

§ 409.1

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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