WSR 17-20-006
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Behavioral Health Administration)

[Filed September 21, 2017, 3:57 p.m., effective October 22, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending rules about grievances, appeals, and hearings in chapter 388-877 WAC to align with the Centers for Medicare and Medicaid Services (CMS) amended federal rules in 42 C.F.R. 438 Subpart F that govern the grievance and appeals system for medicaid managed care. States must comply with these federal rule amendments by July 1, 2017. The new definitions, time frames, and alignment of certain processes for appeals and grievances will provide individuals with a more streamlined and manageable grievance and appeals process, and will allow behavioral health agencies and behavioral health organizations to further align rules applicable to private health insurance and group health plans that apply across the market. The department is limiting amendments to bringing the rules into compliance with federal rules and making necessary edits to change names and terms and clarify language without changing the rule's effect. When these rules become effective, they will supersede emergency rules filed as WSR 17-14-094 that went into effect July 1, 2017.

Citation of Rules Affected by this Order: Amending WAC 388-877-0654, 388-877-0655, 388-877-0660, 388-877-0665, 388-877-0670, 388-877-0675, and 388-877-0680.

Statutory Authority for Adoption: RCW 71.05.560, 71.24.035 (5)(c), 71.24.520, and 71.34.380.

Other Authority: 42 C.F.R. 438 Subpart F, as amended in 81 Fed. Reg. 27498, May 6, 2016.

Adopted under notice filed as WSR 17-11-068 on May 17, 2017.

Changes Other than Editing from Proposed to Adopted Version:

WAC 388-877-0654(4) … behavioral health ombuds services described in ~~under~~ … lowest possible level before and during …

WAC 388-877-0654 new (5) In handling grievances and appeals, each BHO and behavioral health agency must give individuals any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

WAC 388-877-0655(2) new (f) For a resident of a rural area with only one BHO, the denial of an individual's request to exercise their right to obtain services outside the network;

WAC 388-877-0655(2) new (g) The denial of an individual's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

WAC 388-877-0660(2) … grievances ~~or expressions of dissatisfaction~~.

WAC 388-877-0660 (5) and (6) … The grievance ~~cannot~~ does not progress to a hearing …

WAC 388-877-0660 (7)(f) … decision as expeditiously as the individual's health condition requires, and no longer than …

WAC 388-877-0660 (8)(c)(i) … Neither were ~~not~~ involved … nor are subordinates ~~a subordinate~~ of any …

WAC 388-877-0660 (8)(d) … the individual's interest. The BHO must:

(i) Make reasonable efforts to give the individual prompt oral notice of the delay; and

(ii) Within two calendar days, give the individual written notice of the reason for the decision to extend the time frame and inform the individual of the right to file a grievance if the individual disagrees with that decision;

WAC 388-877-0660 (8)(e) and 388-877-0665 (1)(a) … which includes requirements ~~requires~~ that each notice: (i) ~~Is~~ Be written …

WAC 388-877-0665(3) … timely manner, ~~or when the BHO does not act within the grievance and appeal system time frames as identified within this chapter,~~ it is considered an adverse benefit determination. In these cases, the BHO sends a formal notice of adverse benefit determination, which includes the individual's right to request an administrative hearing. When the BHO does not act within the grievance and appeal system time frames as identified within this chapter, it is considered exhaustion of the appeals process and the individual has a right to request an administrative hearing.

WAC 388-877-0670(2) … must ~~file an appeal and receive a notice of the resolution from the BHO~~ exhaust the appeals process before …

WAC 388-877-0670 (4)(a) … evidence and testimony and make legal …

WAC 388-877-0670 (4)(b) … Provide the individual ~~opportunity~~, … ~~to examine~~ the individual's clinical record, including ~~examining~~ new or …

WAC 388-877-0670 (5)(a) … Neither were ~~not~~ involved … nor are subordinates ~~a subordinate~~ of any …

WAC 388-877-0670(6) … An oral filing of a standard ~~an~~ appeal …

WAC 388-877-0670 (6)(c) … resolution as expeditiously as the individual's health requires, and no longer … The BHO must:

(i) Make reasonable efforts to give the individual prompt oral notice of the delay; and

(ii) Within two calendar days, give the individual written notice of the reason for the decision to extend the time frame and inform the individual of the right to file a grievance if the individual disagrees with that decision.

WAC 388-877-0670(7) … An oral filing of a standard ~~an~~ appeal …

WAC 388-877-0670(8) … health provider believes ~~feels~~ that …

WAC 388-877-0670 (8)(b)(ii) … resolution as expeditiously as the individual's health condition requires, and no longer …

WAC 388-877-0670 (9)(b)(i) … of the hearing ~~or if the individual is asking for an expedited hearing~~.

WAC 388-877-0670 (9)(c) … which includes requirements ~~requires~~ that each notice: (i) Be ~~Is~~ written …

WAC 388-877-0675(4) If an individual ~~requests an expedited administrative hearing, the expedited hearing must~~

~~be requested within ten calendar days from the date on the notice of the resolution or notice of determination~~ or the individual's behavioral health provider believes that the time taken for a standard administrative hearing could seriously jeopardize the individual's life, physical or mental health, or ability to attain, maintain, or regain maximum function, an expedited hearing may be requested …

WAC 388-877-0675(7) … of this section. Recovery of the cost of medicaid services is limited to the first sixty days of services after the department or the office of administrative hearings (OAH) receives an administrative hearing request. See RCW 74.09.741.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 7, Repealed 0.

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

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

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

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 7, Repealed 0.

Date Adopted: September 19, 2017.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0654 How individuals ((~~can~~)) may express concern about their rights, services, or treatment. (1) ((~~An individual applying~~)) Individuals who apply for, are eligible for, or ((~~receiving mental~~)) receive behavioral health services ((~~or substance use disorder services, or both,~~)) authorized by a behavioral health organization (BHO)((~~, the individual's representative, or the individual's legal guardian,~~)) may access the BHO's grievance and appeal system to express concern about their rights, services, or treatment.

(2) The BHO's grievance and appeal system includes:

(a) A grievance process as described in WAC 388-877-0660;

(b) An appeal process as described in WAC 388-877-0670; and

(c) Access to administrative hearings as described in WAC 388-877-0675.

(((~~(2) Before requesting an administrative hearing, the individual~~)) (3) Individuals must exhaust((~~:~~

~~(a) The grievance process, subject to WAC 388-877-0660; or~~

~~(b)~~)) the appeal process((~~, subject to WAC 388-877-0670~~)) before they have access to an administrative hearing.

(((~~(3)~~)) (4) Individuals may also use the free and confidential behavioral health ombuds services described in WAC 388-865-0262 through the BHO that contracts with the behavioral health agency in which they receive behavioral health services. Ombuds services are provided independent of BHOs and ((~~agency services providers~~)) behavioral health agencies and are offered to individuals at any time to help them with resolving issues or problems at the lowest possible level before and during the grievance, appeal, or administrative hearing process.

(((~~(4) See WAC 388-865-0262 for more information on ombuds services through the behavioral health ombuds office.~~))

(5) In handling grievances and appeals, each BHO and behavioral health agency must give individuals any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services, upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0655 Grievance and appeal system and administrative hearings—Definitions. The terms and definitions in this section ((~~and WAC 388-877-0200~~)) apply to the behavioral health organization (BHO) grievance and appeal system and administrative hearing rules. Other definitions that apply to behavioral health services may be found at WAC 388-877-0200.

(1) ((~~"Action" means, in the case of a behavioral health organization (BHO):~~

~~(a) The denial or limited authorization of a requested service, including the type or level of service;~~

~~(b) The reduction, suspension, or termination of a previously authorized service;~~

~~(c) The denial in whole or in part, of payment for a service;~~

~~(d) The failure to provide services in a timely manner, as defined by the state; or~~

~~(e) The failure of a BHO or its contracted behavioral health agency to act within the grievance system timeframes as provided in WAC 388-877-0660 through 388-877-0675.~~

~~(2)~~)) "Administrative hearing" means a proceeding before an administrative law judge ((~~that gives an individual an opportunity to be heard in disputes about DSHS programs and services~~)) to review an adverse benefit determination or a BHO decision to deny or limit authorization of a requested nonmedicaid service communicated on a notice of determination.

(2) "Adverse benefit determination" means, in the case of medicaid services administered by the BHO, any one or more of the following:

(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial, in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by the state;

(e) The failure of a BHO to act within the grievance and appeal system time frames as provided in WAC 388-877-0660 through 388-877-0670 regarding the standard resolution of grievances and appeals;

(f) For a resident of a rural area with only one BHO, the denial of an individual's request to exercise their right to obtain services outside the network;

(g) The denial of an individual's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

(3) "Appeal" means ((~~an oral or written request by an individual, or with the individual's written permission, the individual's representative, for the~~)) a review by a behavioral health organization (BHO) ((~~to review~~)) of an ((~~"action,"~~)) adverse benefit determination, as defined in this section. ((~~See also "expedited appeal."~~))

(4) ((~~"Appeal process" is one of the processes included in the grievance system that allows an individual to appeal an action made by the behavioral health organization (BHO) and communicated on a "notice of action."~~

~~(5) "Expedited appeal process" allows an individual, in certain circumstances, to file an appeal that will be reviewed by the behavioral health organization (BHO) more quickly than a standard appeal.~~

~~(6)~~)) "Grievance" means an expression of dissatisfaction about any matter other than an ((~~"action."~~)) adverse benefit determination. Grievances may include, but are not limited to, an individual's right to dispute an extension of time proposed by the BHO to make an authorization decision, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a behavioral health provider or employee, and failure to respect the individual's rights regardless of whether a specific action is requested by the individual.

(((~~(7) "Grievance process" is one of the processes included in the grievance system that allows an individual to express concern or dissatisfaction about a behavioral health service.~~

~~(8)~~)) (5) "Grievance and appeal system" means the processes ((~~through~~)) a ((~~behavioral health organization (BHO) in which an individual applying for, eligible for, or receiving behavioral health services may express dissatisfaction about services~~)) BHO implements to handle appeals of adverse benefit determinations and grievances as well as the processes to collect and track information about them. The BHO must establish the grievance and appeal system ((~~must be established by the BHO, must~~)) and meet the requirements of 42 C.F.R. Sec. 438, Subpart F((~~, and include:~~

~~(a) A grievance process;~~

~~(b) An appeal process; and~~

~~(c) Access to the department's administrative hearing process~~)) (2017).

(((~~(9)~~))) (6) "Individual" means a person who applies for, is eligible for, or receives ((~~behavioral health organization (BHO)~~))) BHO-authorized behavioral health services from an agency licensed by the department as a behavioral health agency. For the purposes of accessing the grievance and appeal system and the administrative hearing process, when another person is acting on an individual's behalf, the definition of individual also includes any of the following ((~~if another person is acting on the individual's behalf~~)):

(a) In the case of a minor, the individual's parent or, if applicable, the individual's custodial parent;

(b) The individual's legal guardian; ((~~or~~))

(c) The individual's representative if the individual gives written ((~~permission~~)) consent;

(d) The individual's behavioral health provider if the individual gives written consent, except that the behavioral health provider cannot request continuation of benefits on the individual's behalf.

(((~~(10)~~))) (7) "Notice of ((~~action~~)) adverse benefit determination" is a written notice a ((~~behavioral health organization (BHO)~~))) BHO provides to an individual to communicate an ((~~"action."~~)) adverse benefit determination.

(((~~(11) "Regional support network" or "RSN" no longer exists as of March 31, 2016. See WAC 388-865-0238, "Behavioral health organization."~~))

(8) "Notice of determination" means a written notice that must be provided to an individual to communicate denial or limited authorization of a nonmedicaid service offered by the BHO. A notice of determination must contain the following:

(a) The reason for denial or offering of alternative services;

(b) A description of alternative services, if available; and

(c) The right to request an administrative hearing, how to request a hearing, and the timeframes for requesting a hearing as identified in WAC 388-877-0675.

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0660 Filing a grievance ((~~process~~)). (1) ((~~The grievance process is used by~~)) An individual or ((~~the~~)) individual's representative may file a grievance to express dissatisfaction in person, orally, or in writing about any matter other than an ((~~"action,"~~)) adverse benefit determination, as defined in WAC 388-877-0655, to:

(a) The behavioral health agency providing the behavioral health services; or

(b) The behavioral health organization (BHO), if the agency is contracted with the BHO.

(2) If an individual receives behavioral health services through a behavioral health agency that is not contracted with a BHO, the agency, through its internal process, is responsible to handle the individual's grievances ((~~or expressions of dissatisfaction~~)).

(3) There is no time limit to file a grievance.

(4) The ombuds ((~~serving the behavioral health agency or BHO~~)) may assist the individual in resolving the grievance at the lowest possible level.

(((~~(4) Grievances are subject to the rules in this section, WAC 388-877-0650, 388-877-0655, and 388-877-0665 through 388-877-0680. An individual may choose to file a grievance with the behavioral health agency that provides the behavioral health services or with the BHO, subject to the following:~~))

(((~~(a)~~))) (5) **Filing a grievance with a behavioral health agency**. If ((~~the~~)) an individual first files a grievance with the behavioral health agency and the individual is not satisfied with the agency's written decision on the grievance, or if the individual does not receive a copy of that decision from the agency within the time required under subsection (((~~(6)~~))) (7) of this section, the individual may then choose to file the grievance with the BHO. ((~~If the individual is not satisfied with~~)) The BHO's written decision on the grievance((~~, or if the individual does not receive a copy of the decision from the BHO within the time required under subsection (6) of this section, the individual can request an administrative hearing to have the grievance reviewed and the BHO's decision or failure to make a timely decision about it~~)) is the final decision. The grievance does not progress to an administrative hearing except under circumstances described in subsection (9) of this section.

(((~~(b)~~))) (6) **Filing a grievance with a BHO.** If the individual first files a grievance with the BHO (((~~(~~)))and not the agency(((~~)~~))), and the individual ((~~either~~)) is not satisfied with the BHO's written decision on the grievance, ((~~or does not receive a copy of the decision within the time required under subsection (6) of this section, the individual can request an administrative hearing to have the grievance reviewed and the BHO's decision or failure to make a timely decision about it. Once an individual gets a decision on a grievance from a BHO,~~)) the individual cannot file the same grievance with the behavioral health agency, even if that agency or its staff member(s) is the subject of the grievance. The BHO's written decision on the grievance is the final decision. The grievance does not progress to an administrative hearing except under circumstances described in subsection (9) of this section.

(((~~(5) An individual may also request an administrative hearing if a written notice regarding the grievance was not received within the timeframes established in subsection (6) of this section.~~)))

(((~~(6)~~))) (7) When an individual files a grievance, the behavioral health agency or BHO ((~~receiving~~)) that receives the grievance must:

(a) Acknowledge the receipt of the grievance in writing within five business days;

(b) Investigate the grievance;

(c) At the individual's request, give the individual reasonable assistance in taking any procedural steps;

(d) Inform the individual about ombuds services and how to access these services;

(e) Apply the rules in subsection (((~~(7)~~))) (8) of this section; and

(((~~(d)~~))) (f) Send the individual who filed the grievance a written notice describing the decision ((~~within~~)) as expeditiously as the individual's health condition requires, and no longer than ninety calendar days from the date the behavioral health agency or BHO receives the grievance ((~~was filed~~)).

(((~~(7)~~))) (8) The behavioral health agency or BHO ((~~receiving~~)) that receives the grievance must ensure all of the following:

(a) Other people((~~, if the individual chooses,~~)) are allowed to participate in the grievance process, if the individual chooses.

(b) ((~~The individual's right to have currently authorized behavioral health services continued pending resolution of the grievance and, if applicable, through subsequent steps of the grievance system.~~

(~~c~~))) That a grievance is resolved even if the individual is no longer receiving behavioral health services.

(((~~(d)~~))) (c) That the persons who make decisions on a grievance:

(i) Neither were ((~~not~~)) involved in any previous level of review or decision making nor are subordinates of any person who reviewed or decided on a previous level of the grievance; ((~~and~~))

(ii) Are mental health or chemical dependency professionals who have appropriate clinical expertise in the type of behavioral health service if ((~~the grievance~~)) deciding a grievance concerning denial of an expedited resolution of an appeal or a grievance that involves any clinical issues((~~.~~)); and

(iii) Consider all comments, documents, records, and other information submitted by the individual or the individual's representative.

(((~~(e)~~))) (d) That the individual and, if applicable, the individual's representative, ((~~receive~~)) receives a written notice containing the decision ((~~within~~)) no later than ninety calendar days from the date ((~~a grievance is received by~~)) the agency or BHO receives a grievance. This ((~~timeframe can~~)) time frame may be extended up to an additional fourteen calendar days((~~:~~

(~~i~~))) if requested by the individual or the individual's representative((~~;~~)) or

(~~ii~~))) by the agency or BHO when additional information is needed and the agency or BHO ((~~can~~)) is able to demonstrate to the department upon the department's request that it needs additional information and ((~~that~~)) the added time is in the individual's interest. The BHO must:

(i) Make reasonable efforts to give the individual prompt oral notice of the delay; and

(ii) Within two calendar days, give the individual written notice of the reason for the decision to extend the time frame and inform the individual of the right to file a grievance if the individual disagrees with that decision.

(((~~(f)~~))) (e) That the written notice includes((~~:~~

(~~i) The decision on~~)) the resolution of the grievance((~~;~~

(~~ii~~))), the reason for the decision((~~;~~)), and the date the decision was made and is in an easily understood format following 42 C.F.R. Sec. 438.10 (2017), which includes requirements that each notice:

(i) Be written in the individual's non-English language, if applicable;

(ii) Contains the BHO's toll-free and TTY/TDY telephone number; and

(iii) Explains the availability of free written translation, oral interpretation to include any non-English language, auxiliary aids such as American sign language and TTY/TDY telephone services, and alternative formats to include large print and Braille.

(((~~iii) The right to request an administrative hearing and the required timeframe to request the hearing.~~

((~~(g)~~)) (f) That full records of all grievances and materials received or compiled in the course of processing and attempting to resolve the grievance are ((~~maintained and~~)):

(i) Kept for ((~~six~~)) a period of no less than ten years after the completion of the grievance process;

(ii) Made available to the department upon request as part of the state quality strategy and made available upon request to the centers for medicare and medicaid services (CMS);

(iii) Kept in confidential files separate from the individual's clinical record; ((~~and~~))

(iv) Not disclosed without the individual's written permission, except to the department or as necessary to resolve the grievance.

(g) Are accurately maintained and contain, at a minimum, all of the following information:

(i) A general description of the reason for the grievance;

(ii) The date received;

(iii) The date of each review or, if applicable, review meeting;

(iv) Resolution at each level of the grievance, if applicable;

(v) Date of resolution at each level, if applicable; and

(vi) Name of the covered person for whom the grievance was filed.

(9) When the BHO does not act within the grievance process time frames described in this section, the individual is considered to have exhausted the appeal process and has a right to request an administrative hearing.

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0665 Notice of ((~~action~~)) adverse benefit determination. (1) ((~~The~~)) A behavioral health organization's (BHO's) notice of ((~~action~~)) adverse benefit determination provided to an individual must be in writing((~~, be~~)) and in ((~~the individual's primary language, be~~)) an easily understood ((~~and,~~)) format following 42 C.F.R. Sec. 438.10(2017), which includes requirements that each notice:

(a) Be written in the individual's non-English language, if applicable;

(b) Contains the BHO's toll-free and TTY/TDY telephone number; and

(c) Explains the availability of free written translation, oral interpretation to include any non-English language, auxiliary aids such as American sign language, TTY/TDY telephone services, and alternative formats to include large print and Braille.

(2) The notice of adverse benefit determination must, at a minimum, explain the following:

(a) The ((~~action~~)) adverse benefit determination the BHO ((~~or its contractor (behavioral health agency)~~)) has ((~~taken~~)) made or intends to ((~~take~~)) make;

(b) The ((~~reason~~)) reasons for the ((~~action and a~~)) adverse benefit determination, including citation of the rule(s) ((~~being implemented~~)) and criteria used for the basis of the decision;

(c) The right of the individual to be provided reasonable access to and copies of all documents, records, and other information relevant to the individual's adverse benefit determination upon request and free of charge;

(d) The individual's right to file an appeal of the adverse benefit determination with the BHO ((~~and the required timeframes if the individual does not agree with the decision or action~~)), including information on exhausting the BHO's one level of appeal and the individual's right to request an administrative hearing;

((~~(d)~~)) (e) The circumstances under which an expedited ((~~resolution~~)) appeal process is available and how to request it; and

((~~(e)~~)) (f) The individual's right to receive behavioral health services while an appeal is pending, how to make the request, and that the individual may be held liable for the cost of services received while the appeal is pending if the appeal decision upholds the decision ((~~or action~~)) in the notice of adverse benefit determination.

((~~(2)~~)) (3) When the BHO or its contracted behavioral health agency does not reach service authorization decisions within the required ((~~timeframes~~)) time frame, or fails to provide services in a timely manner ((~~or act within the grievance system timeframes, as defined in rule~~)), it is considered ((~~a denial~~)) an adverse benefit determination. In these cases, the BHO sends a formal notice of ((~~action, which~~)) adverse benefit determination that includes the individual's right to request an administrative hearing. When the BHO does not act within the grievance and appeal system time frames as identified within this chapter, it is considered exhaustion of the appeals process and the individual has a right to request an administrative hearing.

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 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0670 Filing an appeal ((~~process~~)). (1) ((~~The appeal process is used by~~)) An individual may file an appeal to ask the behavioral health organization (BHO) to review an ((~~action~~)) adverse benefit determination that the BHO has communicated on a written notice of ((~~action (see WAC 388-877-0665)~~)) adverse benefit determination as defined in WAC 388-877-0655. An individual's representative may appeal an ((~~action~~)) adverse benefit determination with the individual's written consent. If a written notice of ((~~action~~)) adverse benefit determination was not received, an appeal may still be filed.

(2) The individual requesting review of an ((~~action~~)) adverse benefit determination must ((~~file an appeal and receive a notice of the resolution from the BHO~~)) exhaust the appeals process before requesting an administrative hearing.

(3) ((~~The appeal process can~~)) Appeals may be:

(a) Standard as described in subsection (6) and (7) of this section; or

(b) Expedited if the criteria in subsection ((~~(7)~~)) (8) of this section are met.

(4) The appeal process must:

(a) Provide an individual a reasonable opportunity to present evidence and ((~~allegations of fact or law~~)) testimony and make legal and factual arguments in person as well as in writing. The BHO must inform the individual of the limited time available.

(b) Provide the individual ((~~opportunity~~)), ((~~before and during the appeal process, to examine~~)) free of charge and sufficiently in advance, the individual's clinical record, including new or additional evidence, medical records, and any other documents and records considered during the appeal process.

(c) Include the following, as applicable, as parties to the appeal:

(i) The individual, the individual's representative, or both; or

(ii) The legal representative of a deceased individual's estate.

(5) The BHO must ensure that the persons who make decisions on an appeal:

(a) Neither were ((~~not~~)) involved in any previous level of review or decision making nor are subordinates of any person who reviewed or decided on a previous level of appeal; ((~~and~~))

(b) Are mental health or chemical dependency professionals who have appropriate clinical expertise in the type of behavioral health service ((~~involved in the appeal.~~)) if deciding an appeal of an adverse benefit determination concerning medical necessity or an appeal that involves any clinical issues; and

(c) Consider all comments, documents, records, and other information submitted by the individual regardless of whether the information was considered in the initial review.

(6) ((~~**Standard appeal process.** The standard appeal process includes the following:~~

(~~a~~))) **Standard appeals for ((~~actions communicated on a notice of action~~)) adverse benefit determination—continued services not requested**. An individual who disagrees with a decision ((~~or action~~)) communicated on a notice of ((~~action~~)) adverse benefit determination may file an appeal orally or in writing. An oral filing of ((~~an~~)) a standard appeal must be followed with a written and signed appeal. The BHO must use the date of an oral appeal as the official filing date to establish the earliest possible filing date. All of the following apply:

(((~~i~~))) (a) The individual must file the appeal within ((~~ninety~~)) sixty calendar days from the date on the notice of ((~~action~~)) adverse benefit determination.

(((~~ii~~))) (b) The BHO must confirm receipt of the appeal in writing within five business days.

(((~~iii~~))) (c) The BHO must send the individual a written notice of the resolution ((~~within forty-five~~)) as expeditiously as the individual's health condition requires, and no longer than thirty calendar days ((~~of receiving~~)) from the day the BHO received the appeal. This ((~~timeframe~~)) time frame may be extended up to fourteen additional calendar days if the individual requests an extension or the BHO ((~~can~~)) is able to demonstrate to the department upon the department's request that it needs additional information and that the added time is in the individual's interest. The BHO must:

(i) Make reasonable efforts to give the individual prompt oral notice of the delay; and

(ii) Within two calendar days, give the individual written notice of the reason for the decision to extend the time frame and inform the individual of the right to file a grievance if the individual disagrees with that decision.

(d) The written notice of the resolution must include((~~:~~)) all the information listed in subsection (9) of this section.

(((~~(A) The BHO's decision;~~

~~(B) The reason for the decision; and~~

~~(C) The right to request an administrative hearing if the individual disagrees with the decision. The hearing must be requested within ninety calendar days from the date on the notice of the resolution.~~

(~~b~~))) (7) **Standard appeals for termination, suspension, or reduction of previously authorized services—continued services requested.** An individual ((~~receiving~~)) who receives a notice of ((~~action~~)) adverse benefit determination from the BHO that terminates, suspends, or reduces previously authorized services may file an appeal orally or in writing and request continuation of those services pending the BHO's decision on the appeal. An oral filing of ((~~an~~)) a standard appeal and request for continuation of services must be followed with a written and signed appeal and include a written request for continuation of services pending the BHO's decision on the appeal. The BHO must use the date of an oral appeal as the official filing date to establish the earliest possible filing date. All of the following apply:

(((~~i~~))) (a) The individual must:

(((~~A~~))) (i) File the appeal with the BHO on or before the later of the following:

(((~~I~~))) (A) Within ten calendar days of the date on the notice of ((~~action~~)) adverse benefit determination; or

(((~~II~~))) (B) The intended effective date of the BHO's proposed ((~~action.~~)) adverse benefit determination; and

(((~~B~~))) (ii) Request continuation of services.

(((~~ii~~))) (b) The BHO must:

(((~~A~~))) (i) Confirm receipt of the appeal and the request for continued services with the individual orally or in writing within five business days;

(((~~B~~))) (ii) Send a notice in writing that follows up on any oral confirmation made; and

(((~~C~~))) (iii) Include in the notice that if the appeal decision is not in favor of the individual, the BHO may recover the cost of the behavioral health services provided pending the BHO decision.

(((~~iii~~))) (c) The BHO's written notice of the resolution must contain((~~:~~

~~(A) The BHO's decision on the appeal;~~

~~(B) The reason for the decision; and~~

~~(C) The right to request an administrative hearing if the individual disagrees with the decision and include the following timeframes:~~

~~(I) Within ten calendar days from the date on the notice of the resolution if the individual is asking that services be continued pending the outcome of the hearing.~~

~~(II) Within ninety calendar days from the date on the notice of the resolution if the individual is not asking for continued services~~)) all of the information listed in subsection (9) of this section.

(((~~(7)~~))) (8) **Expedited appeal process**. If an individual or the individual's behavioral health provider ((~~feels~~)) believes that the time taken for a standard resolution of an appeal could seriously jeopardize the individual's life, physical or mental health ((~~and~~)), or ability to attain, maintain, or regain maximum function, an expedited appeal and resolution of the appeal ((~~can~~)) may be requested. If the BHO denies the request for the expedited appeal and resolution of an appeal, it must transfer the appeal to the ((~~timeframe~~)) time frame for standard resolutions under subsection (6) or (7) of this section, and make reasonable efforts to give the individual prompt oral notice of the denial and follow up within two calendar days with a written notice.

(a) Both of the following apply to expedited appeal requests:

(i) The ((~~action taken on the notice of action is~~)) adverse benefit determination must be for denial of a requested service, termination, suspension, or reduction of previously authorized behavioral health services; ((~~and~~))

(ii) The expedited appeal must be filed with the BHO, either orally or in writing((~~,~~)) and within:

(A) Ten calendar days of the BHO's mailing the written notice of ((~~action that communicated the action,~~)) adverse benefit determination or the intended effective date of the BHO's proposed ((~~action~~)) adverse benefit determination, if the individual is requesting continued benefits; or

(B) ((~~Twenty~~)) Sixty calendar days from the date on the BHO's written notice of ((~~action that communicated the action~~)) adverse benefit determination if the individual is not requesting continued benefits.

(b) The BHO must:

(i) Confirm receipt of the request for an expedited appeal in person or by telephone.

(ii) Send the individual a written notice of the resolution ((~~within three business days of~~)) as expeditiously as the individual's health condition requires, and no longer than seventy-two hours after receiving the request for an expedited appeal.

(c) The BHO may extend the ((~~timeframes~~)) time frames up to fourteen additional calendar days if the individual requests an extension or the BHO ((~~can~~)) is able to demonstrate to the department upon the department's request that it needs additional information and that the added time is in the individual's interest. In this case the BHO must:

(i) Make reasonable efforts to give the individual prompt oral notice of the delay;

(ii) Within two calendar days give the individual written notice of the reason for the decision to extend the time frame and inform the individual of the right to file a grievance if the individual disagrees with that decision; and

(iii) Resolve the appeal as expeditiously as the individual's health condition requires and no later than the date the extension expires.

(d) The BHO must ensure that punitive action is not taken against a behavioral health provider who requests an expedited resolution or who supports an individual's appeal.

(9) The BHO's written notice of the resolution containing the decision on a standard appeal or expedited appeal must:

(a) Clearly state the BHO's decision on the appeal, the reason for the decision, and the date the decision was made;

(b) Inform the individual of the right to an administrative hearing if the individual disagrees with the decision, how to request a hearing, and the following time frames for requesting a hearing:

(i) Within ten calendar days from the date on the notice of the resolution if the individual is asking that services be continued pending the outcome of the hearing.

(ii) Within one hundred twenty calendar days from the date on the notice of the resolution if the individual is not asking for continued services.

(c) Be in an easily understood format following 42 C.F.R. Sec. 438.10(2017), which includes requirements that each notice:

(i) Be written in the individual's non-English language, if applicable;

(ii) Contains the BHO's toll-free and TTY/TDY telephone number; and

(iii) Explains the availability of free written translation, oral interpretation to include any non-English language, auxiliary aids such as American sign language and TTY/TDY telephone services, and alternative formats to include large print and Braille.

(10) When the BHO does not act within the appeal process time frames explained in this section, the individual is considered to have exhausted the appeal process and has a right to request an administrative hearing.

(((~~8~~))) (11) **Duration of continued services during the appeal process.** When an individual has requested continued behavioral health services pending the outcome of the appeal process and the criteria in this section have been met, the BHO ((~~ensures~~)) must ensure the services are continued until one of the following occurs:

(a) The individual withdraws the appeal((~~.~~)); or

(b) The BHO provides a written notice of the resolution that contains a decision that is not in favor of the individual and the individual does not request an administrative hearing within ten calendar days from the date the BHO mails the notice((~~. (See)~~)); see WAC 388-877-0675, administrative hearings, for rules on duration of continued services during the administrative hearing process.((~~)~~))

(((~~(c) The time period of a previously authorized service has expired.~~

~~(d) A behavioral health treatment service limit of a previously authorized service has been fulfilled.~~))

(((~~9~~))) (12) **Reversal of an adverse benefit determination**. If the final written notice of the resolution of the appeal or administrative hearing reverses the adverse benefit determination, the BHO must authorize or provide the behavioral health service(s) no later than seventy-two hours from the date it receives notice of the adverse benefit determination being overturned.

(13) **Recovery of the cost of behavioral health services in adverse decisions of appeals.** If the final written notice of the resolution of the appeal is not in favor of the individual, the BHO may recover the cost of the behavioral health services furnished to the individual while the appeal was pending to the extent that they were provided solely because of the requirements of this section. Recovery of the cost of medic-

aid services is limited to the first sixty days of services after the department or the office of administrative hearings (OAH) receives an administrative hearing request. See RCW 74.09.741.

(((~~(10)~~))) (14) **Recordkeeping and maintenance of appeals**. The BHO must ((~~maintain~~)) ensure that full records of all appeals ((~~and ensure an individual's records~~)) and materials received and compiled in the course of processing and attempting to resolve appeals are:

(a) Kept for ((~~six~~)) a period of no less than ten years after the completion of the appeal process;

(b) Made available to the department upon request as part of the state quality strategy and made available upon request to the centers for medicare and medicaid services (CMS);

(c) Kept in confidential files separate from the individual's clinical record; ((~~and~~))

(d) Not disclosed without the individual's written permission, except to the department or as necessary to resolve the appeal; and

(e) Accurately maintained and contain, at a minimum, all of the following information:

(i) A general description of the reason for the appeal;

(ii) The date received;

(iii) The date of each review or, if applicable, review meeting;

(iv) Resolution at each level of the appeal, if applicable;

(v) Date of resolution at each level, if applicable; and

(vi) Name of the covered person for whom the appeal was filed.

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0675 Administrative hearings. (1) An administrative hearing (also known as "fair hearing") is a proceeding before an administrative law judge (ALJ) that gives an individual, as defined in WAC ((~~388-877-0200~~)) 388-877-0655, an opportunity to be heard in disputes about ((~~a behavioral health program or service~~)) adverse benefit determinations or a decision of a behavioral health organization (BHO) to deny or limit authorization of a requested nonmedicaid service communicated on a notice of determination.

(2) An individual ((~~must first exhaust the grievance process described in WAC 388-877-0660, or the appeal process described in WAC 388-877-0670 before requesting~~)) may request an administrative hearing for the following reasons:

(a) After an individual receives notice that the BHO upheld an adverse benefit determination;

(b) After an individual receives a BHO decision to deny or limit authorization of a requested nonmedicaid service communicated on a notice of determination; or

(c) If the BHO does not act within the grievance or appeal process time frames described in WAC 388-877-0660 and 388-877-0670. In this case, the individual is considered to have exhausted the appeal process and has a right to request an administrative hearing.

(3) An individual ((~~requesting~~)) who requests an administrative hearing must do so within one of the following ((~~timeframes~~)) time frames:

(a) If continued services are not requested, a hearing must be requested within ((~~ninety~~)) one hundred twenty calendar days from((~~:~~

~~(i) The date on the written notice from the agency or behavioral health organization (BHO) at the end of the grievance process; or~~

~~(ii)~~)) the date on the written notice of the resolution received from the BHO at the end of the appeal process or one hundred twenty calendar days from the date on the notice of determination.

(b) If continued medicaid services are requested pending the outcome of the administrative hearing, all of the following apply:

(i) The individual appealed a decision on ((~~a~~)) the notice of ((~~action must be~~)) adverse benefit determination for termination, suspension, or reduction of the individual's behavioral health services ((~~and the individual appealed this decision~~));

(ii) The individual ((~~received a written notification of the resolution of the appeal from the BHO that upholds the decision on the notice of action~~)) appealed the adverse benefit determination and the BHO upheld the adverse benefit determination; and

(iii) The individual requests an administrative hearing and continued behavioral health services within ten calendar days of the date on the written notification of the resolution.

(c) The BHO is not obligated to continue nonmedicaid services pending the result of an administrative hearing when available resources are exhausted, since services cannot be authorized without funding regardless of medical necessity.

(4) If an individual ((~~requests an expedited administrative hearing, the expedited hearing must be requested within ten calendar days from the date on the notice of the resolution~~)) or the individual's behavioral health provider believes that the time taken for a standard administrative hearing could seriously jeopardize the individual's life, physical or mental health, or ability to attain, maintain, or regain maximum function, an expedited hearing may be requested. Subsection (3)(b) and (c) of this section applies if continued behavioral health services are requested.

(5) ((~~If a written notice was not received under subsection (3) or (4) of this section, the individual may still~~)) The BHO's failure to issue an appeal decision in writing within the time frames in WAC 388-877-0670 constitutes exhaustion of the appeal process and the individual may request an administrative hearing.

(6) When the criteria in this section are met for continued services, the BHO ((~~continues~~)) must continue the individual's behavioral health treatment services during the administrative hearing process until one of the following occurs:

(a) The individual withdraws the hearing request.

(b) The administrative law judge issues a hearing decision adverse to the individual.

((~~(c) The period covered by the original authorization of mental health services has expired.~~))

(7) If the administrative hearing decision is not in favor of the individual, the BHO may recover the cost of the behavioral health services furnished to the individual while the hearing was pending to the extent that they were provided solely because of the requirements of this section. Recovery of the cost of medicaid services is limited to the first sixty

days of services after the department or the office of administrative hearings (OAH) receives an administrative hearing request. See RCW 74.09.741.

(8) ((~~For purposes of this chapter,~~)) Administrative hearings include ((~~administrative hearings,~~)) adjudicative proceedings((~~,~~)) and any other similar term referenced under chapter 34.05 RCW, the Administrative Procedure Act, Title 388 WAC, chapter 10-08 WAC, or other law. Chapter 34.05 RCW and chapter 388-02 WAC govern cases where an individual has an issue involving a service that is not funded by medicaid. Chapter 34.05 RCW and chapter 182-526 WAC govern cases where an individual has an issue involving a service that is funded by medicaid.

AMENDATORY SECTION (Amending WSR 16-13-087, filed 6/15/16, effective 7/16/16)

WAC 388-877-0680 Individual rights specific to medicaid recipients. (1) Medicaid recipients have general individual rights and medicaid-specific rights when applying for, eligible for, or receiving behavioral health services authorized by a behavioral health organization (BHO).

(a) General rights that apply to all individuals, regardless of whether an individual is or is not a medicaid recipient, include:

(i) All applicable statutory and constitutional rights;

(ii) The participant rights provided under WAC 388-877-0600; and

(iii) Applicable necessary supplemental accommodation services listed in chapter 388-472 WAC.

(b) Medicaid-specific rights that apply specifically to medicaid recipients include the following. You have the right to:

(i) Receive medically necessary behavioral health services, consistent with access to care standards adopted by the department in its managed care waiver with the federal government. Access to care standards provide minimum standards and eligibility criteria for behavioral health services and are available on the behavioral health administration's (BHA) division of behavioral health and recovery (DBHR) website.

(ii) Receive the name, address, telephone number, and any languages offered other than English, of behavioral health providers in your BHO.

(iii) Receive information about the structure and operation of the BHO.

(iv) Receive emergency or urgent care or crisis services.

(v) Receive post-stabilization services after you receive emergency or urgent care or crisis services that result in admission to a hospital.

(vi) Receive age and culturally appropriate services.

(vii) Be provided a certified interpreter and translated material at no cost to you.

(viii) Receive information you request and help in the language or format of your choice.

(ix) Have available treatment options and alternatives explained to you.

(x) Refuse any proposed treatment.

(xi) Receive care that does not discriminate against you.

(xii) Be free of any sexual exploitation or harassment.

(xiii) Receive an explanation of all medications prescribed and possible side effects.

(xiv) Make a mental health advance directive that states your choices and preferences for mental health care.

(xv) Receive information about medical advance directives.

(xvi) Choose a behavioral health care provider for yourself and your child, if your child is under thirteen years of age.

(xvii) Change behavioral health care providers at any time for any reason.

(xviii) Request and receive a copy of your medical or behavioral health services records, and be told the cost for copying.

(xix) Be free from retaliation.

(xx) Request and receive policies and procedures of the BHO and behavioral health agency as they relate to your rights.

(xxi) Receive the amount and duration of services you need.

(xxii) Receive services in a barrier-free (accessible) location.

(xxiii) Receive medically necessary services in accordance with the early periodic ((~~screen~~)) screening, diagnosis, and treatment (EPSDT) under WAC 182-534-0100, if you are twenty years of age or younger.

(xxiv) Receive enrollment notices, informational materials, materials related to grievances, appeals, and administrative hearings, and instructional materials relating to services provided by the BHO, in an easily understood format and non-English language that you prefer.

(xxv) Be treated with dignity, privacy, and respect, and to receive treatment options and alternatives in a manner that is appropriate to your condition.

(xxvi) Participate in treatment decisions, including the right to refuse treatment.

(xxvii) Be free from seclusion or restraint used as a means of coercion, discipline, convenience, or retaliation.

(xxviii) Receive a second opinion from a qualified professional within your BHO area at no cost, or to have one arranged outside the network at no cost to you, as provided in ((~~42 C.F.R. § 438.206(3)~~)) 42 C.F.R. Sec. 438.206 (b)(3) (2015).

(xxix) Receive medically necessary behavioral health services outside of the BHO if those services cannot be provided adequately and timely within the BHO.

(xxx) File a grievance with the behavioral health agency or BHO if you are not satisfied with a service.

(xxxi) Receive a notice of ((~~action~~)) adverse benefit determination so that you may appeal any decision by the BHO that denies or limits authorization of a requested service, that reduces, suspends, or terminates a previously authorized service, or that denies payment for a service, in whole or in part.

(xxxii) File an appeal if the BHO fails to provide services in a timely manner as defined by the state((~~, or act within the timeframes provided in 42 CFR § 438.408(b)~~)).

(xxxiii) Request an administrative (fair) hearing if your ((~~grievance or~~)) appeal is not resolved in your favor or if the

BHO does not act within the grievance or appeal process time frames described in WAC 388-877-0660 and 388-877-0670.

(xxxiv) Request services by the behavioral health ombuds office to help you ((~~in filing~~)) file a grievance or appeal((~~,~~)) or ((~~to~~)) request an administrative hearing.

(2) A behavioral health agency licensed by the division of behavioral health and recovery (DBHR) ((~~and certified by DBHR to provide~~)) that provides DBHR-certified mental health ((~~and/or~~)) services, DBHR-certified substance use disorder services, or both, must ensure the medicaid rights described in subsection (1)(b) of this section are:

(a) Provided in writing to each medicaid recipient, and if appropriate, the recipient's legal representative, on or before admission;

(b) Upon request, given to the medicaid recipient in an alternative format or language appropriate to the recipient and, if appropriate, the recipient's legal representative;

(c) Translated to the most commonly used languages in the agency's service area; and

(d) Posted in public areas.

Adopted under notice filed as WSR 17-16-138 on August 1, 2017.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 5, Repealed 0.

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 0, Repealed 0.

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

Date Adopted: October 4, 2017.

Chris P. S. Reykdal
State Superintendent
of Public Instruction

WSR 17-21-001
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed October 5, 2017, 8:19 a.m., effective November 5, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: These permanent rules implement section 3 of E2SHB 1546 (2015), which authorizes the superintendent of public instruction to adopt rules administering Washington's college in the high school (CHS) program. The rules have been jointly developed by the office of superintendent of public instruction (OSPI), the state board of [for] community and technical colleges, the student achievement council, and public baccalaureate institutions. The Association of Washington School Principals were consulted during the rules development.

Working with these agencies, including the Council of Presidents representing the public baccalaureate institutions, OSPI convened a workgroup that jointly developed amended rules for chapter 392-725 WAC. Among other things, the amended rules remove OSPI staff from the committee tasked with completing the new CHS program review process in order to ensure that the peer review process inherent within the quality review of these college courses is performed by OSPI's higher education partners. The amended rules also add a new section, specific to codelivery, to ensure the equitable access to quality CHS opportunities for all students.

The amended rules outline quality and eligibility standards that are informed by nationally recognized standards or models, encourage the maximum use of the program, and do not narrow or limit the enrollment options.

Citation of Rules Affected by this Order: New WAC 392-725-235; and amending WAC 392-725-015, 392-725-120, 392-725-200, 372-725-225, and 392-725-325.

Statutory Authority for Adoption: RCW 28A.600.290.

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-015 Definitions. The following definitions in this section apply throughout this chapter.

(1) **"College in the high school course"** means a dual credit course provided on a high school campus or in a high school environment in which an eligible student is given the opportunity to earn high school credit to be awarded by a district, charter school, or tribal compact school and college credit awarded by the participating institution of higher education by completing a college level course with a passing grade. College in the high school courses may be either academic or career and technical (vocational) education.

(2) **"Eligible student"** means any student who meets the following conditions:

(a) The student meets the definition of an enrolled student pursuant to WAC 392-121-106.

(b) The student under the grade placement policies of the district, charter school, or tribal compact school through which the high school credits will be awarded has been deemed to be a tenth, eleventh, or twelfth grade student.

(c) The student has met the student standards pursuant to WAC 392-725-130 and the general requirements and conditions pursuant to WAC 392-725-225(2).

(3) **"Participating institution of higher education"** means an institution of higher education that:

(a) A district, charter school, or tribal compact school has contracted with to provide the college in the high school courses;

(b) Meets the definition in RCW 28B.10.016, is authorized or exempt under the requirements of chapter 28B.85 RCW, or is a public tribal college located in Washington as noted in RCW 28A.600.290 (7)(a);

(c) Meets the college in the high school program standards outlined in WAC 392-725-130 through 392-725-150; and

(d) Is accredited by National Alliance of Concurrent Enrollment Partnerships or commits to the annual reporting of evidence requirement outlined in WAC 392-725-120.

(4) **"National Alliance of Concurrent Enrollment Partnerships"** is the professional organization that works to ensure that college in the high school courses are as rigorous as courses offered on the sponsoring college campuses. National Alliance of Concurrent Enrollment Partnerships has defined a set of quality standards that is the basis of their accreditation process.

(5) **"Council of presidents"** is defined throughout this chapter as the organization representing the interest of public baccalaureate institutions, specific to RCW 28A.600.290(6).

(6) **"Provisional status"** is the status that a college in the high school program may be assigned after the program's evidence of meeting the standards submitted in the annual report was found to be unsatisfactory by the review committee. A program is in provisional status up to six months after the review of the annual report.

(7) **"Fees."**

(a) **"College in the high school fees"** means the per credit fee charged by the participating institution of higher education for the registration for the college course.

(i) The maximum dual credit fee shall not exceed the college in the high school state-funded subsidies allocated in the current Omnibus Appropriations Act.

(ii) The dual credit fee may be less than the college in the high school state-funded subsidies allocation.

(iii) The institution of higher education must receive the corresponding fee for any student seeking to earn college credit from the college in the high school course in accordance with the general requirements identified in WAC 392-725-225 (2)(a) unless the student qualifies for the state-funded subsidies in accordance with WAC 392-725-325(4).

(b) **"Other associated college in the high school fees"** means additional fees required to fully participate in the college in the high school course charged by the participating institution of higher education such as registration fees and fees for consumables.

(8) **"College in the high school state-funded subsidies"** means the amount provided in the Omnibus Appropriations Act that pays the dual credit fee for specific eligible eleventh or twelfth grade students pursuant to RCW 28A.600.290 (1)(b)(i) only and for the limited amount provided in WAC 392-725-325(2).

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-120 Demonstration and reporting of evidence of required college in the high school standards. (1) Participating institutions of higher education shall provide evidence that they meet the most recent National Alliance of Concurrent Enrollment Partnerships student standards, curriculum and assessment standards, faculty standards and evaluation standards unless recommended differently in WAC 392-725-130 through 392-725-160. National Alliance of Concurrent Enrollment Partnerships accreditation is recommended.

(2) As a condition of eligibility pursuant to WAC 392-725-015(3), after the college in the high school course concludes, institutions of higher education shall provide an annual report consisting of evidence that the required standards were met, consistent with the evidence National Alliance of Concurrent Enrollment Partnerships requires to meet standards. The annual report shall be submitted no later than July 1st for review by the college in the high school standards report review committee. Participating institutions of higher education that are accredited by the National Alliance of Concurrent Enrollment Partnerships for the current year of enrollment will be exempt from this requirement.

(3) The ((~~office of superintendent of public instruction~~)) Washington student achievement council shall ((~~convene~~)) be the convener of a college in the high school standards report review committee. This review committee will consist of a representative ((~~of~~)) from the state board of community and technical colleges, ((~~a representative of~~)) the council of presidents, ((~~a representative of~~)) and the student achievement council((~~, and a representative from the office of superintendent of public instruction~~)). Additional members may be included at the discretion of college in the high school standards report review committee.

(4) The review committee will no later than August 15th advise the institution of higher education whether the required standards have been met.

(5) If the review committee finds that the institution of higher education's evidence of meeting the required standards is not satisfactory, the institution of higher education will have no more than six months to make any necessary reporting corrections and/or program adjustments to provide satisfactory evidence. During this period, the program will be under provisional status until evidence shows the program has met the standards or the program is made ineligible.

(6) If after review of the additional evidence, the review committee deems that the standards ((~~are~~)) were not ((~~being~~)) met, then the institution of higher education is ineligible and may not offer the college in the high school program ((~~for~~)) starting with the following ((~~school year~~)) fall term. To regain eligibility, the institution of higher education must, by July 1, submit an updated plan for how the standards will be met.

(7) If the institution of higher education is deemed ineligible, the institution of higher education can appeal to a three person appeals committee convened by the student achievement council, and including representatives from the student achievement council, state board of community and technical colleges and council of presidents. The original review committee members would be excluded from the appellate process.

(8) The review committee will review the National Alliance of Concurrent Enrollment Partnerships standards beginning in 2019 and every three years thereafter, and update the college in the high school standards in WAC 392-725-130 through 392-725-160 as informed by the current National Alliance of Concurrent Enrollment Partnerships standards and feedback from participating school districts, charter schools, tribal compact schools, and institutions of higher education.

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-200 Prior confirmation of high school credit. As a condition to an eligible student's enrollment in college courses, the eligibility of the college in the high school courses which the student intends to take for the award of high school credit and the amount of such credit shall first be established, as follows:

(1) The district, charter school, or tribal compact school shall establish on a course by course basis the amount of high school required or elective credit, or combination thereof, that shall be awarded for each college in the high school course successfully completed by the student based upon the conversion rate set forth in WAC 180-51-050.

(2) If a college in the high school course is not comparable to a district, charter school, or tribal compact school course required for high school graduation, the district, charter school, or tribal compact school superintendent shall determine the amount of required high school credit which shall be awarded following consultation with a representative of the institution of higher education designated for that purpose. The difference between the amount of ((~~required~~)) credit required and the amount of credit earned at the conversion rate set forth in WAC 180-51-050 shall be awarded as elective credit.

(3) Within five school days of a student's request for confirmation of credit, the district, charter school, or tribal compact school superintendent or other designated representative shall confirm in writing the amount of high school required or elective credit, or combination thereof, which shall be awarded upon successful completion of the courses.

(4) Upon confirmation by the college in the high school instructor of a student's successful completion of a college in the high school course under this chapter, the district, charter school, or tribal compact school shall record on the student's secondary school records and transcript the high school credit previously confirmed under the section with a notation that the courses were taken at an institution of higher education pursuant to WAC 392-415-070.

(5) Each district, charter school, or tribal compact school and institution of higher education shall independently have and exercise exclusive jurisdiction over academic and discipline matters involving a student's enrollment and participation in courses of, and the receipt of services and benefits from the district, charter school, tribal compact school or the institution of higher education.

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-225 College in the high school general requirements. (1) Participating districts, charter schools, or tribal compact schools must provide general information about the college in the high school program to all students in grades nine through twelve and to the parents and guardians of those students.

(2) The enrollment of a student who meets the definition of WAC 392-725-015(2) in the college in the high school program shall be governed as follows:

(a) An eligible student seeking to earn college credit is responsible for enrolling into an institution of higher education on or before the deadline established by the institution of higher education.

(b) An eligible student is entitled to enroll in an institution of higher education for college in the high school program purposes subject to each of the following conditions and limitations:

(i) Enrollment is limited to college level courses.

(ii) Prior confirmation pursuant to WAC 392-725-200 by the district, charter school, or tribal compact school of the amount of high school credit to be awarded for a college in the high school course on or before the deadline for enrollment established by the institution of higher education.

(iii) Acceptance of the student by the institution of higher education subject to enrollment requirements and limitations established by the institution((~~, including a determination that the student is competent to profit from the college level course(s) in which the student seeks to enroll~~)).

NEW SECTION

WAC 392-725-235 Co-delivery of college in the high school courses. (1) In cases where a college in the high school course is co-delivered with another dual credit course, such as advanced placement, international baccalaureate, or Cambridge international, the participating institution of higher education, in coordination with the institution's academic department, shall assess curriculum alignment and approve the option to provide a co-delivered course.

(2) In cases where a college in the high school course is co-delivered with another dual credit course, the high school transcript shall reflect the co-delivered courses as follows:

(a) The course title as listed on the high school transcript shall begin with the institute of higher education's curriculum and course number, as described in the office of superintendent of public instruction CEDARS manual.

(b) Any additional course title description for a co-delivered college in the high school course title shall be included pursuant to WAC 392-415-070.

Official course abbreviations for advanced placement, international baccalaureate and Cambridge international shall be included on the high school transcript as listed in appendix Q of the office of superintendent of public instruction CEDARS manual.

(c) For approved co-delivered courses, as provided in subsection (1) of this section, the high school transcript course title and course designators may reflect two dual credit programs in cases where students have met any required prerequisites or other entrance requirements for both programs.

(3) Students choosing to enroll in a co-delivered college in the high school course for the purpose of earning college credit must meet the college in the high school enrollment requirements outlined in WAC 392-725-225(2).

AMENDATORY SECTION (Amending WSR 16-14-030, filed 6/27/16, effective 7/28/16)

WAC 392-725-325 College in the high school state funded subsidies. Pursuant to RCW 28A.600.290 and sub-

ject to the amount ((~~provided~~)) appropriated for such purposes in the Omnibus Appropriations Act, state funded subsidies may be available to pay the cost of college in the high school fees for specific eligible eleventh or twelfth grade students only enrolled in college in the high school courses provided by institutions of higher education that meet the definition in RCW 28B.10.016, or a public tribal college located in Washington as noted in RCW 28A.600.290 (7)(a), and for the limited amount provided in subsection (2) of this section. Public institutions of higher education that are outside of the state of Washington or private institutions of higher education do not qualify for the state funded subsidies.

(1) Prioritization of the available college in the high school state-funded subsidies will be allocated in the following method:

(a) High schools that are and students that reside twenty driving miles or more as measured by the most direct route from the nearest institution of higher education offering running start.

(b) High schools who receive small high school funding enhancement as provided in the Omnibus Appropriations Act.

(c) For the remaining high schools, eligible students who qualify for the new school year for free and reduced price lunch.

(2) Limitation of college in the high school state-funded subsidies are as follows:

(a) For each eligible eleventh and twelfth grade student, the annual credit amounts for subsection (1)(a) through (b) of this section are limited to the annual credit amounts provided in the Omnibus Appropriations Act but may not exceed ten credits for any school year.

(b) The annual credit amounts for subsection (1)(c) of this section are limited to the annual credit amounts provided in the Omnibus Appropriations Act but may not exceed five credits for any school year.

(3) The office of superintendent of public instruction will provide an application process that districts, charter schools, and tribal compact schools will use to apply annually for the college in the high school state-funded subsidies.

(a) Districts, charter schools, and tribal compact schools will apply by July 1st for the new school year's subsidies.

(b) The office of superintendent of public instruction will notify districts, charter schools, and tribal compact schools by September 1st the amount of subsidies awarded for the new school year.

(c) Through the application process, districts, charter schools, and tribal compact schools will provide a list of college in the high school courses per high school for the new school year. The award of subsidies will be limited to the courses provided in the application process.

(d) The list of college in the high school courses will contain the amount of college quarter credits awarded for each course. For this section only, college semester credits will be converted into quarter credits by multiplying the semester credits by 1.5 and rounding up to the nearest whole credit.

(e) Districts, charter schools, and tribal compact schools will provide an estimate of eligible students expected to receive the subsidies within the per student credit limitation provided in the Omnibus Appropriations Act.

(i) For high schools that qualify for the priorities according to subsection (1)(a) and (b) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students.

(ii) For high schools that qualify for the priorities according to subsection (1)(b) and (c) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students that live more than twenty miles from a college offering running start.

(iii) For high schools that qualify for subsection (1)(c) of this section, applicant will provide an estimate of eligible eleventh and twelfth grade students that are expected to qualify for free and reduced price lunch.

(4) Reimbursement of the college in the high school state-funded subsidies will occur as follows:

(a) Beginning with the 2015-16 school year, the college in the high school state-funded subsidies for college in the high school will be allocated at minimum sixty-five dollars per quarter credits.

(b) Starting with the 2017 calendar year, and for every four years after, the funding level for the college in the high school state-funded subsidies will be reviewed by the office of superintendent of public instruction, the student achievement council, the state board for community and technical colleges, and the council of presidents representing the public baccalaureate institutions and make recommendation to the legislature for an increase to the funding level of the college in the high school state funded subsidies.

(c) The college in the high school state-funded subsidies will be paid after the completion of the course.

(d) Districts, charter schools, and tribal compact schools with high schools eligible for the college in the high school state-funded subsidies will submit a request for payment of subsidies form to the office of the superintendent of public instruction. The request for payment will include the actual number of completed credits for eligible eleventh and twelfth grade students who have not exceeded the credit limitation pursuant to subsection (2) of this section.

(e) The office of the superintendent of public instruction will review the request for payment of subsidies form and fund the reporting district, charter school, and tribal compact school one hundred percent of the approved college in the high school subsidies on the following monthly apportionment payment.

(f) One hundred percent of the subsidies generated will be forwarded to the participating institution of higher education that provided the college in the high school program.

WSR 17-21-003

PERMANENT RULES

DEPARTMENT OF HEALTH

(Board of Naturopathy)

[Filed October 5, 2017, 11:10 a.m., effective November 5, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-836-700 Temporary practice permit—Military spouse eligibility and issuance (naturopathic physicians), the board of naturopathy (board) adopted a new section of rule to establish the process and criteria for temporary practice permits for military spouse or state-registered domestic partner applicants whose spouse or partner is the subject of a military transfer to Washington state, and who meet the specific requirements under RCW 18.340.020. The rule adopts by reference secretary rules in chapter 246-12 WAC and implements chapter 18.340 RCW. The applicant must be credentialed in another state with substantially equivalent standards. The temporary practice permit will allow approved military spouse or state-registered domestic partner applicants to practice in the full scope of their profession for up to one hundred eighty days pending issuance of a permanent credential. The code reviser's CR-102 form filed under WSR 17-08-064 noted that the board was creating a new section, WAC 246-836-610, when in fact the rule as proposed was WAC 246-836-700. This was acknowledged in the code reviser's register at the time of the CR-102 filing under WSR 17-08-064. This rule was adopted as WAC 246-836-700.

Citation of Rules Affected by this Order: New WAC 246-836-700.

Statutory Authority for Adoption: RCW 18.36A.160 and 18.340.020.

Adopted under notice filed as WSR 17-08-064 on March 31, 2017.

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

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

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

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

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

Date Adopted: October 5, 2017.

Chad Aschtgen, ND, Chair
Board of Naturopathy

NEW SECTION

WAC 246-836-700 Temporary practice permit—Military spouse eligibility and issuance. A military spouse or state registered domestic partner of a military person may receive a temporary practice permit while completing any specific additional requirements that are not related to training or practice standards for naturopathic physicians. The board adopts the procedural rules as adopted by the department of health in WAC 246-12-051.

WSR 17-21-025
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 10, 2017, 9:12 a.m., effective November 10, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending WAC 388-450-0215 How does the department estimate my assistance unit's income to determine my eligibility and benefits?, to correct a typographical error. This amendment changes incorrect references contained in subsections (4)(a) and (7)(b) from subsection (6) to subsection (5).

Citation of Rules Affected by this Order: Amending WAC 388-450-0215.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.500, 74.04.510, 74.08.090, 74.08A.120.

Adopted under notice filed as WSR 17-14-105 on July 5, 2017.

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

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

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

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

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

Date Adopted: October 9, 2017.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-18-007, filed 8/22/13, effective 10/1/13)

WAC 388-450-0215 How does the department estimate my assistance unit's income to determine my eligibility and benefits? (1) We decide if your assistance unit (AU) is eligible for benefits and calculate your monthly benefits based on an estimate of your AU's gross monthly income and expenses. This is known as prospective budgeting.

(2) We use your current, past, and future circumstances for a representative estimate of your monthly income.

(3) We may need proof of your circumstances to ensure our estimate is reasonable. This may include documents, statements from other people, or other proof as explained in WAC 388-490-0005.

(4) We use one of two methods to estimate income:

(a) **Anticipating monthly income (AM):** With this method, we base the estimate on the actual income we expect your AU to receive in the month ((~~(see subsection (6))~~)), as described in subsection (5) of this section; ((~~and~~)) or

(b) **Averaging income (CA):** With this method, we add the total income we expect your AU to receive for a period of time and divide by the number of months in the period (((~~(see)~~), as described in subsection (6)((~~)~~)) of this section.

(5) Anticipating monthly income: We must use the anticipating monthly method:

(a) When we estimate income for anyone in your AU, if you or anyone in your AU receive SSI-related medical benefits under chapter 182-512 WAC.

(b) When we must allocate income to someone who is receiving SSI-related medical benefits under chapter 182-512 WAC.

(c) In the month of application, when you are a destitute migrant or destitute seasonal farmworker under WAC 388-406-0021. In this situation, we must use anticipating monthly (AM) for all your AU's income.

(d) To budget SSI or Social Security benefits even if we average other sources of income your AU receives.

(6) Averaging income: When we average your income, we consider changes we expect for your AU's income. We determine a monthly amount of your income based on how often you are paid:

(a) If you are paid weekly, we multiply your expected income by 4.3;

(b) If you are paid every other week, we multiply your expected income by 2.15;

(c) In most cases if you receive your income other than weekly or every other week, we estimate your income over your certification period by:

(i) Adding the total income for representative period of time;

(ii) Dividing by the number of months in the time frame; and

(iii) Using the result as a monthly average.

(d) If you receive your yearly income over less than a year because you are self-employed or work under a contract, we average this income over the year unless you are:

(i) Paid on an hourly or piecework basis; or

(ii) A migrant or seasonal farmworker under WAC 388-406-0021.

(7) We use the same method for each month in your certification period, including the month of application, unless:

(a) A full month's income is not anticipated in the month of application. In this situation, we budget your income in the month of application using the anticipated monthly (AM) method and average your income (CA) for the rest of the months in your certification.

(b) You are a destitute migrant or destitute seasonal farmworker. We must budget your income in the month of application using the anticipated monthly method, as required by subsection (((~~(6)~~)) (5) of this section. We may average your income for the rest of the months in your certification period.

(8) If you report a change in your AU's income, and we expect the change to last through the end of the next month after you reported it, we update the estimate of your AU's income based on this change.

(9) If your actual income is different than the income we estimated, we don't make you repay an overpayment under chapter 388-410 WAC or increase your benefits unless you meet one of the following conditions:

(a) You provided incomplete or false information; or

(b) We made an error in calculating your benefits.

WSR 17-21-026

PERMANENT RULES

DEPARTMENT OF LICENSING

[Filed October 10, 2017, 9:29 a.m., effective November 10, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: These rule amendments reflect changes in the distracted driving laws. Specifically, "use of a personal electronic device while driving" and "dangerously distracted driving" will be included in the model traffic ordinance and the moving and nonmoving violations rules. The driver training school WAC is updated to reflect the accurate RCW reference for "use of a personal electronic device while driving." This rule making is necessary to meet the requirements of SSB 5289 (2017), modifying the infraction of and penalties for distracted driving.

Citation of Rules Affected by this Order: Amending WAC 308-104-160, 308-108-165, and 308-330-464.

Statutory Authority for Adoption: RCW 46.01.110, 46.20.2891, 46.82.290, and 46.90.010.

Adopted under notice filed as WSR 17-18-086 on September 5, 2017.

Changes Other than Editing from Proposed to Adopted Version: The adopted language puts references to the repealed statutes (RCW 46.61.667 (1)(b) and 46.61.668 (1)(b)) back into WAC 308-104-160 Moving and nonmoving violations defined. This is because commercial driver's license holders can still be cited for these infractions in other states and the department needs the ability to add these references to the driver's record.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 3, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 3, Repealed 0.

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

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

Date Adopted: October 10, 2017.

Damon Monroe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-16-101, filed 8/2/16, effective 9/2/16)

WAC 308-104-160 Moving and nonmoving violations defined. For purposes of RCW 46.20.2891, 46.65.020, and this chapter, the term "moving violation" means any violation of vehicle laws listed in this section that is committed by the driver of a vehicle, while the vehicle is moving. However, being in actual physical control of a motor vehicle while under the influence of intoxicating liquor or any drug is also considered a moving violation for the purposes of this section. Parking violations, equipment violations or paperwork violations relating to insurance, registration, licensing and inspection are considered "nonmoving violations." Moving violations are those violations included in the following list or violations of substantially similar laws, administrative regulations, local laws, ordinances, regulations, or resolutions of a political subdivision of this state, the federal government, or any other state:

(1) Driving while under the influence of intoxicating liquor or any drug as defined by RCW 46.61.502;

(2) Physical control of a motor vehicle while under the influence of intoxicating liquor or any drug, as defined by RCW 46.61.504;

(3) Vehicular homicide, as defined by RCW 46.61.520;

(4) Vehicular assault, as defined by RCW 46.61.522;

(5) Reckless driving, as defined by RCW 46.61.500;

(6) Racing, as defined by RCW 46.61.530;

(7) Embracing, as defined by RCW 46.61.665;

(8) Hit and run (injury, death, striking the body of a deceased person, or occupied vehicle), as defined by RCW 46.52.020;

(9) Attempting to elude a police vehicle, as defined by RCW 46.61.024;

(10) Driving while driving privilege suspended or revoked, as defined by RCW 46.20.342, 46.20.345, or 46.20.394;

(11) Reckless endangerment of roadway workers, as defined in RCW 46.61.527;

(12) Driver under twenty-one driving or being in physical control of a motor vehicle after consuming alcohol or marijuana, as defined in RCW 46.61.503;

(13) Driving or in physical control of commercial motor vehicle while having alcohol in system, as defined in RCW 46.25.110;

(14) Open container violation (driver), as defined by RCW 46.61.519 or 46.61.745;

(15) Negligent driving in the first degree, as defined by RCW 46.61.5249;

(16) Negligent driving in the second degree, as defined by RCW 46.61.525 or 46.61.526;

(17) Hit and run (unattended vehicle or property), as defined by RCW 46.52.010;

(18) Disobey road sign, as defined by RCW 46.61.050, 46.61.070, or 46.61.450;

(19) Disobey signalman, officer, or firefighter, as defined by RCW 46.61.015, 46.61.020, 46.61.021, or 46.61.022;

(20) Disobey school patrol, as defined by RCW 46.61.385;

(21) Speed too fast for conditions, as defined by RCW 46.61.400;

(22) Speed in excess of maximum limit, as defined by RCW 46.61.400 or 46.61.460;

(23) Speeding in a school zone, as defined by RCW 46.61.440;

(24) Failure to stop, as defined by RCW 46.61.055, 46.61.065, 46.61.195, 46.61.200, 46.61.340, 46.61.345, 46.61.350, 46.61.365, 46.61.370, or 46.61.375;

(25) Failure to yield right of way, as defined by RCW 46.61.180, 46.61.183, 46.61.185, 46.61.190, 46.61.202, 46.61.205, 46.61.210, 46.61.212, 46.61.215, 46.61.220, 46.61.235, 46.61.245, 46.61.261, 46.61.300, or 46.61.427;

(26) Failure to keep to the right, as defined by RCW 46.61.100 or 46.61.105;

(27) Wrong way on a one-way street or rotary traffic island, as defined by RCW 46.61.135;

(28) Improper lane change or travel, as defined by RCW 46.61.140;

(29) Straddling or driving over centerline, as defined by RCW 46.61.140;

(30) Driving on the wrong side of the road, as defined by RCW 46.61.150;

(31) Crossing divider, as defined by RCW 46.61.150;

(32) Improper entrance to or exit from freeway, as defined by RCW 46.61.155;

(33) Violating restrictions on a limited access highway while driving a motor vehicle, as defined by RCW 46.61.160;

(34) High occupancy vehicle lane violation, as defined by RCW 46.61.165;

(35) Improper overtaking or passing, as defined by RCW 46.61.110, 46.61.115, 46.61.120, 46.61.125, 46.61.130, or 46.61.428;

(36) Passing stopped school bus, as defined by RCW 46.61.370;

(37) Passing stopped private carrier bus, as defined by RCW 46.61.375;

(38) Following too closely, as defined by RCW 46.61.145;

(39) Following fire apparatus, as defined by RCW 46.61.635;

(40) Crossing fire hose, as defined by RCW 46.61.640;

(41) Driving on sidewalk, as defined by RCW 46.61.606;

(42) Driving through safety zone, as defined by RCW 46.61.260;

(43) Driving with wheels off roadway, as defined by RCW 46.61.670;

(44) Impeding traffic, as defined by RCW 46.61.100, 46.61.425, or 46.20.427;

(45) Improper turn, as defined by RCW 46.61.290;

(46) Prohibited turn, as defined by RCW 46.61.295;

(47) Failure to signal or improper signal, as defined by RCW 46.61.305, 46.61.310, or 46.61.315;

(48) Improper backing, as defined by RCW 46.61.605;

(49) Unlawful operation of motorcycle on roadway, as defined by RCW 46.61.608, 46.61.612, or 46.61.614;

(50) Reckless endangerment, as defined by RCW 9A.36.050;

(51) Failure to maintain control, as defined by RCW 46.61.445;

(52) Violation of license restriction(s), as defined by RCW 46.20.041 or 46.20.740;

(53) Violation of instruction permit restrictions, as defined by RCW 46.20.055;

(54) Violation of out-of-service order, as defined by RCW 46.25.090;

(55) Obstructed vision or control, as defined by RCW 46.61.615;

(56) Carrying persons or animals outside of vehicle, as defined by RCW 46.61.660;

(57) Carrying passenger in towed vehicle, as defined by RCW 46.61.625;

(58) Coasting on downgrade, as defined by RCW 46.61.630;

(59) Violation of child restraint requirements, as defined by RCW 46.61.687;

(60) Carrying child under the age of five years old on motorcycle, as defined by RCW 46.37.530;

(61) Carrying passenger improperly on motorcycle, as defined by RCW 46.61.610;

(62) No helmet, goggles, mirrors, windshield or face shield, as defined by RCW 46.37.530;

(63) Operating moped on freeway or sidewalk, as defined by RCW 46.61.710;

(64) Driving without lights, as defined by RCW 46.37.-020;

(65) Failure to dim lights, as defined by RCW 46.37.230;

(66) Operating motorcycle without lights, as defined by RCW 46.37.522;

(67) No lamp, reflector, or flag on extended load, as defined by RCW 46.37.140;

(68) Wearing earphones or viewing television in vehicle, as defined by RCW 46.37.480;

(69) Failure to secure load, as defined by RCW 46.37.-490;

(70) Spilling load, as defined by RCW 46.61.655;

(71) Improper towing, as defined by RCW 46.44.070;

(72) Using a ((~~hand-held mobile telephone~~)) personal electronic device while driving ((~~a commercial motor vehicle~~)), as defined by RCW ((~~46.61.667 (1)(b)~~)) 46.61.672; ((~~and~~))

(73) ((~~Texting while driving a commercial motor vehicle~~)) Dangerously distracted driving, as defined by RCW ((~~46.61.668 (1)(b)~~)) 46.61.673;

(74) Using a hand-held mobile telephone while driving, as defined by RCW 46.61.667 (1)(b) (repealed by 2017 c 334 § 2); and

(75) Texting while driving a commercial motor vehicle, as defined by RCW 46.61.668 (1)(b) (repealed by 2017 c 334 § 2).

AMENDATORY SECTION (Amending WSR 09-21-093, filed 10/20/09, effective 11/20/09)

WAC 308-108-165 Prohibition on wireless communication devices during instruction. (1) Driving school instructors must not use ((~~wireless communication~~)) personal electronic devices, hands-free or otherwise, that distract from or interfere with the behind the wheel or classroom instruction task. This includes the use of any communications devices that result in verbal or written text responses while conducting instruction. While supervising the operation of a vehicle, instructors are additionally prohibited from sending or receiving messages with these devices. Ring volumes for these devices, or any phone in proximity, are to be silenced so as not to interfere in any way with the student learning or interacting with the instructor.

(2) This section does not apply to voice activated GPS devices or classroom devices that are being used as part of an approved curriculum. This section also does not preclude the use of devices to report illegal activity, summon medical or other emergency help, or prevent injury to a person or property, as permitted under RCW ((~~46.61.667~~)) 46.61.672.

(3) An unreasonable risk associated with a failure to obey this section is a violation of RCW 18.235.130(4).

AMENDATORY SECTION (Amending WSR 15-24-085, filed 11/30/15, effective 12/31/15)

WAC 308-330-464 RCW sections adopted—Operation and restrictions. The following sections of the Revised Code of Washington (RCW) pertaining to the operation of vehicles and the restriction of certain acts and practices of vehicle operators and passengers as now or hereafter amended are hereby adopted by reference as a part of this chapter in all respects as though such sections were set forth herein in full: RCW 46.61.600, 46.61.605, 46.61.606, 46.61.608, 46.61.610, 46.61.611, 46.61.612, 46.61.614, 46.61.615, 46.61.620, 46.61.625, 46.61.630, 46.61.635, 46.61.640, 46.61.645, 46.61.655, 46.61.660, 46.61.665, ((~~46.61.667, 46.61.668,~~)) 46.61.670, 46.61.672, 46.61.673, 46.61.675, 46.61.680, 46.61.685, 46.61.687, 46.61.688, 46.61.690, 46.61.700, 46.61.705, 46.61.710, 46.61.720, 46.61.723, 46.61.725, 46.61.730, 46.61.735, and 46.61.740.

WSR 17-21-030

PERMANENT RULES

DEPARTMENT OF LICENSING

[Filed October 11, 2017, 9:48 a.m., effective November 11, 2017]

Reviser's note: RCW 34.05.335(4) states that an agency may not adopt a rule before the time established in the published notice. WSR 17-21-030, permanently adopting new section WAC 308-107-090, was adopted and filed before the date of adoption stated in the CR-102. WSR 17-18-080 stated the adoption date would be October 12, 2017. WSR 17-21-030 has been retracted from publication and the agency has refiled the document as WSR 17-22-049 filed on October 25, 2017.

WSR 17-21-040

PERMANENT RULES

HEALTH CARE AUTHORITY

[Filed October 12, 2017, 2:01 p.m., effective November 12, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is replacing estimated acquisition cost with actual acquisition cost to comply with CMS-2345-FC, Covered Outpatient Drug Rule.

Citation of Rules Affected by this Order: Amending WAC 182-531-0050, 182-531-0950, and 182-531-1850.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 17-18-065 on September 1, 2017.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

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

Date Adopted: October 12, 2017.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-09-002, filed 4/5/17, effective 5/6/17)

WAC 182-531-0050 Physician-related services definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, apply to this chapter.

"Acquisition cost" - The cost of an item excluding shipping, handling, and any applicable taxes.

"Acute care" - Care provided for clients who are not medically stable. These clients require frequent monitoring by a health care professional in order to maintain their health status. See also WAC 246-335-015.

"Acute physical medicine and rehabilitation (PM&R)" - A comprehensive inpatient and rehabilitative program coordinated by a multidisciplinary team at an agency-approved rehabilitation facility. The program provides twenty-four hour specialized nursing services and an intense level of specialized therapy (speech, physical, and occupational) for a diagnostic category for which the client shows significant potential for functional improvement (see WAC 182-550-2501).

"Add-on procedure(s)" - Secondary procedure(s) that are performed in addition to another procedure.

"Admitting diagnosis" - The medical condition responsible for a hospital admission, as defined by the ICD diagnostic code.

"Advanced registered nurse practitioner (ARNP)" - A registered nurse prepared in a formal educational program to assume an expanded health services provider role in accordance with WAC 246-840-300 and 246-840-305.

"Allowed charges" - The maximum amount reimbursed for any procedure that is allowed by the agency.

"Anesthesia technical advisory group (ATAG)" - An advisory group representing anesthesiologists who are affected by the implementation of the anesthesiology fee schedule.

"Bariatric surgery" - Any surgical procedure, whether open or by laparoscope, which reduces the size of the stomach with or without bypassing a portion of the small intestine and whose primary purpose is the reduction of body weight in an obese individual.

"Base anesthesia units (BAU)" - A number of anesthesia units assigned to a surgical procedure that includes the usual preoperative, intraoperative, and postoperative visits. This includes the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring by the anesthesiologist.

"Bundled services" - Services integral to the major procedure that are included in the fee for the major procedure. Bundled services are not reimbursed separately.

"Bundled supplies" - Supplies that are considered to be included in the practice expense RVU of the medical or surgical service of which they are an integral part.

"By report (BR)," see WAC 182-500-0015.

"Call" - A face-to-face encounter between the client and the provider resulting in the provision of services to the client.

"Cast material maximum allowable fee" - A reimbursement amount based on the average cost among suppliers for one roll of cast material.

"Center of excellence (COE)" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)," see WAC 182-500-0020.

"Certified registered nurse anesthetist (CRNA)" - An advanced registered nurse practitioner (ARNP) with formal training in anesthesia who meets all state and national criteria for certification. The American Association of Nurse Anesthetists specifies the national certification and scope of practice.

"Children's health insurance plan (CHIP)," see chapter 182-542 WAC.

"Clinical Laboratory Improvement Amendment (CLIA)" - Regulations from the U.S. Department of Health and Human Services that require all laboratory testing sites to have either a CLIA registration or a CLIA certificate of waiver in order to legally perform testing anywhere in the U.S.

"Conversion factors" - Dollar amounts the agency uses to calculate the maximum allowable fee for physician-related services.

"Covered service" - A service that is within the scope of the eligible client's medical care program, subject to the limitations in this chapter and other published WAC.

"CPT," see "current procedural terminology."

"Critical care services" - Physician services for the care of critically ill or injured clients. A critical illness or injury acutely impairs one or more vital organ systems such

that the client's survival is jeopardized. Critical care is given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians and other practitioners who provide physician-related services. CPT is copyrighted and published annually by the American Medical Association (AMA).

"Emergency medical condition(s)," see WAC 182-500-0030.

"Emergency services" - Medical services required by and provided to a patient experiencing an emergency medical condition.

((~~**"Estimated acquisition cost (EAC)"** - The agency's best estimate of the price providers generally and currently pay for drugs and supplies.~~))

"Evaluation and management (E&M) codes" - Procedure codes that categorize physician services by type of service, place of service, and patient status.

"Expedited prior authorization" - The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate to the agency which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

"Experimental" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the federal Food and Drug Administration or other requisite government body, if such approval is required.

"Federally approved hemophilia treatment center" - A hemophilia treatment center (HTC) that:

(1) Receives funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau National Hemophilia Program;

(2) Is qualified to participate in 340B discount purchasing as an HTC;

(3) Has a U.S. Center for Disease Control (CDC) and prevention surveillance site identification number and is listed in the HTC directory on the CDC web site;

(4) Is recognized by the Federal Regional Hemophilia Network that includes Washington state; and

(5) Is a direct care provider offering comprehensive hemophilia care consistent with treatment recommendations set by the Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation in their standards and criteria for the care of persons with congenital bleeding disorders.

"Fee-for-service," see WAC 182-500-0035.

"Flat fee" - The maximum allowable fee established by the agency for a service or item that does not have a relative value unit (RVU) or has an RVU that is not appropriate.

"Geographic practice cost index (GPCI)" - As defined by medicare, means a medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work (work effort), what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

"Global surgery reimbursement," see WAC 182-531-1700.

"HCPCS Level II" - Health care common procedure coding system, a coding system established by Centers for Medicare and Medicaid Services (CMS) to define services and procedures not included in CPT.

"Health care financing administration common procedure coding system (HCPCS)" - The name used for the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) codes made up of CPT and HCPCS level II codes.

"Health care team" - A group of health care providers involved in the care of a client.

"Hospice" - A medically directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington licensed and certified Washington state hospice for terminally ill clients and the clients' families.

"ICD," see "International Classification of Diseases."

"Informed consent" - That an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the client's diagnosis; and

(2) Offered the client an opportunity to ask questions about the procedure and to request information in writing; and

(3) Given the client a copy of the consent form; and

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. Chapter IV 441.257; and

(5) Given the client oral information about all of the following:

(a) The client's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure; and

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital admission" - An admission to a hospital that is limited to medically necessary care based on an evaluation of the client using objective clinical indicators, assessment, monitoring, and therapeutic service required to best manage the client's illness or injury, and that is documented in the client's medical record.

"International Classification of Diseases (ICD)" - The systematic listing that transforms verbal descriptions of diseases, injuries, conditions, and procedures into numerical or alphanumerical designations (coding).

"Investigational" - A term to describe a health care service that lacks sufficient scientific evidence of safety and effectiveness for a particular condition. A service is not "investigational" if the service:

(1) Is generally accepted by the medical professional as effective and appropriate for the condition in question; or

(2) Is supported by an overall balance of objective scientific evidence, that examines the potential risks and potential

benefits and demonstrates the proposed service to be of greater overall benefit to the client in the particular circumstance than another generally available service.

"Life support" - Mechanical systems, such as ventilators or heart-lung respirators, which are used to supplement or take the place of the normal autonomic functions of a living person.

"Limitation extension," see WAC 182-501-0169.

"Long-acting reversible contraceptive (LARC)" - Subdermal implants and intrauterine devices (IUDs).

"Maximum allowable fee" - The maximum dollar amount that the agency will reimburse a provider for specific services, supplies, and equipment.

"Medically necessary," see WAC 182-500-0070.

"Medicare clinical diagnostic laboratory fee schedule" - The fee schedule used by medicare to reimburse for clinical diagnostic laboratory procedures in the state of Washington.

"Medicare physician fee schedule database (MPFSDB)" - The official CMS publication of the medicare policies and RVUs for the RBRVS reimbursement program.

"Medicare program fee schedule for physician services (MPFSPS)" - The official CMS publication of the medicare fees for physician services.

"Mentally incompetent" - A client who has been declared mentally incompetent by a federal, state, or local court.

"Modifier" - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting physician can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"Outpatient," see WAC 182-500-0080.

"Peer-reviewed medical literature" - A research study, report, or findings regarding a medical treatment that is published in one or more reputable professional journals after being critically reviewed by appropriately credentialed experts for scientific validity, safety, and effectiveness.

"Physician care plan" - A written plan of medically necessary treatment that is established by and periodically reviewed and signed by a physician. The plan describes the medically necessary services to be provided by a home health agency, a hospice agency, or a nursing facility.

"Physician standby" - Physician attendance without direct face-to-face client contact and which does not involve provision of care or services.

"Physician's current procedural terminology," see "current procedural terminology (CPT)."

"PM&R," see acute physical medicine and rehabilitation.

"Podiatric service" - The diagnosis and medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the foot and ankle.

"Point-of-sale (POS) actual acquisition cost (AAC)" - The agency determined rate paid to pharmacies through the POS system, which is intended to reflect pharmacy providers' actual acquisition cost.

"Pound indicator (#)" - A symbol (#) indicating a CPT procedure code listed in the agency's fee schedules that is not routinely covered.

"Preventive" - Medical practices that include counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of appropriate laboratory and diagnostic procedures intended to help a client avoid or reduce the risk or incidence of illness or injury.

"Prior authorization," see WAC 182-500-0085.

"Professional component" - The part of a procedure or service that relies on the provider's professional skill or training, or the part of that reimbursement that recognizes the provider's cognitive skill.

"Prognosis" - The probable outcome of a client's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the client's probable life span as a result of the illness.

"Prolonged services" - Face-to-face client services furnished by a provider, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services. The time counted toward payment for prolonged E&M services includes only face-to-face contact between the provider and the client, even if the service was not continuous.

"Provider," see WAC 182-500-0085.

"Radioallergosorbent test" or **"RAST"** - A blood test for specific allergies.

"RBRVS," see resource based relative value scale.

"RBRVS RVU" - A measure of the resources required to perform an individual service or intervention. It is set by medicare based on three components - Physician work, practice cost, and malpractice expense. Practice cost varies depending on the place of service.

"Reimbursement" - Payment to a provider or other agency-approved entity who bills according to the provisions in WAC 182-502-0100.

"Reimbursement steering committee (RSC)" - An interagency work group that establishes and maintains RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Relative value guide (RVG)" - A system used by the American Society of Anesthesiologists for determining base anesthesia units (BAUs).

"Relative value unit (RVU)" - A unit that is based on the resources required to perform an individual service or intervention.

"Resource based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"RSC RVU" - A unit established by the RSC for a procedure that does not have an established RBRVS RVU or has an RBRVS RVU deemed by the RSC as not appropriate for the service.

"RVU," see relative value unit.

"Stat laboratory charges" - Charges by a laboratory for performing tests immediately. "Stat" is an abbreviation for the Latin word "statim," meaning immediately.

"Sterile tray" - A tray containing instruments and supplies needed for certain surgical procedures normally done in an office setting. For reimbursement purposes, tray components are considered by CMS to be nonroutine and reimbursed separately.

"Technical advisory group (TAG)" - An advisory group with representatives from professional organizations whose members are affected by implementation of RBRVS physician fee schedules and other payment and purchasing systems utilized by the agency and the department of labor and industries.

"Technical component" - The part of a procedure or service that relates to the equipment set-up and technician's time, or the part of the procedure and service reimbursement that recognizes the equipment cost and technician time.

AMENDATORY SECTION (Amending WSR 15-20-057, filed 10/1/15, effective 11/1/15)

WAC 182-531-0950 Office and other outpatient physician-related services. (l) The medicaid agency pays eligible providers for the following:

(a) Two calls per month for routine medical conditions for a client residing in a nursing facility; and

(b) One call per noninstitutionalized client, per day, for an individual physician, except for valid call-backs to the emergency room per WAC 182-531-0500.

(2) The provider must provide justification based on medical necessity at the time of billing for visits in excess of subsection (l) of this section and follow the requirements in WAC 182-501-0169.

(3) See the agency's physician-related services billing instructions for procedures that are included in the office call and that cannot be billed separately.

(4) Using selected diagnosis codes, the agency reimburses the provider at the appropriate level of physician office call for history and physical procedures in conjunction with dental surgery services performed in an outpatient setting.

(5) The agency may reimburse providers for injection procedures and/or injectable drug products only when:

(a) The injectable drug is administered during an office visit; and

(b) The injectable drug used is from office stock and which was purchased by the provider from a pharmacy, drug manufacturer, or drug wholesaler.

(6) The agency does not reimburse a prescribing provider for a drug when a pharmacist dispenses the drug.

(7) The agency does not reimburse the prescribing provider for an immunization when the immunization material is received from the department of health; the agency does reimburse an administrative fee.

(8) The agency reimburses immunizations ((~~at estimated acquisition costs (EAC) when the immunizations are not part of the vaccine for children program.~~)) as follows:

(a) For immunizations that are not part of the vaccines for children program through the department of health, the agency reimburses for the immunization:

(i) At the medicare Part B drug file price; or

(ii) When a medicare Part B price is not available, the agency uses the point-of-sale actual acquisition cost (POS AAC) rate effective July 1st of each year; or

(iii) Invoice cost.

(b) The agency reimburses a separate administration fee for these immunizations.

(c) Covered immunizations are listed in the professional administered drugs and physician related/professional services fee schedules.

(d) Refer to WAC 182-531-0150 (1)(r) for vaccines recommended or required for the sole purpose of international travel.

(9) The agency reimburses therapeutic and diagnostic injections subject to certain limitations as follows:

(a) The agency does not pay separately for the administration of intra-arterial and intravenous therapeutic or diagnostic injections provided in conjunction with intravenous infusion therapy services. The agency does pay separately for the administration of these injections when they are provided on the same day as an E&M service. The agency does not pay separately an administrative fee for injectables when both E&M and infusion therapy services are provided on the same day. The agency reimburses separately for the drug(s).

(b) The agency does not pay separately for subcutaneous or intramuscular administration of antibiotic injections provided on the same day as an E&M service. If the injection is the only service provided, the agency pays an administrative fee. The agency reimburses separately for the drug.

(c) The agency reimburses injectable drugs at **acquisition cost.** The provider must document the name, strength, and dosage of the drug and retain that information in the client's file. The provider must provide an invoice when requested by the agency. This subsection does not apply to drugs used for chemotherapy; see subsection (11) in this section for chemotherapy drugs.

(d) The provider must submit a manufacturer's invoice to document the name, strength, and dosage on the claim form when billing the agency for the following drugs:

(i) Classified drugs where the billed charge to the agency is over one thousand, one hundred dollars; and

(ii) Unclassified drugs where the billed charge to the agency is over one hundred dollars. This does not apply to unclassified antineoplastic drugs.

(10) The agency reimburses allergen immunotherapy only as follows:

(a) Antigen/antigen preparation codes are reimbursed per dose.

(b) When a single client is expected to use all the doses in a multiple dose vial, the provider may bill the total number of doses in the vial at the time the first dose from the vial is used. When remaining doses of a multiple dose vial are injected at subsequent times, the agency reimburses the injection service (administration fee) only.

(c) When a multiple dose vial is used for more than one client, the provider must bill the total number of doses provided to each client out of the multiple dose vial.

(d) The agency covers the antigen, the antigen preparation, and an administration fee.

(e) The agency reimburses a provider separately for an E&M service if there is a diagnosis for conditions unrelated to allergen immunotherapy.

(f) The agency reimburses for **RAST** testing when the physician has written documentation in the client's record indicating that previous skin testing failed and was negative.

(11) The agency reimburses for chemotherapy drugs:

(a) Administered in the physician's office only when:

(i) The physician personally supervises the E&M services furnished by office medical staff; and

(ii) The medical record reflects the physician's active participation in or management of course of treatment.

(b) At established maximum allowable fees that are based on ((~~the~~)) medicare Part B pricing ((~~method for calculating the estimated acquisition cost (EAC)~~)), or POS AAC, maximum allowable cost (MAC) ((~~when generics are available~~)), or invoice cost;

(c) For unclassified antineoplastic drugs, the provider must submit the following information on the claim form:

(i) The name of the drug used;

(ii) The dosage and strength used; and

(iii) The National Drug Code (NDC).

(12) Notwithstanding the provisions of this section, the agency reserves the option of determining drug pricing for any particular drug based on the best evidence available to the agency, or other good and sufficient reasons (e.g., fairness/equity, budget), regarding the actual cost, after discounts and promotions, paid by typical providers nationally or in Washington state.

(13) The agency may request an invoice as necessary.

AMENDATORY SECTION (Amending WSR 17-04-039, filed 1/25/17, effective 2/25/17)

WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(l) The medicaid agency bases the payment methodology for most physician-related services on medicare's RBRVS. The agency obtains information used to update the agency's RBRVS from the MPFSPS.

(2) The agency updates and revises the following RBRVS areas each January prior to the agency's annual update.

(3) The agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels. Then,

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, the agency establishes maximum allowable fees, also known as "flat" fees.

(i) The agency does not use the conversion factor for these codes.

(ii) The agency updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at ((~~EAC~~)) the medicare Part B drug file price or POS AAC when there is no Part B rate. (See WAC 182-530-1050 for explanation of ((~~EAC~~)) POS AAC.) When the provider receives immunization materials from the department of health, the agency pays ((~~the provider~~)) only a flat fee ((~~only~~)) for administering the immunization.

(B) A cast material maximum allowable fee is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, the agency reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) The agency reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The technical advisory group reviews RBRVS changes.

(6) The agency also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as the agency's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the agency applies the increase after calculating budget-neutral fees. The agency pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The agency does not allow separate reimbursement for bundled services. However, the agency allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for the agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.

WSR 17-21-042
PERMANENT RULES
TRAFFIC SAFETY COMMISSION

[Filed October 13, 2017, 9:01 a.m., effective November 13, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Revisions to current rules including updating the description of organization to align with our mission, references to our old address, references to RCW that have been recodified and pedestrian bicycle rules and language to reflect compliance with American National Standards Institute/International Safety Equipment Association.

Citation of Rules Affected by this Order: Amended 46.61.440(3); and suspended 34.59.070 [amending WAC 467-01-010, 467-01-020, 467-01-040, 467-01-050, 467-01-060, and 467-03-010].

Statutory Authority for Adoption: RCW 43.59.070.

Adopted under notice filed as WSR 17-18-012 on August 24, 2017.

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

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 10, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 10, Repealed 0.

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

Date Adopted: October 13, 2017.

Pam Pannkuk
Deputy Director

AMENDATORY SECTION (Amending WSR 91-23-101, filed 11/20/91, effective 12/21/91)

WAC 467-01-010 Description of organization. The Washington traffic safety commission is a ten-member commission organized under the provisions of chapter 43.59 RCW, and under which the commission is to ((~~seek solutions to traffic problems caused by increases in motor vehicles on highways, plan and supervise accident prevention programs, coordinate state and local development of traffic safety programs, promote uniform enforcement of traffic safety laws and the establishment of standards for investigation and reporting of traffic accidents, and promote and improve driver education~~)) lead statewide efforts and build partnerships to save lives and prevent injuries on our roadways for the health, safety, and benefit of our communities. The commission consists of the governor, as chairman; the superintendent of public instruction; the director of department of licensing; the secretary of the department of transportation; the chief of the state patrol; the secretary of the department of social and health services; the secretary of the department of health; a representative of the association of Washington cities appointed by the governor; a member of the ((~~association of Washington counties~~)) Washington state association of counties appointed by the governor; and a representative of the judiciary appointed by the governor. The director of the Washington traffic safety commission, appointed by the governor, serves as secretary to the commission and is responsible for carrying into effect the commissions orders and rules and regulations promulgated by the commission. The director is also authorized to employ staff necessary to carry out the orders, rules and regulations of the commission. As secretary, the director coordinates the activities of the commission and supervises the work of the staff of the commission.

AMENDATORY SECTION (Amending WSR 91-23-101, filed 11/20/91, effective 12/21/91)

WAC 467-01-020 Time and place of meetings. Regular public meetings of the Washington traffic safety commission are held quarterly on the ((~~fourth Tuesday~~)) third Thursday in January, April, July, and October ((~~in~~)) at the Washington traffic safety commission ((~~Conference Room, 1000 S. Cherry Street, Olympia, Washington,~~)) or at such other place named by the commission and all provisions of chapter 42.30 RCW shall apply.

AMENDATORY SECTION (Amending WSR 91-23-101, filed 11/20/91, effective 12/21/91)

WAC 467-01-040 Special meeting. A special meeting of the traffic safety commission may be called by the ((~~secre-~~

~~tary~~)) director, or by a majority of the members of the commission, by delivering personally or by mail written notice to all members of the commission at least twenty-four hours before the time of such meeting as specified in the notice. The notice calling a special meeting shall state the purpose for which the meeting is called and the date, hour, and place of such meeting and all provisions of chapter 42.30 RCW shall apply.

AMENDATORY SECTION (Amending WSR 91-23-101, filed 11/20/91, effective 12/21/91)

WAC 467-01-050 Emergency meeting. If, by reason of an emergency, there is a need for expedited action by the commission to meet the emergency, the ((~~secretary~~)) director may provide for a meeting site, and the notice requirements of chapter 42.30 RCW shall be suspended during such emergency. To the extent possible, notice of such emergency meeting will be delivered personally, by telephone, telegram, email, or mail to the members of the commission and interested persons, and shall specify the time and place of the emergency meeting and the business to be transacted. Any action taken by the commission at such emergency meeting may be reconsidered by the commission at its next regular quarterly meeting.

AMENDATORY SECTION (Amending WSR 91-23-101, filed 11/20/91, effective 12/21/91)

WAC 467-01-060 Address of the commission. Persons wishing to obtain information or to make submissions or requests of any kind shall address their correspondence to:

Director
Washington Traffic Safety Commission
((~~1000 South Cherry Street, Mailstop: PD-11~~))
P.O. Box 40944
Olympia, WA 98504

AMENDATORY SECTION (Amending WSR 01-22-011, filed 10/26/01, effective 11/26/01)

WAC 467-03-010 Pedestrian bicycle safety equipment rules. ((~~The director will cause to be designed a~~)) High-visibility protective vests, traffic control flags, warning signs, and other equipment are designed to increase the visibility of persons assisting pedestrians and bicycles at crosswalks, including school and playground zones. This equipment will be ((~~of strong yellow-green fluorescent color or other highly visible materials and have retro-reflective stripes. Samples are to be made available for viewing at the Washington traffic safety commission office in Olympia, WA~~)) in compliance with the most current American National Standards Institute/International Safety Equipment Association (ANSI/ISEA) 107 standard for high visibility safety apparel and accessories.

The ((~~director~~)) Washington traffic safety commission may furnish this equipment to schools and other users through grants from the school zone safety account as provided by RCW 46.61.440(((~~3~~))) (5).

The use of uniforms and equipment designated for use by school patrols, pursuant to WAC 392-151-090 (Standard uniforms) and WAC 392-151-095 (Equipment), by persons assisting pedestrians and bicyclists in school and playground zones, will also be deemed in compliance with this rule.

WSR 17-21-077
PERMANENT RULES
DEPARTMENT OF EARLY LEARNING

[Filed October 16, 2017, 3:48 p.m., effective November 16, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Increasing subsidy amounts by five percent paid to child care centers.

Citation of Rules Affected by this Order: Amending WAC 170-290-0200.

Statutory Authority for Adoption: RCW 43.215.060 and 43.215.070.

Other Authority: SSB 5883 (2017-19 operating budget).

Adopted under notice filed as WSR 17-18-008 on August 24, 2017.

Changes Other than Editing from Proposed to Adopted Version: The rate for Region 2, school-aged care is corrected to read $23.53.

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

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

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

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

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

Date Adopted: October 16, 2017.

Heather Moss
Director

AMENDATORY SECTION (Amending WSR 16-19-107, filed 9/21/16, effective 10/22/16)

WAC 170-290-0200 Daily child care rates—Licensed or certified child care centers and DEL contracted seasonal day camps. (1) **Base rate.** DSHS pays the lesser of the following to a licensed or certified child care center or DEL contracted seasonal day camp:

(a) The provider's private pay rate for that child; or

(b) The maximum child care subsidy daily rate for that child as listed in the following table:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$((~~32.10~~)) 34.03	$((~~27.00~~)) 28.62	$((~~25.50~~)) 27.03	$((~~24.02~~)) 25.46
	Half-Day	$((~~16.05~~)) 17.02	$((~~13.50~~)) 14.31	$((~~12.75~~)) 13.52	$((~~12.01~~)) 12.73
Spokane County	Full-Day	$((~~32.84~~)) 34.81	$((~~27.62~~)) 29.28	$((~~26.10~~)) 27.67	$((~~24.58~~)) 26.05
	Half-Day	$((~~16.42~~)) 17.41	$((~~13.81~~)) 14.64	$((~~13.05~~)) 13.84	$((~~12.29~~)) 13.03
Region 2	Full-Day	$((~~32.44~~)) 34.39	$((~~27.06~~)) 28.68	$((~~25.10~~)) 26.61	$((~~22.20~~)) 23.53
	Half-Day	$((~~16.22~~)) 17.20	$((~~13.53~~)) 14.34	$((~~12.55~~)) 13.31	$((~~11.10~~)) 11.77
Region 3	Full-Day	$((~~42.92~~)) 45.50	$((~~35.78~~)) 37.93	$((~~30.92~~)) 32.78	$((~~30.02~~)) 31.82
	Half-Day	$((~~21.46~~)) 22.75	$((~~17.89~~)) 18.97	$((~~15.46~~)) 16.39	$((~~15.01~~)) 15.91
Region 4	Full-Day	$((~~49.94~~)) 52.94	$((~~41.70~~)) 44.20	$((~~35.00~~)) 37.10	$((~~31.52~~)) 33.41
	Half-Day	$((~~24.97~~)) 26.47	$((~~20.85~~)) 22.10	$((~~17.50~~)) 18.55	$((~~15.76~~)) 16.71
Region 5	Full-Day	$((~~36.62~~)) 38.82	$((~~31.52~~)) 33.41	$((~~27.74~~)) 29.40	$((~~24.62~~)) 26.12
	Half-Day	$((~~18.31~~)) 19.41	$((~~15.76~~)) 16.71	$((~~13.87~~)) 14.70	$((~~12.31~~)) 13.06
Region 6	Full-Day	$((~~36.02~~)) 38.18	$((~~30.92~~)) 32.78	$((~~27.00~~)) 28.62	$((~~26.42~~)) 28.01
	Half-Day	$((~~18.01~~)) 19.09	$((~~15.46~~)) 16.39	$((~~13.50~~)) 14.31	$((~~13.21~~)) 14.01

(Chart effective ((~~07/01/16~~)) 09/01/17)

(i) Centers in Clark County are paid Region 3 rates.

(ii) Centers in Benton, Walla Walla, and Whitman counties are paid Region 6 rates.

(2) The child care center WAC 170-295-0010 and 170-295-0050 allows providers to care for children from one month up to and including the day before their thirteenth birthday. The provider must obtain a child-specific and time-limited exception from their child care licensor to provide care for a child outside the age listed on the center's license. If the provider has an exception to care for a child who has reached the child's thirteenth birthday, the payment rate is the same as subsection (1) of this section, and the five through twelve year age range column is used for comparison.

(3) If the center provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited exception and the child must meet the special needs requirement according to WAC 170-290-0220.

WSR 17-21-082
PERMANENT RULES
DEPARTMENT OF FINANCIAL INSTITUTIONS

[Filed October 16, 2017, 5:00 p.m., effective November 16, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department of financial institutions hereby amends the rules in chapter 208-710 WAC in order to incorporate recent legislative updates to the Washington small business retirement marketplace (codified at RCW 43.330.730 through 43.330.750, and 43.320.180) and to make other minor changes. The marketplace is operated by the Washington department of commerce, but the department of financial institutions is responsible for verifying that the retirement plans that apply to be listed on the marketplace meet the requirements set forth in RCW 43.330.732(7) and 43.330.735.

Pursuant to RCW 43.330.735(11), retirement plans listed on the Washington small business retirement marketplace may not charge enrollees more than one hundred basis points in total annual fees. However, pursuant to an exception provided by recent statutory amendments, financial services firms may charge de minimis fees for new and/or low balance accounts in excess of one hundred basis points in total annual fees if such fees are negotiated and agreed upon by the Washington department of commerce and the financial services firm. The amended rules incorporate this update. In addition, to facilitate the review of applications by the department of financial institutions, the amended rules now require financial services firms applying for verification to submit a retirement plan summary with their application materials. Finally, the amended rules include minor clarifications and plain English updates.

Citation of Rules Affected by this Order: Amending 6.

Statutory Authority for Adoption: RCW 43.330.732, 43.330.735, 43.330.750, 43.320.180.

Adopted under notice filed as WSR 17-14-080 on June 29, 2017.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 4, Repealed 0.

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making:

New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 16, 2017.

Gloria Papiez
Director

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-010 Application of rules. The rules in this chapter implement the provisions of the Washington small business retirement marketplace, RCW 43.330.730 through 43.330.750, and 43.320.180, as they relate to the department of financial institutions.

The legislature created the Washington small business retirement marketplace in order to address the retirement savings access gap in Washington. The purpose of the Washington small business retirement marketplace is to educate small employers on retirement plan availability and promote qualified, low-cost, low-burden retirement savings vehicles and myRa accounts without mandating participation by either employers or employees.

The Washington department of commerce is responsible for the operation of the Washington small business retirement marketplace. The department of commerce will approve retirement plans for inclusion on the Washington small business retirement marketplace provided that the Washington department of financial institutions has verified that the retirement plan and the financial services firm offering it meet the requirements set forth in RCW 43.330.732(7) and 43.330.735.

Financial services firms seeking verification for their retirement plans from the department of financial institutions for the purpose of inclusion on the Washington small business retirement marketplace ((~~shall~~)) must follow the application procedures set forth in this chapter.

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-030 Verification process. (1) Financial services firms that are eligible under WAC 208-710-020 to apply for verification from the department of financial institutions may do so by submitting an application for verification as described in WAC 208-710-040, 208-710-060, ((~~and~~)) or 208-710-070.

(2) The department of financial institutions will review and process initial, renewal, and amendment applications for verification. The department of financial institutions will issue a verification letter for retirement plans that meet the requirements set forth in RCW 43.330.732(7) and 43.330.735. The verification letter will be effective for one year for initial and renewal applications. For amendment applications, the verification letter will be effective for the remainder of the current one-year verification period.

(3) Pursuant to RCW 43.330.735(11), a financial services firm may charge retirement plan enrollees a de minimis fee for new and/or low balance accounts in excess of one hundred basis points in total annual fees only if the department of commerce and the financial services firm negotiate and agree upon the amount of the de minimis fee prior to the issuance of the verification letter.

(4) A financial services firm may withdraw its application for verification at any time by submitting a written request to withdraw to the department of financial institutions.

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-040 Initial application requirements. Financial service firms that seek verification of retirement plans from the department of financial institutions for inclusion on the Washington small business retirement marketplace must submit a separate application for each retirement plan for which verification is sought. The following initial application materials ((~~shall~~)) must be submitted to the department of financial institutions:

(1) A completed application for verification form marked "initial ((~~application~~))";

(2) A copy of the retirement plan agreement;

(3) A copy of the materials routinely used to market the retirement plan to eligible employers;

(4) Any additional documents necessary to identify the funds and other investment products to be offered under the plan, specify the plan's fees and roll-over options, and disclose historical investment performance for the investment products in the plan; ((~~and~~))

(5) The prospectus for each balanced fund and target date fund or other similar fund offered under the retirement plan; and

(6) A summary of the retirement plan's investment options, fees, and other features. The summary should include, but not necessarily be limited to, the following:

(a) The type of retirement plan (e.g., SIMPLE IRA);

(b) The investment options available in the retirement plan;

(c) The fee structure applicable to the different investment options in the retirement plan (including fees payable to the financial services firm offering the retirement plan and any other service providers);

(d) The identity of the custodian of enrollee accounts;

(e) The rollover options for enrollees in the retirement plan;

(f) Whether the financial services firm offering the retirement plan will recommend investments to enrollees, and if so, how the firm will communicate to enrollees the option to select investments other than the recommended investments;

(g) A list of documents an employer must complete to establish the retirement plan and its business relationship with the financial services firm offering the plan;

(h) A list of the documents enrollees must complete to establish their retirement account and their relationship with the financial services firm offering the plan; and

(i) Disclosure of any other fees associated with the retirement plan.

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-050 Application review criteria. The department of financial institutions will review applications for verification to ensure that retirement plans meet the following criteria established by RCW 43.330.732(7) and 43.330.735:

(1) The financial services firm offering the retirement plan must be licensed or hold a certificate of authority and be in good standing with the department of financial institutions, or be regulated by a federal agency with authority over banking, securities, or broker-dealer firms, and meet all federal laws and regulations to offer retirement plans;

(2) The retirement plan must offer a minimum of two product options:

(a) A target date or other similar fund, with asset allocations and maturities designed to coincide with the expected date of retirement; and

(b) A balanced fund.

(3) The retirement plan must include the option for enrollees to roll pretax contributions into a different individual retirement account or another eligible retirement plan after the enrollees cease participation in the retirement plan offered on the Washington small business retirement marketplace;

(4) The financial services firm offering the retirement plan may not charge the participating employer an administrative fee and may not charge enrollees more than one hundred basis points in total annual fees, except that financial services firms may charge retirement plan enrollees a de minimis fee for new and/or low balance accounts in amounts negotiated and agreed upon by the department of commerce and the financial services firm;

(5) The financial services firm offering the retirement plan must provide information about the product's historical investment performance; and

(6) Participation in a retirement plan offered on the Washington small business retirement marketplace ((~~shall~~)) must be voluntary for both eligible employers and qualified employees.

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-060 Annual renewal application procedure. (1) To apply to renew the verification of a retirement plan for inclusion on the Washington small business retirement marketplace for a subsequent one-year period, the financial services firm offering the plan ((~~shall~~)) must submit the following to the department of financial institutions at least thirty days prior to the expiration of the current verification letter:

(a) A completed application for verification form marked "renewal";

(b) The most recently updated versions of the retirement plan, marketing materials, prospectuses, and other plan documents required by WAC 208-710-040 (2) through (((~~5~~))) (6); and

(c) A report indicating the number of eligible employers in Washington who established retirement plans under the financial service provider's approved plan in the last year. The report ((~~shall~~)) must include the total number of new retirement accounts opened in Washington by qualified employees as a result of the adoption of the approved plan by eligible employers in Washington.

(2) If the financial services firm previously negotiated a de minimis fee with respect to new and/or low balance accounts pursuant to RCW 43.330.735(11), the department of commerce and the financial services firm must negotiate and agree upon any changes to such fee prior to the submission of a renewal application.

(3) If the retirement plan meets the requirements set forth in RCW 43.330.732(7), 43.330.735, and WAC 208-710-050 for inclusion on the Washington small business retirement marketplace, the department of financial institutions will issue a renewal of the verification letter for the retirement plan. An application for verification will not be considered renewed until the department of financial institutions issues a new verification letter.

(((~~3~~))) (4) If the retirement plan no longer meets the requirements for inclusion on the Washington small business retirement marketplace, or the application is otherwise deficient, the department of financial institutions will issue a deficiency letter rather than renew the verification letter.

AMENDATORY SECTION (Amending WSR 16-13-016, filed 6/3/16, effective 7/4/16)

WAC 208-710-070 Amendment review procedure. (1) During the time period in which a retirement plan's verification letter is effective, the financial services firm offering the plan must amend its application for verification if material amendments to the retirement plan or its underlying investment options are proposed.

(2) To amend an application for verification, the financial services firm ((~~shall~~)) must submit the following to the department of financial institutions at least thirty days prior to the proposed amendment of the plan:

(a) A completed application for verification marked "amendment"; and

(b) The most recent versions of the retirement plan, marketing materials, prospectuses, and other plan documents required by WAC 208-710-040 (2) through (((~~5~~))) (6).

(3) If the financial services firm previously negotiated a de minimis fee with respect to new and/or low balance accounts pursuant to RCW 43.330.735(11), the department of commerce and the financial services firm must negotiate and agree upon any changes to such fee prior to the submission of an amended application.

(4) If the amended retirement plan meets the requirements set forth in RCW 43.330.732(7), 43.330.735, and WAC 208-710-050 for inclusion on the Washington small business retirement marketplace, the department of financial institutions will issue a verification letter for the amended retirement plan.

WSR 17-21-092
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed October 17, 2017, 4:20 p.m., effective January 1, 2018]

Effective Date of Rule: January 1, 2018.

Purpose: The purpose of this rule making is to implement, carry out, and enforce Initiative 1433, an act relating to fair labor standards, which requires employers provide paid sick leave to employees. These rules:

- Set parameters for the directives in chapter 49.46 RCW; and
- Create definitions and descriptions for paid sick leave pertaining to: Written policies, accrual, usage, variance from required increments of use, reasonable notice, verification for absences exceeding three days, rate of pay, payment of paid sick leave, separation and reinstatement of accrued paid sick leave upon rehire, paid time off programs, shared leave, shift swapping, frontloading, third party administrators, employee use of paid sick leave for unauthorized purposes, employer notification and reporting to employees, and retaliation.

In addition to the paid sick leave proposed rules, amendments are being made to rules updating outdated language concerning people with disabilities to "People-first" language.

This rule making's effective date of January 1, 2018, is an exception to RCW 34.05.380(2) and meets the requirement of RCW 34.05.380 (3)(a).

Enforcement of the retaliation and enforcement directives related to the implementation of Initiative 1433 are being addressed in a separate rule making.

Citation of Rules Affected by this Order: New WAC 296-128-600 Definitions, 296-128-610 Requirements for a written policy—Duty of the department to provide sample policies, 296-128-620 Paid sick leave accrual, 296-128-630 Paid sick leave usage, 296-128-640 Variance from required increments of paid sick leave usage, 296-128-650 Reasonable notice, 296-128-660 Verification for absences exceeding three days, 296-128-670 Rate of pay for use of paid sick leave, 296-128-680 Payment of paid sick leave, 296-128-690 Separation and reinstatement of accrued paid sick leave upon rehire, 296-128-700 Paid time off (PTO) programs, 296-128-710 Shared leave, 296-128-720 Shift swapping, 296-128-730 Frontloading, 296-128-740 Third-party administrators, 296-128-750 Employee use of paid sick leave for unauthorized purposes, 296-128-760 Employer notification and reporting to employees and 296-128-770 Retaliation; amending WAC 296-128-010 Records required, 296-128-055 Definition, 296-128-060 Application for certificate, 296-128-065 Conditions for granting a certificate, 296-128-070 Issuance of certificate, and 296-128-075 Terms of certificate.

Statutory Authority for Adoption: RCW 49.46.810.

Adopted under notice filed as WSR 17-14-113 on July 5, 2017.

Changes Other than Editing from Proposed to Adopted Version: WAC 296-128-600, subsection (1), the department updated the definition for "absences exceeding three days" to change the word "scheduled" to "required." This change to the definition is intended to provide clarity about the ability of employers to require verification for employee absences on days where the employee is not required, or reasonably expected, to work.

WAC 296-128-610, the department updated the term "worker" to "employee" to reflect consistency in the use of terminology throughout the rules.

WAC 296-128-640, subsection (1), the department updated the term "may" to "shall" in order to be consistent with the requirement set forth in subsection (5).

Subsection (5), the department updated the term "will" to "shall" to reflect consistency in the use of terminology throughout the rules.

WAC 296-128-650, subsection (1)(b), the department updated the term "scheduled" to "required." This update is consistent with the change in terminology contained in WAC 296-128-600(1).

WAC 296-128-660, subsection (7), the department updated language to address concerns about an employer's ability to require verification for use of paid sick leave for purposes authorized under federal, state, or other local leave laws. The previous language only addressed the Family and Medical Leave Act.

WAC 296-128-760, subsection (1)(c), similar to WAC 296-128-610, the department added language to the rules addressing the department's commitment to providing employers with model notification policies which meet the standard for compliance.

A final cost-benefit analysis is available by contacting Allison Drake, P.O. Box 44400, Olympia, WA 98504-4400, phone 360-902-5304, fax 360-902-5300, TTY 360-902-5797, email i1433Rules@Lni.wa.gov, web site www.lni.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 18, Amended 1, Repealed 0.

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

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

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

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

Date Adopted: October 17, 2017.

Joel Sacks
Director

AMENDATORY SECTION (Amending Regulation 294.7.001 (part), filed 12/30/60)

WAC 296-128-010 Records required. For all employees who are subject to RCW 49.46.020, employers shall be required to keep and preserve payroll or other records containing the following information and data with respect to

each and every employee to whom said section of said act applies:

(1) Name in full, and on the same record, the employee's identifying symbol or number if such is used in place of name on any time, work, or payroll records. This shall be the same name as that used for Social Security record purposes;

(2) Home address;

(3) Occupation in which employed;

(4) Date of birth if under eighteen;

(5) Time of day and day of week on which the employee's workweek begins. If the employee is part of a workforce or employed in or by an establishment all of whose workers have a workweek beginning at the same time on the same day, a single notation of the time of the day and beginning day of the workweek for the whole workforce or establishment will suffice. If, however, any employee or group of employees has a workweek beginning and ending at a different time, a separate notation shall then be kept for that employee or group of employees;

(6) Hours worked each workday and total hours worked each workweek (for purposes of this section, a "workday" shall be any consecutive twenty-four hours);

(7) Total daily or weekly straight-time earnings or wages; that is, the total earnings or wages due for hours worked during the workday or workweek, including all earnings or wages due during any overtime worked, but exclusive of overtime excess compensation;

(8) Total overtime excess compensation for the workweek; that is, the excess compensation for overtime worked which amount is over and above all straight-time earnings or wages also earned during overtime worked;

(9) Total additions to or deductions from wages paid each pay period. Every employer making additions to or deductions from wages shall also maintain a record of the dates, amounts, and nature of the items which make up the total additions and deductions;

(10) Total wages paid each pay period;

(11) Date of payment and the pay period covered by payment;

(12) Paid sick leave accruals each month, and any unused paid sick leave available for use by an employee;

(13) Paid sick leave reductions each month including, but not limited to: Paid sick leave used by an employee, paid sick leave donated to a co-worker through a shared leave program, or paid sick leave not carried over to the following year ("year" as defined in WAC 296-128-620(6));

(14) The date of commencement of his or her employment, as defined in WAC 296-128-600(2);

(15) Employer may use symbols where names or figures are called for so long as such symbols are uniform and defined.

NEW SECTION

WAC 296-128-600 Definitions. (1) "Absences exceeding three days" means absences exceeding three consecutive days an employee is required to work. For example, assume an employee is required to work on Mondays, Wednesdays, and Fridays, and then the employee uses paid sick leave for any portion of those three work days in a row. If the employee uses paid sick leave again on the following Monday, the employee would have absences exceeding three days.

(2) "Commencement of his or her employment" means no later than the beginning of the first day on which the employee is authorized or required by the employer to be on duty on the employer's premises or at a prescribed workplace.

(3) "Department" means the department of labor and industries.

(4) "Director" means the director of the department of labor and industries, or the director's authorized representative.

(5) "Employee" has the same meaning as RCW 49.46.010(3).

(6) "Employer" has the same meaning as RCW 49.46.010(4).

(7) "Frontloading" means providing an employee with paid sick leave before it has accrued at the rate required by RCW 49.46.210 (1)(a).

(8) "Health-related reason" means a serious public health concern that could result in bodily injury or exposure to an infectious agent, biological toxin, or hazardous material. Health-related reason does not include closures for inclement weather.

(9) "Hours worked" shall be interpreted in the same manner as WAC 296-126-002(8).

(10) "Normal hourly compensation" means the hourly rate that an employee would have earned for the time during which the employee used paid sick leave. For employees who use paid sick leave for hours that would have been overtime hours if worked, employers are not required to apply overtime standards to an employee's normal hourly compensation. Normal hourly compensation does not include tips, gratuities, service charges, holiday pay, or other premium rates, unless the employer or a collective bargaining agreement allow for such considerations. However, where an employee's normal hourly compensation is a differential rate, meaning a different rate paid for the same work performed under differing conditions (e.g., a night shift), the differential rate is not a premium rate.

(11) "Regular and normal wage" has the same meaning as normal hourly compensation.

(12) "Separation" and "separates from employment" mean the end of the last day an employee is authorized or required by the employer to be on duty on the employer's premises or at a prescribed workplace.

(13) "Verification" means evidence that establishes or confirms that an employee's use of paid sick leave is for an authorized purpose under RCW 49.46.210 (1)(b) and (c).

(14) "Workweek" means a fixed and regularly recurring period of one hundred sixty-eight hours, or seven consecutive twenty-four hour periods. It may begin on any day of the week and any hour of the day, and need not coincide with a calendar week.

NEW SECTION

WAC 296-128-610 Requirements for a written policy—Duty of the department to provide sample policies. Where these rules set forth requirements for an employer to

have a written policy (WAC 296-128-650(3), 296-128-660(2), 296-128-710(2), and 296-128-730(4)), the department shall, in consultation with employee and employer representatives, develop sample policies which meet the department's standard for compliance with these rules. The department shall make such sample policies available on the department's web site.

NEW SECTION

WAC 296-128-620 Paid sick leave accrual. (1) Employees accrue paid sick leave for all hours worked. An employee must accrue at least one hour of paid sick leave for every forty hours worked as an employee. Employers may provide employees with a more generous paid sick leave accrual rate.

(2) Paid sick leave for employees who are employed on or before January 1, 2018, will accrue for all hours worked beginning on January 1, 2018. Employees hired after January 1, 2018, begin accruing paid sick leave upon the commencement of his or her employment.

(3) Employers are not required to allow employees to accrue paid sick leave for hours paid when not working. For example, employers are not required to allow employees to accrue paid sick leave during vacation, paid time off, or while using paid sick leave.

(4) Employers must allow employees to carry over at least forty hours of accrued, unused paid sick leave to the following year. If an employee carries over forty hours of unused paid sick leave to the following year, accrual of paid sick leave in the subsequent year would be in addition to the forty hours accrued in the previous year and carried over.

(5) Employers may cap carryover of accrued, unused paid sick leave to the following year at forty hours. Employers may allow for a more generous carryover of accrued, unused paid sick leave to the following year.

(6) "Year," for purposes of this section, means calendar year, fiscal year, benefit year, employment year, or any other fixed consecutive twelve-month period established by an employer policy or a collective bargaining agreement, and used in the ordinary course of the employer's business for the purpose of calculating wages and benefits. Unless otherwise established by the employer, the default definition of "year" is calendar year.

NEW SECTION

WAC 296-128-630 Paid sick leave usage. (1) An employee is entitled to use paid sick leave for the authorized purposes outlined in RCW 49.46.210 (1)(b) and (c).

(2) An employee is entitled to use accrued, unused paid sick leave beginning on the ninetieth calendar day after the commencement of his or her employment. Employers may allow employees to use accrued, unused paid sick leave prior to the ninetieth calendar day after the commencement of his or her employment.

(3) Beginning on the ninetieth calendar day after the commencement of his or her employment, employers must make accrued paid sick leave available to employees for use in a manner consistent with the employer's established payment interval or leave records management system, not to exceed one month after the date of accrual.

(4) Unless a greater increment is approved by a variance as provided by WAC 296-128-640, employers must allow employees to use paid sick leave in increments consistent with the employer's payroll system and practices, not to exceed one hour. For example, if an employer's normal practice is to track increments of work for the purposes of compensation in fifteen-minute increments, then an employer must allow employees to use paid sick leave in fifteen-minute increments.

NEW SECTION

WAC 296-128-640 Variance from required increments of paid sick leave usage. (1) The department shall grant a variance from the increments required by WAC 296-128-630(4) for "good cause." Good cause means situations where an employer can establish that compliance with the requirements for increments of use are infeasible, and that granting a variance does not have a significant harmful effect on the health, safety, and welfare of the involved employees. The existence of a collective bargaining agreement which sets forth increments of use may be used as a factor in determining good cause for granting a variance from the increments required by WAC 296-128-630(4).

(2) An employer may seek a variance from the requirement to provide employees with paid sick leave in increments greater than the increments required by WAC 296-128-630(4) by submitting a written application to the department. The application must contain the following:

(a) A justification for the variance, which establishes good cause for providing paid sick leave in increments greater than the increments required by WAC 296-128-630 (4);

(b) The paid sick leave increments of use being sought;

(c) The group of employees for whom the variance is sought; and

(d) Evidence that the employer provided to the involved employees and, if applicable, to their union representatives, the following:

(i) A copy of the written request for a variance;

(ii) Information about the right of the involved employees and, if applicable, their union representatives, to be heard by the department during the variance application review process;

(iii) Information about the process by which involved employees and, if applicable, their union representatives, may make a written request to the director for reconsideration, subject to the provisions outlined in subsection (7) of this section; and

(iv) The department's address and phone number, or other contact information.

(3) The department must allow the employer, any involved employees and, if applicable, their union representatives, the opportunity for oral or written presentation during the variance application review process whenever circumstances of the particular application warrant it.

(4) No later than sixty days after the date on which the department received the application for a variance, the

department must issue a written decision either granting or denying the variance. The department may extend the sixty-day time period by providing advance written notice to the employer and, if applicable, the union representatives of any involved employees, setting forth a reasonable justification for an extension of the sixty-day time period, and specifying the duration of the extension. The employer must provide involved employees with notice about any such extension.

(5) Variances shall be granted if the department determines that there is good cause for allowing an employer to provide paid sick leave in increments greater than the increments required by WAC 296-128-630(4). The variance order shall state the following:

(a) The paid sick leave increments of use approved in the variance;

(b) The basis for a finding of good cause;

(c) The group of employees impacted; and

(d) The period of time for which the variance will be valid, not to exceed three years from the date of issuance.

(6) Upon making a determination for issuance of a variance, the department must make notification in writing to the employer and, if applicable, the union representatives of any involved employees. If the variance is denied, the written notification will include a stated basis for the denial.

(7) An employer, involved employee and, if applicable, their union representative, may file with the director a request for reconsideration within fifteen days after receiving notice of the variance determination. The request for reconsideration must set forth the grounds upon which the reconsideration is being made. If reasonable grounds exist, the director may grant such review and, to the extent deemed appropriate, afford all interested parties an opportunity to be heard. If the director grants such review, the written decision of the department will remain in place until the reconsideration process is complete.

(8) Unless subject to the reconsideration process, the director may revoke or terminate the variance order at any time after giving the employer at least thirty days' notice before revoking or terminating the order.

(9) Where immediate action is necessary pending further review by the department, the department may issue a temporary variance. The temporary variance will remain valid until the department determines whether good cause exists for issuing a variance. An employer need not meet the requirement in subsection (2)(d) of this section in order to be granted a temporary variance.

(10) If an employer obtains a variance under these rules, the employer must provide the involved employees with information about the increments of use requirements that apply within fifteen days of receiving notification of such approval from the department. An employer must make this information readily available to all employees.

NEW SECTION

WAC 296-128-650 Reasonable notice. (1) An employer may require employees to give reasonable notice of an absence from work for the use of paid sick leave for an authorized purpose under RCW 49.46.210 (1)(b). Employers may require employees to comply with the employer's notification policies, as long as such policies do not interfere with an employee's lawful use of paid sick leave.

(a) If the need for paid sick leave is foreseeable, the employer may require advance notice from the employee. Unless the employer allows less advance notice, the employee must provide notice at least ten days, or as early as practicable, in advance of the use of paid sick leave.

(b) If the need for paid sick leave is unforeseeable, the employer may require notice from the employee. The employee must provide notice to the employer as soon as possible before the required start of their shift, unless it is not practicable to do so. In the event it is impracticable for an employee to provide notice to their employer, a person on the employee's behalf may provide notice to the employer.

(2) If an employer requires employees to give reasonable notice of an absence from work for the use of paid sick leave for an authorized purpose under the Domestic Violence Leave Act, chapter 49.76 RCW, any such reasonable notice requirements must comply with the provisions outlined in WAC 296-135-060.

(3) Employers must have a written policy or a collective bargaining agreement outlining any requirements of an employee to give reasonable notice for the use of paid sick leave, and must make notification of such policy or agreement, prior to requiring an employee to provide reasonable notice. An employer must make this information readily available to all employees. If an employer does not require an employee to give reasonable notice for the use of paid sick leave, a written policy is not required.

NEW SECTION

WAC 296-128-660 Verification for absences exceeding three days. (1) For absences exceeding three days, an employer may require verification that an employee's use of paid sick leave is for an authorized purpose under RCW 49.46.210 (1)(b) and (c).

(2) If an employer requires verification for the use of paid sick leave under RCW 49.46.210 (1)(b) and (c), the employer must have a written policy or a collective bargaining agreement outlining any such requirements. The employer must notify the employee of such policy or agreement, including the employee's right to assert that the verification requirement results in an unreasonable burden or expense on the employee, prior to requiring the employee to provide verification. An employer must make this information readily available to all employees.

(3) If an employer requires an employee to provide verification from a health care provider identifying the need for use of paid sick leave for an authorized purpose under RCW 49.46.210 (1)(b) and (c), the employer must not require that the information provided explain the nature of the condition. If the employer obtains any health information about an employee or an employee's family member, the employer must treat such information in a confidential manner consistent with applicable privacy laws.

(4) Employer-required verification may not result in an unreasonable burden or expense on the employee.

(a) If an employer requires verification, and the employee anticipates that the requirement will result in an

unreasonable burden or expense, the employee must be allowed to provide an oral or written explanation to their employer which asserts:

(i) That the employee's use of paid sick leave was for an authorized purpose under RCW 49.46.210 (1)(b) or (c); and

(ii) How the employer's verification requirement creates an unreasonable burden or expense on the employee.

(b) The employer must consider the employee's explanation. Within ten calendar days of the employee providing an explanation to their employer about the existence of an unreasonable burden or expense, the employer must make a reasonable effort to identify and provide alternatives for the employee to meet the employer's verification requirement in a manner which does not result in an unreasonable burden or expense on the employee. A reasonable effort by the employer to identify and provide alternatives could include, but is not limited to:

(i) Accepting the oral or written explanation provided by the employee, as outlined in (a)(i) and (ii) of this subsection, as a form of verification which meets the employer's verification requirement; or

(ii) Mitigating the employee's out-of-pocket expenses associated with obtaining medical verification.

(c) If after the employer considers the employee's explanation, the employer and employee disagree that the employer's verification requirement results in an unreasonable burden or expense on the employee:

(i) The employer and employee may consult with the department regarding the verification requirement; and

(ii) The employee may file a complaint with the department.

(5) If an employer requires verification that the use of paid sick leave is for an authorized purpose under RCW 49.46.210 (1)(b), verification must be provided to the employer within a reasonable time period during or after the leave. For employee use of paid sick leave under RCW 49.46.210 (1)(b), "reasonable time period" is a period of time defined by a written policy or a collective bargaining agreement, but may not be less than ten calendar days following the first day upon which the employee uses paid sick leave.

(6) If an employer requires verification that the use of paid sick leave is for an authorized purpose under the Domestic Violence Leave Act, chapter 49.76 RCW, any such verification requirements must comply with the provisions outlined in WAC 296-135-070.

(7) For use of paid sick leave for purposes authorized under federal, state, or other local laws that permit employers to make medical inquiries, an employer may require verification from an employee that complies with such certification requirements.

NEW SECTION

WAC 296-128-670 Rate of pay for use of paid sick leave. (1) For each hour of paid sick leave used, an employee must be paid the greater of the minimum hourly wage rate established by RCW 49.46.020 or their normal hourly compensation.

(2) An employer must calculate an employee's normal hourly compensation using a reasonable calculation based on the hourly rate that an employee would have earned for the time during which the employee used paid sick leave. Examples of reasonable calculations to determine normal hourly compensation include, but are not limited to:

(a) For an employee paid partially or wholly on a commission basis, dividing the total earnings by the total hours worked in the full pay periods in the prior ninety days of employment;

(b) For an employee paid partially or wholly on a piece rate basis, dividing the total earnings by the total hours worked in the most recent workweek in which the employee performed identical or substantially similar work to the work they would have performed had they not used paid sick leave;

(c) For a nonexempt employee paid a salary, dividing the annual salary by fifty-two to determine the weekly salary, and then dividing the weekly salary by the employee's normal scheduled hours of work;

(d) For an employee whose hourly rate of pay fluctuates:

(i) Where the employer can identify the hourly rates of pay for which the employee was scheduled to work, a calculation equal to the scheduled hourly rates of pay the employee would have earned during the period in which paid sick leave is used;

(ii) Where the employer cannot identify the hourly rates of pay for which the employee would have earned if the employee worked, a calculation based on the employee's average hourly rate of pay in the current or preceding thirty days, whichever yields the higher hourly rate.

(3) For employees who are scheduled to work a shift of indeterminate length (e.g., a shift that is defined by business needs rather than a specific number of hours), the rate of pay may be calculated by multiplying the employee's normal hourly compensation by the total hours worked by a replacement employee in the same shift, or similarly situated employees who worked that same or similar shift.

(4) An employer must apply a consistent methodology when calculating the normal hourly compensation of similarly situated employees.

NEW SECTION

WAC 296-128-680 Payment of paid sick leave. Unless verification for absences exceeding three days is required by an employer, the employer must pay paid sick leave to an employee no later than the payday for the pay period in which the paid sick leave was used by the employee. If verification is required by the employer, paid sick leave must be paid to the employee no later than the payday for the pay period during which verification is provided to the employer by the employee.

NEW SECTION

WAC 296-128-690 Separation and reinstatement of accrued paid sick leave upon rehire. (1) When an employee separates from employment and is rehired within twelve months of separation by the same employer, whether at the same or a different business location of the employer, the employer must comply with the provisions of RCW 49.46.-210 (1)(k). If an employee separates from employment, the employer is not required to provide financial or other reim-

bursement to the employee for accrued, unused paid sick leave at the time of separation.

(2) An employer may choose to reimburse an employee for any portion of their accrued, unused paid sick leave at the time the employee separates from employment.

(a) If an employer chooses to reimburse an employee for any portion of their accrued, unused paid sick leave at the time the employee separates from employment, any such terms for reimbursement must be mutually agreed upon in writing by both the employer and the employee, unless the right to such reimbursement is set forth elsewhere in state law or through a collective bargaining agreement.

(b) If an employee is rehired by the same employer, whether at the same or a different business location of the employer, within twelve months after the date the employee separates from employment, the employer must reinstate the employee's accrued, unused paid sick leave. An employer need not reinstate any hours of paid sick leave previously provided to the employee through financial or other reimbursement at the time of separation, as long as the value of the paid sick leave was established and paid at a rate that was at least equal to the employee's normal hourly compensation.

(3) When an employee separates from employment and the employee is rehired within twelve months of separation by the same employer, whether at the same or a different business location of the employer, an employee who reached the ninetieth calendar day of employment prior to separation shall have their previously accrued, unused paid sick leave balance available for use upon rehire. If the employee did not reach the ninetieth calendar day of employment prior to separation, the previous period of employment must be counted for purposes of determining the date upon which the employee is entitled to use paid sick leave.

(4) Upon rehire, an employer must provide notification to the employee of the amount of accrued, unused paid sick leave available for use by the employee.

(5) If the period of time an employee separates from employment extends into the following year ("year" as defined at WAC 296-128-620(6)), the employer is not required to reinstate more than forty hours of the employee's accrued, unused paid sick leave.

NEW SECTION

WAC 296-128-700 Paid time off (PTO) programs. (1) Paid time off (PTO) provided to employees by an employer's PTO program (e.g., a program that combines vacation leave, sick leave, or other forms of leave into one pool), created by a written policy or a collective bargaining agreement, satisfies the requirement to provide paid sick leave if the PTO program meets or exceeds the provisions of RCW 49.46.200 and 49.46.210, and all applicable rules, including:

(a) Accrual of PTO leave at a rate of not less than one hour for every forty hours worked as an employee;

(b) Payment for PTO leave at the employee's normal hourly compensation;

(c) Carryover of at least forty hours of accrued, unused PTO leave to the following year ("year" as defined at WAC 296-128-620(6));

(d) Access to use PTO leave for all the purposes authorized under RCW 49.46.210 (1)(b) and (c); and

(e) Employer notification and recordkeeping requirements set forth in WAC 296-128-010 and 296-128-760.

(2) If an employee chooses to use their PTO leave for purposes other than those authorized under RCW 49.46.210 (1)(b) and (c), and the need for use of paid sick leave later arises when no additional PTO leave is available, the employer is not required to provide any additional PTO leave to the employee as long as the employer's PTO program meets or exceeds the provisions of RCW 49.46.200 and 49.46.210, and all applicable rules.

NEW SECTION

WAC 296-128-710 Shared leave. (1) An employer may establish a shared paid sick leave program in which an employee may choose to donate paid sick leave to a co-worker.

(2) If an employer establishes a shared paid sick leave program, the employer must have a written policy or a collective bargaining agreement which specifies that an employee may donate accrued, unused paid sick leave to a co-worker for purposes authorized under RCW 49.46.210 (1)(b) and (c).

The employer must notify employees of such policy or agreement prior to allowing an employee to donate or use shared paid sick leave. An employer must make this information readily available to all employees.

NEW SECTION

WAC 296-128-720 Shift swapping. (1) An employer may not require, as a condition of an employee using paid sick leave, that the employee search for or find a replacement worker to cover the hours during which the employee is using paid sick leave.

(2) Upon mutual agreement by the employer and employee(s) involved, an employee may work additional hours or shifts, or trade shifts with another employee, in lieu of using available paid sick leave for missed hours or shifts that qualify for the use of paid sick leave.

NEW SECTION

WAC 296-128-730 Frontloading. (1) An employer may, but is not required to, frontload paid sick leave to an employee in advance of accrual.

(2) If an employer frontloads paid sick leave, the employer must ensure that such frontloaded paid sick leave complies with the provisions of RCW 49.46.200 and 49.46.210, and all applicable rules.

(3) If an employer frontloads paid sick leave, the employer must do so by using a reasonable calculation, consistent with the accrual requirement set forth under RCW 49.46.210 (1)(a), to determine the amount of paid sick leave the employee would be projected to accrue during the period of time for which paid sick leave is being frontloaded.

(a) If the employer calculates and frontloads, and an employee subsequently uses, an amount of paid sick leave which exceeds the paid sick leave the employee would have otherwise accrued absent frontloading, the employer shall not

seek reimbursement from the employee for such paid sick leave used during the course of ongoing employment.

(b) If an employer frontloads paid sick leave to an employee, but such frontloaded paid sick leave is less than the amount the employee was entitled to accrue under RCW 49.46.210 (1)(a), the employer must make such additional amounts of paid sick leave available for use by the employee as soon as practicable, but no later than thirty days after identifying the discrepancy.

(4) The employer must have a written policy or a collective bargaining agreement which addresses the requirements for use of frontloaded paid sick leave. An employer must notify employees of such policy or agreement prior to frontloading an employee paid sick leave, and must make this information readily available to all employees.

(5) An employer may not make a deduction from an employee's final wages for frontloaded paid sick leave used prior to the accrual rate required by RCW 49.46.210 (1)(a), unless there is a specific agreement in place with the employee allowing for such a deduction. Such deductions must also meet the requirements set forth in RCW 49.48.010 and WAC 296-126-025.

NEW SECTION

WAC 296-128-740 Third-party administrators. (1) Employers may contract with a third-party administrator in order to administer the paid sick leave requirements under RCW 49.46.200 and 49.46.210, and all applicable rules.

(2) Employers are not relieved of their obligations under RCW 49.46.200 and 49.46.210, and all applicable rules, if they elect to contract with a third-party administrator to administer paid sick leave requirements. With the consent of employers, third-party administrators may pool an employee's accrued, unused paid sick leave from multiple employers as long as the accrual rate is at least equal to one hour of paid sick leave for every forty hours worked as an employee. For example, if a group of employers have employees who perform work for various employers at different times, the employers may choose to contract with a third-party administrator to track the hours worked and rate of accrual for paid sick leave for each employee, and pool such accrued, unused paid sick leave for use by the employee when the employee is working for any employers in the same third-party administrator network.

(3) A collective bargaining agreement may outline the provisions for an employer to use a third-party administrator as long as such provisions meet all paid sick leave requirements under RCW 49.46.200 and 49.46.210, and all applicable rules.

NEW SECTION

WAC 296-128-750 Employee use of paid sick leave for unauthorized purposes. (1) If an employer can demonstrate that an employee's use of paid sick leave was for a purpose not authorized under RCW 49.46.210 (1)(b) and (c), the employer may withhold payment of paid sick leave for such hours, but may not subsequently deduct those hours from an employee's legitimately accrued, unused paid sick leave hours.

(2) If an employer withholds payment for the use of paid sick leave for purposes not authorized under RCW 49.46.210 (1)(b) and (c), the employer must provide notification to the employee. If the employee maintains that the use of paid sick leave was for an authorized purpose, the employee may file a complaint with the department.

NEW SECTION

WAC 296-128-760 Employer notification and reporting to employees. (1) Employers must notify each employee of their entitlement to paid sick leave, the rate at which the employee will accrue paid sick leave, the authorized purposes under which paid sick leave may be used, and that retaliation by the employer for the employee's lawful use of paid sick leave and other rights provided under chapter 49.46 RCW, and all applicable rules, is prohibited.

(a) Employers must provide such notification in written or electronic form, and must make this information readily available to all employees.

(b) For employees hired on or after January 1, 2018, employers must notify each employee of such rights no later than the commencement of his or her employment. For existing employees as of January 1, 2018, the employer must notify each employee no later than March 1, 2018.

(c) The department shall, in consultation with employee and employer representatives, develop sample notification policies which meet the department's standard for compliance with these rules. The department shall make such sample notification policies available on the department's web site.

(2) Not less than monthly, employers must provide each employee with written or electronic notification detailing the amount of paid sick leave accrued and the paid sick leave reductions since the last notification, and any unused paid sick leave available for use by the employee. Employers may satisfy the notification requirements by providing this information in regular payroll statements.

(a) Employers are not required to provide monthly notification to an employee if the employee has no hours worked since the last notification.

(b) If an employer chooses to frontload paid sick leave to an employee in advance of accrual:

(i) The employer must make written or electronic notification to an employee no later than the end of the period for which the frontloaded paid sick leave was intended to cover, establishing that the amount of paid sick leave frontloaded to the employee was at least equal to the accrual rate under RCW 49.46.210 (1)(a); and

(ii) The employer is not relieved of their obligation to provide notification, not less than monthly, of the paid sick leave available for use by the employee.

NEW SECTION

WAC 296-128-770 Retaliation. (1) It is unlawful for an employer to interfere with, restrain, or deny the exercise of any employee right provided under or in connection with chapter 49.46 RCW. This means an employer may not use an employee's exercise of any of the rights provided under chapter 49.46 RCW as a negative factor in any employment action

such as evaluation, promotion, or termination, or otherwise subject an employee to discipline for the exercise of any rights provided under chapter 49.46 RCW.

(2) It is unlawful for an employer to adopt or enforce any policy that counts the use of paid sick leave for a purpose authorized under RCW 49.46.210 (1)(b) and (c) as an absence that may lead to or result in discipline by the employer against the employee.

(3) It is unlawful for an employer to take any adverse action against an employee because the employee has exercised their rights provided under chapter 49.46 RCW. Such rights include, but are not limited to: Filing an action, or instituting or causing to be instituted any proceeding under or related to chapter 49.46 RCW; exercising their right to paid sick leave, minimum wage, overtime, tips and gratuities; or testifying or intending to testify in any such proceeding related to any rights provided under chapter 49.46 RCW.

(4) Adverse action means any action taken or threatened by an employer against an employee for their exercise of chapter 49.46 RCW rights, which may include, but is not limited to:

(a) Denying use of, or delaying payment for, paid sick leave, minimum wages, overtime wages, all tips and gratuities, and all service charges, except those service charges itemized as not being payable to the employee or employees servicing the customer;

(b) Terminating, suspending, demoting, or denying a promotion;

(c) Reducing the number of work hours for which the employee is scheduled;

(d) Altering the employee's preexisting work schedule;

(e) Reducing the employee's rate of pay; and

(f) Threatening to take, or taking action, based upon the immigration status of an employee or an employee's family member.

((~~HANDICAPPED~~)) WORKERS WITH A DISABILITY

AMENDATORY SECTION (Amending § 2, Regulation 294.6.005, filed 12/30/60)

WAC 296-128-055 Definition. "((~~Handicapped~~)) Worker with a disability" means an individual whose earning capacity is impaired by age or physical or mental deficiency or injury for the work he or she is to perform.

AMENDATORY SECTION (Amending § 3, Regulation 294.6.005, filed 12/30/60)

WAC 296-128-060 Application for certificate. (1) Application for a certificate authorizing the employment of ((~~handicapped~~)) workers with a disability shall be made upon forms made available by the director or ((~~his~~)) authorized representatives.

(2) The application shall set forth, among other things, the nature of the disability, a description of the occupation at which the ((~~handicapped~~)) worker with a disability is to be employed, and the wage the employer proposes to pay the ((~~handicapped~~)) worker with a disability per hour. The nature of the disability must be set out in detail.

(3) The application shall be signed jointly by the employer and the ((~~handicapped~~)) worker with a disability for whom such application is being made, except as otherwise authorized by the director or ((~~his~~)) an authorized representative.

AMENDATORY SECTION (Amending § 4, Regulation 294.6.005, filed 12/30/60)

WAC 296-128-065 Conditions for granting a certificate. (1) If the application is in proper form and sets forth facts showing:

(a) A subminimum wage is necessary to prevent curtailment of the ((~~handicapped worker's~~)) worker with a disability's opportunities for employment;

(b) The ((~~handicap~~)) disability impairs the earning capacity of the worker for the work he or she is to perform, a certificate may be issued.

(2) The director or ((~~his~~)) an authorized representative may require the submission of additional information to that shown on the application and may require the ((~~handicapped~~)) worker with a disability to take a medical examination where it is deemed necessary in order to determine whether or not the issuance of a certificate is justified.

AMENDATORY SECTION (Amending § 5, Regulation 294.6.005, filed 12/30/60)

WAC 296-128-070 Issuance of certificate. If the application and other available information indicate that the requirements of this regulation are satisfied, the director or ((~~his~~)) an authorized representative shall issue a certificate. Otherwise ((~~he~~)) the director or an authorized representative shall deny a certificate. If issued, copies of the certificate shall be mailed to the employer and the ((~~handicapped~~)) worker with a disability and if denied, the employer and the ((~~handicapped~~)) worker with a disability shall be given written notice of the denial.

AMENDATORY SECTION (Amending § 6, Regulation 294.6.005, filed 12/30/60)

WAC 296-128-075 Terms of certificate. (1) A certificate shall specify, among other things, the name of the ((~~handicapped~~)) worker with a disability, the name of the employer, the occupation in which the ((~~handicapped~~)) worker with a disability is to be employed, the authorized subminimum wage rate and the period of time during which such wage rate may be paid.

(2) A certificate shall be effective for a period to be designated by the director or ((~~his~~)) an authorized representative and a ((~~handicapped~~)) worker with a disability employed under such certificate may be paid subminimum wages only during the effective period of the certificate.

(3) The wage rate set in the certificate shall be fixed at a figure designed to reflect adequately the ((~~handicapped worker's~~)) worker with a disability's earning capacity. No wage rate shall be fixed at less than seventy-five percent of the applicable minimum wage under RCW 49.46.020 unless, after investigation a lower rate appears to be clearly justified.

(4) Any money received by a ((~~handicapped~~)) worker with a disability by reason of any state or federal pension or compensation program for ((~~handicapped persons~~)) workers with a disability shall not be considered as offsetting any part of the wage or remuneration due the ((~~handicapped~~)) worker by the employer.

(5) The worker with a disability or trainee shall be paid not less than one and one-half times the regular rate for hours worked in excess of forty in the workweek or eight in the workday.

(6) The terms of any certificate, including the subminimum wage rate specified therein, may be amended by the director or ((~~his~~)) an authorized representative upon written notice to the parties concerned, if the facts justify such amendment.

WSR 17-21-118

PERMANENT RULES

DEPARTMENT OF LICENSING

[Filed October 18, 2017, 11:17 a.m., effective November 21, 2017]

Effective Date of Rule: November 21, 2017.

Purpose: The proposed language amends rules to establish licensing requirements, fees, and standards of practice for the new theatrical wrestling school license.

Citation of Rules Affected by this Order: Amending WAC 36-13-010 License fees, renewals and requirements, 36-13-020 Definitions, 36-13-030 Ring and safety zone, 36-13-040 Department inspector, and 36-13-110 Miscellaneous provisions for promoters and/or theatrical wrestling schools.

Statutory Authority for Adoption: RCW 67.08.330(4), 67.08.017, 43.24.086.

Adopted under notice filed as WSR 17-18-078 on September 5, 2017.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 5, Repealed 0.

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

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

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

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

Date Adopted: October 18, 2017.

Damon Monroe
Rules Coordinator

Chapter 36-13 WAC

((~~PROFESSIONAL~~)) WRESTLING

AMENDATORY SECTION (Amending WSR 15-23-055, filed 11/12/15, effective 12/13/15)

WAC 36-13-010 License fees, renewals and requirements. (1) The license year is one year from date of issue. License fees are paid annually. Fees shall be as follows:

Wrestling participant	-	$25.00
Inspector	-	$65.00
Event physician	-	No charge
Promoter	-	$200.00
Theatrical wrestling school	-	$500.00

(2) No license fee is required for persons licensed under chapter 36-12 or 36-14 WAC as an inspector, event physician or promoter.

(3) In addition to license requirements found in chapter 67.08 RCW((~~,~~)):

(a) Wrestling participants shall submit a small photograph of themselves that is not more than two years old.

(b) Theatrical wrestling schools:

(i) Must provide proof of having an established place of business that offers training in theatrical wrestling.

(ii) Must provide proof of having an active tax registration through the department of revenue.

(iii) Must reapply for licensure when there is a change in the location or change in ownership.

AMENDATORY SECTION (Amending WSR 02-20-094, filed 10/1/02, effective 1/1/03)

WAC 36-13-020 Definitions. (1) "Participant" is defined as any person engaged physically in the wrestling exhibition or show.

(2) "On-site" is defined as the premises at the theatrical wrestling school training facility.

(3) "Off-site" is defined as any location off the theatrical wrestling school training facility premises.

AMENDATORY SECTION (Amending WSR 02-20-094, filed 10/1/02, effective 1/1/03)

WAC 36-13-030 Ring and safety zone. ((~~(1)~~)) The promoter and/or theatrical wrestling school, excluding on-site theatrical wrestling school events, shall:

(1) Supply a ring that meets the following standards:

(a) The ring platform shall not be less than a ((~~sixteen-foot~~)) twelve-foot square ((~~within the ropes~~)).

(b) The ring floor shall be padded to a thickness of at least one inch. A regular one-piece wrestling mat is preferred, although soft padding of a proper thickness may be used, with a top covering of clean canvas tightly stretched and laced to the ring platform.

(c) ((~~The promoter shall~~)) Keep the mat and covering in a clean and sanitary condition.

(2) ((~~There shall be~~)) Ensure there is a six-foot safety zone between the ring and the first row of spectator seats. The floor in the safety zone may be covered by padded floor mats. The safety zone may extend in an aisle from ringside directly to the locker room. The safety zone shall have a barrier approved by the department, which is at least three feet high. The barrier shall be of sufficient strength and durability to prevent the audience from coming in physical contact with the ((~~wrestling~~)) participants. No person other than security, department representatives, ((~~wrestling~~)) participants or event licensees shall be permitted in the safety zone during any part of an event unless expressly approved by the department representative. The ((~~wrestling~~)) participants shall not leave the confines of the safety zone during a match. Wrestling activities ((~~which~~)) may not include any member of the audience and will be considered unprofessional conduct and subject to penalties under RCW 67.08.180(5) and 67.08.240.

AMENDATORY SECTION (Amending WSR 02-20-094, filed 10/1/02, effective 1/1/03)

WAC 36-13-040 Department inspector. (1) An inspector shall attend all wrestling events and may attend theatrical wrestling school events. The inspector shall ensure all participants are properly licensed (unless exempt from licensure) and all laws, rules, and regulations are enforced. ((~~Wrestling~~)) Participants scheduled to ((~~work~~)) perform at an event shall provide proof of their identity by:

(a) Presenting picture identification to the inspector; and

(b) Signing their legal name that matches the picture identification on a form provided by the inspector.

(2) Inspector, other than a department employee, shall receive a fee not to exceed two percent of the net gate of each event up to a maximum of four hundred dollars and a minimum of thirty-five dollars which shall be paid by the promoter.

AMENDATORY SECTION (Amending WSR 15-23-055, filed 11/12/15, effective 12/13/15)

WAC 36-13-110 Miscellaneous provisions for promoters and/or theatrical wrestling schools. (1) Dangerous conduct; punishment. The referee shall not permit physically dangerous conduct or tactics by any participant. Any participant who fails to discontinue such tactics, after being warned by the referee or a department official shall be disqualified and subject to disciplinary action.

(2) ((~~Wrestling~~)) Participants or other licensees shall not engage in the practice known as "juicing." "Juicing" is the practice of using a razor blade or similar contrivance, or any other means to draw blood from oneself, one's opponent, or from any other participant of the wrestling exhibition or show. The referee shall immediately terminate any match in which blood from a participant appears from "juicing," and the participants shall cease the wrestling match and return to the dressing room. Should an accidental cut to a ((~~wrestling~~)) participant occur, the match may continue but should be concluded as soon as possible at the discretion of the referee.

(3) Duties of licensees. It shall be the duty of the promoter and/or theatrical wrestling school, his/her agents, employees, and the participants in any wrestling show or exhibition to maintain peace and order in the conduct of any show or exhibition. There shall be no abuse of a department official at any time.

(4) ((~~Responsibility of~~)) The promoter((~~.~~)) and/or theatrical wrestling school:

(a) ((~~Each promoter~~)) Shall be directly responsible to the department for the conduct of its employees and any violation of the laws, rules, or regulations of the department by any employee of a promoter and/or theatrical wrestling school shall be deemed to be a violation by the promoter and/or theatrical wrestling school.

(b) ((~~Promoters~~)) Are responsible for any violations of the law or department rules by their participants.

(c) ((~~Promoters~~)) Shall provide an ambulance or paramedical unit with transport and resuscitation capabilities, with a minimum of two attendants, to be present at the event location at all times during the event. A theatrical wrestling school may satisfy this requirement by having an emergency medical technician, as required under RCW 67.08.330, at the event location at all times during the event.

(5) Discrimination. Discrimination against any participant in regard to sex, race, color, creed or national origin shall be referred to the human rights commission.

(6) Appeals.

(a) Licensees may appeal any suspension or revocation to the department in the manner provided in chapter 34.05 RCW.

(b) Such appeals must be received in the department office within twenty days from the date of the notice sent by the department.

(7) Theatrical wrestling schools:

(a) Must notify the department in writing fourteen days prior to holding an off-site event. The notice must include the location, date, and time of the event.

(b) Must maintain a list all participants' names who performed in each event for a minimum of three years and be available at the request of the department.