

WAC 296-30-010 Definitions. The following definitions are used to administer the crime victims compensation program:

Acceptance, accepted condition: A determination by the department that the diagnosis of the claimant's medical or mental health condition is the result of the criminal act. The condition being accepted must be specified by one or more diagnostic codes from the current edition of the International Classification of Diseases, Clinically Modified (ICD-CM), or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Authorization: Notification by a qualified representative of the department that specific treatment, services or equipment provided for the accepted condition is allowable under the claim. Providers must maintain records naming the claim manager who authorizes treatment, services or equipment.

Bodily injury: Any harmful or offensive touching, including severe emotional distress where no touching takes place when:

(1) The victim **is not** the object of the criminal act and:

(a) The distress is intentionally or recklessly inflicted by extreme or outrageous conduct;

(b) Caused the victim to have a reasonable apprehension of imminent bodily harm; and

(c) The victim is in the immediate vicinity at the time of the criminal act.

(2) The victim **is** the object of the criminal act and:

(a) The distress is intentionally or recklessly inflicted by extreme or outrageous conduct; and

(b) Caused the victim to have a reasonable apprehension of imminent bodily harm.

Claimant: A victim who submits an application for benefits, or on whose behalf an application is submitted.

Consultation: The services rendered by a health care provider whose opinion or advice is requested by the treating provider, or by the department, in the evaluation and/or treatment of a claimant. Case management or case staffing does not constitute a consultation.

Criminal act: An act defined in RCW 7.68.020, the occurrence of which can be verified by the department or which is reasonably credible. Physically impossible acts, highly improbable acts for which verification is not available, or unverified memories of acts occurring prior to the age of two will not be accepted as reasonably credible. In evaluating evidence to determine verification of claimed criminal acts, the department will give greater weight to the quality, than to the quantity, of evidence. Evidence that can be considered for verification of claimed criminal acts includes, but is not limited to, one or more of the following:

(1) Police or other investigation reports.

(2) Child protective services or other government agency reports.

(3) Diaries or journals kept by victims and others.

(4) Third party reports from school counselors, therapists and others.

(5) Current medical examinations.

(6) Medical or psychological forensic evaluations. In the absence of other adequate forensic evaluation reports, independent assessments per WAC 296-31-069 may be conducted when indicated.

(7) Legal and historical reports.

(8) Current and past medical and mental health records.

(9) Reports of interviews with the victim's family members, friends, acquaintances and others who may have knowledge of pertinent facts. When such interviews are necessary to determine eligibility, the victim will be given the choice of whether to allow the interviews to be conducted. The victim will also be given the understanding that eligibility may be denied if the interviews are not conducted. The department will act according to the victim's choice.

Crisis intervention: Therapy to alleviate the claimant's most pressing problems. The vital mental and safety functions of the claimant are stabilized by providing support, structure and, if necessary, restraint.

Evidence-based and curative treatment: Treatment practices, interventions and services that are supported by empirically based research and shown to produce consistent and effective outcomes.

Family therapy: Therapy involving one or more members of the claimant's family, excluding the perpetrator, which centers on issues resulting from the claimant's sexual assault pursuant to WAC 296-30-080.

Group therapy: Therapy involving the claimant, and one or more clients who are not related to the claimant, which includes issues related to the claimant's condition and pertinent to other group members.

Immediate family members: Any claimant's parents, spouse, child(ren), siblings, grandparents, and those members of the same household who have assumed the rights and duties commonly associated with a family unit.

Individual therapy: Therapy provided on a one-to-one basis between a provider and client.

Lost wage certification: Documentation from a treating provider based on objective medical evidence stating the claimant is not able to work based on the effects of the crime injury.

Maximum benefit: The maximum amount payable per claim. Medical benefits cannot exceed one hundred fifty thousand dollars per claim pursuant to RCW 7.68.085. Nonmedical benefits cannot exceed forty thousand dollars pursuant to RCW 7.68.070(1).

Mental health provider: Any person, firm, corporation, partnership, association, agency, institution, or other entity providing any kind of mental health services related to the treatment of a claimant. This includes, but is not limited to, hospitals, psychiatrists, psychologists, advanced registered nurse practitioners with a specialty in psychiatric and mental health nursing, registered and/or licensed master level counselors, and other qualified service providers licensed, registered and/or certified with the department of health and registered with the crime victims compensation program. (Refer to WAC 296-31-030 for specific details.)

Payer of last resort: The crime victims compensation program pays after all other public or private insurance programs, up to our fee schedule.

Proper and necessary: Proper and necessary services for the diagnosis or rehabilitative treatment of an accepted condition:

(1) Reflective of accepted standards of good practice within the scope of the provider's license, certification, or registration;

(2) Not delivered primarily for the convenience of the claimant, the claimant's attending provider, or another provider;

(3) Curative or rehabilitative care that produces long lasting changes which reduces the effects of the accepted condition;

(4) Provided at the least cost and in the least intensive setting of care consistent with the other provisions of this definition; and

(5) Concluded once a claimant has reached a state of maximum improvement. Maximum improvement occurs when no fundamental or marked change in an accepted condition can be expected with or without treatment. A claimant's condition may have reached maximum improvement though it might be expected to improve or deteriorate with the passage of time. Once a claimant's condition has reached maximum improvement, treatment that results only in temporary changes is not proper and necessary. Maximum improvement is equivalent to fixed and stable.

Reasonable cooperation: The victim is able to talk to the police and give information to help in the investigation and prosecution of the alleged offender. There may be circumstances in which the victim is not able to fully cooperate. In these instances, consideration is given to the needs of the victim. The department may consider the following issues. The list is not inclusive:

(1) There is fear of retribution from the offender;

(2) There is a mental or physical condition which inhibits cooperation;

(3) The victim is dependent upon the offender for support;

(4) The victim is a minor.

Termination of treatment: Treatment is concluded when it is no longer curative because the accepted condition for which the claim was allowed has become stable. The provider shall submit a report indicating the date the condition became stable to the department.

The result of: The test used to define "the result of" used in RCW 7.68.060 (2)(a) is two-pronged. First, it must be determined that cause in fact exists, and second, it must then be determined that proximate cause exists.

(1) Cause in fact exists if "but for" the acts of the victim the crime that produced the injury would not have occurred.

(2) Proximate cause exists if, once cause in fact is found, it is determined that the acts of the victim:

(a) Resulted in a foreseeable injury to the victim;

(b) Played a substantial role in the injury; and

(c) Were the direct cause of the injury.

Treating provider: A person licensed to practice one or more of the following professions: Medicine and surgery, osteopathic medicine and surgery, chiropractic naturopathic physician, podiatry, dentistry, optometry, advanced registered nurse practitioner (ARNP), mental health therapists, and certified medical physician assistants or osteopathic physician assistants. A treating provider actively treats an injured or ill claimant.

Unjustly enriched: It would not be fair or equitable justice to allow a person to obtain, or have control of, or access to benefits or compensation paid to a victim of crime.

AMENDATORY SECTION (Amending WSR 11-22-054, filed 10/31/11, effective 12/1/11)

WAC 296-30-087 Can a victim be billed for expenses related to their claim? (1) If claim costs are under (~~(fifty thousand dollars)~~)

the maximum benefit, the claimant should not pay any expenses relating to an allowed claim. Providers must bill the claimant's public or private insurance first, and then bill the department.

EXCEPTION: A provider may require the claimant to pay for treatment if the claimant's eligibility is pending. If benefits are authorized, and payable by the department, the provider must refund the claimant in full.

(2) If claim costs exceed (~~fifty thousand dollars~~) the maximum benefit, the claimant is responsible for expenses.

AMENDATORY SECTION (Amending WSR 10-19-111, filed 9/21/10, effective 10/22/10)

WAC 296-30-900 What law controls a claim if a statute is amended after the date of the criminal act? (1) The criminal act occurs when the perpetrator commits the criminal conduct. The statute in effect ((when the criminal act occurred)) at the time the criminal act occurred, as defined in RCW 7.68.020(5), is the controlling law((, except as provided in chapter 122, Laws of 2010 (E2SSB 6504). The act occurs when the perpetrator commits the criminal conduct.

For those crime victims who apply for benefits after April 1, 2010, the law in effect at the time the application is received by the department is the controlling law)). The limited total claim benefit of fifty thousand dollars effective April 1, 2010, which applied retroactively to claims filed on or after July 1, 1981, expired effective July 1, 2015.

(2) The cap of forty thousand dollars on nonmedical benefits pursuant to RCW 7.68.070(1) remains in effect. Medical benefits for claims filed on or after July 1, 1981, have been extended to one hundred fifty thousand dollars per claim pursuant to RCW 7.68.085.

WAC 296-31-060 What reports are required from mental health providers? The crime victims compensation program requires the following reports from mental health providers:

(1) **Initial response and assessment: Form I:** This report is required if you are seeing the client for **six sessions or less**, and must contain:

(a) The client's initial description of the criminal act for which they have filed a crime victims compensation claim;

(b) The client's presenting symptoms/issues by your observations and the client's report;

(c) If the claimant is unable to work as a result of the crime injury, provide an estimate of when the claimant will return to work and why they are unable to work; and

(d) What type of intervention(s) you provided.

EXCEPTION: If you will be providing more than six sessions it is not necessary to complete Form I, instead complete Form II.

(2) **Initial response and assessment: Form II:** This report is required if **more than six sessions** are anticipated. Form II must be submitted no later than the sixth session, and must contain:

(a) The client's initial description of the criminal act for which they have filed a crime victims compensation claim;

(b) A summary of the essential features of the client's symptoms related to the criminal act, beliefs/attributions, vulnerabilities, defenses and/or resources that lead to your clinical impression (refer to current DSM and crime victims compensation program guidelines);

(c) Any preexisting or coexisting emotional/behavioral or health conditions relevant to the crime impact if present, and how they may have been exacerbated by the crime victimization;

(d) Specific diagnoses with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;

(e) Treatment plan based on diagnoses and related symptoms, to include:

(i) Specific treatment goals you and the client have set;

(ii) Treatment strategies to achieve the goals;

(iii) How you will measure progress toward the goals; and

(iv) Any auxiliary care that will be incorporated.

(f) A description of your assessment of the client's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress; and

(g) If the claimant is unable to work as a result of the crime injury, provide an estimate of when the claimant will return to work and why they are unable to work.

(3) **Progress note: Form III:** This report must be completed **after session fifteen has been conducted**, and must contain:

(a) Whether there has been substantial progress towards recovery for the crime related condition(s);

(b) If you expect treatment will be completed within thirty visits (for adults) or forty visits (for children); and

(c) What complicating or confounding issues are hindering recovery.

(4) **Treatment report: Form IV:** This report must be completed for authorization for **treatment beyond thirty sessions for adults or forty sessions for children**, and **again for authorization if treatment will**

go beyond fifty sessions for adults or sixty sessions for children.

Form IV must contain:

(a) The diagnoses at treatment onset with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year;

(b) The current diagnoses, if different now, with current DSM or ICD code(s), including axes 1 through 5, and the highest GAF in the past year; and

(c) Proposed plan for treatment and number of sessions requested, and an explanation of:

(i) Substantial progress toward treatment goals;

(ii) Partial progress toward treatment goals; or

(iii) Little or no progress toward treatment goals.

(5) **Termination report: Form V:** If you **discontinue treatment of a client** for any reason, a termination report should be completed within sixty days of the client's last visit, and must contain:

(a) Date of last session;

(b) Diagnosis at the time client stopped treatment;

(c) Reason for termination (e.g., goals achieved, client terminated treatment, client relocated, referred to other services, etc.); and

(d) At this point in time do you believe there is any permanent loss in functioning as a result of the crime injury? If yes, describe symptoms based on diagnostic criteria for a DSM diagnosis.

(6) **Reopening application: This application is required to reopen a claim** that has been closed more than ninety days, to demonstrate a worsening of the client's condition and a need for treatment. (~~Benefits are limited to fifty thousand dollars per claim.~~) If the claimant has met or exceeded the maximum benefit, we will be unable to pay for reopening exams or diagnostic tests. If the benefits paid on this claim are less than the (~~fifty thousand dollar~~) maximum benefit, we will reimburse you for filing the application, for an office visit, and diagnostic studies needed to complete the application up to the (~~fifty thousand dollar~~) maximum benefit. No other benefits will be paid until a decision is made on the reopening. If the claim is reopened, we will pay benefits for a maximum of sixty days prior to the date we received the reopening application.

WAC 296-33-010 Attendant services. (1) What are attendant services?

Attendant services are proper and necessary personal care services (custodial care) provided to maintain the claimant in their residence.

(2) Who may receive attendant services?

Claimants who are temporarily or permanently totally disabled and rendered physically unable to care for themselves due to the crime may receive attendant services.

(3) Is prior authorization required for attendant services?

Yes. To be covered by the crime victims compensation program, attendant services must be requested by the attending physician and authorized by the department before services begin.

(4) Am I required to use other insurance coverage before the crime victims compensation program will cover attendant services?

Yes, all other insurances both private and public must be used first.

(5) When will the crime victims program stop paying for attendant care services?

The program will stop payment of attendant care services if the service is no longer medically necessary, or the maximum benefit (~~of fifty thousand dollars~~) is reached.

(6) What attendant services does the crime victims program cover?

The program covers proper and necessary attendant services that are provided consistent with the claimant's needs, abilities and safety. Only attendant services that are necessary due to the physical restrictions caused by the crime are covered.

The following are examples of attendant services that may be covered:

- Bathing and personal hygiene;
- Dressing;
- Administration of medications;
- Specialized skin care, including changing or caring for dressings or ostomies;
- Tube feeding;
- Feeding assistance (not meal preparation);
- Mobility assistance, including walking, toileting and other transfers;
- Turning and positioning;
- Bowel and incontinent care; and
- Assistance with basic range of motion exercises.

(7) What attendant services are not covered?

Services the department considers everyday environmental needs, unrelated to the medical needs of the claimant, are not covered. The following are examples of some chore services that are not covered:

- Housecleaning;
- Laundry;
- Shopping;
- Meal planning and preparation;
- Transportation of the claimant;
- Errands for the claimant;
- Recreational activities;
- Yard work;

- Child care.

(8) Will the crime victims compensation program review the attendant services being provided?

Yes. Periodic evaluations by the crime victims compensation program or its designee will be performed. Evaluations may include, but not be limited to, a medical records review and an on-site review of appropriate attendant services consistent with the claimant's needs, ability, and safety.

(9) Who is eligible to become a provider of attendant services?

Attendant services must be provided through an agency licensed, certified or registered to provide home care or home health services.

(10) How can a provider obtain a provider account number from the department?

In order to receive a provider account number from the department, a provider must:

- Complete a provider account application;
- Sign a provider agreement;
- Provide a copy of any practice or other license held;
- Complete, sign and return Form W-9; and
- Meet the department's provider eligibility requirements.

Note: A provider account number is required to receive payment from the department but is not a guarantee of payment for services.

(11) How many hours will be authorized for attendant services?

The crime victims compensation program will determine the maximum hours of authorized care based on an independent nursing assessment conducted in the claimant's residence. More than one provider may be authorized, based on the claimant's needs and the availability of providers. Attendant service providers are limited to a maximum of seventy hours per week per provider.

(12) What are the provider account status definitions?

- Active - Account information is current and provider is eligible to receive payment.
- Inactive - Account is not eligible to receive payment based on action by the department or at provider request. These accounts can be reactivated.
- Terminated - Account is not eligible to receive payment based on action by the department or at provider request. These accounts cannot be reactivated.

(13) When may the department inactivate a provider account?

The department may inactivate a provider account when:

- There has been no billing activity on the account for eighteen months; or
- The provider requests inactivation; or
- Provider communications are returned due to address changes; or
- The department changes the provider application or application procedures; or
- Provider does not comply with department request to update information.

(14) When may the department terminate a provider account?

The department may terminate a provider account when:

- The provider is found ineligible to treat per department rules;
- or
- The provider requests termination; or
 - The provider dies or is no longer in active business status.

(15) How can a provider reactivate a provider account?

To reactivate a provider account, the provider may call or write the department. The department may require the provider to update the

provider application and/or agreement or complete other needed forms prior to reactivation. Account reactivation is subject to department review. If a provider account has been terminated, a new provider application will be required.