

**§ 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****Subpart A—General Provisions**

Sec.

- 419.1 Basis and scope.  
419.2 Basis of payment.

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

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

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

- 419.30 Base expenditure target for calendar year 1999.  
419.31 Ambulatory payment classification (APC) system and payment weights.  
419.32 Calculation of prospective payment rates for hospital outpatient services.

**Subpart D—Payments to Hospitals**

- 419.40 Payment concepts.  
419.41 Calculation of national beneficiary copayment amounts and national Medicare program payment amounts.  
419.42 Hospital election to reduce copayment.  
419.43 Adjustments to national program payment and beneficiary copayment amounts.  
419.44 Payment reductions for procedures.  
419.45 Payment and copayment reduction for devices replaced without cost or when full or partial credit is received.

**Subpart E—Updates**

- 419.50 Annual updates.

**Subpart F—Limitations on Review**

- 419.60 Limitations on administrative and judicial review.

**Subpart G—Transitional Pass-through Payments**

- 419.62 Transitional pass-through payments: General rules.  
419.64 Transitional pass-through payments: Drugs and biologicals.  
419.66 Transitional pass-through payments: Medical devices.

**Subpart H—Transitional Corridors**

- 419.70 Transitional adjustment to limit decline in payment.

AUTHORITY: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

SOURCE: 65 FR 18542, Apr. 7, 2000, unless otherwise noted.

**Subpart A—General Provisions****§ 419.1 Basis and scope.**

- (a) *Basis.* This part implements section 1833(t) of the Act by establishing a