

**§ 489.54 Termination by the OIG.**

(a) *Basis for termination.* (1) The OIG may terminate the agreement of any provider if the OIG finds that any of the following failings can be attributed to that provider.

(i) It has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application or request for payment under Medicare.

(ii) It has submitted, or caused to be submitted, requests for Medicare payment of amounts that substantially exceed the costs it incurred in furnishing the services for which payment is requested.

(iii) It has furnished services that the OIG has determined to be substantially in excess of the needs of individuals or of a quality that fails to meet professionally recognized standards of health care. The OIG will not terminate a provider agreement under paragraph (a) if HCFA 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.<sup>1</sup>

[50 FR 37376, Sept. 13, 1985]

**§ 489.57 Reinstatement after termination.**

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

(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 HCFA 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 HCFA has the authority to impose on an HHA as a penalty under Titles XI, XVIII, or XXI of the Social

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

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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 HCFA on an HHA under Titles XI, XVIII, or XXI of the Social Security Act, plus accrued interest, that, after the HHA or Surety has exhausted all administrative appeals, remains unpaid (because the civil money penalty or assessment has not been paid to, or offset or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid civil money penalty or assessment* also means such civil money penalty or assessment, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

*Unpaid claim* means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that, 90 days after the date of the agency’s notice to the HHA of the overpayment, remains due (because the overpayment has not been paid to, or recouped or compromised by, HCFA) and is not the subject of a written arrangement, acceptable to HCFA, for payment by the HHA. In the event a written arrangement for payment, acceptable to HCFA, is made, an *unpaid claim* also means a Medicare overpayment for which the HHA is responsible, plus accrued interest, that remains due 60 days after the HHA’s default on such arrangement.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

**42 CFR Ch. IV (10–1–00 Edition)**

**§ 489.61 Basic requirement for surety bonds.**

Except as provided in § 489.62, each HHA that is a Medicare participating HHA, or that seeks to become a Medicare participating HHA, must obtain a surety bond (and furnish to HCFA a copy of such surety bond) that meets the requirements of this subpart F and HCFA’s instructions.

**§ 489.62 Requirement waived for Government-operated HHAs.**

An HHA operated by a Federal, State, local, or tribal government agency is deemed to have provided HCFA with a comparable surety bond under State law, and HCFA therefore waives the requirements of this subpart with respect to such an HHA if, during the preceding 5 years the HHA has—

(a) Not had any unpaid claims or unpaid civil money penalties or assessments; and

(b) Not had any of its claims referred by HCFA to the Department of Justice or the General Accounting Office in accordance with part 401 of this chapter.

[63 FR 313, Jan. 5, 1998, as amended at 63 FR 29655, June 1, 1998]

**§ 489.63 Parties to the bond.**

The surety bond must name the HHA as Principal, HCFA as Oblige, and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as Surety.

**§ 489.64 Authorized Surety and exclusion of surety companies.**

(a) An HHA may obtain a surety bond required under § 489.61 only from an authorized Surety.

(b) An authorized Surety is a surety company that—

(1) Has been issued a Certificate of Authority by the U.S. Department of the Treasury in accordance with 31 U.S.C. 9304 to 9308 and 31 CFR parts 223, 224, and 225 as an acceptable surety on Federal bonds and the Certificate has neither expired nor been revoked; and

(2) Has not been determined by HCFA to be an unauthorized Surety for the purpose of an HHA obtaining a surety bond under this section.