

§ 419.45

(1) The full program and beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(2) One-half the full program and the beneficiary copayment amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is induced; or

(3) One-half of the full program and beneficiary copayment amounts if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

[65 FR 18542, Apr. 7, 2000, as amended at 72 FR 66933, Nov. 27, 2007]

§ 419.45 Payment and copayment reduction for devices replaced without cost or when full or partial credit is received.

(a) *General rule.* CMS reduces the amount of payment for an implanted device made under the hospital outpatient prospective payment system in accordance with § 419.66 for which CMS determines that a significant portion of the payment is attributable to the cost of an implanted device, when one of the following situations occur:

(1) The device is replaced without cost to the provider or the beneficiary;

(2) The provider receives full credit for the cost of a replaced device; or

(3) The provider receives partial credit for the cost of a replaced device but only where the amount of the device credit is greater than or equal to 50 percent of the cost of the new replacement device being implanted.

(b) *Amount of reduction to the APC payment.* (1) The amount of the reduction to the APC payment made under paragraphs (a)(1) and (a)(2) of this section is calculated in the same manner as the offset amount that would be applied if the device implanted during a procedure assigned to the APC had transitional pass-through status under § 419.66.

(2) The amount of the reduction to the APC payment made under paragraph (a)(3) of this section is 50 percent of the offset amount that would be applied if the device implanted during a

42 CFR Ch. IV (10–1–10 Edition)

procedure assigned to the APC had transitional pass-through status under § 419.66.

(c) *Amount of beneficiary copayment.* The beneficiary copayment is calculated based on the APC payment after application of the reduction under paragraph (b) of this section.

[71 FR 68228, Nov. 24, 2006, as amended at 72 FR 66933, Nov. 27, 2007]

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, CMS reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* CMS will consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise CMS concerning) the clinical integrity of the groups and weights. The panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting the review.

(c) *Effective dates.* CMS conducts the first annual review under paragraph (a) of this section in 2001 for payments made in 2002.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the following:

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act.