

§ 489.11 Acceptance of a provider as a participant.

(a) *Action by CMS.* If CMS determines that the provider meets the requirements, it will send the provider—

- (1) Written notice of that determination; and
- (2) Two copies of the provider agreement.

(b) *Action by provider.* If the provider wishes to participate, it must return both copies of the agreement, duly signed by an authorized official, to CMS, together with a written statement indicating whether it has been adjudged insolvent or bankrupt in any State or Federal court, or whether any insolvency or bankruptcy actions are pending.

(c) *Notice of acceptance.* If CMS accepts the agreement, it will return one copy to the provider with a written notice that—

- (1) Indicates the dates on which it was signed by the provider's representative and accepted by CMS; and
- (2) Specifies the effective date of the agreement.

[45 FR 22937, Apr. 4, 1980, as amended at 59 FR 56251, Nov. 10, 1994; 62 FR 43937, Aug. 18, 1997]

§ 489.12 Decision to deny an agreement.

(a) *Bases for denial.* CMS may refuse to enter into an agreement for any of the following reasons:

- (1) Principals of the prospective provider have been convicted of fraud (see § 420.204 of this chapter);
- (2) The prospective provider has failed to disclose ownership and control interests in accordance with § 420.206 of this chapter; or
- (3) The prospective provider is unable to give satisfactory assurance of compliance with the requirements of title XVIII of the Act.

(b) [Reserved]

(c) *Compliance with civil rights requirements.* CMS will not enter into a provider agreement if the provider fails to comply with civil rights requirements set forth in 45 CFR parts 80, 84, and 90, subject to the provisions of § 489.10.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 34833, Sept. 30, 1986; 54 FR 4027, Jan. 27, 1989; 59 FR 6578, Feb. 11, 1994; 59 FR 56251, Nov. 10, 1994]

§ 489.13 Effective date of agreement or approval.

(a) *Applicability—*(1) *General rule.* Except as provided in paragraph (a)(2) of this section, this section applies to Medicare provider agreements with, and supplier approval of, entities that, as a basis for participation in Medicare—

- (i) Are subject to survey and certification by CMS or the State survey agency; or
- (ii) Are deemed to meet Federal requirements on the basis of accreditation by an accrediting organization whose program has CMS approval at the time of accreditation survey and accreditation decision.

(2) *Exceptions.* (i) For an agreement with a community mental health center (CMHC) or a Federally qualified health center (FQHC), the effective date is the date on which CMS accepts a signed agreement which assures that the CMHC or FQHC meets all Federal requirements.

(ii) A Medicare supplier approval of a laboratory is effective only while the laboratory has in effect a valid CLIA certificate issued under part 493 of this chapter, and only for the specialty and subspecialty tests it is authorized to perform.

(b) *All Federal requirements are met on the date of survey.* The agreement or approval is effective on the date the survey (including the Life Safety Code survey, if applicable) is completed, if on that date the provider or supplier meets all applicable Federal requirements as set forth in this chapter. (If the agreement or approval is time-limited, the new agreement or approval is effective on the day following expiration of the current agreement or approval.)

(c) *All Federal requirements are not met on the date of survey.* If on the date the survey is completed the provider or supplier fails to meet any of the requirements specified in paragraph (b) of this section, the following rules apply:

- (1) For an agreement with an SNF, the effective date is the date on which—

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(i) The SNF is in substantial compliance (as defined in § 488.301 of this chapter) with the requirements for participation; and

(ii) CMS or the State survey agency receives from the SNF, if applicable, an approvable waiver request.

(2) For an agreement with, or an approval of, any other provider or supplier, (except those specified in paragraph (a)(2) of this section), the effective date is the earlier of the following:

(i) The date on which the provider or supplier meets all requirements.

(ii) The date on which a provider or supplier is found to meet all conditions of participation or coverage, but has lower level deficiencies, and CMS or the State survey agency receives an acceptable plan of correction for the lower level deficiencies, or an approvable waiver request, or both. (The date of receipt is the effective date regardless of when CMS approves the plan of correction or the waiver request, or both.)

(d) *Accredited provider or supplier requests participation in the Medicare program—(1) General rule.* If the provider or supplier is currently accredited by a national accrediting organization whose program had CMS approval at the time of accreditation survey and accreditation decision, and on the basis of accreditation, CMS has deemed the provider or supplier to meet Federal requirements, the effective date depends on whether the provider or supplier is subject to requirements in addition to those included in the accrediting organization's approved program.

(i) *Provider or supplier subject to additional requirements.* If the provider or supplier is subject to additional requirements, the effective date of the agreement or approval is the date on which the provider or supplier meets all requirements, including the additional requirements.

(ii) *Provider or supplier not subject to additional requirements.* For a provider or supplier that is not subject to additional requirements, the effective date is the date of the provider's or supplier's initial request for participation if on that date the provider or supplier met all Federal requirements.

(2) *Special rule: Retroactive effective date.* If a provider or supplier effects the

requirements of paragraphs (d)(1) and (d)(1)(i) or (d)(1)(ii) of this section, the effective date may be retroactive for up to one year to encompass dates on which the provider or supplier furnished, to a Medicare beneficiary, covered services for which it has not been paid.

[62 FR 43936, Aug. 18, 1997]

§ 489.18 Change of ownership or leasing: Effect on provider agreement.

(a) *What constitutes change of ownership—(1) Partnership.* In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.

(2) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation.* The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

(4) *Leasing.* The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

(b) *Notice to CMS.* A provider who is contemplating or negotiating a change of ownership must notify CMS.

(c) *Assignment of agreement.* When there is a change of ownership as specified in paragraph (a) of this section, the existing provider agreement will automatically be assigned to the new owner.

(d) *Conditions that apply to assigned agreements.* An assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued including, but not limited to, the following:

(1) Any existing plan of correction.

(2) Compliance with applicable health and safety standards.

(3) Compliance with the ownership and financial interest disclosure requirements of part 420, subpart C, of this chapter.