

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 non-participating 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.

(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—

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

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