

§ 424.108 Payment to a hospital.

(a) *Conditions for payment.* Medicare pays the hospital for emergency services if the hospital—

(1) Has in effect a statement of election to claim payment for all covered emergency services furnished during a calendar year, in accordance with § 424.104;

(2) Claims payment in accordance with § 424.32; and

(3) Submits evidence requested by CMS to establish that the services meet the requirements of this subpart.

(b) *Subsequent claims.* If the hospital files subsequent claims because the initial claim did not include all the services furnished, those claims must include physicians' statements that—

(1) Contain sufficient information to clearly establish that, when the additional services were furnished, the emergency still existed; and

(2) Indicate when the emergency ended, which, for inpatient hospital services, is the earliest date on which the beneficiary could be safely discharged or transferred to a participating hospital or other institution.

§ 424.109 Payment to the beneficiary.

Medicare pays the beneficiary for emergency services if the following conditions are met:

(a) The hospital does not have in effect an election to claim payment.

(b) The beneficiary, or someone on his or her behalf, submits—

(1) A claim that meets the requirements of § 424.32;

(2) An itemized hospital bill; and

(3) Evidence requested by CMS to establish that the services meet the requirements of this subpart.

Subpart H—Special Conditions: Services Furnished in a Foreign Country**§ 424.120 Scope.**

This subpart sets forth the conditions for payment for services furnished in a foreign country.

§ 424.121 Scope of payments.

Subject to the conditions set forth in this subpart—

(a) Medicare Part A pays, in the amounts specified in § 413.74 of this chapter, for emergency and non-emergency inpatient hospital services furnished by a foreign hospital.

(b) Medicare Part B pays for certain physicians' services and ambulance services furnished in connection with covered inpatient care in a foreign hospital, as specified in § 424.124.

(c) All other services furnished outside the United States are excluded from Medicare coverage, as specified in § 411.9 of this chapter.

[53 FR 6634, Mar. 2, 1988, as amended at 71 FR 48143, Aug. 18, 2006]

§ 424.122 Conditions for payment for emergency inpatient hospital services.

Medicare Part A pays for emergency inpatient hospital services furnished by a foreign hospital if the following conditions are met:

(a) At the time of the emergency that required the inpatient hospital services, the beneficiary was—

(1) In the United States; or

(2) In Canada traveling between Alaska and another State without unreasonable delay and by the most direct route.

(b) The foreign hospital was closer to, or more accessible from, the site of the emergency than the nearest United States hospital equipped to deal with, and available to treat, the individual's illness or injury.

(c) The conditions for payment for emergency services set forth in § 424.103 are met.

(d) The hospital is a hospital as defined in § 424.101, and is licensed, or approved as meeting the conditions for licensing, by the appropriate agency of the country in which it is located.

(e) The determination of whether the hospital was more accessible is made in accordance with § 424.106.

§ 424.123 Conditions for payment for nonemergency inpatient services furnished by a hospital closer to the individual's residence.

Medicare Part A pays for inpatient hospital services furnished by a foreign hospital if the following conditions are met:

§ 424.124

(a) The beneficiary is a resident of the United States.

(b) The foreign hospital is closer or more accessible to the beneficiary's residence than the nearest United States hospital equipped to deal with, and available to treat, the individual's illness or injury.

(c) The foreign hospital is—

(1) A hospital as defined in § 424.101 and, it is licensed, or approved as meeting the conditions for licensing, by the appropriate agency of the country in which it is located; and

(2) Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or accredited or approved by a program of the country where it is located under standards the CMS finds to be essentially equivalent to those of the JCAHO.

(d) The services are covered services that Medicare would pay for if they were furnished by a participating hospital.

[53 FR 6634, Mar. 2, 1988, as amended at 71 FR 48143, Aug. 18, 2006]

§ 424.124 Conditions for payment for physician services and ambulance services.

(a) *Basic rules.* Medicare Part B pays for physician and ambulance services if—

(1) They are furnished—

(i) To an individual who is entitled to Part B benefits; and

(ii) In connection with covered inpatient hospital services; and

(2) They meet the conditions set forth in paragraphs (b) and (c) of this section.

(b) *Physician services.* (1) The physician services are services covered under Medicare Part B and are furnished—

(i) In the hospital, during a period of covered inpatient services; or

(ii) Outside the hospital, on the day of admission and for the same condition that required inpatient admission; and

(2) The physician is legally authorized to practice in the country where he or she furnishes the services.

(c) *Ambulance services.* The ambulance services are—

(1) Necessary because the use of other means of transportation is contra-

42 CFR Ch. IV (10–1–23 Edition)

indicated by the beneficiary's condition; and

(2) Furnished by an ambulance that meets the definition in § 410.41 of this chapter.

[53 FR 6646, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 64 FR 3649, Jan. 25, 1999]

§ 424.126 Payment to the hospital.

(a) *Conditions for payment.* Medicare pays the hospital if it—

(1) Has in effect an election that—

(i) Meets the requirements set forth in § 424.104; and

(ii) Reflects the hospital's intent to claim for all covered services furnished during a calendar year.

(2) Claims payment in accordance with §§ 424.32 and 413.74 of this chapter; and

(3) Submits evidence requested by CMS to establish that the services meet the requirements of this subpart.

(b) *Amount of payment.* Payment is made (in accordance with § 413.74 of this chapter) on the basis of 100 percent of the hospital's customary charges, subject to the applicable deductible and coinsurance provisions set forth elsewhere in this chapter.

§ 424.127 Payment to the beneficiary.

(a) *Conditions for payment of inpatient hospital services.* Medicare pays the beneficiary if—

(1) The hospital does not have in effect an election to claim payment; and

(2) The beneficiary, or someone on his or her behalf, submits—

(i) A claim in accordance with § 424.32;

(ii) An itemized hospital bill; and

(iii) Evidence requested by CMS to establish that the services meet the requirements of this subpart.

(b) *Amount payable for inpatient hospital services.* The amount payable to the beneficiary is determined in accordance with § 424.109(b).

(c) *Conditions for payment for Part B services.* Medicare pays the beneficiary for physicians' services and ambulance services as specified in § 424.121, if an itemized bill for the services is submitted by the beneficiary or someone on his or her behalf and the conditions of § 424.126(a) (2) and (3) are met.

(d) The amount payable to the beneficiary is determined in accordance with § 410.152 of this chapter.

Subpart I—Requirements for Medicare Diabetes Prevention Program Suppliers and Beneficiary Engagement Incentives Under the Medicare Diabetes Prevention Program Expanded Model

SOURCE: 82 FR 53364, Nov. 15, 2017, unless otherwise noted.

§ 424.200 Scope.

This subpart specifies the requirements for Medicare Diabetes Prevention Program suppliers and beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model.

§ 424.205 Requirements for Medicare Diabetes Prevention Program suppliers.

(a) *Definitions.* In addition to the definitions specified at § 410.79(b) and § 414.84(a) of this subchapter, the following definitions apply to this section:

Administrative location means a physical location associated with the MDPP supplier's operations where they are the primary operator in the space, from where coaches are dispatched or based, and where MDPP services may or may not be furnished.

Coach means an individual who furnishes MDPP services on behalf of an MDPP supplier as an employee, contractor, or volunteer.

Coach eligibility end date means the end date indicated by the MDPP supplier in submitting a change to the supplier's MDPP enrollment application in accordance with paragraph (d)(5) of this section that removed the coach's information, or the date the supplier itself was revoked from or withdrew its Medicare enrollment as an MDPP supplier.

Coach eligibility start date, means the start date indicated by the MDPP supplier when submitting the coach's information on the MDPP enrollment application.

Community setting means a location where the MDPP supplier furnishes MDPP services outside of their administrative locations. A community setting is a location open to the public not primarily associated with the supplier. Community settings may include, for example, church basements or multipurpose rooms in recreation centers.

Eligible coach means an individual who CMS has screened and has determined can provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

Ineligible coach means an individual whom CMS has screened and has determined cannot provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

MDPP interim preliminary recognition means a status that CMS has granted to an entity in accordance with paragraph (c) of this section.

(b) *Conditions for MDPP supplier enrollment.* An entity may enroll as an MDPP supplier only if it satisfies the following requirements and all other applicable Medicare enrollment requirements:

(1) Has either an MDPP preliminary recognition, as defined in paragraph (c)(1) of this section or a full CDC DPRP recognition.

(2) Maintains an active and valid TIN and NPI at the organizational level.

(3) Has passed screening requirements as follows:

(i) Upon initial enrollment, at a "high" categorical risk in accordance with § 424.518(c)(2); and

(ii) Upon revalidation, at a "moderate" categorical risk in accordance with § 424.518(b)(2).

(4) Maintains, and submits to CMS through the CMS-approved enrollment application, a roster of all coaches who will be furnishing MDPP services on the entity's behalf that includes each coach's first and last names, middle initial (if applicable), date of birth, Social Security Number (SSN), active and valid NPI, coach eligibility start date, and coach eligibility end date (if applicable). This roster must be updated in accordance with paragraph (d)(5) of this section.