



# RULE-MAKING ORDER

**CR-103E (July 2011)**  
**(Implements RCW 34.05.350)**

**Agency:** Health Care Authority, Washington Apple Health

**Emergency Rule Only**

**Effective date of rule:**

**Emergency Rules**

- Immediately upon filing.
- Later (specify) January 1, 2016

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

- Yes
  - No
- If Yes, explain:

**Purpose:**

Emergency rulemaking is necessary to remove references to billing in 30-minute units from WAC 182-535-1400 by January 1, 2016.

**Citation of existing rules affected by this order:**

Repealed:  
 Amended: WAC 182-535-1400  
 Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160

**Other authority:**

**EMERGENCY RULE**

Under RCW 34.05.350 the agency for good cause finds:

- That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
- That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.
- That in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012, or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this finding:

Effective January 1, 2016, the American Dental Association / Centers for Medicare and Medicaid Services is eliminating the billing code for 30-minute time increments for dental procedures listed in WAC 182-535-1400. The agency became aware of this change in November 2015. Emergency rulemaking is necessary to make these changes by January 1, 2016.

**Date adopted:** December 31, 2015

**NAME (TYPE OR PRINT)**

Wendy Barcus

**SIGNATURE**

**TITLE**

HCA Rules Coordinator

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: December 31, 2015**

**TIME: 10:05 AM**

**WSR 16-02-049**

(COMPLETE REVERSE SIDE)

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	<u>1</u>	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	<u>1</u>	Repealed	_____

**WAC 182-535-1400 Payment for dental-related services.** (1) The agency considers that a provider who furnishes covered dental services to an eligible client has accepted the agency's rules and fees.

(2) Participating providers must bill the agency their usual and customary fees.

(3) Payment for dental services is based on the agency's schedule of maximum allowances. Fees listed in the agency's fee schedule are the maximum allowable fees.

(4) The agency pays the provider the lesser of the billed charge (usual and customary fee) or the agency's maximum allowable fee.

(5) The agency pays dental general anesthesia services for eligible clients as follows:

(a) (~~((The initial thirty minutes constitutes))~~) Fifteen-minute increments are billed as one unit of time. When a dental procedure (~~((requiring dental general anesthesia results in))~~) requires multiple (~~((time))~~) fifteen-minute units and there is a remainder (less than fifteen minutes), the remainder (~~((or fraction))~~) is considered (~~((as one time))~~) one unit.

(b) When billing for anesthesia, the provider must show the actual beginning and ending times in the client's medical record. Anesthesia time begins when the provider starts to physically prepare the client for the induction of anesthesia in the operating room area (or its equivalent), and ends when the provider is no longer in constant attendance (i.e., when the client can be safely placed under postoperative supervision).

(6) The agency pays "by report" on a case-by-case basis, for a covered service that does not have a set fee.

(7) Participating providers must bill a client according to WAC 182-502-0160, unless otherwise specified in this chapter.

(8) If the client's eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment is the client's responsibility. The exception to this is dentures and partial dentures as described in WAC 182-535-1240 and 182-535-1290.