

Medicare beneficiaries who are registered on hospital records as outpatients.

(b) *Scope.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be updated. Subpart F describes limitations on administrative and judicial review. Subpart G describes the transitional payment adjustments that are made before 2004 to limit declines in payment for outpatient services.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS). The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Determination of hospital outpatient prospective payment rates: Packaged costs.* The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are integral,

ancillary, supportive, dependent, or adjunctive to performing a procedure or furnishing a service on an outpatient basis. In general, these packaged costs may include, but are not limited to, the following items and services, the payment for which are packaged or conditionally packaged into the payment for the related procedures or services.

- (1) Use of an operating suite, procedure room, or treatment room;
- (2) Use of recovery room;
- (3) Observation services;
- (4) Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations;
- (5) Supplies and equipment for administering and monitoring anesthesia or sedation;
- (6) Intraocular lenses (IOLs);
- (7) Ancillary services;
- (8) Capital-related costs;
- (9) Implantable items used in connection with diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- (10) Durable medical equipment that is implantable;
- (11) Implantable and insertable medical items and devices, including, but not limited to, prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices;
- (12) Costs incurred to procure donor tissue other than corneal tissue.
- (13) Image guidance, processing, supervision, and interpretation services;
- (14) Intraoperative items and services;
- (15) Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (including but not limited to, diagnostic radiopharmaceuticals, contrast agents, and pharmacologic stress agents);
- (16) Drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals);