

§ 489.55

care. The OIG will not terminate a provider agreement under paragraph (a) if CMS has waived a disallowance with respect to the services in question on the grounds that the provider and the beneficiary could not reasonably be expected to know that payment would not be made. (The rules for determining such lack of knowledge are set forth in §§ 405.330 through 405.334 of this chapter.)

(b) *Notice of termination.* The OIG will give the provider notice of termination at least 15 days before the effective date of termination of the agreement, and will concurrently give notice of termination to the public.

(c) *Appeal by the provider.* A provider may appeal a termination of its agreement by the OIG in accordance with subpart O of part 405 of this chapter.

(d) *Other applicable rules.* The termination of a provider agreement by the OIG is subject to the additional procedures specified in §§ 1001.105 through 1001.109 of this title for notice and appeals.

[51 FR 24492, July 3, 1986, as amended at 51 FR 34788, Sept. 30, 1986]

§ 489.55 Exceptions to effective date of termination.

Payment is available for up to 30 days after the effective date of termination for—

(a) Inpatient hospital services (including inpatient psychiatric hospital services) and posthospital extended care services furnished to a beneficiary who was admitted before the effective date of termination; and

(b) Home health services and hospice care furnished under a plan established before the effective date of termination.¹

[50 FR 37376, Sept. 13, 1985]

§ 489.57 Reinstatement after termination.

When a provider agreement has been terminated by CMS under § 489.53, or by the OIG under § 489.54, a new agreement with that provider will not be accepted unless CMS or the OIG, as appropriate, finds—

¹For termination before July 18, 1984, payment was available through the calendar year in which the termination was effective.

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(a) That the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and

(b) That the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

[51 FR 24493, July 3, 1986]

Subpart F—Surety Bond Requirements for HHAs

SOURCE: 63 FR 313, Jan. 5, 1998, unless otherwise noted.

§ 489.60 Definitions.

As used in this subpart unless the context indicates otherwise—

Assessment means a sum certain that CMS may assess against an HHA in lieu of damages under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Assets includes but is not limited to any listing that identifies Medicare beneficiaries to whom home health services were furnished by a participating or formerly participating HHA.

Civil money penalty means a sum certain that CMS has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social Security Act or under regulations in this chapter.

Participating home health agency means a “home health agency” (HHA), as that term is defined by section 1861(o) of the Social Security Act, that also meets the definition of a “provider” set forth at § 400.202 of this chapter.

Rider means a notice issued by a Surety that a change in the bond has occurred or will occur.

Surety bond means one or more bonds issued by one or more surety companies under 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225, provided the bond otherwise meets the requirements of this section.

Unpaid civil money penalty or assessment means a civil money penalty or assessment imposed by CMS on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, after the HHA or Surety