HOSPITAL INSURANCE BENEFITS

FEDERAL HEALTH INSURANCE FOR THE AGED

(Code of Federal Regulations,
Title 20, Chapter III, Part 405)

REGULATIONS

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIR-1 (6/67)

PREFACE

This document sets forth Subpart A of the Social Security Administration's Regulations No. 5 (Federal Health Insurance for the Aged--20 C.F.R. 405). Subpart A contains the conditions an individual must meet for entitlement to hospital insurance benefits, defines the beginning and ending dates of such entitlement, the types of items and services for which payment may be made, and the conditions for such payment.

This document was prepared for use by those individuals and organizations which have a need for a convenient reference source concerning hospital insurance benefits under title XVIII of the Social Security Act.

SUBPART A

HOSPITAL INSURANCE BENEFITS

SUBPART A

Hospital Insurance Benefits

NOTE: §§ 405.101 to 405.181 issued under sections 1102, 1801–1817, 1871, 49 Stat. 647, as amended, 79 Stat. 291–301; 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

405.101 Hospital Insurance Benefits; General.—An individual who meets the conditions for entitlement to hospital insurance benefits provided under Part A of title XVIII of the Act is eligible to have payment made on his behalf, subject to the conditions and limitations set out in this Part 405 and in the Act, for inpatient hospital services, posthospital extended care services, posthospital home health services, and outpatient hospital diagnostic services furnished to him during any month for which he meets such conditions for entitlement to hospital insurance benefits. Payment for the services covered under the hospital insurance benefits program is made to providers of services eligible to receive payment rather than to the individual to whom the services are furnished.

405.102 Conditions for Entitlement to Hospital Insurance Benefits.—An individual is entitled to hospital insurance benefits under the provisions described in this Subpart A if such individual either:

(*a*) Has attained age 65, and either is entitled to monthly insurance benefits under section 202 of the Act (*see* Subpart D of Part 404 of this chapter) or is a qualified railroad retirement beneficiary; or

(*b*) Qualifies under the transitional provisions of section 103 of the Social Security Amendments of 1965. (*See* § 404.370 of Part 404 of this chapter.)

405.103 Duration of Entitlement to Hospital Insurance Benefits.—(*a*) An individual is entitled to hospital insurance benefits beginning with the first day of the first month after June 1966 for which he meets the conditions described in § 405.102; except that no payment may be made for posthospital extended care services furnished before January 1967, and that no payment may be made for posthospital extended care services or posthospital home health services unless the discharge from the hospital required to qualify such services for payment under this Subpart A occurred after June 30, 1966, or, on or after the first day of the month in which he attains age 65, whichever is later.

(*b*) (1) An individual's entitlement to hospital insurance benefits ends:

(i) With the last day of the month in which he dies, or

(ii) With the last day of the month before the month he no longer meets the requirements:

(a) For entitlement to monthly benefits under section 202 of the Act;

(b) Of section 21 of the Railroad Retirement Act of 1937, if qualified for hospital insurance benefits solely as a railroad retirement beneficiary;

(c) Of the transitional provisions on eligibility for hospital insurance benefits (*see* § 404.370 of Part 404 of this chapter) because such individual has become eligible for monthly benefits under section 202 of the Act.

(2) Entitlement to hospital insurance benefits, if terminated for reason other than death, may be regained by the individual by filing an application for such benefits and meeting any of the conditions specified in § 404.367 of Part 404 of this chapter.

405.110 Inpatient Hospital Services; Scope of Benefits.—(*a*) *Benefits.*—An individual who meets the requirements set forth in § 405.102 is eligible to have payment made on his behalf to a participating hospital (*see* Subpart J of this Part 405 and § 405.150), subject to the conditions and limitations contained in this Part 405 and title XVIII of the Act, for inpatient hospital services (*see* § 405.115) furnished to him for up to 90 days during any spell of illness (*see* Subpart R of this part). (In the case of emergency inpatient hospital services, payment may also be made to certain nonparticipating hospitals—*see* § 405.152.)

(*b*) *Deductible and Coinsurance Amounts.*—Payments for inpatient hospital services furnished during any spell of illness (*see* Subpart R of this part) is reduced by the amount of the applicable deductibles (*see* §§ 405.113 and 405.114) and, in addition, by any applicable coinsurance amount (*see* § 405.115).

(*c*) *90-Day Benefit Limitation for Spell of Illness.*—No payment under this section for inpatient hospital services furnished an individual during any spell of illness (*see* Subpart R of this part) may be made for any such services furnished to him after the 90th day such services have been furnished to him during such spell of illness (*see* § 405.161 for exception).

(*d*) *Lifetime Maximum on Inpatient Psychiatric Hospital Services.*—Notwithstanding the preceding provisions of this section, no payment for inpatient psychiatric hospital services (*see* Subpart J of this part) may be made for any such services furnished

an individual after the 190th day such services have been furnished to him during his lifetime.

405.111 Inpatient Hospital Services; Determining the 90-Day Benefit Limitation—Inpatient of a Psychiatric or Tuberculosis Hospital.—If an individual is an inpatient of a qualified psychiatric or tuberculosis hospital as defined in Subpart J of this Part 405 on the first day for which he is entitled to hospital insurance benefits (*see* § 405.103), the days on which he has already been an inpatient of such hospital in the 90-day period immediately before such day are deducted from the 90 days of inpatient hospital services for which he is entitled to have payment made during his first spell of illness; however, such days preceding entitlement are not counted in determining the 190-day lifetime limit on inpatient psychiatric hospital services (*see* § 405.110(*d*)), and are not counted in determining the first day for which the coinsurance amount is deducted from payment for inpatient hospital services (*see* § 405.115).

EXAMPLE 1: B is an inpatient of a psychiatric hospital on July 1, 1966, the first day for which he is entitled to hospital insurance benefits, and has been an inpatient of such hospital for the 2 years immediately preceding July 1, 1966. No payment will be made for inpatient hospital services furnished to B during that spell of illness.

EXAMPLE 2: C entered a tuberculosis hospital on August 12, 1966, and is still an inpatient of such hospital 50 days later on October 1, 1966, the first day for which he is entitled to hospital insurance benefits. Payment may be made for up to 40 days of inpatient hospital services since C had been an inpatient of the tuberculosis hospital for 50 days preceding the first day for which he was entitled to hospital insurance benefits. However, the 50 days preceding October 1, 1966, is not counted in determining the 60 days of coverage and, therefore, the coinsurance amount (*see* § 405.115) is not applicable with respect to any payment for the 40 days of services for which C is entitled to have payment made on his behalf.

EXAMPLE 3: D is a patient of an institution that is not a qualified psychiatric hospital on August 1, 1966, the first day for which he is entitled to hospital insurance benefits, and has been a patient of the nonqualifying hospital for the one year preceding August 1, 1966. Several days later D is transferred to a participating psychiatric hospital. Payment may be made for up to 90 days of inpatient hospital services after such transfer since inpatient hospital services received in a nonqualifying hospital in the period preceding entitlement are not considered for the purposes of determining the 90-day spell of illness limitation.

405.112 Inpatient Hospital Services; Services Considered for Purposes of 90-Day and 190-Day Limitations.—For purposes of determining the 90-day benefit limitation described in § 405.110(*c*), or § 405.111, or the 190-day benefit limitation described in § 405.110(*d*), inpatient hospital services are taken into account only if:

(*a*) Payment is made with respect to such services; or

(*b*) Payment would be made for such services except for failure to comply with the request and certification requirements (*see* § 405.160).

405.113 Inpatient Hospital Services; Deductible.—(*a*) *Spell of Illness Beginning Prior to 1969.*—The amount payable for inpatient hospital services (*see* §§ 405.150 and 405.151) furnished to an individual during any spell of illness (*see* Subpart R of this part) beginning prior to 1969 is reduced (but not below zero) by an amount equal to the lesser of:

(1) $40; or

(2) The charges imposed with respect to such services or the customary charges for such services, whichever is greater.

(*b*) *Spell of Illness Beginning After 1968.*—Between July 1 and October 1 of 1968, and of each year thereafter, the Secretary shall determine the amount of the inpatient hospital deductible which shall be applicable in the case of any spell of illness (*see* Subpart R of this part) beginning during the suceeding calendar year.

405.114 Inpatient Hospital Services; Whole Blood Cost Deductible.—Where all or part of the first 3 pints of whole blood furnished an individual by a provider of services during a spell of illness is furnished him as part of inpatient hospital services, the amount payable for such services is reduced by the cost of the first 3 pints of whole blood furnished him as part of such services during that spell of illness.

EXAMPLE: During the same spell of illness, *B* receives the following services: Inpatient hospital

service in hospital X from July 1 to July 10, 1967; posthospital extended care services in an extended care facility from July 15 to July 25, 1967; inpatient hospital services in hospital Y from August 15 to August 25, 1967. During this spell of illness, B is furnished 6 pints of whole blood, 2 pints in hospital X, 2 pints in the extended care facility, and 2 pints in hospital Y. The whole blood deductible is applicable to the cost of the 2 pints of whole blood furnished in hospital X, and to the cost of 1 pint furnished in the extended care facility, since these are the first 3 pints of whole blood furnished B by providers of services during the spell of illness. It is not applicable to the cost of any of the whole blood furnished in hospital Y.

405.115 Inpatient Hospital Services; Coinsurance Amount.—(*a*) In any case in which an individual is furnished inpatient hospital services for more than 60 days during a spell of illness (*see* Subpart R of this Part 405) beginning before 1969, the amount payable (*see* §§ 405.150 and 405.151), for the inpatient hospital services furnished after such 60th day during such spell of illness, is reduced by a coinsurance amount equal to $10 for each day, after the 60th day and before the 91st day, on which he is furnished such services.

(*b*) Since the inpatient hospital services coinsurance amount is set by law at one-fourth of the inpatient hospital services deductible, the coinsurance amount applicable for spells of illness beginning after 1968 will reflect any adjustment made in the deductible (*see* § 405.113(*b*)).

405.116 Inpatient Hospital Services; Defined.—(*a*) *Included Services.*—Subject to the conditions, limitations, and exceptions in the succeeding paragraphs of this section, the term "inpatient hospital services" means the following items and services furnished by a qualified hospital, except as provided in paragraph (*e*) of this section (including a psychiatric hospital or a tuberculosis hospital) to an inpatient of such hospital:

(1) Bed and board;
(2) Nursing services and other related services;
(3) Use of hospital facilities;
(4) Medical social services;
(5) Drugs, biologicals, supplies, appliances and equipment;
(6) Certain other diagnostic or therapeutic items or services; and
(7) Medical or surgical services provided by certain interns or residents-in-training.

(*b*) *Bed and Board.*—The reasonable costs are payable in full for hospital room and board furnished an individual in accomodations containing from two to four beds, or in hospitals in which all accommodations are on a ward basis and charges are not related to the number of beds in a room. The reasonable cost of private accommodations is covered in full only where their use is medically indicated, ordinarily only when a patient's condition requires him to be isolated. Where private accommodations are furnished for a patient's comfort, the amount payable under this Subpart A may not exceed the reasonable cost of accommodations containing from two to four beds. Where accommodations less expensive than accommodations containing from two to four beds are furnished a patient and the use of these accommodations was neither at the request of the patient nor for a reason consistent with the purposes of the Act, the amount payable for bed and board is the reasonable cost of two to four bed accommodations minus the difference between the customary charges for such accommodations and the customary charges for the accommodations furnished.

(*c*) *Nursing Services and Other Related Medical Services; Medical Social Services; Use of Hospital Facilities.*—Nursing services and other related services, use of hospital facilities, and medical social services, are considered as inpatient hospital services only if ordinarily furnished by the hospital for the care and treatment of inpatients. The services of a private-duty nurse or other private-duty attendant are excluded from the definition of inpatient hospital services.

(*d*) *Drugs, Biologicals, Supplies, Appliances, and Equipment.*—Drugs, biologicals, supplies, appliances, and equipment (as defined in Subpart R of this Part 405) are included as inpatient hospital services only if furnished to an inpatient for use in the hospital and if ordinarily furnished by such hospital for the care and treatment of inpatients.

(*e*) *Diagnostic or Therapeutic Items or Services.*—Diagnostic or therapeutic items or services other than those provided for in paragraphs (*c*), (*d*) and (*f*) of this section, are considered as inpatient hospital service if furnished by the hospital, or by others under arrangements made by the hospital under which the billing for such services is made through such hospital and if such services are of a kind ordinarily furnished to inpatients either by such hospital or by others under such arrangements (*see* Subpart R of this part for definition of "arrangement").

(f) *Medical or Surgical Services Provided by a Physician, Intern, Resident, or Resident-in-Training.*—Medical or surgical services provided in a hospital by a physican or by a resident or intern, are excluded from the definition of "inpatient hospital services" unless such services are provided by an intern or resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association; or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association; or in the case of a hospital or osteopathic hospital, by an intern or resident-in-training in the field of dentistry under a teaching program approved by the Council on Dental Education of the American Dental Association.

405.120 Posthospital Extended Care Services; Scope of Benefits.—(a) *Benefits and Conditions for Entitlement.*—An individual who meets the requirements described in § 405.102, is eligible to have payment made on his behalf to a participating extended care facility (*see* § 405.150) for up to 100 days of extended care services (§ 405.124) furnished to him in a spell of illness if such extended care services are furnished him after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days (as defined in paragraph (c) of this section). An individual is deemed to have transferred from a hospital if he is admitted to the extended care facility within 14 days (as defined in paragraph (d) of this section) after his discharge from such hospital and such discharge occurred on or after the first day of the month in which the individual attained age 65, or after June 30, 1966, whichever is later.

(b) *Services for Which Payment Is Not Made.*—(1) No payment may be made for any posthospital extended care services furnished an individual on any day after the 100th day such services have been furnished to him during a spell of illness.

(2) Where an individual who has been furnished posthospital extended care services is discharged from the extended care facility, no payment may be made for any subsequent extended care services furnished during such spell of illness unless he is again hospitalized for at least 3 consecutive days and the other conditions in paragraph (a) of this section are met; however, for purposes of this subparagraph, an individual is not deemed to have been discharged from an extended care facility in which he has been receiving posthospital extended care services, if, within 14 days after discharge therefrom, he is readmitted to the same, or any other, extended care facility.

(c) *The 3 Consecutive Days as a Hospital Inpatient; Defined.*—The 3-consecutive-day hospital inpatient requirement is a period of 3 consecutive calendar days, beginning with the calendar day of admission even if less than a 24-hour day, and ending with the day before the calendar day of discharge. Thus, in determining whether the 3-consecutive-day requirement is met, the day of admission is counted as one day; the day of discharge is not counted as a day; and each intervening day is counted as a single day.

(d) *14-Day Period; Defined.*—The 14-day period referred to in paragraph (a) of this section, for determining whether an individual is deemed to have transferred from a hospital, is the period of 14 consecutive calendar days beginning with the calendar day following the day of discharge from the hospital.

(e) *Deductible and Coinsurance Amount.*—Payment (*see* §§ 405.150 and 405.151) for posthospital extended care services is reduced by the coinsurance amount (*see* § 405.124) for any day on which such services are furnished after the 20th day and before the 101st day, during a spell of illness, and does not include the costs of any part of the first 3 pints of whole blood furnished an individual in a spell of illness (*see* § 405.123).

405.122 Posthospital Extended Care Services; Services Considered for Purposes of Limitation on Days of Coverage.—For purposes of the limitation on days of coverage (*see* §§ 405.120(b) and 405.121), extended care services furnished an individual are taken into account only if:

(a) Payment is made with respect to such services; or

(b) Payment would be made except for failure to comply with the request for payment and certification requirements described in § 405.165.

405.123 Posthospital Extended Care Services; Whole Blood Cost Deductible. — The amount payable (*see* §§ 405.150 and 405.151) for posthospital extended care services furnished an individual during a spell of illness (*see* Subpart R of this Part 405) is reduced by an amount equal to the cost of the first 3 pints of whole blood furnished to him as part of such services; except that the deduction provided under this section does not apply to the extent that a deduction for the cost of the first 3 pints of whole blood furnished to him during such spell of illness has been made under § 405.114.

405.124 Posthospital Extended Care Services; Coinsurance Amount.—(*a*) *Spell of Illness Beginning Before 1969.*—In any case in which an individual is furnished posthospital extended care services for more than 20 days during a spell of illness (*see* Subpart R of this Part 405) beginning before 1969, the amount payable for posthospital extended care services furnished after such 20th day is reduced by a coinsurance amount equal to $5 for each day such services are furnished after the 20th day and before the 101st day on which he is furnished such services during such spell of illness.

(*b*) *Spell of Illness Beginning After 1968.*—The posthospital extended care services coinsurance amount applicable for spells of illness beginning after 1968 is one-eighth of the inpatient hospital services deductible. Therefore, the coinsurance amount applicable for spells of illness beginning after 1968 will reflect any adjustment made in the amount of the inpatient hospital deductible for calendar years after 1968 (*see* § 405.113(*b*)).

405.125 Extended Care Services; Defined.—(*a*) *Items and Services Included.*—Subject to the conditions and limitations in the succeeding paragraphs in this section, the term "extended care services" means the following items and services furnished by a qualified extended care facility (except as provided in paragraphs (*d*), (*f*), and (*g*) of this section and subparagraphs (3) and (6) of this paragraph) to an inpatient of such facility:

(1) Nursing care provided by or under the supervision of a registered professional nurse;

(2) Bed and board in connection with the furnishing of such nursing care;

(3) Physical, occupational or speech therapy;

(4) Medical social services;

(5) Drugs, biologicals, supplies, appliances and equipment;

(6) Medical services provided by an intern or resident-in-training of certain hospitals;

(7) Diagnostic or therapeutic services provided by certain hospitals; and

(8) Such other services necessary to the health of the patient as are generally provided by extended care facilities.

(*b*) *Excluded Services.*—No item or service is included as an extended care service if it would not be included as an inpatient hospital service under § 405.116 if furnished to an inpatient of a hospital.

(*c*) *Bed and Board.*—Posthospital extended care facility bed and board is covered in full in accommodations containing two to four beds and in extended care facilities in which all accommodations are on a ward basis and charges are not related to the number of beds in a room. Private accommodations are covered in full only where their use is medically indicated, ordinarily when the patient's condition requires him to be isolated. Where private accommodations are furnished for the patient's comfort and their use is not medically indicated, only the reasonable cost of accommodations containing two to four beds is payable under this Subpart A. Where accommodations less expensive than accommodations containing two to four beds are furnished a patient and the use of these accommodations was neither at the request of the patient nor for a reason consistent with the purposes of the Act, the amount payable for bed and board is the reasonable cost of two to four bed accommodations minus the difference between the customary charges for such accommodations and the customary charges for the accommodations furnished.

(*d*) *Physical, Occupational or Speech Therapy.*—Physical, occupational or speech therapy services are considered as extended care services if furnished by the extended care facility or if furnished by others under arrangements (*see* Subpart R of this Part 405) with them made by the facility under which the billing for such services is through such extended care facility.

(*e*) *Drugs, Biologicals, Supplies, Appliances, and Equipment.*—Drugs, biologicals, supplies, appliances, and equipment are considered as extended care services only if furnished for use in the extended care facility and if ordinarily furnished by such facility for the care and treatment of inpatients. (*See* Subpart R of this part for definition of drugs and biologicals.)

(*f*) *Medical Services Provided by an Intern or Resident-in-Training.*—Medical services provided by an intern or resident-in-training are included as extended care services if provided by an intern or resident-in-training of a hospital with which the extended care facility has in effect an agreement for the transfer of patients and exchange of medical records (*see* Subpart K of this part), and under a teaching program of such hospital approved in accordance with the provisions described in § 405.116(*f*).

(*g*) *Other Diagnostic or Therapeutic Services.*—Other diagnostic or therapeutic services are included as extended care services if provided by a hospital with which the extended care facility has in effect an agreement for the transfer of patients and exchange of clinical records (*see* § 405.1133).

(*h*) *Services Not Generally Provided.*—Except as specifically enumerated in this section, only those

items and services generally provided by extended care facilities are considered as extended care services. For example, though an individual is furnished the use of an operating room by an extended care facility, such service is not included as "extended care service" since operating rooms are not generally maintained as part of extended care facilities.

405.130 Posthospital Home Health Services; General.—Home health service benefits are provided under the hospital insurance benefits plan described in this Subpart A and also under the medical insurance benefits plan described in Subpart B of this part. The conditions for payment for the services vary, however. The basic difference is that under the hospital insurance benefits plan the home health services must be furnished as an extension of inpatient hospital services or posthospital extended care services furnished the individual. Under the medical insurance plan described in Subpart B, it is not necessary that the individual have first been an inpatient of a hospital or extended care facility in order to have payment made for the home health services provided under that plan. The fact that payment may be made under this Subpart A for posthospital home health services for up to 100 visits does not preclude the payment, under Subpart B of this part, for an additional 100 home health service visits furnished to him in the same calendar year if the conditions and requirements for payment are met. The following sections set forth the posthospital home health service benefits and the conditions for entitlement to such benefits.

405.131 Posthospital Home Health Services; Benefits Provided.—An individual who meets the requirements set forth in § 405.102 is eligible to have payment made on his behalf to a home health agency for home health services (as defined in § 405.236) furnished for up to 100 visits (charged in accordance with § 405.238) if the services are furnished:

(*a*) To an individual who is under the care of a physician;

(*b*) After the beginning of one spell of illness and before the beginning of the next;

(*c*) Within the 1-year period after the individual's most recent discharge from a hospital in which he was an inpatient for at least 3 consecutive days (*see* § 405.120(*c*), or, if later, after his most recent discharge from an extended care facility in which he was an inpatient and entitled to have payment made for services furnished therein;

(*d*) Under a plan of treatment, established and periodically reviewed by a physician, which was established within 14 days after the date of the individual's discharge specified in paragraph (*c*) of this section; and

(*e*) By a home health agency which meets the requirements described in Subpart L of this Part 405, or by others under an arrangement with them made by such an agency; and

(*f*) On a visiting basis in the place of residence used as the individual's home, except that services may be furnished on an outpatient basis at a hospital, extended care facility, or certain rehabilitation centers when it is necessary to use equipment which cannot readily be made available in the individual's place of residence (*see* § 405.235 for further rules relating to this requirement).

405.141 Outpatient Hospital Diagnostic Services; Conditions.—(a) An individual who meets the requirements set forth in § 405.102, is eligible to have payment made on his behalf to a participating hospital (or under the conditions described in § 405.152 or § 405.154) for outpatient hospital diagnostic services (described in § 405.145) furnished to him if such items and services:

(1) Are furnished during a diagnostic study (*see* § 405.144);

(2) Are furnished to him on an outpatient basis;

(3) Are furnished by the hospital or if furnished by others under arrangements (as described in Subpart R of this Part 405) made by the hospital, are furnished, in the case of services provided by others, under arrangements made with them by the hospital, in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff; and

(4) Are of the type ordinarily furnished by the hospital (or by others under such arrangement described in subparagraph (3) of this paragraph) to the hospital's outpatients for the purpose of diagnostic study.

(*b*) Diagnostic tests and services may also be covered as "medical and other health services" under the supplementary medical insurance benefits plan (*see* Subpart B of this part) if they could not be covered under this Subpart A.

405.142 Outpatient Hospital Diagnostic Services; Deductibles.—(*a*) *Diagnostic Study Beginning Before 1969.*—Any payment under this Subpart A to a hospital for outpatient hospital

diagnostic services furnished during a diagnostic study beginning before 1969, is reduced by:

(1) $20; plus

(2) 20 percent of the reasonable cost for such services in excess of $20.

(*b*) *Diagnostic Study Beginning After 1968.*—In the case of a diagnostic study beginning after 1968, the outpatient hospital deductible equals one-half of the inpatient hospital deductible applicable with respect to a spell of illness beginning in a calendar year after 1968 (*see* § 405.113(*b*)) plus 20 percent of the reasonable cost for such services in excess of an amount equal to one-half of such inpatient hospital deductible.

405.144 Outpatient Hospital Diagnostic Services; Diagnostic Study Defined.—A "diagnostic study" for purposes of §§ 405.141 and 405.142 consists of the outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (not included in a previous diagnostic study) on which the individual meets the requirements described in § 405.102 and on which he is furnished outpatient hospital diagnostic services. The tests and procedures furnished for the purpose of a diagnostic study need not be related to a single illness or condition.

405.145 Outpatient Hospital Diagnostic Services; Defined.—The term "outpatient hospital diagnostic services" includes diagnostic services if furnished under the conditions described in § 405.141. Services of a physician are excluded. Also excluded are any items or services which would not be included as an "inpatient hospital service" as enumerated in § 405.116 if furnished to an inpatient of a hospital.

405.150 Payment for Services Furnished; General.—Amounts payable under the provisions described in this Subpart A for inpatient hospital services, posthospital extended care services, posthospital home health services or outpatient hospital diagnostic services furnished to an individual, are payable only to the provider of such services and, except as provided in §§ 405.152 and 405.153, payment may be made only to a provider of services eligible to receive payment, that is, a provider which has entered into an agreement with the Secretary under the conditions described in Subpart F of this Part 405.

405.151 Payment for Services Furnished; Determination of Amount Payable Based on Reasonable Cost.—The amount payable to any provider with respect to services for which payment may be made under this Subpart A is, subject to the provisions for reducing such payment (*see* §§ 405.113, 405.114, 405.123, 405.124, and 405.142), the reasonable cost of such services. The method of determining "reasonable cost" is discussed in Subpart D of this Part 405.

405.152 Payment for Services Furnished; Nonparticipating Provider Furnishing Emergency Services.—Payment (in amounts as determined in accordance with § 405.151) may be made to a hospital even though the hospital is not a participating provider (i.e., it has not or could not, because it is not qualified, enter into an agreement with the Secretary under Subpart F of this Part 405) if:

(*a*) The services furnished were emergency inpatient hospital services or emergency outpatient hospital diagnostic services, furnished an individual who meets the requirements in § 405.102;

(*b*) The services are furnished by the hospital (or by others under an arrangement (*see* Subpart R of this part) with the hospital);

(*c*) Payment for the services would have been made if an agreement under such Subpart F of this part had been in effect with the hospital and the hospital otherwise met the conditions for payment;

(*d*) The hospital agrees to comply with respect to the services furnished, with the provisions of such Subpart F of this part regarding the charges for such services which may be imposed on the individual; and

(*e*) The hospital meets the requirements of § 405.1033.

405.153 Payment for Services; Hospital Outside the United States Furnishing Emergency Services.—The authority contained in § 405.152 is applicable to emergency inpatient hospital services furnished an individual by a hospital located outside the United States if:

(*a*) The individual was physically present in a place within the United States (*see* § 404.2(c)(6) of Part 404 of this chapter) at the time the emergency arose which necessitated such inpatient hospital services; and

(*b*) The hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available

for the treatment of, such individual's illness or injury; and

(c) The conditions set forth in § 405.152(*c*) and (*d*) are met.

405.154 Payment for Services Furnished; Federal Providers.—No payment may be made under this Subpart A to any Federal provider of services (except for emergency hospital services furnished under the conditions described in § 405.-152) unless the Secretary determines that such provider is providing services to the public generally as a community institution or agency.

405.155 Payment for Services Furnished; Providers Obligated To Furnish Services at Public Expense.—No payment may be made under this Subpart A to any provider of services for an item or service which the provider is obligated by a law of, or contract with, the United States to render at public expense.

405.160 Payment for Inpatient Hospital Services; Conditions for Payment.—(*a*) *Inpatient Hospital Services.*—Payment may be made to a hospital eligible to receive payment for inpatient hospital services (other than inpatient psychiatric or tuberculosis hospital services) furnished an individual if:

(1) Written request for payment is filed by, or on behalf of (*see* Subpart P of this Part 405) the individual to whom the services were furnished;

(2) A physician certifies, and recertifies as necessary (*see* Subpart P of this part) that such inpatient hospital services were required to be given on an inpatient basis for the individual's medical treatment, or that inpatient diagnostic study was medically required and the services were necessary for such purpose; and

(3) The conditions prohibiting payment, described in §§ 405.162 and 405.163, are not applicble.

(*b*) *Inpatient Psychiatric Hospital Services.*—Payment may be made to a hospital eligible for payment for inpatient psychiatric hospital services furnished an individual if:

(1) Written request for payment is filed by or on behalf of (*see* Subpart P of this part) the individual to whom the services were furnished;

(2) A physician certifies, and recertifies as necessary (*see* Subpart P of this part) that such inpatient psychiatric hospital services were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of the individual, and

(i) That such treatment could reasonably be expected to improve the conditions for which such treatment was necessary; or

(ii) That inpatient diagnostic study was medically required and such services were necessary for such purposes;

(3) The services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services; and

(4) The conditions prohibiting payment, described in §§ 405.162 and 405.163, are not applicable.

(*c*) *Inpatient Tuberculosis Hospital Services.*—Payment may be made to a hospital eligible for payment for inpatient tuberculosis hospital services furnished an individual if:

(1) Written request for such payment is filed by or on behalf of (*see* Subpart P of this part) the individual to whom the services were furnished;

(2) A physician certifies, and recertifies when required (*see* Subpart P of this part), that such services were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of tuberculosis and such treatment could reasonably be expected to improve the condition or render the condition noncommunicable;

(3) The services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable; and

(4) The conditions prohibiting payment described in §§ 405.162 and 405.163 are not applicable.

405.161 Payment for Inpatient Hospital Services; Furnished After 90-Day Limit or After 190-Day Limit.—(*a*) Even though an individual is not entitled to have payment made under this Subpart A for inpatient hospital services because of the 90-day benefit limitation for a spell of illness (*see* § 405.110(c)), or the 190-day lifetime benefit limitation on inpatient psychiatric hospital services, payment may be made for the inpatient hospital services furnished after such 90th day or after such 190th day in the case of inpatient psychiatric hospital services if:

(1) The services were furnished prior to the seventh elapsed day after the day on which the individual was admitted to such hospital (but not seventh elapsed day after the day on which the in- an elapsed day);

(2) Payment is precluded only because of the limitations on days of services discussed in §§ 405. 110–405.112 inclusive;

(3) The hospital acted reasonably and in good faith in assuming that the individual was entitled to have payment made on his behalf for such services; and

(4) The services were furnished prior to notification by the Secretary of such individual's lack of entitlement to have payment made for such services.

(*b*) No benefits may be paid pursuant to paragraph (*a*) of this section if:

(1) The hospital elects not to receive such benefits; or

(2) The hospital fails to refund payments already made by or on behalf of the individual furnished the services, to the person who made such payment (such refund should be made before the first request for payment is submitted after notification of lack of entitlement).

(*c*) Any payment made to a provider of services under this section may, under the provisions of Subpart C of this part, be recovered from the individual furnished the services with respect to which such payment was made.

405.162 Prohibition Against Payment for Inpatient Hospital Services Furnished After Utilization Review Finding That Further Services Are Not Medically Necessary.—Where pursuant to a system of utilization review (*see* Subpart J of this Part 405), a finding has been made that further inpatient hospital services are not medically necessary, payment may be made only for those inpatient hospital services furnished before the fourth day following the day on which the hospital received notice of such finding.

405.163 Prohibition Against Payment for Inpatient Hospital Services Furnished After 20th Consecutive Day by a Hospital Which Has Failed To Make Timely Utilization Review.—Where the Secretary has determined that a hospital has substantially failed to make timely utilization review (*see* Subpart F of this Part 405) in long stay cases and has imposed the limitation on days of services provided in section 1866 (d), no payment may be made under this Subpart A for inpatient hospital insurance services furnished by such hospital to any individual after the 20th consecutive day on which such services have been furnished to him if the individual is admitted after the effective date of such determination.

405.165 Payment for Posthospital Extended Care Services; Conditions.—Payment may be made under this Subpart A for posthospital extended care services only if:

(*a*) Written request for such payment is filed by or on behalf of (*see* Subpart P of this Part 405) the individual to whom such services were furnished;

(*b*) A physician certifies, and recertifies as required (*see* Subpart P of this part) that such services were required to be given on an inpatient basis because the individual needed skilled nursing care on a continuing basis:

(1) For any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution had met the necessary requirements relating respectively to a utilization review plan (*see* Subpart J of this Part 405) and such other requirements as the Secretary finds necessary in the interest of health and safety (*see* Subpart J of this part) for qualification as a "hospital") prior to transfer to the extended care facility; or

(2) For a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of any of the conditions for which he was receiving such inpatient hospital services; and

(*c*) The prohibitions against payment, described in §§ 405.166 and 405.167, are not applicable.

405.166 Prohibition Against Payment for Posthospital Extended Care Services Furnished After a Utilization Review Finding That Services Are Not Medically Necessary.—Where pursuant to a system of utilization review (*see* Subpart K of this Part 405), a finding has been made that further posthospital extended care services are not medically necessary, payment may be made only for those posthospital extended care services furnished before the fourth day following the day on which the extended care facility received notice of such finding.

405.167 Prohibition Against Payment for Services Furnished by a Facility Which Fails To Make Timely Utilization Review.—Payment may not be made for posthospital extended care services furnished an individual on any day after a period specified by the Secretary during which such services have been furnished the individual, if such individual is admitted to the extended care facility after the effective date of the Secretary's determination (which can be effective only after notice to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public) that such facility has substantially failed to make timely utilization review (*see* Subpart F of this Part 405) of long stay cases, and that payment for posthospital extended care services is to be so limited. For prohibition against payment for inpatient hospital services furnished after failure to make timely utilization review, see § 405.163.

405.170 Payment for Posthospital Home Health Services; Conditions.—Payment may be made under this Subpart A for posthospital home health services only if:

(*a*) Written request for such payment is filed by or on behalf of (*see* Subpart P of this Part 405) the individual to whom such services are furnished;

(*b*) A physician certifies, and recertifies when required (*see* Subpart P of this part) that:

(1) The services were required because the individual was confined to his home (except when receiving items or services on an outpatient basis pursuant to the provisions described in Subpart B of this part);

(2) The individual needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving posthospital extended care services, or inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the necessary requirements relating respectively to a utilization review plan (*see* Subpart J of this Part 405) and such other requirements as the Secretary finds necessary in the interests of health and safety (*see* Subpart J of this part));

(3) A plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and

(4) The services were furnished while the individual was under the care of a physician.

405.175 Payment for Outpatient Hospital Diagnostic Services; Conditions.—Payment may be made for outpatient hospital diagnostic services only if:

(*a*) Written request for such payment is filed by or on behalf of (*see* Subpart P of this Part 405) the individual to whom such services were furnished; and

(*b*) A physician certifies (*see* Subpart P of this part) that such services were required for diagnostic study.

405.180 No Payment for Services Furnished to an Alien Before the First Full Calendar Month in the United States.—No payments may be made under this Subpart A with respect to items or services furnished to an individual in any month for which the prohibition in section 202(t)(1) of the Act (suspension of benefits of aliens who are outside the United States for more than 6 calendar months) against payment of monthly benefits to him is applicable or would be applicable if he were entitled to such benefits, because he was outside the United States 6 full consecutive months (*see* Subpart D of Part 404 of this chapter).

405.181 Individual Convicted of Subversive Activities; Effect on Entitlement.—As provided in section 202(u) of the Act:

(*a*) If an individual is convicted under Chapters 37, 105, or 115 of title 18 of the United States Code or under sections 4, 112, or 113 of the Internal Security Act of 1950, as amended, for any offense committed after August 1, 1956, then the court may, in addition to all other penalties provided by law, impose the penalty that, in determining whether such individual is entitled to hospital insurance benefits for the month in which he is convicted or for any month thereafter, there shall not be taken into consideration:

(1) Any wages paid to the individual or to any other individual in the calendar quarter in which such conviction occurs or in any prior calendar quarter; and

(2) Any net earnings from self-employment derived by such individual or any other individual during the taxable year in which such conviction occurs or during any prior taxable year.

(*b*) If such individual is granted a pardon by the President of the United States, the additional penalty provided above shall not apply for any month beginning after the date on which the pardon is granted.