(2) Explains the circumstances that make it impractical for the beneficiary to sign the claim or statement.

(b) *Beneficiary not present for services.* When a representative of the provider, nonparticipating hospital, or supplier signs a claim or request for payment statement under § 424.36(c), he or she must explain why it was not possible to obtain the beneficiary's signature. (For example: ''Patient not physically present for test.'')

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 424.40 Request for payment effective for more than one claim.

(a) *Basic procedure.* A separate request for payment statement prescribed by CMS and signed by the beneficiary (or by his or her representative) may be included in claims by reference, in the circumstances specified in paragraphs (b) through (d) of this section.

(b) *Claims filed by a provider or nonparticipating hospital*—(1) *Inpatient services.* A signed request for payment statement, included in the first claim for Part A services furnished by a facility (a participating hospital or SNF, or a nonparticipating hospital that has elected to claim payment) during a beneficiary's period of confinement, may be effective for all claims for Part A services the facility furnishes that beneficiary during that confinement.

(2) *Home health services and outpatient physical therapy or speech pathology services.* A signed request for payment statement, included in the first claim for home health services or outpatient physical therapy or speech pathology services furnished by a provider under a plan of treatment, may be effective for all claims for home health services or outpatient physical therapy or speech pathology services furnished by the provider under that plan of treatment.

(c) *Signed statement in the provider record*—(1) *Services to inpatients.* A signed request for payment statement in the files of a participating hospital or SNF may be effective for all claims for services furnished to the beneficiary during a single inpatient stay in that facility—

(i) By the hospital or SNF;

(ii) By physicians, if their services are billed by the hospital or SNF in its name; or

(iii) By physicians who bill separately, if the services were furnished in the hospital or SNF.

(2) *Services to outpatients: Providers and renal dialysis facilities.* A signed request for payment statement retained in the provider's or facility's files may be effective indefinitely, for all claims for services furnished to that beneficiary on an outpatient basis—

(i) By the provider or facility;

(ii) By physicians whose services are billed by the provider or facility in its name; or

(iii) By physicians who bill separately, if the services were furnished in the provider or facility.

(3) *Services to outpatients: Independent rural health clinics and Federally qualified health centers.* A signed request for payment statement retained in the clinic's or center's files may be effective indefinitely for all claims for services furnished to that beneficiary by the clinic.

(d) *Signed statement in the supplier's record.* A signed request for payment statement retained in the supplier's file may be effective indefinitely subject to the following restrictions:

(1) This policy does not apply to unassigned claims for rental of durable medical equipment (DME).

(2) With respect to assigned claims for rental or purchase of DME, a new statement is required if another item of equipment is rented or purchased.

[53 FR 6634, Mar. 2, 1988, as amended at 57 FR 24982, June 12, 1992]

§ 424.44 Time limits for filing claims.

(a) *Time limits.* (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) Except as provided in paragraphs (b) and (e) of this section and except for services furnished during the last 3 months of 2009, for services furnished before January 1, 2010, the claim must be filed—

(i) On or before December 31 of the following year for services that were

furnished during the first 9 months of a calendar year; and

(ii) On or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year.

(3) For services furnished during the last 3 months of CY 2009 all claims must be filed no later than December 31, 2010.

(b) *Exceptions to time limits.* Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(4) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.

(ii) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.

(iii) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(5) *Extension of time.* (i) If CMS or one of its contractors determines that a failure to meet the deadline specified in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification that the error or misrepresentation referenced in paragraph (b)(1) of this section was corrected. No extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

(iv) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(4) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

(c) *Extension of period ending on a nonworkday.* If the last day of the period allowed under paragraph (a) or (b) of this section falls on a Federal nonworkday (a Saturday, Sunday, legal holiday, or a day which by statute or Executive Order is declared to be a nonworkday for Federal employees), the time is extended to the next succeeding workday.

(d) *Outpatient diabetes self-management training.* CMS makes payment in half-hour increments to an entity for the furnishing of outpatient diabetes self-management training on or after the approval date CMS approves the entity to furnish the services under part 410, subpart H of this chapter.

(e) As specified in §§ 424.520 and 424.521 of this subpart, there are restrictions on the ability of the following newly-enrolled suppliers to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges:

(1) Physician or nonphysician practitioner organizations.

(2) Physicians.

(3) Nonphysician practitioners.

(4) Independent diagnostic testing facilities.

[53 FR 6634, Mar. 2, 1988, as amended at 65 FR 83153, Dec. 29, 2000; 73 FR 69939, Nov. 19, 2008; 75 FR 73627, Nov. 29, 2010]

Subpart D—To Whom Payment Is Ordinarily Made

§ 424.50 Scope.

(a) This subpart specifies to whom Medicare payment is ordinarily made for different kinds of services.

(b) Subpart E of this part sets forth provisions applicable in special situations.

(c) Subpart F of this part specifies the exceptional circumstances under which payment may be made to an assignee or reassignee.

§ 424.51 Payment to the provider.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare pays the provider for services furnished by a provider.

(b) *Exception.* Medicare pays the beneficiary for outpatient hospital services if the hospital has collected an amount in excess of the unmet deductible and coinsurance, as specified in § 489.30(b)(4) of this chapter.

§ 424.52 Payment to a nonparticipating hospital.

Medicare pays a nonparticipating hospital for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a U.S. hospital, if the hospital has in effect an election to claim payment in accordance with subpart G of this part.

(b) Certain medical and other health services covered under Medicare Part B and furnished by a U.S. hospital, if the hospital meets the requirements of § 424.55 for payment as a supplier.

(c) Emergency or nonemergency inpatient services furnished by a foreign hospital if the hospital has in effect an election to claim payment in accordance with subpart G of this part.

§ 424.53 Payment to the beneficiary.

Medicare pays the beneficiary for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a nonparticipating U.S. hospital that has not elected to claim payment in accordance with subpart G of this part.