

(1) The actual charge for the service provided that payment for such item is not included in the payment amount for other CORF services paid under paragraphs (a) or (c); or

(2) The amount determined using the same methodology for drugs (as defined in §414.704 of this chapter) described in section 1842(o)(1) of the Act provided that payment for such *drug* is not included in the payment amount for other CORF services paid under paragraphs (a) or (c).

(e) *Payment for CORF services when no fee schedule amount for the service.* If there is no fee schedule amount established for a CORF service, payment for the item or service will be the lesser of 80 percent of:

(i) The actual charge for the service provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

(ii) The amount determined under the fee schedule established for a comparable service as specified by the Secretary provided that payment for such item or service is not included in the payment amount for other CORF services paid under paragraphs (a), (c), or (d) of this section.

### Subpart N—Value-Based Payment Modifier Under the Physician Fee Schedule

SOURCE: 77 FR 69368, Nov. 16, 2012, unless otherwise noted.

#### §414.1200 Basis and scope.

(a) *Basis.* This subpart implements section 1848(p) of the Act by establishing a payment modifier that provides for differential payment starting in 2015 to a group of physicians and starting in 2017 to a group and a solo practitioner under the Medicare Physician Fee Schedule based on the quality of care furnished compared to cost during a performance period.

(b) *Scope.* This subpart sets forth the following:

(1) The application of the value-based payment modifier.

(2) Performance and payment adjustment periods.

(3) Reporting mechanisms for the value-based payment modifier.

(4) Alignment of PQRS quality of care measures with the quality measures for the value-based payment modifier.

(5) Additional measures for groups and solo practitioners.

(6) Cost measures.

(7) Attribution for quality of care and cost measures.

(8) Scoring methods for the value-based payment modifier.

(9) Benchmarks for quality of care measures.

(10) Benchmarks for cost measures.

(11) Composite scores.

(12) Reliability of measures.

(13) Payment adjustments.

(14) Value-based payment modifier quality-tiering scoring methodology.

(15) Limitation of review.

(16) Inquiry process.

[77 FR 69368, Nov. 16, 2012, as amended at 79 FR 68005, Nov. 13, 2014]

#### §414.1205 Definitions.

As used in this subpart, unless otherwise indicated—

*Accountable care organization (ACO)* has the same meaning given this term under §425.20 of this chapter.

*Certified registered nurse anesthetist (CRNA)* has the same meaning given this term under section 1861(bb)(2) of the Act.

*Critical access hospital* has the same meaning given this term under §400.202 of this chapter.

*Electronic health record (EHR)* has the same meaning given this term under §414.92 of this chapter.

*Eligible professional* has the same meaning given this term under section 1848(k)(3)(B) of the Act.

*Federally Qualified Health Center* has the same meaning given this term under §405.2401(b) of this chapter.

*Group of physicians (Group)* means a single Taxpayer Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

*Performance period* means the calendar year that will be used to assess the quality of care furnished compared to cost.