

(h) Items and services (other than those described in §§ 489.20(s)(1) through (15)) required to be furnished under § 489.20(s) to a resident of an SNF (defined in § 411.15(p) of this chapter), for which Medicare payment would be made if furnished by the SNF or by other providers or suppliers under arrangements made with them by the SNF. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the SNF for the item or service, and is also prohibited.

[49 FR 324, Jan. 3, 1984, as amended at 51 FR 22052, June 17, 1986; 52 FR 27765, July 23, 1987; 60 FR 63189, Dec. 8, 1995; 64 FR 41683, July 30, 1999; 65 FR 46796, July 31, 2000; 65 FR 62646, Oct. 19, 2000; 66 FR 39601, July 31, 2001]

**§ 489.22 Special provisions applicable to prepayment requirements.**

(a) A provider may not require an individual entitled to hospital insurance benefits to prepay in part or in whole for inpatient services as a condition of admittance as an inpatient, except where it is clear upon admission that payment under Medicare, Part A cannot be made.

(b) A provider may not deny covered inpatient services to an individual entitled to have payment made for those services on the ground of inability or failure to pay a requested amount at or before admission.

(c) A provider may not evict, or threaten to evict, an individual for inability to pay a deductible or a coinsurance amount required under Medicare.

(d) A provider may not charge an individual for (1) its agreement to admit or readmit the individual on some specified future date for covered inpatient services; or (2) for failure to remain an inpatient for any agreed-upon length of time or for failure to give advance notice of departure from the provider's facilities.

[45 FR 22937, Apr. 4, 1980, as amended at 68 FR 46072, Aug. 4, 2003]

**§ 489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.**

A provider that furnishes inpatient hospital services to a retired Federal

worker age 65 or older who is enrolled in a fee-for-service FEHB plan and who is not covered under Medicare Part A, must accept, as payment in full, an amount that approximates as closely as possible the Medicare inpatient hospital prospective payment system (PPS) rate established under part 412. The payment to the provider is composed of a payment from the FEHB plan and a payment from the enrollee. This combined payment approximates the Medicare PPS rate. The payment from the FEHB plan approximates, as closely as possible, the Medicare PPS rate minus any applicable enrollee deductible, coinsurance, or copayment amount. The payment from the enrollee is equal to the applicable deductible, coinsurance, or copayment amount.

[62 FR 56111, Oct. 29, 1997]

**§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.**

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section

ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(b) *Definitions.* As used in this subpart—

*Capacity* means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

*Comes to the emergency department* means, with respect to an individual

who is not a patient (as defined in this section), the individual—

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if—

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a non-hospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

*Dedicated emergency department* means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

*Emergency medical condition* means—

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the ab-

sence of immediate medical attention could reasonably be expected to result in—

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions—

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

*Hospital* includes a critical access hospital as defined in section 1861(m)(1) of the Act.

*Hospital property* means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

*Hospital with an emergency department* means a hospital with a dedicated emergency department as defined in this paragraph (b).

*Inpatient* means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in § 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

*Labor* means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital

medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

*Participating hospital* means (1) a hospital or (2) a critical access hospital as defined in section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

*Patient* means—

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in §410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

*Stabilized* means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

*To stabilize* means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

*Transfer* means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital’s dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions—(1) General.* Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Exception: Application to inpatients.* (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital

offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.*

(i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) *Refusal to consent to transfer.* A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) *Restricting transfer until the individual is stabilized—(1) General.* If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time

of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which—

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility—

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physi-

cian (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at § 412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

(g) *Termination of provider agreement.* If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the

provider agreement in accordance with § 489.53.

(h) *Consultation with Quality Improvement Organizations (QIOs)*—(1) *General.* Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine a physician's or hospital's liability under section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) *Notice of review and opportunity for discussion and additional information.* The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply—

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(4) A copy of the regulations at 42 CFR 489.24.

(B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.

(iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician and/or the hospital a full and fair opportunity to present the views of the physician and/or hospital regarding the case. The following provisions apply to that meeting:

(A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.

(B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.

(C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any non-disclosure requirements set forth in part 476 of this chapter.

(D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to

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support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.

(v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO's findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.

(vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or § 489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.

(4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).

(i) *Release of QIO assessments.* Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician's identity is confidential unless he or she consents to its release. (See §§ 476.132 and 476.133 of this chapter.)

(j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in § 489.20(r)(2), a hospital must have written policies and procedures in place—

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under § 489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under § 489.24 governing appropriate transfers.



(F) An annual assessment of the community call plan by the participating hospitals.

[59 FR 32120, June 22, 1994, as amended at 62 FR 46037, Aug. 29, 1997; 65 FR 18548, Apr. 7, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003; 71 FR 48143, Aug. 18, 2006; 72 FR 47413, Aug. 22, 2007; 73 FR 48758, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009]

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, § 489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

**§ 489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.**

For inpatient services, a hospital that participates in the Medicare program must participate in any health plan contracted under 10 U.S.C. 1079 or 1086 (Civilian Health and Medical Program of the Uniformed Services) and under 38 U.S.C. 613 (Civilian Health and Medical Program of the Veterans Administration) and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full, less applicable deductible, patient cost-share, and noncovered items. Hospitals must meet the requirements of 32 CFR part 199 concerning program benefits under the Department of Defense. This section applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987.

[59 FR 32123, June 22, 1994]

**§ 489.26 Special requirements concerning veterans.**

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Department of Veterans Affairs under 38 U.S.C. 603 and must meet the requirements of 38 CFR part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans admitted on and after July 1, 1987.

[59 FR 32123, June 22, 1994]

**§ 489.27 Beneficiary notice of discharge rights.**

(a) A hospital that participates in the Medicare program must furnish each Medicare beneficiary or enrollee, (or an individual acting on his or her behalf), timely notice as required by section 1866(A)(1)(M) of the Act and in accordance with § 405.1205 and § 422.620. The hospital must be able to demonstrate compliance with this requirement.

(b) *Notification by hospitals and other providers.* Hospitals and other providers (as identified at 489.2(b)) that participate in the Medicare program must furnish each Medicare beneficiary, or representative, applicable CMS notices in advance of discharge or termination of Medicare services, including the notices required under § 405.1200, § 405.1202, § 405.1206, and § 422.624 of this chapter.

[71 FR 68724, Nov. 27, 2006]

**§ 489.28 Special capitalization requirements for HHAs.**

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term “initial reserve operating funds,” to operate the HHA for the three month period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivable from Medicare or other health care insurers.

(b) *Standard.* Initial reserve operating funds are sufficient to meet the requirement of this section if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first three months of operation—or 22.5 percent (one fourth of 90 percent) of the average number of visits reported by the comparison HHAs—whichever is greater.

(c) *Method.* CMS, through the intermediary, will determine the amount of the initial reserve operating funds using reported cost and visit data from