PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

Subpart A—General Provisions

Sec.
489.1 Statutory basis.
489.2 Scope of part.
489.3 Definitions.
489.10 Basic requirements.
489.11 Acceptance of a provider as a participant.
489.12 Decision to deny an agreement.
489.13 Effective date of agreement or approval.
489.18 Change of ownership or leasing: Effect on provider agreement.

Subpart B—Essentials of Provider Agreements

489.20 Basic commitments.
489.21 Specific limitations on charges.
489.22 Special provisions applicable to prepayment requirements.
489.23 Specific limitation on charges for services provided to certain enrollees of fee-for-service FEHB plans.
489.24 Special responsibilities of Medicare hospitals in emergency cases.
489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.
489.26 Special requirements concerning veterans.
489.27 Beneficiary notice of discharge rights.
489.28 Special capitalization requirements for HHAs.
489.29 Special requirements concerning beneficiaries served by the Indian Health Service, Tribal health programs, and urban Indian organization health programs.

Subpart C—Allowable Charges

489.30 Allowable charges: Deductibles and coinsurance.
489.31 Allowable charges: Blood.
489.32 Allowable charges: Noncovered and partially covered services.
489.34 Allowable charges: Hospitals participating in State reimbursement control systems or demonstration projects.
489.35 Notice to intermediary.

Subpart D—Handling of Incorrect Collections

489.40 Definition of incorrect collection.
489.41 Timing and methods of handling.
489.42 Payment of offset amounts to beneficiary or other person.

42 CFR Ch. IV (10–1–14 Edition)

§ 489.52 Termination by the provider.
§ 489.53 Termination by CMS.
§ 489.54 Termination by the OIG.
§ 489.55 Exceptions to effective date of termination.
§ 489.57 Reinstatement after termination.

Subpart E—Surety Bond Requirements for HHAs

§ 489.60 Definitions.
§ 489.61 Basic requirement for surety bonds.
§ 489.62 Requirement waived for Government-operated HHAs.
§ 489.63 Parties to the bond.
§ 489.64 Authorized Surety and exclusion of surety companies.
§ 489.65 Amount of the bond.
§ 489.66 Additional requirements of the surety bond.
§ 489.67 Term and type of bond.
§ 489.68 Effect of failure to obtain, maintain, and timely file a surety bond.
§ 489.69 Evidence of compliance.
§ 489.70 Effect of payment by the Surety.
§ 489.71 Surety’s standing to appeal Medicare determinations.
§ 489.72 Effect of review reversing CMS’s determination.
§ 489.73 Effect of conditions of payment.
§ 489.74 Incorporation into existing provider agreements.

Subparts G–H [Reserved]

Subpart I—Advance Directives

§ 489.100 Definition.
§ 489.102 Requirements for providers.
§ 489.104 Effective dates.

Authority: Secs. 1162, 1128I and 1871 of the Social Security Act (42 U.S.C. 1395hh).

Source: 45 FR 22207, 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
Centers for Medicare & Medicaid Services, HHS § 489.3

review. The sections of the Act specified in paragraphs (a)(1) through (a)(4) of this section are also pertinent.

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

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

(c) 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.

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

(e) 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.

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

§ 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 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.

§ 489.3 Definitions.

For purposes of this part—

Immediate jeopardy means a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

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.

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