	0.35	0.35	0.35	0.35	0.35
Pine Christmas Trees[8]	PX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[9]	DFX	1	0.25	0.25	0.25	0.25	0.25

[1] Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.
[2] Includes Western Larch.
[3] Includes Alaska-Cedar.
[4] Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot. Includes Ponderosa Pine, Western White Pine, and Lodgepole Pine.
[9] Stumpage value per lineal foot.

TABLE 8 Proposed Stumpage Value Table
Stumpage Value Area 10
January 1 through June 30, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$598	$591	$584	$577	$570
		2	532	525	518	511	504
		3	488	481	474	467	460
		4	488	481	474	467	460
Lodgepole Pine	LP	1	208	201	194	187	180
Ponderosa Pine	PP	1	285	278	271	264	257
		2	204	197	190	183	176
Western Redcedar[3]	RC	1	617	610	603	596	589
Western Hemlock and Other Conifer[4]	WH	1	325	318	311	304	297
		2	324	317	310	303	296
		3	324	317	310	303	296
		4	322	315	308	301	294
Red Alder	RA	1	342	335	328	321	314
		2	197	190	183	176	169
Black Cottonwood	BC	1	55	48	41	34	27
Other Hardwood	OH	1	163	156	149	142	135
Douglas-Fir Poles & Piles	DFL	1	772	765	758	751	744
Western Redcedar Poles	RCL	1	1369	1362	1355	1348	1341
Chipwood[5]	CHW	1	1	1	1	1	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes Western Hemlock, Mountain Hemlock, Pacific Silver Fir, Noble Fir, Grand Fir, Subalpine Fir, and all Spruce. Pacific Silver Fir, Noble Fir, Grand Fir, and Subalpine Fir are all commonly referred to as "White Fir."
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot.))

TABLE 1—Proposed Stumpage Value Table
Stumpage Value Area 1
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir	DF	1	$518	$511	$504	$497	$490
		2	453	446	439	432	425
		3	448	441	434	427	420
		4	448	441	434	427	420
Western Redcedar[2]	RC	1	715	708	701	694	687
Western Hemlock[3]	WH	1	316	309	302	295	288
		2	305	298	291	284	277
		3	298	291	284	277	270
		4	298	291	284	277	270
Red Alder	RA	1	544	537	530	523	516
		2	510	503	496	489	482
Black Cottonwood	BC	1	72	65	58	51	44
Other Hardwood	OH	1	165	158	151	144	137
Douglas-Fir Poles & Piles	DFL	1	753	746	739	732	725
Western Redcedar Poles	RCL	1	1224	1217	1210	1203	1196
Chipwood[4]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[5]	RCS	1	164	157	150	143	136
RC & Other Posts[6]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[7]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[7]	TFX	1	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 Alaska-Cedar.
[3] Includes all Hemlock, Spruce, true Fir species and Pines, or any other conifer not listed in this table.
[4] Stumpage value per ton.
[5] Stumpage value per cord.
[6] Stumpage value per 8 lineal feet or portion thereof.
[7] Stumpage value per lineal foot.

TABLE 2—Proposed Stumpage Value Table
Stumpage Value Area 2
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir	DF	1	$518	$511	$504	$497	$490
		2	458	451	444	437	430
		3	458	451	444	437	430
		4	458	451	444	437	430
Western Redcedar[2]	RC	1	715	708	701	694	687
Western Hemlock[3]	WH	1	316	309	302	295	288
		2	316	309	302	295	288
		3	315	308	301	294	287
		4	315	308	301	294	287
Red Alder	RA	1	544	537	530	523	516
		2	510	503	496	489	482
Black Cottonwood	BC	1	72	65	58	51	44
Other Hardwood	OH	1	165	158	151	144	137
Douglas-Fir Poles & Piles	DFL	1	753	746	739	732	725
Western Redcedar Poles	RCL	1	1224	1217	1210	1203	1196
Chipwood[4]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[5]	RCS	1	164	157	150	143	136
RC & Other Posts[6]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[7]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[7]	TFX	1	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 Alaska-Cedar.
[3] Includes all Hemlock, Spruce, true Fir species and Pines, or any other conifer not listed in this table.
[4] Stumpage value per ton.
[5] Stumpage value per cord.
[6] Stumpage value per 8 lineal feet or portion thereof.
[7] Stumpage value per lineal foot.

TABLE 3—Proposed Stumpage Value Table
Stumpage Value Area 3
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$518	$511	$504	$497	$490
		2	493	486	479	472	465
		3	479	472	465	458	451
		4	464	457	450	443	436
Western Redcedar[3]	RC	1	715	708	701	694	687
Western Hemlock and Other Conifer[4]	WH	1	316	309	302	295	288
		2	316	309	302	295	288
		3	313	306	299	292	285
		4	313	306	299	292	285
Red Alder	RA	1	544	537	530	523	516
		2	510	503	496	489	482
Black Cottonwood	BC	1	72	65	58	51	44
Other Hardwood	OH	1	165	158	151	144	137
Douglas-Fir Poles & Piles	DFL	1	753	746	739	732	725
Western Redcedar Poles	RCL	1	1224	1217	1210	1203	1196
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes all Hemlock, Spruce, true Fir species and Pines, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot.

TABLE 4—Proposed Stumpage Value Table
Stumpage Value Area 4
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$575	$568	$561	$554	$547
		2	498	491	484	477	470
		3	479	472	465	458	451
		4	461	454	447	440	433
Lodgepole Pine	LP	1	264	257	250	243	236
Ponderosa Pine	PP	1	296	289	282	275	268
		2	208	201	194	187	180
Western Redcedar[3]	RC	1	715	708	701	694	687
Western Hemlock and Other Conifer[4]	WH	1	345	338	331	324	317
		2	345	338	331	324	317
		3	345	338	331	324	317
		4	345	338	331	324	317
Red Alder	RA	1	544	537	530	523	516
		2	510	503	496	489	482
Black Cottonwood	BC	1	72	65	58	51	44
Other Hardwood	OH	1	165	158	151	144	137
Douglas-Fir Poles & Piles	DFL	1	753	746	739	732	725
Western Redcedar Poles	RCL	1	1224	1217	1210	1203	1196
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot.

TABLE 5—Proposed Stumpage Value Table
Stumpage Value Area 5
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$528	$521	$514	$507	$500
		2	467	460	453	446	439
		3	467	460	453	446	439
		4	390	383	376	369	362
Lodgepole Pine	LP	1	264	257	250	243	236
Ponderosa Pine	PP	1	296	289	282	275	268
		2	208	201	194	187	180
Western Redcedar[3]	RC	1	715	708	701	694	687
Western Hemlock and Other Conifer[4]	WH	1	316	309	302	295	288
		2	307	300	293	286	279
		3	293	286	279	272	265
		4	217	210	203	196	189
Red Alder	RA	1	544	537	530	523	516
		2	510	503	496	489	482
Black Cottonwood	BC	1	72	65	58	51	44
Other Hardwood	OH	1	165	158	151	144	137
Douglas-Fir Poles & Piles	DFL	1	753	746	739	732	725
Western Redcedar Poles	RCL	1	1224	1217	1210	1203	1196
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot.

TABLE 6—Proposed Stumpage Value Table
Stumpage Value Area 6
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$349	$342	$335	$328	$321
Lodgepole Pine	LP	1	264	257	250	243	236
Ponderosa Pine	PP	1	296	289	282	275	268
		2	208	201	194	187	180
Western Redcedar[3]	RC	1	504	497	490	483	476
True Firs and Spruce[4]	WH	1	259	252	245	238	231
Western White Pine	WP	1	256	249	242	235	228
Hardwoods	OH	1	50	43	36	29	22
Western Redcedar Poles	RCL	1	632	625	618	611	604
Small Logs[5]	SML	1	33	32	31	30	29
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCF	1	76	69	62	55	48
LP & Other Posts[7]	LPP	1	0.35	0.35	0.35	0.35	0.35
Pine Christmas Trees[8]	PX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[9]	DFX	1	0.25	0.25	0.25	0.25	0.25

[1] Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.
[2] Includes Western Larch.
[3] Includes Alaska-Cedar.
[4] Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot. Includes Ponderosa Pine, Western White Pine, and Lodgepole Pine.
[9] Stumpage value per lineal foot.

TABLE 7—Proposed Stumpage Value Table
Stumpage Value Area 7
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$349	$342	$335	$328	$321
Lodgepole Pine	LP	1	264	257	250	243	236
Ponderosa Pine	PP	1	296	289	282	275	268
		2	208	201	194	187	180
Western Redcedar[3]	RC	1	504	497	490	483	476
True Firs and Spruce[4]	WH	1	259	252	245	238	231
Western White Pine	WP	1	256	249	242	235	228
Hardwoods	OH	1	50	43	36	29	22
Western Redcedar Poles	RCL	1	632	625	618	611	604
Small Logs[5]	SML	1	33	32	31	30	29
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCF	1	76	69	62	55	48
LP & Other Posts[7]	LPP	1	0.35	0.35	0.35	0.35	0.35
Pine Christmas Trees[8]	PX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[9]	DFX	1	0.25	0.25	0.25	0.25	0.25

[1] Log scale conversions Western and Eastern Washington. See conversion methods WAC 458-40-680.
[2] Includes Western Larch.
[3] Includes Alaska-Cedar.
[4] Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] Stumpage value per lineal foot. Includes Ponderosa Pine, Western White Pine, and Lodgepole Pine.
[9] Stumpage value per lineal foot.

TABLE 8—Proposed Stumpage Value Table
Stumpage Value Area 10
July 1 through December 31, 2007

Stumpage Values per Thousand Board Feet Net Scribner Log Scale[1]

Species Name	Species Code	Timber Quality Code Number	Hauling Distance Zone Number 1	2	3	4	5
Douglas-Fir[2]	DF	1	$561	$554	$547	$540	$533
		2	484	477	470	463	456
		3	465	458	451	444	437
		4	447	440	433	426	419
Lodgepole Pine	LP	1	264	257	250	243	236
Ponderosa Pine	PP	1	296	289	282	275	268
		2	208	201	194	187	180
Western Redcedar[3]	RC	1	701	694	687	680	673
Western Hemlock and Other Conifer[4]	WH	1	331	324	317	310	303
		2	331	324	317	310	303
		3	331	324	317	310	303
		4	331	324	317	310	303
Red Alder	RA	1	530	523	516	509	502
		2	496	489	482	475	468
Black Cottonwood	BC	1	58	51	44	37	30
Other Hardwood	OH	1	151	144	137	130	123
Douglas-Fir Poles & Piles	DFL	1	739	732	725	718	711
Western Redcedar Poles	RCL	1	1210	1203	1196	1189	1182
Chipwood[5]	CHW	1	5	4	3	2	1
RC Shake & Shingle Blocks[6]	RCS	1	164	157	150	143	136
RC & Other Posts[7]	RCP	1	0.45	0.45	0.45	0.45	0.45
DF Christmas Trees[8]	DFX	1	0.25	0.25	0.25	0.25	0.25
Other Christmas Trees[8]	TFX	1	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 Alaska-Cedar.
[4] Includes all Hemlock, Spruce and true Fir species, or any other conifer not listed in this table.
[5] Stumpage value per ton.
[6] Stumpage value per cord.
[7] Stumpage value per 8 lineal feet or portion thereof.
[8] 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 ((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2007:

TABLE 9—Harvest Adjustment Table
Stumpage Value Areas 1, 2, 3, 4, 5, and 10
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2007

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.	- $30.00
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 Areas 6 and 7
((~~January~~)) July 1 through ((~~June 30~~)) December 31, 2007

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.	-$20.00
Class 3	The majority of the harvest unit has rough, broken ground with slopes over 60%. Numerous rock outcrops and bluffs.	-$30.00
Class 4	Applies to logs yarded from stump to landing by helicopter. This does not apply to special forest products.	- $145.00
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
Class 1:	SVA's 1 through 6, and 10	$0.00
Class 2:	SVA 7	$0.00

Note: The adjustment will not be allowed on special forest products.

(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.

WSR 07-10-131
PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed May 2, 2007, 11:46 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 06-13-050.

Title of Rule and Other Identifying Information: Chapter 392-160 WAC, Special service program/transitional bilingual.

Hearing Location(s): Brouillet Conference Room, Office of Superintendent of Public Instruction, 600 South Washington Street, Olympia, WA 98504-7200, on June 12, 2007, at 1:30 - 5:00 p.m.

Date of Intended Adoption: June 13, 2007.

Submit Written Comments to: Alfonso Anaya, P.O. Box 47200, Olympia, WA 98504-7200, e-mail Alfonso.Anaya@k12.wa.us, fax (360) 664-2605, by June 11, 2007.

Assistance for Persons with Disabilities: Contact Phouang Hamilton by June 11, 2007, TTY (360) 664-3631 or (360) 725-6152.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the proposed rule changes is to be in compliance with RCW and to effectively educate English language learners (ELLs).

Reasons Supporting Proposal: Clarification of the contents of the law as it applies to current practices, including the bilingual entrance and exit criteria.

Statutory Authority for Adoption: RCW 28A.180.060.

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

Name of Proponent: [Superintendent of public instruction], governmental.

Name of Agency Personnel Responsible for Drafting, Implementation and Enforcement: Alfonso Anaya, office of superintendent of public instruction, (360) 725-6146.

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

A cost-benefit analysis is not required under RCW 34.05.328.

May 2, 2007
Terry Bergeson
Superintendent of
Public Instruction

AMENDATORY SECTION (Amending Order 84-41, filed 10/2/84)

WAC 392-160-010 School district board of directors duties. Consistent with the provisions of this chapter, every school district board of directors:

(1) Shall make available to each eligible student a transitional bilingual ((~~instruction~~)) instructional program or, if the use of two languages is not practicable as provided in WAC 392-160-040, an alternative instructional program;

(2) Shall communicate, whenever feasible, with parents of students in the bilingual program, or alternative instruction program in a language they can understand; and

(3) Shall provide ((~~in-service~~)) professional development training for administrators, teachers, counselors, and other staff ((~~who are involved in the district's transitional bilingual program, including alternative instructional programs,~~)) on bilingual program models, and/or district's alternative instructional program, appropriate use of instructional strategies ((~~for students of culturally different backgrounds and use of curriculum materials and program models~~)) and curriculum and instructional materials for use with culturally and linguistically diverse students.

AMENDATORY SECTION (Amending Order 12, filed 8/12/91, effective 9/12/91)

WAC 392-160-015 Identification of eligible students. (1) District procedures—Identification of primary language required: Every school district board of directors shall adopt written procedures governing the identification of each student's primary language and the determination of which students with a primary language other than English are eligible students. Such procedures shall include:

(a) ((~~Provisions for the identification of a student's primary language pursuant to an interview with or a written questionnaire~~)) A home language survey, directed to the student and the student's parent(s) or guardian(s)((~~, or a combination of interviews and written questionnaires~~)); and

(b) Provisions for testing students as provided for in this section, WAC 392-160-020, and 392-160-035.

(2) Deadline for determining eligibility of newly enrolled students: The primary language and eligibility of each newly enrolled student shall be established no later than the ((~~twentieth~~)) tenth school day after the date upon which the student commences attendance at a particular school district.

(3) Newly enrolled students who speak little or no English((~~—Determination of eligibility~~)): The eligibility of a newly enrolled student ((~~whose eligibility is reasonably apparent by reason of~~)) is determined by:

(a) The student's ((~~ability to communicate reasonably well in his or her non-English primary language~~)) first language is a language other than English; and

(b) The student's inability to communicate in English to any practical extent as determined by an ((~~interview with the student by appropriate school district staff. No other approved test need be administered if the professional judgment of the school personnel is that the student is eligible as defined in WAC 392-160-005(3)~~)) approved state placement test.

(4) ((~~All other newly enrolled students—Determination of eligibility: The eligibility of all newly enrolled students:~~

~~(a) Who have a primary language other than English; and~~

~~(b) Whose eligibility is not reasonably apparent by reason of the standards established by subsection (3) shall be determined pursuant to WAC 392-160-020.~~

~~(5)~~)) Annual reassessment of all students required: Each school year each school in which an eligible student is enrolled shall conduct an evaluation of the overall academic progress and English language development of the student. This evaluation must include but not be limited to the administration of a standardized test in reading, writing, listening and ((~~language arts~~)) speaking in English as set forth in WAC 392-160-035.

AMENDATORY SECTION (Amending Order 12, filed 8/12/91, effective 9/12/91)

WAC 392-160-020 State approved tests for determining initial eligibility—English proficiency scores. (((~~(1)~~))) Approved English proficiency tests: ((~~The following tests are approved for the purpose of annually determining the English proficiency of newly enrolled students (other than those who speak little or no English) whose primary language is other than English:~~

~~(a) Language assessment scales (LAS and Pre-LAS);~~

~~(b) Basic inventory of natural language (BINL);~~

~~(c) Bilingual syntax measure (BSM); and~~

~~(d) Secondary level English proficiency test (SLEP). (To be used only at 8-12 level).~~

~~(2) Scores which establish an English skills deficiency: In the event a student scores within the appropriate range provided by the test maker to establish such English skill deficiency, the student's English skills shall be deemed sufficiently deficient or absent to impair learning~~

~~(3) The superintendent of public instruction may approve a school district request for use of a test other than those approved for use in this section when such request is supported by evidence that:~~

~~(a) The approved tests for use identified in this section are either unsuitable, inappropriate, or impractical for use by the school district;~~

~~(b) The scores that establish English skills deficiency for the requested test correspond with the scores that establish English skills deficiency for approved tests identified in this section; and~~

~~(c) The skills being measured by the requested test correspond to the skills measured by the approved tests identified in this section.~~)) Washington language proficiency placement test (WLPT).

AMENDATORY SECTION (Amending Order 84-41, filed 10/2/84)

WAC 392-160-026 District application. Each school district that seeks an allocation of state funds for a transitional bilingual instruction program shall submit a program approval application to the superintendent of public instruction no later than ((~~August 1~~)) the end of June of each year: Provided, That in the case of extenuating circumstances or in the case of a change in circumstances such as the unexpected enrollment of eligible students the superintendent of public instruction may allow the belated submission of an application or the submission of a modification to a previously approved application. The application shall apply to programs to be conducted during the ensuing school year and shall provide data and information in accordance with instructions and forms now or hereafter established and published by the superintendent of public instruction in bulletins distributed to school districts.

AMENDATORY SECTION (Amending Order 84-17, filed 6/13/84)

WAC 392-160-027 Board approval. The district's ((~~annual application~~)) transitional bilingual instructional program or alternative instructional program shall be approved by formal action of the district's board of directors by no later than October 31.

AMENDATORY SECTION (Amending Order 84-41, filed 10/2/84)

WAC 392-160-028 Content of district application. The district's annual application shall contain the following:

(1) The number of eligible and/or estimated number of students to be served ((~~during the current school year and the estimated number to be served~~)) in the next school year ((~~for each non-English primary language spoken~~));

(2) A description of the ((~~approved tests to be used in the next school year to determine student eligibility~~)) bilingual instructional program and/or alternative instructional program to be implemented the next school year;

(3) ((~~The estimated number of students who will be enrolled during the next school year in a program funded pursuant to this chapter in excess of three school years (i.e., 540 school days or portions thereof). The numbers of such students shall be identified by the non-English primary language spoken and the type of program to be provided (i.e., bilingual or alternative instructional program);~~

~~(4) The number of students who have been enrolled in a program funded pursuant to this chapter in excess of three school years who are currently served identified by the non-English primary language spoken by each student and the type of program provided each student;~~

~~(5) A description of the bilingual instruction and alternative instructional programs planned for the next school year; and~~

~~(6) A description of the in-service training program that is planned for the next school year.~~)) A description of the professional development activities plan for the next school year; and

(4) A description of the district's plan to build capacity to serve English language learners.

AMENDATORY SECTION (Amending Order 84-17, filed 6/13/84)

WAC 392-160-029 ((~~Program~~)) Application approval. Program approval by the superintendent of public instruction shall be as follows:

(1) Each application that is submitted as required by and pursuant to this chapter shall be approved: Provided, that approval of an application may be withheld in whole or part in the event the superintendent of public instruction deems it necessary to ascertain the completeness and accuracy of the application((~~.~~));

(2) Each school district shall be notified of ((~~program~~)) preliminary application approval or disapproval, in whole or part, within thirty days after the date of receipt of the application by the superintendent of public instruction((~~.~~));

(3) Each preliminary application that is returned to a school district ((~~with approval withheld~~)) as disapproved in whole or part shall be accompanied by an explanation of the reasons ((~~therefor~~)) therefore and a statement of the corrective action necessary for approval; and

(4) Each approved preliminary application shall be submitted for final approval, by no later than October 31, following formal action of the district's board of directors.

AMENDATORY SECTION (Amending Order 84-41, filed 10/2/84)

WAC 392-160-035 Three-year limitation—Testing—Program exit requirements. (1) No student shall continue to be entitled to a transitional bilingual instructional program or alternative instructional program after the student has received instruction in a transitional bilingual instructional program or alternative instructional program conducted pursuant to this chapter within any one or more school districts for a period of three consecutive school years (i.e., 540 school days or portions thereof): Provided, that each such student who is unable to demonstrate an improvement in English language skills that is sufficient to overcome the student's learning impairment (i.e., ((~~unable to score above the 35th percentile on an approved test~~)) the student has not met established exit criteria on WLPT) shall continue to be entitled to an approved bilingual instruction or alternative instructional program.

(2) The approved test for measurement of improvement in English language skills for purposes of exit from the transitional bilingual instructional program or alternative instructional programs shall be ((~~any nationally normed standardized achievement test normally administered by a school district to its students~~)) the Washington language proficiency test (reading/writing/listening/speaking).

(3) No student shall be ((~~entitled to continued enrollment in a transitional bilingual~~)) eligible for continued funding in the transitional bilingual instructional program or alternative program once ((~~the student has scored above the 35th percentile on the reading and language arts portions of a nationally normed standardized test appropriate for the student's age and grade level~~)) they have met or exceeded the state standards as measured by the WLPT.

AMENDATORY SECTION (Amending Order 12, filed 8/12/91, effective 9/12/91)

WAC 392-160-040 Alternative instructional program. School districts under one or more of the following conditions may elect to provide an alternative instructional program:

(1) Necessary instructional materials in the student's primary language are unavailable and the district has made reasonable efforts to obtain necessary materials without success;

(2) The capacity of the district's bilingual ((~~instruction~~)) instructional program is temporarily exceeded by an unexpected increase in the enrollment of eligible students;

(3) Bilingual instruction cannot be provided ((~~affected~~)) to students without substantially impairing their basic education ((~~program~~)) because of their distribution throughout many grade levels or schools, or both; or

(4) Teachers who are trained in bilingual education methods and sufficiently skilled in the non-English primary language(s) are unavailable, and the district has made reasonable attempts to obtain the services of such teachers.

AMENDATORY SECTION (Amending Order 84-41, filed 10/2/84)

WAC 392-160-045 ((~~Handicapped students—No~~)) Students with disabilities—Conditions for transitional bilingual entitlement. ((~~Notwithstanding any other provision of this chapter to the contrary, any eligible student whose English language skill deficiency is caused primarily by one or more of the handicapping conditions defined in chapter 392-171 WAC, as now or hereafter amended, shall not be eligible for the entitlement established pursuant to this chapter.~~)) (1) Students identified as being eligible for both the state transitional bilingual instructional program (TBIP) and special education program will participate in the TBIP to the same degree and consideration given to every other child in the TBIP. Factors to be considered for students under these circumstances are as follows:

(a) Degree to which the disability is a primary contributor of barriers of English proficiency gains;

(b) The administration of the approved state language proficiency assessment; and

(c) Every three years a child can be assessed with an intellectual capacity on the state's approved annual academic assessment. The student's placement on each of these three continuums will determine the nature of the instruction and the education placement.

(2) Notwithstanding any other provisions of this chapter to the contrary, any eligible student whose disability under chapter 392-172A WAC is the primary barrier to the student's English language acquisition shall not be eligible for the entitlement established pursuant to this chapter.