

Subpart H—Payment of Hospital Insurance Benefits

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

SOURCE: 53 FR 6633, Mar. 2, 1988, unless otherwise noted.

§ 409.100 To whom payment is made.

(a) *Basic rule.* Except as provided in paragraph (b) of this section—

(1) Medicare pays hospital insurance benefits only to a participating provider.

(2) For home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA, payment is made to the HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

(b) *Exceptions.* Medicare may pay hospital insurance benefits as follows:

(1) For emergency services furnished by a nonparticipating hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart G of part 424 of this chapter.

(2) For services furnished by a Canadian or Mexican hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart H of part 424 of this chapter.

[53 FR 6633, Mar. 2, 1988, as amended at 65 FR 41211, July 3, 2000]

§ 409.102 Amounts of payment.

(a) The amounts Medicare pays for hospital insurance benefits are generally determined in accordance with part 412 or part 413 of this chapter.

(b) Except as provided in §§ 409.61(d) and 409.89, hospital insurance benefits are subject to the deductible and coinsurance requirements set forth in subpart G of this part.

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AUTHORITY: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

SOURCE: 51 FR 41339, Nov. 14, 1986, unless otherwise noted.

§ 410.1

EDITORIAL NOTE: Nomenclature changes to part 410 appear at 62 FR 46037, Aug. 29, 1997.

Subpart A—General Provisions

§ 410.1 Basis and scope.

(a) *Statutory basis.* This part is based on the indicated provisions of the following sections of the Act:

(1) Section 1832—Scope of benefits furnished under the Medicare Part B supplementary medical insurance (SMI) program.

(2) Section 1833 through 1835 and 1862—Amounts of payment for SMI services, the conditions for payment, and the exclusions from coverage.

(3) Section 1861(qq)—Definition of the kinds of services that may be covered.

(4) Section 1865(b)—Permission for CMS to approve and recognize a national accreditation organization for the purpose of deeming entities accredited by the organization to meet program requirements.

(5) Section 1881—Medicare coverage for end-stage renal disease beneficiaries.

(6) Section 1842(o)—Payment for drugs and biologicals not paid on a cost or prospective payment basis.

(b) *Scope of part.* This part sets forth the benefits available under Medicare Part B, the conditions for payment and the limitations on services, the percentage of incurred expenses that Medicare Part B pays, and the deductible and copayment amounts for which the beneficiary is responsible. (Exclusions applicable to these services are set forth in subpart C of part 405 of this chapter. General conditions for Medicare payment are set forth in part 424 of this chapter.)

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 55 FR 53521, Dec. 31, 1990; 59 FR 63462, Dec. 8, 1994; 63 FR 58905, Nov. 2, 1998; 65 FR 83148, Dec. 29, 2000; 69 FR 66420, Nov. 15, 2004]

§ 410.2 Definitions.

As used in this part—

Community mental health center (CMHC) means an entity that—

(1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service

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area who have been discharged from inpatient treatment at a mental health facility;

(2) Provides 24-hour-a-day emergency care services;

(3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;

(4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; and

(5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

Nominal charge provider means a provider that furnishes services free of charge or at a nominal charge, and is either a public provider or another provider that (1) demonstrates to CMS's satisfaction that a significant portion of its patients are low-income; and (2) requests that payment for its services be determined accordingly.

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Partial hospitalization services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and furnishes the services described in § 410.43.

Participating refers to a hospital, CAH, SNF, HHA, CORF, or hospice that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has a provider agreement to participate in Medicare but only for purposes of providing outpatient physical therapy, occupational therapy, or speech pathology services; or a CMHC that has in effect a similar agreement but only for purposes of providing partial hospitalization services, and *non-participating* refers to a hospital, CAH,