that hospital's applicable adjustment for a subsequent calendar year.

(3) **Budget neutrality.** For CY 2009 and for each subsequent calendar year, CMS makes an adjustment to the conversion factor, so that estimated aggregate payments under the OPPS for such calendar year are not affected by any reductions to hospital adjustments which occur as a result of paragraph (h)(1) of this section.

(4) **Beneficiary copayment.** The beneficiary copayment for services to which the adjustment to the conversion factor specified under paragraph (h)(1) of this section applies is the product of the national beneficiary copayment amount calculated under §419.41 and the ratio of the adjusted conversion factor calculated under paragraph (h)(1) of this section divided by the conversion factor specified under §419.32(b)(1).

(i) **Payment adjustment for certain cancer hospitals.**—(1) **General rule.** CMS provides for a payment adjustment for covered hospital outpatient department services furnished on or after January 1, 2012, by a hospital described in section 1886(d)(1)(B)(v) of the Act.

(2) **Amount of payment adjustment.** The amount of the payment adjustment under paragraph (i)(1) of this section is determined by the Secretary as follows:

(i) If a hospital described in section 1886(d)(1)(B)(v) of the Act has a payment-to-cost ratio (PCR) before the cancer hospital payment adjustment (as determined by the Secretary at cost report settlement) that is greater than the weighted average PCR of other hospitals furnishing services under section 1833(t) of the Act (as determined by the Secretary at the time of the applicable CY Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center final rule with comment period) (referred to as the Target PCR), for covered hospital outpatient department services, the aggregate payment amount provided at cost report settlement to such hospital is equal to zero.

(3) **Budget neutrality.** CMS establishes the payment adjustment under paragraph (i)(1) of this section in a budget neutral manner.


§419.44 **Payment reductions for procedures.**

(a) **Multiple surgical procedures.** When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount for the following procedures are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) **Interrupted procedures.** When a procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(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.
(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.