

§ 410.170 Payment for home health services, for medical and other health services furnished by a provider or an approved ESRD facility, and for comprehensive outpatient rehabilitation facility (CORF) services: Conditions.

Payment under Medicare Part B, for home health services, for medical and other health services, or for CORF services, may be made to the provider or facility only if the following conditions are met:

(a) *Request for payment.* A written request for payment is filed by or on behalf of the individual to whom the services were furnished.

(b) *Physician certification.* (1) For home health services, a physician provides certification and recertification in accordance with § 424.22 of this chapter.

(2) For medical and other health services, a physician provides certification and recertification in accordance with § 424.24 of this chapter.

(3) For CORF services, a physician provides certification and recertification in accordance with § 424.27 of this chapter.

(c) In the case of home dialysis support services described in § 410.52, the services are furnished in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition as required by § 405.2137(b)(3) of this chapter.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988]

§ 410.172 Payment for partial hospitalization services in CMHCs: Conditions.

Medicare Part B pays for partial hospitalization services furnished in a CMHC on behalf of an individual only if the following conditions are met:

(a) The CMHC files a written request for payment on the HCFA form 1450 and in the manner prescribed by HCFA; and

(b) The services are furnished in accordance with the requirements described in § 410.110.

[59 FR 6578, Feb. 11, 1994]

§ 410.175 Alien absent from the United States.

(a) Medicare does not pay Part B benefits for services furnished to an individual who is not a citizen or a national of the United States if those services are furnished in any month for which the individual is not paid monthly social security cash benefits (or would not be paid if he or she were entitled to those benefits) because he or she has been outside the United States continuously for 6 full calendar months.

(b) Payment of benefits resumes with services furnished during the first full calendar month the alien is back in the United States.

[53 FR 6634, Mar. 2, 1988]

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

Subpart A—General Exclusions and Exclusion of Particular Services

Sec.

- 411.1 Basis and scope.
- 411.2 Conclusive effect of PRO determinations on payment of claims.
- 411.4 Services for which neither the beneficiary nor any other person is legally obligated to pay.
- 411.6 Services furnished by a Federal provider of services or other Federal agency.
- 411.7 Services that must be furnished at public expense under a Federal law or Federal Government contract.
- 411.8 Services paid for by a Government entity.
- 411.9 Services furnished outside the United States.
- 411.10 Services required as a result of war.
- 411.12 Charges imposed by an immediate relative or member of the beneficiary's household.
- 411.15 Particular services excluded from coverage.

Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

- 411.20 Basis and scope.
- 411.21 Definitions.
- 411.23 Beneficiary's cooperation.
- 411.24 Recovery of conditional payments.
- 411.25 Third party payer's notice of mistaken Medicare primary payment.
- 411.26 Subrogation and right to intervene.
- 411.28 Waiver of recovery and compromise of claims.

- 411.30 Effect of third party payment on benefit utilization and deductibles.
- 411.31 Authority to bill third party payers for full charges.
- 411.32 Basis for Medicare secondary payments.
- 411.33 Amount of Medicare secondary payment.
- 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.
- 411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.
- Subpart C—Limitations on Medicare Payment for Services Covered Under Workers' Compensation**
- 411.40 General provisions.
- 411.43 Beneficiary's responsibility with respect to workers' compensation.
- 411.45 Basis for conditional Medicare payment in workers' compensation cases.
- 411.46 Lump-sum payments.
- 411.47 Apportionment of a lump-sum compromise settlement of a workers' compensation claim.
- Subpart D—Limitations on Medicare Payment for Services Covered Under Liability or No-Fault Insurance**
- 411.50 General provisions.
- 411.51 Beneficiary's responsibility with respect to no-fault insurance.
- 411.52 Basis for conditional Medicare payment in liability cases.
- 411.53 Basis for conditional Medicare payment in no-fault cases.
- 411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.
- Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions**
- 411.100 Basis and scope.
- 411.101 Definitions.
- 411.102 Basic prohibitions and requirements.
- 411.103 Prohibition against financial and other incentives.
- 411.104 Current employment status.
- 411.106 Aggregation rules.
- 411.108 Taking into account entitlement to Medicare.
- 411.110 Basis for determination of nonconformance.
- 411.112 Documentation of conformance.
- 411.114 Determination of nonconformance.
- 411.115 Notice of determination of nonconformance.
- 411.120 Appeals.
- 411.121 Hearing procedures.
- 411.122 Hearing officer's decision.
- 411.124 Administrator's review of hearing decision.
- 411.126 Reopening of determinations and decisions.
- 411.130 Referral to Internal Revenue Service (IRS).
- Subpart F—Special Rules: Individuals Eligible or Entitled on the Basis of ESRD, Who Are Also Covered Under Group Health Plans**
- 411.160 Scope.
- 411.161 Prohibition against taking into account Medicare eligibility or entitlement or differentiating benefits.
- 411.162 Medicare benefits secondary to group health plan benefits.
- 411.163 Coordination of benefits: Dual entitlement situations.
- 411.165 Basis for conditional Medicare payments.
- Subpart G—Special Rules: Aged Beneficiaries and Spouses Who Are Also Covered Under Group Health Plans**
- 411.170 General provisions.
- 411.172 Medicare benefits secondary to group health plan benefits.
- 411.175 Basis for Medicare primary payments.
- Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans**
- 411.200 Basis.
- 411.201 Definitions.
- 411.204 Medicare benefits secondary to LGHP benefits.
- 411.206 Basis for Medicare primary payments and limits on secondary payments.
- Subpart I—[Reserved]**
- Subpart J—Physician Ownership of, and Referral of Patients or Laboratory Specimens to, Entities Furnishing Clinical Laboratory or Other Health Services**
- 411.350 Scope of subpart.
- 411.351 Definitions.
- 411.353 Prohibition on certain referrals by physicians and limitations on billing.
- 411.355 General exceptions to referral prohibitions related to both ownership/investment and compensation.
- 411.356 Exceptions to referral prohibitions related to ownership or investment interests.

§ 411.1

- 411.357 Exceptions to referral prohibitions related to compensation arrangements.
411.360 Group practice attestation.
411.361 Reporting requirements.

Subpart K—Payment for Certain Excluded Services

- 411.400 Payment for custodial care and services not reasonable and necessary.
411.402 Indemnification of beneficiary.
411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.
411.406 Criteria for determining that a provider, practitioner, or supplier knew that services were excluded from coverage as custodial care or as not reasonable and necessary.
411.408 Refunds of amounts collected for physician services not reasonable and necessary, payment not accepted on an assignment-related basis.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 54 FR 41734, Oct. 11, 1989, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes affecting part 411 appear at 60 FR 45370, Aug. 31, 1995.

Subpart A—General Exclusions and Exclusion of Particular Services

§ 411.1 Basis and scope.

(a) *Statutory basis.* Sections 1814(c), 1835(d), and 1862 of the Act exclude from Medicare payment certain specified services. The Act provides special rules for payment of services furnished by Federal providers or agencies (sections 1814(c) and 1835(d)), by hospitals and physicians outside the United States (sections 1814(f) and 1862(a)(4)), and by hospitals and SNFs of the Indian Health Service (section 1880). Section 1877 sets forth limitations on referrals and payment for clinical laboratory services furnished by entities with which the referring physician (or an immediate family member of the referring physician) has a financial relationship. Sections 1842(l) and 1879 of the Act provide for refund to, or indemnification of, a beneficiary who has paid a provider or supplier for certain services that the provider or supplier knew were excluded from Medicare coverage.

42 CFR Ch. IV (10–1–96 Edition)

(b) *Scope.* This subpart identifies:

- (1) The particular types of services that are excluded;
- (2) The circumstances under which Medicare denies payment for certain services that are usually covered; and
- (3) The circumstances under which Medicare pays for services usually excluded from payment.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 41978, Aug. 14, 1995; 60 FR 45361, Aug. 31, 1995]

§ 411.2 Conclusive effect of PRO determinations on payment of claims.

If a utilization and quality control peer review organization (PRO) has assumed review responsibility, in accordance with part 466 of this chapter, for services furnished to Medicare beneficiaries, Medicare payment is not made for those services unless the conditions of subpart C of part 466 of this chapter are met.

§ 411.4 Services for which neither the beneficiary nor any other person is legally obligated to pay.

(a) *General rule.* Except as provided in § 411.8(b) (for services paid by a governmental entity), Medicare does not pay for a service if—

- (1) The beneficiary has no legal obligation to pay for the service; and
- (2) No other person or organization (such as a prepayment plan of which the beneficiary is a member) has a legal obligation to provide or pay for that service.

(b) *Special conditions for services furnished to individuals in custody of penal authorities.* Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the

same way and with the same vigor that it pursues the collection of other debts.

§ 411.6 Services furnished by a Federal provider of services or other Federal agency.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, Medicare does not pay for services furnished by a Federal provider of services or other Federal agency.

(b) *Exceptions.* Payment may be made—

(1) For emergency hospital services, if the conditions of § 424.103 of this chapter are met;

(2) For services furnished by a participating Federal provider which HCFA has determined is providing services to the public generally as a community institution or agency;

(3) For services furnished by participating hospitals and SNFs of the Indian Health Service; and

(4) For services furnished under arrangements (as defined in § 409.3 of this chapter) made by a participating hospital.

§ 411.7 Services that must be furnished at public expense under a Federal law or Federal Government contract.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, payment may not be made for services that any provider or supplier is obligated to furnish at public expense, in accordance with a law of, or a contract with, the United States.

(b) *Exception.* Payment may be made for services that a hospital or SNF of the Indian Health Service is obligated to furnish at public expense.

§ 411.8 Services paid for by a Government entity.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, Medicare does not pay for services that are paid for directly or indirectly by a government entity.

(b) *Exceptions.* Payment may be made for the following:

(1) Services furnished under a health insurance plan established for employees of the government entity.

(2) Services furnished under a title of the Social Security Act other than title XVIII.

(3) Services furnished in or by a participating general or special hospital that—

(i) Is operated by a State or local government agency; and

(ii) Serves the general community.

(4) Services furnished in a hospital or elsewhere, as a means of controlling infectious diseases or because the individual is medically indigent.

(5) Services furnished by a participating hospital or SNF of the Indian Health Service.

(6) Services furnished by a public or private health facility that—

(i) Is not a Federal provider or other facility operated by a Federal agency;

(ii) Receives U.S. government funds under a Federal program that provides support to facilities that furnish health care services;

(iii) Customarily seeks payment for services not covered under Medicare from all available sources, including private insurance and patients' cash resources; and

(iv) Limits the amounts it collects or seeks to collect from a Medicare Part B beneficiary and others on the beneficiary's behalf to:

(A) Any unmet deductible applied to the charges related to the reasonable costs that the facility incurs in providing the covered services;

(B) Twenty percent of the remainder of those charges;

(C) The charges for noncovered services.

(7) Rural health clinic services that meet the requirements set forth in part 491 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 56 FR 2139, Jan. 22, 1991]

§ 411.9 Services furnished outside the United States.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare does not pay for services furnished outside the United States. For purposes of this paragraph (a), the following rules apply:

(1) The United States includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam,

American Samoa, The Northern Mariana Islands, and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the United States.

(2) Services furnished on board ship are considered to have been furnished in United States territorial waters if they were furnished while the ship was in a port of one of the jurisdictions listed in paragraph (a)(1) of this section, or within 6 hours before arrival at, or 6 hours after departure from, such a port.

(3) A hospital that is not physically situated in one of the jurisdictions listed in paragraph (a)(1) of this section is considered to be outside the United States, even if it is owned or operated by the United States Government.

(b) *Exception.* Under the circumstances specified in subpart H of part 424 of this chapter, payment may be made for covered inpatient services furnished in a foreign hospital and, on the basis of an itemized bill, for covered physicians' services and ambulance service furnished in connection with those inpatient services, but only for the period during which the inpatient hospital services are furnished.

§ 411.10 Services required as a result of war.

Medicare does not pay for services that are required as a result of war, or an act of war, that occurs after the effective date of a beneficiary's current coverage for hospital insurance benefits or supplementary medical insurance benefits.

§ 411.12 Charges imposed by an immediate relative or member of the beneficiary's household.

(a) *Basic rule.* Medicare does not pay for services usually covered under Medicare if the charges for those services are imposed by—

- (1) An immediate relative of the beneficiary; or
- (2) A member of the beneficiary's household.

(b) *Definitions.* As used in this section—

Immediate relative means any of the following:

- (1) Husband or wife.

- (2) Natural or adoptive parent, child, or sibling.

- (3) Stepparent, stepchild, stepbrother, or stepsister.

- (4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.

- (5) Grandparent or grandchild.

- (6) Spouse of grandparent or grandchild.

Member of the household means any person sharing a common abode as part of a single family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by State law.

(c) *Applicability of the exclusion.* The exclusion applies to the following charges in the specified circumstances:

(1) *Physicians' services.* (i) Charges for physicians' services furnished by an immediate relative of the beneficiary or member of the beneficiary's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

(ii) Charges for services furnished incident to a physician's professional services (for example by the physician's nurse or technician), only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary.

(2) *Services other than physicians' services.* (i) Charges imposed by an individually owned provider or supplier if the owner has an excluded relationship to the beneficiary; and

(ii) Charges imposed by a partnership if any of the partners has an excluded relationship to the beneficiary.

(d) *Exception to the exclusion.* The exclusion does not apply to charges imposed by a corporation other than a professional corporation.

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

(a) Routine physical checkups such as—

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptom, complaint, or injury, except for screening mammography (including a physician's interpretation of the results) that meets the conditions for coverage and limitations on coverage of screening mammography specified at § 410.34 of this chapter and the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(2) Examinations required by insurance companies, business establishments, government agencies, or other third parties.

(b) *Eyeglasses or contact lenses, except for:*

(1) Post-surgical prosthetic lenses customarily used during convalescence for eye surgery in which the lens of the eye was removed (e.g., cataract surgery);

(2) Prosthetic lenses for patients who lack the lens of the eye because of congenital absence or surgical removal; and

(3) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

(c) *Eye examinations* for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive error only and procedures performed in the course of any eye examination to determine the refractive state of the eyes, without regard to the reason for the performance of the refractive procedures. Refractive procedures are excluded even when performed in connection with otherwise covered diagnosis or treatment of illness or injury.

(d) *Hearing aids* or examination for the purpose of prescribing, fitting, or changing hearing aids.

(e) *Immunizations, except for—*

(1) Vaccinations or inoculations directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus anti-

toxin or booster vaccine, botulin anti-toxin, antivenom sera, or immune globulin;

(2) Pneumococcal vaccinations that are reasonable and necessary for the prevention of illness; and

(3) Hepatitis B vaccinations that are reasonable and necessary for the prevention of illness for those individuals, as defined in § 410.63(a) of this chapter, who are at high or intermediate risk of contracting hepatitis B.

(f) *Orthopedic shoes* or other supportive devices for the feet, *except when shoes are integral parts of leg braces.*

(g) *Custodial care, except as necessary* for the palliation or management of terminal illness, as provided in part 418 of this chapter. (Custodial care is any care that does not meet the requirements for coverage as SNF care as set forth in §§ 409.30 through 409.35 of this chapter.)

(h) *Cosmetic surgery and related services*, except as required for the prompt repair of accidental injury or to improve the functioning of a malformed body member.

(i) *Dental services* in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, *except for* inpatient hospital services in connection with such dental procedures when hospitalization is required because of—

(1) The individual's underlying medical condition and clinical status; or

(2) The severity of the dental procedures.¹

(j) *Personal comfort services, except as necessary* for the palliation or management of terminal illness as provided in part 418 of this chapter. The use of a television set or a telephone are examples of personal *comfort services.*

(k) *Any services that are not reasonable and necessary* for one of the following purposes:

(1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

¹Before July 1981, inpatient hospital care in connection with dental procedures was covered only when required by the patient's underlying medical condition and clinical status.

(2) In the case of hospice services, for the palliation or management of terminal illness, as provided in part 418 of this chapter.

(3) In the case of pneumococcal vaccine for the prevention of illness.

(4) In the case of the patient outcome assessment program established under section 1875(c) of the Act, for carrying out the purpose of that section.

(5) In the case of hepatitis B vaccine, for the prevention of illness for those individuals at high or intermediate risk of contracting hepatitis B. (Section 410.63(a) of this chapter sets forth criteria for identifying those individuals.)

(1) *Foot care.* (1) *Basic rule.* Except as provided in paragraph (1)(2) of this section, any services furnished in connection with the following:

(i) *Routine foot care*, such as the cutting or removal of corns, or calluses, the trimming of nails, routine hygienic care (preventive maintenance care ordinarily within the realm of self care), and any service performed in the absence of localized illness, injury, or symptoms involving the feet.

(ii) *The evaluation or treatment of subluxations of the feet* regardless of underlying pathology. (Subluxations are structural misalignments of the joints, other than fractures or complete dislocations, that require treatment only by nonsurgical methods.

(iii) *The evaluation or treatment of flattened arches* (including the prescription of supportive devices) regardless of the underlying pathology.

(2) *Exceptions.* (i) Treatment of warts is not excluded.

(ii) Treatment of mycotic toenails may be covered if it is furnished no more often than every 60 days or the billing physician documents the need for more frequent treatment.

(iii) The services listed in paragraph (1)(1) of this section are not excluded if they are furnished—

(A) As an incident to, at the same time as, or as a necessary integral part of a primary covered procedure performed on the foot; or

(B) As initial diagnostic services (regardless of the resulting diagnosis) in connection with a specific symptom or complaint that might arise from a con-

dition whose treatment would be covered.

(m) *Services to hospital inpatients.* (1) *Basic rule.* Except as provided in paragraph (m)(2) of this section, any service furnished to an inpatient of a hospital by an entity other than the hospital, unless the hospital has an arrangement (as defined in §409.3 of this chapter) with that entity to furnish that particular service to the hospital's inpatients. Services subject to exclusion under this paragraph include, but are not limited to, clinical laboratory services, pacemakers, artificial limbs, knees, and hips, intraocular lenses, total parenteral nutrition, and services incident to physicians' services. (As used in this paragraph (m)(1), the term "hospital" includes an RPCH.)

(2) *Exceptions.* The following services are not excluded from coverage:

(i) Physicians' services that meet the criteria of §415.102(a) of this chapter for payment on a reasonable charge or fee schedule basis.

(ii) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act, that are furnished after December 31, 1990.

(iii) Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990.

(iv) Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990.

(v) Services of an anesthetist, as defined in §410.69 of this chapter.

(n) *Certain services of an assistant-at-surgery.*

(1) Services of an assistant-at-surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate PRO or a carrier has approved the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition.

(2) Services on an assistant-at-surgery in a surgical procedure (or class of surgical procedures) for which assistants-at-surgery on average are used in fewer than 5 percent of such procedures nationally.

(o) *Experimental or investigational devices, except for certain devices—*

(1) Categorized by the FDA as a non-experimental/investigational (Category B) device defined in §405.201(b) of this chapter; and

(2) Furnished in accordance with the FDA-approved protocols governing clinical trials.

[54 FR 41734, Oct. 11, 1989; 55 FR 1820, Jan. 19, 1990, as amended at 55 FR 22789, June 4, 1990; 55 FR 31185, Aug. 1, 1990; 57 FR 33897, July 31, 1992; 57 FR 36015, Aug. 12, 1992; 58 FR 30669, May 26, 1993; 59 FR 49834, Sept. 30, 1994; 60 FR 48424, Sept. 19, 1995; 60 FR 63188, Dec. 8, 1995]

Subpart B—Insurance Coverage That Limits Medicare Payment: General Provisions

§411.20 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b)(2)(A)(i) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to—

(i) A beneficiary entitled to Medicare on the basis of ESRD during the first 18 months of that entitlement;

(ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or

(iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

(2) Section 1862(b)(2)(A)(ii) of the Act precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly under any of the following:

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

(b) *Scope.* This subpart sets forth general rules that apply to the types of insurance specified in paragraph (a) of this section. Other general rules that apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995]

§411.21 Definitions.

In this subpart B and in subparts C through H of this part, unless the context indicates otherwise—

Conditional payment means a Medicare payment for services for which another payer is responsible, made either on the bases set forth in subparts C through H of this part, or because the intermediary or carrier did not know that the other coverage existed.

Coverage or covered services, when used in connection with third party payments, means services for which a third party payer would pay if a proper claim were filed.

Monthly capitation payment means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility.

Plan means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

Prompt or promptly, when used in connection with third party payments, except as provided in §411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.

Proper claim means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer.

Secondary, when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare.

Secondary payments means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

Third party payer means an insurance policy, plan, or program that is primary to Medicare.

Third party payment means payment by a third party payer for services that are also covered under Medicare.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995]

§ 411.23 Beneficiary's cooperation.

(a) If HCFA takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If HCFA's recovery action is unsuccessful because the beneficiary does not cooperate, HCFA may recover from the beneficiary.

§ 411.24 Recovery of conditional payments.

If a Medicare conditional payment is made, the following rules apply:

(a) *Release of information.* The filing of a Medicare claim by on or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and workers' compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to HCFA. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) *Right to initiate recovery.* HCFA may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.

(c) *Amount of recovery.* (1) If it is not necessary for HCFA to take legal action to recover, HCFA recovers the lesser of the following:

(i) The amount of the Medicare primary payment.

(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a third party payment recipient, the amount of the third party payment.

(2) If it is necessary for HCFA to take legal action to recover from the primary payer, HCFA may recover twice the amount specified in paragraph (c)(1)(i) of this section.

(d) *Methods of recovery.* HCFA may recover by direct collection or by offset against any monies HCFA owes the entity responsible for refunding the conditional payment.

(e) *Recovery from third parties.* HCFA has a direct right of action to recover

from any entity responsible for making primary payment. This includes an employer, an insurance carrier, plan, or program, and a third party administrator.

(f) *Claims filing requirements.* (1) HCFA may recover without regard to any claims filing requirements that the insurance program or plan imposes on the beneficiary or other claimant such as a time limit for filing a claim or a time limit for notifying the plan or program about the need for or receipt of services.

(2) However, HCFA will not recover its payment for particular services in the face of a claims filing requirement unless it has filed a claim for recovery by the end of the year following the year in which the Medicare intermediary or carrier that paid the claim has notice that the third party is primary to Medicare for those particular services. (A notice received during the last three months of a year is considered received during the following year.)

(g) *Recovery from parties that receive third party payments.* HCFA has a right of action to recover its payments from any entity, including a beneficiary, provider, supplier, physician, attorney, State agency or private insurer that has received a third party payment.

(h) *Reimbursement to Medicare.* If the beneficiary or other party receives a third party payment, the beneficiary or other party must reimburse Medicare within 60 days.

(i) *Special rules.* (1) In the case of liability insurance settlements and disputed claims under employer group health plans and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of § 411.37(b) applies.

(j) *Recovery against Medicaid agency.* If a third party payment is made to a State Medicaid agency and that agency does not reimburse Medicare, HCFA may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the third party payment, whichever is less.

(k) *Recovery against Medicare contractor.* If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, HCFA may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) *Recovery when there is failure to file a proper claim.* (1) *Basic rule.* If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third party payer, and Medicare is unable to recover from the third party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) *Exceptions:* (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) HCFA will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) *Interest charges.* (1) With respect to recovery of payments for items and services furnished before October 31, 1994, HCFA charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services fur-

nished on or after October 31, 1994, HCFA charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision—

(i) HCFA may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by HCFA that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by HCFA and is charged until reimbursement is made; and

(iii) The rate of interest is that provided at 42 CFR 405.376(d).

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995]

§ 411.25 Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in § 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to HCFA. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

[54 FR 41734, Oct. 11, 1989; as amended at 55 FR 1820, Jan. 19, 1990]

§ 411.26 Subrogation and right to intervene.

(a) *Subrogation.* With respect to services for which Medicare paid, HCFA is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) *Right to intervene.* HCFA may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

§ 411.28 Waiver of recovery and compromise of claims.

(a) HCFA may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and § 405.374 of this chapter.

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

§ 411.30 Effect of third party payment on benefit utilization and deductibles.

(a) *Benefit utilization.* Inpatient psychiatric hospital and SNF care that is paid for by a third party payer is not counted against the number of inpatient care days available to the beneficiary under Medicare Part A.

(b) *Deductibles.* Expenses for Medicare covered services that are paid for by third party payers are credited toward the Medicare Part A and Part B deductibles.

§ 411.31 Authority to bill third party payers for full charges.

(a) The fact that Medicare payments are limited to the DRG amount, or the reasonable charge, reasonable cost, capitation or fee schedule rate, does not affect the amount that a third party payer may pay.

(b) With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than title XVIII of the Act or by agreements with the third party payer.

§ 411.32 Basis for Medicare secondary payments.

(a) *Basic rules.* (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare

benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in § 411.33, to supplement the third party payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under § 411.33(e).

(b) *Exception.* Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges.

(c) *General limitation: Failure to file a proper claim.* When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under § 411.33 if the third party payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform HCFA that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

§ 411.33 Amount of Medicare secondary payment.

(a) *Services for which HCFA pays on a Medicare fee schedule or reasonable charge basis.* The Medicare secondary payment is the lowest of the following:

(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the third party payer.

(2) The amount that Medicare would pay if the services were not covered by a third party payer.

(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the third

party payer's allowable charge (without regard to any deductible or co-insurance imposed by the policy or plan) minus the amount actually paid by the third party payer.

(b) *Example:* An individual received treatment from a physician for which the physician charged \$175. The third party payer allowed \$150 of the charge and paid 80 percent of this amount or \$120. The Medicare fee schedule for this treatment is \$125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:

(1) Excess of actual charge minus the third party payment: $\$175 - \$120 = \$55$.

(2) Amount Medicare would pay if the services were not covered by a third party payer: $.80 \times \$125 = \100 .

(3) Third party payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the third party payer: $\$150 - \$120 = \$30$.

The Medicare payment is \$30.

(c)-(d) [Reserved]

(e) *Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate.* The Medicare secondary payment is the lowest of the following:

(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the third party payer), minus the applicable Medicare deductible and coinsurance amounts.

(2) The gross amount payable by Medicare, minus the amount paid by the third party payer.

(3) The provider's charges (or the amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the third party payer.

(4) The provider's charges (or the amount the provider is obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

(f) *Examples:* (1) A hospital furnished 7 days of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totaled \$2,800. The third party

payer paid \$2,360. No part of the Medicare inpatient hospital deductible of \$520 had been met. If the gross amount payable by Medicare in this case is \$2,700, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare inpatient hospital deductible: $\$2,700 - \$520 = \$2,180$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$2,700 - \$2,360 = \$340$.

(iii) The provider's charges minus the third party payment: $\$2,800 - \$2,360 = \$440$.

(iv) The provider's charges minus the Medicare deductible: $\$2,800 - \$520 = \$2,280$. Medicare's secondary payment is \$340 and the combined payment made by the third party payer and Medicare on behalf of the beneficiary is \$2,700. The \$520 deductible was satisfied by the third party payment so that the beneficiary incurred no out-of-pocket expenses.

(2) A hospital furnished 1 day of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totalled \$750. The third party payer paid \$450. No part of the Medicare inpatient hospital deductible had been met previously. The third party payment is credited toward that deductible. If the gross amount payable by Medicare in this case is \$850, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare deductible: $\$850 - \$520 = \$330$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$850 - \$450 = \$400$.

(iii) The provider's charges minus the third party payment: $\$750 - \$450 = \$300$.

(iv) The provider's charges minus the Medicare deductible: $\$750 - \$520 = \$230$. Medicare's secondary payment is \$230, and the combined payment made by the third party payer and Medicare on behalf of the beneficiary is \$680. The hospital may bill the beneficiary \$70 (the \$520 deductible minus the \$450 third party payment). This fully discharges the beneficiary's deductible obligation.

(3) An ESRD beneficiary received 8 dialysis treatments for which a facility charged \$160 per treatment for a total of \$1,280. No part of the beneficiary's \$75 Part B deductible had been met. The third party payer paid \$1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is \$131 or \$1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:

(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $\$1,048 - \$75 - \$194.60 = \778.40 . (The coinsurance is calculated as follows: $\$1,048 \text{ composite rate} - \$75 \text{ deductible} = \$973 \times .20 = \$194.60$).

(ii) The gross amount payable by Medicare minus the third party payment: $\$1,048 - \$1,024 = \$24$.

(iii) The provider's charges minus the third party payment: $\$1,280 - \$1,024 = \$256$.

(iv) The provider's charge minus the Medicare deductible and coinsurance: $\$1,280 - \$75 - \$194.60 = 1010.40$. Medicare pays \$24. The beneficiary's Medicare deductible and coinsurance were met by the third party payment.

(4) A hospital furnished 5 days of inpatient care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services were \$4,000 and the gross amount payable was \$3,500. The provider agreed to accept \$3,000 from the third party as payment in full. The third party payer paid \$2,900 due to a deductible requirement under the third party plan. Medicare considers the amount the provider is obligated to accept as full payment (\$3,000) to be the provider charges. The Medicare secondary payment is the lowest of the following:

(i) The gross amount payable by Medicare minus the Medicare inpatient deductible: $\$3,500 - \$520 = \$2,980$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$3,500 - \$2,900 = \$600$.

(iii) The provider's charge minus the third party payment: $\$3,000 - \$2,900 = \$100$.

(iv) The provider's charges minus the Medicare inpatient deductible: $\$3,000 - \$520 = \$2,480$. The Medicare secondary payment is \$100. When Medicare is the secondary payer, the combined

payment made by the third party payer and Medicare on behalf of the beneficiary is \$3,000. The beneficiary has no liability for Medicare-covered services since the third party payment satisfied the \$520 deductible.

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

§ 411.35 Limitations on charges to a beneficiary or other party when a workers' compensation plan, a no-fault insurer, or an employer group health plan is primary payer.

(a) *Definition.* As used in this section *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for the Medicare deductible and coinsurance provisions and the amounts payable by the third party payer.

(b) *Applicability.* This section applies when a workers' compensation plan, a no-fault insurer or an employer group health plan is primary to Medicare.

(c) *Basic rule.* Except as provided in paragraph (d) of this section, the amounts the provider or supplier may collect or seek to collect, for the Medicare-covered services from the beneficiary or any entity other than the workers' compensation plan, the no-fault insurer, or the employer plan and Medicare, are limited to the following:

(1) The amount paid or payable by the third party payer to the beneficiary. If this amount exceeds the amount payable by Medicare (without regard to deductible or coinsurance), the provider or supplier may retain the third party payment in full without violating the terms of the provider agreement or the conditions of assignment.

(2) The amount, if any, by which the applicable Medicare deductible and coinsurance amounts exceed any third party payment made or due to the beneficiary or to the provider or supplier for the medical services.

(3) The amount of any charges that may be made to a beneficiary under § 413.35 of this chapter when cost limits are applied to the services, or under § 489.32 of this chapter when the services are partially covered, but only to the extent that the third party payer is not responsible for those charges.

(d) *Exception.* The limitations of paragraph (c) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or claimed payment under § 424.64 of this chapter.

§ 411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.

(a) *Recovery against the party that received payment—(1) General rule.* Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if—

(i) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which HCFA seeks to recover.

(2) *Special rule.* If HCFA must file suit because the party that received payment opposes HCFA's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) *Recovery against the third party payer.* If HCFA seeks recovery from the third party payer, in accordance with § 411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) *Medicare payments are less than the judgment or settlement amount.* If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) *Medicare payments equal or exceed the judgment or settlement amount.* If Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) *HCFA incurs procurement costs because of opposition to its recovery.* If HCFA must bring suit against the

party that received payment because that party opposes HCFA's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

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 promptly 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.

§ 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 conditional Medicare payment may be made under either of the following circumstances:

(a) 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.

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

§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 ben-

efits 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 expenses 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' compensation compromise settlement is considered to have paid for one-third of the total medical expenses ($1/3 \times \$18,000 = \$6,000$).

(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
	3,920
Total	3,920

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. The 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.

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 policy-

holder'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 promptly 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 promptly 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]

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

§411.52 Basis for conditional Medicare payment in liability cases.

If HCFA has information that services for which Medicare benefits have been claimed are for treatment of an injury or illness that was allegedly caused by another party, a conditional Medicare payment may be made.

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

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

(a) The beneficiary, or the provider or supplier, 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.

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

§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) *Basic rules*—(1) *Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(2) *Specific limitations.* Except as provided in paragraph (d) of this section, the provider or supplier—

(i) May not bill the liability insurer nor place a lien against the beneficiary's liability insurance settlement for Medicare covered services.

(ii) May only bill Medicare for Medicare-covered services; and

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

(d) *Exceptions*—(1) *Nonparticipating suppliers.* The limitations of paragraph

(c)(2) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or has not claimed payment for them under §424.64 of this chapter.

(2) *Prepaid health plans.* If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through 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.

(3) *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 limitations of paragraph (c)(2) of this section do not apply if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the hospital 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 hospital must withdraw its claim or lien and comply with the limitations imposed by paragraph (c)(2) of this section.

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 HCFA 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 to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code.

Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

FICA stands for the Federal Insurance Contributions Act, the law that imposes social security taxes on employers and employees under section 21 of the Internal Revenue Code.

Group health plan (GHP) means any arrangement made by one or more employers or employee organizations to provide health care directly or through

other methods such as insurance or reimbursement, to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that—

(1) Is of, or contributed to by, one or more employers or employee organizations.

(2) If it involves more than one employer or employee organization, provides for common administration.

(3) Provides substantially the same benefits or the same benefit options to all those enrolled under the arrangement.

The term includes self-insured plans, plans of governmental entities (Federal, State and local), and employee organization plans; that is, union plans, employee health and welfare funds or other employee organization plans. The term also includes employee-pay-all plans, which are plans under the auspices of one or more employers or employee organizations but which receive no financial contributions from them. The term does not include a plan that is unavailable to employees; for example, a plan only for self-employed persons.

IRC stands for Internal Revenue Code.

IRS stands for Internal Revenue Service.

Large group health plan (LGHP) means a GHP that covers employees of either—

(1) A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

(2) Two or more employers, or employee organizations, at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

MSP stands for Medicare secondary payer.

Multi-employer plan means a plan that is sponsored jointly by two or more employers (sometimes called a multiple-employer plan) or by employers and unions (sometimes under the Taft-Hartley law).

Self-employed person encompasses consultants, owners of businesses, and directors of corporations, and members of the clergy and religious orders who are paid for their services by a religious body or other entity.

Similarly situated individual means—

(1) In the case of employees, other employees enrolled or seeking to enroll in the plan; and

(2) In the case of other categories of individuals, other persons in any of those categories who are enrolled or seeking to enroll in the plan.

§ 411.102 Basic prohibitions and requirements.

(a) *ESRD*. (1) A group health plan of any size—(i) May not take into account the ESRD-based Medicare eligibility or entitlement of any individual who is covered or seeks to be covered under the plan; and

(ii) May not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan, on the basis of the existence of ESRD, or the need for dialysis, or in any other manner.

(2) The prohibitions of paragraph (a) of this section do not prohibit a plan from paying benefits secondary to Medicare after the first 18 months of ESRD-based eligibility or entitlement.

(b) *Age*. A GHP of an employer or employee organization of at least 20 employees—

(1) May not take into account the age-based Medicare entitlement of an individual or spouse age 65 or older who is covered (or seeks to be covered) under the plan by virtue of current employment status; and

(2) Must provide, to employees age 65 or older and to spouses age 65 or older of employees of any age, the same benefits under the same conditions as it provides to employees and spouses under age 65.

(c) *Disability*. A GHP of an employer or employee organization of at least 100 employees may not take into account the disability-based Medicare entitlement of any individual who is covered (or seeks to be covered) under the plan by virtue of current employment status.

§ 411.103 Prohibition against financial and other incentives.

(a) *General rule.* An employer or other entity (for example, an insurer) is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a GHP that is, or would be, primary to Medicare. This prohibition precludes offering to Medicare beneficiaries an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare. An example would be primary coverage through his own or a spouse's employer.

(b) *Penalty for violation.* (1) Any entity that violates the prohibition of paragraph (a) of this section is subject to a civil money penalty of up to \$5,000 for each violation; and

(2) The provisions of section 1128A of the Act (other than subsections (a) and (b)) apply to the civil money penalty of up to \$5,000 in the same manner as the provisions apply to a penalty or proceeding under section 1128A(a).

§ 411.104 Current employment status.

(a) *General rule.* An individual has current employment status if—

(1) The individual is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or

(2) The individual is not actively working and—

(i) Is receiving disability benefits from an employer for up to 6 months (the first 6 months of employer disability benefits are subject to FICA taxes); or

(ii) Retains employment rights in the industry and has not had his employment terminated by the employer, if the employer provides the coverage (or has not had his membership in the employee organization terminated, if the employee organization provides the coverage), is not receiving disability benefits from an employer for more than 6 months, is not receiving disability benefits from Social Security, and has GHP coverage that is not pursuant to COBRA continuation coverage (26 U.S.C. 4980B; 29 U.S.C. 1161–1168; 42 U.S.C. 300bb-1 et seq.). Whether or not

the individual is receiving pay during the period of nonwork is not a factor.

(b) *Persons who retain employment rights.* For purposes of paragraph (a)(2) of this section, persons who retain employment rights include but are not limited to—

(1) Persons who are furloughed, temporarily laid off, or who are on sick leave;

(2) Teachers and seasonal workers who normally do not work throughout the year; and

(3) Persons who have health coverage that extends beyond or between active employment periods; for example, based on an hours bank arrangement. (Active union members often have hours bank coverage.)

(c) *Coverage by virtue of current employment status.* An individual has coverage by virtue of current employment status with an employer if—

(1) the individual has GHP or LGHP coverage based on employment, including coverage based on a certain number of hours worked for that employer or a certain level of commissions earned from work for that employer at any time; and

(2) the individual has current employment status with that employer, as defined in paragraph (a) of this section.

(d) *Special rule: Self-employed person.* A self-employed individual is considered to have GHP or LGHP coverage by virtue of current employment status during a particular tax year only if, during the preceding tax year, the individual's net earnings, from work in that year related to the employer that offers the group health coverage, are at least equal to the amount specified in section 211(b)(2) of the Act, which defines "self-employment income" for social security purposes.

(e) *Special Rule: members of religious orders and members of clergy.* (1) *Members of religious orders who have not taken a vow of poverty.* A member of a religious order who has *not* taken a vow of poverty is considered to have current employment status with the religious order if—

(i) The religious order pays FICA taxes on behalf of that member; or

(ii) The individual is receiving cash remuneration from the religious order.

(2) *Members of religious orders who have taken a vow of poverty.* A member of a religious order whose members are required to take a vow of poverty is not considered to be employed by the order if the services he or she performs as a member of the order are considered employment only because the order elects social security coverage under section 3121(r) of the IRC. This exemption applies retroactively to services performed as a member of the order, beginning with the effective dates of the MSP provisions for the aged and the disabled, respectively. The exemption does not apply to services performed for employers outside of the order.

(3) *Members of the clergy.* A member of the clergy is considered to have current employment status with a church or other religious organization if the individual is receiving cash remuneration from the church or other religious organization for services rendered.

(f) *Special rule: Delayed compensation subject to FICA taxes.* An individual who is not working is not considered an employee solely on the basis of receiving delayed compensation payments for previous periods of work even if those payments are subject to FICA taxes (or would be subject to FICA taxes if the employer were not exempt from paying those taxes). For example, an individual who is not working in 1993 and receives payments subject to FICA taxes for work performed in 1992 is not considered to be an employee in 1993 solely on the basis of receiving those payments.

§ 411.106 Aggregation rules.

The following rules apply in determining the number and size of employers, as required by the MSP provisions for the aged and disabled:

(a) All employers that are treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code (IRC) of 1986 (26 U.S.C. 52 (a) and (b)) are treated as a single employer.

(b) All employees of the members of an affiliated service group (as defined in section 414(m) of the IRC (26 U.S.C. 414m)) are treated as employed by a single employer.

(c) Leased employees (as defined in section 414(n)(2) of the IRC (26 U.S.C. 414(n)(2))) are treated as employees of the person for whom they perform services to the same extent as they are treated under section 414(n) of the IRC.

(d) In applying the IRC provisions identified in this section, HCFA relies upon regulations and decisions of the Secretary of the Treasury respecting those provisions.

§ 411.108 Taking into account entitlement to Medicare.

(a) *Examples of actions that constitute "taking into account".* Actions by GHPs or LGHPs that constitute taking into account that an individual is entitled to Medicare on the basis of ESRD, age, or disability (or eligible on the basis of ESRD) include, but are not limited to, the following:

(1) Failure to pay primary benefits as required by subparts F, G, and H of this part 411.

(2) Offering coverage that is secondary to Medicare to individuals entitled to Medicare.

(3) Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions (26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); and 42 U.S.C. 300bb-2.(2)(D)).

(4) In the case of a LGHP, denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability.

(5) Imposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.

(6) Charging a Medicare entitled individual higher premiums.

(7) Requiring a Medicare entitled individual to wait longer for coverage to begin.

(8) Paying providers and suppliers less for services furnished to a Medicare beneficiary than for the same services furnished to an enrollee who is not entitled to Medicare.

(9) Providing misleading or incomplete information that would have the effect of inducing a Medicare entitled individual to reject the employer plan, thereby making Medicare the primary payer. An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that, if he or she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.

(10) Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers, instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer.

(11) Refusing to enroll an individual for whom Medicare would be secondary payer, when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

(b) *Permissible actions.* (1) If a GHP or LGHP makes benefit distinctions among various categories of individuals (distinctions unrelated to the fact that the individual is disabled, based, for instance, on length of time employed, occupation, or marital status), the GHP or LGHP may make the same distinctions among the same categories of individuals entitled to Medicare whose plan coverage is based on current employment status. For example, if a GHP or LGHP does not offer coverage to employees who have worked less than one year and who are *not* entitled to Medicare on the basis of disability or age, the GHP or LGHP is not required to offer coverage to employees who have worked less than one year and who *are* entitled to Medicare on the basis of disability or age.

(2) A GHP or LGHP may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this bene-

fiary because, although he or she has current employment status, the GHP coverage is by virtue of the COBRA law rather than by virtue of the current employment status.

(3) A GHP may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD, when permitted under the COBRA provisions.

[60 FR 45362, Aug. 31, 1995; 60 FR 53876, Oct. 18, 1995]

§ 411.110 Basis for determination of nonconformance.

(a) A “determination of nonconformance” is a HCFA determination that a GHP or LGHP is a nonconforming plan as provided in this section.

(b) HCFA makes a determination of nonconformance for a GHP or LGHP that, at any time during a calendar year, fails to comply with any of the following statutory provisions:

(1) The prohibition against taking into account that a beneficiary who is covered or seeks to be covered under the plan is entitled to Medicare on the basis of ESRD, age, or disability, or eligible on the basis of ESRD.

(2) The nondifferentiation clause for individuals with ESRD.

(3) The equal benefits clause for the working aged.

(4) The obligation to refund conditional Medicare primary payments.

(c) HCFA may make a determination of nonconformance for a GHP or LGHP that fails to respond to a request for information, or to provide correct information, either voluntarily or in response to a HCFA request, on the plan’s primary payment obligation with respect to a given beneficiary, if that failure contributes to either or both of the following:

(1) Medicare erroneously making a primary payment.

(2) A delay or foreclosure of HCFA’s ability to recover an erroneous primary payment.

§ 411.112 Documentation of conformance.

(a) *Acceptable documentation.* HCFA may require a GHP or LGHP to demonstrate that it has complied with the Medicare secondary payer provisions

and to submit supporting documentation by an official authorized to act on behalf of the entity, under penalty of perjury. The following are examples of documentation that may be acceptable:

(1) A copy of the employer's plan or policy that specifies the services covered, conditions of coverage, benefit levels and limitations with respect to persons entitled to Medicare on the basis of ESRD, age, or disability as compared to the provisions applicable to other enrollees and potential enrollees.

(2) An explanation of the plan's allegation that it does not owe HCFA any amount HCFA claims the plan owes as repayment for conditional or mistaken Medicare primary payments.

(b) *Lack of acceptable documentation.* If a GHP or LGHP fails to provide acceptable evidence or documentation that it has complied with the MSP prohibitions and requirements set forth in § 411.110, HCFA may make a determination of nonconformance for both the year in which the services were furnished and the year in which the request for information was made.

§ 411.114 Determination of nonconformance.

(a) *Starting dates for determination of nonconformance.* HCFA's authority to determine nonconformance of GHPs begins on the following dates:

(1) On January 1, 1987 for MSP provisions that affect the disabled.

(2) On December 20, 1989 for MSP provisions that affect ESRD beneficiaries and the working aged.

(3) On August 10, 1993 for failure to refund mistaken Medicare primary payments.

(b) *Special rule for failure to repay.* A GHP that fails to comply with § 411.110 (a)(1), (a)(2), or (a)(3) in a particular year is nonconforming for that year. If, in a subsequent year, that plan fails to repay the resulting mistaken primary payments (in accordance with § 411.110(a)(4)), the plan is also nonconforming for the subsequent year. For example, if a plan paid secondary for the working aged in 1991, that plan was nonconforming for 1991. If in 1994 HCFA identifies mistaken primary payments attributable to the 1991 vio-

lation, and the plan refuses to repay, it is also nonconforming for 1994.

§ 411.115 Notice of determination of nonconformance.

(a) *Notice to the GHP or LGHP.* (1) If HCFA determines that a GHP or an LGHP is nonconforming with respect to a particular calendar year, HCFA mails to the plan written notice of the following:

- (i) The determination.
- (ii) The basis for the determination.
- (iii) The right of the parties to request a hearing.
- (iv) An explanation of the procedure for requesting a hearing.

(v) The tax that may be assessed by the IRS in accordance with section 5000 of the IRC.

(vi) The fact that if none of the parties requests a hearing within 65 days from the date of its notice, the determination is binding on all parties unless it is reopened in accordance with § 411.126.

(2) The notice also states that the plan must, within 30 days from the date on its notice, submit to HCFA the names and addresses of all employers and employee organizations that contributed to the plan during the calendar year for which HCFA has determined nonconformance.

(b) *Notice to contributing employers and employee organizations.* HCFA mails written notice of the determination, including all the information specified in paragraph (a)(1) of this section, to all contributing employers and employee organizations already known to HCFA or identified by the plan in accordance with paragraph (a)(2) of this section. Employers and employee organizations have 65 days from the date of their notice to request a hearing.

§ 411.120 Appeals.

(a) *Parties to the determination.* The parties to the determination are HCFA, the GHP or LGHP for which HCFA determined nonconformance, and any employers or employee organizations that contributed to the plan during the calendar year for which HCFA determined nonconformance.

(b) *Request for hearing.* (1) A party's request for hearing must be in writing (not in facsimile or other electronic

medium) and in the manner stipulated in the notice of nonconformance; it must be filed within 65 days from the date on the notice.

(2) The request may include rationale showing why the parties believe that HCFA's determination is incorrect and supporting documentation.

(3) A request is considered filed on the date it is received by the appropriate office, as shown by the receipt date stamped on the request.

§ 411.121 Hearing procedures.

(a) *Nature of hearing.* (1) If any of the parties requests a hearing within 65 days from the date on the notice of the determination of nonconformance, the HCFA Administrator appoints a hearing officer.

(2) If no party files a request within the 65-day period, the initial determination of nonconformance is binding upon all parties unless it is reopened in accordance with § 411.126.

(3) If more than one party requests a hearing the hearing officer conducts a single hearing in which all parties may participate.

(4) *On the record review.* Ordinarily, the hearing officer makes a decision based upon review of the data and documents on which HCFA based its determination of nonconformance and any other documentation submitted by any of the parties within 65 days from the date on the notice.

(5) *Oral hearing.* The hearing officer may provide for an oral hearing either on his or her own motion or in response to a party's request if the party demonstrates that an oral hearing is necessary. Within 30 days of receipt of the request, the hearing officer gives all known parties written notice of the request and whether the request for oral hearing is granted.

(b) *Notice of time and place of oral hearing.* If the hearing officer provides an oral hearing, he or she gives all known parties written notice of the time and place of the hearing at least 30 days before the scheduled date.

(c) *Prehearing discovery.* (1) The hearing officer may permit prehearing discovery if it is requested by a party at least 10 days before the scheduled date of the hearing.

(2) If the hearing officer approves the request, he or she—

(i) Provides a reasonable time for inspection and reproduction of documents; and

(ii) In ruling on discovery matters, is guided by the Federal Rules of Civil Procedure. (28 U.S.C.A. Rules 26–37)

(3) The hearing officer's orders on all discovery matters are final.

(d) *Conduct of hearing.* The hearing officer determines the conduct of the hearing, including the order in which the evidence and the allegations are presented.

(e) *Evidence at hearing.* (1) The hearing officer inquires into the matters at issue and may receive from all parties documentary and other evidence that is pertinent and material, including the testimony of witnesses, and evidence that would be inadmissible in a court of law.

(2) Evidence may be received at any time before the conclusion of the hearing.

(3) The hearing officer gives the parties opportunity for submission and consideration of evidence and arguments and, in ruling on the admissibility of evidence, excludes irrelevant, immaterial, or unduly repetitious evidence.

(4) The hearing officer's ruling on admissibility of evidence is final and not subject to further review.

(f) *Subpoenas.* (1) The hearing officer may, either on his or her own motion or upon the request of any party, issue subpoenas for either or both of the following if they are reasonably necessary for full presentation of the case:

(i) The attendance and testimony of witnesses.

(ii) The production of books, records, correspondence, papers, or other documents that are relevant and material to any matter at issue.

(2) A party that wishes the issuance of a subpoena must, at least 10 days before the date fixed for the hearing, file with the hearing officer a written request that identifies the witnesses or documents to be produced and describes the address or location in sufficient detail to permit the witnesses or documents to be found.

(3) The request for a subpoena must state the pertinent facts that the party

expects to establish by the witnesses or documents and whether those facts could be established by other evidence without the use of a subpoena.

(4) The hearing officer issues the subpoenas at his or her discretion, and HCFA assumes the cost of the issuance and the fees and mileage of any subpoenaed witness, in accordance with section 205(d) of the Act (42 U.S.C. 405(d)).

(g) *Witnesses.* Witnesses at the hearing testify under oath or affirmation, unless excused by the hearing officer for cause. The hearing officer may examine the witnesses and shall allow the parties to examine and cross-examine witnesses.

(h) *Record of hearing.* A complete record of the proceedings at the hearing is made and transcribed in all cases. It is made available to the parties upon request. The record is not closed until a decision has been issued.

(i) *Sources of hearing officer's authority.* In the conduct of the hearing, the hearing officer complies with all the provisions of title XVIII of the Act and implementing regulations, as well as with HCFA Rulings issued under § 401.108 of this chapter. The hearing officer gives great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by HCFA.

§ 411.122 Hearing officer's decision.

(a) *Timing.* (1) If the decision is based on a review of the record, the hearing officer mails the decision to all known parties within 120 days from the date of receipt of the request for hearing.

(2) If the decision is based on an oral hearing, the hearing officer mails the decision to all known parties within 120 days from the conclusion of the hearing.

(b) *Basis, content, and distribution of hearing decision.* (1) The written decision is based on substantial evidence and contains findings of fact, a statement of reasons, and conclusions of law.

(2) The hearing officer mails a copy of the decision to each of the parties, by certified mail, return receipt requested, and includes a notice that the administrator may review the hearing decision at the request of a party or on his or her own motion.

(c) *Effect of hearing decision.* The hearing officer's decision is the final Departmental decision and is binding upon all parties unless the Administrator chooses to review that decision in accordance with § 411.124 or it is reopened by the hearing officer in accordance with § 411.126.

§ 411.124 Administrator's review of hearing decision.

(a) *Request for review.* A party's request for review of a hearing officer's decision must be in writing (not in facsimile or other electronic medium) and must be received by the Administrator within 25 days from the date on the decision.

(b) *Office of the Attorney Advisor responsibility.* The Office of the Attorney Advisor examines the hearing officer's decision, the requests made by any of the parties or HCFA, and any submission made in accordance with the provisions of this section in order to assist the Administrator in deciding whether to review the decision.

(c) *Administrator's discretion.* The Administrator may—

(1) Review or decline to review the hearing officer's decision;

(2) Exercise this discretion on his or her own motion or in response to a request from any of the parties; and

(3) Delegate review responsibility to the Deputy Administrator. (As used in this section, the term "Administrator" includes "Deputy Administrator" if review responsibility has been delegated.)

(d) *Basis for decision to review.* In deciding whether to review a hearing officer's decision, the Administrator considers—

(1) Whether the decision—

(i) Is based on a correct interpretation of law, regulation, or HCFA Ruling;

(ii) Is supported by substantial evidence;

(iii) Presents a significant policy issue having a basis in law and regulations;

(iv) Requires clarification, amplification, or an alternative legal basis for the decision; and

(v) Is within the authority provided by statute, regulation, or HCFA Ruling; and

(2) Whether review may lead to the issuance of a HCFA Ruling or other directive needed to clarify a statute or regulation.

(e) *Notice of decision to review or not to review.* (1) The Administrator gives all parties prompt written notice of his or her decision to review or not to review.

(2) The notice of a decision to review identifies the specific issues the Administrator will consider.

(f) *Response to notice of decision to review.* (1) Within 20 days from the date on a notice of the Administrator's decision to review a hearing officer's decision, any of the parties may file with the Administrator any or all of the following:

- (i) Proposed findings and conclusions.
- (ii) Supporting views or exceptions to the hearing officer's decision.
- (iii) Supporting reasons for the proposed findings and exceptions.
- (iv) A rebuttal to another party's request for review or to other submissions already filed with the Administrator.

(2) The submissions must be limited to the issues the Administrator has decided to review and confined to the record established by the hearing officer.

(3) All communications from the parties concerning a hearing officer's decision being reviewed by the Administrator must be in writing (not in facsimile or other electronic medium) and must include a certification that copies have been sent to all other parties.

(4) The Administrator does not consider any communication that does not meet the requirements of this paragraph.

(g) *Administrator's review decision.* (1) The Administrator bases his or her decision on the following:

- (i) The entire record developed by the hearing officer.
- (ii) Any materials submitted in connection with the hearing or under paragraph (f) of this section.
- (iii) Generally known facts not subject to reasonable dispute.

(2) The Administrator mails copies of the review decision to all parties within 120 days from the date of the hearing officer's decision.

(3) The Administrator's review decision may affirm, reverse, or modify the

hearing decision or may remand the case to the hearing officer.

(h) *Basis and effect of remand.* (1) *Basis.* The bases for remand do not include the following:

(i) Evidence that existed at the time of the hearing and that was known or could reasonably have been expected to be known.

(ii) A court case that was either not available at the time of the hearing or was decided after the hearing.

(iii) Change of the parties' representation.

(iv) An alternative legal basis for an issue in dispute.

(2) *Effect of remand.* (i) The Administrator may instruct the hearing officer to take further action with respect to the development of additional facts or new issues or to consider the applicability of laws or regulations other than those considered during the hearing.

(ii) The hearing officer takes the action in accordance with the Administrator's instructions in the remand notice and again issues a decision.

(iii) The Administrator may review or decline to review the hearing officer's remand decision in accordance with the procedures set forth in this section.

(i) *Finality of decision.* The Administrator's review decision, or the hearing officer's decision following remand, is the final Departmental decision and is binding on all parties unless the Administrator chooses to review the decision in accordance with this section, or the decision is reopened in accordance with § 411.126.

§ 411.126 Reopening of determinations and decisions.

(a) A determination that a GHP or LGHP is a nonconforming GHP or the decision or revised decision of a hearing officer or of the HCFA Administrator may be reopened within 12 months from the date on the notice of determination or decision or revised decision, for any reason by the entity that issued the determination or decision.

(b) The decision to reopen or not to reopen is not appealable.

§ 411.130 Referral to Internal Revenue Service (IRS).

(a) *HCFA responsibility.* After HCFA determines that a plan has been a nonconforming GHP in a particular year, it refers its determination to the IRS, but only after the parties have exhausted all HCFA appeal rights with respect to the determination.

(b) *IRS responsibility.* The IRS administers section 5000 of the IRC, which imposes a tax on employers (other than governmental entities) and employee organizations that contribute to a nonconforming GHP. The tax is equal to 25 percent of the employer's or employee organization's expenses, incurred during the calendar year in which the plan is a nonconforming GHP, for each GHP, both conforming and nonconforming, to which the employer or employee organization contributes.

Subpart F—Special Rules: Individuals Eligible or Entitled on the Basis of ESRD, Who Are Also Covered Under Group Health Plans**§ 411.160 Scope.**

This subpart sets forth special rules that apply to individuals who are eligible for, or entitled to, Medicare on the basis of ESRD. (Section 406.13 of this chapter contains the rules for eligibility and entitlement based on ESRD.)

[60 FR 45367, Aug. 31, 1995]

§ 411.161 Prohibition against taking into account Medicare eligibility or entitlement or differentiating benefits.

(a) *Taking into account.* (1) *Basic rule.* A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during the coordination period specified in § 411.162(b) and (c). Examples of actions that constitute taking into account Medicare entitlement are listed in § 411.108(a).

(2) *Applicability.* This prohibition applies for ESRD-based Medicare eligibility to the same extent as for ESRD-based Medicare entitlement. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for

Medicare based on ESRD for purposes of paragraphs (b)(2) and (c)(2) through (c)(4) of § 411.162 if the individual meets the other requirements of § 406.13 of this chapter.

(3) *Relation to COBRA continuation coverage.* This rule does not prohibit the termination of GHP coverage under title X of COBRA when termination of that coverage is expressly permitted, upon entitlement to Medicare, under 26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); or 42 U.S.C. 300bb-2.(2)(D).¹ (Situations in which Medicare is secondary to COBRA continuation coverage are set forth in § 411.162(a)(3).)

(b) *Nondifferentiation.* (1) A GHP may not differentiate in the benefits it provides between individuals who have ESRD and others enrolled in the plan, on the basis of the existence of ESRD, or the need for renal dialysis, or in any other manner.

(2) GHP actions that constitute differentiation in plan benefits (and that may also constitute "taking into account" Medicare eligibility or entitlement) include, but are not limited to the following:

(i) Terminating coverage of individuals with ESRD, when there is no basis for such termination unrelated to ESRD (such as failure to pay plan premiums) that would result in termination for individuals who do not have ESRD.

(ii) Imposing on persons who have ESRD, but not on others enrolled in the plan, benefit limitations such as

¹COBRA requires that certain group health plans offer continuation of plan coverage for 18 to 36 months after the occurrence of certain "qualifying events," including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of group health plan coverage unless the individual is given the opportunity to elect, and does so elect, to continue plan coverage at his or her own expense. With one exception, the COBRA amendments expressly permit termination of continuation coverage upon entitlement to Medicare. The exception is that the plan may not terminate continuation coverage of an individual (and his or her qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11 bankruptcy (26 U.S.C. 4980B(g)(1)(D) and 29 U.S.C. 1167.(3)(C)).

less comprehensive health plan coverage, reductions in benefits, exclusions of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations.

(iii) Charging individuals with ESRD higher premiums.

(iv) Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD.

(v) Failure to cover routine maintenance dialysis or kidney transplants, when a plan covers other dialysis services or other organ transplants.

(c) *Uniform Limitations on particular services permissible.* A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

(d) *Benefits secondary to Medicare.* (1) The prohibition against differentiation of benefits does not preclude a plan from paying benefits secondary to Medicare after the expiration of the coordination period described in § 411.162(b) and (c), but a plan may not otherwise differentiate, as described in paragraph (b) of this section, in the benefits it provides.

(2) Example—

Mr. Smith works for employer A, and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B, and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services which Plan B does not cover, such as prescription drugs. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts

and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A, and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 18 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplement policy. That policy pays Medicare deductible and coinsurance amounts but does not pay for items and services not covered by Medicare, which plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones, who has ESRD, than it provides for Mrs. Smith, who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

[60 FR 45368, Aug. 31, 1995]

§ 411.162 Medicare benefits secondary to group health plan benefits.

(a) *General provisions.* (1) *Basic rule.* Except as provided in § 411.163 (with respect to certain individuals who are also entitled on the basis of age or disability), Medicare is secondary to any GHP (including a retirement plan), with respect to benefits that are payable to an individual who is entitled to Medicare on the basis of ESRD, for services furnished during any coordination period determined in accordance with paragraphs (b) and (c) of this section. (No Medicare benefits are payable on behalf of an individual who is eligible but not yet entitled.)

(2) *Medicare benefits secondary without regard to size of employer and beneficiary's employment status.* The size of employer and employment status requirements of the MSP provisions for the aged and disabled do not apply with respect to ESRD beneficiaries.

(3) *COBRA continuation coverage.* Medicare is secondary payer for benefits that a GHP—

(i) Is required to keep in effect under COBRA continuation requirements (as explained in the footnote to § 411.161(a)(3)), even after the individual becomes entitled to Medicare; or

(ii) Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD, even

though not obligated to do so under the COBRA provisions.

(4) *Medicare payments during the coordination period.* During the coordination period, HCFA makes Medicare payments as follows:

(i) Primary payments only for Medicare covered services that are—

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

(B) Not covered under the plan;¹

(C) Covered under the plan but not available to particular enrollees because they have exhausted their benefits; or

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

(ii) Secondary payments, within the limits specified in §§ 411.32 and 411.33, to supplement the amount paid by the GHP if that plan pays only a portion of the charge for the services.

(b) *Beginning of coordination period.*

(1) For individuals who start a course of maintenance dialysis or who receive a kidney transplant before December 1989, the coordination period begins with the earlier of—

(i) The month in which the individual initiated a regular course of renal dialysis; or

(ii) In the case of an individual who received a kidney transplant, the first month in which the individual became entitled to Medicare, or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits.

(2) For individuals other than those specified in paragraph (b)(1) of this section, the coordination period begins with the earlier of—

(i) The first month in which the individual becomes entitled to Medicare part A on the basis of ESRD; or

(ii) The first month the individual would have become entitled to Medicare part A on the basis of ESRD if he or she had filed an application for such benefits.

¹HCFA does not pay if noncoverage of services constitutes differentiation as prohibited by § 411.161(b).

(c) *End of coordination period.* (1) For individuals who start a regular course of renal dialysis or who receive a kidney transplant before December 1989, the coordination period ends with the earlier of the end of the 12th month of dialysis or the end of the 12th month of a transplant. The 12th month of dialysis may be any time from the 9th month through the 12th month of Medicare entitlement, depending on the extent to which the individual was subject to a waiting period before becoming entitled to Medicare.

(2) The coordination period for the following individuals ends with the earlier of the 12th month of eligibility or the 12th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this section, who became entitled to Medicare part A solely on the basis of ESRD during December 1989 and January 1990.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could have become entitled to Medicare Part A solely on the basis of ESRD during December 1989 and January 1990 if they had filed an application.

(iii) Individuals who become entitled to Medicare part A on the basis of ESRD after September 1997.

(iv) Individuals who can become entitled to Medicare part A on the basis of ESRD after September 1997.

(3) The coordination period for the following individuals ends with the earlier of the end of the 18th month of eligibility or the 18th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this section, who become entitled to Medicare part A on the basis of ESRD from February 1990 through April 1997.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could become entitled to Medicare part A on the basis of ESRD from February 1990 through April 1997 if they would file an application.

(4) The coordination periods for the following individuals ends September 30, 1998:

(i) Individuals who become entitled to Medicare part A on the basis of

ESRD from May 1997, through September 1997.

(ii) Individuals who could become entitled to Medicare part A on the basis of ESRD from May 1997, through September 1997, if they would file an application.

(d) *Examples.* Based on the rules specified in paragraphs (b) and (c) of this section and the rules specified in § 406.13 of this subchapter, the following examples illustrate how to determine, in different situations, the number of months during which Medicare is secondary payer.

(1) An individual began dialysis on November 4, 1989. He did not initiate a course in self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on February 1, 1990. Since this individual began dialysis before December 1989, the 12-month period began with the first month of dialysis, November 1989, and ended October 31, 1990. The coordination period in this case is 9 months, February 1990 through October 1990.

(2) An individual began dialysis on January 29, 1990. He did not initiate a course in self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on April 1, 1990. Since the individual began dialysis after November 1989, and became entitled to Medicare after January 1990, the coordination period began with the first month of entitlement, April 1990, and ended September 30, 1991, the end of the 18th month of entitlement.

(3) An individual began a regular course of maintenance dialysis on February 10, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on May 1, 1990. Medicare is secondary payer from May 1, 1990 through October 1991, a total of 18 months.

(4) The same facts exist as in the example under paragraph (d)(3), except that the individual began a course of self-dialysis training during the first 3 calendar months of dialysis. Thus, the effective date of his Medicare entitle-

ment is February 1, 1990, and Medicare is secondary payer from February 1, 1990 through July 1991, a total of 18 months.

(5) An individual began dialysis on September 15, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare effective December 1, 1990. Medicare is secondary payer from December 1, 1990 through May 1992, a total of 18 months.

(6) An individual began dialysis on November 17, 1990. He initiates a course of self-dialysis training in January 1991, and thus becomes entitled to Medicare effective November 1, 1990. Medicare is secondary payer from November 1, 1990, through April 1992, a total of 18 months.

(7) An individual began a regular course of dialysis on December 10, 1990. He does not initiate a course of self-dialysis training nor does he receive a kidney transplant. He decides to delay his enrollment in Medicare because his employer group health plan pays charges in full and he does not wish to incur part B premiums at this time. However, in March 1992, he files for part A and part B Medicare entitlement, and stipulates that he wants his Medicare entitlement to be effective March 1, 1992 (one year later than he could have become entitled). Since this individual could have been entitled to Medicare as early as March 1, 1991, Medicare is secondary payer only from March 1, 1992, through August 1992, a period of 6 months.

(While Medicare is secondary payer for only the last 6 months of this period, the Medicare program is effectively secondary payer for the full coordination period, due to the fact that the individual delayed his Medicare enrollment on account of his employer plan coverage and Medicare made no payments at all during the deferred period.)

(8) The same facts exist as in the example under paragraph (d)(7) of this section, except that the individual defers Medicare entitlement beyond August 1992. (For purposes of this example, Medicare entitlement is not retroactive, but rather takes effect after

August 1992.) There would be no period during which Medicare is secondary payer in this situation. This is because Medicare entitlement does not begin until after the 18-month period expires as specified in paragraph (c)(3)(ii) of this section. Medicare would become primary payer as of the effective date of Medicare entitlement. The employer plan is required to pay primary from December 1, 1990, through August 1992, a total of 21 months.

(9) An individual becomes entitled to Medicare on December 1, 1997. The employer plan is primary payer, and Medicare is secondary payer, from December 1, 1997, through November 30, 1998, a period of 12 months. Medicare becomes primary payer on December 1, 1998, because the extension of the coordination period from 12 to 18 months applies only to items and services furnished before October 1, 1998.

(10) An individual becomes entitled to Medicare on August 1, 1997. Medicare is secondary payer from August 1, 1997, through September 30, 1998, a period of 14 months. Medicare becomes primary payer on October 1, 1998, because the coordination period has expired.

(e) [Reserved]

(f) *Determinations for subsequent periods of ESRD eligibility.* If an individual has more than one period of eligibility based on ESRD, a coordination period will be determined for each period of eligibility in accordance with this section.

[57 FR 36015, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992. Redesignated and amended at 60 FR 45362, 45368, Aug. 31, 1995]

§ 411.163 Coordination of benefits: Dual entitlement situations.

(a) *Basic rule.* Coordination of benefits is governed by this section if an individual is eligible for or entitled to Medicare on the basis of ESRD and also entitled on the basis of age or disability.

(b) *Specific rules.*¹ (1) *Coordination period ended before August 1993.* If the first

18 months of ESRD-based eligibility or entitlement ended before August 1993, Medicare was primary payer from the first month of dual eligibility or entitlement, regardless of when dual eligibility or entitlement began.

(2) *First month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement after February 1992 and before August 10, 1993.* Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement were after February 1992 and before August 10, 1993, Medicare—

(i) Is primary payer from the first month of dual eligibility/entitlement through August 9, 1993;

(ii) Is secondary payer from August 10, 1993, through the 18th month of ESRD-based eligibility or entitlement; and

(iii) Again becomes primary payer after the 18th month of ESRD-based eligibility or entitlement.

(3) *First month of ESRD-based eligibility or entitlement after February 1992 and first month of dual eligibility/entitlement after August 9, 1993.* Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility/entitlement is after August 9, 1993, the rules of § 411.162(b) and (c) apply; that is, Medicare—

(i) Is secondary payer during the first 18 months of ESRD-based eligibility or entitlement; and

(ii) Becomes primary after the 18th month of ESRD-based eligibility or entitlement.

(4) *Medicare continues to be primary after an aged or disabled beneficiary becomes eligible on the basis of ESRD.* (i) *Applicability of the rule.* Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if all of the following conditions are met:

issued a preliminary injunction order on June 6, 1995, which enjoins the Secretary from applying the rule contained in § 411.163(b)(4) for items and services furnished between August 10, 1993 and April 24, 1995, pending the court's decision on the merits. HCFA will modify the rules, if required, based on the final ruling by the court.

¹A lawsuit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging the implementation of one aspect of the OBRA '93 provisions with respect to group health plan retirement coverage. The court

(A) The individual is already entitled on the basis of age or disability when he or she becomes eligible on the basis of ESRD.

(B) The MSP prohibition against "taking into account" age-based or disability-based entitlement does not apply because plan coverage was not "by virtue of current employment status" or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

(C) The plan is paying secondary to Medicare because the plan had justifiably taken into account the age-based or disability-based entitlement.

(i) *Effect of the rule.* The plan may continue to pay benefits secondary to Medicare under paragraph (b)(4)(i) of this section. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

(c) *Examples.* (1) (Rule (b)(1).) Mr. A, who is covered by a GHP, became entitled to Medicare on the basis of ESRD in January 1992. On December 20, 1992, Mr. A attained age 65 and became entitled on the basis of age. Since prior law was still in effect (OBRA '93 amendment was effective in August 1993), Medicare became primary payer as of December 1992, when dual entitlement began.

(2) (Rule (b)(2).) Miss B, who has GHP coverage, became entitled to Medicare on the basis of ESRD in July 1992, and also entitled on the basis of disability in June 1993. Medicare was primary payer from June 1993 through August 9, 1993, because the plan permissibly took into account the ESRD-based entitlement (ESRD was not the "sole" basis of Medicare entitlement); secondary payer from August 10, 1993, through December 1993, the 18th month of ESRD-based entitlement (the plan is no longer permitted to take into account ESRD-based entitlement that is not the "sole" basis of Medicare entitlement); and again became primary payer beginning January 1994.

(3) (Rule (b)(3).) Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and be-

gins a course of maintenance dialysis on June 27, 1993. Effective September 1, 1993, Mr. C. is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 1995, the 18th month of ESRD-based eligibility, and becomes primary payer beginning March 1995.

(4) (Rule (b)(3).) Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 1994, at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the 18-month coordination period (July 1994) Mr. D turned age 65. The coordination period continues without regard to age-based entitlement, with the retirement plan continuing to pay primary benefits through June 1995, the 18th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer.

(5) (Rule (b)(3).) Mrs. E retired at age 62 and maintained GHP coverage as a retiree. In July 1994, she simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 1994) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 1994 through December 1995, the first 18 months of ESRD-based eligibility. Thereafter, Medicare becomes the primary payer.

(6) (Rule (b)(3).) Mr. F, who is 67 years of age, is working and has GHP coverage because of his employment status, subsequently develops ESRD, and begins a course of maintenance dialysis in October 1994. He becomes eligible for Medicare based on ESRD effective January 1, 1995. Under the working aged provision, the plan continues to pay primary to Medicare through December 1994. On January 1, 1995, the working aged provision ceases to apply and the ESRD MSP provision takes effect. In September 1995, Mr. F retires. The GHP must ignore Mr. F's retirement status and continue to pay primary to Medicare through June 1996, the end of the 18-month coordination period.

(7) (Rule (b)(4).) Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her

former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 1995. She automatically becomes eligible for Medicare based on ESRD effective January 1, 1996. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

[60 FR 45369, Aug. 31, 1995; 60 FR 53876, Oct. 18, 1995]

§ 411.165 Basis for conditional Medicare payments.

(a) *General rule.* Except as specified in paragraph (b) of this section, the Medicare intermediary or carrier may make a conditional payment if—

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

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

(b) *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 group health plan limits its payments when the individual is entitled to Medicare.

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

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

[57 FR 36015, Aug. 12, 1992. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995; 60 FR 53877, Oct. 18, 1995]

Subpart G—Special Rules: Aged Beneficiaries and Spouses Who Are Also Covered Under Group Health Plans

§ 411.170 General provisions.

(a) *Basis.* (1) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(i) Individuals who are entitled to Medicare on the basis of age; and

(ii) GHPs of at least one employer of 20 or more employees that cover those individuals.

(2) Under these provisions, the following rules apply:

(i) An employer is considered to employ 20 or more employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(ii) The plan may not take into account the Medicare entitlement of—

(A) An individual age 65 or older who is covered or seeks to be covered under the plan by virtue of current employment status; or

(B) The spouse, including divorced or common-law spouse age 65 or older of an individual (of any age) who is covered or seeks to be covered by virtue of current employment status. (Section 411.108 gives examples of actions that constitute "taking into account.")

(iii) Regardless of whether entitled to Medicare, employees and spouses age 65 or older, including divorced or common-law spouses of employees of any age, are entitled to the same plan benefits under the same conditions as employees and spouses under age 65.

(b) [Reserved]

(c) *Determination of "aged".* (1) An individual attains a particular age on the day preceding the anniversary of his or her birth.

(2) The period during which an individual is considered to be "aged" begins on the first day of the month in which that individual attains age 65.

(3) For services furnished before May 1986, the period during which an individual is considered "aged" ends as follows:

(i) For services furnished before July 18, 1984, it ends on the last day of the

month in which the individual attains age 70.

(ii) For services furnished between July 18, 1984 and April 30, 1986, it ends on the last day of the month *before* the month the individual attains age 70.

(4) For services furnished on or after May 1, 1986, the period has no upper age limit.

[54 FR 41734, Oct. 11, 1989. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995]

§411.172 Medicare benefits secondary to group health plan benefits.

(a) *Conditions that the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by a GHP for services furnished during any month in which the individual—

(1) Is aged;

(2) Is entitled to Medicare Part A benefits under §406.10 of this chapter; and

(3) Meets one of the following conditions:

(i) Is covered under a GHP of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and coverage under the plan is by virtue of the individual's current employment status.

(ii) Is the aged spouse (including a divorced or common-law spouse) of an individual (of any age) who is covered under a GHP described in paragraph (a)(3)(i) of this section by virtue of the individual's current employment status.

(b) *Special rule for multi-employer plans.* The requirements and limitations of paragraph (a) of this section and of (a)(2)(iii) of §411.170 do not apply with respect to individuals enrolled in a multi-employer plan if—

(1) The individuals are covered by virtue of current employment status with an employer that has fewer than 20 employees; and

(2) The plan requests an exception and identifies the individuals for whom it requests the exception as meeting the conditions specified in paragraph (b)(1) of this section.

(c) *Refusal to accept group health plan coverage.* An employee or spouse may refuse the health plan offered by the

employer. If the employee or spouse refuses the plan—

(1) Medicare is primary payer for that individual; and

(2) The plan may not offer that individual coverage complementary to Medicare.

(d) *Reemployed retiree or annuitant.* A reemployed retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered "by reason of current employment status" even if:

(1) The employer provides the same GHP coverage to retirees; or

(2) The premiums for the plan are paid from a retirement or pension fund.

(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.* HCFA 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 em-

ployment 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 HCFA 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.* HCFA 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, HCFA 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.* HCFA 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 HCFA 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—Physician Ownership of, and Referral of Patients or Laboratory Specimens to, Entities Furnishing Clinical Laboratory or Other Health Services

SOURCE: 60 FR 41978, Aug. 14, 1995, 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 clinical laboratory 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 items or services under Part A or Part B report information concerning their ownership, investment, or compensation arrangements in the form, manner, and at the times specified by HCFA.

§ 411.351 Definitions.

As used in this subpart, unless the context indicates otherwise:

Clinical laboratory services means the biological, microbiological, serological, chemical, immunohematological, 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. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

Compensation arrangement means any arrangement involving any remuneration, direct or indirect, between a phy-

sician (or a member of a physician's immediate family) and an entity.

Direct supervision means supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed.

Employee means any individual who, under the usual common law rules that apply in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986), is considered to be employed by, or an employee of, an entity. (Application of these common law rules is discussed at 20 CFR 404.1007 and 26 CFR 31.3121(d)-1(c).)

Entity means a sole proprietorship, trust, corporation, partnership, foundation, not-for-profit corporation, or unincorporated association.

Fair market value means the value in arm's-length transactions, consistent with the general market value. With respect to rentals or leases, *fair market value* means the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee.

Financial relationship refers to a direct or indirect relationship between a physician (or a member of a physician's immediate family) and an entity in which the physician or family member has—

(1) An ownership or investment interest that exists in the entity through equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing laboratory services; or

(2) A compensation arrangement with the entity.

Group practice means a group of two or more physicians, legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association, that meets the following conditions:

(1) Each physician who is a *member of the group*, as defined in this section, furnishes substantially the full range of patient care services that the physician routinely furnishes including medical care, consultation, diagnosis, and treatment through the joint use of shared office space, facilities, equipment, and personnel.

(2) Except as provided in paragraphs (2)(i) and (2)(ii) of this definition, substantially all of the patient care services of the physicians who are members of the group (that is, at least 75 percent of the total patient care services of the group practice members) are furnished through the group and billed in the name of the group and the amounts received are treated as receipts of the group. "Patient care services" are measured by the total patient care time each member spends on these services. For example, if a physician practices 40 hours a week and spends 30 hours on patient care services for a group practice, the physician has spent 75 percent of his or her time providing countable patient care services.

(i) The "substantially all" test does not apply to any group practice that is located solely in an HPSA, as defined in this section, and

(ii) For group practices located outside of an HPSA (as defined in this section) any time spent by group practice members providing services in an HPSA should not be used to calculate whether the group practice located outside the HPSA has met the "substantially all" test, regardless of whether the members' time in the HPSA is spent in a group practice, clinic, or office setting.

(3) The practice expenses and income are distributed in accordance with methods previously determined.

In the case of faculty practice plans associated with a hospital, institution of higher education, or medical school that has an approved medical residency training program in which faculty practice plan physicians perform specialty and professional services, both within and outside the faculty practice, as well as perform other tasks such as research, this definition applies only to those services that are furnished within the faculty practice plan.

Hospital means any separate legally organized operating entity plus any subsidiary, related, or other entities that perform services for the hospital's patients and for which the hospital bills. A "hospital" does not include entities that perform services for hospital patients "under arrangements" with the hospital.

HPSA means, for purposes of this regulation, an area designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act for primary medical care professionals (in accordance with the criteria specified in 42 CFR part 5, appendix A, part I—Geographic Areas). In addition, with respect to dental, mental health, vision care, podiatric, and pharmacy services, an HPSA means an area designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act for dental professionals, mental health professionals, vision care professionals, podiatric professionals, and pharmacy professionals, respectively.

Immediate family member or member of a physician's immediate family means husband or wife; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Laboratory means an entity furnishing biological, microbiological, serological, chemical, immunohematological, 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. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Entities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Members of the group means physician partners and full-time and part-time

physician contractors and employees during the time they furnish services to patients of the group practice that are furnished through the group and are billed in the name of the group.

Patient care services means any tasks performed by a group practice member that address the medical needs of specific patients, regardless of whether they involve direct patient encounters. They can include, for example, the services of physicians who do not directly treat patients, time spent by a physician consulting with other physicians, or time spent reviewing laboratory tests.

Physician incentive plan means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished with respect to individuals enrolled with the entity.

Plan of care means the establishment by a physician of a course of diagnosis or treatment (or both) for a particular patient, including the ordering of items or services.

Referral—

(1) Means either of the following:

(i) Except as provided in paragraph (2) of this definition, the request by a physician for, or ordering of, any item or service for which payment may be made under Medicare Part B, including a request for a consultation with another physician and any test or procedure ordered by or to be performed by (or under the supervision of) that other physician.

(ii) Except as provided in paragraph (2) of this definition, a request by a physician that includes the provision of laboratory services or the establishment of a plan of care by a physician that includes the provision of laboratory services.

(2) Does not include a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services if—

(i) The request is part of a consultation initiated by another physician; and

(ii) The tests or services are furnished by or under the supervision of the pathologist.

Referring physician means a physician (or group practice) who makes a referral as defined in this section.

Remuneration means any payment, discount, forgiveness of debt, or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, except that the following are not considered remuneration:

(1) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

(2) The furnishing of items, devices, or supplies that are used solely to collect, transport, process, or store specimens for the entity furnishing the items, devices, or supplies or are used solely to order or communicate the results of tests or procedures for the entity.

(3) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee-for-service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

(i) The health services are not furnished, and the payment is not made, under a contract or other arrangement between the insurer or the plan and the physician;

(ii) The payment is made to the physician on behalf of the covered individual and would otherwise be made directly to the individual; and

(iii) The amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals.

Transaction means an instance or process of two or more persons doing business. An *isolated transaction* is one involving a single payment between two or more persons. A transaction that involves long-term or installment payments is not considered an isolated transaction.

§ 411.353 Prohibition on certain referrals by physicians and limitations on billing.

(a) *Prohibition on referrals.* Except as provided in this subpart, a physician

who has a financial relationship with an entity, or who has an immediate family member who has a financial relationship with the entity, may not make a referral to that entity for the furnishing of clinical laboratory services for which payment otherwise may be made under Medicare.

(b) *Limitations on billing.* An entity that furnishes clinical laboratory services under a referral that is prohibited by paragraph (a) of this section may not present or cause to be presented a claim or bill to the Medicare program or to any individual, third party payer, or other entity for the clinical laboratory services performed under that referral.

(c) *Denial of payment.* No Medicare payment may be made for a clinical laboratory service that is furnished under a prohibited referral.

(d) *Refunds.* An entity that collects payment for a laboratory service that was performed under a prohibited referral must refund all collected amounts on a timely basis.

§ 411.355 General exceptions to referral prohibitions related to both ownership/investment and compensation.

The prohibition on referrals set forth in § 411.353 does not apply to the following types of services:

(a) *Physicians' services,* as defined in § 410.20(a), that are furnished personally by (or under the personal supervision of) another physician in the same group practice as the referring physician.

(b) *In-office ancillary services.* Services that meet the following conditions:

(1) They are furnished personally by one of the following individuals:

- (i) The referring physician.
- (ii) A physician who is a member of the same group practice as the referring physician.
- (iii) Individuals who are directly supervised by the referring physician or, in the case of group practices, by another physician in the same group practice as the referring physician.

(2) They are furnished in one of the following locations:

- (i) A building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unre-

lated to the furnishing of clinical laboratory services.

(ii) A building that is used by the group practice for the provision of some or all of the group's clinical laboratory services.

(3) They are billed by one of the following:

(i) The physician performing or supervising the service.

(ii) The group practice of which the performing or supervising physician is a member.

(iii) An entity that is wholly owned by the physician or the physician's group practice.

(c) *Services furnished to prepaid health plan enrollees by one of the following organizations:*

(1) An HMO or a CMP in accordance with a contract with HCFA under section 1876 of the Act and part 417, subparts J through M, of this chapter.

(2) A health care prepayment plan in accordance with an agreement with HCFA under section 1833(a)(1)(A) of the Act and part 417, subpart U, of this chapter.

(3) An organization that is receiving payments on a prepaid basis for the enrollees through a demonstration project under section 402(a) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or under section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b-1 note).

(4) A qualified health maintenance organization (within the meaning of section 1310(d) of the Public Health Service Act).

(d) *Services furnished in an ambulatory surgical center (ASC) or end stage renal disease (ESRD) facility, or by a hospice* if payment for those services is included in the ASC rate, the ESRD composite rate, or as part of the per diem hospice charge, respectively.

§ 411.356 Exceptions to referral prohibitions related to ownership or investment interests.

For purposes of § 411.353, the following ownership or investment interests do not constitute a financial relationship:

(a) *Publicly traded securities.* Ownership of investment securities (including shares or bonds, debentures, notes, or other debt instruments) that may be

purchased on terms generally available to the public and that meet the requirements of paragraphs (a)(1) and (a)(2) of this section.

(1) They are either—

(i) Listed for trading on the New York Stock Exchange, the American Stock Exchange, or any regional exchange in which quotations are published on a daily basis, or foreign securities listed on a recognized foreign, national, or regional exchange in which quotations are published on a daily basis; or

(ii) Traded under an automated inter-dealer quotation system operated by the National Association of Securities Dealers.

(2) In a corporation that had—

(i) Until January 1, 1995, total assets at the end of the corporation's most recent fiscal year exceeding \$100 million; or

(ii) Stockholder equity exceeding \$75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years.

(b) *Mutual funds.* Ownership of shares in a regulated investment company as defined in section 851(a) of the Internal Revenue Code of 1986, if the company had, at the end of its most recent fiscal year, or on average during the previous 3 fiscal years, total assets exceeding \$75 million.

(c) *Specific providers.* Ownership or investment interest in the following entities:

(1) A laboratory that is located in a rural area (that is, a laboratory that is not located in an urban area as defined in §412.62(f)(1)(ii) of this chapter) and that meets the following criteria:

(i) The laboratory testing that is referred by a physician who has (or whose immediate family member has) an ownership or investment interest in the rural laboratory is either—

(A) Performed on the premises of the rural laboratory; or

(B) If not performed on the premises, the laboratory performing the testing bills the Medicare program directly for the testing.

(ii) Substantially all of the laboratory tests furnished by the entity are furnished to individuals who reside in a rural area. Substantially all means no less than 75 percent.

(2) A hospital that is located in Puerto Rico.

(3) A hospital that is located outside of Puerto Rico if one of the following conditions is met:

(i) The referring physician is authorized to perform services at the hospital, and the physician's ownership or investment interest is in the entire hospital and not merely in a distinct part or department of the hospital.

(ii) Until January 1, 1995, the referring physician's ownership or investment interest does not relate (directly or indirectly) to the furnishing of clinical laboratory services.

§ 411.357 Exceptions to referral prohibitions related to compensation arrangements.

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements:

(1) The agreement is set out in writing and is signed by the parties and specifies the premises covered by the lease.

(2) The term of the agreement is at least 1 year.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the lease are set in advance and are consistent with fair market value.

(5) The charges are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The agreement would be commercially reasonable even if no referrals

were made between the lessee and the lessor.

(b) *Rental of equipment.* Payments made by a lessee to a lessor for the use of equipment under the following conditions:

(1) A rental or lease agreement is set out in writing and signed by the parties and specifies the equipment covered by the lease.

(2) The equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee.

(3) The lease provides for a term of rental or lease of at least 1 year.

(4) The rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(5) The lease would be commercially reasonable even if no referrals were made between the parties.

(c) *Bona fide employment relationships.* Any amount paid by an employer to a physician (or immediate family member) who has a bona fide employment relationship with the employer for the provision of services if the following conditions are met:

(1) The employment is for identifiable services.

(2) The amount of the remuneration under the employment is—

(i) Consistent with the fair market value of the services; and

(ii) Except as provided in paragraph (c)(4) of this section, is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.

(3) The remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer.

(4) Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).

(d) *Personal service arrangements.* (1) *General.* Remuneration from an entity

under an arrangement to a physician or immediate family member of the physician, including remuneration for specific physicians' services furnished to a nonprofit blood center, if the following conditions are met:

(i) The arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement.

(ii) The arrangement covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity.

(iii) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(iv) The term of the arrangement is for at least 1 year.

(v) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and, except in the case of a physician incentive plan, is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(vi) The services to be furnished under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

(2) *Physician incentive plan exception.* In the case of a physician incentive plan between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

(i) No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services furnished with respect to a specific individual enrolled in the entity.

(ii) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary under section 1876(i)(8)(A)(ii) of the Act, the plan complies with any requirements the

Secretary has imposed under that section.

(iii) Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of paragraph (d)(2) of this section.

(3) Until January 1, 1995, the provisions in paragraph (d)(1) and (2) of this section do not apply to any arrangements that meet the requirements of section 1877(e)(2) or section 1877(e)(3) of the Act as they read before they were amended by the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66).

(e) *Physician recruitment.* Remuneration provided by a hospital to recruit a physician that is intended to induce the physician to relocate to the geographic area served by the hospital in order to become a member of the hospital's medical staff, if all of the following conditions are met:

(1) The arrangement and its terms are in writing and signed by both parties.

(2) The arrangement is not conditioned on the physician's referral of patients to the hospital.

(3) The hospital does not determine (directly or indirectly) the amount or value of the remuneration to the physician based on the volume or value of any referrals the physician generates for the hospital.

(4) The physician is not precluded from establishing staff privileges at another hospital or referring business to another entity.

(f) *Isolated transactions.* Isolated financial transactions, such as a one-time sale of property or a practice, if all of the conditions set forth in paragraphs (c)(2) and (c)(3) of this section are met with respect to an entity in the same manner as they apply to an employer. There can be no additional transactions between the parties for 6 months after the isolated transaction, except for transactions which are specifically excepted under the other provisions in §§ 411.355 through 411.357.

(g) *Arrangements with hospitals.* (1) Until January 1, 1995, any compensation arrangement between a hospital

and a physician or a member of a physician's immediate family if the arrangement does not relate to the furnishing of clinical laboratory services; or

(2) Remuneration provided by a hospital to a physician if the remuneration does not relate to the furnishing of clinical laboratory services.

(h) *Group practice arrangements with a hospital.* An arrangement between a hospital and a group practice under which clinical laboratory services are provided by the group but are billed by the hospital if the following conditions are met:

(1) With respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1861(b)(3) of the Act.

(2) The arrangement began before December 19, 1989, and has continued in effect without interruption since then.

(3) With respect to the clinical laboratory services covered under the arrangement, substantially all of these services furnished to patients of the hospital are furnished by the group under the arrangement.

(4) The arrangement is in accordance with an agreement that is set out in writing and that specifies the services to be furnished by the parties and the compensation for services furnished under the agreement.

(5) The compensation paid over the term of the agreement is consistent with fair market value, and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The compensation is provided in accordance with an agreement that would be commercially reasonable even if no referrals were made to the entity.

(i) *Payments by a physician.* Payments made by a physician—

(1) To a laboratory in exchange for the provision of clinical laboratory services; or

(2) To an entity as compensation for other items or services that are furnished at a price that is consistent with fair market value.

§ 411.360 Group practice attestation.

(a) Except as provided in paragraph (b) of this section, a group practice (as defined in section 1877(h)(4) of the Act and § 411.351) must submit a written statement to its carrier annually to attest that, during the most recent 12-month period (calendar year, fiscal year, or immediately preceding 12-month period) 75 percent of the total patient care services of group practice members was furnished through the group, was billed under a billing number assigned to the group, and the amounts so received were treated as receipts of the group.

(b) A newly-formed group practice (one in which physicians have recently begun to practice together) or any group practice that has been unable in the past to meet the requirements of section 1877(h)(4) of the Act must—

(1) Submit a written statement to attest that, during the next 12-month period (calendar year, fiscal year, or next 12 months), it expects to meet the 75-percent standard and will take measures to ensure the standard is met; and

(2) At the end of the 12-month period, submit a written statement to attest that it met the 75-percent standard during that period, billed for those services under a billing number assigned to the group, and treated amounts received for those services as receipts of the group. If the group did not meet the standard, any Medicare payments made for clinical laboratory services furnished by the group during the 12-month period that were conditioned upon the standard being met are overpayments.

(c) Once any group has chosen whether to use its fiscal year, the calendar year, or some other 12-month period, the group practice must adhere to this choice.

(d) The attestation must contain a statement that the information furnished in the attestation is true and accurate and must be signed by a group representative.

(e) A group that intends to meet the definition of a group practice in order to qualify for an exception described in §§ 411.355 through 411.357, must submit the attestation required by paragraph (a) or paragraph (b)(1) of this section, as applicable, to its carrier no later

than 60 days after receipt of the attestation instructions from its carrier.

[60 FR 41978, Aug. 14, 1995, as amended at 60 FR 63440, Dec. 11, 1995]

§ 411.361 Reporting requirements.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, all entities furnishing items or services for which payment may be made under Medicare must submit information to HCFA concerning their financial relationships (as defined in paragraph (d) of this section), in such form, manner, and at such times as HCFA specifies.

(b) *Exception.* The requirements of paragraph (a) of this section do not apply to entities that provide 20 or fewer Part A and Part B items and services during a calendar year, or to designated health services provided outside the United States.

(c) *Required information.* The information submitted to HCFA under paragraph (a) of this section must include at least the following:

(1) The name and unique physician identification number (UPIN) of each physician who has a financial relationship with the entity;

(2) The name and UPIN of each physician who has an immediate relative (as defined in § 411.351) who has a financial relationship with the entity;

(3) The covered items and services provided by the entity; and

(4) With respect to each physician identified under paragraphs (c)(1) and (c)(2) of this section, the nature of the financial relationship (including the extent and/or value of the ownership or investment interest or the compensation arrangement, if requested by HCFA).

(d) *Reportable financial relationships.* For purposes of this section, a financial relationship is any ownership or investment interest or any compensation arrangement, as described in section 1877 of the Act.

(e) *Form and timing of reports.* Entities that are subject to the requirements of this section must submit the required information on a HCFA-prescribed form within the time period specified by the servicing carrier or intermediary. Entities are given at

least 30 days from the date of the carrier's or intermediary's request to provide the initial information. Thereafter, an entity must provide updated information within 60 days from the date of any change in the submitted information. Entities must retain documentation sufficient to verify the information provided on the forms and, upon request, must make that documentation available to HCFA or the OIG.

(f) *Consequences of failure to report.* Any person who is required, but fails, to submit information concerning his or her financial relationships in accordance with this section is subject to a civil money penalty of up to \$10,000 for each day of the period beginning on the day following the applicable deadline established under paragraph (e) of this section until the information is submitted. Assessment of these penalties will comply with the applicable provisions of part 1003 of this title.

(g) *Public disclosure.* Information furnished to HCFA under this section is subject to public disclosure in accordance with the provisions of part 401 of this chapter.

Subpart K—Payment for Certain Excluded Services

§411.400 Payment for custodial care and services not reasonable and necessary.

(a) *Conditions for payment.* Notwithstanding the exclusions set forth in §411.15 (g) and (k). Medicare pays for "custodial care" and "services not reasonable and necessary" if the following conditions are met:

(1) The services were furnished by a provider or by a practitioner or supplier that had accepted assignment of benefits for those services.

(2) Neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded from coverage under §411.15 (g) or (k).

(b) *Time limits on payment.* (1) *Basic rule.* Except as provided in paragraph (b)(2) of this section, payment may not be made for inpatient hospital care, posthospital SNF care, or home health

services furnished after the earlier of the following:

(i) The day on which the beneficiary has been determined, under §411.404, to have knowledge, actual or imputed, that the services were excluded from coverage by reason of §411.15(g) or §411.15(k).

(ii) The day on which the provider has been determined, under §411.406 to have knowledge, actual or imputed, that the services are excluded from coverage by reason of §411.15(g) or §411.15(k).

(2) *Exception.* Payment may be made for services furnished during the first day after the limit established in paragraph (b)(1) of this section, if the PRO or the intermediary determines that the additional period of one day is necessary for planning post-discharge care. If the PRO or the intermediary determines that yet another day is necessary for planning post-discharge care, payment may be made for services furnished during the second day after the limit established in paragraph (b)(1) of this section.

§411.402 Indemnification of beneficiary.

(a) *Conditions for indemnification.* If Medicare payment is precluded because the conditions of §411.400(a)(2) are not met. Medicare indemnifies the beneficiary (and recovers from the provider, practitioner, or supplier), if the following conditions are met:

(1) The beneficiary paid the provider, practitioner, or supplier some or all of the charges for the excluded services.

(2) The beneficiary did not know and could not reasonably have been expected to know that the services were not covered.

(3) The provider, practitioner, or supplier knew, or could reasonably have been expected to know that the services were not covered.

(4) The beneficiary files a proper request for indemnification before the end of the sixth month after whichever of the following is later:

(i) The month in which the beneficiary paid the provider, practitioner, or supplier.

(ii) The month in which the intermediary or carrier notified the beneficiary (or someone on his or her

behalf) that the beneficiary would not be liable for the services.

For good cause shown by the beneficiary, the 6-month period may be extended.

(b) *Amount of indemnification.*¹ The amount of indemnification is the total that the beneficiary paid the provider, practitioner, or supplier.

(c) *Effect of indemnification.* The amount of indemnification is considered an overpayment to the provider, practitioner, or supplier, and as such is recoverable under this part or in accordance with other applicable provisions of law.

§ 411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

(a) *Basic rule.* A beneficiary who receives services that constitute custodial care under § 411.15(g) or that are not reasonable and necessary under § 411.15(k), is considered to have known that the services were not covered if the criteria of paragraphs (b) and (c) of this section are met.

(b) *Written notice.* Written notice has been given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines. A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion. For example, program payment may not be made for the treatment of obesity, no matter what form the treatment may take. After the beneficiary who is treated for obesity with dietary control is informed in writing that Medicare will not pay for treatment of obesity, he or she will be presumed to know that there will be no Medicare payment for any form of subsequent treatment of this condition, including use of a combination of exercise, machine treatment, diet, and medication.

(c) *Source of notice.* The notice was given by one of the following:

¹For services furnished before 1988, the indemnification amount was reduced by any deductible or coinsurance amounts that would have been applied if the services had been covered.

(1) The PRO, intermediary, or carrier.

(2) The group or committee responsible for utilization review for the provider that furnished the services.

(3) The provider, practitioner, or supplier that furnished the service.

§ 411.406 Criteria for determining that a provider, practitioner, or supplier knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

(a) *Basic rule.* A provider, practitioner, or supplier that furnished services which constitute custodial care under § 411.15(g) or that are not reasonable and necessary under § 411.15(k) is considered to have known that the services were not covered if any one of the conditions specified in paragraphs (b) through (e) of this section is met.

(b) *Notice from the PRO, intermediary or carrier.* The PRO, intermediary, or carrier had informed the provider, practitioner, or supplier that the services furnished were not covered, or that similar or reasonably comparable services were not covered.

(c) *Notice from the utilization review committee or the beneficiary's attending physician.* The utilization review group or committee for the provider or the beneficiary's attending physician had informed the provider that these services were not covered.

(d) *Notice from the provider, practitioner, or supplier to the beneficiary.* Before the services were furnished, the provider, practitioner or supplier informed the beneficiary that—

(1) The services were not covered; or

(2) The beneficiary no longer needed covered services.

(e) *Knowledge based on experience, actual notice, or constructive notice.* It is clear that the provider, practitioner, or supplier could have been expected to have known that the services were excluded from coverage on the basis of the following:

(1) Its receipt of HCFA notices, including manual issuances, bulletins, or other written guides or directives from intermediaries, carriers, or PROs, including notification of PRO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical

procedures subject to preadmission review by a PRO.

(2) FEDERAL REGISTER publications containing notice of national coverage decisions or of other specifications regarding noncoverage of an item or service.

(3) Its knowledge of what are considered acceptable standards of practice by the local medical community.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 48425, Sept. 19, 1995]

§ 411.408 Refunds of amounts collected for physician services not reasonable and necessary, payment not accepted on an assignment-related basis.

(a) *Basic rule.* Except as provided in paragraph (d) of this section, a physician who furnishes a beneficiary services for which the physician does not undertake to claim payment on an assignment-related basis must refund any amounts collected from the beneficiary for services otherwise covered if Medicare payment is denied because the services are found to be not reasonable and necessary under § 411.15(k).

(b) *Time limits for making refunds.* A timely refund of any incorrectly collected amounts of money must be made to the beneficiary to whom the services were furnished. A refund is timely if—

(1) A physician who does not request a review within 30 days after receipt of the denial notice makes the refund within that time period; or

(2) A physician who files a request for review within 30 days after receipt of the denial notice makes the refund within 15 days after receiving notice of an initial adverse review determination, whether or not the physician further appeals the initial adverse review determination.

(c) *Notices and appeals.* If payment is denied for nonassignment-related claims because the services are found to be not reasonable and necessary, a notice of denial will be sent to both the physician and the beneficiary. The physician who does not accept assignment will have the same rights as a physician who submits claims on an assignment-related basis, as detailed in subpart H of part 405 and subpart B of part 473, to appeal the determination, and

will be subject to the same time limitations.

(d) *When a refund is not required.* A refund of any amounts collected for services not reasonable and necessary is not required if—

(1) The physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service; or

(2) Before the service was provided—

(i) The physician informed the beneficiary, or someone acting on the beneficiary's behalf, in writing that the physician believed Medicare was likely to deny payment for the specific service; and

(ii) The beneficiary (or someone eligible to sign for the beneficiary under § 424.36(b) of this chapter) signed a statement agreeing to pay for that service.

(e) *Criteria for determining that a physician knew that services were excluded as not reasonable and necessary.* A physician will be determined to have known that furnished services were excluded from coverage as not reasonable and necessary if one or more of the conditions in § 411.406 of this subpart are met.

(f) *Acceptable evidence of prior notice to a beneficiary that Medicare was likely to deny payment for a particular service.* To qualify for waiver of the refund requirement under paragraph (d)(2) of this section, the physician must inform the beneficiary (or person acting on his or her behalf) that the physician believes Medicare is likely to deny payment.

(1) The notice must—

(i) Be in writing, using approved notice language;

(ii) Cite the particular service or services for which payment is likely to be denied; and

(iii) Cite the physician's reasons for believing Medicare payment will be denied.

(2) The notice is not acceptable evidence if—

(i) The physician routinely gives this notice to all beneficiaries for whom he or she furnishes services; or

(ii) The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the service.

(g) *Applicability of sanctions to physicians who fail to make refunds under this section.* A physician who knowingly and willfully fails to make refunds as required by this section may be subject to sanctions as provided for in chapter V, parts 1001, 1002, and 1003 of this title.

[55 FR 24568, June 18, 1990; 55 FR 35142, 35143, Aug. 28, 1990]

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

Subpart A—General Provisions

Sec.

- 412.1 Scope of part.
- 412.2 Basis of payment.
- 412.4 Discharges and transfers.
- 412.6 Cost reporting periods subject to the prospective payment systems.
- 412.8 Publication of schedules for determining prospective payment rates.
- 412.10 Changes in the DRG classification system.

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

- 412.20 Hospital services subject to the prospective payment systems.
- 412.22 Excluded hospitals and hospital units: General rules.
- 412.23 Excluded hospitals: Classifications.
- 412.25 Excluded hospital units: Common requirements.
- 412.27 Excluded psychiatric units: Additional requirements.
- 412.29 Excluded rehabilitation units: Additional requirements.
- 412.30 Exclusion of new rehabilitation units and expansion of units already excluded.

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

- 412.40 General requirements.
- 412.42 Limitations on charges to beneficiaries.
- 412.44 Medical review requirements: Admissions and quality review.
- 412.46 Medical review requirements: Physician acknowledgement.
- 412.48 Denial of payment as a result of admissions and quality review.
- 412.50 Furnishing of inpatient hospital services directly or under arrangements.

- 412.52 Reporting and recordkeeping requirements.

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

- 412.60 DRG classification and weighting factors.
- 412.62 Federal rates for inpatient operating costs for fiscal year 1984.
- 412.63 Federal rates for inpatient operating costs for fiscal years after Federal fiscal year 1984.

Subpart E—Determination of Transition Period Payment Rates for the Prospective Payment System for Inpatient Operating Costs

- 412.70 General description.
- 412.71 Determination of base-year inpatient operating costs.
- 412.72 Modification of base-year costs.
- 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.
- 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.
- 412.76 Recovery of excess transition period payment amounts resulting from unlawful claims.

Subpart F—Payment for Outlier Cases

- 412.80 General provisions.
- 412.82 Payment for extended length-of-stay cases (day outliers).
- 412.84 Payment for extraordinarily high-cost cases (cost outliers).
- 412.86 Payment for extraordinarily high-cost day outliers.

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

- 412.90 General rules.
- 412.92 Special treatment: Sole community hospitals.
- 412.96 Special treatment: Referral centers.
- 412.98 Special treatment: Christian Science Sanatoria.
- 412.100 Special treatment: Renal transplantation centers.
- 412.102 Special treatment: Hospitals reclassified as rural.
- 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.
- 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.