

period and the actual number of visits for RHC or FQHC services furnished during the period; and

(ii) The estimated costs and visits for RHC services or FQHC services for the succeeding reporting period and such other information as CMS may require to establish the payment rate.

(3) *Late reports.* If the RHC or FQHC does not submit an adequate annual report on time, the MAC may reduce or suspend payments to preclude excess payment to the RHC or FQHC.

(4) *Inadequate reports.* If the RHC or FQHC does not furnish a report or furnishes a report that is inadequate for the MAC to make a determination of program payment, CMS may deem all payments for the reporting period to be overpayments.

(5) *Postponement of due date.* For good cause shown by the RHC or FQHC, the MAC may, with CMS's approval, grant a 30-day postponement of the due date for the annual report.

(6) *Reports following termination of agreement or change of ownership.* The report from a RHC or FQHC which voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change in ownership (see §§ 405.2436–405.2438) is due no later than 45 days following the effective date of the termination of agreement or change of ownership.

(d) *Collection of additional claims data.* Beginning January 1, 2011, a Medicare FQHC must report on its Medicare claims such information as the Secretary determines is needed to develop and implement a prospective payment system for FQHCs including, but not limited to all pertinent HCPCS (Healthcare Common Procedure Coding System) code(s) corresponding to the service(s) provided for each Medicare FQHC visit (as defined in § 405.2463).

[43 FR 8261, Mar. 1, 1978, as amended at 75 FR 73613, Nov. 29, 2010; 79 FR 25479, May 2, 2014]

§ 405.2472 Beneficiary appeals.

A beneficiary may request a hearing by an intermediary (subject to the limitations and conditions set forth in subpart H of this part) if:

(a) The beneficiary is dissatisfied with a MAC's determination denying a request for payment made on his or her behalf by a RHC or FQHC;

(b) The beneficiary is dissatisfied with the amount of payment; or

(c) The beneficiary believes the request for payment is not being acted upon with reasonable promptness.

[43 FR 8261, Mar. 1, 1978. Redesignated and amended at 57 FR 24978, June 12, 1992; 79 FR 25480, May 2, 2014]

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

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