

(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.

(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:

(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 of 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.

(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

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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 certified registered nurse anesthetist, as defined in section 1861(bb) of the Act.

(7) 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.

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

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

(10) 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

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specified in § 411.15(p)(3)(i) through (p)(3)(iv) of this chapter as ending the individual's status as an SNF resident.

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

(12) Services described in paragraphs (s)(1) through (6) of this section when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act.

(13) 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.

(14) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260-36262; 36489; 36530-36535; 36640; 36823; and 96405-96542.

(15) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030-79440.

(16) 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, 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.

(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

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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.

[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.

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.

(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 length of time or for failure to give advance notice of departure from the provider's facilities.

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

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

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

[62 FR 56111, Oct. 29, 1997]

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

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

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

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section,

or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

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

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

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

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

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

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

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

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

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past

practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

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

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

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

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

individual is brought onto hospital property;

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

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

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

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

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

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

Emergency medical condition means—

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

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

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

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

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through

the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

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

Patient means—

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

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

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

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

Transfer means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or in-

directly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

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

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

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

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

(2) *Exception: Application to inpatients.*

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

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

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

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.*

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

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

(iii) An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation

does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

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

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

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

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

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

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

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

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

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

(ii) The receiving facility—

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

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

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the in-

formed 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) *Beneficiary 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.

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

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

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

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

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

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

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

§ 489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.

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

[59 FR 32123, June 22, 1994]

§ 489.26 Special requirements concerning veterans.

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

[59 FR 32123, June 22, 1994]

§ 489.27 Beneficiary notice of discharge rights.

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

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

[71 FR 68724, Nov. 27, 2006]

§ 489.28 Special capitalization requirements for HHAs.

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term “initial reserve operating funds,” 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 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 liq-

uid 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 three 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.

(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 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]

§ 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 \$75 deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible.

(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