

§ 414.80

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service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(i) *Reconsideration.* An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) *Filing requirements.* (i) The request must be filed within 30 calendar days of 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.

(j) *Change of ownership.* An accreditation organization whose accreditation program(s) is (are) approved and recognized by CMS that wishes to undergo a change of ownership are subject to the requirements set out at § 488.5(f) of this chapter.

[74 FR 62006, Nov. 25, 2009, as amended at 87 FR 25427, Apr. 29, 2022]

§ 414.80 Incentive payment for primary care services.

(a) *Definitions.* As defined in this section—

Eligible primary care practitioner means one of the following:

(i) A physician (as defined in section 1861(r)(1) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 08-family practice, 11-internal medicine, 37-pediatrics, or 38-geriatrics.

(B) At least 60 percent of the physician's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

(ii) A nurse practitioner, clinical nurse specialist, or physician assistant (as defined in section 1861(aa)(5) of the Act) who meets all of the following criteria:

(A) Enrolled in Medicare with a primary specialty designation of 50-nurse practitioner, 89-certified clinical nurse, or 97-physician assistant.

(B) At least 60 percent of the practitioner's allowed charges under the physician fee schedule (excluding hospital inpatient care and emergency department visits) during a reference period specified by the Secretary are for primary care services.

Primary care services means—

(i) New and established patient office or other outpatient evaluation and management (E/M) visits;

(ii) Initial, subsequent, discharge, and other nursing facility E/M services;

(iii) New and established patient domiciliary, rest home (for example, boarding home), or custodial care E/M services;

(iv) Domiciliary, rest home (for example, assisted living facility), or home care plan oversight services; and

(v) New and established patient home E/M visits.

(b) *Payment.* (1) For primary care services furnished by an eligible primary care practitioner on or after January 1, 2011 and before January 1, 2016, payment is made on a quarterly basis in an amount equal to 10 percent of the payment amount for the primary care services under Part B, in addition to the amount the primary care practitioner would otherwise be paid for the primary care services under Part B.

(2) The payment described in paragraph (b)(1) of this section is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a critical access hospital (CAH) paid under the optional method, to the CAH based on an institutional claim.

[75 FR 73617, Nov. 29, 2010]

§ 414.84 Payment for MDPP services.

(a) *Definitions.* In addition to the definitions specified at § 410.79(b) and § 424.205(a) of this chapter, the following definitions apply to this section.

Attendance payment means a payment that is made to an MDPP supplier for furnishing services to an MDPP beneficiary when the MDPP beneficiary attends an MDPP core or core maintenance session. CMS will allow up to 22 sessions (alone or in combination with other codes, not to exceed 22 sessions in a 12-month timeframe).

Bridge payment means a one-time payment to an MDPP supplier for furnishing its first MDPP session to an MDPP beneficiary who has previously received one or more MDPP services from a different MDPP supplier.

Performance goal means a weight loss goal that an MDPP beneficiary must achieve during the MDPP services period for an MDPP supplier to be paid a performance payment.

Performance payment means a payment made to an MDPP supplier for furnishing certain MDPP services to an MDPP beneficiary when the MDPP beneficiary achieves the applicable performance goal.

(b) *Performance payment.* CMS makes one or more types of performance payments to an MDPP supplier as specified in this paragraph (b). Each type of performance payment is made only if the beneficiary achieves the applicable performance goal. Certain performance goals are allowed only once per MDPP beneficiary and include the performance goals in paragraphs (b)(1)(i) and (b)(2)(i) of this section. A performance payment is made only on an assignment-related basis in accordance with § 424.55 of this chapter, and MDPP suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount. CMS will make a performance payment only to an MDPP supplier that complies with all applicable enrollment and program requirements and only for MDPP services that are furnished by an eligible coach, on or after his or her coach eligibility start date and, if applicable, before his or her coach eligibility end date. As a