WAC 182-550-1050 Hospital services definitions. The following definitions and abbreviations, those found in chapter 182-500 WAC, Medical definitions, and definitions and abbreviations found in other sections of this chapter apply to this chapter. When a term is not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the medical definitions found in *Taber's Cyclopedic Medical Dictionary* apply.

"Accommodation costs" - The expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Accredited" or **"accreditation"** - A term used by nationally recognized health organizations, such as the commission on accreditation of rehabilitation facilities (CARF), to indicate a facility meets both professional and community standards of medical care.

"Acute" - A medical condition of severe intensity with sudden onset. For the purposes of the acute physical medicine and rehabilitation (Acute PM&R) program, acute means an intense medical episode, not longer than three months.

"Acute care" - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional to maintain their health status.

"Acute physical medicine and rehabilitation (acute PM&R)" - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at an agency-approved rehabilitation facility. The program provides 24-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a 24 hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

"Administrative day" or **"administrative days"** - One or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate.

"Administrative day rate" - The agency's statewide medicaid average daily nursing facility rate.

"Aggregate cost" - The total cost or the sum of all constituent costs.

"Aggregate operating cost" - The total cost or the sum of all operating costs.

"All-patient DRG grouper (AP-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions between August 1, 2007, and June 30, 2014.

"All-patient refined DRG grouper (APR-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions on and after July 1, 2014.

"Allowable" - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

"Allowed amount" - The initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or

charge," that the agency allows as the basis for payment computation before final adjustments, deductions, and add-ons.

"Allowed charges" - The total billed charges for allowable services.

"Allowed covered charges" - The total billed charges for services minus the billed charges for noncovered services, denied services, or both.

"Ambulatory payment classification (APC)" - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Ambulatory surgery" - A surgical procedure that is not expected to require an inpatient hospital admission.

"Ancillary services" - Additional or supporting services provided by a hospital to a client during the client's hospital stay. These services include, but are not limited to: Laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" - The level of care required to best manage a client's illness or injury based on:

(1) The severity of illness and the intensity of services required to treat the illness or injury; or

(2) A condition-specific episode of care.

"Audit" - An assessment, evaluation, examination, or investigation of a health care provider's accounts, books, and records, including:

(1) Health, financial, and billing records pertaining to billed services paid by the agency through Washington apple health, by a person not employed or affiliated with the provider, to verify the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical, and health records, including mathematical computations and special studies conducted supporting the medicare cost report (Form 2552-96 and 2552-10 or successor form), submitted to the agency to establish program rates for payment to hospital providers.

"Authorization" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

"Bad debt" - An operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Bedside nursing services" - Services included under the room and board services paid to the facility and provided by nursing service personnel. These services include, but are not limited to: Medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing and other point of care testing, catheterizations, tube feedings and irrigations, and equipment monitoring services.

"Billed charge" - The charge submitted to the agency by the provider.

"Bordering city hospital" - A hospital located in one of the cities listed in WAC 182-501-0175.

"Budget neutral" - A condition in which a claims model produces aggregate payments to hospitals that are the same under two separate payment systems. See also **"budget neutrality factor."**

"Budget neutrality factor" - A multiplier used by the agency to ensure that modifications to the payment method and rates are budget neutral. See also **"budget neutral."**

"Budget target" - Funds appropriated by the legislature or through the agency's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjuster" - A multiplier applied to the outpatient prospective payment system (OPPS) payment to ensure aggregate payments do not exceed the established budget target.

"Bundled services" - Interventions integral to or related to the major procedure. The agency does not pay separately for these services.

"Case mix" - A relative value assigned to a DRG or classification of patients in a medical care environment representing the resource intensity demands placed on an institution.

"Case mix index (CMI)" - The average relative weight of all cases treated in a hospital during a defined period.

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

"Charity care" - See chapter 70.170 RCW.

"Children's health insurance program (CHIP)" - The federal Title XXI program under which medical care is provided to uninsured children younger than age 19. Part of Washington apple health.

"Children's hospital" - A hospital primarily serving children.

"Client" - A person who receives or is eligible to receive services through agency programs.

"CMS PPS input price index" - A measure, expressed as a percentage, of the annual inflationary costs for hospital services.

"Commission on accreditation of rehabilitation facilities (CARF)" - See http://www.carf.org/home/.

"Comprehensive hospital abstract reporting system (CHARS)" - The department of health's (DOH's) inpatient hospital data collection, tracking, and reporting system.

"Condition-specific episode of care" - Care provided to a client based on the client's primary condition, complications, comorbidities, standard treatments, and response to treatments.

"Contract hospital" - A hospital contracted by the agency to provide specific services.

"Conversion factor" - A hospital-specific dollar amount that is used in calculating inpatient payments.

"Core provider agreement (CPA)" - The basic contract the agency holds with providers serving Washington apple health clients.

"Cost report" - See **"medicare cost report."**

"Costs" - Agency-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report."

"Covered charges" - Billed charges submitted to the agency on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" - See **"hospital covered service"** and WAC 182-501-0050.

"Critical border hospital" - An acute care hospital located in a bordering city (see WAC 182-501-0175 for list) that the agency has, through analysis of admissions and hospital days, designated as critical to provide health care for Washington apple health clients.

"Current procedural terminology (CPT)" - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is

copyrighted and published annually by the American Medical Association (AMA).

"Deductible" - The dollar amount a client is responsible for before an insurer, such as medicare, starts paying or the initial specific dollar amount for which the client is responsible.

"Department of social and health services (DSHS)" - The Washington state agency that provides food assistance, financial aid, medical and behavioral health care, and other services to eligible children, families, and vulnerable adults and seniors of Washington state.

"Diagnosis code" - A set of numeric or alphanumeric characters assigned by the current published ICD-CM coding guidelines used by the agency as a shorthand symbol to represent the nature of a disease or condition.

"Diagnosis-related group (DRG)" - A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use. Classification of patients is based on the current published ICD-CM coding guidelines used by the agency, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

"Direct medical education costs" - The direct costs of providing an approved medical residency program as recognized by medicare.

"Discharging hospital" - The institution releasing a client from the acute care hospital setting.

"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 on the same day. Not all significant procedures are subject to a discount factor.

"Disproportionate share hospital (DSH) payment" - A supplemental payment made by the agency to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan. See WAC 182-550-4900.

"Disproportionate share hospital (DSH) program" - A program through which the agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients in accordance with legislative direction and established payment methods. See 1902 (a)(13)(A)(iv) of the Social Security Act. See also WAC 182-550-4900 through 182-550-5400.

"Dispute conference" - See **"hospital dispute conference."**

"Distinct unit" - A distinct area for psychiatric, rehabilitation, or withdrawal management services which has been certified by medicare within an acute care hospital or approved by the agency within a children's hospital.

"Division of behavioral health and recovery services (DBHR)" - The division within HCA that administers mental health, problem gambling, and substance abuse programs authorized by chapters 43.20A, 71.05, 71.24, 71.34, and 70.96A RCW.

"DRG" - See **"diagnosis-related group."**

"DRG allowed amount" - The DRG relative weight multiplied by the conversion factor.

"DRG average length-of-stay" - The agency's average length-of-stay for a DRG classification established during an agency DRG rebasing and recalibration project.

"DRG-exempt services" - Services paid through methods other than DRG, such as per diem rate, per case rate, or ratio of costs-to-charges (RCC).

"DRG payment" - The total payment made by the agency for a client's inpatient hospital stay. The DRG payment is the DRG allowed amount plus the high outlier minus any third-party liability, client participation, medicare payment, and any other adjustments applied by the agency.

"DRG relative weight" - A factor used in the calculation of DRG payments. As of July 1, 2014, the medicaid agency uses the 3M™ Corporation's national weights developed for the all-patient refined-diagnosis-related group (APR-DRG) software.

"Emergency medical condition" - See WAC 182-500-0030.

"Emergency room" or **"emergency facility"** or **"emergency department"** - A distinct hospital-based facility which provides unscheduled services to clients who require immediate medical attention. An emergency department must be capable of providing emergency medical, surgical, and trauma care services 24 hours a day, seven days a week. A physically separate extension of an existing hospital emergency department may be considered a freestanding emergency department as long as the extension provides comprehensive emergency medical, surgical, and trauma care services 24 hours a day, seven days a week.

"Emergency services" - Health care services required by and provided to a client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Inpatient maternity services are considered emergency services by the agency.

"Enhanced ambulatory patient groupings (EAPG)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after July 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.

"Equivalency factor (EF)" - A factor that may be used by the agency in conjunction with other factors to determine the level of a state-administered program payment. See WAC 182-550-4800.

"Exempt hospital - DRG payment method" - A hospital that for a certain client category is reimbursed for services to Washington apple health clients through methodologies other than those using DRG conversion factors.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Experimental service" - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC 182-531-0050. 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 (FDA) or other requisite government body if approval is required.

"Fee-for-service" - See WAC 182-500-0035.

"Fiscal intermediary" - Medicare's designated fiscal intermediary for a region or category of service, or both.

"Fixed per diem rate" - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

"Formal release" - When a client:

(1) Discharges from a hospital or distinct unit;

(2) Dies in a hospital or distinct unit;

(3) Transfers from a hospital or distinct unit as an acute care transfer; or

(4) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility.

"Global surgery days" - The number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

"Graduate medical education costs" - The direct and indirect costs of providing medical education in teaching hospitals. See "direct medical education costs" and "indirect medical education costs."

"Grouper" - See **"all-patient DRG grouper (AP-DRG)"** and **"all-patient refined DRG grouper (APR-DRG)."**

"Health care authority (medicaid agency)" - The Washington state agency that administers Washington apple health.

"High outlier" - A DRG claim classified by the agency as being allowed a high outlier payment that is paid under the DRG payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the agency. See WAC 182-550-3700.

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

"Hospital" - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a medicare or state-certified distinct rehabilitation unit, a "psychiatric hospital" as defined in this section, or any other distinct unit of the hospital.

"Hospital cost report" - See **"cost report."**

"Hospital covered service" - Any service, treatment, equipment, procedure, or supply provided by a hospital, covered under a Washington apple health program, and within the scope of an eligible client's Washington apple health program.

"Hospital readmission" - A situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital.

"Indirect medical education costs" - The indirect costs of providing an approved medical residency program as recognized by medicare.

"Inflation adjustment" - For cost inflation, this is the hospital inflation adjustment. This adjustment is determined by using the inflation factor method approved by the legislature. For charge inflation, this is the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) Hospital Census and Charges by Payer report.

"Inpatient hospital admission" - A formal admission to a hospital based on an evaluation of the client using objective clinical indicators to provide medically necessary, acute inpatient care. These indicators include assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury. All applicable indicators must be documented in the client's health record. The decision to admit a client to inpatient status should be based on the con-

dition-specific episode of care, severity of illness presented, and the intensity of services rendered. The agency does not deem inpatient hospital admissions as covered or noncovered solely on the basis of the length of time the client actually spends in the hospital. Generally, a client remains overnight and occupies a bed. Inpatient status can apply even if the client is discharged or transferred to another acute hospital and does not actually use a hospital bed overnight. For the agency to recognize a stay as inpatient there must be a physician admission order in the client's medical record indicating the status as inpatient.

"Inpatient medicaid DRG conversion factor" - A dollar amount that represents selected hospitals' average costs of treating medicaid and CHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay medicaid and CHIP claims under the DRG payment method. See WAC 182-550-3800 for how this conversion factor is calculated.

"Inpatient services" - Health care services provided to a client during hospitalization whose condition warrants formal admission and treatment in a hospital.

"Inpatient state-administered program conversion factor" - A DRG conversion factor reduced from the inpatient medicaid DRG conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims under the DRG payment method.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases (ICD-9-CM and ICD-10-CM)" - The systematic listing of diseases, injuries, conditions, and procedures as numerical or alpha numerical designations (coding).

"Length of stay (LOS)" - The number of days of inpatient hospitalization, calculated by adding the total number of days from the admission date to the discharge date, and subtracting one day.

"Long-term acute care (LTAC) services" - Inpatient intensive long-term care services provided in agency-approved LTAC hospitals to eligible Washington apple health clients who meet criteria for level 1 or level 2 services. See WAC 182-550-2565 through 182-550-2596.

"LTAC level 1 services" - LTAC services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one of the following:

(1) Ventilator weaning care; or

(2) Care for a client who has:

(a) Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and

(b) At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

"LTAC level 2 services" - LTAC services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

(1) Ventilator care for a client who is ventilator-dependent and is not weanable and has complex medical needs; or

(2) Care for a client who:

(a) Has a tracheostomy;

(b) Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and

(c) Has at least one comorbid condition (such as quadriplegia).

"Major diagnostic category (MDC)" - One of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG and APR-DRG classification systems.

"Medical care services (MCS)" - See WAC 182-500-0070.

"Medical education costs" - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical visit" - Diagnostic, therapeutic, or consultative services provided to a client by a health care professional in an outpatient setting.

"Medicare cost report" - The medicare cost report (Form 2552-96 or Form 2552-10), or successor document, completed and submitted annually by a hospital provider.

"Medicare crossover" - A claim involving a client who is eligible for both medicare benefits and medicaid.

"Medicare physician fee schedule (MPFS)" - The official CMS publication of relative value units and medicare payment policy indicators for the resource-based relative value scale (RBRVS) payment program.

"Medicare Part A" - See WAC 182-500-0070.

"Medicare Part B" - See WAC 182-500-0070.

"Medicare payment principles" - The rules published in the federal register regarding payment for services provided to medicare clients.

"Military hospital" - A hospital reserved for the use of military personnel, their dependents, and other authorized users.

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

"National Correct Coding Initiative (NCCI)" - A national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the *American Medical Associations' Current Procedural Terminology (CPT®)* manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National Drug Code (NDC)" - The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a five-four-two grouping. The first five digits comprise the labeler code assigned to the manufacturer by the FDA. The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

"National payment rate (NPR)" - A rate for a given procedure code, published by CMS, that does not include a state- or location-specific adjustment.

"National Provider Identifier (NPI)" - A standard, unique identifier for health care providers assigned by CMS. The agency's ProviderOne system pays for inpatient and outpatient services using only one NPI per provider. The agency may make an exception for inpatient claims billed with medicare-certified, distinct unit NPIs.

"Nationwide rate" - See **"national payment rate (NPR)."**

"NCCI edit" - A software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency fee schedules, billing instructions, and other publications. The agency has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards, or agency policy.

"Newborn" or **"neonate"** or **"neonatal"** - A person younger than 29 days old.

"Nonallowed service or charge" - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160.

"Noncovered charges" - Billed charges a provider submits to the agency on a claim and indicates them on the claim as noncovered.

"Noncovered service or charge" - A service or charge the agency does not consider or pay for as a "hospital covered service." This service or charge may not be billed to the client, except under the conditions identified in WAC 182-502-0160.

"Nursing service personnel" - A group of health care professionals that includes, but is not limited to: Registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant/nursing assistant certified (CNA/NAC).

"Observation services" - A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed 48 hours. The agency or the agency's designee may determine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service.

"Operating costs" - All expenses incurred providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" or **"orthotic"** - A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Outliers" - Cases with extraordinarily high costs when compared to other cases in the same DRG.

"Out-of-state hospital" - Any hospital located outside the state of Washington and the bordering cities designated in WAC 182-501-0175. For Washington apple health clients requiring psychiatric services, an "out-of-state hospital" is any hospital located outside the state of Washington.

"Outpatient" - A client who is receiving health care services, other than inpatient services, in a hospital setting.

"Outpatient care" - See **"outpatient hospital services."**

"Outpatient enhanced ambulatory payment grouper (EAPG)" - A software program the agency uses for classifying and editing in enhanced ambulatory payment grouping-based OPPS.

"Outpatient hospital" - A hospital authorized by DOH to provide outpatient services.

"Outpatient hospital services" - Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services.

"Outpatient prospective payment system (OPPS) conversion factor" - See **"outpatient prospective payment system (OPPS) rate."**

"Outpatient prospective payment system (OPPS) rate" - A hospital-specific multiplier assigned by the agency that is one of the components of the APC payment calculation.

"Outpatient surgery" - A surgical procedure that is not expected to require an inpatient hospital admission.

"Pass-throughs" - Certain drugs, devices, and biologicals, as identified by CMS, for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own APC.

"Per diem" - A method which uses a daily rate to calculate payment for services provided as a "hospital covered service."

"PM&R" - See **"Acute PM&R."**

"Point of care testing (POCT)" - A test designed to be used at or near the site where the patient is located, that does not require permanent dedicated space, and that is performed outside the physical facilities of the clinical laboratory.

"Primary care case management (PCCM)" - The coordination of health care services under the agency's Indian health center or tribal clinic managed care program. See WAC 182-538-068.

"Principal diagnosis" - The condition chiefly responsible for the admission of the patient to the hospital.

"Prior authorization" - See WAC 182-500-0085.

"Private room rate" - The rate customarily charged by a hospital for a one-bed room.

"Prospective payment system (PPS)" - A payment system in which what is needed to calculate payments (methods, types of variables, and other factors) is set in advance and is knowable by all parties before care is provided. In a retrospective payment system, what is needed (actual costs or charges) is not available until after care is provided.

"Prosthetic device" or **"prosthetic"** - A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Psychiatric hospital" - A medicare-certified distinct psychiatric unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital. Eastern state hospital and western state hospital are excluded from this definition.

"Public hospital district" - A hospital district established under chapter 70.44 RCW.

"Ratable" - A factor used to calculate inpatient payments for state-administered programs.

"Ratio of costs-to-charges (RCC)" - A method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the percentage applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the agency, and payment to the hospital for some DRG-exempt services.

"Rebasing" - The process used by the agency to update hospital payment policies, related variables (rates, factors, thresholds, multipliers, and caps), and system processes (edits, adjudication, grouping, etc.).

"Recalibration" - The process of recalculating DRG relative weights using historical data.

"Rehabilitation units" - Specifically identified rehabilitation hospitals and designated rehabilitation units of hospitals that meet agency and medicare criteria for distinct rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Reserve days" - The days beyond the ninetieth day of hospitalization of a medicare patient for a benefit period or incidence of illness. See also **"lifetime hospitalization reserve."**

"Revenue code" - A nationally assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" - Routine supplies and services provided to a client during the client's hospital stay. This includes, but is not limited to, a regular or special care hospital room and related furnishings, room supplies, dietary and bedside nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" - See WAC 182-549-1100.

"Rural hospital" - An acute care health care facility capable of providing or assuring availability of inpatient and outpatient hospital health services in a rural area.

"Semi-private room rate" - A rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Significant procedure" - A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

"Specialty hospitals" - Children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

"Spenddown" - See chapter 182-519 WAC.

"State plan" - The plan filed by the agency with CMS, Department of Health and Human Services (DHHS), outlining how the state will administer medicaid and CHIP services, including the hospital program.

"Status indicator (SI)" - A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method.

"Subacute care" - Care provided to a client which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Substance use disorder (SUD)" - See RCW 71.05.020.

"Survey" - An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with program requirements.

"Swing bed" - An inpatient hospital bed certified by CMS for either acute inpatient hospital or skilled nursing services.

"Swing-bed day" - A day in which a client is receiving skilled nursing services in a hospital-designated swing bed at the hospital's census hour.

"Total patient days" - All patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" - To move a client from one acute care setting to a higher level acute care setting for emergency care or to a post-acute, lower level care setting for ongoing care.

"Transferring hospital" - The hospital or distinct unit that transfers a client to another acute care or subacute facility or distinct unit, or to a nonhospital setting.

"UB-04" - The uniform billing document required for use nationally by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing for services provided to patients. This document includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved and modified by the Washington state payer group or the agency.

"Vendor rate increase" - An adjustment determined by the legislature, that may be used to periodically increase rates for payment to vendors, including health care providers, that do business with the state.

"Washington apple health program" - Any health care program administered through the medicaid agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-06-040, s 182-550-1050, filed 2/27/25, effective 4/1/25; WSR 21-15-128, § 182-550-1050, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-1050, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-1050, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-1050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-052, § 388-550-1050, filed 6/28/07, effective 8/1/07; WSR 04-20-057, § 388-550-1050, filed 10/1/04, effective 11/1/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. WSR 03-19-043, § 388-550-1050, filed 9/10/03, effective 10/11/03. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-1050, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, .11303 and .2652. WSR 99-14-039, § 388-550-1050, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-1050, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]