WAC 296-23A-0710 Definitions. "Alternate outpatient payment." A payment for proper and necessary services calculated using a method other than the APC method, such as the outpatient hospital rate or fee schedule.

"Ambulatory payment classification (APC) bill." An outpatient bill for hospital services that are grouped and paid using APCs.

"Ambulatory payment classification (APC) weight." The relative value assigned to each APC by CMS. For information on calculating the APC weights, please see 42 C.F.R., Chapter IV, Part 419, et al. Medicare Program; Prospective Payment System for Hospital Outpatient Services.

"Ambulatory payment classification (APC)." A grouping for outpatient visits which are similar both clinically and in the resources used.

"Ambulatory surgery centers (ASCs)." Ambulatory surgery centers as defined by the department. ASCs are excluded from the APC payment system.

"Blended rate." The dollar amount used to determine APC payments.

"Bundling." Including the costs of supplies and certain other items with the costs of APCs. Bundled services will not be paid separately.

"Cancer hospitals." Freestanding hospitals specializing in the treatment of individuals who have a neoplasm diagnosis.

"Children's hospitals." Freestanding hospitals specializing in the treatment of individuals less than fourteen years of age.

"CMS." Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration (HCFA).

"Correct coding initiative." A process to encourage hospitals to code the most appropriate diagnosis and procedure for the services rendered.

"Critical access hospitals." Critical access hospitals as defined by the department of health.

"Current procedural terminology (CPT)." A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, interventions performed by physicians; the American Medical Association (AMA) publishes it annually.

"Discount factor." The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times.

"Exempt services." Services and hospitals that have been identified by CMS and/or L&I as exempt from the APC-based payment system.

"Health care common procedure coding system (HCPCS)." Medicare's procedure coding system, which consists of Level 1 CPT Codes, Level 2 National Codes, and Level 3 Local Codes.

"Incidental services." Proper and necessary services that are integral to the delivery of the significant procedure or medical visit and are not separately reimbursable.

"Inpatient only procedures." Certain procedures designated by CMS as being of sufficient resource intensity that an inpatient setting is always required.

"Modifier." A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. Modifiers add clarification to procedures and can affect payment. Modifiers are listed in the current CPT and HCPCS manuals.

"Non-APC services." Services specifically excluded by CMS or by L&I from APC payment.

"Out-of-state hospitals." Any hospital not physically located within the state of Washington.

"Outpatient code editor." A prepayment analysis program designed to exclude certain diagnostic and procedure codes from being classified within the APC payment system.

"Outpatient prospective payment system (OPPS)." A payment system that groups hospital outpatient visits into APCs and multiplies the relative weight factor by the OPPS conversion rate to determine the appropriate payment.

"Outpatient services." Proper and necessary health care services and treatment ordinarily furnished by a hospital in which the injured worker is not admitted as an inpatient.

"Outpatient." A patient who receives proper and necessary health care services or supplies in a hospital-type setting but is not admitted as an inpatient.

"Partial hospitalization." Mental health services provided in an inpatient setting without the traditional inpatient overnight stay.

"Pediatric services." Proper and necessary health care services and treatment ordinarily furnished by a hospital in which the injured worker is under the age of fourteen.

"Psychiatric hospitals." Freestanding hospitals specializing in the treatment of individuals with a mental health disease.

"Rehabilitation hospitals." Freestanding hospitals specializing in the treatment of individuals in need of rehabilitative services.

"Related encounters or related services." Multiple encounters which are:

- Provided within the same window of service; and
- By the same provider (hospital).

"Single visit." A single visit includes all related services that are combined for reimbursement when they occur with the same hospital during the window of service.

"Special programs." Programs specifically designated by the department.

"Transitional pass-through." Certain drugs, devices and biologicals, as identified by CMS that are entitled to a specified payment until CMS assigns and reimburses them under their own APC.

"Window of service." A single date of service. All services associated with the visit for that date constitute a single visit, even when those services are provided on different days.

[Statutory Authority: RCW 51.04.030 and 51.12.330. WSR 06-12-073, § 296-23A-0710, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020. WSR 03-21-069, § 296-23A-0710, filed 10/14/03, effective 12/1/03. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. WSR 01-24-045, § 296-23A-0710, filed 11/29/01, effective 1/1/02.]