

(iii) Is not a sole community hospital as defined in §412.92 of this chapter; and

(iv) Is not an essential access community hospital under §412.109 of this chapter.

(3) *Permanent treatment for cancer hospitals and children's hospitals.* In the case of a hospital described in §412.23(d) or §412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

(4) *Temporary treatment for sole community hospitals located in rural areas for covered hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2004 and before January 1, 2006.* For covered hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2004, and continuing through December 31, 2005, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is a sole community hospital, under §412.92 of this chapter; and

(ii) Is located in a rural area as defined in §412.63(b) or §412.64(b), as applicable, of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act.

(5) *Temporary treatment for small sole community hospitals on or after January 1, 2009 and through December 31, 2009.* For covered hospital outpatient services furnished on or after January 1, 2009, and continuing through December 31, 2009, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital—

(i) Is a sole community hospital as defined in §412.92 of this chapter or is an essential access community hospital as described under §412.109 of this chapter; and

(ii) Has 100 or fewer beds as defined in §412.105(b) of this chapter.

(6) *Temporary treatment for sole community hospitals on or after January 1,*

2010, and through December 31, 2011. For covered hospital outpatient services furnished on or after January 1, 2010, through December 31, 2011, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital is a sole community hospital as defined in §412.92 of this chapter or is an essential access community hospital as described under §412.109 of this chapter.

(7) *Temporary treatment of small sole community hospitals on or after January 1, 2012 through December 31, 2012.* (i) For covered hospital outpatient services furnished on or after January 1, 2012 through December 31, 2012, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital—

(A) Is a sole community hospital as defined in §412.92 of this chapter or is an essential access community hospital as described under §412.109 of this chapter; and

(B) Has 100 or fewer beds as defined in §412.105(b) of this chapter, except as provided in paragraph (d)(7)(ii) of this section.

(ii) For covered hospital outpatient services furnished on or after January 1, 2012 through February 29, 2012, the bed size limitation under paragraph (d)(7)(i)(B) of this section does not apply.

(e) *Prospective payment system amount defined.* In this section, the term “prospective payment system amount” means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this section or any reduction in coinsurance elected under §419.42), including amounts payable as copayment under §419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) *Pre-BBA amount defined—(1) General rule.* In this paragraph, the “pre-BBA amount” means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year,

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an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) *Base payment-to-cost-ratio defined.* For purposes of this paragraph, CMS shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The “base payment-to-cost ratio” for a hospital or CMHC means the ratio of—

(i) The provider's payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996; or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period.

(g) *Interim payments.* CMS makes payments under this section to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) *No effect on coinsurance.* No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in § 419.41.

(i) *Application without regard to budget neutrality.* The additional payments made under this section—

(1) Are not considered an adjustment under § 419.43(f); and

(2) Are not implemented in a budget neutral manner.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 69 FR 832, Jan. 6, 2004; 69 FR 65863, Nov. 15, 2004; 71 FR 68228, Nov. 24, 2006; 72 FR 66933, Nov. 27, 2007; 73 FR 68814, Nov. 18, 2008; 74 FR 60681, Nov. 20, 2009; 75 FR 72265, Nov. 24, 2010; 76 FR 74583, Nov. 30, 2011; 77 FR 68559, Nov. 15, 2012]

§ 419.71 Payment reduction for certain X-ray imaging services.

(a) *Definition.* For purposes of this section, the term “computed radiography technology” means cassette-based imaging which utilizes an imaging plate to create the image involved.

(b) *Payment reduction for film X-ray imaging services.* For an imaging service that is an X-ray taken using film and that is furnished during 2017 or a subsequent year, the payment amount for such service (including the X-ray component of a packaged service) is reduced by 20 percent.

(c) *Payment reduction for computed radiography imaging services.* The payment amount for an imaging service that is an X-ray taken using computed radiography technology (including the X-ray component of a packaged service) is reduced by—

(1) 7 percent, for such services furnished in CY 2018, 2019, 2020, 2021, or 2022.

(2) 10 percent, for such services furnished in CY 2023 or a subsequent calendar year.

(d) *Application without regard to budget neutrality.* The reductions taken under this section are not considered adjustments under section 1833(t)(2)(E) of the Act and are not implemented in a budget neutral manner.

[82 FR 52637, Nov. 13, 2017; 82 FR 59497, Dec. 14, 2017]

Subpart I—Prior Authorization for Outpatient Department Services

SOURCE: 84 FR 61491, Nov. 12, 2019, unless otherwise noted.

§ 419.80 Basis and scope of this subpart.

(a) *Basis.* The provisions in this subpart are issued under the authority of section 1833(t)(2)(F) of the Act, which