

#### § 424.104

(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.

(2) To comply with the provisions of subpart D of part 489 of this chapter relating to proper disposition of monies incorrectly collected from, or on behalf of a beneficiary.

(3) To request payment under the Medicare program based on amounts specified in § 413.74 of this chapter.

(b) *Filing of election statement.* An election statement must be filed on a form designated by CMS, signed by an authorized official of the hospital, and either received by CMS, or postmarked, before the close of the calendar year of election.

(c) *Acceptance and effective date of election.* If CMS accepts the election statement, the election is effective as of the earliest day of the calendar year of election from which CMS determines the hospital has been in continuous compliance with the requirements of section 1814(d) of the Act.

(d) *Appeal by hospital.* Any hospital dissatisfied with a determination that it does not qualify to claim reimbursement shall be entitled to appeal the determination as provided in part 498 of this chapter.

(e) *Conditions for reinstatement after notice of failure to continue to qualify.* If CMS has notified a hospital that it no longer qualifies to receive reimbursement for a calendar year, CMS will not accept another election statement from that hospital until CMS finds that—

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(1) The reason for its failure to qualify has been removed; and

(2) There is reasonable assurance that it will not recur.

#### § 424.106 Criteria for determining whether the hospital was the most accessible.

(a) *Basic requirement.* (1) The hospital must be the most accessible one available and equipped to furnish the services.

(2) CMS determines accessibility based on the factors specified in paragraphs (b) and (c) of this section and the conditions set forth in paragraph (d) of this section.

(b) *Factors that are considered.* CMS considers the following factors in determining whether a nonparticipating hospital in a rural area meets the accessibility requirements:

(1) The relative distances of participating and nonparticipating hospitals in the area.

(2) The transportation facilities available to these hospitals.

(3) The quality of the roads to each hospital.

(4) The availability of beds at each hospital.

(5) Any other factors that bear on whether or not the services could be provided sooner in the nonparticipating hospitals than in a participating hospital in the general area.

In urban and suburban areas where both participating and nonparticipating hospitals are similarly available, CMS presumes that the services could have been provided in a participating hospital unless clear and convincing evidence shows that there was a medical or practical need to use the nonparticipating hospital.

(c) *Factors that are not considered.* CMS gives no consideration to the following factors in determining whether the nonparticipating hospital was the most accessible hospital:

(1) The personal preference of the beneficiary, the physician, or members of the family.

(2) The fact that the attending physician did not have staff privileges in a participating hospital which was available and the most accessible to the beneficiary.

(3) The location of previous medical records.

(d) *Conditions under which the accessibility requirement is met.* If a beneficiary must be taken to a hospital immediately for required diagnosis and treatment, the nonparticipating hospital meets the accessibility requirement if—

(1) It was the nearest hospital to the point where the emergency occurred, it was medically equipped to handle the type of emergency, and it was the most accessible, on the basis of the factors specified in paragraph (b) of this section; or

(2) There was a closer participating hospital equipped to handle the emergency, but the participating hospital did not have a bed available or would not accept the individual.

#### § 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,