

**§ 411.52 Basis for conditional Medicare payment in liability cases.**

(a) A conditional Medicare payment may be made in liability cases under either of the following circumstances:

(1) The beneficiary has filed a proper claim for liability insurance benefits but the intermediary or carrier determines that the liability insurer will not pay promptly for any reason other than the circumstances described in § 411.32(a)(1). This includes cases in which the liability insurance carrier has denied the claim.

(2) The beneficiary has not filed a claim for liability insurance benefits.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006]

**§ 411.53 Basis for conditional Medicare payment in no-fault cases.**

(a) A conditional Medicare payment may be made in no-fault cases under either of the following circumstances:

(1) The beneficiary has filed a proper claim for no-fault insurance benefits but the intermediary or carrier determines that the no-fault insurer will not pay promptly for any reason other than the circumstances described in § 411.32(a)(1). This includes cases in which the no-fault insurance carrier has denied the claim.

(2) The beneficiary, because of physical or mental incapacity, failed to meet a claim-filing requirement stipulated in the policy.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

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**§ 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.**

(a) *Definition.* As used in this section, *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential

liability insurance payments, but are recoverable in accordance with § 411.24.

(b) *Applicability.* This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

(c) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(d) *Exception—(1) Prepaid health plans.* If the services were furnished through an organization that has a contact under section 1876 of the Act (that is, an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of § 417.528 of this chapter apply.

(2) *Special rules for Oregon.* For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

(i) The provider or supplier may elect to bill a liability insurer or place a lien against the beneficiary's liability settlement for Medicare covered services, rather than bill only Medicare for Medicare covered services, if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the provider or supplier files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the provider or supplier:

(A) Must withdraw its claim with the liability insurer and/or withdraw its lien against a potential liability settlement.

(B) May only bill Medicare for Medicare covered services.

(C) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under 413.35 of this chapter (when cost limits are applied to these