(s) Effective December 8, 2003, screening mammography services and effective January 1, 2005, diagnostic mammography services.

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

(u) Outpatient diabetes self-management training.

(v) Effective January 1, 2017, items and services that do not meet the definition of excepted items and services under § 419.48(a).

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 69 FR 65863, Nov. 15, 2004; 75 FR 72265, Nov. 24, 2010; 78 FR 50969, Aug. 19, 2013; 78 FR 75196, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 81 FR 79879, Nov. 14, 2016; 82 FR 35, Jan. 3, 2017; 85 FR 86302, Dec. 29, 2020; 86 FR 63993, Nov. 16, 2021]

§ 419.23 Removal of services and procedures from the Inpatient Only List.

(a) *Inpatient Only List.* CMS maintains a list of services and procedures that the Secretary designates as requiring inpatient care under § 419.22(n) that are not paid under the hospital outpatient prospective payment system. This list is referred to as the Inpatient Only List.

(b) *Removals from the Inpatient Only List.* CMS assesses annually whether a service or procedure on the Inpatient Only List described in paragraph (a) of this section should be removed from the list by determining whether the service or procedure meets at least one of the following criteria:

(1) Most outpatient departments are equipped to provide the service or procedure to the Medicare population.

(2) The simplest service or procedure described by the code may be performed in most outpatient departments.

(3) The service or procedure is related to codes that CMS has already removed from the Inpatient Only List described in paragraph (a) of this section.

(4) CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.

(5) CMS determines that the service or procedure can be appropriately and safely performed in an ambulatory surgical center, and is specified as a covered ambulatory surgical procedure under § 416.166 of this chapter, or CMS has proposed to specify it as a covered ambulatory surgical procedure under § 416.166 of this chapter.

[86 FR 63993, Nov. 16, 2021]

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) CMS estimates the aggregate amount that would be payable for hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of coinsurance that would be payable by beneficiaries to hospitals for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part.

(b) The estimated aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory payment classification (APC) system and payment weights.

(a) *APC groups.* (1) CMS classifies outpatient services and procedures that are comparable clinically and in terms of resource use into APC groups. Except as specified in paragraph (a)(2) of this section, items and services within a group are not comparable with respect to the use of resources if the highest geometric mean cost for an item or service within the group is more than 2 times greater than the lowest geometric mean cost for an item or service within the group.

(2) CMS may make exceptions to the requirements set forth in paragraph (a)(1) in unusual cases, such as low volume items and services, but may not make such an exception in the case of