which payment is made on a fee schedule basis.

(4) Imposes a charge for completing and submitting the standard claims form.

[66 FR 55332, Nov. 1, 2001, as amended at 67 FR 80041, Dec. 31, 2003; 69 FR 66424, Nov. 15, 2004; 70 FR 70332, Nov. 21, 2005; 72 FR 66401, Nov. 27, 2007; 73 FR 69936, Nov. 19, 2008; 74 FR 62006, Nov. 25, 2009; 75 FR 73617, Nov. 29, 2010; 76 FR 73471, Nov. 28, 2011; 77 FR 69363, Nov. 16, 2012; 78 FR 74812, Dec. 10, 2013; 83 FR 60074, Nov. 23, 2018]

§ 414.66 Incentive payments for physician scarcity areas.

(a) *Definition.* As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

[69 FR 66424, Nov. 15, 2004]

§ 414.67 Incentive payments for services furnished in Health Professional Shortage Areas.

(a) *Health Professional Shortage Area (HPSA) physician bonus program.* A HPSA physician incentive payment will be made subject to the following:

(1) HPSA bonuses are payable for services furnished by physicians as defined in section 1861(r) of the Act in areas designated as of December 31 of the prior year as geographic primary medical care HPSAs as defined in section 332(a)(1)(A) of the Public Health Service Act.

(2) HPSA bonuses are payable for services furnished by psychiatrists in areas designated as of December 31 of the prior year as geographic mental health HPSAs if the services are not already eligible for the bonus based on being in a geographic primary care HPSA.

(3) Physicians eligible for the HPSA physician bonus are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(4) Physicians furnishing services in areas that are designated as geographic HPSAs prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA bonus payments are made must use the AQ modifier to receive the HPSA physician bonus payment.

(b) *HPSA surgical incentive payment program.* A HPSA surgical incentive payment will be made subject to the following:

(1) A major surgical procedure as defined in § 414.2 of this part is furnished by a general surgeon on or after January 1, 2011 and before January 1, 2016 in an area recognized for the HPSA physician bonus program under paragraph (a)(1) of this section.

(2) Payment will be made on a quarterly basis in an amount equal to 10 percent of the Part B payment amount for major surgical procedures furnished as described in paragraph (b)(1) of this section, in addition to the amount the physician would otherwise be paid.

(3) Physicians furnishing services in areas that are designated as geographic HPSAs eligible for the HPSA physician bonus program under paragraph (a)(1) of this section prior to the beginning of the year but not included on the published list of zip codes for which automated HPSA surgical incentive payments are made should report HCPCS modifier -AQ to receive the HPSA surgical incentive payment.

(4) The payment described in paragraph (b)(2) of this section is made to

the surgeon or, where the surgeon 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]

§ 414.68 Imaging accreditation.

(a) *Scope and purpose.* Section 1834(e) of the Act requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) *Definitions.* As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.

(ii) Computed tomography.

(iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act.

(c) *Application and reapplication procedures for accreditation organizations.* An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards authorized by section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians (who may be the same person), such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier, including a thorough evaluation of equipment performance and safety;

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

(v) Procedures to assist the beneficiary in obtaining the beneficiary's imaging records on request; and

(vi) Procedures to notify the accreditation organization of any changes to the modalities subsequent to the organization's accreditation decision.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements authorized by section 1834(e) of the Act. The accreditation organization must maintain or adopt standards that are equal to, or more stringent than, those of Medicare.

(3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.