

requirements specified in §482.58 or §485.645 of this chapter, respectively.

(c) *Special rules for determining the reasonable cost of posthospital SNF care furnished in cost reporting periods beginning prior to July 1, 2002.* The reasonable cost of posthospital SNF care furnished by a swing-bed hospital is determined as follows:

(1) The reasonable cost of routine SNF services is based on the average Medicare rate per patient day for routine services provided in freestanding SNFs in the region where the swing-bed hospital is located. The rates are calculated using the regions as defined in section 1886(d)(2)(D) of the Social Security Act. The rates are based on the most recent year for which settled cost reporting period data are available, increased in a compounded manner, using the increase applicable to the SNF routine cost limits, up to and including the calendar year for which the rates are in effect. If the current Medicare swing-bed rate for routine extended care services furnished by a swing-bed hospital during a calendar year is less than the rate for the prior calendar year, payment is made based on the prior calendar year's rate.

(2) The reasonable cost of ancillary services furnished as posthospital SNF care is determined in the same manner as the reasonable cost of other ancillary services furnished by the hospital in accordance with §413.53(a)(1).

(d) *Additional requirements—(1) General rule.* For services furnished in cost reporting periods beginning prior to July 1, 2002, in order for Medicare payment to be made to a swing-bed hospital with more than 49 beds (but fewer than 100), the following payment requirements must be met:

(i) If there is an available SNF bed in the geographic region, a posthospital SNF care patient must be transferred within 5 days (excluding weekends and holidays) of the availability date, unless the patient's physician certifies within the 5-day period that transfer is not medically appropriate.

(ii) The number of patient days for posthospital SNF care in a cost reporting period does not exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the pe-

riod. In those States that do not license their hospital beds, the hospitals must use the total number of hospital beds reported on their most recent Certificate of Need (CON), excluding bassinets. If during the cost reporting period, there is an increase or decrease in the number of "licensed" beds, the number of "licensed" beds for each part of the period is to be multiplied by the number of days for which that number of "licensed" beds was available. After totalling the results, compute 15 percent of the total available "licensed" bed days to determine the payment limitation.

(2) *Payment restrictions.* (i) The hospital must not seek payment for posthospital SNF care after the end of the 5 day period (excluding weekends and holidays) beginning on the availability date of a SNF bed unless the patient's physician has certified, within that 5 day period, that the transfer of the patient to the SNF was not medically appropriate.

(ii) The hospital must not seek payment for posthospital SNF care in a cost reporting period to the extent that they exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the period. In those States that do not license hospital beds, the hospital must use the average number of hospital beds reported on its most recent CON, excluding bassinets.

(3) *Payment exception.* Payment will continue to be made during the cost reporting period in which the 15 percent limit specified in paragraph (d)(1)(ii) of this section is reached for those patients who are receiving posthospital SNF care at the time the hospital reaches the limit.

[51 FR 34793, Sept. 30, 1986, as amended at 54 FR 37274, Sept. 7, 1989; 56 FR 54545, Oct. 22, 1991; 58 FR 30671, May 26, 1993; 61 FR 51616, Oct. 3, 1996; 62 FR 46037, Aug. 29, 1997; 66 FR 39600, July 31, 2001; 69 FR 49265, Aug. 11, 2004; 79 FR 27153, May 12, 2014; 85 FR 47633, Aug. 5, 2020]

§413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1833(a)(4) and (i)(3) of the Act and establishes the method for

determining Medicare payments for services related to covered ambulatory surgical center (ASC) procedures performed in a hospital on an outpatient basis. It does not apply to services furnished by an ASC operated by a hospital that has an agreement with CMS to be paid in accordance with §416.30 of this chapter. (For regulations governing ASCs see part 416 of this chapter.)

(b) *Definitions.* For purposes of this section—

Facility services are those items and services, as specified in §416.61 of this chapter, that are furnished by a hospital on an outpatient basis in connection with covered ASC surgical procedures, as described in §416.65 of this chapter.

Standard overhead amount means an amount equal to the prospectively determined payment rate that would be paid for the procedure if it had been furnished by an ASC in the same geographic area.

(c) *Payment principle.* The aggregate amount of payments for facility services, furnished in a hospital on an outpatient basis, that are related to covered ASC surgical procedures (covered under §416.65 of this chapter) is equal to the lesser of—

(1) The hospital's reasonable cost or customary charges, as determined in accordance with §413.13, reduced by deductibles and coinsurance; or

(2) The blended payment amount as described in paragraph (d) of this section, which is based on hospital-specific cost and charge data and rates paid to free-standing ASCs.

(d) *Blended payment amount.* (1) For cost reporting periods beginning on or after October 1, 1987 but before October 1, 1988, the blended payment amount is equal to the sum of—

(i) 75 percent of the hospital-specific amount (the lesser of the hospital's reasonable cost or customary charges, reduced by deductibles and coinsurance); and

(ii) 25 percent of the ASC payment amount (that is, 80 percent of the result obtained by subtracting the deductibles from the sum of the standard overhead amounts.)

(2) For the period of time beginning with the first day of a hospital's cost

reporting period that begins on or after October 1, 1988 and ends on December 31, 1990, the blended payment amount is equal to 50 percent of the hospital-specific amount and 50 percent of the ASC payment amount.

(3) For portions of cost reporting periods beginning on or after January 1, 1991, the blended payment amount is equal to 42 percent of the hospital-specific amount and 58 percent of the ASC payment amount.

(4) For cost reporting periods beginning on or after October 1, 1988 and before January 1, 1995, the blended payment amount is equal to the sum of 75 percent of the hospital-specific amount and 25 percent of the ASC payment amount for a hospital that makes an application to its contractor and meets the following requirements.

(i) More than 60 percent of the hospital's inpatient hospital discharges, as described in §412.60 of this chapter, occurring during its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, are classified in diagnosis related groups 36 through 74.

(ii) During its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987, more than 30 percent of the hospital's total revenues is derived from outpatient services.

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

(e) *Aggregation of cost, charges, and the blended amount.* For purposes of determining the correct payment amount under paragraphs (c) and (d) of this section, all reasonable costs and customary charges attributable to facility services furnished during a cost reporting period are aggregated and treated separately from the reasonable costs and customary charges attributable to

all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug. 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992; 65 FR 18541, Apr. 7, 2000]

§413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

(a) *Basis and purpose.* (1) This section implements section 1833(n) of the Act and establishes the method for determining Medicare payments for radiology services and other diagnostic procedures performed by a hospital on an outpatient basis.

(2) For purposes of this section—

(i) Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services; and

(ii) Other diagnostic procedures are those identified by CMS, and do not include diagnostic radiology procedures or diagnostic laboratory tests.

(b) *Payment for hospital outpatient radiology services.* (1) The aggregate payment for hospital outpatient radiology services furnished on or after October 1, 1988 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §413.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment amount described in paragraph (b)(2) of this section.

(2) The blended payment amount for hospital outpatient radiology services furnished on or after October 1, 1988, but before October 1, 1989, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge or fee schedule amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 62 per-

cent of the prevailing charges (or for services furnished on or after January 1, 1989, the fee schedule amount established) for the same services when furnished by participating physicians in their offices in the same locality.

(3) For hospital outpatient radiology services furnished on or after October 1, 1989, the blended payment amount is equal to the sum of 50 percent of the hospital-specific amount and 50 percent of the fee schedule amount.

(4) For hospital outpatient radiology services furnished on or after January 1, 1991, the blended payment amount is equal to the sum of 42 percent of the hospital-specific amount and 58 percent of the fee schedule amount.

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* (1) The aggregate payment for other diagnostic procedures performed by a hospital on an outpatient basis on or after October 1, 1989 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §414.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment described in paragraph (c)(2) of this section.

(2) The blended payment amount for other diagnostic procedures furnished on or after October 1, 1989, but before October 1, 1990, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual