(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