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PART 489--PROVIDER AGREEMENTS AND SUPPLIER APPROVAL--Table of Contents

Subpart A--General Provisions

Sec. 489.2 Scope of part.

(a) Subpart A of this part sets forth the basic requirements for submittal and acceptance of a provider agreement under Medicare. Subpart B of this part specifies the basic commitments and limitations that the provider must agree to as part of an agreement to provide services. Subpart C specifies the limitations on allowable charges to beneficiaries for deductibles, coinsurance, copayments, blood, and services that must be part of the provider agreement. Subpart D of this part specifies how incorrect collections are to be handled. Subpart F sets forth the circumstances and procedures for denial of payments for new admissions and for withholding of payment as an alternative to termination of a provider agreement.

(b) The following providers are subject to the provisions of this part:

- (1) Hospitals.
- (2) Skilled nursing facilities (SNFs).
- (3) Home health agencies (HHAs).
- (4) Clinics, rehabilitation agencies, and public health agencies.
- (5) Comprehensive outpatient rehabilitation facilities (CORFs).
- (6) Hospices.
- (7) Critical access hospital (CAHs).
- (8) Community mental health centers (CMHCs).

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(c)(1) Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient physical therapy, and speech pathology services.

(2) CMHCs may enter into provider agreements only to furnish partial hospitalization services.

[45 FR 22937, Apr. 4, 1980, as amended at 47 FR 56297, Dec. 15, 1982; 48 FR 56036, Dec. 15, 1983; 51 FR 24492, July 3, 1986; 58 FR 30676, May 26,

1993; 59 FR 6578, Feb. 11, 1994; 62 FR 46037, Aug. 29, 1997]