

## §412.101

- (1) Tissue typing, including tissue typing furnished by independent laboratories;
- (2) Donor and recipient 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 recipient 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 surgeon 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]

### §412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

#### (a) 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 (b) of this section.

(2) In order to qualify for this adjustment, a hospital must have less than 200 discharges during the fiscal year, as reflected in its cost report specified in paragraph (a)(3) of this section, and be located more than 25 road miles from the nearest subsection (d) hospital.

(3) The fiscal intermediary makes the determination of the discharge count

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for purposes of determining a hospital's qualification for the adjustment based on the hospital's most recent submitted cost report.

(4) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary with sufficient evidence that it meets the distance requirement specified under paragraph (a)(2) of this section. The fiscal intermediary will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

(b) *Determination of the adjustment amount.* The low-volume adjustment for hospitals that qualify under paragraph (a) of this section is 25 percent for each Medicare discharge.

(c) *Eligibility of new hospitals for the adjustment.* A new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets the number of discharge requirements during the fiscal year and has provided its fiscal intermediary with sufficient evidence that it meets the distance requirement, as specified under paragraph (a)(2) of this section.

[69 FR 49244, Aug. 11, 2004]

### §412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in subpart D of this part, may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

(a) *First year adjustment.* The hospital's rural average standardized amount and disproportionate share payments as described in §412.106 are adjusted on the basis of an additional amount that equals two-thirds of the difference between the urban standardized amount and disproportionate share payments applicable to the hospital before its reclassification and the