

and training sessions including an explanation of the cost difference between the two modalities.

(3) Class size and patients' training schedules.

(4) Number of training sessions required, by treatment modality, to train patients.

(5) Number of patients trained for the current year and the prior 2 years on a monthly basis.

(6) Projection for the next 12 months of future training candidates.

(7) The number and qualifications of staff at training sessions.

(f) *Accelerated training exception.* (1) A pediatric ESRD facility may bill Medicare for a dialysis training session only when a patient receives a dialysis treatment (normally 3 times a week for hemodialysis). Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities; ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

(2) If a pediatric ESRD facility elects to train all its patients using a particular treatment modality more often than during each dialysis treatment and, as a result, the number of billable training dialysis sessions is less than the number of actual training sessions, the facility may request a composite rate exception, limited to the lesser of the—

(i) Facility's projected training cost per treatment; or

(ii) Cost per treatment the facility receives in training a patient if it had trained patients only during a dialysis treatment, that is, three times per week.

(3) An ESRD facility may bill a maximum of 25 training sessions per patient for hemodialysis training and 15 sessions for CCPD and CAPD training.

(4) In computing the payment amount under an accelerated training exception, CMS uses a minimum number of training sessions per patient (15 for hemodialysis and 5 for CAPD and CCPD) when the facility actually provides fewer than the minimum number of training sessions.

(5) To justify an accelerated training exception request, an ESRD facility

must document that a significant number of training sessions for a particular modality are provided during a shorter but more condensed period.

(6) The facility must submit with the exception request a list of patients, by modality, trained during the most recent cost report period. The list must include each beneficiary's—

(i) Name;

(ii) Age; and

(iii) Training status (completed, not completed, being retrained, or in the process of being trained).

(7) The total treatments from the patient list must be the same as the total treatments reported on the cost report filed with the request.

[70 FR 70331, Nov. 21, 2005]

§413.194 Appeals.

(a) *Appeals under section 1878 of the Act.* (1) A facility that disputes the amount of its allowable Medicare bad debts reimbursed by CMS under §413.89(h)(3) may request review by the contractor or the Provider Reimbursement Review Board (PRRB) in accordance with subpart R to part 405 of this chapter.

(2) A facility must request and obtain a final agency decision prior to seeking judicial review of a dispute regarding the amount of allowable Medicare bad debts.

(b) *Other appeals.* (1) A facility that has requested higher payment per treatment in accordance with §413.180 may request review from the contractor or the PRRB if CMS has denied the request in whole or in part. In such a case, the procedure in subpart R of part 405 of this chapter is followed to the extent that it is applicable.

(2) The PRRB has the authority to review the action taken by CMS on the facility's requests. However, the PRRB's decision is subject to review by the Administrator under §405.1875 of this chapter.

(3) A facility must request and obtain a final agency decision, in accordance with paragraph (b)(1) of this section, prior to seeking judicial review of the denial, in whole or in part, of the exception request.

(c) *Procedure.* (1) The facility must request review within 180 days of the

§ 413.195

42 CFR Ch. IV (10–1–23 Edition)

date of the decision on which review is sought.

(2) The facility may not submit to the reviewing entity, whether it is the contractor or the PRRB, any additional information or cost data that had not been submitted to CMS at the time CMS evaluated the exception request.

(d) *Determining amount in controversy.* For purposes of determining PRRB jurisdiction under subpart R of part 405 of this chapter for the appeals described in paragraph (b) of this section—

(1) The amount in controversy per treatment is determined by subtracting the amount of program payment from the amount the facility requested under § 413.180; and

(2) The total amount in controversy is calculated by multiplying the amount in controversy per treatment by the projected number of treatments for the exception request period.

[62 FR 43668, Aug. 15, 1997, as amended at 81 FR 77965, Nov. 4, 2016]

§ 413.195 Limitation on Review.

Administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the following is prohibited: The determination of payment amounts under section 1881(b)(14)(A) of the Act, the establishment of an appropriate unit of payment under section 1881(b)(14)(C) of the Act, the identification of renal dialysis services included in the bundled payment, the adjustments under section 1881(b)(14)(D) of the Act, the application of the phase-in under section 1881(b)(14)(E) of the Act, and the establishment of the market basket percentage increase factors under section 1881(b)(14)(F) of the Act.

[75 FR 49199, Aug. 12, 2010]

§ 413.196 Notification of changes in rate-setting methodologies and payment rates.

(a) CMS or the facility's contractor notifies each facility of changes in its payment rate. This notice includes changes in individual facility payment rates resulting from corrections or revisions of particular geographic labor cost adjustment factors.

(b) Changes in payment rates resulting from incorporation of updated cost data or general revisions of geographic labor cost adjustment factors are announced by notice published in the FEDERAL REGISTER without opportunity for prior comment. Revisions of the rate-setting methodology are published in the FEDERAL REGISTER in accordance with the Department's established rulemaking procedures.

(c) Effective for items and services furnished on or after January 1, 2011 and before January 1, 2012, CMS adjusts the composite rate portion of the basic case-mix adjusted composite payment system described in § 413.220 by the ESRD bundled market basket percentage increase factor.

(d) Effective for items and services furnished on or after January 1, 2012, CMS updates on an annual basis the following:

(1) The per-treatment base rate and the composite rate portion of the basic case-mix adjusted composite payment system described in § 413.220 by the ESRD bundled market basket percentage increase factor minus a productivity adjustment factor.

(2) The wage index using the most current hospital wage data.

(3) The fixed dollar loss amount as defined in § 413.237 of this part to ensure that outlier payments continue to be 1.0 percent of total payments to ESRD facilities.

[62 FR 43668, Aug. 15, 1997, as amended at 75 FR 49199, Aug. 12, 2010]

§ 413.198 Recordkeeping and cost reporting requirements for outpatient maintenance dialysis.

(a) *Purpose and Scope.* This section implements section 1881(b)(2)(B)(i) of the Act by specifying recordkeeping and cost reporting requirements for ESRD facilities under part 494 of this chapter. The records and reports will enable CMS to determine the costs incurred in furnishing outpatient maintenance dialysis as defined in § 413.170(a).

(b) *Recordkeeping and reporting requirements.* (1) Each facility must keep adequate records and submit the appropriate CMS-approved cost report in accordance with §§ 413.20 and 413.24, which