

Centers for Medicare & Medicaid Services, HHS

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has not yet expired, by sending the notice specified in § 405.1887(a) of this subpart.

[73 FR 30265, May 23, 2008, as amended at 78 FR 75195, Dec. 10, 2013; 85 FR 59019, Sept. 18, 2020]

§ 405.1887 Notice of reopening; effect of reopening.

(a) In exercising its reopening authority under § 405.1885, CMS (for Secretary determinations), the contractor or the reviewing entity, as applicable, must provide written notice to all parties to the determination or decision that is the subject of the reopening. Notices of—

(1) Reopening by a CMS reviewing official or the Board must be sent promptly to the Administrator.

(2) Contractor reopenings of determinations that are currently pending before the Board or the Administrator must meet the requirements specified in § 405.1885(c)(3) and (c)(4) of this subpart.

(b) Upon receipt of the notice required under § 405.1887(a) of this subpart, the parties to the prior Secretary or contractor determination or decision by a reviewing entity, as applicable, must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their positions.

(c) Upon concluding its reopening, CMS, the contractor or the reviewing entity, as applicable, must provide written notice promptly to all parties to the determination or decision that is the subject of the reopening, informing the parties as to what matter(s), if any, is revised, with a complete explanation of the basis for any revision.

(d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision (as described in § 405.1889 of this subpart).

[73 FR 30266, May 23, 2008]

§ 405.1889 Effect of a revision; issue-specific nature of appeals of revised determinations and decisions.

(a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after

the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

[73 FR 30266, May 23, 2008]

Subparts S–T [Reserved]

Subpart U—Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services

AUTHORITY: Secs. 1102, 1861, 1862(a), 1871, 1874, and 1881 of the Social Security Act (42 U.S.C. 1302, 1320b–8, 1395x, 1395y(a), 1395hh, 1395kk, and 1395rr), unless otherwise noted.

SOURCE: 41 FR 22511, June 3, 1976, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§§ 405.2100–405.2101 [Reserved]

§ 405.2102 Definitions.

As used in this subpart, the following definitions apply:

Network, ESRD. All Medicare-approved ESRD facilities in a designated geographic area specified by CMS.

Network organization. The administrative governing body to the network and liaison to the Federal government.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 43 FR 48950, Oct. 19, 1978; 51 FR 30361, Aug. 26, 1986; 53 FR 6547, Mar. 1, 1988; 55 FR 9575, Mar. 14, 1990; 72 FR 15273, Mar. 30, 2007; 73 FR 20473, Apr. 15, 2008; 79 FR 66261, Nov. 6, 2014]

§ 405.2110 Designation of ESRD networks.

CMS designated ESRD networks in which the approved ESRD facilities

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collectively provide the necessary care for ESRD patients.

(a) *Effect on patient choice of facility.* The designation of networks does not require an ESRD patient to seek care only through the facilities in the designated network where the patient resides, nor does the designation of networks limit patient choice of physicians or facilities, or preclude patient referral by physicians to a facility in another designated network.

(b) *Redesignation of networks.* CMS will redesignate networks, as needed, to ensure that the designations are consistent with ESRD program experience, consistent with ESRD program objectives specified in § 405.2101, and compatible with efficient program administration.

[51 FR 30361, Aug. 26, 1986]

§ 405.2111 [Reserved]

§ 405.2112 ESRD network organizations.

CMS will designate an administrative governing body (network organization) for each network. The functions of a network organization include but are not limited to the following:

(a) Developing network goals for placing patients in settings for self-care and transplantation.

(b) Encouraging the use of medically appropriate treatment settings most compatible with patient rehabilitation and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs.

(c) Developing criteria and standards relating to the quality and appropriateness of patient care and, with respect to working with patients, facilities, and providers of services, for encouraging participation in vocational rehabilitation programs.

(d) Evaluating the procedures used by facilities in the network in assessing patients for placement in appropriate treatment modalities.

(e) Making recommendations to member facilities as needed to achieve network goals.

(f) On or before July 1 of each year, submitting to CMS an annual report that contains the following information:

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(1) A statement of the network goals.

(2) The comparative performance of facilities regarding the placement of patients in appropriate settings for—

(i) Self-care;

(ii) Transplants; and

(iii) Vocational rehabilitation programs.

(3) Identification of those facilities that consistently fail to cooperate with the goals specified under paragraph (f)(1) of this section or to follow the recommendations of the medical review board.

(4) Identification of facilities and providers that are not providing appropriate medical care.

(5) Recommendations with respect to the need for additional or alternative services in the network including self-dialysis training, transplantation and organ procurement.

(g) Evaluating and resolving patient grievances.

(h) Appointing a network council and a medical review board (each including at least one patient representative) and supporting and coordinating the activities of each.

(i) Conducting on-site reviews of facilities and providers as necessary, as determined by the medical review board or CMS, using standards of care as specified under paragraph (c) of this section.

(j) Collecting, validating, and analyzing such data as necessary to prepare the reports required under paragraph (f) of this section and the Secretary's report to Congress on the ESRD program and to assure the maintenance of the registry established under section 1881(c)(7) of the Act.

[53 FR 1620, Jan. 21, 1988]

§ 405.2113 Medical review board.

(a) *General.* The medical review board must be composed of physicians, nurses, and social workers engaged in treatment relating to ESRD and qualified to evaluate the quality and appropriateness of care delivered to ESRD patients, and at least one patient representative.

(b) *Restrictions on medical review board members.* (1) A medical review board member must not review or provide advice with respect to any case in which he or she has, or had, any professional

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involvement, received reimbursement or supplied goods.

(2) A medical review board member must not review the ESRD services of a facility in which he or she has a direct or indirect financial interest (as described in section 1126(a)(1) of the Act).

[51 FR 30361, Aug. 26, 1986, as amended at 53 FR 1620, Jan. 21, 1988]

§ 405.2114 [Reserved]

§§ 405.2131–405.2184 [Reserved]

Subparts V–W [Reserved]

Subpart X—Rural Health Clinic and Federally Qualified Health Center Services

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 43 FR 8261, Mar. 1, 1978, unless otherwise noted.

§ 405.2400 Basis.

Subpart X is based on the provisions of the following sections of the Act:

(a) Section 1833—Amounts of payment for supplementary medical insurance services.

(b) Section 1861(aa)—Rural health clinic services and Federally qualified health center services covered by the Medicare program.

(c) Section 1834(o)—Federally qualified health center prospective payment system beginning October 1, 2014.

(d) Section 1834(y)—Payment for certain services furnished by rural health clinics.

[79 FR 25473, May 2, 2014, as amended at 88 FR 82176, Nov. 22, 2023]

§ 405.2401 Scope and definitions.

(a) *Scope*. This subpart establishes the requirements for coverage and reimbursement of rural health clinic and Federally qualified health center services under Medicare.

(b) *Definitions*. As used in this subpart, unless the context indicates otherwise:

Allowable costs means costs that are incurred by a RHC or FQHC that is authorized to bill based on reasonable costs and are reasonable in amount and

proper and necessary for the efficient delivery of RHC and FQHC services.

Beneficiary means an individual enrolled in the Supplementary Medical Insurance program for the Aged and Disabled (part of title XVIII of the Act).

Certified nurse midwife (CNM) means an individual who meets the applicable education, training, and other requirements of § 410.77(a) of this chapter.

Clinical psychologist (CP) means an individual who meets the applicable education, training, and other requirements of § 410.71(d) of this chapter.

Clinical social worker (CSW) means an individual who meets the applicable education, training, and other requirements of § 410.73(a) of this chapter.

CMS stands for Centers for Medicare & Medicaid Services.

Coinsurance means that portion of the RHC's charge for covered services or that portion of the FQHC's charge or PPS rate for covered services for which the beneficiary is liable (in addition to the deductible, where applicable).

Covered services means items or services for which the beneficiary is entitled to have payment made on his or her behalf under this subpart.

Deductible means the amount incurred by the beneficiary during a calendar year as specified in § 410.160 and § 410.161 of this chapter.

Employee means any individual who, under the common law rules that apply in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986), is considered to be employed by, or an employee of, an entity. (Application of these common law rules is discussed in 20 CFR 404.1007 and 26 CFR 31.3121(d)–1(c).)

Federally qualified health center (FQHC) means an entity that has entered into an agreement with CMS to meet Medicare program requirements under § 405.2434 and—

(1) Is receiving a grant under section 330 of the Public Health Service (PHS) Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the PHS Act;