

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 less 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 the amount needed to make the hospital's PCR at cost report settlement (as determined by the Secretary) equal to the target PCR (as determined by the Secretary).

(ii) 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.

(j) *Additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators—(1) General rule.* For cost reporting periods beginning on or after

January 1, 2023, CMS provides for a payment adjustment for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators as described in paragraph (j)(2) of this section.

(2) *Amount of adjustment.* The payment adjustment is based on the estimated difference in the reasonable cost incurred by the hospital for domestic National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period as compared to other National Institute for Occupational Safety and Health approved surgical N95 respirators purchased during the cost reporting period.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (j)(2) of this section in a budget neutral manner.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 47677, Aug. 3, 2000; 66 FR 55856, Nov. 2, 2001; 69 FR 832, Jan. 6, 2004; 70 FR 68727, Nov. 10, 2005; 70 FR 76178, Dec. 23, 2005; 71 FR 68227, Nov. 24, 2006; 72 FR 66932, Nov. 27, 2007; 73 FR 68814, Nov. 18, 2008; 75 FR 72265, Nov. 24, 2010; 76 FR 74583, Nov. 30, 2011; 81 FR 79879, Nov. 14, 2016; 87 FR 72291, Nov. 23, 2022]

§ 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 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.* (1) Subject to the provisions of paragraph (b)(2) of this section, 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—

(i) 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;

(ii) 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

(iii) 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.

(2) For all device-intensive procedures (defined as having a device offset of greater than 40 percent), the device offset portion of the device-intensive procedure payment is subtracted prior to determining the program payment and beneficiary copayment amounts identified in paragraph (b)(1)(ii) of this section.

[65 FR 18542, Apr. 7, 2000, as amended at 72 FR 66933, Nov. 27, 2007; 80 FR 70606, Nov. 13, 2015; 81 FR 79879, Nov. 14, 2016]

§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 (2) of this section is calculated as the lesser of the device

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 or the amount of the credit described in paragraph (a)(2) of this section.

(2) The amount of the reduction to the APC payment made under paragraph (a)(3) of this section is calculated as the lesser of the device 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 or the amount of the credit described in paragraph (a)(3) of this section.

(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; 85 FR 86302, Dec. 29, 2020]

§419.46 Participation, data submission, and validation requirements under the Hospital Outpatient Quality Reporting (OQR) Program.

(a) *Statutory authority.* Section 1833(t)(17) of the Act authorizes the Secretary to implement a quality reporting program in a manner so as to provide for a 2.0 percentage point reduction in the OPD fee schedule increase factor for a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit data required to be submitted on measures in accordance with the Secretary's requirements in this part.

(b) *Participation in the Hospital OQR Program.* To participate in the Hospital OQR Program, a hospital as defined in section 1886(d)(1)(B) of the Act and is paid under the OPPS must—

(1) Register on the QualityNet website before beginning to report data;

(2) Identify and register a QualityNet security official as part of the registration process under paragraph (b)(1) of this section; and

(3) Submit at least one data element.

(c) *Withdrawal from the Hospital OQR Program.* A participating hospital may