

EDITORIAL NOTE: Nomenclature changes to part 411 appear at 71 FR 9471, Feb. 24, 2006

Subpart A—General Exclusions and Exclusion of Particular Services

§411.1 Basis and scope.

(a) *Statutory basis.* Sections 1814(a) and 1835(a) of the Act require that a physician certify or recertify a patient's need for home health services but, in general, prohibit a physician from certifying or recertifying the need for services if the services will be furnished by an HHA in which the physician has a significant ownership interest, or with which the physician has a significant financial or contractual relationship. Sections 1814(c), 1835(d), and 1862 of the Act exclude from Medicare payment certain specified services. The Act provides special rules for payment of services furnished by the following: Federal providers or agencies (sections 1814(c) and 1835(d)); hospitals and physicians outside of the U.S. (sections 1814(f) and 1862(a)(4)); and hospitals and SNFs of the Indian Health Service (section 1880 of the Act). Section 1877 of the Act sets forth limitations on referrals and payment for designated health services furnished by entities with which the referring physician (or an immediate family member of the referring physician) has a financial relationship.

(b) *Scope.* This subpart identifies:

- (1) The particular types of services that are excluded;
- (2) The circumstances under which Medicare denies payment for certain services that are usually covered; and
- (3) The circumstances under which Medicare pays for services usually excluded from payment.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 41978, Aug. 14, 1995; 60 FR 45361, Aug. 31, 1995; 66 FR 952, Jan. 4, 2001]

§411.2 Conclusive effect of QIO determinations on payment of claims.

If a utilization and quality control quality improvement organization (QIO) has assumed review responsibility, in accordance with part 466 of this chapter, for services furnished to Medicare beneficiaries, Medicare payment is not made for those services un-

less the conditions of subpart C of part 466 of this chapter are met.

§411.4 Services for which neither the beneficiary nor any other person is legally obligated to pay.

(a) *General rule.* Except as provided in §411.8(b) (for services paid by a governmental entity), Medicare does not pay for a service if—

- (1) The beneficiary has no legal obligation to pay for the service; and
- (2) No other person or organization (such as a prepayment plan of which the beneficiary is a member) has a legal obligation to provide or pay for that service.

(b) *Special conditions for services furnished to individuals in custody of penal authorities.* Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule. Payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

[54 FR 41734, Oct. 11, 1989, as amended at 72 FR 47410, Aug. 22, 2007]

§411.6 Services furnished by a Federal provider of services or other Federal agency.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, Medicare does not pay for services furnished by a

§ 411.7

42 CFR Ch. IV (10–1–23 Edition)

Federal provider of services or other Federal agency.

(b) *Exceptions.* Payment may be made—

(1) For emergency hospital services, if the conditions of § 424.103 of this chapter are met;

(2) For services furnished by a participating Federal provider which CMS has determined is providing services to the public generally as a community institution or agency;

(3) For services furnished by participating hospitals and SNFs of the Indian Health Service; and

(4) For services furnished under arrangements (as defined in § 409.3 of this chapter) made by a participating hospital.

§ 411.7 Services that must be furnished at public expense under a Federal law or Federal Government contract.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, payment may not be made for services that any provider or supplier is obligated to furnish at public expense, in accordance with a law of, or a contract with, the United States.

(b) *Exception.* Payment may be made for services that a hospital or SNF of the Indian Health Service is obligated to furnish at public expense.

§ 411.8 Services paid for by a Government entity.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, Medicare does not pay for services that are paid for directly or indirectly by a government entity.

(b) *Exceptions.* Payment may be made for the following:

(1) Services furnished under a health insurance plan established for employees of the government entity.

(2) Services furnished under a title of the Social Security Act other than title XVIII.

(3) Services furnished in or by a participating general or special hospital that—

(i) Is operated by a State or local government agency; and

(ii) Serves the general community.

(4) Services furnished in a hospital or elsewhere, as a means of controlling in-

fectious diseases or because the individual is medically indigent.

(5) Services furnished by a participating hospital or SNF of the Indian Health Service.

(6) Services furnished by a public or private health facility that—

(i) Is not a Federal provider or other facility operated by a Federal agency;

(ii) Receives U.S. government funds under a Federal program that provides support to facilities that furnish health care services;

(iii) Customarily seeks payment for services not covered under Medicare from all available sources, including private insurance and patients' cash resources; and

(iv) Limits the amounts it collects or seeks to collect from a Medicare Part B beneficiary and others on the beneficiary's behalf to:

(A) Any unmet deductible applied to the charges related to the reasonable costs that the facility incurs in providing the covered services;

(B) Twenty percent of the remainder of those charges;

(C) The charges for noncovered services.

(7) Rural health clinic services that meet the requirements set forth in part 491 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 56 FR 2139, Jan. 22, 1991]

§ 411.9 Services furnished outside the United States.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare does not pay for services furnished outside the United States. For purposes of this paragraph (a), the following rules apply:

(1) The United States includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, The Northern Mariana Islands, and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the United States.

(2) Services furnished on board ship are considered to have been furnished in United States territorial waters if they were furnished while the ship was in a port of one of the jurisdictions listed in paragraph (a)(1) of this section, or within 6 hours before arrival