

**Subpart G—Special Conditions:
Emergency Services Furnished
by a Nonparticipating Hos-
pital**

§ 424.100 Scope.

This subpart sets forth procedures and criteria that are followed in determining whether Medicare will pay for emergency services furnished by a hospital that is located in the United States and does not have in effect a provider agreement, that is, an agreement to participate in Medicare.

§ 424.101 Definitions.

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

Emergency services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

Hospital means a facility that—

(1) 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;

(2) Is not primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, as described in section 1861(j)(1)(A) of the Act;

(3) Provides 24-hour nursing service in accordance with section 1861(e)(5) of the Act; and

(4) Is licensed, or is approved as meeting the standards for licensing, by the State or local licensing agency.

Reasonable charges means customary charges insofar as they are reasonable.

§ 424.102 Situations that do not constitute an emergency.

Without additional evidence of a threat to life or health, the following situations do not in themselves indicate a need for emergency services:

(a) Lack of care at home.

(b) Lack of transportation to a participating hospital.

(c) Death of the patient in the hospital.

§ 424.103 Conditions for payment for emergency services.

Medicare pays for emergency services furnished to a beneficiary by a nonparticipating hospital or under arrangements made by such a hospital if the conditions of this section are met.

(a) *General requirements.* (1) The services are of the type that Medicare would pay for if they were furnished by a participating hospital.

(2) The hospital has in effect an election to claim payment for all emergency services furnished in a calendar year in accordance with § 424.104.

(3) The need for emergency services arose while the beneficiary was not an inpatient in a hospital.

(4) In the case of inpatient hospital services, the services are furnished during a period in which the beneficiary could not be safely discharged or transferred to a participating hospital or other institution.

(5) The determination that the hospital was the most accessible hospital available and equipped to furnish the services is made in accordance with § 424.106.

(b) *Medical information requirements.* A physician (or, if appropriate, the hospital) submits medical information that—

(1) Describes the nature of the emergency and specifies why it required that the beneficiary be treated in the most accessible hospital;

(2) Establishes that all the conditions in paragraph (a) of this section are met; and

(3) Indicates 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.

§ 424.104 Election to claim payment for emergency services furnished during a calendar year.

(a) *Terms of the election.* The hospital agrees to the following:

(1) To comply with the provisions of subpart C of part 489 of this chapter relating to charges for items and services the hospital may make to the beneficiary, or any other person on his or her behalf.