

Medicare General Information, Eligibility, and Entitlement

Chapter 5 - Definitions

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10 - Part A Provider and Related Definitions (Rev. 1, 09-11-02)

Section 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as:

(1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) A community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each must meet in order for their services to be considered covered are described in the following sections.

10.1 - Provider Agreements

The following provider types must have provider agreements under Medicare:

- Hospitals,
- Skilled nursing facilities (SNFs),
- Home health agencies (HHAs),
- Clinics, rehabilitation agencies, and public health agencies,
- Comprehensive outpatient rehabilitation facilities (CORFs),
- Hospices,
- Critical access hospitals (CAHs), and
- Community mental health centers (CMHCs).

Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient therapy services as defined in section 10 above. CMHCs may enter into provider agreements only to furnish partial hospitalization services.

The term "provider agreement" is defined in 42 CFR 489.3 as an agreement between CMS and one of these providers specified in this section to provide services and to comply with the requirements of section 1866 of the Act.

A provider which has executed an agreement becomes qualified to participate after the agreement is accepted. When the agreement is made retroactive, the provider must comply with the terms of the agreement and the provisions of title XVIII and regulations issued thereunder as of the retroactive date. For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a record keeping capability sufficient to determine the costs of services furnished to Medicare beneficiaries.

Provider agreements require the providers to comply with regulations. Therefore, new provider agreements are not made when regulations change.

Providers as defined in this section may also function as suppliers and bill the program for other services provided as suppliers if they meet the applicable requirements for supplying the specific service.

10.1.1 - Basic Commitment in Provider Agreement (Rev. 58, Issued: 03-06-09, Effective: 06-08-09, Implementation: 06-08-09)

Section 1866 of the Act and 42 CFR 489 require the provider to agree to the following:

1. To limit its charges to beneficiaries and to other individuals on their behalf to:
 - The deductible and coinsurance amounts (see §10.1.2 for details);
 - The blood deductible (see §10.1.4 for details); and
 - Services requested by the beneficiary. (See §10.1.5)
2. To return any amounts incorrectly collected from a beneficiary or any other person on the beneficiary's behalf;
3. To notify the A/B MAC (A) or (HHH) promptly if it hires an individual who at any time during the preceding year was employed in a managerial, accounting, auditing, or similar capacity by a MAC;
4. In the case of a hospital or a Critical Access Hospital (CAH), either to furnish directly or to make arrangements (as defined in §10.3 of this chapter) for all Medicare-covered services to inpatients of a hospital or a CAH except the following:
 - Physicians' services that meet the criteria of 42 CFR 405.550(b) for payment on a reasonable charge basis;

- Physician assistant services, as defined in section 1861(s)(2)(K)(I) of the Act, that are furnished after December 31, 1990;
- Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990;
- Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990; and
- Services of an anesthetist, as defined in 42 CFR 410.69.

5. 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 PRO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services. The requirement of this paragraph applies only if, for the area in which the hospital or CAH is located, there is a PRO that has a contract with CMS under Part B of title XI of the Act;

6. 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;

7. To bill other primary payers before billing;

8. 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;

9. 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; to reimburse Medicare any overpaid amount up to the amount that would have been paid had the provider filed a proper claim timely.

10. 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," the hospital must withdraw its claim or lien and bill Medicare for covered services;

11. In the case of home health agencies, 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;

12. In the case of hospital emergency department services that provide for medical screening to determine if an emergency medical condition exists, CMS guidelines provided in CFR 42 489.24(d) for transfer of patients to other facilities should be followed;

13. In the case of hospital emergency department services 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 CFR 42 489.24(d);

14. In the case of inpatient hospital services for admissions on and after January 1, 1987, to participate in the Tricare program;

15. In the case of inpatient hospital services for admissions on and after July 1, 1987, to admit veterans whose admission is authorized by the VA and to meet related VA admission and payment requirements;

16. In the case of a hospital, to give each beneficiary a notice about his or her discharge rights at or about the time of the individual's admission;

17. In the case of a hospital with an emergency department:

- 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
- To post conspicuously information indicating whether or not the hospital or critical access hospital participates in the Medicaid program under a State plan approved under title XIX;

18. In the case of a hospital with an emergency department (including both the transferring and receiving hospitals), to maintain:

- 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;
- A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition; and
- A central log on each individual who comes to the emergency department 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.

19. Effective December 1, 1991, in the case of a hospital to comply with the advance directive provisions of 4206 of OBRA 1990. Hospitals must, in accordance with written policies and procedures, for all adult individuals:

- Inform them, in writing, of State laws regarding advance directives;
- Inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that State law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive);
- Document in the individual's medical record whether the individual has executed an advance directive;
- Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so); and
- Educate staff and the community on issues concerning advance directives.

20. Effective October 1, 2007, CMS revised the regulations governing provider agreements that require hospitals to disclose physician ownership information to patients when a referring physician (or his or her immediate family member) has an ownership interest in the hospital. Pursuant to 42 CFR 489.20(u), hospitals must: (1) 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. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital and that the list of physician owners or immediate family members of physicians is available upon request and must be provided to the patient at the time of the request; and (2) 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 held by the physician or held by an immediate family member of the physician. Disclosure must be made at the time of the referral.

Effective October 1, 2008, hospitals that do not have any physician owners who refer patients to the hospital are exempt from the disclosure requirements (See 42 CFR 489.20(v)). In addition, CMS may deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital (See 42 CFR 489.12).

10.1.2 - Part A Deductible and Coinsurance (Rev. 1, 09-11-02)

This section is a further explanation of §10.1.1 above.

The provider may charge the beneficiary or his or her representative:

- The amount of the inpatient hospital deductible or, if less, the actual charges for the services;
- 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;
- The posthospital extended care coinsurance amount; and
- In the case of durable medical equipment (DME) furnished as a home health service, 20 percent of the fee schedule amount.

10.1.3 - Part B Deductible and Coinsurance (Rev. 1, 09-11-02)

This section is a further explanation of §10.1.1 above.

The provider may charge the beneficiary or other person on his or her behalf: the \$100 deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible.

For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary's deductible status. If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to \$100. If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

The hospital is required to indicate on the claim the amounts collected.

In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the fee schedule amount for the services, with the following exception: If the DME is used, purchased by, or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.

10.1.4 - Blood (Rev. 18, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

This section is a further explanation of §10.1.1.

A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished during the calendar year. The charges may not exceed the provider's customary charges.

The provider may not charge for any whole blood or packed red cells in any of the following circumstances:

- The provider obtained the blood or red cells at no charge other than a processing or service charge;
- The blood or packed red cells have been replaced; or
- The provider (or its blood supplier) receives from an individual, or a blood bank, a replacement offer. This offer is applicable if the replacement blood would not endanger the health of a recipient and if the prospective donor's health would not be endangered by making a blood donation. In this case the provider is precluded from charging even if it or its blood supplier rejects the replacement offer.
- Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §231 regarding billing for blood and blood products under the Hospital Outpatient Prospective Payment System (OPPS).

10.1.5 - Services Requested by Beneficiary (Rev. 1, 09-11-02)

This section is a further explanation of §10.1.1.

If services furnished at the request of a beneficiary (or his or her representative) are more expensive than, or in excess of, services covered under Medicare, a provider may charge the beneficiary an amount that does not exceed the difference between (1) the provider's customary charges for the services furnished; and (2) the provider's customary charges for the kinds and amounts of services that are covered under Medicare.

A provider may not charge for these services unless they have been requested by the beneficiary (or his or her representative) and may not require a beneficiary to request services as a condition of admission.

To avoid misunderstanding and disputes, a provider must inform any beneficiary who requests a service for which a charge will be made that there will be a specified charge for that service.

10.1.6 - Provider Charges to Beneficiary Where Provider Customarily Furnishes More Expensive Services Not Requested by Beneficiary (Rev. 1, 09-11-02)

A provider that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual.

The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in which such charges are imposed, exceeds the applicable limit imposed under the provisions of 42 CFR 413.30.

This charge may be made only if:

- The A/B MAC (A) or (HHH) determines that the charges have been calculated properly in accordance with the provisions of this regulation section;
- The services are not emergency services as defined in §20.1 or §20.2 of this chapter;
- The admitting physician has no direct or indirect financial interest in such provider;
- CMS has provided notice to the public through notice in a newspaper of general circulation servicing the provider's locality and such other notice as the Secretary may require, of any charges the provider is authorized to impose on individuals entitled to benefits under Medicare on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare; and
- The provider has identified such charges to such individual or person acting on his/her behalf as charges to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare.

10.1.7 - Hospitals Participating in State Reimbursement Control Systems or Demonstration Projects **(Rev. 1, 09-11-02)**

This section is a further explanation of §10.1.1.

A hospital receiving payment for a covered hospital stay under:

- Either a State reimbursement control system approved under 1886 (c) of the Act; or
- A demonstration project authorized under section 402(a) of Pub. L. 90 - 248 (42 U.S.C. 1395b - 1) or section 222(a) of Pub. L. 92 - 603 (42 U.S.C.1395b - 1 (NOTE)); and
- Would otherwise be subject to the prospective payment system set forth in part 412 of this chapter, may also charge a beneficiary for custodial care and medically

unnecessary services described in CFR CUR 412.42(c), after the conditions of 412.42(c)(1) through(c)(4) are met.

10.1.8 - Medicare Secondary Payer Involvement of Failure to File Proper Claims (Rev. 1, 09-11-02)

This section is a further explanation of §10.1.1.

A provider that has not filed a proper claim and has received a reduced payment because of this from a payer primary to Medicare agrees:

- 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
- To charge the beneficiary only (a) 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 (b) an amount equal to any third-party payment reduction attributable to failure to file a proper claim, but only if the provider can show that:
 - 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
 - The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than mental or physical incapacity.

10.1.9 - Advance Directive Requirements (Rev. 1, 09-11-02)

Effective December 1, 1991, participating hospitals must comply with the advance directive provisions of §4206 of OBRA 1990. Therefore, an agreement per §1866 of the Act with a hospital includes that the hospital must, in accordance with written policies and procedures, for all adult individuals: inform them, in writing, of state laws regarding advance directives; inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that state law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive); document in the individual's medical record whether the individual has executed an advance directive; not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so); and educate staff and the community on issues concerning advance directives.

10.1.10 - Posting of Signs in Hospital Emergency Departments

Section 6018(a)(2) of the Omnibus Budget Reconciliation Act of 1989 (OBRA §89), effective July 1, 1990, requires hospitals with emergency departments to post signs which specify the rights (under section 1867 of the Social Security Act) of women in labor and individuals with emergency medical conditions to examination and treatment.

To comply with these requirements, hospitals must post signs that meet the following criteria:

- At a minimum, the signs must specify the rights of unstable individuals with emergency conditions and women in labor who come to the emergency department for health care services;
- It must indicate whether the facility participates in the Medicaid program;
- The wording of the sign must be clear and in simple terms understandable by the population serviced;
- Print the signs in English and other major languages that are common to the population of the area serviced;
- The letters within the signs must be clearly readable at a distance of at least 20 feet or the expected vantage point of the emergency department patrons; and
- Post signs 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 (e.g., entrance, admitting area, waiting room, treatment area).

The sample below may be adapted, contains sufficient information to satisfy these requirements, and may be adapted to satisfy the visibility requirement.

IT'S THE LAW!

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR

YOU HAVE THE RIGHT TO RECEIVE, WITHIN THE CAPABILITIES OF THIS
HOSPITAL'S STAFF AND FACILITIES:

An appropriate medical SCREENING EXAMINATION

Necessary STABILIZING TREATMENT (including treatment for an unborn child)

And if necessary

An appropriate TRANSFER to another facility

Even if

YOU CANNOT PAY OR DO NOT HAVE MEDICAL INSURANCE

OR

YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

This hospital (does/does not) participate in the Medicaid program

10.2 - Admission of Medicare Patients for Care and Treatment

(Rev. 120, Issued: 11-02-18, Effective: 12- 04-18, Implementation: 12- 04-18)

The participation of a provider of services, which voluntarily files an agreement to participate in the health insurance program, contemplates that such provider will admit Medicare beneficiaries for care and treatment, and upon admission, will provide them with such services as are ordinarily furnished by the provider to its patients generally.

A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by CMS as a basis for termination of the agreement for cause (see the regulations at [42 CFR 489.53\(a\)\(2\)](#), *and also see Pub. 100-04, Medicare Claims Processing Manual, chapter 1, §30.1.3*).

10.3 - Under Arrangements

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services.

The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress NOTES

relating to all services received, and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders. In the case of home health services and outpatient physical therapy or speech-language pathology services, the provider must ensure that the required plan of treatment is periodically reviewed by the physician and secure from the physician the required certifications and recertifications. Additionally, the provider (other than a SNF) must ensure that the medical necessity of such services is reviewed on a sample basis by the utilization review (UR) committee if one is in place, the facility's health professional staff, or an outside UR group. (Effective October 1, 1990, a SNF is no longer required to have a plan for UR.) The provider, including a SNF that conducts optional UR services, is responsible for medical necessity decisions made under arrangement by an outside group.

10.4 - Term of Agreements

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

An agreement with a hospital, HHA, hospice, and (for the purposes of furnishing outpatient physical therapy, occupational therapy, or speech-language pathology services) a clinic, a rehabilitation agency, or public health agency is not time limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary termination, or involuntary termination, or a change of ownership.

10.4.1 - Agreement with a SNF

(Rev. 1, 09-11-02)

All agreements with SNFs are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. In appropriate situations, the agreement may also contain a cancellation clause. Therefore, when it is determined that a SNF is eligible and that its agreement for participation in the Medicare program will be accepted for filing, the term of the agreement will be determined in the following manner:

- A. No Deficiencies - If a SNF is certified as being in full compliance with all standards contained in the requirements for participation for SNFs, the term of the agreement is, as appropriate to the period of certification for it has been approved, for a term of up to 12 full calendar months.
- B. Deficiencies - If a SNF is certified as not being in full compliance, the term of the agreement is, as appropriate to the period of certification or conditional period of certification for which it has been approved:
 - 1. For a term which expires no later than the close of the 60th day following the last day of the time period specified in the written plan providing for the correction of deficiencies in meeting the requirements for participation, provided that such term does not exceed 12 full calendar months or

2. Provide a conditional term of up to 12 full calendar months, subject to a cancellation clause that the agreement may be canceled on a predetermined date (no later than the close of the 60th day following the last day of the time period specified in the written plan providing for the correction of deficiencies in meeting the requirements for participation), provided that date will occur within the 12-month term.

If the health and safety of Medicare patients are not jeopardized, the term of an agreement may be extended for 2 full calendar months when necessary to prevent irreparable harm to the facility, to prevent hardship to Medicare beneficiaries furnished care, or if it is impracticable within the term of the agreement to determine whether the SNF is complying with the provisions of the Act and regulations issued thereunder.

10.4.2 - Agreement with Rurhal Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) (Rev. 1, 09-11-02)

Agreements between RHCs/FQHCs and CMS are generally for a term of 1 year. They may be annually renewed by mutual agreement of the RHC/FQHC and CMS, i.e., a new agreement need not be signed each year. Special circumstances may result in a term of less than 1 year for an initial agreement, e.g., a clinic or center may wish the agreement year to run concurrently with the RHC/FQHC's fiscal year or have some other technical considerations.

10.5 - Responsibilities of Participating Provider (Rev. 1, 09-11-02)

Upon acceptance for participation, a provider becomes responsible for remaining in compliance with the terms of the agreement and the provisions of title XVIII and regulations issued thereunder. Where the agreement is made retroactive, the provider must comply with its responsibilities as of the retroactive date. Payment to the provider for covered items and services it furnishes on or after the effective date of the agreement will require that the provider have a recordkeeping capability sufficient for determining the cost of services furnished Medicare beneficiaries.

The termination of participation (see [§10.6](#) of this chapter) does not immediately abrogate all of the provider's responsibilities and in specific matters a responsibility may extend beyond the effective date of termination. For example, the provider continues to be responsible (as applicable) for those provisions of the law and regulations which provide for program coverage to remain in effect for specified periods of time beyond the effective termination date, for those beneficiaries who were accepted for care and treatment by the provider before such date. The provider also continues to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

10.6 - Termination of Provider Participation

(Rev. 1, 09-11-02)

A provider may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

10.6.1 - Voluntary Termination

(Rev. 1, 09-11-02)

A provider may terminate its agreement (and in the case of a SNF, it may terminate its agreement prior to the close of the specified term of its agreement) by filing with the Secretary a written notice of its intention to terminate the agreement. The Secretary may accept the termination date stated in the notice (the date must be the first day of a month and, in the case of a SNF, must occur within the specified term of such facility's agreement) or set a different date. However, the termination date set by the Secretary may not be more than 6 months from the date the provider's notice is filed.

10.6.2 - Involuntary Termination, Including SNF Agreement Cancellations

(Rev. 1, 09-11-02)

The Secretary may terminate an agreement (and in the case of a SNF, he/she may terminate its agreement prior to the close of the specified term of the agreement) with a provider if it is determined that the provider:

- Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations;
- No longer meets the appropriate requirements for participation;
- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or
- Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of a SNF agreement at the close of the predetermined date stated in the cancellation clause contained in such agreement (see §10.6.2 of this chapter) is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable requirements for participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals

procedures contained in 42 CFR Part 498. There is no reconsideration step before the opportunity for a hearing.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services, i.e., to be a swing bed facility, does not automatically result in the involuntary termination of the hospital's agreement relating to the provision of hospital services.

10.6.3 - Expiration and Renewal - Nonrenewal of SNF Term Agreements **(Rev. 1, 09-11-02)**

All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. When the term of an agreement is extended (see §10.6.3 of this chapter), the close of the last day of its specified term is the close of the day of the extension of the agreement. Thus, when the term of an agreement is extended, the provider's participation in the program continues, and the agreement does not expire until the close of the last day to which it has been extended.

Since an agreement with a SNF is not automatically renewable from term to term, each term agreement with a SNF requires that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement form previously accepted for filing, provided the SNF continues to qualify for participation and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met, there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

When the time-limited agreement (including an agreement which has had its term extended) is renewed on the day immediately following the close of the last day of its term, the expiration of the agreement is not considered a termination of participation in the program.

However, once an agreement with a SNF is (1) not renewed, or (2) voluntarily terminated by the SNF, or (3) involuntarily terminated (including cancellations) by the Secretary, the previously accepted agreement cannot again be accepted and renewed. In such cases, the SNF is required to execute and file a new agreement if it is again found eligible to participate in the Medicare program. The effective date of the new agreement must be determined in accordance with regulatory provisions (42 CFR 489.13).

The Secretary's determination not to accept and renew a SNF agreement is a determination relating to the qualifications of the SNF in the period immediately following the close of the SNF's existing agreement and the SNF is entitled to request a

reconsideration of the determination in accordance with the appeals procedure contained in 42 CFR part 405, subpart 0. Such determinations involve a finding that:

- Based on a State agency resurvey and recertification, the SNF will not be approved for a period of certification because it is out of compliance with one or more requirements for participation;
- Based on a State agency resurvey and recertification, the SNF continues to be out of compliance with the same standard(s) in the requirements for participation as were found out of compliance during the term of the agreement and the facility will not be approved for a new period of certification; or
- The SNF has violated the terms of its agreement or the provisions of title XVIII or regulations promulgated thereunder.

In cases of nonrenewal by the Secretary, the A/B MAC (A)'s role is the same as for involuntary terminations.

10.6.4 - Determining Payment for Services Furnished After Termination of Provider Agreement

(Rev. 42, Issued: 11-09-06, Effective: N/A, Implementation: 12-11-06)

Effective with the date a provider agreement (or swing bed approval) terminates no payment is made to the provider under such agreement for the following:

A. Hospital

1. Termination-Hospital Agreement - Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.
2. Termination-Swing Bed Approval - Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B. Skilled Nursing Facility

1. Termination-SNF - Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (see §10.6.1 of this chapter) or

involuntarily terminated by the Secretary for cause (see §10.6.2 of this chapter), except that payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

C. HHA and Hospice

Payment may be made for services under a plan of treatment for up to 30 days following the effective termination date of a home health agency or hospice if the plan was established before the termination date.

D. Providers - Termination

See Medicare Claims Processing Manual Chapter 1 for billing instructions concerning other items and services, including outpatient physical therapy or speech-language pathology and diagnostic services, furnished on or after the effective date of termination on or after the day following the close of such agreement.

10.6.5 - Change of Provider Ownership (Rev. 1, 09-11-02)

When an organization having a provider agreement undergoes a change of ownership, the agreement is automatically assigned to the new owner. A participating provider which plans to change ownership should give advance notice of its intention so that necessary action can be taken in the event the newly-owned institution does not wish to participate in the Medicare program.

A participating provider which plans to enter into a lease arrangement (in whole, or in part) should also give advance notice of its intention. A change of ownership would occur for example:

- Where a sole proprietor transfers title to an enterprise to another party;
- Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of such partnership and creates a successor partnership or other entity;
- Where an incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation or where two or more corporate providers consolidate and such consolidation results in the creation of a new corporate entity; or
- Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

Whenever A/B MACs (A) learn of an impending change of ownership, or possible change of ownership, they inform the regional office immediately. They refer any questions they may have concerning change of ownership situations to the regional office.

20 - Hospital Defined

(Rev. 42, Issued: 11-09-06, Effective: N/A, Implementation: 12-11-06)

A hospital (other than psychiatric) means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

To be eligible to participate in Medicare, a hospital must also be an institution which:

- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of physicians;
- Has a requirement that every patient must be under the care of a physician;
- Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
- Has in effect a hospital utilization review plan;
- Is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing; and
- Meets other health and safety requirements found necessary by the Secretary of Health, and Human Services. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with exceptions specified in the law).

Such an institution, if approved to participate as a hospital, may also be approved as a swing bed facility pursuant to demonstration authority or if the hospital is a rural hospital with less than 100 beds. (See §30.3 below.)

20.1 - Definition of Emergency Inpatient and Outpatient Services

(Rev. 1, 09-11-02)

Payment may be made for certain Part A inpatient hospital services and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the

threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. The determination of emergency services depends upon three separate findings:

- The hospital meets the definition of an emergency hospital (see §20.2 of this chapter),
- The services meet the definition of emergency services (see Claims Processing Manual, Chapter 3, §110), and
- The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital.

20.2 - Definition of an Emergency Services Hospital (Rev. 1, 09-11-02)

An emergency services hospital is a nonparticipating hospital which meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (A Federal hospital need not be licensed under State or local licensing laws to meet the definition of emergency hospital.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that §20.1 describes in defining the term hospital, and must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. (See the definition of a SNF in §30 of this chapter.) Psychiatric hospitals that meet these requirements can qualify as emergency hospitals.

Inpatient hospital services and related physician and ambulance services furnished outside the U.S. are covered under the limited conditions in Medicare Claims Processing Manual Chapter 1.

20.3 - Psychiatric Hospital (Rev. 1, 09-11-02)

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must meet the Medicare conditions of participation for hospitals or be deemed to meet those conditions based on accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), have a utilization review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

20.4 - Certification of Parts of Institutions as Hospital (Rev. 1, 09-11-02)

Under certain conditions a distinct part of a psychiatric institution may be certified as a psychiatric or general hospital.

20.5 - Part of a Psychiatric Institutions as a Psychiatric Hospital (Rev. 1, 09-11-02)

A distinct part of a psychiatric institution can be certified as a psychiatric hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

20.6 - General Hospital Facility of Psychiatric Hospital (Rev. 1, 09-11-02)

A general hospital facility within a psychiatric hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is a self-contained operational entity distinct from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part" of an institution as a general hospital. Services furnished in a separately certified general hospital facility are not subject to any of the benefit limitations applicable to the other parts of the institution, i.e., the reduction in benefit days in the first spell of illness and the 190-day lifetime maximum on inpatient services in psychiatric hospitals.

20.7 - Part of a General Hospital as a Psychiatric Hospital (Rev. 1, 09-11-02)

There is no provision for a psychiatric wing of a general hospital to be certified as a psychiatric hospital. The distinct part provisions apply only to psychiatric institutions and not to general hospitals. However, this does not prevent the certification of a psychiatric hospital which is a part of a medical center or other large complex, provided the hospital operates as a separate functioning entity, i.e., it is located in a separate building, wing, or part of a building, has its own administration and maintains separate fiscal records.

30 - Skilled Nursing Facility Defined (Rev. 1, 09-11-02)

A SNF is an institution or a distinct part of an institution (see §30.1 of this chapter), such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see §30.2 of this chapter for transfer agreements and §10.1 of this chapter, for definition of a participating hospital) and which:

- Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and
- Meets the requirements for participation in 1819(a) through 1819 (d) as amended by 4201 of OBRA 1987 of the Social Security Act and in regulations at 42 CFR 483, B.

A qualified SNF is one that meets all the requirements in the preceding definition. For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases. (This restriction does not apply to title XIX (Medicaid)). Also, the term "skilled nursing facility" does not include swing bed hospitals authorized to provide and be paid for extended care services. Swing bed hospitals must meet many of the same requirements that apply to SNFs (for more details regarding swing bed hospitals, see §30.3.)

30.1 - Distinct Part of an Institution as a SNF (Rev. 1, 09-11-02)

The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or Nursing Facility (NF) services. To qualify for participation in the program as a distinct part SNF of an institution, it must be physically separate from the rest of the institution, i.e., it must represent an entire physically identifiable unit consisting of all the beds within that unit, such as a separate building, floor, wing, or ward. A distinct part must be fiscally separate for cost reporting purposes. Although it is required that the distinct part be identifiable as a separate unit within the institution, it need not necessarily be confined to a single location within the institution's physical plant. The distinct part may, for example, consist of several floors or wards which are scattered throughout several different buildings within the institutional complex. In each case, however, the patients of the distinct part must be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution do not comprise a distinct part for purposes of being approved by Medicare as a SNF.

An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. Where an institution or institutional complex owns and operates a SNF and/or a NF distinct part, that SNF and/or NF distinct part is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number.

30.2 - Transfer Agreements

(Rev. 114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

To participate in the program, a SNF must have a written transfer agreement with one or more participating hospitals (see §10.1 of this chapter) providing for the transfer of patients between the hospital and the SNF, and for the interchange of medical and other information. If an otherwise qualified SNF has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See 42 CFR 483.70(j) for the detailed requirements for transfer agreements.)

30.3 - Hospital Providers of Extended Care Services

(Rev.114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)

In order to address the shortage of rural SNF beds for Medicare patients, rural hospitals with fewer than 100 beds may be reimbursed under Medicare Part A for furnishing post hospital extended care services to Medicare beneficiaries if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Such a hospital, known as a swing bed hospital, can "swing" its beds between hospital and SNF levels of care, on an as needed basis. In accordance with §1883 of the Act, rural hospitals with fewer than 100 beds must make application and request approval to be a swing bed hospital from the regional office. In order to obtain swing bed approval, the hospital must:

- As noted above, be located in a rural area (i.e., located outside of an "urbanized area," as defined by the Census Bureau and based on the most recent census, see 42 CFR 482.58(a)(2)) and have fewer than 100 beds (excluding intensive care-type beds and newborn bassinets)
- Have a Medicare provider agreement, as a hospital;
- Be substantially in compliance with the SNF participation requirements identified in 42 CFR 482.58; (most other SNF participation requirements would be largely met by virtue of the facility's compliance with comparable hospital conditions);
- Not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c); and
- Not have had a swing bed approval terminated within the 2 years previous to application for swing bed participation.

However, the Department may grant swing bed approval, on a demonstration basis, with hospitals meeting all of the statutory requirements except bed size and geographic location.

Prior to October 1, 1990, a swing-bed hospital could also furnish intermediate care facility (ICF) type services to non-Medicare patients. Effective with services furnished on or after October 1, 1990, the distinction between SNFs and ICFs for certifying a

facility for the Medicaid program was eliminated. Thus, for purposes of the Medicaid program, facilities may no longer be certified as ICFs but instead may be certified only as nursing facilities (NFs) and can provide services as defined in §1919(a)(1) of the Act. Effective October 1, 1990, such services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients are referred to as NF-type services.

See §10.3 of Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, for additional information on Part A coverage of SNF-level swing-bed services as extended care services.

40 - Religious Nonmedical Health Care Institution Defined (Rev. 35, Issued: 02-10-06; Effective/Implementation Dates: 05-11-06)

In order for a Medicare or Medicaid provider to meet the definition of an RNHCI, it must satisfy the ten qualifying provisions as contained in Section 1861(ss)(1) of the Act. Section 1861(ss)(1) of the Act states that an RNHCI means an institution that:

1. Is described in Subsection (c)(3) of Section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under Subsection (a) of that section. The inability to either gain or retain this status will disqualify an institution from participation as an RNHCI.
2. Is lawfully operated under all applicable Federal, State, and local laws and regulations. Federal law supersedes State and local laws unless the State and local requirements are more stringent than the Federal requirements.
3. Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical services would be inconsistent with their religious beliefs. Medicare does not cover the religious component of the healing.
4. Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of these patients. This care frequently involves: assistance in moving, turning, positioning, and ambulation; meeting nutritional needs; and comfort and support measures.
5. Furnishes nonmedical items and services to inpatients on a 24-hour basis.
6. Does not furnish, on the basis of its religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.
7. Is not owned by, under common ownership with, or has an ownership interest of 5 percent or more in, a provider of medical treatment or services, and is not

affiliated with a provider of medical treatment or services, or with an individual who has an ownership interest of 5 percent or more in, a provider of medical treatment or services. For purposes of this requirement, an affiliation does not exist in the circumstances described in Section 1861(ss)(4) of the Act or 42 CFR 403.738(c).

8. Has in effect a utilization review plan that:

- Provides for review of admissions to the institution, of the duration of stays, of cases of continuous extended duration, and of the items and services furnished by the institution;
- Requires that the reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution;
- Provides that records be maintained of the meetings, decisions, and actions of the committee; and
- Meets other requirements as the Secretary finds necessary to establish an effective utilization review plan.

9. Provides information the Secretary may require to implement Section 1821 of the Act, including information relating to quality of care and coverage determinations.

10. Meets other requirements the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution. These requirements include the conditions of participation in 42 CFR 403, Subpart G. An RNHCI must meet or exceed the conditions of participation in order to qualify as a Medicare provider. The RNHCI must also have a valid provider agreement with CMS.

50 - Home Health Agency Defined

(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

- It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, occupational therapy, or speech-language pathology, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by:
 - Furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

- Furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

NOTE: A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

- It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse;
- It maintains clinical records on all patients;
- It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations); and
- It meets other conditions found by the Secretary of the Department of Health and Human Services to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

50.1 - Subdivisions of Agencies as Home Health Agencies (Rev. 1, 09-11-02)

When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

50.2 - Arrangements by Home Health Agencies (Rev. 19, Issued: 03-11-05, Effective/Implementation: N/A)

A. A home health agency (HHA) may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services discharges the liability of the patient or any other person to pay for the services. Whether the items and services are provided by the HHA itself or by another agency under arrangement, both must agree not to charge the patient for covered items and services and must also agree to return money incorrectly collected.

In permitting HHAs to furnish services under arrangements, it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the agency must exercise professional responsibility over the arranged-for services and ensure compliance with the home health conditions of participation.

The agency's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The agency must accept the patient for treatment in accordance with its administration policies, maintain a complete and timely clinical record of the patient that includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and ensure that the medical necessity of such services is reviewed on a sample basis by the agency's staff or an outside review group.

There are three situations in which an HHA may have arrangements with another health organization or person to provide home health services to patients:

- Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another organization or individual to provide the nursing or other therapeutic services that it cannot provide directly;
- Where an agency that is already approved for participation, makes arrangements with others to provide services or items it does not provide directly; and
- Where an agency that is already approved for participation makes arrangements with a hospital, skilled nursing facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment that cannot be made available to the patient in his/her place of residence.

B. If an agency's subdivision (acting in its capacity as an HHA) makes an arrangement with its parent agency for the provision of certain items or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the HHA and another provider participating in the health insurance program (hospital, skilled nursing facility, or HHA, and, in the case of physical therapy, occupational therapy, or speech-language pathology services, clinics, rehabilitation agencies, and public health

agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization that is not a qualified provider of services, there must be a written contract that includes all of the following:

1. A description of the services to be provided.
 2. The duration of the agreement and how frequently it is to be reviewed.
 3. A description of how personnel will be supervised.
 4. A statement that the contracting organization will provide services in accordance with the plan of care established by the patient's physician in conjunction with the HHA's staff.
 5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.
 6. A description of the method of determining reasonable costs and reimbursement by the HHA for the specific services to be provided by the contracting organization.
 7. An assurance that the contracting organization will comply with title VI of the Civil Rights Act.
- If an HHA notifies a beneficiary of noncoverage of services that another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is still considered to be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangements with the home health agency, absent evidence to the contrary. Thus, if a beneficiary appeals the noncoverage of any or all of the arranged for services furnished after the notice, and a ruling is made in favor of the beneficiary, those services ruled on favorably would be reimbursable since they would constitute services furnished under arrangements by a certified HHA. If the denial is sustained, however, the other party cannot bill the beneficiary for the denied services since the HHA, not the other party, is responsible for the care rendered.

50.3 - Arrangements with Parent Agency and Other Entities (Rev. 1, 09-11-02)

If an agency's subdivision (acting in its capacity as an HHA) makes an arrangement with its parent agency for the provision of certain items or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the HHA and another provider participating in the health insurance program (hospital, skilled nursing facility, or HHA, and, in the case of physical therapy, occupational therapy, or speech-language pathology services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

If the arrangements are with an agency or organization that is not a qualified provider of services, there must be a written contract that includes all of the following:

- A description of the services to be provided;
- The duration of the agreement and how frequently it is to be reviewed;
- A description of how personnel will be supervised;
- A statement that the contracting organization will provide services in accordance with the plan of care established by the patient's physician in conjunction with the HHA's staff;
- A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training;
- A description of the method of determining reasonable costs and reimbursement by the HHA for the specific services to be provided by the contracting organization; and
- An assurance that the contracting organization will comply with title VI of the Civil Rights Act.

50.4 - Notice of Noncoverage of Services

(Rev. 1, 09-11-02)

If an HHA notifies a beneficiary of noncoverage of services that another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is still considered to be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangement.

50.5 - Rehabilitation Centers

(Rev. 19, Issued: 03-11-05, Effective/Implementation: N/A)

When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, skilled nursing facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances. Given the statutory definition, a community mental health center is not considered a rehabilitation center.

60 - Hospice Defined

(Rev. 1, 09-11-02)

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and meets the conditions of participation for hospices, and has a valid provider agreement.

60.1 - Subdivision of Organizations as Hospices

(Rev. 1, 09-11-02)

When a subdivision of an organization, such as the home care department of a hospital, wishes to participate as a hospice, the subdivision must meet the hospice conditions of participation and must maintain records in such a way that activities and expenditures attributable to services provided under the hospice program are identifiable.

60.2 - Arrangements by Hospices

(Rev. 1, 09-11-02)

Hospices are required to provide core services directly, that is, nursing services, medical social services, and counseling. Other covered services may be provided under arrangement.

70 - Physician Defined

(Rev. 1, 09-11-02)

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection §70.2), doctor of podiatric medicine (within the limitations in subsection §70.3), or doctor of optometry (within the limitations of subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

The issuance by a State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State

law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards determine whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered.

The issuance by a State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards determine whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered.

NOTE: The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

70.1 - Doctors of Medicine and Osteopathy (Rev. 1, 09-11-02)

The requirement that a doctor of medicine be legally authorized to practice medicine and surgery by the State in which he/she performs his/her services means a physician is licensed to practice medicine and surgery.

A doctor of osteopathy who is legally authorized to practice medicine and surgery by the State in which he/she performs his/her services qualifies as a physician. In addition, a licensed osteopath or osteopathic practitioner qualifies as a physician to the extent that he/she performs services within the scope of his/her practice as defined by State law.

70.2 – Dentists (Rev. 1, 09-11-02)

A dentist qualifies as a physician if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered

dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

70.3 - Doctors of Podiatric Medicine **(Rev. 1, 09-11-02)**

A doctor of podiatric medicine is a physician, but only with respect to those functions which he/she is legally authorized to perform in the State in which he/she performs them. The professional services furnished by a doctor of podiatric medicine within the scope of his/her applicable State license (except services which are specifically excluded) are physician's services payable on a reasonable charge basis under Part B. Where permissible by State law, these services include ordering laboratory tests that are reasonably related to the legal scope of podiatric practice, that are reasonable and necessary for the diagnosis or treatment of a patient's condition and are not in connection with excluded services, such as treatment of flat foot and routine foot care.

A doctor of podiatric medicine may hold any of the following professional degrees: Pod. D. or D. P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropodist, Graduate Chiropodist, or in some instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

For purposes of the Medicare program, a doctor of podiatric medicine is considered a physician for any of the following purposes:

- Making the required physician certification and recertification of the medical necessity for services;
- Having a patient in a home health agency under his/her care, and establishing and periodically reviewing a home health plan of treatment; or
- Serving as a member of a Utilization Review (UR) committee, but only if at least two of the physicians on the UR committee are doctors of medicine or osteopathy. The performance of these functions must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

A doctor of podiatric medicine is not a physician for the purpose of performing any of the physician activities required to qualify an institution or organization as a SNF.

70.4 - Physicians in Federal Hospitals **(Rev. 1, 09-11-02)**

There are many physicians performing services in hospitals operated by the Federal Government, e.g., military, Veterans Administration, and Public Health Service hospitals. Normally, the services provided by a physician in a Federal hospital are not payable except when the hospital provides services to the public as a community institution. A physician working in the scope of his/her Federal employment is considered a physician even though he/she may not have a license to practice in the State in which he/she is employed.

70.5 – Optometrists **(Rev. 1, 09-11-02)**

A. Services Furnished Through March 31, 1987

Prior to April 1, 1987, a doctor of optometry who was legally authorized to practice optometry by the State in which he or she performed such a function was considered a physician under Medicare, but only for the purpose of services related to the condition of aphakia. Aphakia is defined as the absence of the natural crystalline lens of the eye, whether or not an intraocular lens has been implanted. The services performed by optometrists within this definition were subject to limitations set by the State relating to the scope of practice of optometry.

The following are examples of examination services which were covered when furnished by optometrists if related to the condition of aphakia: case history, external examination, ophthalmoscopy, biomicroscopy, tonometry, visual fields, ocular motility, binocular function, and evaluation for contact lenses, if the optometrist furnishing these services is legally authorized to perform them.

B. Services Furnished After March 31, 1987

Effective April 1, 1987, a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements. (See Benefit Policy Manual for information concerning exclusions from coverage that apply to vision care services.)

70.6 – Chiropractors **(Rev. 1, 09-11-02)**

A. General

A licensed chiropractor who meets uniform minimum standards (see subsection C) is a physician for specified services. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray, provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered. An X-ray obtained by a chiropractor for his or her own

diagnostic purposes before commencing treatment may suffice for claims documentation purposes. This means that if a chiropractor orders, takes, or interprets an X-ray to demonstrate a subluxation of the spine, the X-ray can be used for claims processing purposes. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.

B. Licensure and Authorization to Practice

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished.

C. Uniform Minimum Standards

1. Prior to July 1, 1974, Chiropractors licensed or authorized to practice prior to July 1, 1974, and those individuals who commenced their studies in a chiropractic college before that date must meet all of the following minimum standards to render payable services under the program:

a. Preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

b. Graduation from a college of chiropractic approved by the State's chiropractic examiners that included the completion of a course of study covering a period of not less than 3 school years of 6 months each year in actual continuous attendance covering adequate course of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and

c. Passage of an examination prescribed by the State's chiropractic examiners covering the subjects listed in subsection b.

2. After June 30, 1974 - Individuals commencing their studies in a chiropractic college after June 30, 1974, must meet all of the following additional requirements:

a. Satisfactory completion of 2 years of pre-chiropractic study at the college level;

b. Satisfactory completion of a 4-year course of 8 months each year (instead of a 3-year course of 6 months each year) at a college or school of chiropractic that includes not less than 4,000 hours in the scientific and chiropractic courses specified in subsection 1.b, plus courses in the use and effect of X-ray and chiropractic analysis; and

c. The practitioner must be over 21 years of age.

70.7 - Interns and Residents **(Rev. 1, 09-11-02)**

A. General

For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved graduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting; e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow," it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, services of interns and residents are paid as provider services by the A/B MAC (A).

B. Services Furnished by Interns and Residents Within the Scope of an Approved Training Program

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. Effective with services furnished on or after July 1, 1987, this includes services furnished in a setting which is not part of the provider where a hospital has agreed to incur all or substantially all of the costs of training in the nonprovider facility. The Medicare A/B MAC (A) is required to notify the A/B MAC (B) of such agreements. Where the provider does not incur all or substantially all of the training costs and the services are performed by a licensed physician, the services are payable on a fee schedule basis by the A/B MAC (B). Prior to July 1, 1987, the covered services of interns and residents were paid by the A/B MAC (B) on a reasonable charge basis as physician services if furnished by a licensed physician off the provider premises regardless of who incurred the training costs.

C. Services Furnished by Interns and Residents Outside the Scope of an Approved Training Program-Moonlighting

Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physicians' services and paid on a fee schedule or reasonable charge basis where the requirements in the first 2 bullets below are met. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians' services and paid on a fee schedule or reasonable charge basis where the following criteria are met:

- The services are identifiable physicians' services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition;
- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and
- The services performed can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents.

80 - Health Maintenance Organizations (HMOs) Defined (Rev. 1, 09-11-02)

An HMO for Medicare purposes is a public or private organization that provides, either directly or through arrangement with others, comprehensive health services to enrolled members. An HMO must service those who live within a specified service area. It must provide services based on a predetermined periodic rate or periodic per capita rate basis without regard to the frequency or extent of covered services it furnishes. An HMO must also meet other statutory requirements.

An HMO's service area is a geographic area in which a full range of its services are offered to its members. This geographic area differs from an HMO's enrollment area since it may include locations outside its service area where it offers less than its full range of services. (For example, an HMO may cover house calls in emergencies in its service area but not for members who live outside the service area.)

Section 1876 of the Act allows a Medicare beneficiary eligible for Part A and Part B, or Part B only, to choose to have covered items and services furnished through a Medicare qualified HMO. An HMO enters into a contract with the Secretary in order to participate under Medicare.

90 - Other Definitions (Rev. 1, 09-11-02)

NOTE: We anticipate adding to this section as we find the need to define other terms.

90.1 - Supplier Defined (Rev. 1, 09-11-02)

The term supplier means an entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners.

The following suppliers must meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers.

An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital).

A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

90.2 - Laboratory Defined **(Rev. 1, 09-11-02)**

Laboratory means a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

90.3 - Practitioners Defined **(Rev. 1, 09-11-02)**

Practitioners except for physicians are health professionals who may deliver covered Medicare services if the services are incident to a physician's service or if there is specific authorization in the law. The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants in rural health clinics, designated manpower shortage area or HMOs, qualified clinical psychologists, clinical social workers, certified nurse midwives, and certified registered nurse anesthetists.

90.4 - Group Practice Defined **(Rev. 1, 09-11-02)**

A group practice is a group of two or more physicians and non-physician practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association:

- In which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;
- For which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;
- In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and
- Which meets such other standards as the Secretary may impose by regulation to implement §1877(h)(4) of the Social Security Act. The group practice definition also applies to health care practitioners.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R120GI</u>	11/02/2018	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)	12/04/2018	11004
<u>R114GI</u>	03/16/2018	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	06/19/2018	10512
<u>R101GI</u>	09/16/2016	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF)	10/18/2016	9748
<u>R58GI</u>	03/06/2009	Disclosure of Physician Ownership in Hospitals	06/08/2009	6306
<u>R42GI</u>	11/09/2006	Swing bed Hospital Updates	12/11/2006	5114
<u>R35GI</u>	02/10/2006	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institution (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries with RNHCI Elections	05/11/2006	4218
<u>R28GI</u>	08/12/2005	Conforming Changes for Change Request 3648 for Pub. 100-01	09/12/2005	3912
<u>R19GI</u>	03/11/2005	Definition of Home Health Agency	N/A	3698
<u>R18GI</u>	03/04/2005	Billing for Blood and Blood Products Under the Hospital Outpatient Prospective Payment System (OPPS)	07/05/2005	3681
<u>R01MGI</u>	09/11/2002	Initial Publication of Manual	NA	NA

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