

(11) An entity approved by CMS to furnish outpatient diabetes self-management training.

(12) End-stage renal disease (ESRD) treatment facility that is approved by CMS as meeting the conditions for coverage of its services.

(13) A site approved by CMS to furnish intensive cardiac rehabilitation services.

[52 FR 22446, June 12, 1987, as amended at 53 FR 6551, Mar. 1, 1988; 57 FR 24984, June 12, 1992; 58 FR 30677, May 26, 1993; 59 FR 6579, Feb. 11, 1994; 59 FR 56251, Nov. 10, 1994; 61 FR 32350, June 24, 1996; 62 FR 46037, Aug. 29, 1997; 65 FR 18549, Apr. 7, 2000; 65 FR 83154, Dec. 29, 2000; 68 FR 66721, Nov. 28, 2003; 71 FR 31054, May 31, 2006; 72 FR 15280, Mar. 30, 2007; 73 FR 36462, June 27, 2008; 74 FR 62014, Nov. 25, 2009; 84 FR 63204, Nov. 15, 2019]

§ 498.3 Scope and applicability.

(a) *Scope.* (1) This part sets forth procedures for reviewing initial determinations that CMS makes with respect to the matters specified in paragraph (b) of this section, and that the OIG makes with respect to the matters specified in paragraph (c) of this section. It also specifies, in paragraph (d) of this section, administrative actions that are not subject to appeal under this part.

(2) The determinations listed in this section affect participation in the Medicare program. Many of the procedures of this part also apply to other determinations that do not affect participation in Medicare. Some examples follow:

(i) CMS's determination to terminate an NF's Medicaid provider agreement.

(ii) CMS's determination to cancel the approval of an ICF/IID under section 1910(b) of the Act.

(iii) CMS's determination, under the Clinical Laboratory Improvement Act (CLIA), to impose alternative sanctions or to suspend, limit, or revoke the certificate of a laboratory even though it does not participate in Medicare.

(iv) CMS's determination to impose sanctions on the individual who is the administrator of a NF for failure to comply with the requirements at § 483.75(r) of this chapter.

(3) The following parts of this chapter specify the applicability of the provisions of this part 498 to sanctions or

remedies imposed on the indicated entities or individuals:

(i) Part 431, subpart D—for nursing facilities (NFs).

(ii) Part 488, subpart E (§ 488.330(e))—for SNFs and NFs.

(iii) Part 488, subpart E (§ 488.330(e)) and subpart F (§ 488.446)—for SNFs and NFs and their administrators.

(b) *Initial determinations by CMS.* CMS makes initial determinations with respect to the following matters:

(1) Whether a prospective provider qualifies as a provider.

(2) Whether a prospective department of a provider, remote location of a hospital, satellite facility, or provider-based entity qualifies for provider-based status under § 413.65 of this chapter, or whether such a facility or entity currently treated as a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity no longer qualifies for that status under § 413.65 of this chapter.

(3) Whether an institution is a hospital qualified to elect to claim payment for all emergency hospital services furnished in a calendar year.

(4) Whether an institution continues to remain in compliance with the qualifications for claiming reimbursement for all emergency services furnished in a calendar year.

(5) Whether a prospective supplier meets the conditions for coverage of its services as those conditions are set forth elsewhere in this chapter.

(6) Whether the services of a supplier continue to meet the conditions for coverage.

(7) Whether a physical therapist in independent practice or a chiropractor meets the requirements for coverage of his or her services as set forth in subpart D of part 486 of this chapter and § 410.22 of this chapter, respectively.

(8) The termination of a provider agreement in accordance with § 489.53 of this chapter, or the termination of a rural health clinic agreement in accordance with § 405.2404 of this chapter, or the termination of a Federally qualified health center agreement in accordance with § 405.2436 of this chapter.

(9) CMS's cancellation, under section 1910(b) of the Act, of an ICF/IID's approval to participate in Medicaid.

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(10) Whether, for purposes of rate setting and reimbursement, an ESRD treatment facility is considered to be hospital-based or independent.

(11) [Reserved]

(12) Whether a hospital, skilled nursing facility, home health agency, or hospice program meets or continues to meet the advance directives requirements specified in subpart I of part 489 of this chapter.

(13) Except as provided at paragraph (d)(12) of this section for SNFs, NFs, and HHAs, the finding of noncompliance leading to the imposition of enforcement actions specified in § 488.406 or § 488.820 of this chapter, but not the determination as to which sanction was imposed. The scope of review on the imposition if a civil money penalty is specified in §§ 488.438(e) and 488.845(h) of this chapter.

(14) The level of noncompliance found by CMS in a SNF, NF, or HHA but only if a successful challenge on this issue would affect—

(i) The range of civil money penalty amounts that CMS could collect (for SNFs or NFs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in § 488.438(e) of this chapter and for HHAs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in § 488.845(h) of this chapter); or

(ii) A finding of substandard quality of care that results in the loss of approval for a SNF or NF of its nurse aide training program.

(15) The effective date of a Medicare provider agreement or supplier approval.

(16) The finding of substandard quality of care that leads to the loss by a SNF or NF of the approval of its nurse aide training program.

(17)(i) Whether to deny or revoke a provider's or supplier's Medicare enrollment in accordance with § 424.530 or § 424.535 of this chapter;

(ii) Whether, under § 424.535(c)(2)(i) of this chapter, to add years to a provider's or supplier's existing reenrollment bar; or

(iii) Whether, under § 424.535(c)(3) of this chapter, an individual or entity other than the provider or supplier that is the subject of the second rev-

ocation was the actual subject of the first revocation.

(18) The level of noncompliance found by CMS with respect to the failure of an individual who is the administrator of a SNF to comply with the requirements at § 483.75(r) of this chapter, and the appropriate sanction to be imposed under § 488.446 of this chapter.

(19) Whether a physician or practitioner has failed to properly opt-out, failed to maintain opt-out, failed to timely renew opt-out, failed to privately contract, or failed to properly terminate opt-out.

(20) An individual or entity is to be included on the preclusion list as defined in § 422.2 or § 423.100 of this chapter.

(c) *Initial determinations by the OIG.* The OIG makes initial determinations with respect to the following matters:

(1) The termination of a provider agreement in accordance with part 1001, subpart C of this title.

(2) The suspension, or exclusion from coverage and the denial of reimbursement for services furnished by a provider, practitioner, or supplier, because of fraud or abuse, or conviction of crimes related to participation in the program, in accordance with part 1001, subpart B of this title.

(3) The imposition of sanctions in accordance with part 1004 of this title.

(d) *Administrative actions that are not initial determinations.* Administrative actions that are not initial determination (and therefore not subject to appeal under this part) include but are not limited to the following:

(1) The finding that a provider or supplier determined to be in compliance with the conditions or requirements for participation or for coverage has deficiencies.

(2) The finding that a prospective provider does not meet the conditions of participation set forth elsewhere in this chapter, if the prospective provider is, nevertheless, approved for participation in Medicare on the basis of special access certification, as provided in subpart B of part 488 of this chapter.

(3) The refusal to enter into a provider agreement because the prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(4) The finding that an entity that had its provider agreement terminated may not file another agreement because the reasons for terminating the previous agreement have not been removed or there is insufficient assurance that the reasons for the exclusion will not recur.

(5) The determination not to reinstate a suspended or excluded practitioner, provider, or supplier because the reason for the suspension or exclusion has not been removed, or there is insufficient assurance that the reason will not recur.

(6) The finding that the services of a laboratory are covered as hospital services or as physician's services, rather than as services of an independent laboratory, because the laboratory is not independent of the hospital or of the physician's office.

(7) The refusal to accept for filing an election to claim payment for all emergency hospital services furnished in a calendar year because the institution—

- (i) Had previously charged an individual or other person for services furnished during that calendar year;
- (ii) Submitted the election after the close of that calendar year; or
- (iii) Had previously been notified of its failure to continue to comply.

(8) The finding that the reason for the revocation of a supplier's right to accept assignment has not been removed or there is insufficient assurance that the reason will not recur.

(9) The finding that a hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association is not in compliance with a condition of participation, and a finding that that hospital is no longer deemed to meet the conditions of participation.

(10) For a SNF, NF, or HHA—

- (i) The finding that the provider's deficiencies pose immediate jeopardy to the health or safety of the residents or patients;
- (ii) Except as provided in paragraph (b)(13) of this section, a determination by CMS as to the provider's level of noncompliance; and
- (iii) For SNFs and NFs, the imposition of State monitoring.

(11) The choice of alternative sanction or remedy to be imposed on a provider or supplier.

(12) The determination that the accreditation requirements of a national accreditation organization do not provide (or do not continue to provide) reasonable assurance that the entities accredited by the accreditation organization meet the applicable long-term care requirements, conditions for coverage, conditions of certification, conditions of participation, or CLIA condition level requirements.

(13) The determination that requirements imposed on a State's laboratories under the laws of that State do not provide (or do not continue to provide) reasonable assurance that laboratories licensed or approved by the State meet applicable CLIA requirements.

(14) The choice of alternative sanction or remedy to be imposed on a provider or supplier.

(15) A decision by the State survey agency as to when to conduct an initial survey of a prospective provider or supplier.

(e) *Exclusion of civil rights issues.* The procedures in this subpart do not apply to the adjudication of issues relating to a provider's compliance with civil rights requirements that are set forth in part 489 of this chapter. Those issues are handled through the Department's Office of Civil Rights.

[52 FR 22446, June 12, 1987]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 498.3, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 498.4 NFs subject to appeals process in part 498.

A NF is considered a provider for purposes of this part when it has in effect an agreement to participate in Medicaid, including an agreement to participate in both Medicaid and Medicare and it is a—

- (a) State-operated NF; or
- (b) Non State-operated NF that is subject to compliance action as a result of—
 - (1) A validation survey by CMS; or