

Subpart A—Hospital Insurance Benefits: General Provisions

§ 409.1 Statutory basis.

This part is based on the identified provisions of the following sections of the Social Security Act:

(a) Sections 1812 and 1813 establish the scope of benefits of the hospital insurance program under Medicare Part A and set forth deductible and coinsurance requirements.

(b) Sections 1814 and 1815 establish conditions for, and limitations on, payment for services furnished by providers.

(c) Section 1820 establishes the critical access hospital program.

(d) Section 1861 describes the services covered under Medicare Part A, and benefit periods.

(e) Section 1862(a) specifies exclusions from coverage.

(f) Section 1881 sets forth the rules for individuals who have end-stage renal disease (ESRD), for organ donors, and for dialysis, transplantation, and other services furnished to ESRD patients.

[60 FR 50441, Sept. 29, 1995, as amended at 65 FR 62646, Oct. 19, 2000]

§ 409.2 Scope.

Subparts A through G of this part describe the benefits available under Medicare Part A and set forth the limitations on those benefits, including certain amounts of payment for which beneficiaries are responsible.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.3 Definitions.

As used in this part, unless the context indicates otherwise—

Arrangements means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.

Covered refers to services for which the law and the regulations authorize Medicare payment.

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.

Participating refers to a hospital or other facility that meets the conditions of participation and has in effect a Medicare provider agreement.

Qualified hospital means a facility that—

(a) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;

(b) Is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;

(c) Provides 24-hour nursing service in accordance with Sec. 1861(e)(5) of the Act;

(d) If it is a U.S. hospital, is licensed, or approved as meeting the standards for licensing, by the State or local licensing agency; and

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate foreign licensing agency, and for purposes of furnishing nonemergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or by a foreign program under standards that CMS finds to be equivalent to those of JCAHO.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 51 FR 41338, Nov. 14, 1986; 71 FR 48135, Aug. 18, 2006]

§ 409.5 General description of benefits.

Hospital insurance (Part A of Medicare) helps pay for inpatient hospital or inpatient CAH services and posthospital SNF care. It also pays for home health services and hospice care. There are limitations on the number of days of care that Medicare can pay for and there are deductible and coinsurance amounts for which the beneficiary is responsible. For each type of service, certain conditions must be met as specified in the pertinent sections of this subpart and in part 418 of this chapter regarding hospice care. Conditions for

payment of emergency inpatient services furnished by a nonparticipating U.S. hospital and for services furnished in a foreign country are set forth in subparts G and H of part 424 of this chapter.

[71 FR 48135, Aug. 18, 2006]

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

§ 409.10 Included services.

(a) Subject to the conditions, limitations, and exceptions set forth in this subpart, the term “inpatient hospital or inpatient CAH services” means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- (1) Bed and board.
- (2) Nursing services and other related services.
- (3) Use of hospital or CAH facilities.
- (4) Medical social services.
- (5) Drugs, biologicals, supplies, appliances, and equipment.
- (6) Certain other diagnostic or therapeutic services.
- (7) Medical or surgical services provided by certain interns or residents-in-training.
- (8) Transportation services, including transport by ambulance.

(b) *Inpatient hospital services* does not include the following types of services:

- (1) Posthospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.
- (2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.
- (3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.
- (4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.
- (5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985; 58 FR 30666, May 26, 1993; 64 FR 3648, Jan. 25, 1999; 65 FR 18535, Apr. 7, 2000]

§ 409.11 Bed and board.

(a) *Semiprivate and ward accommodations.* Except for applicable deductible and coinsurance amounts, Medicare Part A pays in full for bed and board and semiprivate (2 to 4 beds), or ward (5 or more beds) accommodations.

(b) *Private accommodations—(1) Conditions for payment in full.* Except for applicable deductible and coinsurance amounts, Medicare Part A pays in full for a private room if—

- (i) The patient's condition requires him or her to be isolated;
- (ii) The hospital or CAH has no semiprivate or ward accommodations; or
- (iii) The hospital's or CAH's semiprivate and ward accommodations are fully occupied by other patients, were so occupied at the time the patient was admitted to the hospital or CAH, respectively, for treatment of a condition that required immediate inpatient hospital or inpatient CAH care, and have been so occupied during the interval.

(2) *Period of payment.* In the situations specified in paragraph (b)(1) (i) and (iii) of this section, Medicare pays for a private room until the patient's condition no longer requires isolation or until semiprivate or ward accommodations are available.

(3) *Conditions for patient's liability.* The hospital or CAH may charge the patient the difference between its customary charge for the private room and its most prevalent charge for a semiprivate room if—

- (i) None of the conditions of paragraph (b)(1) of this section is met; and
- (ii) The private room was requested by the patient or a member of the family, who, at the time of the request, was informed what the hospital's or CAH's charge would be.

[48 FR 12541, Mar. 25, 1983, as amended at 58 FR 30666, May 26, 1993]