

**§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 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 the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings, including procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body, as specifically identified by the List of CPT/HCPCS Codes. All services so identified on the List of CPT/HCPCS Codes are clinical laboratory services for purposes of this subpart. Any service not specifically identified as a clinical laboratory service on the List of CPT/HCPCS Codes is not a clinical laboratory service for purposes of this subpart.

*Commercially reasonable* means that the particular arrangement furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties.

*Consultation* means a professional service furnished to a patient by a physician if the following conditions are satisfied:

(1) The physician's opinion or advice regarding evaluation or management or both of a specific medical problem is requested by another physician.