CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3199	**Date: February 20, 2015**
	Change Request 8940

SUBJECT: Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims

I. SUMMARY OF CHANGES: This Change Request (CR) revises the instruction found in the Medicare Claims Processing manual for processing foreign, emergency and shipboard claims.

EFFECTIVE DATE: April 21, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2015
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	1/10.1.4/Services Received by Medicare Beneficiaries Outside the United States
D	1/10.1.4/10.1.4.1/ Physician and Ambulance Services Furnished in Connection With Covered Foreign Inpatient Hospital Services
D	1/10.1.4/10.1.4.2/Carriers Designated to Process Foreign Claims
D	1/10.1.4/10.1.4.3/Contractor Processing Guidelines
D	1/10.1.4/10.1.4.4/Medicare Approved Charges for Services Rendered in Canada or Mexico
D	1/10.1.4/10.1.4.5/Appeals of Denied Charges for Physicians and Ambulance Services in Connection With Foreign Hospitalization
D	1/10.1.4/10.1.4.6/Claims for Services Furnished in Canada and Mexico to Qualified Railroad Retirement Beneficiaries
D	1/10.1.4/10.1.4.7 - Shipboard Services Billed to the Carrier
D	1/10.1.4/10.1.4.8/Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States
D	3/110/Emergency and Foreign Hospital Services
D	3/110/110.1/Services Rendered in Nonparticipating Providers
D	3/110/110.2/Establishing an Emergency
D	3/110/110.3/Qualifications of an Emergency Services Hospital
D	3/110/110.4/Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation
D	3/110/110.5/Coverage Requirements for Emergency Hospital Services in Foreign Countries
D	3/110/110.6/Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence
D	3/110/110.7/Coverage of Physician and Ambulance Services Furnished Outside U.S.
D	3/110/110.8/Claims for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries
D	3/110/110.9/Nonemergency Part B Medical and Other Health Services
D	3/110/110.11/Elections to Bill for Services Rendered Nonparticipating Hospitals
D	3/110/110.12/Processing Claims
D	3/110.12/110.12.1/Accessibility Criteria
D	3/110.12/110.12.2/Medical Necessity
D	3/110.12/110.12.3/Time Limitation on Emergency and Foreign Claims
D	3/110/110.13/Appeals on Claims for Emergency and Foreign Services

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
D	3/120/Payment for Services Received in Nonparticipating Providers
D	3/120/120.1/Payment for Services from Foreign Hospitals
D	3/120.1/120.1.1 - Attending Physician's Statement and Documentation of Medicare Emergency
D	3/120/120.2/Designated Contractors
D	3/120/120.3/Model Letters, Nonparticipating Hospital and Emergency Claims
D	3/120.3/120.3.1/Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year
D	3/120.3/120.3.2/Model Letter to Nonparticipating Hospital That Did Not Elect to Bill for Current Year
D	3/120.3120.3.3 - Model Letter to Nonparticipating Hospital That Requests to Bill the Program
D	3/120.3/120.3.4/Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
D	3/120.3/120.3.5/Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
D	3/120.3/120.3.6/Denial - Military Personnel/Eligible Dependents
D	3/120.3/120.3.7/Full Denial - Shipboard Claim - Beneficiary filed
D	3/120.3/120.3.8/Full Denial - Foreign Claim - Beneficiary Filed
N	32/340/Emergency and Foreign Hospital Services
N	32/340.1/Services Rendered By Nonparticipating Providers
N	32/340.2/Establishing an Emergency
N	32/340.3/Qualifications of an Emergency Services Hospital
N	32/340.4/Coverage Requirements for Emergency Hospital Services in Foreign Countries
N	32/340.5/Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence
N	32/340.6/Coverage of Physician and Ambulance Services Furnished Outside U.S.
N	32/340.7/Claims for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries
N	32/340.8/Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation
N	32/340.9 /Nonemergency Part B Medical and Other Health Services
N	32/340.10/Elections to Bill for Services Rendered By Nonparticipating Hospitals
N	32/340.11/Processing Claims

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/340/340.11.1/Contractors Designated to Process Foreign Claims
N	32/340/340.11.2/Contractor Processing Guidelines
N	32/340/340.11.3/Medicare Approved Charges for Services Rendered in Canada or Mexico
N	32/340/340.11.4/Accessibility Criteria
N	32/340/340.11.5/Medical Necessity
N	32/340/340.11.6/Time Limitation on Emergency and Foreign Claims
N	32/340/340.11.7/Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States
N	32/340/340.12/Appeals on Claims for Emergency and Foreign Services
N	32/350/Payment for Services Received By Nonparticipating Providers
N	32/350.1/Payment for Services from Foreign Hospitals
N	32/350.1/350.1.1/Attending Physician's Statement and Documentation of Medicare Emergency
N	32/350.2/Designated Contractors
N	32/350.3/Model Letters, Nonparticipating Hospital and Emergency Claims
N	32/350.3/350.3.1/Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year
N	32/350.3/350.3.2/Model Letter to Nonparticipating Hospital That Did Not Elect to Bill for Current Year
N	32/350.3/350.3.3/Model Letter to Nonparticipating Hospital That Requests to Bill the Program
N	32/350.3/350.3.4/Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
N	32/350.3/350.3.5/Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
N	32/350.3/350.3.6/Denial - Military Personnel/Eligible Dependents
N	32/350.3/350.3.7/Full Denial - Shipboard Claim - Beneficiary filed
N	32/350.3/350.3.8/Full Denial - Foreign Claim - Beneficiary Filed

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions

regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3199	Date: February 20, 2015	Change Request: 8940

SUBJECT: Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims

EFFECTIVE DATE: April 21, 2015*Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 21, 2015

I. GENERAL INFORMATION

A. Background: This Change Request (CR) revises the instruction found in the Medicare Claims Processing Manual for processing foreign, emergency and shipboard claims.

B. Policy: The purpose of this Change Request (CR) is to revise Publication 100-04, "Medicare Claims Processing Manual" regarding foreign, emergency and shipboard claims. The policy from the following chapters and sections will be removed:

- Chapter One, Section 10.1.4 "Services Received by Medicare Beneficiaries Outside the United States"
- Chapter Three, Section 110 "Emergency and Foreign Hospital Services"
- Chapter Three, Section 120 "Payment for Services Received in Nonparticipating Providers"

and will be placed in Chapter 32, Section 340 and 350 of the Medicare Claims Processing Manual.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8940.1	Medicare Contractors shall be aware of revisions to the Medicare Claims Processing manual regarding processing of foreign, emergency and shipboard claims.	X	X							RRB

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Frederick Grabau, Frederick.Grabau@cms.hhs.gov (Policy (For services furnished outside the U.S.)) , Shauntari Cheely, Shauntari.Cheely@cms.hhs.gov (Claims Processing) , Sarah Shirey - Losso, Sarah.Shirey-Losso@cms.hhs.gov (Claims Processing)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev.3199, Issued: 02-20-15)

Transmittals for Chapter 32

340 - Emergency and Foreign Hospital Services

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

The conditions for payment for services furnished in a foreign country can be found in 42 CFR 424.120-127, Subpart H - Special Conditions: Emergency Services Furnished In a Foreign Country. The payment exclusion for services furnished outside the U.S. is located at 42 CFR 411.9 and 42 CFR 411.9(a)(2) describes the applicability of the payment exclusion when services are furnished on board a ship.

340.1 - Services Rendered By Nonparticipating Providers

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

A. Services in Nonparticipating Domestic Hospital

Payment may be made for certain Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. Items and services furnished in a domestic nonparticipating hospital may be reimbursed if the following apply:

- *The hospital meets the definition of an emergency hospital. (See §340.3.)*
- *The services meet the definition of emergency services. (See §340.2.)*

- *The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §340.4.)*

B. Services Received by Medicare Beneficiaries outside the United States

Items and services furnished outside the United States and certain services rendered on board a ship are excluded from coverage except for the following services:

- *Emergency inpatient hospital services where the emergency occurred:*
  - *While the beneficiary was physically present in the United States; or*
  - *In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another State.*

- *Emergency or nonemergency inpatient hospital services furnished by a hospital located outside the United States, if the hospital was closer to, or substantially more accessible from, the beneficiary's United States residence than the nearest participating United States hospital that was adequately equipped to deal with, and available to provide treatment for the illness or injury*

- *Physician and ambulance services furnished in connection with a covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the United States .*

- *Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry*

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States. A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

C. Ship Physician's Office is in the United States.

When the physician's office is inside of the United States, the Contractor designated to process the shipboard claim is determined by the beneficiary's residence.

D. Ship Physician's Office is Outside of the United States.

When the physician's office is outside of the United States, the Contractor designated to process the shipboard claim is determined by the beneficiary's residence.

MSN message 16.240 (English)

Services provided aboard a ship are covered only when the ship is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.

MSN message 16.240 (Spanish)

Servicios proporcionados abordo de un barco son cubiertos solamente cuando el barco está en aguas territoriales de los Estados Unidos. Además, el servicio debe ser proporcionado por un médico con licencia para practicar en los Estados Unidos.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while he or she was within the United States or purchased the item from an American firm.

Under the Railroad Retirement Act, payment is made to qualified Railroad Retirement beneficiaries (QRRBs) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- *Whether the requirements are met for the inpatient services; and*
- *Whether the physician and/or ambulance services were furnished in connection with the services.*

Services for an individual who has elected religious nonmedical health care status may be covered if the above requirements are met but this revokes the religious nonmedical health care institution election.

340.2 - Establishing an Emergency

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Claims for emergency services must be accompanied by a physician's statement describing the nature of the emergency and stating that the services were necessary to prevent the death, or the serious impairment of, the beneficiary. A statement that an emergency existed is not sufficient. In addition, when inpatient services are involved, the statement must include the date when, in the physicians' judgment, the emergency ceased.

The finding of whether the patient's condition required emergency diagnosis or treatment is ordinarily based upon the physician's evaluation of the patient's condition immediately upon the beneficiary's arrival at the hospital.

However, the emergency nature of the situation may have been assessed by a physician who attended the patient where the incident resulting in hospitalization occurred (for example, a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the claim that emergency hospitalization was necessary.

Most emergencies are of relatively short duration so that only one bill is submitted. Generally, only one physician's statement is necessary. However, in the rare situation where an emergency continued over an extended period, subsequent requests for payment must be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A statement that the emergency continued to exist is not acceptable.

Additional information to support a finding that the services were emergency services from the physician, the hospital, and others (e.g., the police department at the scene of an accident) may be requested.

Medical necessity can be documented by the physician on a CMS-l77l, Attending Physician's Statement and Documentation of Medicare Emergency or by the beneficiary's medical records. The CMS-1771 can be obtained from:

Centers for Medicare & Medicaid Services
Forms Management Section
7500 Security Blvd.
Baltimore, MD 21244-1850

Or, the form can be downloaded from http://cms.hhs.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

340.3 - Qualifications of an Emergency Services Hospital

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

An emergency services hospital is a nonparticipating hospital that meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (A Federal hospital need not be licensed under State or local licensing laws to meet this definition.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type described in defining the term hospital.

The hospital must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. Psychiatric hospitals can qualify as emergency hospitals.

340.4 - Coverage Requirements for Emergency Hospital Services Furnished Outside of the United States

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

The following requirements must be met for payment to be made for emergency services received by Medicare beneficiaries in foreign hospitals:

- *The hospital must meet the definition of an emergency hospital and be licensed or approved by the appropriate agency of the country in which it is located.*

- *The services meet the criteria of emergency services.*

The foreign hospital must be closer to or substantially more accessible from the site of the emergency than the nearest U.S. hospital that was adequately equipped and available to treat the illness or injury.

1. Emergency Occurred in the U.S. (See §340.1.B for definition of the U.S.)
If the individual was physically present in the U.S. at the time the emergency occurred, the individual's reason for departure from the U.S. must have been specifically to obtain treatment at the foreign hospital. Services are not covered where the person's departure from the U.S. is part of a trip abroad and the foreign hospital is more accessible simply because the individual was in the process of travel. For example, the airplane on which the individual was traveling could not readily return to permit the person's removal.

2. Emergency Occurred in Canada

If the emergency occurred in Canada, the beneficiary must have been traveling, without unreasonable delay, by the most direct route between Alaska and another State. Benefits are not payable if the emergency occurred while a beneficiary was vacationing. The requirement of travel without unreasonable delay by the most direct route will be considered met if the emergency occurred while the beneficiary was enroute between Alaska and another State by the shortest practicable route, or while making a necessary stopover in connection with such travel.

NOTE: An emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

Ordinarily, the "shortest practicable route" is the one that results in the least amount of travel in Canada, consistent with the mode of travel used between the point of entry into Canada and the intended point of departure. The amount of travel in the U.S., prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel resulted in a saving of time or was necessary because of such factors as:

- *Road or weather conditions;*

- *The age of the traveler;*
- *Health, or physical condition of the traveler;*
- *The need to make suitable travel arrangements; or*
- *The need to obtain acceptable accommodations.*

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching their destination (e.g., for the principal purpose of sightseeing or vacationing).

> *The term "necessary stopover" means a routine stopover for rest, food, or servicing of the vehicle, and a non-routine stopover (even though of significant duration) caused by such factors as unsuitable road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.*

340.5 - Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)
Coverage is provided for inpatient hospital services furnished in a foreign hospital that is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest available participating U.S. hospital that is adequately equipped to deal with the illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred.

"Residence" means the beneficiary's fixed and permanent home to which they intend to return whenever they are away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

The foreign hospital must meet accreditation requirements equivalent to Joint Commission standards. For example, the Canadian Council on Hospital Accreditation (CCHA) has equivalent requirements. Thus, Canadian hospitals accredited by the CCHA meet the qualifying requirements. In the case of Mexican hospitals, the Dallas or San Francisco RO makes the determination, depending upon the hospital's location. Claims for services provided in countries other than Canada or Mexico should be sent to the MAC that is responsible for the state or territory where the emergency arose. In other words, the foreign claim would be processed similarly to how claims are processed in the state or territory where the emergency arose.

See §340.11.4 below for discussion of accessibility criteria.

Some claims for services furnished in a foreign hospital nearest to the beneficiary's U.S. residence will not be "emergency." In these nonemergency situations, it may be necessary to deny payment in whole or part, (even though it has been approved with regard to accessibility) because the services are not medically reasonable and necessary or involve custodial care (i.e., exclusions under §§1862(a)(1) and (9)). However, in the case of denials under the medical necessity and custodial care exclusions, the MAC applies the limitation on liability considerations under §1879 of the Act before issuing the denial notice.

The MAC examines claims involving medical necessity or custodial care denials to determine if there is any evidence that the beneficiary (or the person acting on behalf of the beneficiary) was aware that the beneficiary did not require, or no longer required, a covered level of care. The foreign hospital, since it is not participating, is not under any obligation to furnish a written notice of noncoverage to a beneficiary in order to protect itself from being held liable under the §1879 waiver of liability provision. However, there may be instances where the medical records of the denied foreign claim show that the beneficiary was advised that the beneficiary did not require, or no longer required, Medicare covered services, (e.g., written notice of noncoverage from the hospital's staff or a prior CMS denial notice). It will probably be rare where a finding is made that the beneficiary had knowledge of noncoverage, so that, generally, payments are made under the waiver of liability provision. The MAC uses appropriate Medicare Summary Notice (MSN) and

Remittance Advice denial messages for determinations involving the limitation on liability provision. For additional information regarding the application of the §1879 liability provisions, see IOM 100-4, Chapter 30.

340.6 – Coverage of Physician and Ambulance Services Furnished Outside U.S.

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Payment is made for necessary physician and ambulance services that meet the other coverage requirements of the Medicare program, and are furnished in connection with a covered foreign hospitalization.

A. Coverage of Physician and Ambulance Services Furnished Outside the U.S.

Where inpatient services in a foreign hospital are covered, payment may also be made for:

- *Physicians' services furnished to the beneficiary while he/she is an inpatient,*
- *Physicians' services furnished to the beneficiary outside the hospital on the day of his/her admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized (including the services of a physician who furnishes emergency services in Canadian waters on the day the patient is admitted to a Canadian hospital for a covered emergency stay) and,*
- *Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission as an inpatient. Return trips from a foreign hospital are not covered.*

In cases involving foreign ambulance services, the general requirements in chapter 15 are also applicable, subject to the following special rules:

- *If the foreign hospitalization was determined to be covered on the basis of emergency services, the medical necessity requirements outlined in chapter 15 are considered met.*
- *The definition of "physician," for purposes of coverage of services furnished outside the U.S., is expanded to include a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services are furnished.*
- *Only the beneficiary may file for Part B benefits. The assignment method may not be used. However, where the beneficiary is deceased, the rule for settling Part B underpayments is applicable, i.e., payment may be made to the foreign physician or ambulance company on the basis of an unpaid bill, provided the physician or ambulance company accepts the MACs reasonable charge determination as the full charge.*
- *The regular deductible and coinsurance requirements apply to physician and ambulance services.*

340.7 - Claims for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

All claims for hospital and/or related physician or ambulance services furnished in Canada to qualified railroad retirement beneficiaries (QRRB's) are forwarded first to the Railroad Retirement Board (RRB). Under the Railroad Retirement Act, payment is made by the RRB to Qualified Railroad Retirement Beneficiaries (QRRB) for covered hospital services furnished in Canadian hospitals as well as in the U.S. The Railroad Retirement Act does not cover physician and ambulance services; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- *Whether the requirements in §§340.1.B and 340.6 are met in regard to the inpatient services; and*

- *Whether the requirements in§340.6.A are met in regard to the physician and/or ambulance services were furnished in connection with the services*

If either is not met, RRB denies the claim and notifies the beneficiary. If met, RRB refers the claim to the RRB MAC, Palmetto GBA, to determine if the coverage criteria for physician and/or ambulance services are met.
The hospital must forward all claims for services furnished QRRBs in Canada to:

Retirement Medicare Section
U.S. Railroad Retirement Board
844 North Rush Street
Chicago, IL 60611-2092

If a QRRB is a resident of Canada, Medicare payments are reduced by the amount of payment made for the same services by the Canadian Provincial Health Insurance Plan.

B. Claims for services furnished in other foreign countries

The RRB does not pay for health care services furnished in Mexico or any foreign countries other than Canada.
All claims for inpatient hospital services and/or related physician or ambulance services furnished in Mexico to QRRB's should be forwarded directly to the Railroad Retirement Board. If the Railroad Retirement Board determines that the requirements in §340.6.A are not met, the Railroad Retirement Board will deny the claim and send notice to the beneficiary. If the requirements in §340.6.A or B are met, the Railroad Retirement Board will hold any potentially allowable Part B claim until an MAC determination regarding the coverage of Part A services has been made. When the information regarding Part A coverage is available, the Railroad Retirement Board will send the Part B claim, together with pertinent information regarding the Part A determination, to Palmetto Government Benefits for consideration of whether the other requirements for Part B coverage are met, and further processing.

340.8 - Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Services furnished by a laboratory that does not meet the hospital laboratory conditions of participation and is operated under a lease arrangement in a domestic emergency hospital are covered only if they are emergency inpatient services reimbursable under Part A.

A MAC may send a claim from such a laboratory and identify it as an "Emergency Lead." The MAC checks its files to see if a claim for emergency services was filed and, if so, determines whether the laboratory services were furnished during the period of emergency. If the emergency claim was forwarded to the appropriate MAC for processing, it enters the date received on the laboratory claim.

If no emergency claim was filed, or laboratory services were not furnished in the period covered by the emergency claim, the MAC develops the claim as a possible emergency. It includes the laboratory claim with any subsequent claim.

If no emergency is alleged, the MAC records on the claim that no emergency existed and disallows it.

340.9 - Nonemergency Part B Medical and Other Health Services

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

A. Coverage

Nonemergency services to Medicare beneficiaries may be paid for if the coverage requirements for the services are met, and are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- *Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)*
- *X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)*
- *Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic tests, or the provisions of x-ray or radium therapy.*
- *Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.*
- *Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.*

B. Distinction Between Emergency and Nonemergency Medical and Other Health Services

Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to the hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals - blood is a biological - which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech-language pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services can be only under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, it may be made for diagnostic laboratory tests furnished by an emergency hospital only if the hospital meets the conditions of participation relating to hospital laboratories. It may be made only for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by it, only if it meets the conditions of participation relating to radiology departments.

C. Claims Processing

The hospital enters the annotation "nonemergency-hospital accepts assignment" in Remarks of the Form CMS-1450. If it is determined that some or all of the services are not covered under the nonemergency provisions, the claim is returned to it (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

340.10 - Elections to Bill for Services Rendered By Nonparticipating Hospitals

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

A. Nonparticipating U.S. Hospitals

As a nonparticipating U.S. hospital meeting emergency requirements, the hospital has the option to bill the program during a calendar year by filing an election with its MAC. If it files an election, it should submit claims for the following services furnished all Medicare beneficiaries throughout the year:

- *Emergency inpatient services; and*
- *Emergency outpatient services.*

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must agree to refund any monies incorrectly collected. It may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file a claim. The beneficiary may request information from the hospital or the MAC as appropriate.

During November of each year, the MAC will send the non-participating hospital a letter (see §350.3.1). Also, during November of each year, the MAC will send a letter to each domestic hospital, giving it an opportunity to elect to bill Medicare if it has not been doing so (§350.3.2).

If during the year the hospital requests to bill the program, its MAC will send the model letter in §350.3.3.

B. Billing for Services Furnished Prior to Certification

The following rules apply if a bill is submitted for services rendered before and after a hospital's certification (participation) date:

- *PPS hospitals are paid the DRG, if the date of discharge is after the certification date.*
- *Other hospitals are paid for services rendered after the certification date. However, the hospital must include services before certification date on its cost report.*

It should annotate in the upper right hand corner of the claim "Emergency Conversion."

C. Foreign Hospitals

Foreign hospitals may submit a statement to the appropriate MAC stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When the MAC is aware that a hospital is willing to bill the program for all covered services, it solicits the hospital's agreement to:

- *Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);*
- *Not bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and*
- *Refund to the beneficiary any monies incorrectly collected.*

A hospital may not file an election for a calendar year if it has charged any beneficiary for covered services during that year.

D. Submitting Claims

The beneficiary or the hospital that has elected to bill the program may submit emergency claims for payment to the appropriate MAC for evaluation of accessibility or emergency factors.

The hospital completes the claim (Form CMS-1450 or electronic equivalent) according to billing instructions in Chapter 25. It enters "hospital filed emergency admission" in Item 94 "Remarks." It sends the completed bill and the necessary emergency documentation (Form CMS-1771, Attending Physicians Statement and Documentation of Medicare Emergency) or medical records to substantiate the emergency to the appropriate MAC.

NOTE: See §350.2, "Designated Contractors."

If the hospital submits a claim but has not filed an election to bill the program, the MAC will contact the hospital to determine if it is qualified and wish to bill the program. If it declines, the claim will be denied. A claim will be solicited from the beneficiary.

If the hospital has filed a billing election and the beneficiary files a claim, the beneficiary's claim is denied and the MAC contacts the hospital regarding the claim.

340.11 - Processing Claims

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

All claims are subject to development to determine whether the Medicare secondary payer provisions apply. (See Pub. 100-05, Medicare Secondary Payer Manual.)

A. Nonparticipating Hospitals

The processing MAC is responsible for making accessibility and medical emergency determinations for physician and ambulance services.

1. Claims Subject to Technical Denials

The following claims are subject to technical denial:

- *Foreign nonemergency services claims if:*
    - *The residence requirement is not met. (See §340.5.)*
    - *The hospital rendering the service does not meet Joint Commission or equivalent accreditation requirements set by a hospital approval program of the country in which it is located.*
    - *The accessibility requirements are not met. (See §340.11.4.)*
- *Canadian travel claims when the requirements in §350.4 are not met.*
- *Emergency services claims for which the hospital does not meet the definition of an emergency hospital.*
- *Claims for which the query response shows the beneficiary is not entitled to benefits.*
- *Any foreign claim when Part A benefits are exhausted and Part B physician or ambulance claims are not involved.*

2. Either the Accessibility or Medical Emergency Requirements are Not Met

Claim is denied but retained in case of an appeal by the beneficiary.

NOTE: Even though Part A or Part B emergency services furnished by U.S. hospitals are denied, Part B payment may be possible for Medical and Other Health Services specified in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6. Claim is retained in case of an appeal by the beneficiary.

3. Emergency Services Partially Denied

When the medical emergency is approved but not for the entire period, the claim is processed and payment made for the covered period.

B. Foreign Part B Physician and Ambulance Claims

The hospital must attach any Part B claim for foreign physician and ambulance services to the corresponding Part A claim and forward to the MAC.

If the MAC determines that the inpatient services were covered, it sends the physician and/or independent ambulance claim to the designated MAC for processing and payment. (See §340.6.)

If the Part A claim is denied on the basis of accessibility of medical emergency, the MAC denies the Part B claim, and sends a MSN to the beneficiary. It retains copies in case of an appeal by the beneficiary.

NOTE: Even though Part A benefits are totally or partially exhausted, payment may be made by the MAC for physician and independent ambulance services furnished if all coverage requirements are met.

If a Part A claim was partially denied because the emergency terminated, the MAC makes a decision on the claim and any provider-based ambulance claim. It sends copies to the appropriate MAC for processing.

340.11.1 - Contractors Designated to Process Foreign Claims

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Per contractor Statement of Work (SOW) all contractors are designated to process claims for physicians' and ambulance services furnished in connection with a covered foreign hospital stay for their beneficiaries who reside in the states/areas for which they process claims.

All contractors are designated to determine whether the requirements in §340.6 are met for claims for inpatient services based upon the geographic location of the foreign hospitals furnishing the services.

All contractors are designated to process these claims if there is evidence that the Part B services were furnished in connection with covered foreign inpatient hospital services. If there is no evidence, the Contractor must send a front-end rejection notice in accordance with §340.11.2.

340.11.2 - Contractor Processing Guidelines

(Rev.)

Per contractor Statement of Work (SOW) all contractors are responsible for processing foreign, emergency and shipboard claims for their beneficiaries who reside in the states/areas for which they process claims.

The A/B MAC determines whether the requirements in §340.6.A are met. If these requirements are not met, the A/B MAC denies the Part A claim and related Part B claim and notifies the beneficiary. Where the A/B MAC determines that the requirements in §340.6.A are met, the A/B MAC determines whether other applicable Part A coverage requirements are met. If the A/B MAC disallows the Part A claim, it denies the related Part B claim and notifies the beneficiary. However, the A/B MAC will not be involved in the processing of foreign claims if, for any reason, the related Part A claim is denied.

If the claim does not show that the beneficiary was hospitalized, the A/B MAC sends the beneficiary a front-end rejection notice. In filling out the Notification of Medicare Determination, the A/B MACs should check

"other" and include the following explanation: "Foreign physician or ambulance services are not covered unless they were furnished in connection with a covered inpatient stay."

340.11.3 - Medicare Approved Charges for Services Rendered in Canada or Mexico

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

For Canadian services, the Medicare approved charge will be the lower of:

1. *The allowed amount for the same service in the U.S. locality closest to where the service was furnished (as determined by the designated MAC), or*

2. *The Canadian Provincial fee.*

Therefore, the designated MAC must obtain the most recent schedule of fees published by the appropriate Canadian Province. Most of the designated MACs deal with only one Provincial schedule.

For Mexican services, the maximum charge is the Medicare allowed amount for the same service in the locality closest to where the service was furnished (as determined by the designated MAC).

340.11.4 - Accessibility Criteria

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

A. Emergency Claims

The MAC uses the same criteria in domestic and foreign emergency claims. This includes services in a foreign religious non-medical health care institution and Canadian Travel claims. (See §340.4 and §340.9.)

Emergency determinations take into account such matters as relative distances of a participating hospital, and road conditions. The MAC considers whether the nature of the emergency required immediate transportation to the nearest available hospital (i.e., the nonparticipating hospital) or, without hazard to the patient, would have permitted the additional transportation time to take the patient to a more distant participating hospital in the same general area.

The MAC does not consider in its determination such factors involving selection of a hospital which reflect the personal preferences of the individual or physician, (e.g., physician does not have staff privileges at the participating hospital) nearness to beneficiary's residence, presence of previous medical records at the nonparticipating hospital, cost, or type of accommodations available.

The following sections discuss documentation of the accessibility requirement and provide guidelines for making a determination where the participating hospital is:

- *Closer to the site of the emergency than is the admitting nonparticipating hospital;*

- *Fifteen or fewer miles farther from the site of the emergency than is the nonparticipating hospital; or*

- *Sixteen or more miles farther from the site of the emergency than is the admitting nonparticipating hospital.*

In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it is presumed, in the absence of clear and convincing evidence to the contrary, that the services could have been provided in the participating hospital.

1. Participating Hospital Closer to Site of Emergency

If there is an adequately equipped participating hospital with available beds closer to the site of the emergency than the nonparticipating hospital, accessibility is not met. Claim is denied unless extenuating circumstances were present that necessitated admission to the nonparticipating hospital, e.g., because of road or traffic conditions additional travel time would have been needed.

2. Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

In this situation the accessibility is provisionally not met. The claim is reviewed to determine if the nature of the emergency required the immediate transportation to the nonparticipating hospital. If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient to the participating hospital without undue hazard, the accessibility requirement is not met. The claim is denied.

3. Participating Hospital More than 15 Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

The accessibility requirement is deemed met.

B. Foreign Nonemergency Claims

The following presumptions are applied to the relative accessibility of the nearest participating U.S. and foreign hospitals.

1. Admitting Foreign Hospital is Closer to the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is met.

2. Admitting Foreign Hospital is Farther From the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is not met unless evidence establishes the practical necessity for the beneficiary's admission. This requirement is met if the use of a closer participating U.S. hospital was impractical, e.g., non-availability of beds, needed equipment or personnel, or transportation not available.

In determining whether a foreign hospital is more accessible than a participating hospital, the MAC does not consider the personal preference of the beneficiary, physician, or others in the selection of a hospital, the type of accommodations available, or the nonavailability of staff privileges to the attending physician.

C. Documenting Accessibility for Emergency Claims

The MAC uses Form CMS-2628, Foreign HI Claim or Emergency Services Accessibility Documentation and Determination, to document accessibility in emergency claims. Access Form CMS-2628 from CMS at the following Web address: http://cms.hhs.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

It checks the "met" block for claims that fall in the categories described in §§340.11.A.1 or §340.11.A.3, and there are special circumstances of a nature not requiring medical judgment (e.g., Part I, Section C, Items 1, 2, and 5: bed unavailability, lack of transportation).

It checks the "not met" block for claims that fall in the category described in §340.11.A.1, and there are no special circumstances.
It checks the "not met-medical factors" for claims that fall in the category described in §340.11.A.1, and there are special circumstances requiring medical judgment (i.e., Part I, Section C, Items 4 and 6 unusual medical circumstances or nonavailability of needed equipment or personnel in the participating hospital).

340.11.5 - Medical Necessity

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

A. Emergency Services

Reimbursement for emergency inpatient hospital services is permitted only for those periods during which the patient's state of injury or disease is such that a health or life-endangering emergency existed and continued to exist, requiring immediate care that could be provided only in a hospital. The allegation that an emergency existed must be substantiated by sufficient medical information from the physician or hospital. If the physician's statement does not provide it, or is not supplemented by adequate clinical corroboration of this allegation, it does not constitute sufficient evidence.

Death of the patient does not necessarily establish the existence of a medical emergency, since in some chronic, terminal illnesses, time is available to plan admission to a participating hospital. The lack of adequate care at home or lack of transportation to a participating hospital does not constitute a reason for emergency hospital admission, without an immediate threat to the life and health of the patient. Since the existence of medical necessity for emergency services is based upon the physician's assessment of the patient prior to admission, serious medical conditions developing after a non-emergency admission are not "emergencies" under the emergency services provisions of the Act.

The emergency ceases when it becomes safe, from a medical standpoint, to move the individual to a participating hospital, another institution, or to discharge the individual.

B. Criteria

Since the decision that a medical emergency existed can be a matter of subjective medical judgment involving the entire gamut of disease and accident situations, it is impossible to provide arbitrary guidelines.

1. Diagnosis is Considered "Usually an Emergency"

An emergency condition is an unanticipated deterioration of a beneficiary's health which requires the immediate provision of inpatient hospital services because the patient's chances of survival, or regaining prior health status, depends upon the speed with which medical or surgical procedures are, or can be, applied. While many diagnoses (e.g., myocardial infarction, acute appendicitis) are normally considered emergencies, the hospital must check medical documentation for internal consistencies (e.g., signs and symptoms upon admission, notations concerning changes in a preexisting condition, results of diagnostic tests).

EXAMPLE: If the diagnosis is given as "coronary," the physician's statement is "coronary," without further explanatory remarks, and the statement of services rendered gives no indication that an electrocardiogram was taken, or that the patient required intensive care, etc., further information is required. On the other hand, if the diagnosis is one that ordinarily indicates a medical and/or surgical emergency, and the treatment, diagnostic procedures, and period of hospitalization are consistent with the diagnosis, further documentation may be unnecessary. An example is: admitting diagnosis - appendicitis; discharge diagnosis - appendicitis; surgical procedures - appendectomy; period of inpatient stay - 7 days.

2. Patient Dies During Hospitalization

If an emergency existed at the time of admission and the patient subsequently expires, the claim is allowed for emergency services if the period of coverage is reasonable. However, death of the patient is not prima facie evidence that an emergency existed; e.g., death can occur as a result of elective surgery or in the case of a chronically ill patient who has a long terminal hospitalization. Such claims are denied.

3. Patient's Physician Does Not Have Staff Privileges at a Participating Hospital

The fact that the beneficiary's attending physician does not have staff privileges at a participating hospital has no bearing on the emergency services determination. If the lack of staff privileges in an accessible participating hospital is the governing factor in the decision to admit the beneficiary to an "emergency hospital," the claim is denied irrespective of the seriousness of the medical situation.

4. Beneficiary Chooses to be Admitted to a Nonparticipating Hospital

The claim is denied if the beneficiary chooses to be admitted to a non-participating hospital as a personal preference (e.g., participating hospital is on the other side of town) when a bed for the required service is available in an accessible, participating hospital.

5. Beneficiary Cannot be Cared for Adequately at Home

The patient who cannot be cared for adequately at home does not necessarily require emergency services. The claim is denied in the absence of an injury, the appearance of a disease or disorder, or an acute change in a pre-existing disease state which poses an immediate threat to the life or health of the individual and which necessitates the use of the most accessible hospital equipped to furnish emergency services.

6. Lack of Suitable Transportation to a Participating Hospital

Lack of transportation to a participating hospital does not, in and of itself, constitute a reason for emergency services. The availability of suitable transportation can be considered only when the beneficiary's medical condition contraindicates taking the time to arrange transportation to a participating hospital. The claim is denied if there is no immediate threat to the life or health of the individual, and time could have been taken to arrange transportation to a participating hospital.

7. "Emergency Condition" Develops Subsequent to a Non-emergency Admission to a Nonparticipating Hospital

Program payment cannot be made for emergency services furnished by a nonparticipating hospital when the emergency condition arises after a non-emergency admission. An example: treatment of postoperative complications following an elective surgical procedure or treatment of a myocardial infarction that occurred during a hospitalization for an elective surgical procedure. The existence of medical necessity for emergency services is based upon the physician's initial assessment of the apparent condition of the patient at the time of the patient's arrival at the hospital, i.e., prior to admission.

8. Additional "Emergency Condition" Develops Subsequent to an Emergency Admission to a Nonparticipating Hospital

If the patient enters a nonparticipating hospital under an emergency situation and subsequently has other injuries, diseases or disorders, or acute changes in preexisting disease conditions, related or unrelated to the condition for which the patient entered, which pose an immediate threat to life or health, emergency services coverage continues. Emergency services coverage ends when it becomes safe from a medical standpoint to move the patient to an available bed in a participating institution or to discharge the patient, whichever occurs first.

C. Documenting Medical Necessity

1. Physician's Supporting Statement

Claims for emergency services by a non-participating hospital should be accompanied by an Attending Physician's Statement and Documentation of Medicare Emergency, Form CMS-1771 or its equivalent. This form describes the nature of the emergency, furnishing relevant clinical information about the patient, and

certifying that the services rendered were required as emergency services. However, a copy of the patient's hospital records may be submitted instead. It should include history, physical, and admission notes, the medical record admission sheet, nurses' notes, doctors' orders, discharge summary, and all progress notes. A statement that an emergency existed, or the listing of diagnoses, without supporting information, is not sufficient. In addition, the statement must include the date, in the physician's judgment, the emergency ceased. The physician who attended the patient at the hospital makes the statement concerning emergency services. Only in exceptional situations, with appropriate justification, may another physician having full knowledge of the case, make the certification.

2. Beneficiary's Statement in Canadian Travel Claims

In Canadian travel claims, the beneficiary's statement is considered in making a determination regarding medical necessity for emergency services; i.e., whether an emergency occurred while a beneficiary was traveling between Alaska and another State by the most direct route without unreasonable delay. (See §340.4.)

340.11.6 - Time Limitation on Emergency and Foreign Claims
(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

The regular time limits apply to requests and claims for payment for emergency hospital services and hospital services outside the U.S., for physician and ambulance services furnished in connection with foreign hospitalization, and for nonemergency services furnished by a domestic nonparticipating hospital. See Chapter 1 for a description of these requirements.

A. Beneficiary Denial Notices

MACs shall send denial letters for non-covered foreign related claims.

Part B MACs will send an MSN for covered foreign emergency and shipboard claims related to a covered Part A foreign claim. An MSN is also sent for shipboard services provided within US territories.

B. Termination of Emergency Services

No payment will be made for inpatient or outpatient emergency services rendered after a reasonable period of medical care in relation to the emergency condition in question. Some services may be covered in a domestic nonparticipating hospital as Part B Medical and Other Health Services. (See the Medicare Benefit Policy Manual, Chapter 6.) If, based upon all information, the total period claimed for emergency services coverage does not exceed the time required for a reasonable period of emergency medical care, the entire inpatient stay is covered. The fact that a medical record or other information states that the patient showed definite improvement several days prior to discharge is not necessarily an indication that the need for emergency services ceased as of that date. The concept of a reasonable period of emergency medical care is most easily applied when relatively short-term medical care is followed by the patient's progressive improvement. There are situations or conditions in which the determination of the end of covered emergency services may be more difficult because the patient's impairment is prolonged, there is no progressive improvement, or the patient's course may be progressively downhill, even though the condition is not critical. The stroke patient may be in this category. In such cases the need for emergency medical care usually ceases before the need for medical care in an institutional setting (i.e., hospital or SNF) ceases. Thus, the reasonable period of emergency care does not include the entire hospital stay if the stay was prolonged beyond the point when major diagnostic evaluation and treatment were carried out.

The MAC will make the determination based upon all information available. As a general rule, if the period claimed for emergency services exceeds by more than 3 to 5 days the date on which the record definitely indicates that there was substantial improvement in the patient's condition so that the patient could possibly have been moved to a participating facility or discharged without damage to health, the period beyond the 3 to 5 days is denied. If the total period claimed for emergency services exceeds by no more than 3 to 5 days

the date on which the record indicates substantial improvement in the patient's condition, the entire period is allowed.

This rule is intended to screen out short stay emergency hospitalization cases in which the patient was either discharged or transferred to a participating provider within a reasonable time after the medical record definitely indicated substantial improvement in the patient's condition.

The reasonable period of emergency care is that period required to provide relief of acute symptoms or for initial management of the condition while arrangements are made for definitive treatment. Two examples:

- *Prostatic hypertrophy which results in acute urinary retention; and*
- *Mental illness with suicidal and/or homicidal tendencies.*

In acute urinary retention, the reasonable period of emergency medical care includes the period required for catheterization and stabilization of the patient. The patient could then be transferred to a participating hospital for surgery or other required treatment. For the suicidal or homicidal patient, a reasonable period of emergency medical care includes the time required for initial management of the case while arrangements are made for transfer (by commitment or otherwise) to a participating hospital. A period of 24 to 48 hours of emergency care is usually sufficient in both cases.

340.11.7 – Payment Denial for Medicare Services furnished to Alien Beneficiaries Who are Not Lawfully Present in the United States

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service.

The CWF must establish an auxiliary file based on enrollment data contained in the Enrollment Data Base maintained by the Centers for Medicare & Medicaid Services in order to appropriately edit the claims specifically associated with alien beneficiaries. The auxiliary file will be the basis for an edit that rejects claims for a beneficiary that was not lawfully present in the U.S. on the date of service. MACs and DMACs must deny claims for items and services, rejected by CWF on the basis that the beneficiary was not lawfully present in the U.S. on the date of service. MACs and DMACs must refer to the CWF documentation on this subject for the error code MSN Message 5.7, assigned to this editing.

Upon receipt of an error code MSN Message 5.7, MACs, DMACs, intermediaries, and RHHIs must deny the claim and use reason code (CARC) 177 – "Patient has not met the required eligibility requirements." When CWF rejects a claim, MACs and DMACs must use MSN message 5.7, "Medicare payment may not be made for the item or service because, on the date of service, you were not lawfully present in the United States." 5.7, Medicare no puede pagar por este artículo o servicio porque, en la fecha en que lo recibió, usted no estaba legalmente en los Estados Unidos.

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that the beneficiary was lawfully present in the United States on the date of service In addition, this same information must be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information "Medicare Services for Alien Beneficiaries Lawfully present the United States" is available on your Web site.

NOTE: Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), codified at 8 U.S.C. §1611, prohibits aliens who are not "qualified aliens" from receiving Federal public benefits including Medicare.

However, Section 5561 of the Balanced Budget Act of 1997 (BBA) amended Section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for non-qualified alien beneficiaries, who are

lawfully present in the United States and who meet certain other conditions. Specifically, payment may be made for services furnished to an alien who is lawfully present in the United States (and provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 1.3.

340.12 - Appeals on Claims for Emergency and Foreign Services

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

When a MAC receives a beneficiary appeal of a claim submitted by the beneficiary for services provided by a non-participating provider, the MAC will process the appeal in accordance with the guidelines in IOM 100-4 chapter 29.

When a MAC receives an appeal from a non-participating provider of a claim that was submitted by, or on behalf of, a beneficiary, the MAC shall dismiss the appeal request as the non-participating provider is not a proper party. The MAC shall send a copy of the dismissal to the beneficiary. A non-participating provider does not have standing to file an appeal for the individual claims for payment it submits on behalf of a beneficiary, or for claims the beneficiary submits for services it has furnished. See, 42 CFR 405.906(a)(3) and 405.902 (for the definition of provider); IOM 100-4, Ch. 29, §210 and the glossary in IOM 100-4, Ch. 29, §110 (for the definition of provider). Only a beneficiary (or the beneficiary's authorized representative, or an appointed representative on behalf of the beneficiary) can appeal claim determinations for services furnished by a non-participating provider.

NOTE: Non-participating providers have appeal rights under the provider and supplier enrollment appeals process in 42 CFR Part 498 for MAC determinations related to the non-participating provider's election to file claims (see §340.10).

NOTE: The RRB conducts Part B redeterminations under the Railroad Retirement Act for services rendered in Canada.

350 - Payment for Services Received By Nonparticipating Providers

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

The condition of payment regulations for emergency services received in Nonparticipating Providers can be found in the 42 CFR 424.100-109, Subpart G—Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital.

The Form CMS-1450 or its electronic equivalent must be used.

A. Hospital Filed Claims

1. Inpatient Services

The payment rate for inpatient claims is 100 percent of the nonparticipating provider's customary charges (see 42 C.F.R. 413.74(b) and 42 C.F.R. 424.104(a)(3)).

The cost of the services is adjusted by any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

Payment will be made to Federal hospitals that furnish emergency services, on an inpatient basis, to individuals entitled to hospital benefits. Payment will be based on the lower of the actual charges from the hospital or rates published for Federal hospitals in the "Federal Register" under Office of Management and Budget - Cost of Hospital and Medical Care and Treatment Furnished by the United States; Certain Rates Regarding Recovery from Tortiously Liable Third Persons.

Medicare will not pay Federal hospitals for emergency items or services furnished to veterans, retired military personnel or eligible dependents. However, Medicare can pay for the inpatient deductible charged by VA hospitals, or credit that amount to the Medicare Part A deductible, for emergency services furnished to veterans. If a Part A claim is denied, a denial notice will be forwarded to the beneficiary from the MAC. The beneficiary can use this notice to forward to their private insurer, if applicable.

The VA or DOD hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

2. Outpatient Services

The amount paid by Medicare for emergency outpatient claims is obtained as follows:

- *Eighty-five percent of the total covered charges is the estimated cost figure. The applicable Part B deductible is subtracted. Coinsurance is subtracted from the remainder.*

- *Subtracting the deductible from 85 percent of the total covered charges and applying the 20 percent coinsurance rate to the remainder obtains the patient's coinsurance amount. The hospital will be paid cost (85 percent of covered charges) minus deductible and coinsurance.*

3. Part B Medical and Other Health Services

Part B medical and other health services, including hospital-based ambulance services whether hospital or beneficiary filed, may be covered and paid on a non-emergency basis. To calculate the amount paid by Medicare, the hospital subtracts the Part B deductible from the total covered charges and applies the 80 percent payment rate.

4. Special Letters for Partially or Totally Denied (Hospital-Filed) Claims for Emergency Inpatient Services
The patient receives a notice from CMS covering the emergency payment of a partially denied claim. A denial letter and a Part B explanation of benefits is sent to the patient. The MAC includes its address on this letter.

B. Beneficiary Filed Claim

1. Emergency Inpatient Claims

The payment computation follows:

- *Any noncovered accommodation charge is subtracted from the total accommodation charges. The amount of the inpatient deductible or coinsurance met on this bill is subtracted. Any remainder is multiplied by 60 percent.*

- *The total noncovered ancillary charge is subtracted from the total ancillary charge. Any inpatient deductible or coinsurance that remains is subtracted. The remainder is multiplied by 80 percent.*

- *The benefit amounts obtained are added.*

2. Emergency Outpatient Services

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply the 80 percent payment rate.

3. Part B Medical and Other Health Services

Part B medical and other health services furnished by nonparticipating hospitals, including hospital-based ambulance services, may be covered and paid on an non-emergency basis.

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply an 80 percent payment rate.

4. Special Letters for Patient-Filed Claims for Emergency Inpatient Services

For emergency admissions to nonparticipating hospitals where direct payment is made to the patient, the MAC sends the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made. Part B payments are made for ancillary services not covered by Part A and are also explained in a letter. This letter also explains the beneficiary's right of appeal.

The MAC retains a duplicate of all notices sent for documentation in any appeals process. It enters the date the notice is released on both copies of all notices.

Sample paragraphs:

- *"Enclosed is a check for $_____, which is the amount Medicare can pay for inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital)."*

- *"Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended)."*

  "Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66 2/3 percent of the other charges which were not separately identified on the hospital bill."

- *"Medicare does not pay (the first $ ____ of charges) (the first three pints of blood) ($ ____ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)"*

- *"If lifetime reserve days are used, add $ ___ a day from _____ to _____."*

- *"If you believe your Medicare hospital insurance should have covered all or more of your expenses, you may get in touch with us at the address shown on this letter."*

- *"If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You may make the request by mail to the address shown on this letter. If you come in person, please bring this notice with you."*

- *"This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from _____ through _____. These services are listed on the enclosed form."*

- *"If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended)."*

- *"We are enclosing a check for $ _____. This is your payment under Part B for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form."*

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

350.1 - Payment for Services from Foreign Hospitals
(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

The condition of payment regulations for emergency services received in Nonparticipating Providers can be found in the 42 CFR 424.100-109, Subpart G—Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital

A. Hospital Filed Claim

A foreign hospital that elects to bill the Medicare program receives 100 percent of its customary charges, subject to applicable deductible and coinsurance amounts. The hospital establishes its customary charges for the services by submitting an itemized bill with each claim. This eliminates the need to file a cost report.

Regardless of the billing form used, the MAC must:

- *Recode the bill using revenue codes for the Form CMS-1450;*
- *Prepare an HUIP or HUOP input record for CWF; and*
- *Send a Medicare Summary Notice (MSN) to the beneficiary.*

The nonparticipating hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

Payment is subject to the official exchange rate on the date the patient is discharged.

B. Beneficiary Filed Claim

To calculate the amount paid by Medicare for Part B Hospital-Based Ambulance Claims, the hospital must subtract any unmet Part B deductible from the total covered charges and apply the 80 percent payment rate.

Payment to the beneficiary is subject to the official exchange rate on the date of discharge.

350.1.1 - Attending Physician's Statement and Documentation of Medicare Emergency
(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Form CMS-1771 - go to http://cms.hhs.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

Form CMS-2628 - go to http://cms.hhs.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

350.2 - Designated Contractors
(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Per Contractor Statement of Work (SOW) all contractors are designated to process claims for physicians' and ambulance services furnished in connection with a covered hospital stay in Canada and Mexico for their beneficiaries who reside in the states/areas for which they process claims.

350.3 - Model Letters, Nonparticipating Hospital and Emergency Claims

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

350.3.1 - Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:_____

Dear _____:

Your election to bill the Medicare program for emergency services furnished to Medicare beneficiaries will expire on December 31. Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year.

If you elect to bill the program, please return to us in the enclosed self-addressed envelope a statement signed by an authorized official of your hospital stating that you elect to claim payment under the Medicare program. An election to bill cannot be withdrawn during the year. If a statement is not received by December 31, we will assume that you do not wish to continue to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting the MAC serving nonparticipating hospitals in your State. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

Please contact us if you need any further information. In addition, if at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare MAC for complete particulars.

Sincerely,

350.3.2 - Model Letter to Nonparticipating Hospital That Did Not Elect to Bill for Current Year

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:_____

Dear _____:

Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Although your hospital did not elect to bill the program for the current calendar year, you may wish to bill for the coming year. If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

If we have not received a statement from you by December 31, we will assume that you do not wish to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely,

350.3.3 - Model Letter to Nonparticipating Hospital That Requests to Bill the Program

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:_____

Dear _____:

This refers to your inquiry concerning payment for emergency hospital services rendered to a Medicare beneficiary in a hospital which is not participating in the Medicare program. Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if you elect to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Your hospital may now choose to bill the program for all emergency services furnished to Medicare beneficiaries during the current calendar year, if you have not yet charged any Medicare beneficiary this year for emergency hospital services rendered to him.

If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely,

350.3.4 - Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

Contractors shall include beneficiary appeal rights language and include in the mailing a redetermination request form where applicable.

MODEL DENIAL NOTICE A
(MAC'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital). This is because the (hospital) does not participate in the Medicare program and it has been determined that your treatment there does not qualify as emergency care.
Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. *Care which is necessary to prevent the death or serious impairment to the health of the individual; and*

b. *Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) that has a bed available and is equipped to handle the emergency.*

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

•Beneficiary name
•Medicare Health Insurance Claim (HIC) number
•Specific service and/or item(s) for which a redetermination is being requested
•Specific date(s) of service
•Signature of the beneficiaryy or the beneficiary's authorized or appointed representative.

You may send the request to our address above. Please keep a copy of any written correspondence for your files.

Sincerely,

350.3.5 - Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

MODEL DENIAL NOTICE A
(MAC'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

This refers to your request for payment under Medicare for the services received while a patient at (hospital), from _____ through _____.

Payment can be made under the hospital insurance part of Medicare only for the costs of your hospitalization from _____ to _____.

The (hospital) does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. *Care which is necessary to prevent the death or serious impairment to the health of the individual; and*

b. *Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.*

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on _____. At that time, your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days of the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- *Beneficiary name*
- *Medicare Health Insurance Claim (HIC) number*
- *Specific service and/or item(s) for which a redetermination is being requested*
- *Specific date(s) of service*
- *Signature of the beneficiary or the beneficiary's authorized or appointed representative.*

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,

350.3.6 - Denial - Military Personnel/Eligible Dependents

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

MODEL DENIAL NOTICE A
(MAC'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from_____ through_____ at (hospital).

Under the law, medical services that have been furnished by a Federal hospital to retired members of the armed services, or their eligible dependents, are not covered under the Medicare program.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

•Beneficiary name
•Medicare Health Insurance Claim (HIC) number
•Specific service and/or item(s) for which a redetermination is being requested
•Specific date(s) of service
•Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,

350.3.7 - Full Denial - Shipboard Claim - Beneficiary Filed

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

MODEL DENIAL NOTICE
(MAC'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number: _____

DETERMINATION ON SHIPBOARD SERVICES

We are sorry, but medical services provided on the (vessel/ship's name) cruise ship are not covered. The Medicare program can make payment for medically necessary shipboard services only if all of the following requirements are met:

1. *The services are furnished while the ship is within the territorial waters of the United States (in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).*
2. *The services are furnished to an individual who is entitled to Part B benefits;*
3. *The services are furnished in connection with covered inpatient hospital services;*
4. *The services furnished on the ship are for the same condition that required inpatient admission;*
5. *The physician is legally authorized to practice in the country where he or she furnishes the services.*

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

•Beneficiary name
•Medicare Health Insurance Claim (HIC) number
•Specific service and/or item(s) for which a redetermination is being requested
•Specific date(s) of service
•Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.
Sincerely,

350.3.8 - Full Denial - Foreign Claim - Beneficiary Filed

(Rev.3199, Issued: 02-20-15, Effective: 04-21-15, Implementation: 04-21-15)

MODEL DENIAL NOTICE
(MAC'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number: _____

DETERMINATION ON FOREIGN HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital) in (country).

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- *Beneficiary name*
- *Medicare Health Insurance Claim (HIC) number*
- *Specific service and/or item(s) for which a redetermination is being requested*
- *Specific date(s) of service*
- *Signature of the beneficiary or the beneficiary's authorized or appointed representative.*

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,