

§ 411.40

is received, CMS applies a pro rata reduction to the final conditional payment amount in accordance with § 411.37 and issues a final MSP recovery demand letter.

(2) An applicable plan may only obtain a final conditional payment amount related to a pending liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment in the form and manner described in § 411.38(b) if the applicable plan has properly registered to use the Web portal and has obtained from the beneficiary, and submitted to the appropriate CMS contractor, proper proof of representation. The applicable plan may obtain read only access if the applicable plan obtains from the beneficiary, and submits to the appropriate CMS contractor, proper consent to release.

(d) *Obligations with respect to future medical items and services.* Final conditional payment amounts obtained via the Web portal represent Medicare covered and otherwise reimbursable items and services that are related to the beneficiary's settlement, judgment, award, or other payment furnished before the time and date stamped on the final conditional payment summary form.

[78 FR 57804, Sept. 20, 2013, as amended at 81 FR 30492, May 17, 2016]

Subpart C—Limitations on Medicare Payment for Services Covered Under Workers' Compensation

§ 411.40 General provisions.

(a) *Definition.* “Workers’ compensation plan of the United States” includes the workers’ compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as the systems provided under the Federal Employees’ Compensation Act and the Longshoremen’s and Harbor Workers’ Compensation Act.

(b) *Limitations on Medicare payment.* (1) Medicare does not pay for any services for which—

(i) Payment has been made, or can reasonably be expected to be made

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under a workers’ compensation law or plan of the United States or a state; or

(ii) Payment could be made under the Federal Black Lung Program, but is precluded solely because the provider of the services has failed to secure, from the Department of Labor, a provider number to include in the claim.

(2) If the payment for a service may not be made under workers’ compensation because the service is furnished by a source not authorized to provide that service under the particular workers’ compensation program, Medicare pays for the service if it is a covered service.

(3) Medicare makes secondary payments in accordance with §§ 411.32 and 411.33.

[54 FR 41734, Oct. 11, 1989, as amended at 71 FR 9470, Feb. 24, 2006]

§ 411.43 Beneficiary’s responsibility with respect to workers’ compensation.

(a) The beneficiary is responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under workers’ compensation.

(b) Except as specified in § 411.45(a), Medicare does not pay until the beneficiary has exhausted his or her remedies under workers’ compensation.

(c) Except as specified in § 411.45(b), Medicare does not pay for services that would have been covered under workers’ compensation if the beneficiary had filed a proper claim.

(d) However, if a claim is denied for reasons other than not being a proper claim, Medicare pays for the services if they are covered under Medicare.

§ 411.45 Basis for conditional Medicare payment in workers’ compensation cases.

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

(1) The beneficiary has filed a proper claim for workers’ compensation benefits, but the intermediary or carrier determines that the workers’ compensation carrier will not pay promptly. This includes cases in which a workers’ compensation carrier has denied a claim.

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

(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, as amended at 73 FR 9685, Feb. 22, 2008]

§411.46 Lump-sum payments.

(a) *Lump-sum commutation of future benefits.* If a lump-sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump-sum payment.

(b) *Lump-sum compromise settlement.* (1) A lump-sum compromise settlement is deemed to be a workers' compensation payment for Medicare purposes, even if the settlement agreement stipulates that there is no liability under the workers' compensation law or plan.

(2) If a settlement appears to represent an attempt to shift to Medicare the responsibility for payment of medical expenses for the treatment of a work-related condition, the settlement will not be recognized. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

(c) *Lump-sum compromise settlement: Effect on services furnished before the date of settlement.* Medicare pays for medical expenses incurred before the lump-sum compromise settlement only to the extent specified in §411.47.

(d) *Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement—(1) Basic rule.* Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical ex-

penses incurred after the date of the settlement are payable under Medicare.

(2) *Exception.* If the settlement agreement allocates certain amounts for specific future medical services, Medicare does not pay for those services until medical expenses related to the injury or disease equal the amount of the lump-sum settlement allocated to future medical expenses.

§411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.

(a) *Determining amount of compromise settlement considered as a payment for medical expenses.* (1) If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining Medicare payments.

(2) If the settlement does not give reasonable recognition to both elements of a workers' compensation 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 ($\$8,000/\$24,000=1/3$), the workers'