

## § 411.50

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award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows:

(i) Determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised.

(ii) Multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of the settlement. The product is the amount of the workers' compensation settlement to be considered as payment for medical expenses.

*Example:* As the result of a work injury, an individual suffered loss of income and incurred medical expenses for which the total workers' compensation payment would have been \$24,000 if the case had not been compromised. The medical expenses amounted to \$18,000. The workers' compensation carrier made a settlement with the beneficiary under which it paid \$8,000 in total. A separate award was made for legal fees. Since the workers' compensation compromise settlement was for one-third of the amount which would have been payable under workers' compensation had the case not been compromised ( $\$8,000/\$24,000 = \frac{1}{3}$ ), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses ( $\frac{1}{3} \times \$18,000 = \$6,000$ ).

(b) *Determining the amount of the Medicare overpayment.* When conditional Medicare payments have been made, and the beneficiary receives a compromise settlement payment, the Medicare overpayment is determined as set forth in this paragraph (b). The amount of the workers' compensation payment that is considered to be for medical expenses (as determined under paragraph (a) of this section) is applied, at the workers' compensation rate of payment prevailing in the particular jurisdiction, in the following order:

(1) First to any beneficiary payments for services payable under workers' compensation but not covered under Medicare.

(2) Then to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part B. (These include deductible and coinsurance amounts and,

in unassigned cases, the charge in excess of the reasonable charge.)

(3) Last to any beneficiary payments for services payable under workers' compensation and also covered under Medicare Part A. (These include Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted.)

The difference between the amount of the workers' compensation payment for medical expenses and any beneficiary payments constitutes the Medicare overpayment. The beneficiary is liable for that amount.

*Example:* In the example in paragraph (a) of this section, it was determined that the workers' compensation settlement paid for \$6,000 of the total medical expenses. The \$18,000 in medical expenses included \$1,500 in charges for services not covered under Medicare, \$7,500 in charges for services covered under Medicare Part B, and \$9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider or supplier must accept as payment in full.

The Medicare reasonable charge for physicians' services was \$7,000 and Medicare paid \$5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was \$8,000. Medicare paid the hospital \$7,480 (\$8,000—the Part A deductible of \$520).

In this situation, the beneficiary's payments totalled \$3,920:

Services not covered under Medicare	\$1,500
Excess of physicians' charges over reasonable charges	500
Medicare Part B coinsurance	1,400
Part A deductible	520
<b>Total</b>	<b>3,920</b>

The Medicare overpayment, for which the beneficiary is liable, would be \$2,080 (\$6,000—\$3,920).

### Subpart D—Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance

#### § 411.50 General provisions.

(a) *Limits on applicability.* The provisions of this subpart C do not apply to any services required because of accidents that occurred before December 5, 1980.

(b) *Definitions.*

*Automobile* means any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

*Liability insurance* means insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.

*Liability insurance payment* means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

*No-fault insurance* means insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It is sometimes called "medical payments coverage", "personal injury protection", or "medical expense coverage".

*Prompt or promptly*, when used in connection with payment by a liability insurer means payment within 120 days after the earlier of the following:

(1) The date a claim is filed with an insurer or a lien is filed against a potential liability settlement.

(2) The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

*Self-insured plan* means a plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. This term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort

Claims Act. An entity that engages in a business, trade, or profession is deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

*Underinsured motorist insurance* means insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

*Uninsured motorist insurance* means insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

(c) *Limitation on payment for services covered under no-fault insurance.* Except as provided under §§411.52 and 411.53 with respect to conditional payments, Medicare does not pay for the following:

(1) Services for which payment has been made or can reasonably be expected to be made under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made under any no-fault insurance other than automobile no-fault.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 71 FR 9470, Feb. 24, 2006]

#### **§411.51 Beneficiary's responsibility with respect to no-fault insurance.**

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no-fault insurance.

(b) Except as specified in §411.53, Medicare does not pay until the beneficiary has exhausted his or her remedies under no-fault insurance.

(c) Except as specified in §411.53, Medicare does not pay for services that would have been covered by the no-fault insurance if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper

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claim, Medicare pays for the services if they are covered under Medicare.

### **§ 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.

[71 FR 9470, Feb. 24, 2006]

### **§ 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

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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

services) or under 489.32 of this chapter (when services are partially covered).

[54 FR 41734, Oct. 11, 1989, as amended at 68 FR 43942, July 25, 2003]

### Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions

SOURCE: 60 FR 45362, Aug. 31, 1995, unless otherwise noted.

#### §411.100 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b) of the Act provides in part that Medicare is secondary payer, under specified conditions, for services covered under any of the following:

(i) Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. (Section 1862(b)(1)(A))

(ii) Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in §411.163, group health plans are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (Section 1862(b)(1)(C))

(iii) Large group health plans (that is, plans of employers that employ at least 100 employees) and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. (Section 1862(b)(1)(B))

(2) Sections 1862(b)(1)(A), (B), and (C) of the Act provide that group health plans and large group health plans may not take into account that the individuals described in paragraph (a)(1) of this section are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD.

(3) Section 1862(b)(1)(A)(i)(II) of the Act provides that group health plans of employers of 20 or more employees must provide to any employee or spouse age 65 or older the same benefits, under the same conditions, that it provides to employees and spouses under 65. The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare.

(4) Section 1862(b)(1)(C)(ii) of the Act provides that group health plans may not differentiate in the benefits they provide between individuals who have ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. Actions that constitute "differentiating" are listed in §411.161(b).

(b) *Scope.* This subpart sets forth general rules pertinent to—

(1) Medicare payment for services that are covered under a group health plan and are furnished to certain beneficiaries who are entitled on the basis of ESRD, age, or disability.

(2) The prohibition against taking into account Medicare entitlement based on age or disability, or Medicare eligibility or entitlement based on ESRD.

(3) The prohibition against differentiation in benefits between individuals who have ESRD and other individuals covered under the plan.

(4) The requirement to provide to those 65 or over the same benefits under the same conditions as are provided to those under 65.

(5) The appeals procedures for group health plans that CMS determines are nonconforming plans.

#### §411.101 Definitions.

As used in this subpart and in subparts F through H of this part—

*COBRA* stands for Consolidated Omnibus Budget Reconciliation Act of 1985.

*Days* means calendar days.

*Employee* (subject to the special rules in §411.104) means an individual who—

(1) Is working for an employer; or

(2) Is not working for an employer but is receiving payments that are subject to FICA taxes, or would be subject