

§413.122

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deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

(e) *Aggregation of cost, charges, and the blended amount.* For purposes of determining the correct payment amount under paragraphs (c) and (d) of this section, all reasonable costs and customary charges attributable to facility services furnished during a cost reporting period are aggregated and treated separately from the reasonable costs and customary charges attributable to all other services furnished in the hospital.

[52 FR 36773, Oct. 1, 1987; 52 FR 37715, Oct. 8, 1987, as amended at 55 FR 33699, Aug. 17, 1990; 55 FR 34797, Aug. 24, 1990; 57 FR 36017, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992; 65 FR 18541, Apr. 7, 2000]

§413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

(a) *Basis and purpose.* (1) This section implements section 1833(n) of the Act and establishes the method for determining Medicare payments for radiology services and other diagnostic procedures performed by a hospital on an outpatient basis.

(2) For purposes of this section—

(i) Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services; and

(ii) Other diagnostic procedures are those identified by CMS, and do not include diagnostic radiology procedures or diagnostic laboratory tests.

(b) *Payment for hospital outpatient radiology services.* (1) The aggregate payment for hospital outpatient radiology services furnished on or after October 1, 1988 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §413.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment amount described in paragraph (b)(2) of this section.

(2) The blended payment amount for hospital outpatient radiology services furnished on or after October 1, 1988,

but before October 1, 1989, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge or fee schedule amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 62 percent of the prevailing charges (or for services furnished on or after January 1, 1989, the fee schedule amount established) for the same services when furnished by participating physicians in their offices in the same locality.

(3) For hospital outpatient radiology services furnished on or after October 1, 1989, the blended payment amount is equal to the sum of 50 percent of the hospital-specific amount and 50 percent of the fee schedule amount.

(4) For hospital outpatient radiology services furnished on or after January 1, 1991, the blended payment amount is equal to the sum of 42 percent of the hospital-specific amount and 58 percent of the fee schedule amount.

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* (1) The aggregate payment for other diagnostic procedures performed by a hospital on an outpatient basis on or after October 1, 1989 is equal to the lesser of the following:

(i) The hospital's reasonable cost or customary charges, as determined in accordance with §414.13, reduced by the applicable Part B annual deductible and coinsurance amounts.

(ii) The blended payment described in paragraph (c)(2) of this section.

(2) The blended payment amount for other diagnostic procedures furnished on or after October 1, 1989, but before October 1, 1990, is equal to the sum of—

(i) 65 percent of the hospital-specific amount (the hospital's reasonable cost or customary charges, whichever is less, reduced by the applicable Part B annual deductible and coinsurance amounts); and

(ii) 35 percent of a prevailing charge amount that is calculated as 80 percent of the amount determined by subtracting the applicable Part B annual deductible from 42 percent of the prevailing charges for the same services furnished by participating physicians in their offices in the same locality.

(3) For other diagnostic procedures performed by a hospital on or after October 1, 1990, the blended payment is equal to 50 percent of the hospital-specific amount and 50 percent of the prevailing charge amount.

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

[56 FR 8842, Mar. 1, 1991, as amended at 57 FR 36017, Aug. 12, 1992; 65 FR 18542, Apr. 7, 2000]

§ 413.123 Payment for screening mammography performed by hospitals on an outpatient basis.

(a) *Basis and scope.* This section implements section 1834(c)(1)(C) of the Act and establishes the method for determining Medicare payment for screening mammographies performed by hospitals.

(b) *Payment to hospitals for outpatient services.* Payment to hospitals for screening mammography services performed on an outpatient basis is determined in accordance with the technical component billing requirements in § 405.534(d) of this chapter.

[55 FR 53522, Dec. 31, 1990, as amended at 59 FR 49834, Sept. 30, 1994]

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of these services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

(b) For purposes of determining the blended payment amounts of ambulatory surgical center approved surgical procedures performed in the hospital outpatient setting under § 413.118 and hospital outpatient radiology services and other diagnostic procedures under § 413.122, the reduction is applicable only to the hospital-specific portion of the blended payment amounts.

[57 FR 36017, Aug. 12, 1992, as amended at 59 FR 26960, May 25, 1994; 62 FR 46037, Aug. 29, 1997; 65 FR 18542, Apr. 07, 2000]

§ 413.125 Payment for home health agency services.

(a) For additional rules on the allowability of certain costs incurred by home health agencies, see §§ 409.46 and 409.49(b) of this chapter.

(b) The reasonable cost of outpatient rehabilitation services furnished by a home health agency to homebound patients who are not entitled to home health benefits may not exceed the amounts payable under the physician fee schedule for comparable services effective January 1, 1999.

[59 FR 65497, Dec. 20, 1994, as amended at 63 FR 58910, Nov. 2, 1998]

Subpart G—Capital-Related Costs

§ 413.130 Introduction to capital-related costs.

(a) *General rule.* Capital-related costs and an allowance for return on equity are limited to the following:

(1) Net depreciation expense as determined under §§ 413.134, 413.144, and 413.149, adjusted by gains and losses realized from the disposal of depreciable assets under § 413.134(f).