

§ 424.3

This subpart A provides a general overview. Other subparts deal specifically with—

(1) The requirement that the need for services be certified and that a physician establish a plan of treatment (subpart B);

(2) The procedures and time limits for filing claims (subpart C);

(3) The individuals or entities to whom payment may be made (subparts D and E);

(4) The limitations on assignment and reassignment of claims (subpart F);

(5) Special requirements that apply to services furnished by nonparticipating U.S. hospitals and foreign hospitals (subparts G and H); and

(6) The replacement and reclamation of Medicare payment checks (subpart M).

(c) *Other applicable rules.* Except for § 424.40(c)(3), this part does not deal with the conditions for payment of rural health clinic (RHC) services, Federally qualified health center (FQHC) services, or ambulatory surgical center (ASC) services. Those conditions are set forth in part 405, subpart X, and part 481 subpart A of this chapter for RHC and FQHC services; and in part 416 of this chapter, for ASC services. The rules for physician certification of terminal illness, required in connection with hospice care, are set forth in § 418.22 of this chapter.

[53 FR 6634, Mar. 2, 1988, as amended at 60 FR 38271, July 26, 1995; 60 FR 50442, Sept. 29, 1995; 62 FR 46035, Aug. 29, 1997; 71 FR 20775, Apr. 21, 2006; 71 FR 48409, Aug. 18, 2006]

§ 424.3 Definitions.

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

HCPCS means Healthcare Common Procedure Coding System.

ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification.

Nonparticipating hospital means a hospital that does not have in effect a provider agreement to participate in Medicare.

42 CFR Ch. IV (10-1-23 Edition)

Participating hospital means a hospital that has in effect a provider agreement to participate in Medicare.

[53 FR 6634, Mar. 2, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 63 FR 26311, May 12, 1998; 70 FR 45055, Aug. 4, 2005]

§ 424.5 Basic conditions.

(a) As a basis for Medicare payment, the following conditions must be met:

(1) *Types of services.* The services must be—

(i) Covered services, as specified in part 409 or part 410 of this chapter; or

(ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with §§ 405.332 through 405.334 of this chapter, pertaining to limitation of liability.

(2) *Sources of services.* The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.

(3) *Beneficiary of services.* Except as provided in § 409.68 of this chapter, the services must have been furnished while the individual was eligible to have payment made for them. (Section 409.68 provides for payment of inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)

(4) *Certification of need for services.* When required, the provider must obtain certification and recertification of the need for the services in accordance with subpart B of this part.

(5) *Claim for payment.* The provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment, in accordance with subpart C of this part.

(6) *Sufficient information.* The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

(b) Additional conditions applicable in certain circumstances or to certain