Centers for Medicare & Medicaid Services, HHS  §412.101

(3) Annual notice. CMS sets forth the national and regional criteria in the annual notice of prospective payment rates published under §412.8(b). These criteria are compared to an applying hospital’s number of discharges for the same cost reporting period used to develop the regional criteria in this section in determining if the hospital qualifies for referral center status for cost reporting periods beginning on or after October 1 of the Federal fiscal year to which the notice applies.

(50 FR 12741, Mar. 29, 1985)

EDITORIAL NOTE: For Federal Register citations affecting §412.96, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 412.98 [Reserved]

§ 412.100 Special treatment: Renal transplantation centers.

(a) Adjustments for renal transplantation centers. (1) CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.

(2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

(b) Costs of kidney acquisition. Expenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency. These costs include—

(1) Tissue typing, including tissue typing furnished by independent laboratories;

(2) Donor and beneficiary evaluation;

(3) Other costs associated with excising kidneys, such as donor general routine and special care services;

(4) Operating room and other inpatient ancillary services applicable to the donor;

(5) Preservation and perfusion costs;

(6) Charges for registration of beneficiary with a kidney transplant registry;

(7) Surgeons’ fees for excising cadaver kidneys;

(8) Transportation;

(9) Costs of kidneys acquired from other providers or kidney procurement organizations;

(10) Hospital costs normally classified as outpatient costs applicable to kidney excisions (services include donor and donee tissue typing, work-up, and related services furnished prior to admission);

(11) Costs of services applicable to kidney excisions which are rendered by residents and interns not in approved teaching programs; and

(12) All pre-admission physicians services, such as laboratory, electroencephalography, and surgeo fees for cadaver excisions, applicable to kidney excisions including the costs of physicians services.

[50 FR 12741, Mar. 29, 1985, as amended at 57 FR 39824, Sept. 1, 1992]


(a) Definitions. Beginning in FY 2011, the terms used in this section are defined as follows:

Medicare discharges means discharge of inpatients entitled to Medicare Part A, including discharges associated with individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare and also discharges of individuals enrolled in a MA organization under Medicare Part C.

Road miles means “miles” as defined in §412.92(c)(1).

(b) General considerations. (1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (c) of this section.

(2) In order to qualify for this adjustment, a hospital must meet the following criteria:

(i) For FY 2005 through FY 2010 and FY 2014 and subsequent fiscal years, a hospital must have fewer than 200 total