

Subpart H—Coinsurance

§ 418.400 Individual liability for coinsurance for hospice care.

An individual who has filed an election for hospice care in accordance with § 418.24 is liable for the following coinsurance payments. Hospices may charge individuals the applicable coinsurance amounts.

(a) *Drugs and biologicals.* An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed \$5. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug copayment schedule must be reviewed for reasonableness and approved by the intermediary before it is used.

(b) *Respite care.* (1) The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by CMS for a respite care day.

(2) The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

(3) The individual hospice coinsurance period—

(i) Begins on the first day an election filed in accordance with § 418.24 is in effect for the beneficiary; and

(ii) Ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

§ 418.402 Individual liability for services that are not considered hospice care.

Medicare payment to the hospice discharges an individual's liability for payment for all services, other than the hospice coinsurance amounts described in § 418.400, that are considered

covered hospice care (as described in § 418.202). The individual is liable for the Medicare deductibles and coinsurance payments and for the difference between the reasonable and actual charge on unassigned claims on other covered services that are not considered hospice care. Examples of services not considered hospice care include: Services furnished before or after a hospice election period; services of the individual's attending physician, if the attending physician is not an employee of or working under an arrangement with the hospice; or Medicare services received for the treatment of an illness or injury not related to the individual's terminal condition.

§ 418.405 Effect of coinsurance liability on Medicare payment.

The Medicare payment rates established by CMS in accordance with § 418.306 are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the payment rates, CMS offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.

[56 FR 26919, June 12, 1991]

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

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Subpart A—General Provisions

§419.1 Basis and scope.

(a) *Basis.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished on or after July 1, 2000 by hospital outpatient departments to 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 di-

rectly 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);

(17) Certain clinical diagnostic laboratory tests; and

(18) Certain services described by add-on codes.

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment system.

(1) The costs of direct graduate medical education activities as described in §§413.75 through 413.83 of this chapter.

(2) The costs of nursing and allied health programs as described in §413.85 of this chapter.

(3) The costs associated with interns and residents not in approved teaching programs as described in §415.202 of this chapter.

(4) The costs of teaching physicians attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under §415.160.

(5) The reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthesiologists (certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements, for hospitals that meet the requirements under §412.113(c) of this chapter.

(6) Bad debts for uncollectible deductibles and coinsurances as described in §413.89(b) of this chapter.

(7) Organ acquisition costs paid under Part B.

(8) Corneal tissue acquisition or procurement costs for corneal transplant procedures.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 70 FR 47490, Aug. 12, 2005; 77 FR 68558, Nov. 15, 2012; 78 FR 75196, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 80 FR 70606, Nov. 13, 2015]

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after August 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.* (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.

(2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

(3) A hospital located outside one of the 50 States, the District of Columbia, and Puerto Rico is excluded from the hospital outpatient prospective payment system.

(4) A hospital of the Indian Health Service.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001]

§ 419.21 Hospital services subject to the outpatient prospective payment system.

Except for services described in § 419.22, effective for services furnished on or after July 1, 2000, payment is made under the hospital outpatient prospective payment system for the following:

(a) Medicare Part B services furnished to hospital outpatients des-

ignated by the Secretary under this part.

(b) Services designated by the Secretary that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits but are entitled to benefits under Part B of the program.

(c) Partial hospitalization services furnished by community mental health centers (CMHCs).

(d) The following medical and other health services furnished by a home health agency (HHA) to patients who are not under an HHA plan or treatment or by a hospice program furnishing services to patients outside the hospice benefit:

- (1) Antigens.
- (2) Splints and casts.
- (3) Hepatitis B vaccine.

(e)(1) Effective January 1, 2005 through December 31, 2008, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

(2) Effective January 1, 2009, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 12 months after the date of the individual's initial enrollment in Part B.

[65 FR 18542, Apr. 7, 2000, as amended at 67 FR 66813, Nov. 1, 2002; 69 FR 65863, Nov. 15, 2004; 71 FR 68227, Nov. 24, 2006; 75 FR 72265, Nov. 24, 2010]

§ 419.22 Hospital services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system (except when packaged as a part of a bundled payment):

(a) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(b) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

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(c) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(d) Certified nurse-midwife services, as defined in section 1861(gg) of the Act.

(e) Services of qualified psychologists, as defined in section 1861(ii) of the Act.

(f) Services of an anesthetist as defined in § 410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Physical therapy services, speech-language pathology services, and occupational therapy services described in section 1833(a)(8) of the Act for which payment is made under the fee schedule described in section 1834(k) of the Act.

(i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l).

(j) Except as provided in § 419.2(b)(11), prosthetic devices and orthotic devices.

(k) Except as provided in § 419.2(b)(10), durable medical equipment supplied by the hospital for the patient to take home.

(l) Except as provided in § 419.2(b)(17), clinical diagnostic laboratory tests.

(m)(1) Services provided on or before December 31, 2010, for patients with ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(2) Renal dialysis services provided on or after January 1, 2011, for patients with ESRD that are paid under the ESRD benefit, as described in subpart H of part 413 of this chapter.

(n) Services and procedures that the Secretary designates as requiring inpatient care.

(o) Hospital outpatient services furnished to SNF residents (as defined in § 411.15(p) of this chapter) as part of the patient's resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital "under arrangements" but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

(p) Services that are not covered by Medicare by statute.

(q) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

(r) Services defined in § 419.21(b) that are furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B.

(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 a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) The payment rate determined for an APC group in accordance with § 419.32, and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part, apply to

(b) *APC weighting factors.* (1) Using hospital outpatient claims data from calendar year 1996 and data from the most recent available hospital cost reports, CMS determines the geometric mean costs for the services and procedures within each APC group.

(2) CMS assigns to each APC group an appropriate weighting factor to reflect the relative geometric mean costs for the services within the APC group compared to the geometric mean costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) CMS determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the “labor-related portion” of hospital outpatient costs.

(2) CMS standardizes the geometric mean costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

[65 FR 18542, Apr. 7, 2000, as amended at 77 FR 68558, Nov. 15, 2012]

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* CMS calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.43(e).

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar year 2000, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar year 2001—

(A) For services furnished on or after January 1, 2001 and before April 1, 2001, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point; and

(B) For services furnished on or after April 1, 2001 and before January 1, 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act, and increased by a transitional percentage allowance equal to 0.32 percent.

(iii) For the portion of calendar year 2002 that is affected by these rules, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point, without taking into account the transitional percentage allowance referenced in § 419.32(b)(ii)(B).

(iv)(A) For calendar year 2003 and subsequent years, by the OPD fee schedule increase factor, which, subject to the adjustments specified in paragraph (b)(1)(iv)(B) of this section, is the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(B) The percentage increase determined under paragraph (b)(1)(iv)(A) of this section is reduced by the following for the specific calendar year:

(1) For calendar year 2010, 0.25 percentage point;

(2) For calendar year 2011, 0.25 percentage point; and

(3) For calendar year 2012, a multifactor productivity adjustment (as determined by CMS) and 0.1 percentage point.

(4) For calendar year 2013, a multifactor productivity adjustment (as de-

termined by CMS) and 0.1 percentage point.

(5) For calendar year 2014, a multifactor productivity adjustment (as determined by CMS) and 0.3 percentage point.

(6) For calendar year 2015, a multifactor productivity adjustment (as determined by CMS) and 0.2 percentage point.

(7) For calendar year 2016, a multifactor productivity adjustment (as determined by CMS), and 0.2 percentage point.

(8) For calendar year 2017, a multifactor productivity adjustment (as determined by CMS) and 0.75 percentage point.

(9) For calendar year 2018, a multifactor productivity adjustment (as determined by CMS) and 0.75 percentage point.

(10) For calendar year 2019, a multifactor productivity adjustment (as determined by CMS) and 0.75 percentage point.

(11) For calendar year 2020 and subsequent years, a multifactor productivity adjustment (as determined by CMS).

(2) Beginning in calendar year 2000, CMS may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

(d) *Budget neutrality.* (1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

(2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare

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Prescription Drug, Improvement, and Modernization Act of 2003.

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 59922, Nov. 30, 2001; 67 FR 9568, Mar. 1, 2002; 69 FR 832, Jan. 6, 2004; 75 FR 72265, Nov. 24, 2010; 76 FR 74582, Nov. 30, 2011; 77 FR 68559, Nov. 15, 2012; 78 FR 75196, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 80 FR 70606, Nov. 13, 2015; 81 FR 79879, Nov. 14, 2016; 82 FR 52637, Nov. 13, 2017; 82 FR 59497, Dec. 14, 2017; 83 FR 59179, Nov. 21, 2018; 85 FR 86302, Dec. 29, 2020]

EFFECTIVE DATE NOTE: At 66 FR 59922, Nov. 30, 2001, § 419.32 was amended by revising paragraph (b)(1), effective Jan. 1, 2002. At 66 FR 67494, Dec. 31, 2001, paragraph (b)(1)(iii) was delayed indefinitely.

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

(a) In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary copayment amount as described in § 419.41(a). The Medicare program payment amount for each APC group is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) Coinsurance percentage is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the greater of the following: the ratio of the APC group unadjusted copayment amount to the annual APC group payment rate, or 20 percent.

(2) Program payment percentage is calculated as the lower of the following: the ratio of the APC group payment rate minus the APC group unadjusted copayment amount, to the APC group payment rate, or 80 percent.

(3) Unadjusted copayment amount is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of copayment amount to inpatient hospital deductible amount.* The copayment amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital de-

ductible established under section 1813(b) of the Act for that year.

[66 FR 59922, Nov. 30, 2001]

§ 419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.

(a) To calculate the unadjusted copayment amount for each APC group, CMS—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary copayment amount for the APC group.

(b) CMS calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted copayment amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(c) To determine payment amounts due for a service paid under the hospital outpatient prospective payment system, CMS makes the following calculations:

(1) Makes the wage index adjustment in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the preliminary Medicare program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the copayment amount.

(i) The copayment amount for an APC cannot exceed the amount of the inpatient hospital deductible, established in accordance with § 409.82 of this chapter, for that year. For purposes of this paragraph (c)—

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(A) Effective for drugs and biologicals furnished on or after January 1, 2001, the copayment amount for multiple APCs for a single drug or biological furnished on the same day will be aggregated and treated as the copayment amount for one APC.

(B) Effective for drugs and biologicals furnished on or after July 1, 2001, the copayment amount for the APC or APCs for a drug or biological furnished on the same day will be aggregated with the copayment amount for the APC that reflects the administration of the drug or biological furnished on that day and treated as the copayment amount for one APC.

(ii) Effective for services furnished from April 1, 2001 through December 31, 2001, the national unadjusted coinsurance rate for an APC cannot exceed 57 percent of the prospective payment rate for that APC.

(iii) The national unadjusted coinsurance rate for an APC cannot exceed 55 percent in calendar years 2002 and 2003; 50 percent in calendar year 2004; 45 percent in calendar year 2005; and 40 percent in calendar year 2006 and thereafter.

(iv) The copayment amount is computed as if the adjustment under §§ 419.43(d) and (e) (and any adjustments made under § 419.43(f) in relation to these adjustments) and § 419.43(h) had not been paid.

(5) Adds the amount by which the copayment amount would have exceeded the inpatient hospital deductible for that year to the preliminary Medicare program payment amount determined in paragraph (c)(3) of this section to determine the final Medicare program payment amount.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 73 FR 68814, Nov. 18, 2008]

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may not elect to reduce copayment amounts for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than—

(1) June 1, 2000, for coinsurance elections for the period July 1, 2000 through December 31, 2000; or

(2) December 1 preceding the beginning of each subsequent calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the copayment amount (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced coinsurance remains in effect unchanged during the year for which the election was made.

(e) In electing reduced coinsurance, a hospital may elect a copayment amount that is less than that year's wage-adjusted copayment amount for the group but not less than 20 percent of the APC payment rate as determined under § 419.32 or, in the case of payments calculated under § 419.43(h), not less than 20 percent of the APC payment rate as determined under § 419.43(h).

(f) The hospital may advertise and otherwise disseminate information concerning the reduced level of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not allowed in any other ambulatory settings or physician offices.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 67829, Nov. 13, 2000; 66 FR 59923, Nov. 30, 2001; 73 FR 68814, Nov. 18, 2008]

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

(a) *General rule.* CMS determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary copayment amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* CMS determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the “labor-related portion” of hospital outpatient costs) in accordance with §419.31(c)(1).

(c) *Wage index factor.* (1) CMS uses the hospital inpatient prospective payment system wage index established in accordance with Part 412 of this chapter to make the adjustment specified under paragraph (a) of this section.

(2) For services furnished beginning January 1, 2011, the wage index factor provided for in paragraph (c)(1) of this section applicable to any hospital outpatient department that is located in a frontier State, as defined in §412.64(m) of this chapter, may not be less than 1.00.

(3) The additional payments made under the provisions of paragraph (c)(2) of this section are not implemented in a budget neutral manner.

(d) *Outlier adjustment*—(1) *General rule.* Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital’s charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under §419.32(c), as adjusted under §419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under §419.66.

(ii) At the option of CMS, a fixed dollar amount.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (d)(1) of this section is determined by CMS and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) *Limit on aggregate outlier adjustments*—(i) *In general.* The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by CMS before the beginning of the year) may not ex-

ceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (d)(3)(i) of this section, the term “applicable percentage” means a percentage specified by CMS up to (but not to exceed)—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) *Transitional authority.* In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, CMS may—

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by CMS), rather than for specific departments within the hospital.

(5) *Cost-to-charge ratios for calculating charges adjusted to cost.* For hospital outpatient services (or groups of services) as defined in paragraph (d)(1) of this section performed on or after January 1, 2009—

(i) CMS may specify an alternative to the overall ancillary cost-to-charge ratio otherwise applicable under paragraph (d)(5)(ii) of this section. A hospital may also request that its Medicare contractor use a different (higher or lower) cost-to-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS.

(ii) The overall ancillary cost-to-charge ratio applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period.

(iii) The Medicare contractor may use a statewide average cost-to-charge ratio if it is unable to determine an accurate overall ancillary cost-to-charge ratio for a hospital in one of the following circumstances:

(A) A new hospital that has not yet submitted its first Medicare cost report. (For purposes of this paragraph, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with §489.18 of this chapter.)

(B) A hospital whose overall ancillary cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §419.50(a).

(C) Any other hospital for whom accurate data to calculate an overall ancillary cost-to-charge ratio are not available to the Medicare contractor.

(6) *Reconciliation.* For hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009—

(i) Any reconciliation of outlier payments will be based on an overall ancillary cost-to-charge ratio calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the service is settled.

(ii) At the time of any reconciliation under paragraph (d)(6)(i) of this section, outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by CMS, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

(7) *Community mental health center (CMHC) outlier payment cap.* Outlier payments made to CMHCs for services provided on or after January 1, 2017 are subject to a cap, applied at the individual CMHC level, so that each CMHC's total outlier payments for the calendar year do not exceed 8 percent of that CMHC's total per diem payments for the calendar year. Total per diem payments are total Medicare per

diem payments plus the total beneficiary share of those per diem payments.

(e) *Budget neutrality.* CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

(f) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment under paragraph (d)(1) of this section:

(1) Drugs and biologicals that are paid under a separate APC; and

(2) Items and services paid at charges adjusted to costs by application of a hospital-specific cost-to-charge ratio.

(g) *Payment adjustment for certain rural hospitals—(1) General rule.* CMS provides for additional payment for covered hospital outpatient services not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—

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

(ii) Is located in a rural area as defined in §412.64(b) of this chapter or is treated as being located in a rural area under §412.103 of this chapter.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section:

(i) Drugs and biologicals that are paid under a separate APC;

(ii) Devices paid under 419.66; and

(iii) Items and services paid at charges adjusted to costs by application of a hospital-specific cost-to-charge ratio.

(5) *Copayment.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating copayment amounts.

(6) *Outliers.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating outlier payments.

(h) *Applicable adjustments to conversion factor for CY 2009 and for subsequent calendar years—(1) General rule.* For CY 2009 and for subsequent calendar years, the applicable adjustment to the conversion factor specified in § 419.32(b)(1)(iv) is reduced by 2.0 percentage points for any hospital that fails to meet the standards for reporting of hospital outpatient quality measures as established by the Secretary for the corresponding calendar year.

(2) *Limitation.* Any reduction to a hospital's adjustment to its conversion factor specified in § 419.32(b)(1)(iv) which occurs as a result of paragraph (h)(1) of this section will apply only to the calendar year involved and will not be taken into account in computing that hospital's applicable adjustment for a subsequent calendar year.

(3) *Budget neutrality.* For CY 2009 and for each subsequent calendar year, CMS makes an adjustment to the conversion factor, so that estimated aggregate payments under the OPPI for such calendar year are not affected by any reductions to hospital adjustments which occur as a result of paragraph (h)(1) of this section.

(4) *Beneficiary copayment.* The beneficiary copayment for services to which the adjustment to the conversion factor specified under paragraph (h)(1) of this section applies is the product of the national beneficiary copayment amount calculated under § 419.41 and the ratio of the adjusted conversion factor calculated under paragraph (h)(1) of this section divided by the conversion factor specified under § 419.32(b)(1).

(i) *Payment adjustment for certain cancer hospitals—(1) General rule.* CMS provides for a payment adjustment for covered hospital outpatient depart-

ment services furnished on or after January 1, 2012, by a hospital described in section 1886(d)(1)(B)(v) of the Act.

(2) *Amount of payment adjustment.* The amount of the payment adjustment under paragraph (i)(1) of this section is determined by the Secretary as follows:

(i) If a hospital described in section 1886(d)(1)(B)(v) of the Act has a payment-to-cost ratio (PCR) before the cancer hospital payment adjustment (as determined by the Secretary at cost report settlement) that is less than the weighted average PCR of other hospitals furnishing services under section 1833(t) of the Act (as determined by the Secretary at the time of the applicable CY Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center final rule with comment period) (referred to as the Target PCR), for covered hospital outpatient department services, the aggregate payment amount provided at cost report settlement to such hospital is equal to the amount needed to make the hospital's PCR at cost report settlement (as determined by the Secretary) equal to the target PCR (as determined by the Secretary).

(ii) If a hospital described in section 1886(d)(1)(B)(v) of the Act has a payment-to-cost ratio (PCR) before the cancer hospital payment adjustment (as determined by the Secretary at cost report settlement) that is greater than the weighted average PCR of other hospitals furnishing services under section 1833(t) of the Act (as determined by the Secretary at the time of the applicable CY Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center final rule with comment period) (referred to as the Target PCR), for covered hospital outpatient department services, the aggregate payment amount provided at cost report settlement to such hospital is equal to zero.

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(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (i)(1) of this section in a budget neutral manner.

[65 FR 18542, Apr. 7, 2000, as amended at 65 FR 47677, Aug. 3, 2000; 66 FR 55856, Nov. 2, 2001; 69 FR 832, Jan. 6, 2004; 70 FR 68727, Nov. 10, 2005; 70 FR 76178, Dec. 23, 2005; 71 FR 68227, Nov. 24, 2006; 72 FR 66932, Nov. 27, 2007; 73 FR 68814, Nov. 18, 2008; 75 FR 72265, Nov. 24, 2010; 76 FR 74583, Nov. 30, 2011; 81 FR 79879, Nov. 14, 2016]

§ 419.44 Payment reductions for procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) *Interrupted procedures.* (1) Subject to the provisions of paragraph (b)(2) of this section, when a procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(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

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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 withdraw from the Hospital OQR Program by submitting to CMS a withdrawal form that can be found in the secure portion of the QualityNet website. The hospital may withdraw any time up to and including August 31 of the year prior to the affected annual payment updates. A withdrawn hospital will not be able to later sign up to participate in that payment update, is subject to a reduced annual payment update as specified under paragraph (i) of this section, and is required to renew participation as specified in paragraph (b) of this section in order to participate in any future year of the Hospital OQR Program.

(d) *Submission of Hospital OQR Program data.* (1) *General rule.* Except as provided in paragraph (e) of this section, hospitals that participate in the Hospital OQR Program must submit to

CMS data on measures selected under section 1833(t)(17)(C) of the Act in a form and manner, and at a time, specified by CMS. Hospitals sharing the same CCN must combine data collection and submission across their multiple campuses for all clinical measures for public reporting purposes.

(2) *Submission deadlines.* Submission deadlines by measure and by data type are posted on the QualityNet website. All deadlines occurring on a Saturday, Sunday, or legal holiday, or on any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order are extended to the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.

(3) *Initial submission deadlines for a hospital that did not participate in the previous year's Hospital OQR Program.*

(i) Hospitals that did not participate in the previous year's Hospital OQR Program must initially submit data beginning with encounters occurring during the first calendar quarter of the year prior to the affected annual payment update.

(ii) Hospitals that did not participate in the previous year's Hospital OQR Program must follow data submission deadlines as specified in paragraph (d)(2) of this section.

(iii) Hospitals with a Medicare acceptance date before or after January 1 of the year prior to an affected annual payment update must follow data submission deadlines as specified in paragraph (d)(2) of this section.

(4) *Review and corrections period.* For both chart-abstracted and web-based measures, hospitals have a review and corrections period, which runs concurrently with the data submission period. During this timeframe, hospitals can enter, review, and correct data submitted. However, after the submission deadline, this data cannot be changed.

(e) *Exception.* CMS may grant an exception to one or more data submission deadlines and requirements in the event of extraordinary circumstances beyond the control of the hospital, such as when an act of nature affects an entire region or locale or a systemic

problem with one of CMS' data collection systems directly or indirectly affects data submission. CMS may grant an exception as follows:

(1) *Upon request by the hospital.* Specific requirements for submission of a request for an exception are available on the QualityNet Web site.

(2) *At the discretion of CMS.* CMS may grant exceptions to hospitals that have not requested them when CMS determines that an extraordinary circumstance has occurred.

(f) *Validation of Hospital OQR Program data.* CMS may validate one or more measures selected under section 1833(t)(17)(C) of the Act by reviewing documentation of patient encounters submitted by selected participating hospitals.

(1) Upon written request by CMS or its contractor, a hospital must submit to CMS supporting medical record documentation that the hospital used for purposes of data submission under the program. The specific sample that a hospital must submit will be identified in the written request. A hospital must submit the supporting medical record documentation to CMS or its contractor within 30 days of the date identified on the written request, in the form and manner specified in the written request.

(2) A hospital meets the validation requirement with respect to a calendar year if it achieves at least a 75-percent reliability score, as determined by CMS.

(3) CMS will select a random sample of 450 hospitals for validation purposes, and will select an additional 50 hospitals for validation purposes based on the following criteria:

(i) The hospital fails the validation requirement that applies to the previous year's payment determination; or

(ii) The hospital has an outlier value for a measure based on the data it submits. An "outlier value" is a measure value that is greater than 5 standard deviations from the mean of the measure values for other hospitals, and indicates a poor score; or

(iii) Any hospital that has not been randomly selected for validation in any of the previous 3 years; or

(iv) Any hospital that passed validation in the previous year, but had a

two-tailed confidence interval that included 75 percent.

(4) Hospitals that are selected and receive a score for validation of chart-abstracted measures may request an educational review in order to better understand the results within 30 calendar days from the date the validation results are made available. If the results of an educational review indicate that a hospital's medical records selected for validation for chart-abstracted measures was incorrectly scored, the corrected quarterly validation score will be used to compute the hospital's final validation score at the end of the calendar year.

(g) *Reconsiderations and appeals of Hospital OQR Program decisions.* (1) A hospital may request reconsideration of a decision by CMS that the hospital has not met the requirements of the Hospital OQR Program in paragraph (b) of this section for a particular calendar year. Except as provided in paragraph (e) of this section, a hospital must submit a reconsideration request to CMS via the QualityNet website, no later than March 17, or if March 17 falls on a nonwork day, on the first day after March 17 which is not a nonwork day as defined in paragraph (d)(2) of this section, of the affected payment year as determined using the date the request was mailed or submitted to CMS.

(2) A reconsideration request must contain the following information:

(i) The hospital's CMS Certification Number (CCN);

(ii) The name of the hospital;

(iii) The CMS-identified reason for not meeting the requirements of the affected payment year's Hospital OQR Program as provided in any CMS notification to the hospital;

(iv) The hospital's basis for requesting reconsideration. The hospital must identify its specific reason(s) for believing it should not be subject to the reduced annual payment update;

(v) The hospital-designated personnel contact information, including name, email address, telephone number, and mailing address (must include physical mailing address, not just a post office box);

(vi) The hospital-designated personnel's signature;

(vii) A copy of all materials that the hospital submitted to comply with the requirements of the affected Hospital OQR Program payment determination year; and

(viii) If the hospital is requesting reconsideration on the basis that CMS determined it did not meet the affected payment determination year's validation requirement set forth in paragraph (f)(1) of this section, the hospital must provide a written justification for each appealed data element classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score are eligible to be reconsidered.

(3) A hospital that is dissatisfied with a decision made by CMS on its reconsideration request may file an appeal with the Provider Reimbursement Review Board under part 405, subpart R, of this chapter.

(h) *Requirements for Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS) Survey.* OAS CAHPS is the Outpatient and Ambulatory Surgical Center Consumer Assessment of Healthcare Providers and Systems Survey that measures patient experience of care after a recent surgery or procedure at either a hospital outpatient department or an ambulatory surgical center. Hospital outpatient departments must use an approved OAS CAHPS survey vendor to administer and submit OAS CAHPS data to CMS.

(1) [Reserved]

(2) CMS approves an application for an entity to administer the OAS CAHPS Survey as a vendor on behalf of one or more hospital outpatient departments when the applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official OAS CAHPS website, and agrees to comply with the current survey administration protocols that can be found on the official OAS CAHPS Survey website. An entity must be an approved OAS CAHPS Survey vendor in order to administer and submit OAS CAHPS Survey data to CMS on behalf of one or more hospital outpatient departments.

(i) *Retention and removal of quality measures under the Hospital OQR Program—(1) General rule for the retention of*

quality measures. Quality measures adopted for the Hospital OQR Program measure set for a previous payment determination year are retained for use in subsequent payment determination years, except when they are removed, suspended, or replaced as set forth in paragraphs (i)(2) and (3) of this section.

(2) *Immediate measure removal.* For cases in which CMS believes that the continued use of a measure as specified raises patient safety concerns, CMS will immediately remove a quality measure from the Hospital OQR Program and will promptly notify hospitals and the public of the removal of the measure and the reasons for its removal through the Hospital OQR Program ListServ and the QualityNet website.

(3) *Measure removal, suspension, or replacement through the rulemaking process.* Unless a measure raises specific safety concerns as set forth in paragraph (i)(2) of this section, CMS will use the regular rulemaking process to remove, suspend, or replace quality measures in the Hospital OQR Program to allow for public comment.

(i) *Factors for consideration of removal of quality measures.* CMS will weigh whether to remove measures based on the following factors:

(A) *Factor 1.* Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped out" measures);

(B) *Factor 2.* Performance or improvement on a measure does not result in better patient outcomes;

(C) *Factor 3.* A measure does not align with current clinical guidelines or practice;

(D) *Factor 4.* The availability of a more broadly applicable (across settings, populations, or conditions) measure for the topic;

(E) *Factor 5.* The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic;

(F) *Factor 6.* The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic;

(G) *Factor 7.* Collection or public reporting of a measure leads to negative

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unintended consequences other than patient harm; and

(H) *Factor 8.* The costs associated with a measure outweigh the benefit of its continued use in the program.

(ii) *Criteria to determine topped-out measures.* For the purposes of the Hospital OQR Program, a measure is considered to be topped-out under paragraph (i)(3)(i)(A) of this section when it meets both of the following criteria:

(A) Statistically indistinguishable performance at the 75th and 90th percentiles (defined as when the difference between the 75th and 90th percentiles for a hospital's measure is within two times the standard error of the full data set); and

(B) A truncated coefficient of variation less than or equal to 0.10.

(iii) *Application of measure removal factors.* The benefits of removing a measure from the Hospital OQR Program will be assessed on a case-by-case basis. Under this case-by-case approach, a measure will not be removed solely on the basis of meeting any specific factor.

[78 FR 75196, Dec. 10, 2013, as amended at 79 FR 67031, Nov. 10, 2014; 80 FR 70606, Nov. 13, 2015; 81 FR 79879, Nov. 14, 2016; 82 FR 52637, Nov. 13, 2017; 82 FR 59497, Dec. 14, 2017; 83 FR 59179, Nov. 21, 2018; 85 FR 86302, Dec. 29, 2020; 86 FR 63993, Nov. 16, 2021]

§ 419.48 Definition of excepted items and services.

(a) Excepted items and services are items or services that are furnished on or after January 1, 2017—

(1) By a dedicated emergency department (as defined at § 489.24(b) of this chapter); or

(2) By an excepted off-campus provider-based department defined in paragraph (b) of this section that has not impermissibly relocated or changed ownership.

(b) For the purpose of this section, “excepted off-campus provider-based department” means a “department of a provider” (as defined at § 413.65(a)(2) of this chapter) that is located on the campus (as defined in § 413.65(a)(2) of this chapter) or within the distance described in such definition from a “remote location of a hospital” (as defined in § 413.65(a)(2) of this chapter) that meets the requirements for provider-

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based status under § 413.65 of this chapter. This definition also includes an off-campus department of a provider that was furnishing services prior to November 2, 2015 that were billed under the OPPS in accordance with timely filing limits.

(c) Payment for items and services that do not meet the definition in paragraph (a) of this section will generally be made under the Medicare Physician Fee Schedule on or after January 1, 2017.

[81 FR 79880, Nov. 14, 2016; 82 FR 36, Jan. 3, 2017]

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, CMS reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* CMS will consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise CMS concerning) the clinical integrity of the groups and weights. The panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting the review.

(c) *Effective dates.* CMS conducts the first annual review under paragraph (a) of this section in 2001 for payments made in 2002.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the following:

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act.

(c) Periodic adjustments described in section 1833(t)(9) of the Act.

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

(e) The determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under § 419.43(d) or the determination of insignificance of cost, the duration of the additional payments (consistent with subpart G of this part), the determination of initial and new categories under § 419.66, the portion of the Medicare hospital outpatient fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under § 419.62(c).

[65 FR 18542, Apr. 7, 2000, as amended at 66 FR 55856, Nov. 2, 2001]

Subpart G—Transitional Pass-through Payments

SOURCE: 66 FR 55856, Nov. 2, 2001, unless otherwise noted.

§ 419.62 Transitional pass-through payments: General rules.

(a) *General.* CMS provides for additional payments under §§ 419.64 and 419.66 for certain innovative medical devices, drugs, and biologicals.

(b) *Budget neutrality.* CMS establishes the additional payments under §§ 419.64 and 419.66 in a budget neutral manner.

(c) *Uniform prospective reduction of pass-through payments.* (1) If CMS estimates before the beginning of a calendar year that the total amount of pass-through payments under §§ 419.64 and 419.66 for the year would exceed the applicable percentage (as described in paragraph (c)(2) of this section) of the total amount of Medicare payments under the outpatient prospective payment system. CMS will reduce, pro rata, the amount of each of the additional payments under §§ 419.64 and 419.66 for that year to ensure that the applicable percentage is not exceeded.

(2) The applicable percentages are as follows:

(i) For a year before CY 2004, the applicable percentage is 2.5 percent.

(ii) For 2004 and subsequent years, the applicable percentage is a percentage specified by CMS up to (but not to exceed) 2.0 percent.

(d) *CY 2002 incorporated amount.* For the portion of CY 2002 affected by these rules, CMS incorporated 75 percent of the estimated pass-through costs (before the incorporation and any pro rata reduction) for devices into the procedure APCs associated with these devices.

[66 FR 55856, 55865, Nov. 2, 2001; 67 FR 9568, Mar. 1, 2002]

EFFECTIVE DATE NOTE: At 66 FR 55865, Nov. 2, 2001, § 419.62 was amended by adding paragraph (d), effective Jan. 1, 2002. At 66 FR 67494, Dec. 31, 2001, the amendment was delayed indefinitely.

§ 419.64 Transitional pass-through payments: Drugs and biologicals.

(a) *Eligibility for pass-through payment.* CMS makes a transitional pass-through payment for the following drugs and biologicals that are furnished as part of an outpatient hospital service:

(1) *Orphan drugs.* A drug or biological that is used for a rare disease or condition and has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(2) *Cancer therapy drugs and biologicals.* A drug or biological that is used in cancer therapy, including, but not limited to, a chemotherapeutic agent, an antiemetic, a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, and a bisphosphonate if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

(3) *Radiopharmaceutical drugs and biological products.* A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine services if payment for the drug or biological as an outpatient hospital service was being made on August 1, 2000.

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(4) *Other drugs and biologicals.* A drug or biological that meets the following conditions:

(i) It was first payable as an outpatient hospital service after December 31, 1996.

(ii) CMS has determined the cost of the drug or biological is not insignificant in relation to the amount payable for the applicable APC (as calculated under § 419.32(c)) as defined in paragraph (b) of this section.

(iii) A biological that is not surgically implanted or inserted into the body.

(iv) A biological that is not a skin substitute or similar product that aids wound healing.

(b) *Cost.* CMS determines the cost of a drug or biological to be not insignificant if it meets the following requirements:

(1) *Services furnished before January 1, 2003.* The expected reasonable cost of a drug or biological must exceed 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(2) *Services furnished after December 31, 2002.* CMS considers the average cost of a new drug or biological to be not insignificant if it meets the following conditions:

(i) The estimated average reasonable cost of the drug or biological in the category exceeds 10 percent of the applicable APC payment amount for the service related to the drug or biological.

(ii) The estimated average reasonable cost of the drug or biological exceeds the cost of the drug or biological portion of the APC payment amount for the related service by at least 25 percent.

(iii) The difference between the estimated reasonable cost of the drug or biological and the estimated portion of the APC payment amount for the drug or biological exceeds 10 percent of the APC payment amount for the related service.

(c) *Limited period of payment.* CMS limits the eligibility for a pass-through payment under this section to a period of at least 2 years, but not more than 3 years, that begins as follows:

(1) For a drug or biological described in paragraphs (a)(1) through (a)(3) of this section—August 1, 2000.

(2) For a drug or biological described in paragraph (a)(4) of this section—the date that CMS makes its first pass-through payment for the drug or biological.

(d) *Amount of pass-through payment.* Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological equals the amount determined under section 1842(o) of the Social Security Act, minus the portion of the APC payment amount that CMS determines is associated with the drug or biological.

[65 FR 18542, Apr. 7, 2000, as amended at 69 FR 832, Jan. 6, 2004; 69 FR 65863, Nov. 15, 2004; 74 FR 60680, Nov. 20, 2009; 79 FR 67031, Nov. 10, 2014]

§ 419.66 Transitional pass-through payments: Medical devices.

(a) *General rule.* CMS makes a pass-through payment for a medical device that meets the requirements in paragraph (b) of this section and that is described by a category of devices established by CMS under the criteria in paragraph (c) of this section.

(b) *Eligibility.* A medical device must meet the following requirements:

(1) If required by the FDA, the device must have received FDA premarket approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215 of this chapter), or meet another appropriate FDA exemption for premarket approval or clearance. Under this provision, the pass-through payment application for a medical device must be submitted within 3 years from the date of the initial FDA approval or clearance, if required, unless there is a documented, verifiable delay in U.S. market availability after FDA approval or clearance is granted, in which case CMS will consider the pass-through payment application if it is submitted within 3 years from the date of market availability.

(2) The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).

(3) The device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted (either permanently or temporarily) or applied in or on a wound or other skin lesion.

(4) The device is not any of the following:

(i) Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

(ii) A material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than radiological site marker).

(c) *Criteria for establishing device categories.* CMS uses the following criteria to establish a category of devices under this section:

(1) CMS determines that a device to be included in the category is not appropriately described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

(2) CMS determines either of the following:

(i) The device to be included in the category has demonstrated that it will substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part compared to the benefits of a device or devices in a previously established category or other available treatment; or

(ii) For devices for which pass-through payment status will begin on or after January 1, 2020, as an alternative pathway to paragraph (c)(2)(i) of this section, a new device is part of the Food and Drug Administration's (FDA's) Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation.

(3) Except for medical devices identified in paragraph (e) of this section, CMS determines the cost of the device is not insignificant as described in paragraph (d) of this section.

(d) *Cost criteria.* CMS considers the average cost of a category of devices to be not insignificant if it meets the following conditions:

(1) The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service related to the category of devices.

(2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the related service by at least 25 percent.

(3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10 percent of the APC payment amount for the related service.

(e) *Devices exempt from cost criteria.* The following medical devices are not subject to the cost requirements described in paragraph (d) of this section, if payment for the device was being made as an outpatient service on August 1, 2000:

(1) A device of brachytherapy.

(2) A device of temperature-monitored cryoablation.

(f) *Identifying a category for a device.* A device is described by a category, if it meets the following conditions:

(1) Matches the long descriptor of the category code established by CMS.

(2) Conforms to guidance issued by CMS relating to the definition of terms and other information in conjunction with the category descriptors and codes.

(g) *Limited period of payment for devices.* CMS limits the eligibility of a pass-through payment established under this section to a period of at least 2 years, but not more than 3 years, beginning on the first date on which pass-through payment is made.

(h) *Amount of pass-through payment.* Subject to any reduction determined under §419.62(b), the pass-through payment for a device is the hospital's charge for the device, adjusted to the actual cost for the device, minus the

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amount included in the APC payment amount for the device.

[66 FR 55856, Nov. 2, 2001, as amended at 67 FR 66813, Nov. 1, 2002; 70 FR 68728, Nov. 10, 2005; 74 FR 60680, Nov. 20, 2009; 78 FR 75198, Dec. 10, 2013; 79 FR 67031, Nov. 10, 2014; 80 FR 70606, Nov. 13, 2015; 81 FR 79880, Nov. 14, 2016; 84 FR 61491, Nov. 12, 2019; 85 FR 86303, Dec. 29, 2020]

Subpart H—Transitional Corridors

SOURCE: 65 FR 18542, Apr. 7, 2000, unless otherwise noted. Redesignated at 66 FR 55856, Nov. 2, 2001.

§ 419.70 Transitional adjustments to limit decline in payments.

(a) *Before 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;

(3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

(4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

(b) *For 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2002, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part

is increased by 70 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.61 and the pre-BBA amount exceeds the product of 0.60 and the prospective payment system amount; or

(3) Less than 80 percent of the pre-BBA amount, the amount of payment under this part is increased by 13 percent of the pre-BBA amount.

(c) *For 2003.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2003, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 60 percent of the amount of this difference; or

(2) Less than 90 percent of the pre-BBA amount, the amount of payment under this part is increased by 6 percent of the pre-BBA amount.

(d) *Hold harmless provisions—*(1) *Temporary treatment for small rural hospitals before January 1, 2006.* For covered hospital outpatient services furnished in a calendar year before January 1, 2006, 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 located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

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

(2) *Temporary treatment for small rural hospitals on or after January 1, 2006.* For covered hospital outpatient services furnished in a calendar year from January 1, 2006 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 95 percent of that difference for services furnished during CY 2006, 90 percent of that difference for services furnished during CY 2007, and 85 percent of that difference for services furnished during

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CYs 2008, 2009, 2010, 2011, and 2012 if the hospital—

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

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

(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

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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, 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.

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(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 authorizes the Secretary to develop a method for controlling unnecessary increases in the volume of covered hospital outpatient department services.

(b) *Scope.* This subpart specifies the process and requirements for prior authorization for certain hospital outpatient department services as a condition of Medicare payment.

§ 419.81 Definitions.

As used in this subpart, unless otherwise specified, the following definitions apply:

List of hospital outpatient department services requiring prior authorization means the list of hospital outpatient department services described in § 419.83(a) that CMS adopts in accordance with § 419.83(b) that require prior authorization as a condition of Medicare payment.

Prior authorization means the process through which a request for provisional affirmation of coverage is submitted to CMS or its contractors for review before the service is provided to the beneficiary and before the claim is submitted for processing.

Provisional affirmation means a preliminary finding that a future claim meets the Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act.

§ 419.82 Prior authorization for certain covered hospital outpatient department services.

(a) *Prior authorization as condition of payment.* As a condition of Medicare payment for the services in the categories of services on the list of hospital outpatient department services requiring prior authorization as specified in § 419.83(a), a provider must submit to CMS or its contractors a prior authorization request in accordance with the requirements of paragraph (c) of this section.

(b) *Denial of claim.* (1) CMS or its contractors will deny a claim for a service that requires prior authorization if the provider has not received a provisional

affirmation of coverage on the claim from CMS or its contractor unless the provider is exempt under § 419.83(c).

(2) CMS or its contractor may deny a claim that has received a provisional affirmation based on either of the following:

(i) Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or

(ii) Information not available at the time of a prior authorization request.

(3) CMS or its contractor may deny claims for services related to services on the list of hospital outpatient department services for which the provider has received a denial.

(c) *Submission of prior authorization request.* A provider must submit to CMS or its contractor a prior authorization request for any service on the list of outpatient department services requiring prior authorization.

(1) *Prior authorization request requirements.* A prior authorization request must—

(i) Include all documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act.

(ii) Be submitted before the service is provided to the beneficiary and before the claim is submitted.

(2) *Request for expedited review.* A provider may submit a request for expedited review of a prior authorization request. The request for expedited review must comply with the requirements in paragraphs (c)(1)(i) and (ii) of this section and include documentation showing that the processing of the prior authorization request must be expedited due to the beneficiary's life, health, or ability to regain maximum function being in serious jeopardy.

(d) *Reviews*—(1) *Review of prior authorization request.* Upon receipt of a prior authorization request, CMS or its contractor will review the request for compliance with applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act.

(i) CMS or its contractor will issue a provisional affirmation to the provider if it is determined that applicable

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Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act are met.

(ii) CMS or its contractor will issue a non-affirmation to the provider if it is determined that applicable Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act are not met.

(iii) The provisional affirmation or non-affirmation will be issued within 10 business days of receipt of the prior authorization request.

(2) *Review of expedited review request.* Upon receipt of a request for expedited review, CMS or its contractor will complete an expedited review of the prior authorization request if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function, and issue a provisional affirmation or non-affirmation decision in accordance with paragraph (d)(1) of this section within 2 business days of the expedited review request.

(e) *Resubmission.* (1) A provider may resubmit a prior authorization request, upon receipt of a non-affirmation, consistent with the requirements in paragraph (c)(1) of this section.

(2) A provider may resubmit a request for expedited review consistent with the requirements in paragraph (c)(1) of this section.

§ 419.83 List of hospital outpatient department services requiring prior authorization.

(a) *Service categories for the list of hospital outpatient department services requiring prior authorization.* (1) The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2020:

- (i) Blepharoplasty.
- (ii) Botulinum toxin injections.
- (iii) Panniculectomy.
- (iv) Rhinoplasty.
- (v) Vein ablation.

(2) The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2021:

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(i) Cervical Fusion with Disc Removal.

(ii) Implanted Spinal Neurostimulators.

(3) Technical updates to the list of services, such as changes to the name of the service or CPT code, will be published on the CMS website.

(b) *Adoption of the list of services.* CMS will adopt the list of hospital outpatient department service categories requiring prior authorization and any updates or geographic restrictions through formal notice-and-comment rulemaking.

(c) *Exemptions.* CMS may elect to exempt a provider from the prior authorization process in § 419.82 upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules in chapter IV of this title or in Title XVIII of the Social Security Act through such prior authorization process.

(1) An exemption will remain in effect until CMS elects to withdraw the exemption.

(2) Notice of an exemption or withdrawal of an exemption will be provided at least 60 days prior to the effective date.

(d) *Suspension of prior authorization process or services.* CMS may suspend the outpatient department services prior authorization process requirements generally or for a particular service(s) at any time by issuing notification on the CMS website.

[84 FR 61491, Nov. 12, 2019, as amended at 85 FR 86303, Dec. 29, 2020]

§§ 419.84–419.89 [Reserved]

PART 420—PROGRAM INTEGRITY: MEDICARE

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