the receipt of CMS notice of an adverse determination or non-renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(2) CMS response to a filing request. In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) Hearing requirements and rules. (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(1) Authorized representatives;

(2) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(3) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though such evidence may be inadmissible under the Federal Rules of Civil Procedure.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer’s decision is final.

(4) Hearing requirements and rules. (i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(1) Authorized representatives;

(2) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(3) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though such evidence may be inadmissible under the Federal Rules of Civil Procedure.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer’s decision is final.

[74 FR 62006, Nov. 25, 2009]
§ 414.90 Physician Quality Reporting System.

(a) Basis and scope. This section implements the following provisions of the Act:

(1) 1848(a)—Payment Based on Fee Schedule.

(2) 1848(k)—Quality Reporting System.

(3) 1848(m)—Incentive Payments for Quality Reporting.

(b) Definitions. As used in this section, unless otherwise indicated—

Covered professional services means services for which payment is made under, or is based on, the Medicare physician fee schedule as provided under section 1848(k)(3) of the Act and which are furnished by an eligible professional.

Eligible professional means any of the following:

(i) A physician.

(ii) A practitioner described in section 1842(b)(18)(C) of the Act.

(iii) A physical or occupational therapist or a qualified speech-language pathologist.

(iv) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Group practice means a physician group practice, as defined by a TIN, with 25 or more individual eligible professionals (or, as identified by NPIs) who have reassigned their billing rights to the TIN.

Maintenance of Certification Program means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification Program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program must include the following:

(i) The program requires the physician to maintain a valid unrestricted license in the United States.

(ii) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(iii) The program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty.

(iv) The program requires successful completion of a qualified maintenance of certification program practice assessment.

Maintenance of Certification Program Practice Assessment means an assessment of a physician’s practice that—

(i) Includes an initial assessment of an eligible professional’s practice that is designed to demonstrate the physician’s use of evidence-based medicine;

(ii) Includes a survey of patient experience with care; and

(iii) Requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under paragraph (h) of this section and then to remeasure to assess performance improvement after such intervention.

Measures group means a subset of four or more Physician Quality Reporting System measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.