Chapter 296-23A WAC
HOSPITALS

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

296-23A-100 General information. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-100, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-16-004 (Order 87-18), § 296-23A-100, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-100, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-105 Payment for hospital inpatient and outpatient services. [Statutory Authority: RCW 51.04.020(4) and 51.04.-030. 92-24-066, § 296-23A-105, filed 12/1/92, effective 1/1/93; 87-24-050 (Order 87-23), § 296-23A-105, filed 11/30/87, effective 1/1/88; 87-03-005 (Order 86-47), § 296-23A-105, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-106 Reimbursement for inpatient services by per case rates and percentage of allowed charges. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, §

296-23A-106, filed 12/1/92, effective 1/1/93.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-110 Hospital outpatient fee schedule information. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-110, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-110, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-115 Hospital outpatient services conversion factors. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-115, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 91-02-063, § 296-23A-115, filed 12/28/90, effective 1/28/91; 88-24-011 (Order 88-28), § 296-23A-115, filed 12/1/88, effective 1/1/89; 87-03-005 (Order 86-47), § 296-23A-115, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-120 Questionable eligibility. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-120, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-125 Refund of incorrect payments. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-125, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-130 Treatment of unrelated illness or injury. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-130, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-130, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-135 Closed claims. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-135, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-140 Take-home Rx's. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-140, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-145 Routine laboratory procedures on admission. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-145, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-150 Billing procedures. [Statutory Authority: RCW 51.04.-020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-150, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 90-04-057, § 296-23A-150, filed 2/2/90, effective 3/5/90; 87-16-004 (Order 87-18), § 296-23A-150, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-150, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-155 New hospitals. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 87-24-050 (Order 87-23), § 296-23A-155, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-160 Excluded and included services. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-160, filed 12/1/92, effective 1/1/93; 87-24-050 (Order 87-23), § 296-23A-160, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.-030 and 51.36.080.

296-23A-165 Out-of-state hospitals. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-24-050 (Order 87-23), § 296-23A-165, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-170 Outliers. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-170, filed 12/1/92, effective 1/1/93; 90-04-057, § 296-23A-170, filed 2/2/90, effective 3/5/90; 87-24-050 (Order 87-23), § 296-23A-170, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-175 Interim bills. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-24-050 (Order 87-23), § 296-23A-175, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-180 Readmissions. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 87-24-050 (Order 87-23), § 296-23A-180, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-185 Transfers. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-24-050 (Order 87-23), § 296-23A-185, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-190 Adjustment of rates. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-190, filed 12/1/92, effective 1/1/93; 87-24-050 (Order 87-23), § 296-23A-190, filed 11/30/87, effective 1/1/88.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.-030 and 51.36.080.

296-23A-200 General information—Hospital outpatient radiology. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-200, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-200, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-205 Billing procedures. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-205, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 91-17-038, § 296-23A-205, filed 8/16/91, effective 9/30/91; 89-17-039 (Order 89-09), § 296-23A-205, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-205, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-210 Injection procedures. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-210, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-215 Responsibility for x-rays. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-215, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-220 Duplication of X rays. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-220, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-225 Additional views. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-225, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-230 Unlisted service or procedure. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-230, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-230, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-235 Special report. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-235, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-235, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-240 Head and neck. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 92-24-066, § 296-23A-240, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-240,

filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-240, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-240, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-242 Chest. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-242, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-242, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-242, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-242, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-244 Spine and pelvis. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 92-24-066, § 296-23A-244, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-244, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-244, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-244, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-244, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-246 Upper extremities. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 92-24-066, § 296-23A-246, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-246, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-246, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-246, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-246, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-248 Lower extremities. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 92-24-066, § 296-23A-248, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-248, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-248, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-248, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-250 Abdomen. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-250, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-250, filed 3/8/91, effective 5/1/91; 87-03-005 (Order 86-47), § 296-23A-250, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-252 Gastrointestinal tract. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-252, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-252, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-252, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-252, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-252, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.-030 and 1993 c 159.

296-23A-254 Urinary tract. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-254, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-254, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-254, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-254, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-254, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-256 Gynecological and obstetrical. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-256, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-256, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-256, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-256, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-256, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.-030 and 1993 c 159.

296-23A-258 Vascular system. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-258, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-258, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-258, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-258, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-258, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.-030 and 1993 c 159.

296-23A-260 Miscellaneous. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 92-24-066, § 296-23A-260, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-260, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-260, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-260, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-260, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-262 Diagnostic ultrasound. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-262, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-262, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-262, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-262, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-262, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-264 Therapeutic radiology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-264, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-264, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-264, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-264, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-266 Nuclear medicine. [Statutory Authority: RCW 51.04.-020(4) and 51.04.030. 92-24-066, § 296-23A-266, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-266, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-266, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-266, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-266, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-268 Therapeutic. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-268, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-268, filed 3/8/91, effective 5/1/91; 87-03-005 (Order 86-47), § 296-23A-268, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-300 General information—Hospital outpatient pathology and laboratory. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-300, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 89-17-039 (Order 89-09), § 296-23A-300, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-300, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-310 Billing procedures. [Statutory Authority: RCW 51.04.-020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-310, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-310, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-315 Unlisted service or procedure. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-315, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-315, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-320 Special report. [Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 93-16-072, § 296-23A-320, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-320, filed 1/8/87.] Repealed by 97-

06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-325 Panel or profile tests. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-325, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-325, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-325, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-325, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-325, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-330 Urinalysis. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-330, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-330, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-330, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-330, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-335 Chemistry and toxicology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-335, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-335, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-335, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-335, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-335, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-340 Hematology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-340, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-340, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-340, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-340, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-340, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-345 Immunology. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 92-24-066, § 296-23A-345, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-345, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-345, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-345, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-345, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-350 Microbiology. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 92-24-066, § 296-23A-350, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-350, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-350, filed 8/10/89, effective 9/10/89; 87-03-005 (Order 86-47), § 296-23A-350, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-355 Cytopathology. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 92-24-066, § 296-23A-355, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-355, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-355, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-355, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-355, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-360 Miscellaneous. [Statutory Authority: RCW 51.04.020 (4) and 51.04.030. 92-24-066, § 296-23A-360, filed 12/1/92, effective 1/1/93; 91-07-008, § 296-23A-360, filed 3/8/91, effective 5/1/91; 89-17-039 (Order 89-09), § 296-23A-360, filed 8/10/89, effective 9/10/89; 87-16-004 (Order 87-18), § 296-23A-360, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-360, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-400 Hospital outpatient physical therapy rules. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 96-10-086, § 296-23A-400, filed 5/1/96, effective 7/1/96; 95-05-072, § 296-23A-400, filed 2/15/95, effective 3/18/95. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159. 94-02-045, § 296-23A-400, filed 12/30/93, effective 3/1/94; 93-16-072, § 296-23A-400, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020(4) and 51.04.030. 89-08-002 (Order 89-01), § 296-23A-400, filed 3/23/89, effective 5/1/89; 87-03-005 (Order 86-47), § 296-23A-400, filed 1/8/87.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

296-23A-410 Muscle testing. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-410, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-415 Modalities. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-415, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-420 Procedures. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 87-03-005 (Order 86-47), § 296-23A-420, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-425 Tests and measurements. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 91-17-038, § 296-23A-425, filed 8/16/91, effective 9/30/91; 87-16-004 (Order 87-18), § 296-23A-425, filed 7/23/87; 87-03-005 (Order 86-47), § 296-23A-425, filed 1/8/87.] Repealed by 93-16-072, filed 8/1/93, effective 9/1/93. Statutory Authority: RCW 51.04.020, 51.04.030 and 1993 c 159.

296-23A-430 Work hardening. [Statutory Authority: RCW 51.04.020(4) and 51.04.030. 89-08-002 (Order 89-01), § 296-23A-430, filed 3/23/89, effective 5/1/89.] Repealed by 97-06-066, filed 2/28/97, effective 4/1/97. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080.

PART 1 - GENERAL INFORMATION

WAC 296-23A-0100 Where can I find general information and rules pertaining to the care of workers? Hospitals may find general information and rules pertaining to the care of workers in chapters 296-20, 296-21 and 296-23 WAC, department bulletins and other department publications. This list is not exhaustive and hospitals remain responsible for other applicable rules.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0100, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0110 When will the department or self-insurer pay for hospital services? The department or self-insurer will pay for hospital services when proper and necessary for the treatment of the accepted occupational disease or injury.

See WAC 296-20-01002 for the definition of medically necessary.

See WAC 296-20-075 for further rules regarding hospitalization.

See WAC 296-20-03001 for treatment requiring authorization.

See WAC 296-20-03002 for treatment not authorized.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0110, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0120 What services are subject to review by the department or self-insurer? The department uses utilization review criteria and all hospital inpatient and outpatient services and billed charges are subject to review by the department, self-insurer or a representative chosen by the department or self-insurer.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0120, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0130 How does the department establish hospital payment rates? The department will establish and update hospital payment rates, methods and policies in consultation with interested persons at times determined by the department. The department will publish a description of payment methods, rates, and policies for hospital services at least thirty calendar days prior to implementation.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0130, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0140 How can interested persons request advance notice of changes to hospital payment rates, methods and policies? The department will give at least thirty calendar days notice to interested persons who request advance notice of changes to hospital payment rates, methods and policies. Interested persons may request advance notice by contacting the department at the following address:

Department of Labor and Industries
Health Services Analysis
Mailing List for Hospital Payment Rates
P.O. Box 44322
Olympia, Washington 98504-4322

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0140, filed 2/28/97, effective 4/1/97.]

PART 1.1 - SUBMITTING BILLS

WAC 296-23A-0150 How must hospitals submit bills for hospital services? Hospitals must submit bills for hospital services using the current National Uniform Billing Form (billing form), or electronically using department file format specifications. Providers using the paper billing form must follow both the billing instructions provided by the department and the Washington state version of the *National Uniform Billing Data Element Specifications* as adopted by the National Uniform Billing Committee.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0150, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0160 How must hospitals submit charges for ambulance and professional services? Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the current Health Insurance Claim Form (as defined by the National Uniform Claim Committee), using the provider account number(s) assigned by the department for these services. Hospitals using any of the electronic transfer options must follow department instructions for electronic billing.

[Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080. 07-08-088, § 296-23A-0160, filed 4/3/07, effective 5/23/07. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0160, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0170 How must hospitals bill the department or self-insurer for preadmission services? Preadmission services performed in a hospital outpatient setting within one day prior to hospital admission must be billed as hospital inpatient services.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0170, filed 2/28/97, effective 4/1/97.]

PART 1.2 - SUPPORTING DOCUMENTATION REQUIREMENTS

WAC 296-23A-0180 What supporting documentation must hospitals send for hospital services? Hospitals must send the following supporting documentation for hospital services:

- Admission history and physical examination
- Discharge summary for stays over forty-eight hours
- Emergency room reports
- Operative reports
- Anesthesia records
- Other documentation as requested by the department or self-insurer.

Hospitals must place the worker's name and claim number on the upper right-hand corner of each page of supporting documentation submitted.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0180, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0190 Where must hospitals send supporting documentation for hospital services for state fund claims? Do not submit supporting documentation with the bill for services. Hospitals must send supporting documentation for hospital services for state fund claims to:

Department of Labor and Industries
Claims Section
P.O. Box 44291
Olympia, WA 98504-4291

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0190, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0195 When must providers using electronic medium submit supporting documentation? Providers using any of the electronic transfer options provided by the department must send the department or self-insurer the required supporting documentation within thirty calendar days of the date billing information was sent to the department on electronic medium. Providers must comply with the electronic billing instructions supplied by the department regarding the submission of hospital bill documentation.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0195, filed 2/28/97, effective 4/1/97.]

PART 2 - PAYMENT METHODS FOR HOSPITAL SERVICES

WAC 296-23A-0200 How does the department pay for hospital inpatient services? The department will pay for hospital inpatient services according to the following table:

Hospital Type or Location	*Do Diagnosis Related Group (DRG) payment methods apply?*	*Do per diem payment methods apply?*	*Do percent of allowed charges (POAC) payment methods apply to hospital inpatient services?*
Children's Hospitals	No	No	Yes, paid 100% of allowed charges
Chronic Pain Management Program	Exempt, paid per department agreement.	Exempt, paid per department agreement.	Exempt, paid per department agreement.
Health Maintenance Organizations	No	No	Yes, paid 100% of allowed charges
Military	No	No	Yes, paid 100% of allowed charges
Veterans Administration	No	No	Yes, paid 100% of allowed charges
State psychiatric facility	No	No	Yes, paid 100% of allowed charges
All other Washington hospitals	Yes	Yes, statewide average per diem rates apply for designated categories: Chemical dependency, psychiatric, rehabilitation, low volume medical, and low volume surgical DRGs	Yes, applies to low cost outlier payments and high cost outlier payments above the high cost outlier threshold

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0200, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-06-027, § 296-23A-0200, filed 2/24/00, effective 3/26/00; 97-06-066, § 296-23A-0200, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0210 How do self-insurers pay for hospital inpatient services? Self-insurers will pay for hospital inpatient services using percent of allowed charges (POAC) factors, according to the following table:

Hospital Type or Location	*Do percent of allowed charges (POAC) payment methods apply to hospital inpatient services?*
Military, Veteran's Administration, Health Maintenance Organizations, State Psychiatric Facilities, Children's Hospitals	Yes, paid 100% of allowed charges
All other Washington hospitals	Yes, paid the hospital specific POAC factor

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-06-027, § 296-23A-0210, filed 2/24/00, effective 3/26/00; 97-06-066, § 296-23A-0210, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0220 How does the department pay for hospital outpatient services? The department will pay for hospital outpatient services according to the following table:

Hospital Type or Service Location	*Does the Ambulatory Payment Classification System apply?*	*Do percent of allowed charges (POAC) payment methods apply?*	*Do the department's Medical Aid Rules and Fee Schedules apply to hospital outpatient radiology, laboratory, pathology, occupational therapy, and physical therapy services?*
Children's hospitals	No	Yes, paid 100% of allowed charges	Yes
Chronic Pain Management Program	No	Exempt, paid per department agreement	Exempt, paid per department agreement
Health Maintenance Organizations	Yes, paid statewide average per APC rate	Yes, applies to certain hospital outpatient services excluded from OPPS except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

Hospital Type or Service Location	*Does the Ambulatory Payment Classification System apply?*	*Do percent of allowed charges (POAC) payment methods apply?*	*Do the department's Medical Aid Rules and Fee Schedules apply to hospital outpatient radiology, laboratory, pathology, occupational therapy, and physical therapy services?*
Military	No	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
Veterans Administration	No	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
State psychiatric facility	No	Yes, paid 100% of allowed charges	Yes
Other psychiatric hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Rehabilitation hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Cancer hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Critical access hospitals	No	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
All other Washington hospitals	Yes	Yes, applies to certain hospital outpatient services excluded from OPPS except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

Hospitals are reimbursed only for the technical component of rates listed in the fee schedules, for outpatient radiology, pathology and laboratory services.

See chapter 296-23 WAC for rules on radiology, pathology, laboratory, physical therapy, occupational therapy, and work hardening services.

See WAC 296-23A-700 for rules on prospective payment system for hospital outpatient services.

See WAC 296-20-132 and 296-20-135 for information on the conversion factor used for certain hospital outpatient services.

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0220, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0220, filed 11/29/01, effective 1/1/02. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-06-027, § 296-23A-0220, filed 2/24/00, effective 3/26/00; 97-06-066, § 296-23A-0220, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0221 How does the self-insurer pay for hospital outpatient services? The self-insurer will pay for hospital outpatient services according to the following table:

Hospital Type or Service Location	*Do percent of allowed charges (POAC) payment methods apply?*	*Do the department's Medical Aid Rules and Fee Schedules apply to hospital outpatient radiology, laboratory, pathology, occupational therapy, and physical therapy services?*
Children's hospitals	Yes, paid 100% of allowed charges	Yes
Chronic Pain Management Program	Not Applicable	Not Applicable
Health Maintenance Organizations	Yes, paid 100% of allowed charges	Yes
Military	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges
Veterans Administration	Yes, paid 100% of allowed charges	No, paid 100% of allowed charges

State psychiatric facility	Yes, paid 100% of allowed charges	Yes
Other psychiatric hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Rehabilitation hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
Cancer hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes
All other Washington hospitals	Yes, applies to hospital outpatient services except radiology, laboratory, pathology, occupational therapy, and physical therapy	Yes

Hospitals are reimbursed only for the technical component of rates listed in the fee schedules, for outpatient radiology, pathology and laboratory services.

See chapter 296-23 WAC for rules on radiology, pathology, laboratory, physical therapy, occupational therapy, and work hardening services.

See WAC 296-23A-700 for rules on the prospective payment system for hospital outpatient services.

See WAC 296-20-132 and 296-20-135 for information on the conversion factor used for certain hospital outpatient services.

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0221, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0221, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0230 How does the department or self-insurer pay out-of-state hospitals for hospital services? The department or self-insurer pays out-of-state hospitals for hospital services using a percent of allowed charges (POAC) factor or department fee schedule. The POAC factor may differ for services performed in inpatient and outpatient settings. Payment rates to hospitals located outside of Washington state are calculated by multiplying the out-of-state percent of allowed charges factor (POAC) by the allowed charges.

Amount paid = (out-of-state POAC Factor) X (Allowed Charges).

Out-of-state hospital providers should bill and the department or self-insurer will pay out-of-state hospitals services according to the following table:

Hospital Professional and Ambulance Services	*Hospital Outpatient Services*	*Hospital Inpatient Services*
Professional and ambulance services should be billed with CPT and HCPCS codes on current Health Insurance Claim Forms (as defined by the National Uniform Claim Committee) under separate provider numbers. These services will be paid using the fee schedule rates and payment policies stated in the Washington *Medical Aid Rules and Fee Schedules*.	All hospital outpatient services should be billed on UB forms under the hospital provider number with revenue codes. These services will be paid at the out-of-state percent of allowed charges (POAC) factor as stated in the Washington *Medical Aid Rules and Fee Schedules*.	All hospital inpatient services should be billed on UB forms under the hospital provider number using revenue codes. These services will be paid at the out-of-state percent of allowed charges (POAC) factor as stated in the Washington *Medical Aid Rules and Fee Schedules*.
Military and veteran's administration professional and ambulance services should be billed on current Health Insurance Claim Forms (as defined by the National Uniform Claim Committee) and will be paid at 100% of allowed charges.	Military, veteran's administration, health maintenance organization, children's, and state-run psychiatric hospitals will be paid at 100% of allowed charges for outpatient hospital services.	Military, veteran's administration, health maintenance organization, children's, and state-run psychiatric hospitals will be paid at 100% of allowed charges for inpatient hospital services.

[Statutory Authority: RCW 51.04.020, 51.36.080, 7.68.030, 7.68.080. 07-08-088, § 296-23A-0230, filed 4/3/07, effective 5/23/07. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-09-078, § 296-23A-0230, filed 4/18/00, effective 7/1/00; 97-06-066, § 296-23A-0230, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0240 How does the department define and pay a new hospital? New hospitals are those open for less than one year prior to the implementation of the department's most recent hospital payment rates. The department will pay new hospitals according to the following table:

Hospital Type or Location	*What Diagnosis Related Group (DRG) base price applies?*	*What Per Diem Payment Rates Apply?*	*What percent of allowed charges (POAC) factor applies?*
Military, Veterans Administration, State Psychiatric, Health Maintenance Organization, Children's,	Exempt	Exempt	Paid 100% of allowed charges
Chronic Pain Management Program	Exempt, paid per department agreement	Exempt, paid per department agreement	Exempt, Paid per department agreement
Other Washington Hospital	Weighted median case-mix adjusted average cost per case for Washington DRG hospitals, except major teaching hospitals	Washington statewide average per diem rates	Washington statewide average POAC

A new hospital will be paid using its hospital-specific POAC within three years of receiving a provider account number(s) from the department.

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0240, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080. 00-06-027, § 296-23A-0240, filed 2/24/00, effective 3/26/00; 97-06-066, § 296-23A-0240, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0250 Does a change in hospital ownership affect a hospital's payment rate? A change in ownership does not constitute the creation of a new hospital. If a hospital changes ownership, rates will remain the same as those payable to the previous owner.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0250, filed 2/28/97, effective 4/1/97.]

PART 2.1 - PERCENT OF ALLOWED CHARGES (POAC) PAYMENT METHODS AND POLICIES

WAC 296-23A-0300 When do percent of allowed charges (POAC) payment factors apply? The department may designate from time to time, those hospitals and hospital services to be paid using POAC factors.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0300, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0310 What is the method for calculating percent of allowed charges (POAC) factors? POAC factors are based on medicare cost report data and are calculated by dividing adjusted operating expenses by adjusted patient revenues. The department will allow costs for graduate medical education and charity care. Allowable costs for charity care shall not exceed a maximum of two percent of the facility's total allowable costs. A hospital's POAC factor shall not exceed one hundred percent of allowed charges.

Payment rates are calculated by multiplying the POAC factor by the allowed charges.

Amount Paid = (POAC Factor) X (Allowed Charges)

Each hospital will be notified of their revised POAC factor thirty days prior to implementation. Incorrect data or erroneous calculations can be appealed in accordance with WAC 296-23A-0600.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0310, filed 2/28/97, effective 4/1/97.]

PART 2.2 - PER DIEM PAYMENT METHODS AND POLICIES

WAC 296-23A-0350 When do per diem rates apply? The department may designate from time to time, those hospitals and hospital services paid on a per diem basis. For example, the department may develop per diem rates for the following diagnosis-related-group (DRG) categories:

- Psychiatric;
- Rehabilitation;
- Substance abuse;
- Medical;
- Surgical; and
- Other categories as determined by the department.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0350, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0360 What is the method for calculating per diem rates? Per diem rates are calculated by dividing the total costs for all relevant cases in the historical data base by the total number of days. The total number of days is equal to the sum of the number of days for each relevant case. The number of days per case is equal to last date of service minus the first date of service. The department will allocate costs at the detailed revenue code level using medicare cost report data and medicare definitions for allowable costs. The department will allow costs for graduate medical education and charity care. Allowable costs for charity care shall not exceed a maximum of two percent of the facility's total allowable costs.

Payment rates are equal to the applicable per diem rate multiplied by the number of days allowed by the department. The department does not pay for the day of discharge. Payment shall not exceed allowed billed charges.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0360, filed 2/28/97, effective 4/1/97.]

PART 2.3 - DIAGNOSIS-RELATED-GROUP PAYMENT METHODS AND POLICIES

WAC 296-23A-0400 What is a "diagnosis-related-group" payment system? A diagnosis-related-group (DRG) system categorizes patients into clinically coherent and homogenous groups with respect to resource use. The department will use an all-patient grouper to perform the diagnostic categorization. To the extent feasible, where DRG relative weights meet acceptable reliability and validity standards, the department will use DRG per case rates for payment of hospital inpatient services.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0400, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0410 How does the department calculate diagnosis-related-group (DRG) relative weights? In calculating DRG relative weights, the department will:

(1) Allocate costs for hospital services at a detailed revenue code level using medicare cost report data and medicare definitions for allowable costs. The department will allow costs for graduate medical education and charity care. Allowable costs for charity care shall not exceed a maximum of two percent of the facility's total allowable costs.

(2) Classify department hospital admissions data and hospital discharge data in the Washington state department of health's comprehensive hospital abstract reporting system (CHARS), using an all-patient grouper.

(3) Establish relative weights from department of labor and industries' hospital admission data. If the department's data is not sufficient to calculate stable relative weights, the department may use hospital discharge data in the Washington state department of health's comprehensive hospital abstract reporting system (CHARS) or another appropriate data source.

(4) Exclude the following types of cases from DRG relative weight calculations: Transfers, statistical outliers, length of stay equal to zero, psychiatric, substance abuse and rehabilitation DRGs, out-of-state hospitals, other hospitals and services designated as exempt from DRG payment rates.

See WAC 296-23A-0470 and 296-23A-0480 for exclusions and exceptions to DRG payments for hospital services.

(5) Test each DRG statistically for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(6) Replace unstable department relative weights with stable CHARS derived relative weights.

(7) Standardize department and CHARS relative weights to a statewide case-mix index of 1.0.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0410, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0420 How does the department determine the base price for hospital services paid using per case rates? The department determines the base price for hospital services paid using per case rates according to the following table:

Type of Hospital	*Base Price*
Major Teaching Hospital: Harborview Medical Center or University of Washington	Hospital-specific case-mix adjusted average cost per case
Other DRG Hospital	Weighted median case-mix adjusted average cost per case for DRG hospitals, except major teaching hospitals

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0420, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0430 How does the department calculate a hospital specific case-mix adjusted average cost per case? The department determines the case-mix adjusted average cost per case for each hospital by:

(1) Allocating costs for hospital services at a detailed revenue code level using medicare cost report data and medicare definitions for allowable costs. The department will allow costs for graduate medical education and charity care. Allowable costs for charity care shall not exceed a maximum of two percent of the facility's total allowable costs;

(2) Totaling the costs of all DRG cases;

(3) Dividing the total by the number of cases; and

(4) Then dividing that number by the hospital's case-mix index.

(5) Per case costs are indexed to the payment period for inflation and other factors.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0430, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0440 How does the department calculate the base price for DRG hospitals, except major teaching hospitals? The department calculates the base price for DRG hospitals, except major teaching hospitals by:

(1) Calculating each hospital's case-mix adjusted average cost per case;

(2) Weighting each hospital's case-mix adjusted average cost per case by the number of cases at that hospital;

(3) Determining the median (fiftieth percentile) of the list of case-mix adjusted average costs per case.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0440, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0450 What cases does the department exclude from base price calculations? The department excludes the following types of cases from base price calculations:

- Transfers;
- Statistical outliers;
- Length of stay equal to zero;
- Psychiatric, substance abuse and rehabilitation DRGs;
- Out-of-state hospitals; and
- Other hospitals and services designated as exempt from DRG payment rates.

See WAC 296-23A-0470 and 296-23A-0480 for exclusions and exceptions to DRG payments for hospital services.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0450, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0460 How does the department calculate the diagnosis-related-group (DRG) per case payment rate for a particular hospital? The DRG per case rate for a particular hospital is calculated by multiplying the assigned DRG relative weight for that admission by the applicable base price.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0460, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0470 Which exclusions and exceptions apply to diagnosis-related-group (DRG) payments for hospital services? The following exclusions and exceptions apply to DRG payments for hospital services:

- Psychiatric, rehabilitation, and chemical dependency (substance abuse) services will be excluded from payment by DRG rates. These services will be paid using per diem payment rates.
- Ambulance and air transportation services are excluded from DRG payments.
- Bills assigned to a DRG that is defined as ungroupable will be denied.
- Bills where the principal diagnosis is invalid as a discharge diagnosis will be denied.
- Bills where the injured worker has been admitted and discharged in less than twenty-four hours will be reviewed by the department and may be paid as hospital outpatient services.
- The department may choose to exclude other DRGs from DRG payment rates due to concerns about access, case volume or other considerations. These services will be paid using the applicable percent of allowed charges (POAC) factor and per diem rates.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0470, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0480 Which hospitals does the department exclude from diagnosis-related-group (DRG) payments? The following hospitals are excluded from DRG payments:

- Military, Veterans Administration, state psychiatric facilities, health maintenance organizations (HMO), and children's hospitals will be paid their allowed charges.
- Department-approved chronic pain management programs will be paid according to department agreement or contract.
- Hospitals located outside of Washington will be paid a percent of allowed charges (POAC).
- Other hospitals, as determined by the department, may be excluded from DRG reimbursement rates due to concerns about access, case volume or other considerations. These facilities will be paid using the applicable POAC factor and per diem rates.

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0480, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0480, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0490 Which hospital services does the department include in diagnosis-related-group (DRG) rates? Unless otherwise specified, the department will include in the DRG rate all hospital services provided to an injured worker admitted to a hospital. Hospital services must be medically necessary for the treatment of the accepted occupational disease or injury.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0490, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0500 When does a case qualify for high outlier status? Outlier payments apply only to diagnosis-related-group (DRG) reimbursed cases with unusually high or low costs. Outlier status does not apply to cases paid using a percent of allowed charges (POAC) factor or per diem rates.

A case is considered a high cost outlier if the costs for the case exceed the outlier threshold for the assigned diagnosis-related-group. The costs for a case are determined by multiplying the allowed charges for the case by the hospital specific POAC factor. The threshold used to define a high outlier case is the greater of a dollar threshold of twelve thousand dollars or two standard deviations above the statewide average cost for each DRG paid by the department.

The dollar threshold may be adjusted annually for inflation or other factors as determined by the department. The standard deviations for DRGs will be computed from all relevant cases in the historical data base, excluding statistical outliers.

[Statutory Authority: RCW 51.04.020, 51.04.030. 00-24-066, § 296-23A-0500, filed 12/1/00, effective 1/1/01. Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0500, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0520 How does the department pay for high outlier cases? Cases defined as high cost outliers will be reimbursed at the diagnosis-related-group (DRG) payment rate plus one hundred percent of costs in excess of the threshold. Costs are determined by multiplying the allowed charges by the hospital specific percent of allowed charges (POAC) factor.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0520, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0530 How does a case qualify for low outlier status? To qualify as a low outlier, the allowed charges multiplied by that hospital's percent of allowed charges (POAC) factor must be less than ten percent of the statewide diagnosis-related-group (DRG) rate or five hundred dollars whichever is greater. The standard deviations for DRGs will be computed from all relevant cases in the historical data base, excluding statistical outliers.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0530, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0540 How does the department pay for low outlier cases? Low outlier cases are paid by multiplying each hospital's specific percent of allowed charges (POAC) factor by the allowed charges for the case.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0540, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0550 Under what circumstances will the department pay for interim bills? The department will deny interim bills which are assigned to diagnosis-related-groups (DRGs) paid per case rates by the department.

If an interim bill is coded as a diagnosis-related-group (DRG) not paid per case rates by the department, then the bill will be paid using the applicable percent of allowed charges (POAC) factor and per diem rates. If a subsequent bill coded as a DRG paid per case rates by the department, for the same injured worker, has a first date of service within seven days of the last date of service of the previous bill, then the bills will be subject to review and adjustment by the department.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0550, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0560 How does the department define and pay for hospital readmissions? The department will review hospital readmissions occurring within seven days of discharge and will determine whether the second admission resulted from premature discharge. Payment for services associated with readmission will depend upon the review. For example:

- If the second admission is determined unnecessary, reimbursement may be denied.
- If the admission was avoidable, the two admissions may be combined and a single diagnosis-related-group (DRG) payment made.
- If two different DRG assignments are involved, reimbursement for the appropriate DRG will be based upon review of the case.
- Readmissions involving different hospitals will be reviewed by the department and may be paid using the payment method for transfers.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0560, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0570 How does the department define a transfer case? A transfer case is defined as an injured worker's admission to another acute care hospital within seven days of that worker's previous discharge. All bills for transfer cases will be subject to review by the department and payment will be determined based on that analysis. The transferring hospital may qualify for high and low outlier status.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0570, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0575 How does the department pay a transferring hospital for a transfer case? When the stay at the transferring hospital is a diagnosis-related-group (DRG) paid by the department, and does not qualify as a low outlier, the transferring hospital is paid a graduated per diem rate for each day of care allowed by the department. If the case qualifies as a low cost outlier, the hospital will be paid the graduated per diem amount or low cost outlier payment amount, whichever is lower. The per diem rate is determined by dividing that hospital's rate for the appropriate DRG by that DRG's average length of stay as determined by the department. Payment for the first day of service will be two times the per diem rate. For subsequent allowed days, the basic per diem rate will be paid up to the full DRG payment amount. Unless the case qualifies as a high outlier, payment to the transferring hospital will not exceed the appropriate DRG rate that would have been paid had the injured worker not been transferred to another hospital.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0575, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0580 How does the department pay the receiving hospital for a transfer case? The hospital receiving a transfer will be paid according to the department's review of the case. If the receiving hospital's stay is a diagnosis-related-group (DRG) paid by the department, then the hospital will receive the appropriate per case and outlier payments. If the case is not a DRG paid by the department, then the hospital is paid using applicable percent of allowed charges (POAC) factor or per diem rates.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0580, filed 2/28/97, effective 4/1/97.]

PART 3 - REQUESTING A HOSPITAL RATE ADJUSTMENT

WAC 296-23A-0600 How can a hospital request a rate adjustment? Hospitals may submit a request for adjustment to their rate if:

- The rate methodology or principles of reimbursement established in department publications were incorrectly applied, or
- Incorrect data or erroneous calculations were used in the establishment of the hospital's rate.

In all circumstances, requests for adjustments to rates must show how the rate adjustment was calculated and contain sufficient detail to permit an audit. Requests must specify the nature and the amount of the adjustment sought. The burden of proof is on the requesting hospital.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0600, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0610 Where must hospitals submit requests for rate adjustments? Hospitals must submit requests for rate adjustments in writing to:

Department of Labor and Industries
Health Services Analysis
Request for Hospital Rate Adjustment
P.O. Box 44322
Olympia, Washington 98504-4322.

Requests must be received within sixty days after the facility receives notice of its payment rates.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0610, filed 2/28/97, effective 4/1/97.]

WAC 296-23A-0620 What action will the department take upon receipt of a request for a rate adjustment? Upon receipt of the request, the department shall determine the need for a conference with the hospital and will contact the facility to arrange a conference if needed. The

conference, if needed, must be held within sixty days of the department's receipt of the request.

Within thirty calendar days of the receipt of the request for review or the date of the conference, the department shall notify the facility of the action to be taken by the department.

If the department's review of the material submitted by the hospital results in a favorable determination for the hospital, the department will modify the hospital's payment rate(s). The revised rate(s) will apply to all bills with a date of admission on or after a date chosen by the department. The chosen date will be within one hundred twenty days of the department's and hospital's agreement to modify the rate(s).

If the department's review of the material submitted by the hospital results in an unfavorable determination for the hospital, the hospital may file an appeal with the board of industrial insurance appeals.

[Statutory Authority: RCW 51.04.020, 51.04.030 and 51.36.080. 97-06-066, § 296-23A-0620, filed 2/28/97, effective 4/1/97.]

PART 4 - AMBULATORY PAYMENT CLASSIFICATION PAYMENT METHODS AND POLICIES

WAC 296-23A-0700 What is the "ambulatory payment classification" (APC) payment system? The APC outpatient prospective payment system (OPPS) is a reimbursement method that categorizes outpatient visits into groups according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. The groups are called Ambulatory Payment Classifications (APCs). The department uses a modified version of the Centers for Medicare and Medicaid Services' (CMS) Prospective Payment System for Hospital Outpatient Department Services to pay some hospitals for covered outpatient services provided to injured workers. The department will utilize CMS' current outpatient code editor to categorize outpatient visits.

The payment system methodology uses CMS' outpatient prospective payment system's relative weight factor for each APC group and a blend of statewide and hospital-specific rates for each APC.

For a complete description of CMS' Prospective Payment System for Hospital Outpatient Department Services see 42 C.F.R., Chapter IV, Part 419, et al.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0700, filed 11/29/01, effective 1/1/02.]

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. 06-12-073, § 296-23A-0710, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020. 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. 01-24-045, § 296-23A-0710, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0720 How does the department calculate the hospital-specific per APC rate used for paying outpatient services under the outpatient prospective payment system (OPPS)? (1) OPPS payment rates are calculated with a formula that blends a hospital-specific rate and a statewide rate. Each hospital's historic labor and industries' reimbursement level in combination with the department's statewide payments will determine payment rates.

(2) For the statewide rate, the department:

(a) Determines the total number of APC procedures that the department paid the covered hospitals. The relative weights for all of these APCs are summed.

(b) Determines the total dollar amount the department paid for those APCs.

(c) Determines the total dollar amount the department paid as outlier payments.

(d) Subtracts the total outlier payments in (c) of this subsection from the total dollar amount in (b) of this subsection and then divides the adjusted dollar amount by the APC relative weight total from (a) of this subsection.

(Sum of APC payments - Sum of outlier payments)/Sum of APC relative weights = Statewide rate

(3) For the hospital-specific rate, the department:

(a) Segregates all the APCs for each hospital and totals the relative weights for each hospital.

(b) Determines the total dollar amount the department historically paid each hospital for those APCs.

(c) Determines the total dollar amount the department historically paid each hospital as an outlier payment for those APCs.

(d) Subtracts the total hospital-specific outlier payments in (c) of this subsection from the total hospital-specific APC payments in (b) of this subsection and then divides the hospital's adjusted dollar amount by the hospital-specific APC relative weight total from (a) of this subsection.

(Sum of hospital-specific APC payment - Sum of hospital-specific outlier payments)/Sum of the hospital-specific APC relative weights = Hospital-specific rate

(4) The final per APC rate paid to a hospital is a blended combination of the hospital-specific and statewide rates.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0720, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0730 How does the department determine the APC relative weights? The relative weight for each APC is the current relative weight listed by CMS for the corresponding APC.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0730, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0740 How does the department calculate payments for covered outpatient services through the outpatient prospective payment system (OPPS)? (1) Billed services that are reimbursed by the OPPS are grouped into one or more APCs using the outpatient code editor software.

(2) Additional payment may be made for services classified by CMS as transitional pass-through.

(3) Incidental services are grouped within an APC and are not paid separately.

(4) The OPPS APC payment method uses an APC relative weight for each classification group (APC) and the current hospital-specific blended rate to determine the APC payment for an individual service.

(5) For each additional APC listed on a single claim for services, the payment is calculated with the same formula and then discounted. L&I follows all discounting policies used by CMS for the Medicare Prospective Payment System for Hospital Outpatient Department Services.

(6) APC payment for each APC = (APC relative weight x hospital-specific blended rate)* discount factor (if applicable) x units (if applicable).

(7) The total payment on an APC claim is determined mathematically as follows:

(a) Sum of APC payments for each APC +

(b) Additional payment for each transitional pass-through (if applicable) +

(c) Additional outlier payment (if applicable).

(8) L&I follows all billing policies used by CMS for the Medicare Prospective Payment System for Hospital Outpatient Department Services with respect to:

(a) Billing of units of service;

(b) Outlier claims;

(c) Use of modifiers;

(d) Distinguishing between single and multiple visits during a span of time and reporting a single visit on one claim, but multiple visits with unrelated medical conditions on multiple claims; and

(e) For paying terminated procedures based on services actually provided and documented in the medical record, and properly indicated by the hospital through the CPT codes and modifiers submitted on the claim.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0740, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0750 What exclusions and exceptions apply to ambulatory-payment-classification (APC) payments for hospital services? (1) Critical access hospitals as identified by the Washington state department of health (DOH).

(2) All out-of-state hospitals.

(3) Military/veterans hospitals.

(4) Psychiatric hospitals.

(5) Rehabilitation hospitals.

(6) Cancer hospitals.

(7) Children's hospitals.

(8) Ambulatory surgery centers.

(9) Any outpatient service or special program identified by the department or by CMS as being a non-APC service.

(10) Any inpatient-only procedures as identified by CMS.

(11) Any APCs identified by the department as a non-APC service.

[Statutory Authority: RCW 51.04.030 and 51.12.330. 06-12-073, § 296-23A-0750, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0750, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0770 How will excluded outpatient services and hospitals be paid? Services excluded from APC-payment, if deemed appropriate for reimbursement, will be reimbursed using an alternate outpatient payment method, such as a specific fee schedule and/or using the hospital-specific or the statewide average percent of allowed charges (POAC).

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0770, filed 11/29/01, effective 1/1/02.]

WAC 296-23A-0780 What information needs to be submitted for the hospital to be paid for outpatient services? Each claim for services must include the required elements as described within the current L&I hospital billing and administrative guidelines.

Note: Includes Provider General Billing Manual; Billing Instructions for Hospital Services; Provider Bulletins; and Provider Updates.

[Statutory Authority: RCW 51.04.020, 51.04.030, 51.36.080, 51.36.085. 01-24-045, § 296-23A-0780, filed 11/29/01, effective 1/1/02.]