(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, the date on which enrollment requirements have been 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) that 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 (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)(i)(A) or (c)(2)(i)(B) of this section.

[75 FR 50418, Aug. 16, 2010]

§ 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.
§ 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:

(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.

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:

(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.