

§ 411.175

42 CFR Ch. IV (10–1–23 Edition)

(e) *Secondary payments.* Medicare pays secondary benefits, within the limitations specified in §§ 411.32 and 411.33, to supplement the primary benefits paid by the group health plan if that plan pays only a portion of the charge for the services.

(f) *Disabled aged individuals who are considered employed.* (1) For services furnished on or after November 12, 1985, and before July 17, 1987, a disabled, nonworking individual age 65 or older was considered employed if he or she—

(i) Was receiving, from an employer, disability payments that were subject to tax under the Federal Insurance Contributions Act (FICA); and

(ii) For the month before the month of attainment of age 65, was not entitled to disability benefits under title II of the Act and 20 CFR 404.315 of the SSA regulations.

(2) For services furnished on or after July 17, 1987, an individual is considered employed if he or she receives, from an employer, disability benefits that are subject to tax under FICA, even if he or she was entitled to Social Security disability benefits before attaining age 65.

(g) *Individuals entitled to Medicare on the basis of age who are also eligible for or entitled to Medicare on the basis of ESRD.* If an aged individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995; 60 FR 53877, Oct. 18, 1995]

§ 411.175 Basis for Medicare primary payments.

(a) *General rule.* CMS makes Medicare primary payments for covered services that are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(2) Not covered by the plan for any individuals or spouses who are enrolled by virtue of the individual's current employment status;

(3) Covered under the plan but not available to particular individuals or spouses enrolled by virtue of current employment status because they have

exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional Medicare payments: Basic rule.* Except as provided in paragraph (c) of this section, Medicare may make a conditional primary payment if—

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim under the group health plan and the plan has denied the claim in whole or in part; or

(2) The beneficiary, because of physical or mental incapacity, failed to file proper claim.

(c) *Conditional primary payments: Exception.* Medicare does not make conditional primary payments under either of the following circumstances:

(1) The claim is denied for one of the following reasons:

(i) It is alleged that the group health plan is secondary to Medicare.

(ii) The plan limits its payments when the individual is entitled to Medicare.

(iii) The plan covers the services for individuals or spouses who are enrolled in the plan by virtue of current employment status and are under age 65 but not for individuals and spouses who are enrolled on the same basis but are age 65 or older.

(iv) Failure to file a proper claim if that failure is for any reason other than physical or mental incapacity of the beneficiary.

(2) The group health plan fails to furnish information requested by CMS and necessary to determine whether the employer plan is primary to Medicare.

[54 FR 41734, Oct. 11, 1989. Redesignated and amended at 60 FR 45362, 45371, Aug. 31, 1995]

Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans

SOURCE: 60 FR 45371, Aug. 31, 1995, unless otherwise noted.

§ 411.200 Basis.

(a) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(1) Individuals who are entitled to Medicare on the basis of disability; and

(2) Large group health plans (LGHPs) that cover those individuals.

(b) Under these provisions, the LGHP may not take into account the Medicare entitlement of a disabled individual who is covered (or seeks to be covered) under the plan by virtue of his or her own current employment status or that of a member of his or her family. (§411.108 gives examples of actions that constitute taking into account.)

§ 411.201 Definitions.

As used in this subpart—

Entitled to Medicare on the basis of disability means entitled or deemed entitled on the basis of entitlement to social security disability benefits or railroad retirement disability benefits. (§406.12 of this chapter explains the requirements an individual must meet in order to be entitled or deemed to be entitled to Medicare on the basis of disability.)

Family member means a person who is enrolled in an LGHP based on another person's enrollment; for example, the enrollment of the named insured individual. Family members may include a spouse (including a divorced or common-law spouse), a natural, adopted, foster, or stepchild, a parent, or a sibling.

§ 411.204 Medicare benefits secondary to LGHP benefits.

(a) Medicare benefits are secondary to benefits payable by an LGHP for services furnished during any month in which the individual—

(1) Is entitled to Medicare Part A benefits under §406.12 of this chapter;

(2) Is covered under an LGHP; and

(3) Has LGHP coverage by virtue of his or her own or a family member's current employment status.

(b) *Individuals entitled to Medicare on the basis of disability who are also eligible for, or entitled to, Medicare on the basis of ESRD.* If a disabled individual is, or could upon filing an application become, entitled to Medicare on the basis

of ESRD, the coordination of benefits rules of subpart F of this part apply.

§ 411.206 Basis for Medicare primary payments and limits on secondary payments.

(a) *General rule.* CMS makes Medicare primary payments for services furnished to disabled beneficiaries covered under the LGHP by virtue of their own or a family member's current employment status if the services are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(2) Not covered under the plan for the disabled individual or similarly situated individuals;

(3) Covered under the plan but not available to particular disabled individuals because they have exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional primary payments: Basic rule.* Except as provided in paragraph (c) of this section, CMS may make a conditional Medicare primary payment for any of the following reasons:

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim with the LGHP and the LGHP has denied the claim in whole or in part.

(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

(c) *Conditional primary payments: Exceptions.* CMS does not make conditional Medicare primary payments if—

(1) The LGHP denies the claim in whole or in part for one of the following reasons:

(i) It is alleged that the LGHP is secondary to Medicare.

(ii) The LGHP limits its payments when the individual is entitled to Medicare.

(iii) The LGHP does not provide the benefits to individuals who are entitled to Medicare on the basis of disability and covered under the plan by virtue of current employment status but does

§ 411.350

42 CFR Ch. IV (10–1–23 Edition)

provide the benefits to other similarly situated individuals enrolled in the plan.

(iv) The LGHP takes into account entitlement to Medicare in any other way.

(v) There was failure to file a proper claim for any reason other than physical or mental incapacity of the beneficiary.

(2) The LGHP, an employer or employee organization, or the beneficiary fails to furnish information that is requested by CMS and that is necessary to determine whether the LGHP is primary to Medicare.

(d) *Limit on secondary payments.* The provisions of § 411.172(e) also apply to services furnished to the disabled under this subpart.

Subpart I [Reserved]

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

SOURCE: 69 FR 16126, Mar. 26, 2004, unless otherwise noted.

§ 411.350 Scope of subpart.

(a) This subpart implements section 1877 of the Act, which generally prohibits a physician from making a referral under Medicare for designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship.

(b) This subpart does not provide for exceptions or immunity from civil or criminal prosecution or other sanctions applicable under any State laws or under Federal law other than section 1877 of the Act. For example, although a particular arrangement involving a physician's financial relationship with an entity may not prohibit the physician from making referrals to the entity under this subpart, the arrangement may nevertheless violate another provision of the Act or other laws administered by HHS, the Federal Trade Commission, the Securities and Exchange Commission, the Internal Revenue Service, or any other Federal or State agency.

(c) This subpart requires, with some exceptions, that certain entities furnishing covered services under Medicare report information concerning ownership, investment, or compensation arrangements in the form, in the manner, and at the times specified by CMS.

(d) This subpart does not alter an individual's or entity's obligations under—

(1) The rules regarding reassignment of claims (§ 424.80 of this chapter);

(2) The rules regarding purchased diagnostic tests (§ 414.50 of this chapter);

(3) The rules regarding payment for services and supplies incident to a physician's professional services (§ 410.26 of this chapter); or

(4) Any other applicable Medicare laws, rules, or regulations.

[85 FR 77656, Dec. 2, 2020]

§ 411.351 Definitions.

The definitions in this subpart apply only for purposes of section 1877 of the Act and this subpart. As used in this subpart, unless the context indicates otherwise:

Centralized building means all or part of a building, including, for purposes of this subpart only, a mobile vehicle, van, or trailer that is owned or leased on a full-time basis (that is, 24 hours per day, 7 days per week, for a term of not less than 6 months) by a group practice and that is used exclusively by the group practice. Space in a building or a mobile vehicle, van, or trailer that is shared by more than one group practice, by a group practice and one or more solo practitioners, or by a group practice and another provider or supplier (for example, a diagnostic imaging facility) is not a centralized building for purposes of this subpart. This provision does not preclude a group practice from providing services to other providers or suppliers (for example, purchased diagnostic tests) in the group practice's centralized building. A group practice may have more than one centralized building.

Clinical laboratory services means the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from