

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 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.

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(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 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.

(17) Those RHC and FQHC services that are described in §405.2411(b)(2) of this chapter.

(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

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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 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.

(y) In the case of a hospital or critical access hospital, to provide notice, as specified in paragraphs (y)(1) and (2) of this section, to each individual entitled to Medicare benefits under Title XVIII of the Act when such individual receives observation services as an outpatient for more than 24 hours. Notice must be provided to the individual not later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted. Notice may be provided before such individual receives 24 hours of observation services as an outpatient.

(1) *Written notice.* Hospitals and critical access hospitals must use a standardized written notice, as specified by

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the Secretary, which includes the following information:

(i) An explanation of the status of the individual as an outpatient receiving observation services and not as an inpatient of the hospital or critical access hospital and the reason for status as an outpatient receiving observation services; and

(ii) An explanation of the implications of such status as an outpatient on services furnished by the hospital or critical access hospital (including services furnished on an inpatient basis), such as Medicare cost-sharing requirements, and subsequent eligibility for Medicare coverage for skilled nursing facility services.

(2) *Oral notice.* The hospital must give an oral explanation of the written notification described in paragraph (y)(1) of this section.

(3) *Signature requirements.* The written notice specified in paragraph (y)(1) of this section must either—

(i) Be signed by the individual who receives observation services as an outpatient or a person acting on the individual's behalf to acknowledge receipt of such notification; or

(ii) If the individual who receives observation services as an outpatient or the person acting on behalf of the individual refuses to provide the signature described in paragraph (y)(1) of this section, is signed by the staff member of the hospital or critical access hospital who presented the written notification and includes the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented.

[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, § 489.20(1) through (r) were added. Paragraphs (m), (r)(2), and (r)(3) of this section contain information collection and recordkeeping 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