

§ 488.1265 Termination of provider agreement.

(a) *Effect of termination by CMS.* Termination of the provider agreement ends—

(1) Payment to the hospice program; and

(2) Any enforcement remedy.

(b) *Basis for termination.* CMS terminates a hospice program's provider agreement under any one of the following conditions:

(1) The hospice program is not in compliance with the conditions of participation.

(2) The hospice program fails to submit an acceptable plan of correction within the timeframe specified by CMS.

(3) The hospice program fails to relinquish control to the temporary manager, if that remedy is imposed by CMS.

(4) The hospice program fails to meet the eligibility criteria for continuation of payment as set forth in § 488.1260(a)(1).

(c) *Notice.* CMS notifies the hospice program and the public of the termination, in accordance with procedures set forth in § 489.53 of this chapter.

(d) *Procedures for termination.* CMS terminates the provider agreement in accordance with procedures set forth in § 489.53 of this chapter.

(e) *Payment post termination.* Payment is available for up to 30 calendar days after the effective date of termination for hospice care furnished under a plan established before the effective date of termination as set forth in § 489.55 of this chapter.

(f) *Appeal.* A hospice program may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

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SOURCE: 45 FR 22937, Apr. 4, 1980, unless otherwise noted.

Subpart A—General Provisions

§ 489.1 Statutory basis.

(a) This part implements section 1866 of the Social Security Act (the Act). Section 1866 of the Act specifies the terms of provider agreements, the grounds for terminating a provider agreement, the circumstances under which payment for new admissions may be denied, and the circumstances under which payment may be withheld for failure to make timely utilization review. The sections of the Act specified in paragraphs (a)(1) through (a)(4) of this section are also pertinent.

(1) Section 1861 of the Act defines the services covered under Medicare and the providers that may be reimbursed for furnishing those services.

(2) Section 1864 of the Act provides for the use of State survey agencies to ascertain whether certain entities meet the conditions of participation.

(3) Section 1865(a)(1) of the Act provides that an entity accredited by a national accreditation body found by the Secretary to satisfy the Medicare conditions of participation, conditions for coverage, or conditions of certification or requirements for participation shall

be treated as meeting those requirements. Section 1865(a)(2) of the Act requires the Secretary to consider when making such a finding, among other things, the national accreditation body's accreditation requirements and survey procedures.

(4) Section 1871 of the Act authorizes the Secretary to prescribe regulations for the administration of the Medicare program.

(b) Although section 1866 of the Act speaks only to providers and provider agreements, the following rules in this part also apply to the approval of supplier entities that, for participation in Medicare, are subject to a determination by CMS on the basis of a survey conducted by the SA or CMS surveyors; or, in lieu of an SA or CMS-conducted survey, accreditation by an accrediting organization whose program has CMS approval in accordance with the requirements of part 488 of this chapter at the time of the accreditation survey and accreditation decision, in accordance with the following:

(1) The definition of immediate jeopardy at § 489.3.

(2) The effective date rules specified in § 489.13.

(3) The requirements specified in § 489.53(a)(2), (13), and (18), related to termination by CMS of participation in Medicare.

(c) Section 1861(o)(7) of the Act requires each HHA to provide CMS with a surety bond.

[75 FR 50418, Aug. 16, 2010, as amended at 80 FR 29839, May 22, 2015]

§ 489.2 Scope of part.

(a) Subpart A of this part sets forth the basic requirements for submittal and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. Subpart C specifies the limitations on allowable charges to beneficiaries for deductibles, coinsurance, copayments, blood, and services that must be part of the provider agreement. Subpart D of this part specifies how incorrect collections are to be handled. Subpart F sets forth the circumstances and procedures for denial of payments for new admissions

and for withholding of payment as an alternative to termination of a provider agreement.

(b) The following providers are subject to the provisions of this part:

- (1) Hospitals.
- (2) Skilled nursing facilities (SNFs).
- (3) Home health agencies (HHAs).
- (4) Clinics, rehabilitation agencies, and public health agencies.
- (5) Comprehensive outpatient rehabilitation facilities (CORFs).
- (6) Hospices.
- (7) Critical access hospital (CAHs).
- (8) Community mental health centers (CMHCs).
- (9) Religious nonmedical health care institutions (RNHCIs).
- (10) Opioid treatment programs (OTPs).
- (11) Rural emergency hospitals (REHs).

(c)(1) Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient physical therapy, and speech pathology services.

(2) CMHCs may enter into provider agreements only to furnish partial hospitalization services and intensive outpatient services.

(3) OTPs may enter into provider agreements only to furnish opioid use disorder treatment services.

[45 FR 22937, Apr. 4, 1980, as amended at 47 FR 56297, Dec. 15, 1982; 48 FR 56036, Dec. 15, 1983; 51 FR 24492, July 3, 1986; 58 FR 30676, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 62 FR 46037, Aug. 29, 1997; 68 FR 66720, Nov. 28, 2003; 84 FR 63204, Nov. 15, 2019; 87 FR 72309, Nov. 23, 2022; 88 FR 82184, Nov. 22, 2023]

§ 489.3 Definitions.

For purposes of this part—

Immediate jeopardy means a situation in which the provider's or supplier's non-compliance with one or more requirements, conditions of participation, conditions for coverage, or conditions for certification has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or patient.

Physician-owned hospital means any participating hospital (as defined in § 489.24) in which a physician, or an immediate family member of a physician (as defined in § 411.351 of this chapter), has an ownership or investment interest

in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital. This definition does not include a hospital with physician ownership or investment interests that satisfy the requirements at § 411.356(a) or (b) of this chapter.

Provider agreement means an agreement between CMS and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.

[48 FR 39837, Sept. 1, 1983, as amended at 51 FR 24492, July 3, 1986; 54 FR 5373, Feb. 2, 1989; 59 FR 56250, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995; 72 FR 47412, Aug. 22, 2007; 73 FR 48757, Aug. 19, 2008; 80 FR 29840, May 22, 2015]

§ 489.10 Basic requirements.

(a) Any of the providers specified in § 489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter. The RNHCIs must meet the conditions for coverage, conditions for participation and the requirements set forth in this section and elsewhere in this chapter. The OTPs must meet the requirements set forth in this section and elsewhere in this chapter.

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;

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(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and beneficiaries of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Age Discrimination Act and 45 CFR part 90; and

(4) Other pertinent requirements of the Office of Civil Rights of HHS.

(c) In order for a hospital, SNF, HHA, hospice, or RNHCI to be accepted, it must also meet the advance directives requirements specified in subpart I of this part.

(d) The State survey agency will ascertain whether the provider meets the conditions of participation or requirements (for SNFs) and make its recommendations to CMS.

(e) In order for a home health agency to be accepted, it must also meet the surety bond requirements specified in subpart F of this part.

(f) In order for a home health agency to be accepted as a new provider, it must also meet the capitalization requirements specified in subpart B of this part.

[58 FR 61843, Nov. 23, 1993, as amended at 59 FR 6578, Feb. 11, 1994; 63 FR 312, Jan. 5, 1998; 68 FR 66720, Nov. 28, 2003; 84 FR 63204, Nov. 15, 2019]

§ 489.11 Acceptance of a provider as a participant.

(a) *Action by CMS.* If CMS determines that the provider meets the requirements, it will send the provider—

(1) Written notice of that determination; and

(2) Two copies of the provider agreement.

(b) *Action by provider.* If the provider wishes to participate, it must return both copies of the agreement, duly signed by an authorized official, to CMS, together with a written statement indicating whether it has been adjudged insolvent or bankrupt in any State or Federal court, or whether any insolvency or bankruptcy actions are pending.

(c) *Notice of acceptance.* If CMS accepts the agreement, it will return one copy to the provider with a written notice that—

(1) Indicates the dates on which it was signed by the provider's representative and accepted by CMS; and

(2) Specifies the effective date of the agreement.

[45 FR 22937, Apr. 4, 1980, as amended at 59 FR 56251, Nov. 10, 1994; 62 FR 43937, Aug. 18, 1997]

§ 489.12 Decision to deny an agreement.

(a) *Bases for denial.* CMS may refuse to enter into an agreement for any of the following reasons:

(1) Principals of the prospective provider have been convicted of fraud (see § 420.204 of this chapter);

(2) The prospective provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter;

(3) The prospective provider is a physician-owned hospital as defined in § 489.3 and does not have procedures in place for making physician ownership disclosures to patients in accordance with § 489.20(u); or

(4) The prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(b) [Reserved]

(c) *Compliance with civil rights requirements.* CMS will not enter into a provider agreement if the provider fails to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90, subject to the provisions of § 489.10.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 34833, Sept. 30, 1986; 54 FR 4027, Jan. 27, 1989; 59 FR 6578, Feb. 11, 1994; 59 FR 56251, Nov. 10, 1994; 72 FR 47413, Aug. 22, 2007]

§ 489.13 Effective date of agreement or approval.

(a) *Applicability*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare are subject to a determination by CMS on the basis of—

(i) A survey conducted by the State survey agency or CMS surveyors; or

(ii) In lieu of such State survey agency or CMS conducted survey, accreditation by an accreditation organization whose program has CMS approval in accordance with section 1865 of the Act at the time of the accreditation survey and accreditation decision.

(2) *Exceptions.* (i) For an agreement with a community mental health center (CMHC) or a federally qualified health center (FQHC), the effective date is the date on which CMS accepts a signed agreement which assures that the CMHC or FQHC meets all Federal requirements.

(ii) A Medicare supplier approval of a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform.

(iii) For an agreement with an opioid treatment program (OTP), the effective date is the effective date of billing as established under § 424.520(d) or § 424.521(a), as applicable.

(b) *All health and safety standards are met on the date of survey.* The agreement or approval is effective on the date the State agency, CMS, or the CMS contractor survey (including the Life Safety Code survey, if applicable) is completed, or on the effective date of the accreditation decision, as applicable, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. (If the agreement or approval is time-limited, the new agreement or approval is effective on the day following the expiration of the current agreement or approval.) However, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met. Federal requirements include, but are not limited to—

(1) Enrollment requirements established in part 424, subpart P, of this chapter. CMS determines, based upon its review and verification of the prospective provider's or supplier's enrollment application, the date on which enrollment requirements have been met;

(2) The requirements identified in §§ 489.10 and 489.12; and

(3) The applicable Medicare health and safety standards, such as the applicable conditions of participation, the requirements for participation, the conditions for coverage, or the conditions for certification.

(c) *All health and safety standards are not met on the date of survey.* If, on the date the survey is completed, the provider or supplier has failed to meet any one of the applicable health and safety standards, the following rules apply for determining the effective date of the provider agreement or supplier approval, assuming that no other Federal requirements remain to be satisfied. However, if other Federal requirements remain to be satisfied, notwithstanding the provisions of paragraphs (c)(1) through (c)(3) of this section, the effective date of the agreement or approval may not be earlier than the latest of the dates on which CMS determines that each applicable Federal requirement is met.

(1) For an agreement with an SNF, the effective date is the date on which—

(i) The SNF is in substantial compliance (as defined in § 488.301 of this chapter) with the requirements for participation; and

(ii) CMS or the State survey agency receives from the SNF, if applicable, an approvable waiver request.

(2) For an agreement with, or an approval of, any other provider or supplier, (except those specified in paragraph (a)(2) of this section), the effective date is the earlier of the following:

(i) The date on which the provider or supplier meets all applicable conditions of participation, conditions for coverage, or conditions for certification; or, if applicable, the date of a CMS-approved accreditation organization program's positive accreditation decision, issued after the accreditation organization has determined that the provider or supplier meets all applicable conditions.

(ii) The date on which a provider or supplier is found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies, and—

(A) CMS or the State survey agency receives an acceptable plan of correction for the lower-level deficiencies

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(the date of receipt is the effective date regardless of when the plan of correction is approved); or, if applicable, a CMS-approved accreditation organization program issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or

(B) CMS receives an approvable waiver request (the date of receipt is the effective date regardless of when CMS approves the waiver request).

(3) For an agreement with any other provider or an approval of any other supplier (except those specified in paragraph (a)(2) of this section) that is found to meet all conditions of participation, conditions for coverage, or conditions for certification, but has lower-level deficiencies and has submitted both an approvable plan of correction/positive accreditation decision and an approvable waiver request, the effective date is the later of the dates that result when calculated in accordance with paragraph (c)(2)(ii)(A) or (c)(2)(ii)(B) of this section.

[75 FR 50418, Aug. 16, 2010, as amended at 84 FR 63204, Nov. 15, 2019]

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) *What constitutes change of ownership*—(1) *Partnership*. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) *Unincorporated sole proprietorship*. Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation*. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) *Leasing*. The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) *Notice to CMS*. A provider who is contemplating or negotiating a change of ownership must notify CMS.

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(c) *Assignment of agreement*. When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) *Conditions that apply to assigned agreements*. An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.

(4) Compliance with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(e) *Effect of leasing*. The provider agreement will be assigned to the lessee only to the extent of the leased portion of the facility.

[45 FR 22937, Apr. 4, 1980, as amended at 59 FR 56251, Nov. 10, 1994]

Subpart B—Essentials of Provider Agreements

§ 489.20 Basic commitments.

The provider agrees to the following:

(a) To limit its charges to beneficiaries and to other individuals on their behalf, in accordance with provisions of subpart C of this part.

(b) To comply with the requirements of subpart D of this part for the return or other disposition of any amounts incorrectly collected from a beneficiary or any other person in his or her behalf.

(c) To comply with the requirements of § 420.203 of this chapter when it hires certain former employees of intermediaries.

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

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(1) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a reasonable charge basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act, that are furnished after December 31, 1990.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(e) In the case of a hospital or CAH that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a QIO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services. The requirement of this paragraph (e) applies only if, for the area in which the hospital or CAH is located, there is a QIO that has a contract with CMS under part B of title XI of the Act.

(f) To maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented.

(g) To bill other primary payers before Medicare.

(h) If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.

(i) If the provider receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim—

(1) To bill Medicare for an amount no greater than would have been payable as secondary payment if the primary insurer's payment had been based on a proper claim; and

(2) To charge the beneficiary only: (i) The amount it would have been entitled to charge if it had filed a proper

claim and received payment based on such a claim; and

(ii) An amount equal to any primary payment reduction attributable to failure to file a proper claim, but only if the provider can show that—

(A) It failed to file a proper claim solely because the beneficiary, for any reason other than mental or physical incapacity, failed to give the provider the necessary information; or

(B) The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than mental or physical incapacity.

(j) In the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, hospitals may bill liability insurers first. However, if the liability insurer does not pay "promptly", as defined in § 411.50 of this chapter, the hospital must withdraw its claim or lien and bill Medicare for covered services.

(k) In the case of home health agencies that provide home health services to Medicare beneficiaries under subpart E of part 409 and subpart C f part 410 of this chapter, to offer to furnish catheters, catheter supplies, ostomy bags, and supplies related to ostomy care to any individual who requires them as part of their furnishing of home health services.

(l) In the case of a hospital as defined in § 489.24(b) to comply with § 489.24.

(m) In the case of a hospital as defined in § 489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of § 489.24(e).

(n) In the case of inpatient hospital services, to participate in any health plan contracted for under 10 U.S.C. 1079 or 1086 or 38 U.S.C. 613, in accordance with § 489.25.

(o) In the case of inpatient hospital services, to admit veterans whose admission has been authorized under 38 U.S.C. 603, in accordance with § 489.26.

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(p) To comply with § 489.27 of this part concerning notification of Medicare beneficiaries of their rights associated with the termination of Medicare services.

(q) In the case of a hospital as defined in § 489.24(b)—

(1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

(r) In the case of a hospital as defined in § 489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan, in accordance with § 489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under § 489.24 in accordance with the resources available to the hospital; and

(3) A central log on each individual who comes to the emergency department, as defined in § 489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of the SNF, except the following:

(1) Physicians' services that meet the criteria of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Services performed under a physician's supervision by a physician assistant who meets the applicable definition in section 1861(aa)(5) of the Act.

(3) Services performed by a nurse practitioner or clinical nurse specialist who meets the applicable definition in section 1861(aa)(5) of the Act and is working in collaboration (as defined in section 1861(aa)(6) of the Act) with a physician.

(4) Services performed by a certified nurse-midwife, as defined in section 1861(gg) of the Act.

(5) Services performed by a qualified psychologist, as defined in section 1861(ii) of the Act.

(6) Services performed by a marriage and family therapist, as defined in section 1861(lll)(2) of the Act.

(7) Services performed by a mental health counselor, as defined in section 1861(lll)(4) of the Act.

(8) Services performed by a certified registered nurse anesthetist, as defined in section 1861(bb) of the Act.

(9) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

(10) Erythropoietin (EPO) for dialysis patients, as defined in section 1861(s)(2)(O) of the Act.

(11) Hospice care, as defined in section 1861(dd) of the Act.

(12) An ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF in connection with one of the circumstances specified in § 411.15(p)(3)(i) through (p)(3)(iv) of this chapter as ending the individual's status as an SNF resident.

(13) The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those electrocardiogram test services furnished during 1998.

(14) Services described in paragraphs (s)(1) through (8) of this section when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act.

(15) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020, J9040–J9151, J9170–J9185, J9200–J9201, J9206–J9208, J9211, J9230–J9245, and J9265–J9600, and as of January 1, 2004, by HCPCS codes A9522, A9523, A9533, and A9534 (as subsequently modified by CMS), and any additional chemotherapy items identified by CMS.

(16) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262, 36489, 36530–36535, 36640, 36823, and 96405–96542 (as subsequently modified by CMS), and any additional chemotherapy administration services identified by CMS.

(17) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440 (as subsequently modified by CMS), and any additional radioisotope services identified by CMS.

(18) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340, L5500–L5611, L5613–L5986, L5988, L6050–L6370, L6400–6880, L6920–L7274, and L7362–L7366 (as subsequently modified by CMS) and any additional customized prosthetic devices identified by CMS, which are delivered for a resident's use during a stay in the SNF and intended to be used by the resident after discharge from the SNF.

(19) Those blood clotting factors indicated for the treatment of patients with hemophilia and other bleeding disorders identified, as of July 1, 2020, by HCPCS codes J7170, J7175, J7177–J7183, J7185–J7190, J7192–J7195, J7198–J7203, J7205, and J7207–J7211 (as subsequently modified by CMS) and items and services related to the furnishing of such factors, and any additional blood clotting factors identified by CMS and items and services related to the furnishing of such factors.

(20) Those RHC and FQHC services that are described in § 405.2411(b)(2) of this chapter.

(t) Hospitals that are not otherwise subject to the Occupational Safety and

Health Act of 1970 (or a State occupational safety and health plan that is approved under section 18(b) of the Occupational Safety and Health Act) must comply with the bloodborne pathogens (BBP) standards under 29 CFR 1910.1030. A hospital that fails to comply with the BBP standards may be subject to a civil money penalty in accordance with section 17 of the Occupational Safety and Health Act of 1970, including any adjustments of the civil money penalty amounts under the Federal Civil Penalties Inflation Adjustment Act, for a violation of the BBP standards. A civil money penalty will be imposed and collected in the same manner as civil money penalties under section 1128A(a) of the Social Security Act.

(u) Except as provided in paragraph (v) of this section, in the case of a physician-owned hospital as defined at § 489.3—

(1) To furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care, in accordance with § 482.13(b)(2) of this subchapter. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a physician-owned hospital specified in § 489.3 and that the list of the hospital's owners or investors who are physicians or immediate family members (as defined at § 411.351 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(2) To require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment

interest in the hospital that is held by the physician or by an immediate family member (as defined at §411.351 of this chapter) of the physician. Disclosure must be required at the time the referral is made.

(v) The requirements of paragraph (u) of this section do not apply to any physician-owned hospital that does not have at least one referring physician (as defined at §411.351 of this chapter) who has an ownership or investment interest in the hospital or who has an immediate family member who has an ownership or investment interest in the hospital, provided that such hospital signs an attestation statement to that effect and maintains such attestation in its records.

(w)(1) In the case of a hospital as defined in §489.24(b), to furnish written notice to all patients at the beginning of their planned or unplanned inpatient hospital stay or at the beginning of any planned or unplanned outpatient visit for observation, surgery or any other procedure requiring anesthesia, if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with §482.13(b)(2) of this subchapter. For purposes of this paragraph, a planned hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service. An unplanned hospital stay or outpatient visit begins at the earliest point at which the patient presents to the hospital.

(2) In the case of a hospital that is a main provider and has one or more remote locations of a hospital or one or more satellites, as these terms are defined in §413.65(a)(2), §412.22(h), or §412.25(e) of this chapter, as applicable, the determination is made separately for the main provider and each remote location or satellite whether notice to patients is required. Notice is required at each location at which inpatient services are furnished at which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week.

(3) The written notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in §489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital.

(4) Before admitting a patient or providing an outpatient service to outpatients for whom a notice is required, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a doctor of medicine or doctor of osteopathy may not be present during all hours services are furnished to the patient.

(5) Each dedicated emergency department, as that term is defined in §489.24(b), in a hospital in which a doctor of medicine or doctor of osteopathy is not present 24 hours per day, 7 days per week must post a notice conspicuously in a place or places likely to be noticed by all individuals entering the dedicated emergency department. The posted notice must state that the hospital does not have a doctor of medicine or a doctor of osteopathy present in the hospital 24 hours per day, 7 days per week, and must indicate how the hospital will meet the medical needs of any patient with an emergency medical condition, as defined in §489.24(b), at a time when there is no doctor of medicine or doctor of osteopathy present in the hospital.

(x) To comply with §488.30 of this chapter, to pay revisit user fees when and if assessed.

(y) In the case of a hospital or critical access hospital, to provide notice, as specified in paragraphs (y)(1) and (2) of this section, to each individual entitled to Medicare benefits under Title XVIII of the Act when such individual receives observation services as an outpatient for more than 24 hours. Notice must be provided to the individual not later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted. Notice may be provided before such individual receives 24 hours

of observation services as an outpatient.

(1) *Written notice.* Hospitals and critical access hospitals must use a standardized written notice, as specified by the Secretary, which includes the following information:

(i) An explanation of the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reason for status as an outpatient receiving observation services; and

(ii) An explanation of the implications of such status as an outpatient on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as Medicare cost-sharing requirements, and subsequent eligibility for Medicare coverage for skilled nursing facility services.

(2) *Oral notice.* The hospital must give an oral explanation of the written notification described in paragraph (y)(1) of this section.

(3) *Signature requirements.* The written notice specified in paragraph (y)(1) of this section must either—

(i) Be signed by the individual who receives observation services as an outpatient or a person acting on the individual's behalf to acknowledge receipt of such notification; or

(ii) If the individual who receives observation services as an outpatient or the person acting on behalf of the individual refuses to provide the signature described in paragraph (y)(1) of this section, is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented.

[45 FR 22937, Apr. 4, 1980]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 489.20, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, § 489.20(1) through (r) were added. Paragraphs (m), (r)(2), and (r)(3) of this section contain information collection and recordkeeping requirements and will not be-

come effective until approval has been given by the Office of Management and Budget.

§ 489.21 Specific limitations on charges.

Except as specified in subpart C of this part, the provider agrees not to charge a beneficiary for any of the following:

(a) Services for which the beneficiary is entitled to have payment made under Medicare.

(b) Services for which the beneficiary would be entitled to have payment made if the provider—

(1) Had in its files the required certification and recertification by a physician relating to the services furnished to the beneficiary;

(2) Had furnished the information required by the intermediary in order to determine the amount due the provider on behalf of the individual for the period with respect to which payment is to be made or any prior period;

(3) Had complied with the provisions requiring timely utilization review of long stay cases so that a limitation on days of service has not been imposed under section 1866(d) of the Act (see subpart K of part 405 and part 482 of this chapter for utilization review requirements); and

(4) Had obtained, from the beneficiary or a person acting on his or her behalf, a written request for payment to be made to the provider, and had properly filed that request. (If the beneficiary or person on his or her behalf refuses to execute a written request, the provider may charge the beneficiary for all services furnished to him or her.)

(c) Inpatient hospital services furnished to a beneficiary who exhausted his or her Part A benefits, if CMS reimburses the provider for those services.

(d) Custodial care and services not reasonable and necessary for the diagnosis or treatment of illness or injury, if—

(1) The beneficiary was without fault in incurring the expenses; and

(2) The determination that payment was incorrect was not made until after the third year following the year in which the payment notice was sent to the beneficiary.

(e) Inpatient hospital services for which a beneficiary would be entitled

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to have payment made under Part A of Medicare but for a denial or reduction in payments under regulations at § 412.48 of this chapter or under section 1886(f) of the Act.

(f) Items and services furnished to a hospital inpatient (other than physicians' services as described in § 415.102(a) of this chapter or the services of an anesthetist as described in § 405.553(b)(4) of this chapter) for which Medicare payment would be made if furnished by the hospital or by other providers or suppliers under arrangements made with them by the hospital. For this purpose, a charge by another provider or supplier for such an item or service is treated as a charge by the hospital for the item or service, and is also prohibited.

(g) [Reserved]

(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 in-

ability 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 nonhospital-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 absence 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(mm)(1) of the Act and a rural emergency hospital as defined in section 1861(kkk)(2).

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:

- (i) A hospital;
- (ii) 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; or
- (iii) A rural emergency hospital as defined in section 1861(kkk)(2) 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 nonphysician 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 physician (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 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.

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(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; 78 FR 50971, Aug. 19, 2013; 87 FR 72309, Nov. 23, 2022]

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, § 489.24 was added. Paragraphs (d) and (g) of this section 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

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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,” at the time of application submission and at all times during the enrollment process up to the expiration of the 3-month period following the conveyance

of Medicare billing privileges to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor, exclusive of actual or projected accounts receivable from Medicare.

(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 submitted cost reports for the first full year of operation from at least three HHAs that the intermediary serves that are comparable to the HHA that is seeking to enter the Medicare program, considering such factors as geographic location and urban/rural status, number of visits, provider-based versus free-standing, and proprietary versus non-proprietary status. The determination of the adequacy of the required initial reserve operating funds is based on the average cost per visit of the comparable HHAs, by dividing the sum of total reported costs of the HHAs in their first year of operation by the sum of the HHAs' total reported visits. The resulting average cost per visit is then multiplied by the projected visits for the first three months of operation of the HHA seeking to enter the program, but not less than 90 percent of average visits for a three month period for the HHAs used in determining the average cost per visit.

(1) In selecting the comparative HHAs as described in this paragraph (c), the CMS contractor shall only select HHAs that have provided cost reports to Medicare. When selecting cost reports for the comparative analysis, CMS will exclude low utilization or no utilization cost reports.

(2) [Reserved]

(d) *Required proof of availability of initial reserve operating funds.* The HHA must provide CMS with adequate proof of the availability of initial reserve operating funds. Such proof, at a minimum, will include a copy of the statement(s) of the HHA's savings, checking, or other account(s) that contains the funds, accompanied by an attestation from an officer of the bank or other financial institution (if the financial institution offers such attestations) that the funds are in the account(s) and that the funds are immediately available to the HHA. In some cases, an HHA may have all or part of the initial reserve operating funds in cash equivalents. For the purpose of this section, cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and that present insignificant risk of changes in value. A cash equivalent that is not readily convertible to a known amount of cash as needed during the initial 3-month period for which the initial reserve operating funds are required does not qualify in meeting the initial reserve operating funds requirement. Examples of cash equivalents for the purpose of this section are Treasury bills, commercial paper, and money market funds. As with funds in a checking, savings, or other account, the HHA also must be able to document the availability of any cash equivalents. CMS later may require the HHA to furnish another attestation from the financial institution that the funds remain available, or, if applicable, documentation from the HHA that any cash equivalents remain available, until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization. The officer of the HHA who will be certifying the accuracy of the information on the HHA's cost report must certify what portion of the required initial reserve operating funds is non-borrowed funds, including funds invested in the business by the owner. That amount must be at least 50 percent of the required initial reserve operating funds. The remainder of the reserve operating funds may be secured through borrowing or line of credit from an unrelated lender.

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(e) *Borrowed funds.* If borrowed funds are not in the same account(s) as the HHA's own non-borrowed funds, the HHA also must provide proof that the borrowed funds are available for use in operating the HHA, by providing, at a minimum, a copy of the statement(s) of the HHA's savings, checking, or other account(s) containing the borrowed funds, accompanied by an attestation from an officer of the bank or other financial institution (if the financial institution offers such attestations) that the funds are in the account(s) and are immediately available to the HHA. As with the HHA's own (that is, non-borrowed) funds, CMS later may require the HHA to establish the current availability of such borrowed funds, including furnishing an attestation from a financial institution or other source, as may be appropriate, and to establish that such funds will remain available until a date when the HHA will have been surveyed by the State agency or by an approved accrediting organization.

(f) *Line of credit.* If the HHA chooses to support the availability of a portion of the initial reserve operating funds with a line of credit, it must provide CMS with a letter of credit from the lender. CMS later may require the HHA to furnish an attestation from the lender that the HHA, upon its certification into the Medicare program, continues to be approved to borrow the amount specified in the letter of credit.

(g) *Billing Privileges.* (1) CMS may deny Medicare billing privileges to an HHA unless the HHA meets the initial reserve operating funds requirements of this section.

(2) CMS may revoke the Medicare billing privileges of an HHA that fails to maintain and comply with the initial reserve operating funds requirements of this section for the three-month period after it receives its Medicare billing privileges.

[63 FR 312, Jan. 5, 1998, as amended at 75 FR 70465, Nov. 17, 2010; 86 FR 62430, Nov. 9, 2021]

§ 489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, and urban Indian organization health programs.

(a) Hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act) that participate in the Medicare program and furnish inpatient hospital services must accept the payment methodology and no more than the rates of payment established under 42 CFR part 136, subpart D as payment in full for the following programs:

(1) A contract health service (CHS) program under 42 CFR part 136, subpart C, of the Indian Health Service (IHS);

(2) A CHS program under 42 CFR part 136, subpart C, carried out by an Indian Tribe or Tribal organization pursuant to the Indian Self-Determination and Education Assistance Act, as amended, Public Law 93–638, 25 U.S.C. 450 *et seq.*; and

(3) A program funded through a grant or contract by the IHS and operated by an urban Indian organization under which items and services are purchased for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603 (f) and (h)).

(b) Hospitals and critical access hospitals may not refuse service to an individual on the basis that the payment for such service is authorized under programs described in paragraph (a) of this section.

[72 FR 30711, June 4, 2007]

Subpart C—Allowable Charges

§ 489.30 Allowable charges: Deductibles and coinsurance.

(a) *Part A deductible and coinsurance.* The provider may charge the beneficiary or other person on his or her behalf:

(1) The amount of the inpatient hospital deductible or, if less, the actual charges for the services;

(2) The amount of inpatient hospital coinsurance applicable for each day the individual is furnished inpatient hospital services after the 60th day, during a benefit period; and

(3) The posthospital SNF care coinsurance amount.

(4) In the case of durable medical equipment (DME) furnished as a home health service, 20 percent of the customary charge for the service.

(b) *Part B deductible and coinsurance.*

(1) The basic allowable charges are the Part B annual deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible, except as specified in paragraphs (b)(6) and (7) of this section.

(2) For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary's deductible status.

(i) If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to \$75.

(ii) If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

(3) In either of the cases discussed in paragraph (b)(2) of this section, the hospital is required to file with the intermediary, on a form prescribed by CMS, information as to the services, charges, and amounts collected.

(4) The intermediary must reimburse the beneficiary if reimbursement is authorized and credit the expenses to the beneficiary's deductible if the deductible has not yet been met.

(5) In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the customary (insofar as reasonable) charge for the services, with the following exception: If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.

(6) In the case of a rebatable drug (as defined in section 1847A(i)(2)(A) of the Act), including a selected drug (as defined in section 1192(c) of the Act), furnished on or after April 1, 2023, in a calendar quarter in which the payment amount for such drug as specified in section 1847A(i)(3)(A)(i)(I)(aa) or (bb), as applicable, exceeds the inflation-adjusted amount (as defined in section 1847A(i)(3)(C) of the Act) for such drug,

the basic allowable charges are the Part B annual deductible and 20 percent of the inflation-adjusted payment amount for the rebatable drug in excess of that deductible, which is applied as a percent to the payment amount for such calendar quarter.

(7) In the case of insulin furnished on or after July 1, 2023 through an item of durable medical equipment covered under section 1861(n) of the Act, the coinsurance amount shall not exceed \$35 for a month's supply of such insulin each calendar month. This limitation on the coinsurance amount shall apply for the duration of the calendar month in which the date of service (or services) occurs. In addition, the coinsurance amount shall not exceed \$105.00 for 3 months' supply of insulin. This limitation on the coinsurance amount shall apply for the duration of the calendar month in which the date of service (or services) occurs and the 2 following calendar months.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 41350, Nov. 14, 1986; 88 FR 79552, Nov. 16, 2023]

§ 489.31 Allowable charges: Blood.

(a) *Limitations on charges.* (1) A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished under Medicare Part A during a calendar year, or furnished under Medicare Part B during a calendar year.

(2) The charges may not exceed the provider's customary charges.

(3) The provider may not charge for any whole blood or packed red cells in any of the circumstances specified in § 409.87(c)(2) of this chapter.

(b) *Offset for excessive charges.* If the charge exceeds the cost to the provider, that excess will be deducted from any Medicare payments due the provider.

[56 FR 23022, May 20, 1991, as amended at 57 FR 36018, Aug. 12, 1992]

§ 489.32 Allowable charges: Non-covered and partially covered services.

(a) *Services requested by beneficiary.* If services furnished at the request of a

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beneficiary (or his or her representative) are more expensive than, or in excess of, services covered under Medicare—

(1) A provider may charge the beneficiary an amount that does not exceed the difference between—

(i) The provider's customary charges for the services furnished; and

(ii) The provider's customary charges for the kinds and amounts of services that are covered under Medicare.

(2) A provider may not charge for the services unless they have been requested by the beneficiary (or his or her representative) nor require a beneficiary to request services as a condition of admission.

(3) To avoid misunderstanding and disputes, a provider must inform any beneficiary who requests a service for which a charge will be made that there will be a specified charge for that service.

(b) *Services not requested by the beneficiary.* For special provisions that apply when a provider customarily furnishes more expensive services, see § 413.35 of this chapter.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 34833, Sept. 30, 1986]

§ 489.34 Allowable charges: Hospitals participating in State reimbursement control systems or demonstration projects.

A hospital receiving payment for a covered hospital stay under either a State reimbursement control system approved under 1886(c) of the Act or a demonstration project authorized under section 402(a) of Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1 (note)) and that would otherwise be subject to the prospective payment system set forth in part 412 of this chapter may charge a beneficiary for noncovered services as follows:

(a) For the custodial care and medically unnecessary services described in § 412.42(c) of this chapter, after the conditions of § 412.42(c)(1) through (c)(4) are met; and

(b) For all other services in accordance with the applicable rules of this subpart C.

[54 FR 41747, Oct. 11, 1989]

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§ 489.35 Notice to intermediary.

The provider must inform its intermediary of any amounts collected from a beneficiary or from other persons on his or her behalf.

Subpart D—Handling of Incorrect Collections

§ 489.40 Definition of incorrect collection.

(a) As used in this subpart, “incorrect collections” means any amounts collected from a beneficiary (or someone on his or her behalf) that are not authorized under subpart C of this part.

(b) A payment properly made to a provider by an individual not considered entitled to Medicare benefits will be deemed to be an “incorrect collection” when the individual is found to be retroactively entitled to benefits.

§ 489.41 Timing and methods of handling.

(a) *Refund.* Prompt refund to the beneficiary or other person is the preferred method of handling incorrect collections.

(b) *Setting aside.* If the provider cannot refund within 60 days from the date on the notice of incorrect collection, it must set aside an amount, equal to the amount incorrectly collected, in a separate account identified as to the individual to whom the payment is due. This amount incorrectly collected must be carried on the provider's records in this manner until final disposition is made in accordance with the applicable State law.

(c) *Notice to, and action by, intermediary.* (1) The provider must notify the intermediary of the refund or setting aside required under paragraphs (a) and (b) of this section.

(2) If the provider fails to refund or set aside the required amounts, they may be offset against amounts otherwise due the provider.

§ 489.42 Payment of offset amounts to beneficiary or other person.

(a) In order to carry out the commitment to refund amounts incorrectly collected, CMS may determine that amounts offset in accordance with § 489.41 are to be paid directly to the

beneficiary or other person from whom the provider received the incorrect collection, if:

(1) CMS finds that the provider has failed, following written request, to refund the amount of the incorrect collection to the beneficiary or other person; and

(2) The provider agreement has been terminated in accordance with the provisions of subpart E of this part.

(b) Before making a determination to make payment under paragraph (a) of this section, CMS will give written notice to the provider (1) explaining that an incorrect collection was made and the amount; (2) requesting the provider to refund the incorrect collection to the beneficiary or other person; and (3) advising of CMS's intention to make a determination under paragraph (a) of this section.

(c) The notice will afford an authorized official of the provider an opportunity to submit, within 20 days from the date on the notice, written statement or evidence with respect to the incorrect collection and/or offset amounts. CMS will consider any written statement or evidence in making a determination.

(d) Payment to a beneficiary or other person under the provisions of paragraph (a) of this section:

(1) Will not exceed the amount of the incorrect collection; and

(2) May be considered as payment made to the provider.

Subpart E—Termination of Agreement and Reinstatement After Termination

§ 489.52 Termination by the provider.

(a) *Notice to CMS.* (1) A provider that wishes to terminate its agreement, except for a SNF as specified in paragraph (a)(2) of this section, must send CMS written notice of its intention in accordance with paragraph (a)(3) of this section.

(2) A SNF that wishes to terminate its agreement due to closure of the facility must send CMS written notice of its intention at least 60 days prior to the date of closure, as required at § 483.70(1) of this chapter.

(3) The notice may state the intended date of termination which must be the first day of the month.

(b) *Termination date.* (1) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the provider's notice of intent.

(2) CMS may accept a termination date that is less than 6 months after the date on the provider's notice if it determines that to do so would not unduly disrupt services to the community or otherwise interfere with the effective and efficient administration of the Medicare program.

(3) A cessation of business is deemed to be a termination by the provider, effective with the date on which it stopped providing services to the community.

(4) A provider may request a retroactive termination date if no Medicare beneficiary received services from the facility on or after the requested termination date.

(c) *Public notice.* (1) The provider must give notice to the public at least 15 days before the effective date of termination.

(2) The notice must—

(i) Specify the termination date; and

(ii) Explain to what extent services may continue after that date, in accordance with the exceptions set forth in § 489.55.

[45 FR 22937, Apr. 4, 1980, as amended at 76 FR 9512, Feb. 18, 2011; 81 FR 68872, Oct. 4, 2016; 82 FR 38516, Aug. 14, 2017; 88 FR 77880, Nov. 13, 2023]

§ 489.53 Termination by CMS.

(a) *Basis for termination of agreement.* CMS may terminate the agreement with any provider if CMS finds that any of the following failings is attributable to that provider, and may, in addition to the applicable requirements in this chapter governing the termination of agreements with suppliers, terminate the agreement with any supplier to which the failings in paragraphs (a)(2), (13) and (18) of this section are attributable:

(1) It is not complying with the provisions of title XVIII and the applicable regulations of this chapter or with the provisions of the agreement.

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(2) The provider or supplier places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care.

(3) It no longer meets the appropriate conditions of participation or requirements (for SNFs and NFs) set forth elsewhere in this chapter. In the case of an RNHCI, it no longer meets the conditions for coverage, conditions of participation and requirements set forth elsewhere in this chapter. In the case of an OTP, it no longer meets the requirements set forth in this section and elsewhere in this chapter.

(4) It fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due.

(5) It refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for payment under Medicare.

(6) It failed to furnish information on business transactions as required in § 420.205 of this chapter.

(7) It failed at the time the agreement was entered into or renewed to disclose information on convicted individuals as required in § 420.204 of this chapter.

(8) It failed to furnish ownership information as required in § 420.206 of this chapter.

(9) It failed to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90.

(10) In the case of a hospital or a critical access hospital as defined in section 1861(mm)(1) of the Act that has reason to believe it may have received an individual transferred by another hospital in violation of § 489.24(d), the hospital failed to report the incident to CMS or the State survey agency.

(11) In the case of a hospital requested to furnish inpatient services to CHAMPUS or CHAMPVA beneficiaries or to veterans, it failed to comply with § 489.25 or § 489.26, respectively.

(12) It failed to furnish the notice of discharge rights as required by § 489.27.

(13) The provider or supplier refuses to permit copying of any records or

other information by, or on behalf of, CMS, as necessary to determine or verify compliance with participation requirements.

(14) The hospital knowingly and willfully fails to accept, on a repeated basis, an amount that approximates the Medicare rate established under the inpatient hospital prospective payment system, minus any enrollee deductibles or copayments, as payment in full from a fee-for-service FEHB plan for inpatient hospital services provided to a retired Federal enrollee of a fee-for-service FEHB plan, age 65 or older, who does not have Medicare Part A benefits.

(15) It had its enrollment in the Medicare program revoked in accordance to § 424.535 of this chapter.

(16) It has failed to pay a revisit user fee when and if assessed.

(17) In the case of an HHA or hospice program, it failed to correct any deficiencies within the required time frame.

(18) The provider or supplier fails to grant immediate access upon a reasonable request to a state survey agency or other authorized entity for the purpose of determining, in accordance with § 488.3, whether the provider or supplier meets the applicable requirements, conditions of participation, conditions for coverage, or conditions for certification.

(b) *Termination of agreements with certain hospitals.* In the case of a hospital or critical access hospital that has an emergency department, as defined in § 489.24(b), CMS may terminate the provider agreement if—

(1) The hospital fails to comply with the requirements of § 489.24 (a) through (e), which require the hospital to examine, treat, or transfer emergency medical condition cases appropriately, and require that hospitals with specialized capabilities or facilities accept an appropriate transfer; or

(2) The hospital fails to comply with § 489.20(m), (q), and (r), which require the hospital to report suspected violations of § 489.24(e), to post conspicuously in emergency departments or in a place or places likely to be noticed by all individuals entering the emergency departments, as well as those individuals waiting for examination and

treatment in areas other than traditional emergency departments, (that is, entrance, admitting area, waiting room, treatment area), signs specifying rights of individuals under this subpart, to post conspicuously information indicating whether or not the hospital participates in the Medicaid program, and to maintain medical and other records related to transferred individuals for a period of 5 years, a list of on-call physicians for individuals with emergency medical conditions, and a central log on each individual who comes to the emergency department seeking assistance.

(c) *Termination of agreements with hospitals that fail to make required disclosures.* In the case of a physician-owned hospital, as defined at § 489.3, CMS may terminate the provider agreement if the hospital failed to comply with the requirements of § 489.20(u) or (w). In the case of other participating hospitals, as defined at § 489.24, CMS may terminate the provider agreement if the participating hospital failed to comply with the requirements of § 489.20(w).

(d) *Notice of termination—(1) Timing: basic rule.* Except as provided in paragraphs (d)(2) and (d)(3) of this section, CMS gives the provider notice of termination at least 15 days before the effective date of termination of the provider agreement.

(2) *Timing exceptions: Immediate jeopardy situations—(i) Hospitals.* If CMS finds that a hospital is in violation of § 489.24(a) through (f), and CMS determines that the violation poses immediate jeopardy to the health or safety of individuals who present themselves to the hospital for emergency services, CMS—

(A) Gives the hospital a preliminary notice indicating that its provider agreement will be terminated in 23 days if it does not correct the identified deficiencies or refute the finding; and

(B) Gives a final notice of termination, and concurrent notice to the public, at least 2, but not more than 4, days before the effective date of termination of the provider agreement.

(ii) *Skilled nursing facilities (SNFs).* For an SNF with deficiencies that pose immediate jeopardy to the health or safety of residents, CMS gives notice at

least 2 days before the effective date of termination of the provider agreement.

(iii) *Home health agencies (HHAs).* For an HHA with deficiencies that pose immediate jeopardy to the health and safety of patients, CMS gives notice to the HHA at least 2 days before the effective date of termination of the provider agreement.

(3) *Notice of LTC facility closure.* In the case of a facility where CMS terminates a facility's participation under Medicare or Medicaid in the absence of immediate jeopardy, CMS determines the appropriate date for notification.

(4) *Content of notice.* The notice states the reasons for, and the effective date of, the termination, and explains the extent to which services may continue after that date, in accordance with § 489.55.

(5) *Notice to public.* CMS concurrently gives notice of the termination to the public.

(e) *Appeal by the provider.* A provider may appeal the termination of its provider agreement by CMS in accordance with part 498 of this chapter.

[51 FR 24492, July 3, 1986]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 489.53, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

§ 489.54 Termination by the OIG.

(a) *Basis for termination.* (1) The OIG may terminate the agreement of any provider if the OIG finds that any of the following failings can be attributed to that provider.

(i) It has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application or request for payment under Medicare.

(ii) It has submitted, or caused to be submitted, requests for Medicare payment of amounts that substantially exceed the costs it incurred in furnishing the services for which payment is requested.

(iii) It has furnished services that the OIG has determined to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care. The OIG will not terminate a provider agreement under paragraph (a) if

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CMS has waived a disallowance with respect to the services in question on the grounds that the provider and the beneficiary could not reasonably be expected to know that payment would not be made. (The rules for determining such lack of knowledge are set forth in §§ 405.330 through 405.334 of this chapter.)

(b) *Notice of termination.* The OIG will give the provider notice of termination at least 15 days before the effective date of termination of the agreement, and will concurrently give notice of termination to the public.

(c) *Appeal by the provider.* A provider may appeal a termination of its agreement by the OIG in accordance with subpart O of part 405 of this chapter.

(d) *Other applicable rules.* The termination of a provider agreement by the OIG is subject to the additional procedures specified in §§ 1001.105 through 1001.109 of this title for notice and appeals.

[51 FR 24492, July 3, 1986, as amended at 51 FR 34788, Sept. 30, 1986]

§ 489.55 Exceptions to effective date of termination.

(a) Payment is available for up to 30 days after the effective date of termination for:

(1) Inpatient hospital services (including inpatient psychiatric hospital services) and post hospital extended care services (except as specified in paragraph (b) of this section with respect to LTC facilities) furnished to a beneficiary who was admitted before the effective date of termination; and

(2) Home health services and hospice care furnished under a plan established before the effective date of termination.

(b) The Secretary may, as the Secretary determines is appropriate, continue to make payments with respect to residents of a long-term care facility that has submitted a notification of closure as required at § 483.70(1) of this chapter during the period beginning on the date such notification is submitted and ending on the date on which the residents are successfully relocated.

[76 FR 9512, Feb. 18, 2011, as amended at 78 FR 16805, Mar. 19, 2013; 81 FR 68872, Oct. 4, 2016]

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§ 489.57 Reinstatement after termination.

When a provider agreement has been terminated by CMS under § 489.53, or by the OIG under § 489.54, a new agreement with that provider will not be accepted unless CMS or the OIG, as appropriate, finds—

(a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

[51 FR 24493, July 3, 1986]

Subpart F—Surety Bond Requirements for HHAs

SOURCE: 63 FR 313, Jan. 5, 1998, unless otherwise noted.

§ 489.60 Definitions.

As used in this subpart unless the context indicates otherwise—

Assessment means a sum certain that CMS may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that CMS has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Participating home health agency means a “home health agency” (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a “provider” set forth at § 400.202 of this chapter.

Rider means a notice issued by a Surety that a change in the bond has occurred or will occur.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided

the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by CMS on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, after the HHA or Surety has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an *unpaid civil money penalty or assessment* also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

Unpaid claim means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency's notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or compromised by, CMS) and is not the subject of a written arrangement, acceptable to CMS, for payment by the HHA. In the event a written arrangement for payment, acceptable to CMS, is made, an *unpaid claim* also means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA's default on such arrangement.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.61 Basic requirement for surety bonds.

Except as provided in § 489.62, each HHA that is a Medicare participating HHA, or that seeks to become a Medicare participating HHA, must obtain a surety bond (and furnish to CMS a copy of such surety bond) that meets the requirements of this subpart F and CMS's instructions.

§ 489.62 Requirement waived for Government-operated HHAs.

An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided CMS with a comparable surety bond

under State law, and CMS therefore waives the requirements of this subpart with respect to such an HHA if, during the preceding 5 years the HHA has—

(a) Not had any unpaid claims or unpaid civil money penalties or assessments; and

(b) Not had any of its claims referred by CMS to the Department of Justice or the General Accounting Office in accordance with part 401 of this chapter.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.63 Parties to the bond.

The surety bond must name the HHA as Principal, CMS as Obligee, and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety.

§ 489.64 Authorized Surety and exclusion of surety companies.

(a) An HHA may obtain a surety bond required under § 489.61 only from an authorized Surety.

(b) An authorized Surety is a surety company that—

(1) Has been issued a Certificate of Authority by the U.S. Department of the Treasury in accordance with 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225 as an acceptable surety on Federal bonds and the Certificate has neither expired nor been revoked; and

(2) Has not been determined by CMS to be an unauthorized Surety for the purpose of an HHA obtaining a surety bond under this section.

(c) CMS determines that a surety company is an unauthorized Surety under this section—

(1) If, upon request by CMS, the surety company fails to furnish timely confirmation of the issuance of, and the validity and accuracy of information appearing on, a surety bond an HHA presents to CMS that shows the surety company as Surety on the bond;

(2) If, upon presentation by CMS to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond, the surety company fails to timely pay CMS in full the amount requested, up to the face amount of the bond; or

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(3) For other good cause.

(d) Any determination CMS makes under paragraph (c) of this section is effective immediately when notice of the determination is published in the FEDERAL REGISTER and remains in effect until a notice of reinstatement is published in the FEDERAL REGISTER.

(e) Any determination CMS makes under paragraph (c) of this section does not affect the Surety's liability under any surety bond issued by a surety company to an HHA before notice of such determination is published in accordance with paragraph (d) of this section.

(f) A determination by CMS that a surety company is an unauthorized Surety under this section is not a debarment, suspension, or exclusion for the purposes of Executive Order No. 12549 (3 CFR, 1986 comp., p. 189).

§ 489.65 Amount of the bond.

(a) *Basic rule.* The amount of the surety bond must be \$50,000 or 15 percent of the Medicare payments made by CMS to the HHA in the HHA's most recent fiscal year for which a cost report has been accepted by CMS, whichever is greater.

(b) *Computation of the 15 percent: Participating HHA.* The 15 percent is computed as follows:

(1) For the initial bond—on the basis of Medicare payments made by CMS to the HHA in the HHA's most recent fiscal year as shown in the HHA's most recent cost report that has been accepted by CMS. If the initial bond will cover less than a full fiscal year, the computation of the 15 percent will be based on the number of months of the fiscal year that the bond will cover.

(2) For subsequent bonds—on the basis of Medicare payments made by CMS in the most recent fiscal year for which a cost report has been accepted. However, if payments in the first six months of the current fiscal year differ from such an amount by more than 25 percent, then the amount of the bond is 15 percent of such payments projected on an annualized basis.

(c) *Computation of 15 percent: An HHA that seeks to become a participating HHA by obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA by purchasing the

assets or the ownership interest of a participating or formerly participating HHA, the 15 percent is computed on the basis of Medicare payments made by CMS to the participating or formerly participating HHA in the most recent fiscal year that a cost report has been accepted.

(d) *Change of ownership.* For an HHA that undergoes a change of ownership the 15 percent is computed on the basis of Medicare payments made by CMS to the HHA for the most recently accepted cost report.

(e) *An HHA that seeks to become a participating HHA without obtaining assets or ownership interest.* For an HHA that seeks to become a participating HHA without purchasing the assets or the ownership interest of a participating or formerly participating HHA, the 15 percent computation does not apply.

(f) *Exception to the basic rule.* If an HHA's overpayment in the most recently accepted cost report exceeds 15 percent of annual payments, CMS may require the HHA to secure a bond in an amount up to or equal to the amount of overpayment, provided the amount of the bond is not less than \$50,000.

(g) *Expiration of the 15 percent provision.* For an annual surety bond, or for a rider on a continuous surety bond, that is required to be submitted on or after June 1, 2005, notwithstanding any reference in this subpart to 15 percent as a basis for determining the amount of the bond, the amount of the bond or rider, as applicable, must be \$50,000 or such amount as CMS specifies in accordance with paragraph (f) of this section, whichever amount is greater.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.66 Additional requirements of the surety bond.

The surety bond that an HHA obtains under this subpart must meet the following additional requirements:

(a) The bond must guarantee that within 30 days of receiving written notice from CMS of an unpaid claim or unpaid civil money penalty or assessment, which notice contains sufficient evidence to establish the Surety's liability under the bond, the Surety will pay CMS, up to the stated amount of the bond—

(1) The full amount of any unpaid claim, plus accrued interest, for which the HHA is responsible; and

(2) The full amount of any unpaid civil money penalty or assessment imposed by CMS on the HHA, plus accrued interest.

(b) The bond must provide the following:

(1) The Surety is liable for unpaid claims, unpaid civil money penalties, and unpaid assessments that are discovered when the surety bond is in effect, regardless of when the payment, overpayment, or other event giving rise to the claim, civil money penalty, or assessment occurred, provided CMS makes a written demand for payment from the Surety during, or within 90 days after, the term of the bond.

(2) If the HHA fails to furnish a bond meeting the requirements of this subpart F for the year following expiration of the term of an annual bond, or if the HHA fails to submit a rider when a rider is required to be submitted under this subpart, or if the HHA's provider agreement is terminated, the last bond or rider, as applicable, submitted by the HHA to CMS, which bond or applicable rider meets the requirements of this subpart, remains effective and the Surety remains liable for unpaid claims, civil money penalties, and assessments that—

(i) CMS determines or imposes on or asserts against the HHA based on overpayments or other events that took place during or prior to the term of the last bond or rider; and

(ii) Were determined or imposed during the 2 years following the date the HHA failed to submit a bond or required rider or the date the HHA's provider agreement is terminated, whichever is later.

(c) The bond must provide that the Surety's liability to CMS under the bond is not extinguished by any action of the HHA, the Surety, or CMS, including but not necessarily limited to any of the following actions:

(1) Action by the HHA or the Surety to terminate or limit the scope or term of the bond. The Surety's liability may be extinguished, however, when—

(i) The Surety furnishes CMS with notice of such action not later than 10 days after receiving notice from the

HHA of action by the HHA to terminate or limit the scope of the bond, or not later than 60 days before the effective date of such action by the Surety; or

(ii) The HHA furnishes CMS with a new bond that meets the requirements of this subpart.

(2) The Surety's failure to continue to meet the requirements of § 489.64(a) or CMS's determination that the surety company is an unauthorized Surety under § 489.64(b).

(3) Termination of the HHA's provider agreement.

(4) Any action by CMS to suspend, offset, or otherwise recover payments to the HHA.

(5) Any action by the HHA to—

(i) Cease operation;

(ii) Sell or transfer any asset or ownership interest;

(iii) File for bankruptcy; or

(iv) Fail to pay the Surety.

(6) Any fraud, misrepresentation, or negligence by the HHA in obtaining the surety bond or by the Surety (or by the Surety's agent, if any) in issuing the surety bond, except that any fraud, misrepresentation, or negligence by the HHA in identifying to the Surety (or to the Surety's agent) the amount of Medicare payments upon which the amount of the surety bond is determined will not cause the Surety's liability to CMS to exceed the amount of the bond.

(7) The HHA's failure to exercise available appeal rights under Medicare or to assign such rights to the Surety.

(d) The bond must provide that actions under the bond may be brought by CMS or by CMS's fiscal intermediaries.

(e) The bond must provide the Surety's name, street address or post office box number, city, state, and zipcode to which the CMS notice provided for in paragraph (a) of this section is to be sent.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

§ 489.67 Term and type of bond.

(a) Each participating HHA that does not meet the criteria for waiver under § 489.62 must submit to CMS in a form as CMS may specify, a surety bond for a term beginning January 1, 1998. If an

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annual bond is submitted for the initial term, it must be effective through the end of the HHA's current fiscal year.

(b) *Type of bond.* The type of bond required to be submitted by an HHA under this subpart may be either—

(1) An annual bond (that is, a bond that specifies an effective annual period corresponding to the HHA's fiscal year); or

(2) A continuous bond (that is, a bond that remains in full force and effect from term to term unless it is terminated or canceled as provided for in the bond or as otherwise provided by law) that is updated by the Surety, via the issuance of a rider, for a particular fiscal year for which the bond amount has changed or will change.

(c) *HHA that seeks to become a participating HHA.* (1) An HHA that seeks to become a participating HHA must submit a surety bond with its enrollment application (Form CMS-855, OMB number 0938-0685). The term of the initial surety bond must be effective from the effective date of provider agreement as specified in § 489.13 of this part. However, if the effective date of the provider agreement is less than 30 days before the end of the HHA's current fiscal year, the HHA may obtain a bond effective through the end of the next fiscal year, provided the amount of the bond is the greater of \$75,000 or 20 percent of the amount determined from the computation specified in § 489.65(c) as applicable.

(2) An HHA that seeks to become a participating HHA through the purchase or transfer of assets or ownership interest of a participating or formerly participating HHA must also ensure that the surety bond is effective from the date of such purchase or transfer.

(d) *Change of ownership.* An HHA that undergoes a change of ownership must submit the surety bond to CMS not later than the effective date of the change of ownership and the bond must be effective from the effective date of the change of ownership through the remainder of the HHA's fiscal year.

(e) *Government-operated HHA that loses its waiver.* A government-operated HHA that, as of January 1, 1998, meets the criteria for waiver under § 489.62 but thereafter is determined by CMS to not meet such criteria, must submit a

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surety bond to CMS within 60 days after it receives notice from CMS that it no longer meets the criteria for waiver.

(f) *Change of Surety.* An HHA that obtains a replacement surety bond from a different Surety to cover the remaining term of a previously obtained bond must submit the new surety bond to CMS within 30 days of obtaining the bond from the new Surety.

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

[63 FR 315, Jan. 5, 1998, as amended at 63 FR 10731, Mar. 4, 1998; 63 FR 29656, June 1, 1998; 63 FR 41171, July 31, 1998]

§ 489.68 Effect of failure to obtain, maintain, and timely file a surety bond.

(a) The failure of a participating HHA to obtain, file timely, and maintain a surety bond in accordance with this subpart F and CMS's instructions is sufficient under § 489.53(a)(1) for CMS to terminate the HHA's provider agreement.

(b) The failure of an HHA seeking to become a participating HHA to obtain and file timely a surety bond in accordance with this Subpart F and CMS's instructions is sufficient under § 489.12(a)(3) for CMS to refuse to enter into a provider agreement with the HHA.

§ 489.69 Evidence of compliance.

(a) CMS may at any time require an HHA to make a specific showing of being in compliance with the requirements of this Subpart F and may require the HHA to submit such additional evidence as CMS considers sufficient to demonstrate the HHA's compliance.

(b) If requested by CMS to do so, the failure of an HHA to timely furnish sufficient evidence to CMS to demonstrate compliance with the requirements of this Subpart F is sufficient for CMS to terminate the HHA's provider agreement under § 489.53(a)(1) or to refuse to enter into a provider agreement with the HHA under § 489.12(a)(3), as applicable.

§ 489.70 Effect of payment by the Surety.

A Surety's payment to CMS under a bond for an unpaid claim or an unpaid civil money penalty or assessment, constitutes—

(a) Collection of the unpaid claim or unpaid civil money penalty or assessment (to the extent the Surety's payment on the bond covers such unpaid claim, civil money penalty, or assessment); and

(b) A basis for termination of the HHA's provider agreement under § 489.53(a)(1).

§ 489.71 Surety's standing to appeal Medicare determinations.

A Surety has standing to appeal any matter that the HHA could appeal, provided the Surety satisfies all jurisdictional and procedural requirements that would otherwise have applied to the HHA, and provided the HHA is not, itself, actively pursuing its appeal rights under this chapter, and provided further that, with respect to unpaid claims, the Surety has paid CMS all amounts owed to CMS by the HHA on such unpaid claims, up to the amount of the bond.

[63 FR 29656, June 1, 1998]

§ 489.72 Effect of review reversing determination.

In the event a Surety has paid CMS on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and to the extent the HHA that obtained such bond (or the Surety under § 489.71) is subsequently successful in appealing the determination that was the basis of the unpaid claim or unpaid civil money penalty or assessment that caused the Surety to pay CMS under the bond, CMS will refund to the Surety the amount the Surety paid to CMS to the extent such amount relates to the matter that was successfully appealed by the HHA (or by the Surety), provided all review, including judicial review, has been completed on such matter. Any additional amounts owing as a result of the appeal will be paid to the HHA.

§ 489.73 Effect of conditions of payment.

If a Surety has paid an amount to CMS on the basis of liability incurred under a bond obtained by an HHA under this subpart F, and CMS subsequently collects from the HHA, in whole or in part, on such unpaid claim, civil money penalty, or assessment that was the basis for the Surety's liability, CMS reimburses the Surety such amount as CMS collected from the HHA, up to the amount paid by the Surety to CMS, provided the Surety has no other liability to CMS under the bond.

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

[63 FR 29656, June 1, 1998]

§ 489.74 Incorporation into existing provider agreements.

The requirements of this subpart F are deemed to be incorporated into existing HHA provider agreements effective January 1, 1998.

[63 FR 315, Jan. 5, 1998. Redesignated at 63 FR 29656, June 1, 1998]

Subparts G–H [Reserved]**Subpart I—Advance Directives**

SOURCE: 57 FR 8203, Mar. 6, 1992, unless otherwise noted.

§ 489.100 Definition.

For purposes of this part, *advance directive* means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

§ 489.102 Requirements for providers.

(a) Hospitals, critical access hospitals, rural emergency hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies

and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

(1) Provide written information to such individuals concerning—

(i) An individual's rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

(ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:

(A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(B) Identify the state legal authority permitting such objection; and

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(2) Document in a prominent part of the individual's current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive;

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the

State) regarding advance directives. The provider must inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;

(5) Provide for education of staff concerning its policies and procedures on advance directives; and

(6) Provide for community education regarding issues concerning advance directives that may include material required in paragraph (a)(1) of this section, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of providers. The same written materials do not have to be provided in all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. A provider must be able to document its community education efforts.

(b) The information specified in paragraph (a) of this section is furnished:

(1) In the case of a hospital, at the time of the individual's admission as an inpatient.

(2) In the case of a skilled nursing facility at the time of the individual's admission as a resident.

(3)(i) In the case of a home health agency, in advance of the individual coming under the care of the agency. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(ii) In the case of personal care services, in advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(4) In the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program.

(5) In the case of a rural emergency hospital, at the time of the individual's registration as a patient.

(c) The providers listed in paragraph (a) of this section—

(1) Are not required to provide care that conflicts with an advance directive.

(2) Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

(d) Prepaid or eligible organizations (as specified in sections 1833(a)(1)(A) and 1876(b) of the Act) must meet the requirements specified in § 417.436 of this chapter.

(e) If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the provider may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

[57 FR 8203, Mar. 6, 1992, as amended at 59 FR 45403, Sept. 1, 1994; 60 FR 33294, June 27, 1995; 62 FR 46037, Aug. 29, 1997; 64 FR 67052, Nov. 30, 1999; 68 FR 66720, Nov. 28, 2003; 88 FR 59336, Aug. 28, 2023]

§ 489.104 Effective dates.

These provisions apply to services furnished on or after December 1, 1991 payments made under section 1833(a)(1)(A) of the Act on or after December 1, 1991, and contracts effective on or after December 1, 1991.

PART 491—CERTIFICATION OF CERTAIN HEALTH FACILITIES

Subpart A—Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage

Sec.

491.1 Purpose and scope.

491.2 Definitions.

491.3 Certification procedures.

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491.5 Location of clinic.

491.6 Physical plant and environment.

491.7 Organizational structure.

491.8 Staffing and staff responsibilities.

491.9 Provision of services.

491.10 Patient health records.

491.11 Program evaluation.

491.12 Emergency preparedness.

AUTHORITY: 42 U.S.C. 263a and 1302.

Subpart A—Rural Health Clinics: Conditions for Certification; and FQHCs Conditions for Coverage

§ 491.1 Purpose and scope.

This subpart sets forth the conditions that rural health clinics or FQHCs must meet in order to qualify for reimbursement under Medicare (title XVIII of the Social Security Act) and that rural health clinics must meet in order to qualify for reimbursement under Medicaid (title XIX of the Act).

[57 FR 24982, June 12, 1992]

§ 491.2 Definitions.

As used in this subpart, unless the context indicates otherwise:

Certified nurse-midwife (CNM) means an individual who meets the applicable education, training, and other requirements at § 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 means an individual who meets the applicable education, training, and other requirements at § 410.73(a) of this chapter.

Direct services means services provided by the clinic's staff.

FQHC means an entity as defined in § 405.2401(b).