AMENDATORY SECTION (Amending WSR 01-24-045, filed 11/29/01, effective 1/1/02)

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~~)) Unless otherwise stated in departmental payment policies, the department follows billing policies used by the Centers for Medicare and Medicaid Services (CMS) for the hospital outpatient prospective payment system 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.

AMENDATORY SECTION (Amending WSR 01-24-045, 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~~)) Unless otherwise indicated in departmental payment policies, the department follows billing policies used by the Centers for Medicare and Medicaid Services (CMS) for the hospital outpatient prospective pricing system 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.