

(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 hospital stay or outpatient visit 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. The notice 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 physician present in the hospital. For purposes of this paragraph, 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 outpatient service.

(2) Before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

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

[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.fdsys.gov](http://www.fdsys.gov).

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, in § 489.20, paragraphs (1) through (r) were added. Paragraphs (m), (r)(2) and (r)(3) contain information collection and record-keeping requirements and will not become 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.

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(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 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 inability to pay a deductible or a coinsurance amount required under Medicare.

(d) A provider may not charge an individual for (1) its agreement to admit or readmit the individual on some specified future date for covered inpatient services; or (2) for failure to remain an inpatient for any agreed-upon