

be determined according to the OPO's or laboratory's estimate of its projected costs for the fiscal year.

(3) Payments made on the basis of the interim rate will be reconciled directly with the OPO or laboratory after the close of its fiscal year, in accordance with paragraph (e) of this section.

(4) Information on the interim rate for all freestanding OPOs and histocompatibility laboratories shall be disseminated to all transplant hospitals and intermediaries.

(e) *Retroactive adjustment*—(1) *Cost reports*. Information provided in cost reports by freestanding OPOs and histocompatibility laboratories must meet the requirements for cost data and cost finding specified in paragraphs (a) through (e) of § 413.24. These cost reports must provide a complete accounting of the cost incurred by the agency or laboratory in providing covered services, the total number of Medicare beneficiaries who received those services, and any other data necessary to enable the intermediary to make a determination of the reasonable cost of covered services provided to Medicare beneficiaries.

(2) *Audit and adjustment*. A cost report submitted by a freestanding OPO or histocompatibility laboratory will be reviewed by the intermediary and a new interim reimbursement rate for the succeeding fiscal year will be established based upon this review. A retroactive adjustment in the amount paid under the interim rate will be made in accordance with § 413.64(f). If the determination of reasonable cost reveals an overpayment or underpayment resulting from the interim reimbursement rate paid to transplant hospitals, a lump sum adjustment will be made directly between that intermediary and the OPO or laboratory.

(f) For services furnished on or after April 1, 1988, no payment may be made for services furnished by an OPO that does not meet the requirements of part 486, subpart G of this chapter.

(g) *Appeals*. Any OPO or histocompatibility laboratory that disagrees with an intermediary's cost determination under this section is entitled to an intermediary hearing, in accordance with the procedures contained in §§ 405.1811 through 405.1833, if

the amount in controversy is \$1,000 or more.

[62 FR 43668, Aug. 15, 1997, as amended at 71 FR 31046, May 31, 2006]

§ 413.202 Organ procurement organization (OPO) cost for kidneys sent to foreign countries or transplanted in patients other than Medicare beneficiaries.

An OPO's total costs for all kidneys is reduced by the costs associated with procuring kidneys sent to foreign transplant centers or transplanted in patients other than Medicare beneficiaries. OPOs, as defined in § 486.302 of this chapter, must separate costs for procuring kidneys that are sent to foreign transplant centers and kidneys transplanted in patients other than Medicare beneficiaries from Medicare allowable costs prior to final settlement by the Medicare fiscal intermediaries. Medicare costs are based on the ratio of the number of usable kidneys transplanted into Medicare beneficiaries to the total number of usable kidneys applied to reasonable costs. Certain long-standing arrangements that existed before March 3, 1988 (for example, an OPO that procures kidneys at a military transplant hospital for transplant at that hospital), will be deemed to be Medicare kidneys for cost reporting statistical purposes. The OPO must submit a request to the fiscal intermediary for review and approval of these arrangements.

[62 FR 43668, Aug. 15, 1997, as amended at 71 FR 31046, May 31, 2006]

§ 413.203 Transplant center costs for organs sent to foreign countries or transplanted in patients other than Medicare beneficiaries.

(a) A transplant center's total costs for all organs is reduced by the costs associated with procuring organs sent to foreign transplant centers or transplanted in patients other than Medicare beneficiaries. Organs are defined in § 486.302 (only covered organs will be paid for on a reasonable cost basis).

(b) Transplant center hospitals must separate costs for procuring organs that are sent to foreign transplant centers and organs transplanted in patients other than Medicare beneficiaries from Medicare allowable costs

§413.210

prior to final cost settlement by the Medicare fiscal intermediaries.

(c) Medicare costs are based on the ratio of the number of usable organs transplanted into Medicare beneficiaries to the total number of usable organs applied to reasonable costs.

§413.210 Conditions for payment under the end-stage renal disease (ESRD) prospective payment system.

Except as noted in §413.174(f), items and services furnished on or after January 1, 2011, under section 1881(b)(14)(A) of the Act and as identified in §413.217 of this part, are paid under the ESRD prospective payment system described in §413.215 through §413.235 of this part.

(a) *Qualifications for payment.* To qualify for payment, ESRD facilities must meet the conditions for coverage in part 494 of this chapter.

(b) *Payment for items and services.* CMS will not pay any entity or supplier other than the ESRD facility for covered items and services furnished to a Medicare beneficiary. The ESRD facility must furnish all covered items and services defined in §413.217 of this part either directly or under arrangements.

[75 FR 49199, Aug. 12, 2010]

EFFECTIVE DATE NOTE: At 75 FR 49199, Aug. 12, 2010, §413.210 was added, effective January 1, 2011.

§413.215 Basis of payment.

(a) Except as otherwise provided under §413.235 or §413.174(f) of this part, effective January 1, 2011, ESRD facilities receive a predetermined per treatment payment amount described in §413.230 of this part, for renal dialysis services, specified under section 1881(b)(14) of the Act and as defined in §413.217 of this part, furnished to Medicare Part B fee-for-service beneficiaries.

(b) In addition to the per-treatment payment amount, as described in §413.215(a) of this part, the ESRD facility may receive payment for bad debts of Medicare beneficiaries as specified in §413.178 of this part.

[75 FR 49200, Aug. 12, 2010]

42 CFR Ch. IV (10–1–10 Edition)

EFFECTIVE DATE NOTE: At 75 FR 49200, Aug. 12, 2010, §413.215 was added, effective January 1, 2011.

§413.217 Items and services included in the ESRD prospective payment system.

The following items and services are included in the ESRD prospective payment system effective January 1, 2011:

(a) Renal dialysis services as defined in §413.171; and

(b) Home dialysis services, support, and equipment as identified in §410.52 of this chapter.

[75 FR 49200, Aug. 12, 2010]

EFFECTIVE DATE NOTE: At 75 FR 49200, Aug. 12, 2010, §413.217 was added, effective January 1, 2011.

§413.220 Methodology for calculating the per-treatment base rate under the ESRD prospective payment system effective January 1, 2011.

(a) *Data sources.* The methodology for determining the per treatment base rate under the ESRD prospective payment system utilized:

(1) Medicare data available to estimate the average cost and payments for renal dialysis services.

(2) ESRD facility cost report data capturing the average cost per treatment.

(3) The lowest per patient utilization calendar year as identified from Medicare claims is calendar year 2007.

(4) Wage index values used to adjust for geographic wage levels described in §413.231 of this part.

(5) An adjustment factor to account for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by ESRD facilities.

(b) *Determining the per treatment base rate for calendar year 2011.* Except as noted in §413.174(f), the ESRD prospective payment system combines payments for the composite rate items and services as defined in §413.171 of this part and the items and services that, prior to January 1, 2011, were separately billable items and services, as defined in §413.171 of this part, into a single per treatment base rate developed from 2007 claims data. The steps to calculating the per-treatment base rate for 2011 are as follows: