AUTHORITY: Secs. 1102, 1128I and 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1351i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

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 effective date rules in this part are made applicable also to the approval of suppliers that meet the requirements specified in § 489.13.

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

[75 FR 50418, Aug. 16, 2010]

§ 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).

(c)(1) Clinics, rehabilitation agencies, and public health agencies may enter