FOR FURTHER INFORMATION CONTACT:
Kathleen O. Willard, (202) 906–6789, Office of Thrift Supervision, 1700 G. Street NW., Washington, DC 20552.

By The Office of Thrift Supervision.
M. Danny Wall,
Director.

[FR Doc. 89–23934 Filed 10–10–89; 8:45 am]
BILLING CODE 6720–01–M

Sunshine Act Meetings

Federal Register
Vol. 54, No. 195
Wednesday, October 11, 1989

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

October 5, 1989.

TIME AND DATE: 10:00 a.m., Thursday, October 5, 1989.

PLACE: Room 600, 1730 K Street, NW., Washington, DC.

STATUS: Closed (Pursuant to 5 U.S.C. 552b(c)(10)).

MATTERS TO BE CONSIDERED: In addition to the previously announced item, the Commission will consider and act upon the following:

2. *Clinchfield Coal Company v. Secretary of Labor and United Mine Workers of America*, Docket No. VA 89-67-R. (Issues include consideration of petitions for discretionary review.)

It was determined by a unanimous vote of Commissioners that a closed meeting be held on this item and that no earlier announcement of the meeting was possible.

CONTACT PERSON FOR MORE INFO: Jean Ellen, (202) 653-5629/(202) 708-9300 for TDD Relay 800-877-8339 for Toll Free.

Jean H. Ellen,

Agenda Clerk.

[FR Doc. 89-24075 Filed 10-6-89; 1:38 pm]

BILLING CODE 6735-01-M

FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS:

TIME AND DATE: 11:00 a.m., Monday, October 16, 1989.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW, Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.
2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: October 6, 1989.

Jennifer J. Johnson,

Associate Secretary of the Board

[FR Doc. 89-24105 Filed 10-10-89; 8:45 am]

BILLING CODE 6210-01-M

INTERNATIONAL TRADE COMMISSION

[USITC SE-88-33]

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: 54 FR 39496—dated September 26, 1989.

PREVIOUSLY ANNOUNCED TIME AND DATE OF THE MEETING: 11:00 a.m., Thursday, October 5, 1989.

ADDITIONAL MEETING SCHEDULED FOR: 10:00 a.m., Friday, October 6, 1989.

Notice is given that the Commission meeting previously announced for Thursday, October 5, 1989, was recessed and an additional meeting will take place on Friday, October 6, 1989. In conformity with 19 CFR 201.37(b), Commissioners Brunsdale, Eckes, Rohr, Cass, and Newquist voted to reschedule the meeting. Commissioner Lodwick disapproved. It was affirmed that no earlier announcement of the additional meeting was possible, and directed the issuance of this notice at the earliest practicable time.

CONTACT PERSON FOR MORE INFORMATION: Kenneth R. Mason, Secretary, (202) 252-1000

Dated: October 5, 1989

Kenneth R. Mason,

Secretary

[FR Doc. 89-24102 Filed 10-6-89; 2:58 p.m.]

BILLING CODE 7020-02-M

Corrections

Federal Register
Vol. 54, No. 195
Wednesday, October 11, 1989

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF AGRICULTURE

Rural Electrification Administration

7 CFR Part 1765

Telephone Materials, Equipment, and Construction - Telephone Program

Correction

In rule document 89-22282 beginning on page 39262 in the issue of Monday, September 25, 1989, make the following correction:

On page 39280, in the signature block, the title should read "Acting Administrator".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Parts 510 and 558

Animal Drugs, Feeds, and Related Products; Change of Sponsor

Correction

In rule document 89-22158 beginning on page 38645 in the issue of Wednesday, September 20, 1989, make the following correction:

On page 38646, in the first column, in the signature line, the title should read,"Deputy Director, Office of New Animal Drug Evaluation, Center for Veterinary Medicine."

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 89-ASW-19]

Proposed Alteration of VOR Federal Airways; Texas

Correction

In proposed rule document 89-20852 beginning on page 36997 in the issue of Wednesday, September 6, 1989, make the following correction:

§ 71.123 [Corrected]

On page 36998, in the second column, under **§ 71.123 [Amended]**, the heading **V-575 [Amended]** should read **V-574 [Amended]**.

BILLING CODE 1505-01-D

federal register

Wednesday
October 11, 1989

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 405 et al.

Medicare; Secondary Payer and Recovery Against Third Parties; Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 411, 412 and 489

[BPD-302-F; RIN 0938-AC05]

Medicare as Secondary Payer and Medicare Recovery Against Third Parties

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: These rules—

1. Update and revise policies dealing with Medicare as secondary payer;
2. Revise policy on the exclusion of services of immediate relatives of the beneficiary or members of the beneficiary's household;
3. Revise policy on the exclusion of services furnished outside the United States;
4. Clarify policy on the "no legal obligation to pay" exclusion as it applies to services furnished to prisoners; and
5. Reflect a recent statutory amendment that provides an additional exception to the exclusion of services that are "not reasonable and necessary".

The changes in the Medicare secondary payer provisions reflect amendments made to section 1862(b) of the Social Security Act (the Act) by section 2344 of the Deficit Reduction Act of 1984 (Pub. L. 98–369), section 9201 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99–272), and section 4036(a) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203). Separate regulations will be issued to implement section 9319 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), which made Medicare secondary payer for certain disabled Medicare beneficiaries under age 65 who are covered under a large group health plan.

EFFECTIVE DATE: These rules are effective November 13, 1989.

FOR FURTHER INFORMATION, CONTACT:

Herbert Shankroff, (301) 966–7171; Identification and billing of other primary payers by providers; prompt reimbursement to Medicare when providers or suppliers receive payment from other primary payers.

Herbert Pollock (301) 966–4474; All other provisions.

SUPPLEMENTARY INFORMATION:

I. Background

During the first 15 years of the Medicare program, Medicare was primary payer for all services to Medicare beneficiaries, with the sole exception of services covered under workers' compensation. It was not until 1980 that Congress began to amend section 1862 of the Act to make Medicare secondary, first to no-fault and liability insurance, and later to employer group health plans that cover end-stage renal disease (ESRD) patients and that cover employed aged and aged spouses of employed individuals. Despite regulations and instructions, implementation has fallen short of expectations. It is hospitals that are most directly affected by these changes because it is primarily hospital services that are covered by private insurance.

Experience has been that many "Medicare secondary payer" (MSP) claims are not identified for MSP processing and that hospitals do not have procedures to identify other insurance that the beneficiary may have. This situation has been documented by—

- A Bureau of Quality Control study (summer of 1984), which found that up to 90 percent of all working aged claims were billed to Medicare rather than the other insurer because the hospital did not ask the beneficiary for information on other insurance or did not follow through on that information.
- Bureau of Program Operations (BPO) on-site review of hospitals, which revealed that hospitals did not have procedures to use at the time of admission to identify other insurers.
- BPO investigation of hospital software vendors, which revealed that the standard software packages for hospital admission routines do not include sufficient questions about insurers other than Medicare.

As a result, the claims that would properly be billed to another payer are sometimes mistakenly billed to Medicare. In some instances, the intermediary is able to identify the claim as an MSP claim and, at considerable expense, follow through to achieve the MSP savings. In many other instances, there is no way for the intermediary to know that a particular beneficiary has other insurance. In those cases, the claim is paid mistakenly and MSP savings are lost unless the situation is later identified and recovery made.

This problem is particularly acute when the health insurance policyholder is not the Medicare patient, but his or her spouse. There is no way of identifying this person (who may be under 65 years of age) through HCFA/SSA records. Only the hospital can identify this type of MSP case.

A second observation on program experience was made by the Office of the Inspector General (OIG) in a memorandum dated March 18, 1985. The OIG review of hospitals indicates that some hospitals bill both Medicare and the other insurer (which is contrary to Medicare program instructions) and, instead of refunding Medicare's payment, retain it, unless Medicare requests that it be refunded. The hospital has no incentive to refund the money. Since it is unlikely that the intermediary will find the case and ask for the refund, the hospital keeps a credit balance on the patient account and holds the payment.

Mistaken payments must be recovered. Medicare conditional payments, made when a claim against the other insurer is contested or payment is otherwise delayed, are also subject to recovery. Recent legislation has a direct bearing on this aspect of the program, as explained below.

Statutory Changes

A. Deficit Reduction Act of 1984

Section 2344 of the Deficit Reduction Act of 1984 (Pub. L. 98–369) amended sections 1862(b)(1), 1862(b)(2)(B), and 1862(b)(3)(A)(ii) of the Act as follows:

1. Makes explicit the Federal government's right to recover from—
   - Third parties that are required to pay before Medicare; and
   - Any entity (such as a beneficiary, provider, physician or State agency) that has received payment from a third party that is required to pay before Medicare.
2. Provides that the government—
   - Is subrogated to the right of any individual or other entity to receive payments from a third party payer to the extent of Medicare payment; and
   - May join or intervene in any action related to the events that gave rise to the need for the items or services for which Medicare paid.
3. Adds the word "promptly" to section 1862(b)(1), thus providing that Medicare payments are limited to the extent that payment has been made or can reasonably be expected to be made "promptly" by workers' compensation, or automobile, liability, or no-fault insurance. Medicare makes conditional primary payments only if the other insurer will not pay promptly.
4. Adds the phrase "or could be" to sections 1862 (b)(1), (b)(2)(B), and (b)(3)(A)(ii), thus providing that Medicare conditional payments are subject to recoupment when information is received that primary payment "could be" made by a workers' compensation plan, an automobile, liability, or no-fault insurer, or an employer group health plan, even though payment has not yet been made. This change reinforces Medicare's position as secondary payer, that is, it expressly permits HCFA to

pursue recovery of conditional or mistaken payments as soon as HCFA learns that another insurer is liable for the payment.

The provisions of section 2344 were self-implementing. A notice to that effect was published on July 17, 1985 at 50 FR 28988.

B. Consolidated Omnibus Budget Reconciliation Act of 1985

Section 9201 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99–272 enacted April 7, 1986) eliminated the age 70 upper limit for individuals subject to the working aged provision, effective May 1, 1986. This amendment makes Medicare secondary payer to employer group health plan coverage for employed individuals age 65 or over and spouses age 65 or over of employed individuals of any age. Previously, Medicare was secondary for these individuals only until they attained age 70.

C. Omnibus Budget Reconciliation Act of 1987

1. *Section 4036(a).* Section 4036(a) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100–203), enacted December 22, 1987, provides that Medicare may not make conditional primary payments on behalf of an ESRD beneficiary who is covered by an employer group health plan if the plan "can reasonably be expected" to pay. Under previous law, Medicare could make conditional primary payments if the Secretary determined that the plan would not pay as promptly as Medicare. This change makes the conditional payment criteria for ESRD beneficiaries the same as for working aged beneficiaries who are covered by employer group health plans. This change is effective for services furnished on or after January 21, 1988. The section 4036(a) provision supersedes HCFA's implementation of a court order that was issued in 1984 and is summarized below.

In *National Association of Patients on Hemodialysis* v. *Heckler* (Civil Action No. 83–2210 (D.D.C.)), the district court for the District of Columbia held that HCFA's existing regulations, dealing with conditional primary Medicare payments when Medicare is secondary to employer group health plans for ESRD beneficiaries, were not consistent with the statute. Those regulations provided that Medicare could pay conditional primary benefits only if the Medicare contractor knew from experience or ascertained that the employer plan payments in general were substantially less prompt than Medicare's. The court held that the regulations were not consistent with the statutory language which directed the Secretary to deny primary Medicare benefits only if—

- The employer group health plan has paid; or
- The Secretary has determined that the employer plan will pay as promptly as Medicare.

Manual instructions implementing the court decision were issued in 1985. They stipulated that providers and suppliers were no longer required to bill the employer plan first in ESRD cases; they had the option to bill Medicare first. Contractors were instructed to pay conditional Medicare benefits if billed first and to attempt to recover later from the employer plan.

2. *Section 4085(i)(15).* Section 4085(i)(15) of Pub L. 100–203 provides a fourth exception to the exclusion of services that are not reasonable and necessary "for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member". Under this amendment, Medicare payment is available for services that are reasonable and necessary to carry out the purpose of the patient outcome assessment program established under section 1875(c) of the Act.

Notice of Proposed Rulemaking (NPRM)

On June 15, 1988, we published a notice (53 FR 22335) proposing to redesignate Subpart C of Part 405 of the Medicare rules as a new Part 411, and to revise the rules to reflect the statutory changes discussed above and to provide the greatest possible uniformity in the policies applicable to third party payer situations.

II. Summary of Analysis and Responses to Comments

We received 51 timely letters of comment from hospitals and medical centers, religious organizations, insurance companies and carriers, health organizations, law firms, individuals, a hospice, a medical society, a veterans' organization, and a State agency. The changes proposed in the NPRM, the comments received on the proposals, and our responses to those comments are discussed below.

General Comments

Comment: The commenter suggested that, in the definitions of "secondary" and "secondary payments," the term "insurance" be replaced with the more generic "coverage", which would include self-funded plans.

Response: We accepted this comment and revised § 411.21 accordingly.

Comment: The commenter believes that the provisions of these regulations should not apply to hospice patients, because it is a disservice to discuss private insurance benefits, copayments, and noncoverage with terminal patients and their families. Also, the commenter believes it is discriminatory to deny Medicare benefits because Medicare beneficiaries have insurance that is primary to Medicare. The commenter believes that involving private insurance can cause billing problems that will create hardships for hospice patients.

Response: There is no provision in the Medicare law that permits HCFA to exempt hospice patients from Medicare secondary provisions. If a Medicare beneficiary has hospice coverage through an insurance plan that is primary to Medicare, the law requires that the private insurance plan pay first. Also, the hospice, as a Medicare participating provider, is obligated to elicit information from patients and their families regarding insurance that is primary to Medicare. Hospices, not patients, are responsible for billing the other insurance.

Comment: The commenter believes that the rules limiting Medicare payments when no fault insurance, a workers' compensation plan, liability insurance, or employer group health plans are primary to Medicare are detrimental to small rural hospitals that are without staff attorneys and lack employees with legal backgrounds. Also, these rules and the rules for calculating Medicare secondary payment amounts are much more complicated than necessary.

Response: Hospitals need not have staff attorneys or personnel with legal backgrounds in order to comply with these regulations. Rural hospitals, like other Medicare participating providers, are required to elicit information from patients regarding insurance that may be primary to Medicare and to bill third party payers that are primary to Medicare. This workload is necessitated by the law that makes certain third party payers primary to Medicare. We do not believe that these rules and the rules for calculating Medicare secondary payment amounts are excessively complicated.

Comments: One commenter considered that §§ 411.43, 411.65, and 411.75, which preclude Medicare conditional payments when a beneficiary fails to file a proper third party claim, are inconsistent with the intent of the law in that they place health care providers at risk of nonpayment for a beneficiary's lack of diligence, a factor over which providers have no control. The commenter believes that the regulations should

clarify whether a provider may proceed against the beneficiary when it was the beneficiary's responsibility to file a claim and the beneficiary failed to do so.

Another commenter objected to § 411.24(l), which allows HCFA to recover a conditional payment from a provider if a provider fails to file a proper claim for third party benefits. This commenter believes this provision is inappropriate when beneficiaries fail to give a provider information about other insurance coverage.

A third stated that § 411.24(l) should contain a definition of "proper claim" and indicate how to determine the amount a primary insurer would reimburse a provider on the basis of a proper claim.

Response: The statute would be circumvented if Medicare assumed financial liability for services for which a third party payer would pay, except for the fact that someone failed to file a proper claim. Providers and beneficiaries could place primary liability on Medicare simply by failing to bill third party payers properly. Accordingly, the general rule is that Medicare will not make conditional payments when—

- A provider responsible for filing a third party claim on behalf of the beneficiary fails to file a proper claim; or
- A beneficiary responsible for filing a third party claim fails to file a proper claim for any reason other than physical or mental incapacity.

However, in response to the first two comments, this final rule makes the following changes:

Revises § 411.24(l) to specify that Medicare will not recover from the provider if the provider can show that the beneficiary gave erroneous information about other insurance coverage, such as denying the employer group health plan coverage that he or she has. (In such cases, the beneficiary is responsible for repayment.)

Revises proposed § 489.20(i) to make clear that, under specified circumstances, a provider may charge the beneficiary the amount of the third party payment reduction attributable to failure to file a proper claim. This rule applies if the provider can show that—

- It failed to file a proper claim solely because the beneficiary, for any reason other than physical or mental incapacity, failed to give the provider the necessary information; or
- The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than physical or mental incapacity.

"Proper claim" is defined in § 411.21. Providers can obtain information from primary insurers with respect to the amount they would have paid the provider on the basis of a proper claim. Accordingly, we have not adopted the third suggestion.

Comment: Several commenters suggested that HCFA make conditional payments when a group health plan that is primary to Medicare refuses to pay primary benefits. The commenters consider that the proposed rules, by barring such payments, place the burden on health care providers to enforce the MSP provisions against recalcitrant employer group health plans. Commenters believe that Congress intended that HCFA pursue these claims.

The commenters also believe that the conditional payment policy for group health plans that are primary to Medicare, should be based on the same "promptness" criterion that is applicable when a workers' compensation plan, or no-fault or liability insurance is primary to Medicare.

Response: In the case of workers' compensation and no-fault or liability insurance, Congress included the word "promptly", indicating that Medicare should make conditional payments when payment by a third party payer could not "reasonably be expected to be made promptly". In contrast, Congress did not include a "promptness" criterion in provisions regarding employer health plans: "Payment under this title may not be made * * * to the extent that payment * * * has been made, or can reasonably be expected to be made under a group health plan."

The statute thus indicates that Medicare should not pay when it is "reasonable" to expect an employer group health plan to pay. If an employer plan is primary to Medicare under the law, it is reasonable to expect the plan to comply with the law. When a plan fails to comply with the law, it is the provider's responsibility to pursue collection from the plan, just as it is the provider's responsibility to pursue collection in any other situation in which a third party is responsible for payment. The statute clearly does not provide that Medicare assume the financial burden of recovering from employer plans that fail to meet their obligations under the law. Moreover, section 9319 of OBRA '86 amended section 1862(b) of the Act to add a subsection (b)(5) to create a private right of action with double damages if a responsible third party fails to pay primary benefits. It should be noted that in these situations, providers are prohibited from billing Medicare beneficiaries.

Comment: Two commenters expressed general concern that HCFA has been negligent in communicating with providers and group health plans about their role in the Medicare secondary payer (MSP) program. One commenter stated that insurers and group health plans are hindered by lack of HCFA guidance with respect to coordination of benefits with Medicare and that the proposed regulations are inadequate in this respect.

Response: HCFA recognizes that it is necessary to keep the community at large informed about the MSP program. In an effort to increase public awareness, since 1986 HCFA has engaged in a public information program about MSP. This program has been targeted to reach employers, insurers, providers of services, and beneficiaries. Medicare contractors and others have been meeting with the various target groups to provide the MSP message.

However, we agree that the regulations ought to provide more specific guidance for all third party payers with respect to coordination of benefits. Accordingly, we have added a new § 411.25 to delineate the responsibilities of a third party payer when it discovers that HCFA has made a primary Medicare payment in a situation in which the third party payer should have made, or did make, a primary payment. In summary, the third party must inform HCFA of the specific situation, and describe the circumstances (such as type of coverage and MSP category), and specify the time period during which it is the primary payer.

In making this change, we discovered that we had inadvertently failed to include in § 411.21 a general definition of "plan" applicable to all categories of third party payers under section 1862(b) of the Act. We have corrected this oversight.

Comment: One commenter was concerned that unpaid claims were returned to providers inappropriately because erroneous data was included in HCFA's regional data exchange system.

Response: HCFA is continually improving the regional data exchange system to eliminate erroneous data. Erroneous or outdated information is corrected upon receipt and verification.

Comment: The proposed rules require that the beneficiary must cooperate in HCFA's action to recover benefits from a primary payer. The commenter believes that HCFA should provide due process rights for beneficiaries and advise beneficiaries via published guidelines exactly the duties that are

imposed on them by the word "cooperate."

Response: HCFA has enumerated the conditions of beneficiary responsibility in §§ 411.43, 411.51, 411.65, and 411.75. Essentially, beneficiaries are responsible for filing claims with a third party payer or informing providers of coverage that is primary to Medicare so that providers may bill the third party payers on their behalf. Standard due process provisions apply to recovery of conditional payments from beneficiaries.

To Implement Statutory Amendments

A. Prompt Payment

1. *Proposal.* To implement the statutory amendment that added the word "promptly" to section 1862(b)(1) of the Act, we proposed that Medicare make conditional primary payments when the workers' compensation carrier or the no-fault insurer will not pay promptly, that is, within 120 days after receipt of the claim.

We did not propose to change the existing rules for liability insurance. Medicare makes conditional primary payments if the beneficiary has filed or has a right to file a liability claim. However, because of a court decision, a special rule applies in Oregon. Under this rule, the "promptness" criterion applies to liability claims involving Oregon hospitals. This is discussed under section G.3., of this preamble.

2. *Comments and responses.*

Comment: Several commenters expressed concern that the definition of "promptly", as applied to conditional payment, requires a provider to wait for payment for an excessive period of time after the potential primary payer has denied the claim. One commenter suggested that when there are multiple payers that are primary to Medicare the promptness period should not apply to each payee individually.

Response: The 120 days is the maximum amount of time a provider might have to wait for a third party payment before billing Medicare. If the provider can document that a potential primary payer will not pay the claim—for example, with a written rejection of the claim, it can submit the bill to Medicare without further delay. Since a payer that is primary to Medicare cannot pay until it is billed, the 120-day period must apply to each payer. If the provider receives a partial payment or a denial of payment from one primary payer and then bills another, the 120-day period would apply in the case of the second billing as well.

B. Authority to Recover as Soon as Liability Is Known to Exist, Subrogation, and Right to Intervene

1. *Proposal.* As discussed above under "Statutory Changes", the addition of the phrase "or could be" makes explicit that HCFA can seek recovery of conditional primary payments when it learns that another party is primary payer, without waiting for the other party to actually pay (411.24(b)). If HCFA is unable to recover conditional Medicare payments from a beneficiary or other party that receives payment from an entity that is primary to Medicare, HCFA has the right to recover its payment from that entity in spite of the fact that the entity has already reimbursed the beneficiary or other party (§ 411.24(i)). Therefore, entities that are primary to Medicare should ensure that Medicare has no claim against payments they plan to make to individuals who are entitled to Medicare benefits.

HCFA's clarified recovery rights, including subrogation and the right to intervene, apply to all payers that are primary to Medicare. These rights are set forth in § 411.24 and § 411.26.

In view of the clarified recovery rights, we proposed to remove the requirement (in § 405.319(b) of the current rules) for obtaining a repayment agreement from the beneficiary as a prerequisite for Medicare conditional payment in workers' compensation cases.

2. *Comments and responses.*

Comment: Several commenters objected to § 411.24(b), which pertains to HCFA's authority to recover any conditional payment made to a provider even if the provider has not received any payment from a third party payer. The commenters believe that HCFA should recoup conditional payments only after a primary payer has actually made payment, not when payment "could be made". If HCFA recovers when payment "could be made", HCFA should pay interest of 12 percent per annum if the third party is ultimately determined not to be primary to Medicare.

Response: Under the law, HCFA has the right to recoup conditional Medicare payments from a provider or other person when it learns that payment "could be made" to the provider or other person by a third party payer. However, it is HCFA's policy to first attempt to recover from the third party payer. Thus, as a practical matter, HCFA does not recover from a provider that has not received a third party payment. HCFA may request a provider to bill a designated primary payer. In such cases, HCFA's request notifies the provider that HCFA will recover its conditional payment.

There is no provision in the Medicare law that would permit Medicare to pay interest in the event that an insurer, which HCFA believes to be a primary payer, ultimately is determined not to be primary to Medicare. In this situation, the provider or other person must resubmit its claim to Medicare.

Comment: One commenter believes that the use of the term "entity" in § 411.24(d) (which states: "HCFA may recover by direct collection or by offset against monies HCFA owes the entity responsible for refunding the conditional payment") is an attempt to include employer group health plans and insurers in the application of this section. Group health plans and insurers would never be in receipt of conditional Medicare payment and would therefore not be responsible for refunding this payment.

Response: Under the law, conditional Medicare payments may be recovered from any entity responsible for primary payment, for example, employers, insurers, underwriters, and third party administrators, as well as from any entity that received a conditional payment, such as a provider or beneficiary. The liability of entities responsible for payment is more directly addressed in section 411.24(e), which states: "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."

Comment: Several commenters objected to §§ 411.24 (e) and (g), which respectively reflect HCFA's right to recover from any entity responsible for paying primary benefits for services or any entity that has been paid by a third party payer. One commenter believes statutory liability for payment is imposed only on an employer group health plan and cannot be extended to insurers or administrators of the plan. The commenter suggested that the regulation be amended to reflect that an insurer or administrator cannot be liable to HCFA if it has not assumed the liability in its contract with the employer or plan. Another commenter said that HCFA should recover from either the employer or the employer's insurance carrier. Otherwise, the commenter believes that HCFA can receive "double recovery" under § 411.24(e) because this provision does not provide for return of monies collected to either the insurer or employer.

Response: Sections 411.24 (e) and (g) reflect statutory authority. Sections 1862(b) (2) and (3) of the Social Security Act both state, in part: "In order to recover payment made under this title [title XVIII] for an item or service, the United States may bring an action against *any entity* which would be responsible for payment with respect to such item or service (or any portion thereof) *under such a plan,* or against any entity * * * which has been paid with respect to such item or service under such plan, * * *" (Emphasis added.) Employers, insurers, underwriters and third party administrators are responsible for making payments "under such a plan" in accordance with the coverage provisions of the group health plan and in accordance with the law that makes group health plan coverage primary to Medicare. In cases in which the Medicare provisions conflict with a health plans, party administrators, Medicare law must prevail. (*Colonial Penn Insurance Co.* v. *Heckler,* 721, F 2d 431 (3rd Cir. 1983) and *Abrams* v. *Heckler,* 582 F. Supp. 1115 (S.D.N.Y. 1984). Accordingly, Medicare has the right to recover from any of those entities.

Third party administrators, insurers and underwriters hold themselves out as having expertise in health plan administration and being knowledgeable about the various legal and other requirements applicable to health plans. party administrators, insurers, and underwriters submit claims and make payment decisions on a day-to-day basis, often without direct involvement of the entity (such as the employer) that may *ultimately* be responsible for payment. Accordingly, it is appropriate for Medicare to recover directly from the third party administrator or insurer, and leave that entity to seek whatever recourse is available to it under its contract or other arrangement.

Also, as stipulated in the law, HCFA may recover from any entity that has received payment with respect to a service. HCFA will not pursue duplicate recoveries. Once HCFA recovers its benefits on any particular claim, it will not seek to recover the same benefits from another entity. We have amended proposed § 411.24(e) to make clear that third party administrators are among the entities responsible for refunding conditional Medicare payments.

Comment: Several commenters objected to § 411.24(f), which states that HCFA may recover without regard to any claims filing requirements imposed by the insurance program or plan, and applicable to the beneficiary, such as a time limit for filing a claim or a time limit for notifying a plan or program about the need for, or receipt of, services. The commenters believe that HCFA should be required to comply with the claims filing requirements of all insurers and health care coverage benefit plans. Also, HCFA should be required to make a claim within 1 year after a service has been furnished. The commenters believe that this section appears to unconstitutionally infringe upon contractual rights and obligations and purports to give HCFA greater rights than are afforded a person or group to whom an insurer issues a particular contract. Some contract provisions include specific time limits for filing and/or a reduction or complete loss of benefits for services that are not pre-approved. One commenter also stated that these contract provisions would also apply to services furnished by non-participating providers to an HMO member in a non-emergency situation without approval by the HMO. This would significantly affect participation in current Medicare risk-based HMO contracts. This proposal would also abrogate contract provisions establishing timely filing and other procedural requirements.

Response: This comment is acceptable in part. HCFA cannot be bound by the insurer's time frames for filing claims because those periods begin with the date of service. Under such a rule, HCFA would be unable to recover its benefits if it did not learn that the particular insurer is primary to Medicare until after the claim filing period expired.

This would conflict with the Medicare law. Congress expressly provided a direct right of recovery which begins "when notice or other information is received" (Section 1862(b) (1), (2), and (3)). Although Medicare's separately articulated subrogation rights, also contained in these sections, may be affected by a beneficiary's awareness of a claims filing limitation, Medicare's direct right of recovery is clearly unaffected by the concerns that the commenters express. Moreover, Federal law would overcome conflicting contractual or State law provisions. (See *Colonial Penn Insurance Co.* v. *Heckler* 721 F.2d 431 (3rd Cir. 1983) and *Abrams* v. *Heckler,* 582 F.Supp. 1155 (S.D.N.Y. 1984).)

We agree, however, that HCFA should observe some reasonable timeframe for filing claims—one that is similar to the timeframe for filing Medicare claims. Specifically, HCFA will file its claim by the end of the year following the year in which the Medicare contractor that paid the claim has notice that the insurer or other third party is primary payer for the particular services, and that Medicare's primary payment is, therefore, recoverable. (Notices received during the last three months of a year are considered to have been received in the following year.)

This timeframe has the advantage of being familiar to individuals involved in the Medicare claims process. As we have stated, under the law, the date HCFA receives such notice is the day that HCFA's claim arises. HCFA cannot be responsible for filing a claim within a period that starts before the Medicare intermediary or carrier that paid the claim has notice that provides the basis for recovery. We have revised proposed § 411.24(f) accordingly.

We do not see how § 411.24(f) would adversely affect HMOs because the regulations applicable to HMOs are at § 417.528 of the Medicare rules. In addition, in the case of risk-basis HMOs—

- Payment is on a prospective capitation basis and the payment is not reduced retroactively; and
- Medicare does not make any payments if a Medicare beneficiary goes outside an employer group prepaid health plan (such as an HCPP or HMO), when the same type of services could have been obtained or can be paid for by the HMO. This means that if Medicare pays in error, the entire payment is an overpayment.

Furthermore, under § 417.528, both cost and risk HMOs may charge an employer group health plan or another organization that is a primary payer for covered services that were furnished by the HMO.

Comment: Several commenters suggested deleting the rule (§ 411.24(i)), which provides that if HCFA is unable to recover from a party that received a third party payment, HCFA may recover from the third party payer even though it has already reimbursed the beneficiary or other party. The commenters believe that there is no justification for compelling a third party payer to pay the same claim twice.

Response: This comment is acceptable in part. Third party payers are responsible for reimbursing the proper party. Under section 1862(b) of the Act, HCFA is subrogated to "any right of an individual or any other entity to payment." The statute clearly gives the Medicare program a priority right of recovery. It is reasonable to expect a primary payer to take steps to ensure that it pays the proper party.

We agree that when an employer group health plan (EGHP) or no-fault insurer routinely pays primary benefits on behalf of a Medicare beneficiary without knowledge of Medicare's primary payment, the insurer has acted responsibly and should not be liable for reimbursing HCFA if HCFA is unable to recover from the party that received the insurer's primary payment. However, if a third party pays an entity other than Medicare even though it was, or should have been, aware that Medicare had made a conditional primary payment, the third party must reimburse Medicare.

We have modified the proposed § 411.24(i) so that it applies only to these circumstances and to liability insurance settlements and disputed EGHP and no-fault claims.

Liability insurers should be aware of Medicare involvement, and therefore should not pay a claim without first checking to find out if Medicare has made conditional payments. The EGHP or no-fault insurer should be aware that, if the claim was disputed, Medicare may have made a conditional payment. Accordingly, if the insurer later decides to pay the claim, it should contact Medicare to determine Medicare's claim and obtain advice regarding reimbursement.

Comment: One commenter stated that § 411.24(k), which permits recovery of conditional payments from a Medicare intermediary or carrier by offsetting funds due the intermediary or carrier, is contrary to the Administrative Procedures Act and in violation of a contractor's agreement.

Response: The Federal Claims Collection Act (FCCA) regulations require government agencies to pursue aggressively collection of a debt due the United States (4 CFR 102.1). If the debtor refuses to pay, offset against any amount owed by the government is one recommended method of collection. Authority to offset is well established under common law and is also found in § 401.607(a)(2) of the Medicare regulations and in Departmental regulations at 42 CFR 30.15(c)(5). The FCCA does not preclude a debtor from pursuing applicable administrative or judicial remedies if offset is applied. We have broadened the provision to apply to contractors, including intermediaries and carriers, as authorized under the law.

Comment: One commenter expressed the view that the proposed rules would place unreasonable burdens on physicians because it would be necessary for physicians to become expert in insurance rules, particularly the rules that govern primary and secondary payments. The commenter argues that physicians cannot be expected to acquire such knowledge, and, therefore, the rules would inappropriately put physicians at financial risk.

Response: These regulations do not place unreasonable burdens on physicians or put physicians "at risk." Physicians who accept assignment are responsible under the regulations to attempt to identify, and file a proper claim with, any third party that is primary to Medicare. If physicians follow this procedure and bill primary insurers first, Medicare will be billed only as secondary payer. A physician who follows the proper procedures but is unable to identify a third party that is primary to Medicare may bill Medicare in the usual manner, and would not be at risk.

Comment: One commenter believes that the proposed rule does not clearly state that Medicare is primary payer with respect to Medicaid. The commenter suggested that the final rule clearly state that Medicaid is an exception to the rules for Medicare as secondary payer.

Response: The proposed rule did not, and this final rule does not, change the order of payment between Medicare and Medicaid. It is not necessary for the regulations to state that Medicare is primary payer with respect to Medicaid. The law dealing with Medicare as secondary payer makes Medicare secondary only to workers' compensation, no-fault insurance, liability insurance, and certain group health plans. Since the regulations do not state that Medicaid pays before Medicare, the existing order of payment remains unchanged, that is, Medicare is primary; Medicaid is the payer of last resort.

However, § 411.26(a) provides that Medicare has a right to recover before Medicaid from any third party entity that, under section 1862(b) of the Act, is primary to both Medicare and Medicaid. Thus, if both Medicare and Medicaid have paid for services covered by such a third party payer and the amount payable by the third party is insufficient to reimburse both programs in full, Medicare must recover first. Medicare's priority right of recovery is appropriate and does not violate the concept of Medicaid being the payer of last resort. Under section 1862(b) of the Act, the Medicare program (1) may recover its benefits from a third party payer, (2) is subrogated to the right of a Medicare beneficiary and the right of *any other* entity to payment by a third party payer, and (3) may recover its payments from *any* entity that has been paid by a third party payer. Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) if payment can reasonably be expected by a third party that is primary to Medicare. If a third party pays, Medicare makes no payment to the extent of the third party payment. Delay of a third party payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, if a third party pays less than the charges, Medicare may be responsible for paying secondary benefits. If a third party pays the charges, Medicare may not pay at all.

Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment when none is authorized under the law or improperly increasing the amount of any Medicare secondary payment.

C. Self-implementing Statutory Changes

The following changes were based on self-implementing provisions of the statute that did not require us to exercise any discretion in implementing the corresponding regulation changes. We received no public comments on these provisions.

1. Removal of upper age limit for working aged. This change is reflected in § 411.70 of these final regulations.

2. Coverage of services that are reasonable and necessary to carry out the purposes of the patient outcome evaluation program. This change is reflected in § 411.15(k)(4) of these final regulations.

To Implement Policy Changes

A. To Ensure Identification of Other Payers that Are Primary to Medicare and Prompt Reimbursement When the Beneficiary, Provider, or Supplier Receives Payment from these Payers

1. *Background.* a. Part 489 of the Medicare rules deals with provider agreements. Section 489.20, which sets forth the commitments that a provider must make when it executes a provider agreement, did not include any requirement that the provider identify other insurance, bill primary payers before billing Medicare or refund Medicare payments that duplicate payments by a payer that is primary to Medicare. Previous rules did not expressly address HCFA's right to obtain information from another payer with whom a claim had been or could have been filed. Although the changes in the law have clarified HCFA's ability to recover conditional payments, it is

obvious that there can be no recovery without identification of other insurers that are primary to Medicare.

Furthermore, in order to determine Medicare's proper payment under the law, it may be necessary for HCFA to contact other payers that may be primary to Medicare with regard to benefit coordination.

2. *Proposal.* We proposed to amend § 489.20 to require providers to make four additional commitments, as follows:

a. To maintain a system for identifying, during the admission process, other payers that are primary to Medicare.

b. Except in the case of liability insurance, to bill the other insurer first.

c. When it receives payment from both Medicare and another payer that is primary to Medicare, to reimburse Medicare within 30 days of receipt of the duplicate payment (Section 411.24, which deals with HCFA's recovery rights, would also require beneficiaries and other parties that receive duplicate payments to reimburse HCFA within 30 days of receipt of the duplicate payment.)

d. If it receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim with that payer—

- To bill Medicare only to the extent that secondary benefits would have been payable if the primary insurer had reimbursed the provider on the basis of a proper claim; and
- To charge the beneficiary no more than it would have been entitled to charge if it had filed a proper claim with the primary insurer.

(This fourth commitment is discussed under section H of this preamble, which deals with Medicare Secondary Payments.)

We proposed to stipulate, in § 411.24(a), that the filing of a Medicare claim, by or on behalf of the beneficiary, expressly authorizes the third party payer to release any information pertinent to the Medicare claim.

3. *Comments and responses.*

Comment—One commenter objected to the requirement that would be added to the provider agreement with respect to primary payments reduced because of failure to file a proper claim. Under the new requirement, a provider who had received a reduced payment from a primary insurer because it had not filed a proper claim with that insurer would be permitted—

- To bill Medicare only to the extent that secondary benefits would have been payable if the primary payer had not reduced its payment because of the lack of a proper claim; and
- To charge the beneficiary no more than it would have been entitled to charge if it had filed a proper claim.

The commenter stated that, under contract law, the beneficiary should be responsible to pay the hospital the difference in payment that is attributable to the provider's failure to bill properly.

Response: The changes to § 489.20 require the provider to maintain a system to identify other primary payers and to bill them before billing Medicare, except in the case of liability insurance. The provider must, needless to say, submit a proper bill to the primary payer in order to obtain the payment due.

The Secretary establishes the conditions for participation in the Medicare program. A provider, if it wishes to participate in Medicare, must agree to comply with these conditions. We believe that neither the beneficiary nor Medicare should be responsible for reimbursing a provider for a primary payer's reduction of payment when that reduction is the result of the provider's failure to submit a proper claim as required. As discussed earlier in this preamble, we would make an exception if the provider can show that its failure to file a proper claim was solely the beneficiary's fault.

Comment: Several commenters were concerned with the provision of § 489.20(h), which requires the refund of any Medicare payment within 30 days of receipt of the duplicate third party payment. One commenter stated that duplicate payments are entered into a credit balance account, which is reviewed monthly, but frequently it takes longer than 30 days to identify the party to whom the refund is due.

Response: Many providers do not refund credit balances until those balances are identified and reported by HCFA auditors. Accordingly, we believe it is necessary to require that providers regularly review those accounts and make refunds to Medicare as may be appropriate. In view of the difficulty some providers may encounter, we will change the time limit for refunds from 30 days to 60 days of receipt of the subsequent payment.

Comment: Several commenters objected to the requirement that hospitals maintain a system which, during the admissions process, identifies any primary payers other than Medicare. Some of these commenters envision detailed and costly data processing systems.

Response: Section 489.20(f) incorporates into regulations a required practice that is currently found in the provider manuals. This requirement is that providers question beneficiaries during the admissions process to identify potential other party payers. This is not a new requirement and has not been found to be costly or burdensome.

Comment: One commenter expressed concern that § 411.24(a), (which states that the filing of a claim by or on behalf of a beneficiary constitutes an express authorization for release to Medicare of any information pertinent to the Medicare claim) may violate the National Association of Insurance Commissioners (NAIC) Model Insurance Privacy and Confidentiality Act.

Response: Authorization to release information necessary to process the claim is part of the Medicare claims filing procedures. This rule gives notice to third party insurers and other entities (including State Medicaid and workers' compensation agencies, and data depositories) that anyone filing a Medicare claim has authorized Medicare to obtain information relevant to that claim.

We recognize that Medicaid programs are not third party payers, that is, are not primary to Medicare. However, a Medicaid agency may have information that is relevant to a Medicare claim against a third party. A State Medicaid agency must release any information pertinent to a Medicare claim on request. HCFA will use the information for Medicare claims processing and coordination of benefits purposes only.

B. To Reflect a Changed Interpretation of the "Immediate Relative" Exclusion

1. *Background.* a. Section 1862(a)(11) of the Act precludes payment for expenses that "constitute charges imposed by an immediate relative of the beneficiary or a member of the beneficiary's household". Previous § 405.315, which implemented what is commonly referred to as the "immediate relative exclusion"—

(1) Referred only to Medicare Part B;

(2) Barred payment for charges other than actual costs incurred by the physician or other person (hereafter referred to as "out-of-pocket expenses") for items furnished to relatives or household members;

(3) Defined "immediate relative" and "member of household";

(4) Noted that the person who imposes the charges may be a person other than the one who furnished the services;

(5) Exempted from the exclusion—

(a) Charges imposed by a partnership except when all the partners bear the excluded relationship to the patient; and

(b) Charges imposed by a corporation, regardless of the beneficiary's

relationship to the directors, officers, and stockholders of the corporation; and

(6) Made the exclusion applicable to charges imposed by an individual proprietorship if the individual who owns and operates the business is an immediate relative or member of the beneficiary's household.

b. Reexamination of § 405.315 led us to conclude that our previous interpretation of section 1862(a)(11) of the Act was inconsistent with the purpose of that provision, namely—

(1) To bar Medicare payment for items and services that would ordinarily be furnished gratis because of the relationship of the provider or physician to the beneficiary; and

(2) To avoid payment for medically unnecessary services.

c. Congress recognized that, in family situations, it is difficult to differentiate between medically necessary services and those that are furnished because of affection or concern. Thus, the exclusion was also intended to guard against potential program abuse.

The prohibition is unqualified. Neither the statutory language nor the legislative history support certain of our previous interpretations under which we—

(1) Limited the exclusion to services of physicians and suppliers, payable on a charge basis under Medicare Part B, while continuing to pay for services payable under Medicare Part A, and for actual out-of-pocket expenses incurred by physicians or suppliers to furnish their relatives items such as drugs or prosthetic devices; and

(2) Exempted from the exclusion physicians who are members of a partnership or corporation.

d. We have concluded that Congress intended to exclude the following:

(1) Services furnished under Medicare Part A as well as under Medicare Part B.

(2) All charges imposed by persons having an excluded relationship, including out-of-pocket expenses.

(3) Services furnished by physicians who are immediate relatives or household members, regardless of whether they work within a partnership or a professional corporation, or as individual practitioners.

2. *Proposal.* We proposed to revise § 405.315 (redesignated as § 411.12) to—

a. Remove the reference to Medicare Part B, so that the exclusion applies to both parts of the Medicare program;

b. Remove the exemption of out-of-pocket expenses;

c. Amend the definition of "immediate relative" to include adoptive sibling and spouse of grandparent or grandchild, which were omitted inadvertently; and

d. Specify that the exclusion applies to the following:

(1) Physician services and services furnished incident to those services if the physician who furnished the services or who ordered or supervised services incident to his or her services has an excluded relationship to the beneficiary, even if the bill or claim is submitted by a nonrelated individual or by an entity such as a partnership or a professional corporation.

(2) Services other than physician services when charges are imposed by—

(a) An individually owned provider or supplier, if the owner has an excluded relationship to the beneficiary; or

(b) A partnership, if any of the partners has an excluded relationship to the beneficiary.

Charges imposed by a corporation other than a professional corporation would not be excluded.

3. *Comments and responses.* We received no comments on these proposals.

C. To Clarify the "No Legal Obligation to Pay" Exclusion as It Applies to Services Furnished to Prisoners

1. *Background.* Section 405.311, which implemented section 1862(a)(2) of the Act, precludes Medicare payment for services when—

- The individual who receives the services has no legal obligation to pay for them; and
- No other person has a legal obligation to provide or pay for those services.

Prisoners generally have the status of public charges and as such, have no obligation to pay for the medical care they receive. Under those circumstances, previous § 405.311 barred Medicare payment. However, § 405.311 was not clear concerning the applicalion of the exclusion when a prisoner received services and is legally obligated to pay for the services. General instructions issued by HCFA provide for payment in the latter circumstances. Under those instructions, the fact that State law or regulation provides that certain prisoners or groups of prisoners may be charged for medical care is not enough to establish legal obligation. It is necessary to show that the State regularly enforces the legal obligation by routinely billing and seeking collection from all these prisoners for medical care they receive.

2. *Proposal.* We proposed to specify in the pertinent rule (now § 411.4) that Medicare payment for services to prisoners may be made—

- Only if State law requires prisoners to repay the cost of the services; and
- Only if the State actually enforces the requirement by billing and pursuing collection of amounts owed in the same way and with the same vigor that it pursues the collection of other debts.

3. *Comments and responses.*

Comment: The commenter believes that State and local officials try to avoid paying for medical care furnished to persons in their custody but who are not formally charged with a crime. For Medicare to benefit from the provision in § 411.4 relating to prisoners, the commenter believes that local officials would have to be held responsible for anyone in their custody whether or not they have been charged.

Response: Section 411.4 provides that Medicare will not pay for services furnished to persons in the custody of State and local officials under a penal statute whether or not they have been formally charged with a crime. The regulation is in accord with State law and legal precedents that require State and local penal officials to provide persons in their custody with a reasonable level of medical care. It is unnecessary for the regulation to hold officials so responsible, even if that could be done by Federal regulation. If a provider encounters an official that disclaims responsibility for furnishing care to a beneficiary in custody, the provider may enlist the aid of its Medicare intermediary to inform the official that Medicare will not pay in these cases. The intermediary may also explain the circumstances under which the regulations allow Medicare payment when State law and practice hold individuals responsible for paying for medical care furnished by the State.

D. To Clarify the Rules on the Exclusion of Services Furnished Outside the United States

1. *Background.* Section 405.313 of the previous rules, based on section 1862(a)(4) of the Act—

- Excluded services that are not furnished within the United States; and
- Defined the "United States" to include the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

General instructions issued by HCFA further specify that—

- U.S. territorial waters are part of the United States; and
- Shipboard services furnished in a U.S. port or on the same day the ship arrived at, or departed from, that port are considered as furnished in U.S. territorial waters.

There were three reasons for revising this rule:

- The definition of "United States" needed to be expanded to include the Northern Mariana Islands. Under the Covenant to establish the

Commonwealth of the Northern Mariana Islands (Pub. L. 94–241), effective January 9, 1978, "those laws which provide Federal services and financial assistance programs * * *" apply to the Marianas as they do to Guam.

• The "same day" rule was too vague and too broad to be satisfactory. It could result in claims for services furnished in a foreign port (for example, in the Bahamas) that is less than 24 hours sailing distance from a U.S. port.

• Despite the specific language of the current definition of "United States", people tended to think that facilities owned and operated by the U.S. government are part of the United States, no matter where in the world they are located. As a result of this misconception, we frequently received claims for services furnished in U.S. Army hospitals in Europe, the Canal Zone, etc., and requests for hearings on the denial of benefits for those services.

2. *Proposal.* Consistent with the preceding discussion, we proposed to—

• Add the Northern Mariana Islands and U.S. territorial waters to the definition of the United States;

• Specify that shipboard services are considered furnished in U.S. territorial waters if they are furnished while a ship is in a U.S. port or within 6 hours before arrival at, or after departure from, a U.S. port; and

• Specify that a hospital that is not located within the United States as defined, is not part of the United States even though it is owned or operated by the U.S. government.

3. *Comments and responses.* We received no comments on these proposals.

E. To Update and Clarify Policies on Services Covered under Workers' Compensation

1. *Background.* The workers' compensation rules needed revision to remove outdated content and to make them consistent with the rules pertaining to other types of insurance that are primary to Medicare.

Some of the rules had become obsolete because workers' compensation laws and plans and medical care delivery systems have changed. For example, the laws and plans have fewer limitations on number of days of care and amounts payable, and ward accommodations are no longer used.

2. *Proposal.* In the NPRM, we proposed to—

• Delete obsolete provisions, including those that deal with limitations in workers' compensation laws regarding the number of days of care or the amount payable, and payment for ward accommodations.

• Delete the provision dealing with Medicare payment for ancillary services not payable by workers' compensation. These cases would be covered by §§ 411.32 and 411.33, which set forth the basis and amounts of Medicare secondary payments when a third party payer does not pay in full.

• Stipulate that the beneficiary must cooperate in any action HCFA takes against a workers' compensation carrier. Since this rule applies to all entities that are primary to Medicare, it would be set forth in § 411.23.

• Apply workers' compensation payments toward Medicare deductible amounts (§ 411.30).

• Specify different policies for lump sum workers' compensation payments that are commutations of future benefits (§ 411.46), and those that are compromise settlements (§ 411.47).

• Make clear that Medicare does not pay for services for which payment would have been made under the Federal Black Lung Program administered by the Department of Labor (DOL) if the DOL fails to pay solely because the provider did not obtain a provider number that must be included with the claim for DOL payment (§ 411.40(b)).

3. *Comments and responses.*

Comment: Section 411.40 makes a provider responsible for the payment of services if payment could have been made under the Black Lung Program, but is precluded because the provider failed to obtain a provider number from the DOL. A commenter suggested that this provision ignores normal contract law, which holds a patient responsible for the services.

Response: While it is true that a Medicare beneficiary is ultimately responsible for services that are not payable by Medicare, providers also have obligations to their patients and to the Medicare program under their provider agreements. Provider numbers are routinely issued by the DOL and are needed in order for Black Lung claims to be processed. We do not believe that it is unreasonable for Medicare as the secondary payer to require a provider to comply with a routine obligation of this nature.

F. To Incorporate Changed Policy on No-fault Insurance

1. *Background.* With respect to no-fault insurance, current rules—

• Applied only to *automobile* no-fault, not to other kinds of no-fault insurance such as homeowners;

• Provided for Medicare conditional payment if the no-fault insurance payment will be delayed "for any reason";

• Did not address the beneficiary's responsibility for obtaining payment under no-fault insurance; and

• Did not permit third party payments to be credited against the Medicare deductibles. (This limitation also applied to payments under workers' compensation, automobile medical and liability insurance.)

We believe that—

• Medicare should be secondary payer to all types of no-fault insurance, not just automobile no-fault, since the law is not limited to automobile no fault.

• Medicare should not make a conditional payment when a no-fault insurer refuses to pay primary benefits on the grounds that it is secondary to Medicare.

• Beneficiaries should be responsible for taking necessary action to obtain any payments that can reasonably be expected under no-fault insurance as they are required to do in the case of workers' compensation.

• All third party payments should be credited against the Medicare deductibles. (The more recent amendments provide for employer plan payments to be credited.)

2. *Proposal.* We proposed the following changes:

• In § 411.50(b), to expand the definition of "no-fault insurance" to include all other types of no-fault insurance, in addition to automobile no-fault.

• In § 411.53, to provide that Medicare conditional payment will not be made if the no-fault insurance payment will be delayed because the insurer claims that its benefits are secondary to Medicare benefits.

• In § 411.51, to require that beneficiaries take any necessary action to obtain payment under no-fault insurance, and specify the circumstances under which Medicare does or does not pay.

• In § 411.30, to provide that all third party payments are credited towards the Medicare deductibles.

3. *Comments and responses.*

Comment: One commenter objected to the expanded definition of no-fault insurance in section 411.50, which provides that Medicare is secondary to non-automobile no-fault insurance such as home owners and commercial insurance. The commenter stated that "no-fault" insurance is unique to automobile insurance and, therefore, the term should not be defined to include non-automobile insurance.

Response: The expanded definition of no-fault insurance is based on the

language of section 1862(b)(1) of the Act, which reads, in part:

"Payment under this title may not be made with respect to any item or service to the extent payment has been made, or can reasonably be expected to be made promptly * * * under a workmen's compensation law or plan * * * or under an automobile *or* liability insurance policy or plan (including a self insurance plan) *or* under no-fault insurance." (Emphasis added.)

The disjunctive "or" in the statutory language, which twice separates the word "automobile" from the expression "no-fault insurance", indicates that Congress intended that the term "no fault insurance" encompass any type of insurance payments made without regard to who may have been responsible for the injury, not just automobile no-fault insurance.

Comment: A commenter believes that § 411.53(a) should be amended to exclude from Medicare coverage cases when a no-fault insurer has made only a partial payment. It would then be possible for providers to collect their full charges. The commenter stated that certain no-fault insurers are denying full payment alleging that hospitals are entitled to receive no more than the Medicare DRG payment for Medicare beneficiaries who are involved in automobile accidents, even though the no-fault insurer is billed. The commenter proposes to remedy this situation by having the final regulations state that when a no-fault insurer makes only a partial payment, the services should be excluded from Medicare coverage. This would allow the provider to be able to enforce collection of the amount due that exceeds the Medicare DRG payment.

Response: Under section 1862(b) of the Act, responsibility for payment for Medicare covered services is shifted from Medicare to certain third party insurers. The fact that Medicare is not the primary payer does not affect the status of the services as covered services under the Medicare law. Section 1862(b) is a nonpayment rather than a noncoverage provision. Thus, when a private insurer is a primary payer, Medicare may still be obligated to pay secondary benefits up to the DRG amount in accordance with the law. To amend Medicare regulations as the commenter wishes would be contrary to the law. However, we have included a new section 411.31 entitled, "Authority to bill third party payers for full charges", which states that providers may bill third party payers (except liability insurers) and expect their full charges to be paid, unless this would specifically contravene a law or an agreement with the insurer.

There is no action that HCFA can take to force a third party payer to pay in excess of the DRG amount. However, if a third party payer pays the DRG amount when charges exceed the DRG, but pays charges when the DRG is greater, a provider may have a basis for prevailing on a third party payer to change its method of reimbursement. This could be accomplished either through the Office of the State Insurance Commissioner (or other appropriate State authority) or through the courts.

Comment: One commenter proposed that the provision for Medicare conditional payments when the workers' compensation or no-fault payment will not be made promptly (§§ 411.45 and 411.53) be modified to include HMOs, health and medical care corporations, commercial health insurance, Taft-Hartley Plans, and other self-funded arrangements. The basis for the suggestion is that all these carriers and employers have an obligation to assume liability for payment.

Response: We do not agree that these classes of possible third party payers should be mentioned since payments made by them as a class may not always be primary to Medicare. To the extent that individual payers are primary to Medicare, they are already included in the provision. Furthermore, it would not be correct to say that conditional payments may be made when an *employer plan* does not pay promptly. Section 1862(b)(1) of the Medicare law states that when workers' compensation or no-fault insurance does not pay promptly, Medicare may pay conditional benefits. The provisions dealing with employer group health plans (sections 1862(b) (2) and (3)) do not include the term "promptly". If these payers were included as a class, it would appear to create this improper result.

G. To Clarify Policies on Liability Insurance

1. *Background.* With respect to liability insurance, current rules—

a. Left the way open for an insured individual or other entity to avoid use of its liability coverage by paying out-of-pocket instead of reporting the incident to the liability insurer.

b. In defining terms, under § 405.322—

(1) Included self-insured plans within the definition of liability insurance;

(2) Included, within the definition of "self-insured plan", a statement that it is a plan under which an entity is "authorized by State law to carry its own risk";

(3) Did not specify that, for purposes of the Medicare Act, payments under the Federal Tort Claims Act (FTCA) are a type of liability payment under a self-insured plan; and

(4) Did not specify that payments made by an insured party to cover deductibles imposed by the liability insurance policy are considered to be liability insurance payments.

c. Did not clearly state that a provider has no right to charge a liability insurer or a beneficiary who has received a liability insurance payment;

d. Provided that Medicare will make a conditional payment if the beneficiary has filed or has a right to file a liability claim; and

e. Did not specifically include underinsured motorist insurance (except as a type of uninsured motorist insurance) in the definition of liability insurance.

In the situation noted under the above paragraph a, HCFA was paying for services covered by liability insurance, with no opportunity to recover from the insurer. The omissions from the definitions aggravated the problem.

As explained in the preamble to the NPRM, providers should not be permitted to bill a liability insurer or to place a lien against a liability settlement for the following reasons:

- With respect to Medicare covered services, sections 1866(a) and 1842(b)(3)(B)(ii) of the Act permit providers, and suppliers who have accepted assignment, to bill the beneficiary only for applicable deductible and coinsurance amounts.
- Services for which liability insurance payments have been made or can reasonably be expected do not lose their identity as covered services. Since the amounts a beneficiary receives or is due to receive from a liability insurer are his or her own funds, billing the liability insurer or the beneficiary or filing a lien against the settlement would violate the statutory prohibition.
- In the case of liability insurance, the provider or supplier has no standing to sue or send a bill to the insurer. Since only the beneficiary—not the provider or supplier—has a right to sue the liability insurer, a bill to the liability insurer or a lien against the settlement would, in effect, be a bill to the beneficiary.
- Bills to liability insurers or beneficiaries or liens against liability settlements, if effectuated, reduce the beneficiary's recovery from the insurer unduly, since liability payments include compensation for damages other than medical expenses.

The restriction does not apply to providers and suppliers that furnish services to individuals enrolled—

- In a health maintenance organization (HMO) or a competitive medical plan (CMP) that has a contract with the Secretary under section 1876 of the Act; or
- In a health care prepaid plan (HCPP) that is paid in accordance with section 1833(a)(1)(A) of the Act.

(The rules applicable to HMOs and CMPs are set forth in § 417.528 of the Medicare regulations, and those rules, through cross-references in Subpart D of Part 417, are made applicable to HCPPs.)

Although it is necessary to limit provider charges, we believe that, because of HCFA's clarified recovery rights, no limitations need be placed on making Medicare conditional payments in liability insurance cases.

2. Proposal.

In the NPRM, we proposed to make the following changes:

a. In § 411.50(b), to—

(1) Expand the definition of "liability insurance payment" to include out-of-pocket payments by entities that carry liability insurance, including payments by the insured party to cover deductibles required by the liability policy; and

(2) Revise the definition of "self-insured plan" to include the FTCA and to remove the statement "authorized by State law".

b. Under § 411.54, to specify that providers, and suppliers who have accepted assignment, are precluded from billing liability insurers, from billing beneficiaries who have received liability insurance payments, and from filing liens against liability settlements.

c. In § 411.52, to specify that a conditional payment may be made when Medicare benefits are claimed for treatment of an injury or illness allegedly caused by another party.

d. In § 411.50(b), to clarify the definition of "liability insurance" by specifying that underinsured motorist insurance is an example of liability insurance.

3. *Comments and responses.*

Comment: Several commenters believe that the MSP statutory provisions allow hospitals to recoup, from a beneficiary's liability recovery, up to the full amount of the hospital's charges, even though the lower prospective payment system (PPS) amount would constitute payment in full if the services were paid for by Medicare. The commenters believe that Medicare program instructions and the proposed conforming regulations are unconstitutional and invalid in limiting hospitals to the PPS amount. The commenters also believe that the regulations are contrary to the statute (§ 1862(b)(1)), which they assert excludes from Medicare coverage any services for which payment has been made or can reasonably be expected to be made promptly under liability insurance.

Response: Allowing hospitals to file liens and bill liability insurers for the hospitals' full charges (rather than billing Medicare) would violate the participating hospitals' commitment not to bill Medicare beneficiaries for covered services. As noted above—

- Services that are payable under liability insurance are still Medicare covered services; and
- Allowing hospitals to file liens and to bill liability insurers for their full charges could result in out-of-pocket losses for beneficiaries. If the hospital's charges were more than the liability insurance payment, the hospital could take the beneficiary's entire recovery.

Comment: A commenter questioned whether or not § 411.54 of the proposed regulations, which prohibits hospitals from billing liability insurance, applies to hospitals affiliated with health maintenance organizations (HMOs) and health care prepayment plans (HCPPs).

Response: As noted above, § 417.528 of the current Medicare rules applies to HMOs with contracts under section 1876 of the Act whether paid on a cost or capitation basis and to HCPPs. HMOs are permitted to bill liability insurance because the statute explicitly instructs them to do so. HCPPs, although paid under section 1833(a)(1)(A) of the Act, are subject to the same rules as HMOs as provided in § 417.802 of the Medicare regulations. In these final rules, § 411.54(d)(2) is revised to reflect this policy.

Comment: A commenter asked if the standard provider agreement will be modified to recognize that HMO-affiliated hospitals that treat beneficiaries enrolled under a risk-basis contract are permitted, under § 417.528(b) to bill liability insurers.

Response: HMO affiliated hospitals do not bill on behalf of the HMO. HMOs do their own billing, and may bill liability insurers under § 417.528(b). There is no need to modify the provider agreement.

Comment: An organization that enrolls some Medicare beneficiaries under a risk-basis HMO contract with Medicare and also enrolls other Medicare beneficiaries under an HCPP arrangement asked whether for the beneficiaries under a risk-basis HMO contract it could charge a liability insurer on the basis of hospital charges or was limited to the Medicare DRG amount.

Response: Section 417.528(b) authorizes an HMO to "charge the insurance carrier, employer, or other entity * * * or the Medicare enrollee. * * *" This regulation does not specify the basis for the charge because the law does not authorize HCFA to require a particular billing method or basis (The law provides that HMOs are to charge "in accordance with the charges allowed under such law or policy", but makes no mention of the Medicare DRG amount.) We expect an HMO to use a uniform method and basis for billing all enrollees.

Comment: Since HCFA pays HCPPs on an aggregate cost (rather than service-by-service) basis, the commenter asked how the Medicare carrier can determine how much to recover from a liability insurer for Part B services for which the HCPP is not allowed to bill the liability insurer. The commenter argued that the HCPP should be permitted to bill the liability insurer for Part B services, and include as an offset on its cost report, any sums thus obtained from the insurer.

Response: As noted above, we have revised § 411.54 to permit HCPPs to bill liability insurers just as HMOs and CMPs with contracts under section 1876 of the Act.

Comment: The commenter asked whether (in cases involving liability insurance) a hospital that must bill Medicare and accept the DRG payment amount, must comply with a beneficiary's request for a statement of billed charges rather than the DRG amount.

Response: It is common practice (and may be required under State law) for hospitals to furnish patients with a statement of billed charges even though the hospital may have been paid less by a third party, for example, because of a discount agreed to by the hospital with an insurer, or under a State program. There is no reason to treat a Medicare beneficiary's request differently.

We believe that any patient has a right to know the charges for the services he or she received. Moreover, hospital charges are the standard measure of damages applied in tort recovery actions that involve liability insurance. A patient who is denied information on the amount of the hospital charges would find it very difficult to prove the nature and extent of his or her injuries. Accordingly, we have added this requirement at § 411.54.

Comment: The commenter is not clear as to whether or not the proposed regulations, particularly the prohibition

against billing liability insurance (§§ 411.54(c) and 489.20(g)), apply to outpatient hospital and physician services.

Response: The regulations state that they apply to providers of services and suppliers. We generally define terms at the beginning of the Code of Federal Regulations that applies to the Medicare and Medicaid programs (§§ 400.200 through 400.203). In § 400.202, the term "provider" is defined as including entities that furnish outpatient hospital services; the term "supplier" is defined as including physicians. The meaning of these terms is the same throughout the regulations, unless some other meaning is stated. The term "Medicare payment" used here means payment for any type of covered service, including hospital outpatient services.

Comment: The commenter believes that the regulations should make clear whether Medicare is the primary payer when the person presumed to have caused the injury has no liability insurance.

Response: We agree that clarification is needed. We have modified the definition of "self-insured plan" in section 411.50(b) so that it does not imply that self-insured plans are *limited* to entities that engage in a business, trade or profession. The revised definition cites such entities, along with nonprofit organizations, as examples of entities that may have self-insured plans. We note that the mere absence of insurance purchased from a carrier does not necessarily constitute a "plan" of self-insurance. If HCFA determines that the absence of insurance purchased from a carrier does not constitute a "self-insured plan" in a particular case, HCFA will not attempt to recover its payments from the entity that lacks insurance coverage. Section 411.50(b) also defines "liability insurance payment" as including "out-of pocket payments" and payments made under a self insured plan. Under these definitions, payments made by the self-insured individual or entity are primary to Medicare.

Comment: The commenter questioned if a provider that has been paid part of its charges by a no fault automobile insurer can bill Medicare for its regular DRG payment when liability insurance may also be available but cannot be billed because of the prohibition against billing liability insurance. The commenter believes that permitting the provider to bill for the entire DRG payment would not adversely affect the amount of the settlement or judgment the beneficiary would otherwise receive.

Response: Sections 411.32 and 411.33(e) make clear that when a provider has received a portion of its charges from a third party payer, that provider may bill Medicare only for secondary payment. Although the commenter's suggestion would not, it is true, disadvantage the beneficiary seeking a liability payment, it would be inconsistent with the statutory provisions which require that Medicare pay only to the extent that payment has not been made by the third party. Thus, Medicare may make only a secondary payment.

Comment: Several hospitals commented that being paid by Medicare an amount based on a DRG rather than their charges shortchanges them. They consider that, since liability insurers pay all the beneficiary's accident-related medical expenses based either on charges or on what Medicare has paid, payment of the DRG amount either enriches the beneficiary or saves the insurer money. Further, the commenters believe that limiting hospitals to the PPS amount would cause financial hardship, because the cost of treating the traumatic injuries typical in liability insurance cases is much greater than the amount allowed under Medicare PPS. The commenters suggest that they be permitted to collect their full charges from liability insurance.

Response: HCFA's policy of requiring providers to bill Medicare in liability insurance situations reflects Congressional intent. The legislative history of section 1862(b)(1) of the Act states that Medicare would "pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined". H.R. Rep. No. 96–1167, 96th Cong., 2d Sess. 389 (1980). The Senate history reflects similar intentions. Staff of the Senate Committee on Finance, 96th Congress 2d Session, *Spending Reductions: Recommendations of the Committee on Finance Required by the Reconciliation Process in Section 3(a)(15) of H. Con. Res. 307, the First Budget Resolution for Fiscal Year 1981* 42 (Committee Print 1980). Additionally, there are programatic reasons for HCFA's policy.

Payment of full charges would enable hospitals to profit at the expense of Medicare beneficiaries. Hospitals are allowed to collect their charges when insurance other than liability is primary under the MSP provisions because that procedure does not disadvantage beneficiaries. Insurers other than liability pay according to the terms of the coverage *for which the beneficiary has contracted.* The amounts paid are for express losses such as medical expenses, lost wages, etc. When a hospital collects from such insurers, it is *not* collecting from the beneficiary's personal funds. Liability insurance is different. It is not a contractual arrangement between a beneficiary and an insurer; it is a contractual arrangement between a policyholder (i.e., the tortfeasor) and an insurer, which is intended to protect the *policyholder* from potential financial loss resulting from a tort for which he or she is responsible. As noted above, and in the preamble to the proposed rule, a provider or supplier has no standing to sue or send a bill to the insurer. Since only the beneficiary (i.e., the injured party)—not the provider or supplier—has a right to sue the liability insurer, collecting from a beneficiary's liability insurance settlement is tantamount to collecting from the beneficiary's personal funds.

Moreover, liability insurance is unlike other insurances which specify the amounts or percentages payable for various medical procedures and whether or not such procedures are covered by the insurer. Liability insurance generally provides a lump sum coverage amount for all liability, including any unspecified medical damages. Thus, in liability insurance contexts all allocations are subject to negotiation or court order. If more is paid for medical expenses, the insurer will try to pay less for other losses or to compensate the injured party less for intangibles like pain and suffering, which never apply in non-liability insurance contexts.

When the amount of liability insurance is small in relation to the amount of a hospital's charges because the limits of the policy are low, or because the insurer offers a small amount to settle a case of questionable liability, the hospital may collect the entire liability payment remaining after payment of the beneficiary's attorney's fees. That would leave the beneficiary nothing for pain and suffering, etc., and could leave Medicare liable for the beneficiary's other covered medical expenses.

HCFA's policy, therefore, does not serve to enrich beneficiaries at the expense of hospitals. Rather, it protects beneficiaries from being disadvantaged in liability insurance cases. HCFA's policy does not save liability insurers money, since their payments are generally based on the injured person's medical *bills*, not on amounts paid by the person's insurers, including Medicare, which may be less than the billed amounts. In many States, evidence of insurance is not admissible in tort actions, or is admitted only for

limited purposes. In addition, under the commonly applicable "collateral source" rule, insurance that may cover medical expenses collateral to the defendant's obligation to pay, such as disability or health insurance, is not considered in determining amounts a person receives from the defendant.

Furthermore, the Medicare statute establishes the methodology to be used in paying for hospital services. When hospitals are paid in accordance with that methodology, they are getting amounts which, on average, reflect the cost of furnishing services economically and efficiently. They are not getting less than Congress mandated. While they may get less than their charges in a particular case, in other cases they may get more.

Comment: A commenter believes that existing regulations (§ 405.324(a)(3)(ii)) clearly recognize that hospitals would be permitted to collect liability insurance for services to Medicare patients.

Response: Section 405.324(a)(3)(ii) recognizes that hospitals might collect from liability insurers. However, that regulation works in the context of the whole body of regulations and the statute itself. Other regulations make clear that the Medicare beneficiary is to be protected from having to pay anything for covered services except certain specified amounts. The overriding principle is that the beneficiary is to be no worse off because of a particular provision than without it. That is why hospitals were once permitted to bill *willing* liability insurers. This was expected to occur after a relatively minor injury when the responsible party was anxious to settle the matter and the beneficiary asked for little more than that his medical care be paid for by the responsible party or its insurer.

Hospitals were never authorized to file liens against potential liability payments. Liens, by their very nature, smack of compulsion, rather than volition. When it came to HCFA's attention that hospitals were filing liens, and in light of 1984 changes in the statute making it clear that Medicare payment could be denied only if a liability insurance payment could be expected to be made *promptly*, the policy was changed to prohibit hospitals from billing liability insurers in any case. For the following reasons, the clarified and revised policy is the only one in keeping with the letter and spirit of current law:

1. Only rarely can liability insurance be expected to pay "promptly".

2. Hospitals had misused their option to bill "willing" liability insurers by—

- Billing when the beneficiary had filed suit and liability was being disputed; and
- Filing liens.

The prohibition against billing liability insurers will apply nationwide except in the State of Oregon. In *Oregon Association of Hospitals et. al. v. Sullivan* (Case No. CV 88-625 FR), the United States District Court for the District of Oregon has ruled that hospitals have the right "to recover up to their total charges from a liability insurer that is a primary payer and can reasonably be expected to pay promptly". HCFA is appealing this ruling. However, while HCFA's appeal is proceeding, HCFA will comply with the court's ruling in the State of Oregon. Accordingly, unless the ruling is reversed on appeal, or overturned by a statutory clarification, a special rule applies. In Oregon, hospitals may, as an alternative to billing Medicare, collect up to their full charges from a liability insurer that pays "promptly". For general purposes, § 411.21 defines "promptly" with respect to third party payments as payment made within 120 days after receipt of a claim. For the special Oregon situation, with respect to liability insurers, § 411.50 defines "prompt" payment as payment within 120 days from the earlier of the following:

- The date a claim, or lien against a potential liability settlement, is filed.
- The date a service was furnished, or, in the case of inpatient hospital services, the date of discharge.

If the liability insurer does not pay within the applicable 120-day period, the hospital may not collect from the liability insurer because the payment cannot "reasonably be expected to be made promptly". In such case, the hospital must withdraw its claim or its lien against a potential liability settlement, or be subject to HCFA sanctions, such as termination of its right to participate in the Medicare program. Sections 411.54(d) and 489.20(g) of the proposed rules are revised to reflect application in the State of Oregon.

H. To Provide Uniform Rules for Computing the Amount of Medicare Secondary Payment, and to Limit Charges When a Proper Claim Is Not Filed

1. *Background.* Under previous rules applicable to employer group health plans—

a. The Medicare secondary payment was computed on the basis of the amount of the third party payment, without reference to situations in which the latter was reduced because of failure to file a proper claim.

b. For services paid on a reasonable charge basis, the methods for computing the Medicare secondary payment differed in a way that could result in lower payments for assigned than for unassigned claims.

c. For services paid on other than a reasonable charge basis, the Medicare secondary payment was computed on the basis of the Medicare payment rate, which could be more than the charges.

In the situation noted under the above paragraph a, we believe that providers and suppliers, and beneficiaries who are not physically or mentally incapacitated, are responsible for filing proper claims and for any third party payment reduction that results from their failure to file proper claims. Therefore—

- Medicare should not have to increase its secondary payment when the primary insurer pays less because a proper claim was not filed; and
- The beneficiary should not be subject to higher charges because the provider or supplier fails to file a proper claim.

In the situations noted in paragraphs b. and c. above, we believe that—

- Lower payments for assigned claims are unfair and could discourage acceptance of assignment, which is desirable for beneficiaries; and
- The law intends that Medicare supplement the amount paid by the primary payer only in an amount that, combined with the primary payment, equals the charges for the services, or the amount the provider or supplier is obligated to accept as full payment. (When a provider or supplier is obligated to accept as full payment an amount less than its charges, HCFA considers that lower amount to be the provider's or supplier's charges.)

2. *Proposal.* To deal with the problems noted above, we proposed that—

a. When a primary insurer pays less because a proper claim was not filed—

(1) The Medicare secondary payment will be no greater than it would have been if the primary insurer had paid on the basis of a proper claim; and

(2) A provider may charge Medicare and the beneficiary no more than it would be entitled to charge if it had filed a proper claim (§§ 411.32(c) and 489.20(i)).

b. For services paid for on a reasonable charge basis (or on a monthly capitation basis that is now used for certain ESRD services), the computation method is the same for assigned as for unassigned claims (§ 411.33).

c. For services paid on other than a reasonable charge basis, a revised formula ensures that the Medicare secondary payments are not greater than the excess of the charges over the primary payments (§ 411.33(e)).

3. *Comments and responses.*

Comment: Two commenters objected to § 411.33(e), which addresses the amount of Medicare secondary payment for providers paid on a basis other than reasonable charge or capitation. They believe that it does not take into account the legislative provisions for provider payment under PPS. The commenters believe that the proposal limits payment to the provider's charges even when the PPS payment may exceed charges. The commenters believe that this provision is contrary to the PPS provisions, which provide payment based on a DRG, in that it permits HCFA to ignore the PPS rate and limit the combined third party payment and Medicare secondary payment to the provider's charges. The commenters suggested that the Medicare secondary payment be calculated by subtracting the third party payment from the gross amount payable by Medicare.

Response: As was pointed out in the Notice of Proposed Rulemaking published on June 15, 1988 (53 FR 22340), § 1862(b)(3)(B) of the Act permits Medicare secondary payments only if the employer group health plan pays less than the charges. We therefore feel that the intent of the law is for Medicare to supplement the amount paid by a primary payer up to the provider's charges. If HCFA were to base Medicare secondary payment on a PPS amount that is greater than the charges, HCFA's secondary payment policy would be anomalous. For instance, if a provider charged $10,000 for services for which the Medicare PPS rate is $18,000, and the primary payer paid $10,000, Medicare would make no payment, since the statute does not permit Medicare secondary payments where a third party payer pays the charges in full. Yet, if the third party payer paid one dollar less than the charges ($9,999), Medicare would have to pay $8,001 (the difference between the $18,000 PPS amount and the $9,999 paid by the third party payer). We have chosen a policy that does not lead to this anomalous result.

I. To Clarify Interpretation of the Working Aged Provisions.

1. *Background.* Previous rules—

a. Did not specify what is meant by "employed"

b. Did not clearly interpret how the statutory language "by reason of such employment" applies in the case of reemployed retirees and annuitants.

c. Did not specify that employer group health plans include "employee-pay-all" plans.

d. Made Medicare primary for members of a multiemployer plan whom the plan identifies as employees of employers of fewer than 20 employees (§ 405.340(b)(1)(ii)).

e. Provided (in § 405.341(d)) that an individual who was receiving employer disability payments was not considered to be employed if that individual was not receiving remuneration subject to taxation under the Federal Insurance Contributions Act (FICA), or before attaining age 65, was entitled to disability benefits under title II of the Act.

f. Provided (in § 405.341(c)(2)) that Medicare would pay primary benefits for Medicare-covered services that were not covered under the employer plan; and could make a Medicare conditional payment when employer plan payment was denied "for any reason" (§ 405.344(a)).

We considered it necessary to—

- Correct the omissions noted under paragraphs a through c above;
- Eliminate the exemption under the above paragraph d, for consistency with more recent legislation on large group health plan coverage of disabled active individuals (which does not exempt employees of employers of less than 100 employees in a multiemployer plan);
- Apply to the working aged the principle established by that same legislation, that "disabled" individuals may be considered "employed"; and
- Establish more reasonable limits with respect to the provisions noted under the above paragraph f.

2. *Proposal.* In the NPRM, we proposed to—

a. Make clear that the Medicare working aged provisions apply not only to employees but also to the self-employed, such as owners of businesses or independent contractors, and to members of the clergy and of religious bodies (§ 411.70(d)).

b. Make clear that a reemployed annuitant or retiree who is covered by an employer group health plan is considered covered "by reason of employment", even if—

(1) The plan is the same plan that previously provided coverage to that individual when he was a retiree or annuitant; or

(2) The premiums for the plan are paid from a retirement pension or fund (§ 411.72(c)).

c. Modify the definition of "employer group health plan" to make clear that it includes plans under the auspices of employers that make no financial contribution, the so-called "employee-pay-all" plans.

d. Remove from the definition of "employer group health plan" (§ 411.70(d)), the statement that a multiemployer plan does not have to pay primary benefits for individuals whom it can identify as employed by employers of less than 20 employees. (This requirement previously appeared in § 405.340(b)(1).)

e. Specify that, effective July 17, 1987, individuals who receive employer disability payments that are subject to taxation under FICA are considered employed (for purposes of the working aged provisions), even if they received social security disability benefits before attaining age 65. (July 17, 1987 is the effective date of HCFA general instructions issued under section 9319 of Pub. L. 100-203.)

f. Make clear, in § 411.75, the circumstances under which HCFA does or does not make Medicare primary payments and conditional primary payments.

3. *Comments and responses.*

Comment: Fourteen commenters opposed defining "employed" to include members of the clergy and religious orders who are paid for their services by a religious body or other entity. Most commenters stressed the disproportionate harmful effect on members of religious communities and the insufficiency of funds to pay for their medical expenses. They also considered that there is no statutory authority for the definition. They noted that the status of the clergy is not specifically addressed in section 1862(b)(3), and expressed their belief that section 210(a)(8)(A) of the Social Security Act (which defines the term "employment" for social security coverage purposes) specifically excludes the services of members of the clergy and religious orders from the term "employment".

Response: For purposes of 1862(b)(3) of the Act, the term "employed" includes not only employees, but self-employed persons such as directors of corporations and owners of businesses, as well as individuals who are engaged in "employment" as defined in section 210(a) of the Act. Contrary to the commenters' belief, section 210(a)(8) of the Act provides that, for social security purposes, the term "employment" includes service performed by members of the clergy and religious orders if an election of coverage under section 3121 of the Internal Revenue Code of 1954 is in effect. It is precisely because of this provision that members of electing orders qualify for Medicare benefits. It would be entirely inconsistent with the

statute to hold that the very employment which qualifies a person for Medicare benefits is not employment for purposes of determining that Medicare is secondary payer with respect to that person's group health plan. As with other workers covered under section 1862(b)(3) of the Act, when a member of the clergy or a religious order retires, Medicare becomes primary payer and the employer group health plan may make secondary payments. We have revised the proposed definition of "employed" to make clear that a member of a religious order is considered employed only if the religious order pays FICA taxes on behalf of the member.

Comment: Two commenters objected to including the self-employed within the definition of the term "employed." They expressed the view that self-employed individuals do not receive pay from employers and therefore should not be considered "employed." They asked which self-employed individuals are included in the definition of employed and whether employers must offer EGHP coverage to all individuals age 65 and over who are self-employed.

Response: There is nothing in section 1862(b)(3) of the Act that limits its application to "employees." This statutory provision requires that the individual be "employed" and have the group health coverage "by reason of such employment". This includes self-employment activity that is related to the entity that provides the group health coverage.

Under this provision, Medicare is secondary to employer group health plan coverage provided to a self-employed individual because of his or her self-employment activity. Although employers are not required to provide group health plan coverage to self-employed individuals, many of them do. If an employer chooses to provide coverage to self-employed individuals who are also Medicare beneficiaries, that coverage is primary to Medicare.

Self-employed persons pay taxes on self-employment income under the Self-Employment Contributions Act of 1954 and on that basis receive social security quarters of coverage for purposes of qualifying for social security benefits. Once they have earned the required quarters of coverage they are treated the same as employees for benefits under the Act, including Medicare. It would be inconsistent to hold that employment which counts toward Medicare entitlement under Title II of the Social Security Act does not count as employment for purposes of the "working aged" secondary payer provision under title XVIII of the Act. However, we recognize that section 211(b)(2) of the Act currently defines the term "self-employment income" for social security coverage as net earnings from self-employment of $400 or more. We believe that a person should not be considered self-employed for purposes of the "working aged" provision if his earnings from self-employment are less than the amount specified in section 211(b)(2). Therefore, we have revised the proposed definition of "employed" in section 411.70 to provide that a self-employed individual is considered employed for Medicare secondary payer purposes during a particular tax year only if, during the preceding tax year, the individual's net earnings from self-employment activity related to the entity that offers the group health coverage, equals or exceeds the amount specified in section 211(b)(2) of the Act.

The second part of the question relates to the Age Discrimination in Employment Act (ADEA). This Act requires employers to offer health coverage under the same terms and conditions to older and younger employees. Since the ADEA uses the term "employee", it does not apply to the self-employed.

Comment: Two commenters requested revision of section 411.72 to clarify that a reemployed individual who is a retiree or annuitant is covered by an employer group health plan "by reason of employment" only if the individual would be covered by the employer group health plan if he were a currently working nonretired person.

Response: We are clarifying the term "by reason of employment" in section 411.72. The employer must offer the same coverage to actively working former retirees and annuitants as is offered actively working non-retired individuals. If the employer does not offer group health coverage to a particular category of non-retired employee, e.g., employees hired on a contingency basis only, then the employer is not required to offer group health coverage to a former retiree who works on a contingency basis only. Coverage provided to such individuals is not considered coverage "by reason of employment," and therefore may be secondary to Medicare.

Comment: One commenter pointed out that employers and temporary employees have difficulties in adjusting to changes in Medicare's status as primary or secondary when retirees return to work on a temporary basis. Retirees may be discouraged from taking temporary jobs, particularly if they have to pay all or a portion of the premiums for insurance provided through their employers (which is primary to Medicare) instead of lower premiums for their retirement-based health insurance (which is secondary to Medicare). The commenter suggests that once an employee retires and Medicare becomes the primary payer, Medicare continue as primary until the retiree has been reemployed for at least 12 months.

Response: The law requires Medicare to be secondary payer whenever an individual has group health plan coverage "by reason of employment". The term "by reason of employment" applies to periods of temporary employment, and thus precludes Medicare from making primary payments during any period (no matter how brief) in which the individual is covered by the employer plan "by reason of employment". We recognize that there may be administrative difficulties in processing some claims when Medicare status changes from primary to secondary and back again. HCFA has instituted significant improvements in its data collection system to facilitate processing of claims in which third party payers are involved.

Comment: Several commenters objected to our proposed removal of the provision that makes Medicare primary payer for enrollees of a multiemployer plan whom the plan can identify as employed by employers of fewer than 20 employees. Some of those commenters thought that we proposed to make this change retroactive to January 1, 1983, and were particularly concerned about the impact of this retroactive change on health resources, as HCFA moved to recoup Medicare primary payments made in those circumstances. They also noted that neither the statute nor the legislative history authorized the proposed change. Congress stipulated that the working aged provisions did not apply to employers of fewer than 20 employees and did not qualify this exemption for employers that use a multiemployer plan.

Response: We did not intend to make the change retroactive and have decided not to make the change. In § 411.72 of the final rule we have restored the provision that we proposed to remove. Our decision was based on the above comments and also on—

- Comments from the religious community and others expressing concern about the disproportionate impact on small employers; and
- An opinion expressed by the Equal Employment Opportunity Commission in its Notice N–915–026 of May 12, 1988, that section 4(g) of the Age Discrimination in Employment Act (ADEA) does not require employers of

fewer than 20 employees who participate in a multiemployer plan to provide the same health insurance coverage under the same circumstances to older and younger employees. Since section 4(g) of the ADEA was enacted primarily to serve as an enforcement mechanism for the working aged provision, the two provisions should be interpreted as consistently as possible.

J. To Provide Uniform Rules for Determination of the Amount of Medicare Recovery from a Party that has Incurred Costs to Obtain a Judgment or Settlement that Resulted in a Third Party Payment

1. *Background.* Under § 405.324(b) of the previous rules, when a beneficiary received a liability insurance payment as a result of a judgment or settlement, Medicare reduced its recovery to account for the procurement costs, that is, costs such as attorney fees that the beneficiary incurred in order to obtain the judgment or settlement.

Although procurement costs are generally incurred by a beneficiary in connection with liability insurance, occasionally they may be incurred by another party or in connection with other types of insurance that are primary to Medicare.

We believe that, as a matter of equity, procurement costs should also be considered when another party has incurred such costs and when the judgment or settlement is obtained under other types of insurance primary to Medicare.

However, there need to be some exceptions and limitations. HCFA should not allow for procurement costs that do not reduce the amount of a judgment or settlement payment that is actually available to the party. This is the case, for instance, under the many workers' compensation laws that provide separate awards for attorney fees.

Furthermore, there should be a special rule for a situation in which HCFA itself incurs procurement costs, for example, when the government must file suit because the party that received payment opposes HCFA's recovery.

2. *Proposal.* We proposed to broaden the current rules, as noted under the above discussion and include them in Subpart B, which is of general applicability, as a new § 411.37 that specifies the amounts of Medicare recovery under different circumstances:

a. If the Medicare payment is less than the judgment or settlement payment, HCFA would share proportionately in the party's procurement costs.

b. If Medicare payment equals or exceeds the judgment or settlement payments, HCFA would recover only the amount that remains after subtracting the party's total procurement costs.

c. If HCFA incurs procurement costs of its own because the party that received payment opposes HCFA's recovery, the recovery amount would be the lower of the following:

(1) The Medicare payment.

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

3. *Comments and responses.* We received no comments on these proposals.

K. Clarifying Changes

1. *Proposal.* Of the clarifying changes that were proposed in the NPRM, and are retained in the final rule, one elicited comment as shown below.

a. In § 411.6 (which excludes from Medicare payment services furnished by a Federal provider), we added a paragraph (b)(4) to make clear that services of a Federal provider (for example, a Veterans Administration (VA) hospital) are not excluded if they are furnished under arrangements made by a participating hospital. This ensures that a participating hospital can secure for its patients necessary services that it cannot itself provide.

b. Consistent with Departmental rules (45 CFR 30.15) and other HCFA rules (42 CFR 401.607), § 411.24(d) makes clear that HCFA may recover by offset against any monies it owes to the entity responsible for refunding the Medicare conditional primary payment.

c. In § 411.35, we have clarified the limits on the amounts that a provider or supplier may charge the beneficiary (or someone on his or her behalf) when workers' compensation, no-fault insurance, or an employer plan is primary to Medicare.

2. *Comments and responses.*

Comment: The commenter believes that current regulations give veterans the impression that they must receive all care at a VA facility. Specifically, the commenter suggested that we revise § 411.6 to indicate that veterans who choose not to use VA benefits are entitled to use their Medicare coverage; and § 411.8 to make clear that veterans are entitled to primary Medicare benefits when the VA neither furnishes nor authorizes non-VA physicians or suppliers to furnish the services.

Response: There is nothing in the regulations to suggest that veterans entitled to receive care at a VA facility, or from private sources at VA expense, are not entitled to use Medicare instead. We believe that the concerns expressed by the commenter are more properly addressed through administrative processes rather than regulations. The Medicare contractor manuals and *The Medicare Handbook* clearly indicate that veterans have the option to use either their Medicare or their VA entitlement. An individual's entitlement to Medicare is not circumscribed because of eligibility under another entitlement program. The Medicare contractor manuals clearly state that an individual's entitlement to VA benefits is *not* a basis for denying a Medicare claim.

L. Organization Change.

In order to eliminate needless repetition, Subpart B of the new part 411 sets forth those definitions and rules that apply equally to all or most of the types of insurance that are primary to Medicare. These include definitions of "conditional payment", "secondary payment", "third party payment", and "proper claim", the rules on recovery of conditional payments, and the effect of third party payment on benefit utilization and deductibles.

M. Other Changes.

1. *Definition of "multiemployer plan".* It has been brought to our attention that the health insurance industry distinguishes between "multiple employer plans"—which are sponsored by employers only, and "multi-employer plans"—which are sponsored jointly by employers and unions.

In § 411.70(d), we have added a definition of "multiemployer plan" specifying that it includes both of the kinds of plans identified above.

2. *Correction of an oversight: Indemnification of beneficiaries.* In developing the proposed rules published on June 15, 1988, we overlooked the fact that section 4096 of the Omnibus Budget Reconciliation Act of 1987 amended section 1879(b) of the Social Security Act to change indemnification policy. Under this policy, a beneficiary is indemnified for payments he or she made to a provider for services which the provider knew (but the beneficiary did not know) were excluded from coverage as "not reasonable and necessary" or as custodial care. Before the section 4096 change, deductible and coinsurance amounts were excluded from the indemnification amount. Under the amended law, the beneficiary is also indemnified for deductible and coinsurance payments.

We revised proposed § 411.402 (which redesignates previous § 405.332) to conform it to the changes in the law.

3. *Conforming changes required by the Medicare Catastrophic Coverage Act of 1988 (MCCA) and the establishment of part 411.* Subpart G of Part 405 of the Medicare rules, which deals with beneficiary appeals under Medicare Part A, contains numerous references to "posthospital" SNF care, and to § 405.310 (g) and (k). Conforming changes in the subpart are required because—

- The MCCA removed the requirement that SNF care be for a condition that was previously treated in a hospital; and
- Section 405.310 has been redesignated under the new part 411 as § 411.15.

We also took advantage of this opportunity to substitute lists of designated items for some excessively long sentences and to provide paragraph headings to guide the reader.

4. *Additional clarifying change.* We have added a new § 411.32(a)(1) to make clear that Medicare benefits are secondary to benefits payable by entities that are primary to Medicare even when State law or the payer that is primary to Medicare states that its benefits are secondary to Medicare's or otherwise limits its payments to Medicare beneficiaries. This rule was stated in §§ 411.50(c)(2) and 411.62(a)(4) of the NPRM. Since this rule applies generally to Subparts C through F, it is being placed in Subpart B and replaces §§ 411.50(c)(2) and 411.62(a)(4).

III. Redesignation

As part of the overall plan to reorganize the Medicare rules and provide adequate room for expansion, most of subpart C of part 405 is redesignated under a new part 411—Exclusions from Medicare, with a separate subpart for each type of third party payer. A redesignation table is presented at the end of this preamble to help the reader locate specific content under the new numbers.

IV. Regulatory Impact Statement

Executive Order (E.O.) 12291 requires us to prepare and publish regulatory impact analysis for any regulation that meets one of the E.O. criteria for a "major rule", that is, a rule that is likely to result in: an annual effect on the economy of $100 million or more; a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a regulation will not have a significant economic impact on a substantial number of small entities. For the purposes of the RFA, we treat all providers and third party insurers as small entities. Also, section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis if this rule may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must also conform to provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside a metropolitan statistical area.

Many provisions of this rule either conform to recent statutory changes or reflect current HCFA operating policies as expressed in program instructions and manuals. These regulatory provisions, of themselves, will not affect Medicare program expenditures. The other provisions of this rule will correct overly narrow interpretations of existent statutory authority, extend statutory precedents applying to some third party payers to additional categories of payers, or clarify and increase the consistency of our MSP rules. Of these rule changes, we anticipate that all but one will have a negligible impact upon program expenditures.

The change at § 411.50(b), under which the definition of "no fault insurance" is extended to include all types of no fault insurance, brings our regulations into line with the intended scope of section 1862(b)(1) of the Act. The enacting legislation (section 953 of the Omnibus Reconciliation Act of 1980) clearly does not limit Medicare's secondary status to automobile no fault situations. However, previous regulations at § 405.322 (published on April 5, 1983 at 48 FR 14810) only partially implemented the statute by making Medicare the secondary payer to automobile no fault medical coverage only. We did not consider other forms of no fault liability insurance. Because of this oversight, our intermediaries and carriers have been precluded from pursuing Trust Fund savings that would otherwise be available. This rule change allows us to maximize Trust Fund savings to the extent permitted by law. While we cannot at this time produce a precise estimate of the savings that will be achieved by this change, we expect that the maximum available savings will fall significantly short of the E.O. 12291 thresholds specified above.

We expect that implementation of these rule changes will not have a significant economic impact on a substantial number of small entities. For example, amending § 489.20 to require certain additional commitments in all provider agreements serves largely to highlight the importance of identifying MSP claims. Our intermediary and provider instructions already require hospitals and other providers to systematically identify and, where appropriate, bill payers that are primary to Medicare first.

Subsequent to the OIG study, discussed under "Background" above, we instituted a computerized cross reference system to identify claims that should have been billed to payers primary to Medicare. Once these payers are identified by the computer tracking system, the claims are referred back to the provider responsible for initial billing. Under this system, Medicare no longer pays such bills automatically.

This computerized cross reference system may eventually bring about some administrative cost savings, to the extent that intermediaries may not be required to process claims that providers properly charge to third party payers. Providers may also reap several benefits once they take advantage of the fact that, in many circumstances, Medicare is the secondary payer. Current manuals instruct hospitals and other providers on how to identify payers that are primary to Medicare. The marginal advantages for providers would be savings on the administrative costs of billing Medicare, and additional income when the third party payer pays a higher rate than Medicare would normally pay as primary payer. These benefits are already available to providers under current instructions, and will not be altered by these proposed rules.

For these reasons, we have determined that a regulatory impact analysis is not required. Further, we have determined, and the Secretary certifies, that this final rule will not have significant economic impact on a substantial number of small entities and will not have a significant impact on the operations of a substantial number of small rural hospitals. We have therefore not prepared a regulatory flexibility analysis.

V. Paperwork Reduction Act

Sections 405.702, 405.710(b)(1), 411.25, 411.32(c) (last sentence), 411.54(c)(1), 411.65(b)(2), 411.75(c)(2), and 489.20(f),

contain information collection, recordkeeping and reporting requirements subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1980. We have sent these requirements to OMB for review. When they approve them we will publish a notice to that effect in the **Federal Register.**

If you comment on these requirements, please send a copy of that comment directly to: Attention: Allison Herron, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3002, New Executive Office Bldg., Washington, DC 20503.

VI. List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Medicare, Recovery against third parties, Secondary payments.

42 CFR Part 489

Health facilities, Medicare.

REDESIGNATION TABLE FOR 42 CFR PART 405, SUBPART C

Old section	New section
405.308(a)	Removed as duplicative of § 412.42.
405.308(b)	489.34.
405.310	411.15.
405.310–1	411.2.
405.311	411.4.
405.311a	411.6.
405.311b	411.7.
405.312	411.8
405.313	411.9.
405.314	411.10
405.315	411.12.
405.316	411.40.
405.317(a)–(c)	411.30.
405.317(d)–(f)	Removed as inconsistent with current policy.
405.318	411.43.
405.319(a)	Removed for inclusion in instructions.
405.319(a)	411.45.
405.320 and 321(a)	411.46.
405.321(b)	411.47.
405.322(a)–(d)	411.50.
405.322(e)	411.23.
405.323(a)	411.28.
405.323(a)	Removed as outdated.
405.323(b)	411.50.
405.323(c)(1)	411.53.
405.323(c)(2)	411.23.
405.323(c)(3) and (4)	411.24.
405.323(c)(5)	Removd as meaningless.
405.324(a)	411.52.
405.324(b)	411.37.
405.325	411.30.
405.326	411.60.
405.327	411.62.
405.328(a)–(d)	411.33.
405.328(e) and (f)	411.30.
405.329	411.65.
405.330	411.400.
405.332	411.402.

REDESIGNATION TABLE FOR 42 CFR PART 405, SUBPART C—Continued

Old section	New section
405.334	411.404.
405.336	411.406.
405.340	411.70.
405.341	411.72.
405.342(a) and (b)	411.33.
405.342(c) and (d)	411.30.
405.343	411.35.
405.344(a)	411.75.
405.344(b)	411.24.

42 CFR chapter IV is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Subpart C of part 405 is amended as follows:

Subpart C—Exclusions, Recovery of Overpayments, Liability of a Certifying Officer and Suspension of Payment

1. The subpart title, the table of contents, and the authority citation are revised to read as follows:

Subpart C—Recovery of Overpayments and Suspension of Payment

Sec.

405.301 Scope of subpart.

Liability for Payments to Providers and Suppliers, and Handling of Incorrect Payments

405.350 Individual's liability for payments made to providers and other persons for items and services furnished the individual.

405.351 Incorrect payments for which the individual is not liable.

405.352 Adjustment of title XVIII incorrect payments.

405.353 Certification of amount that will be adjusted against individual title II or railroad retirement benefits.

405.354 Procedures for adjustment or recovery—title II beneficiary.

405.355 Waiver of adjustment or recovery.

405.356 Principles applied in waiver of, adjustment or recovery.

405.359 Liability of certifying or disbursing officer.

Suspension of Payment to Providers and Suppliers and Collection and Compromise of Overpayments

405.370 Suspension of payments to providers of services and other suppliers of services.

405.371 Proceeding for suspension.

405.372 Submission of evidence and notification of administrative determination to suspend.

405.373 Subsequent action by intermediary or carrier.

405.374 Collection and compromise of claims for overpayments.

405.375 Withholding Medicare payments to recover Medicaid overpayments.

405.376 Interest charges on overpayments and underpayments to providers and suppliers.

Authority: Secs. 1102, 1815, 1833, 1842, 1866, 1870, 1871, and 1879 of the Social Security Act; 42 U.S.C. 1302, 1395g, 1395(1) 1395u, 1395cc, 1395gg, 1395hh, and 1395pp, and 31 U.S.C. 3711.

2. Section 405.301 is revised to read as follows:

§ 405.301 Scope of subpart.

This subpart sets forth the policies and procedures for handling of incorrect payments and recovery of overpayments.

§§ 405.308 through 405.344 [Removed]

3. Sections 405.308 through 405.344 are removed.

B. Subpart G of part 405 is amended as set forth below:

1. The subpart heading is revised to read as follows:

Subpart G—Reconsiderations and Appeals Under Medicare Part A

2. Section 405.701 is amended to revise the section heading, provide paragraph headings, and add a new paragraph (d), to read as follows:

§ 405.701 Basis and scope.

(a) *Statutory basis.* * * *

(b) *Scope.* * * *

(c) *Applicable social security regulations.* * * *

(d) *Other applicable Medicare regulations.* Part 411 of this chapter (Exclusions from Medicare and Limitations of Medicare Payment), and Part 424 of this chapter (Conditions for Medicare Payment) also contain provisions pertinent to the determinations covered under this subpart.

3. Section 405.702 is revised to read as follows:

§ 405.702 Notice of initial determination.

(a) In all cases, with respect to services for which Medicare Part A payment has been claimed by or on behalf of an individual, the Medicare intermediary—

(1) Determines whether the services are covered under Medicare Part A;

(2) Determines whether payment is due and if so, the amount of payment due;

(3) Pays the amount due, if any; and

(4) Gives the individual written notice of the initial determination on the claim.

(b) The intermediary also notifies the provider if—

(1) The services are not covered because they constitute "custodial care"

or are "not reasonable and necessary"; and

(2) Payment cannot be made because the provider or the individual or both knew, or could reasonably have been expected to know, that the services were not covered.

(c) The notice states in detail the reasons for the determination and informs the individual and the provider of their right to reconsideration if they are dissatisfied with the initial determination.

(d) The intermediary mails the notice to the individual and the provider at their last known addresses.

4. Section 405.704 is updated and revised to read as follows:

§ 405.704 Actions that are initial determinations.

(a) *Determinations that pertain to individual application and entitlement.* Actions subject to this subpart include the following determinations:

(1) Whether the individual is entitled to Medicare Part A or Medicare Part B benefits.

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA specifies in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence.

(3) A denial of a request for withdrawal of an application for Medicare Part A or Part B.

(4) A denial of a request for cancellation of a "request for withdrawal".

(5) A determination that an individual, previously determined to be entitled to Medicare benefits is no longer entitled to those benefits, including a determination based on nonpayment of premiums.

(b) *Determinations pertaining to requests for payment under Medicare Part A.* Actions subject to this subpart include determinations with respect to the following:

(1) The coverage of services furnished.

(2) The amount of an applicable deductible.

(3) The application of the coinsurance feature.

(4) The number of days of inpatient care used in relation to the psychiatric hospital 190-day life-time maximum.

(5) [Reserved]

(6) The number of days of SNF care used in the calendar year.

(7) [Reserved]

(8) The physician certification requirement.

(9) The request for payment requirement.

(10) [Reserved]

(11) The medical necessity of services (See Parts 466 and 473 of this chapter for provisions pertaining to initial and reconsidered determinations made by a PRO.

(12) When services are excluded from coverage as custodial care or as not reasonable and necessary, in accordance with Subpart K of part 411 of this chapter, whether the individual or the provider who furnished the services, or both, knew or could reasonably have been expected to know that the services were excluded from coverage.

(13) Any other issues having a present or potential effect on the amount of benefits to be paid under Medicare Part A, including a determination as to whether there has been an overpayment or underpayment of Part A benefits, and if so, the amount.

(14) Whether a waiver of adjustment or recovery under Subpart C of Part 405 of this chapter is appropriate when an overpayment of Medicare Part A benefits has been made with respect to an individual.

5. Section 405.708 is revised to read as follows:

§ 405.708 Effect of initial determination.

An initial determination under § 405.704(b) is final and binding upon the individual on whose behalf Part A payment has been requested or, if that individual is deceased, upon the representative of the individual's estate, unless the determination is reconsidered in accordance with §§ 405.710 through 405.717, or revised in accordance with § 405.750. The individual or the individual's representative is the party to the initial determination.

6. Section 405.710 is revised to read as follows:

§ 405.710 Right to reconsideration.

(a) *Individual's right to reconsideration.* (1) An individual who is a party to an initial determination and who is dissatisfied with the determination may request reconsideration in accordance with § 405.711, regardless of the amount in controversy.

(2) If the individual is deceased, the representative of the estate may request reconsideration.

(b) *Provider's right to reconsideration.* A provider that is a party to an initial determination on a request for payment, and that is dissatisfied with the determination, may request reconsideration in accordance with § 405.711, regardless of the amount in controversy, but only if both of the following conditions are met:

(1) The individual on whose behalf the provider requested payment has indicated in writing that he or she does not intend to request reconsideration.

(2) The intermediary has determined that—

(i) The services are excluded from coverage as custodial care or as not reasonable and necessary; and

(ii) The individual or the provider, or both knew or could reasonably have been expected to know that the services were excluded under subpart K of part 411 of this chapter.

§ 405.715 [Amended]

7. In § 405.715, in paragraph (b), "405.704(a)(12)" is changed to "§ 405.704(b)(12)".

8. Section 405.740 is amended to revise paragraphs (e), (f) and (h) to read as follows:

§ 405.740 Principles for determining the amount in controversy.

* * * * *

(e) Any series of home health visits shall be considered collectively in determining the amount in controversy.

(f) Appeals from determinations pertaining to Part A benefits are not ordinarily additive except when the same factor is at issue in more than one claim.

* * * * *

(h) If payment is made for services that are ordinarily excluded from coverage as custodial care or not reasonable and necessary, the amount in controversy is the amount that the individual would have been charged for the services (less any applicable deductible and coinsurance amounts) if payment had not been made for the services in accordance with Subpart K of Part 411 of this chapter.

II. A new part 411 is added, to redesignate, revise, and amplify the content removed from part 405, Subpart C of this chapter, to read as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

Subpart A—General Exclusions and Exclusion of Particular Services

Sec.

Sec.

Authority: Secs. 1102, 1862 and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1395hh).

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).

(b) *Scope.* This subpart identifies:

(1) The particular t ypes 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.

§ 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 estabilished 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 receives government funds under a health support program that requires the facility to seek reimbursement, for services not covered under Medicare, from all available sources such as private insurance, patients' cash resources, etc.

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

§ 411.9 Services furnished outside the United States

(b) *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's 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's 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 corpration.

§ 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; or

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

(b) *Eyeglasses or contact lenses, except for* post-surgical customarily used during convalescence from eye surgery in which the lens of the eye was removed (e.g., cataract surgery); or prosthetic lenses for patients who lack the lens of the eye because of congential absence or surgical removal.

(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 antitoxin, or booster vaccine, botulin antitoxin, antivenom sera, or immune globulin; and

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

(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.

(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.

(l) *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 in 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 (l)(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 condition 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.

(2) *Exceptions.* Physicians' services that meet the criteria of § 405.550(b) of this chapter for payment on a reasonable charge basis, and services of an anesthetist employed by a physician that meet the conditions of § 405.553(b)(4) of this chapter, are not excluded.

(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.)

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

§ 411.20 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b)(1) of the Act precludes Medicare payments 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.

(2) Sections 1862 (b)(2) and (b)(3) of the Act (omitting the word "promptly") preclude Medicare payments for services to the extent that payment has been made or can reasonably be expected to be made under an employer group health plan, with respect to a beneficiary who is under age 65 and entitled to Medicare solely on the basis of ESRD or who is age 65 or over and either employed, or the spouse of an employed individual of any age.

(b) *Scope.* This subpart sets forth the rules that are applicable to all or several of the types of insurance coverage that are the subject of Subparts C through F of this part.

§ 411.21 Definitions.

As used in this subpart and Subparts C through F of this part—*"Conditional payment"* means a Medicare payment for services for which another insurer is primary payer, made either on the bases set forth in Subparts C through F 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.

"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

[1] Before 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.

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.

§ 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.* HCFA may recover an amount equal to the Medicare payment or the amount payable by the third party, whichever is less. (The "amount payable by the third party" does not include the doubled portion of damages the third party may have paid under section 1862(b)(5) of the Act or any other punitive damages.)

(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 employer group health plan and no-fault insurance claims that are disputed, 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.

§ 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 ought to have made primary payment, it must give HCFA notice to that effect.

(b) The notice must describe the specific situation and the circumstances (such as the type of insurance coverage) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) In the case of plan that is not a self-insured or self-administered plan, the requirements of this section apply to the insurer, underwriter, or third party administrator.

§ 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 reimbursed by Medicare on a reasonable charge basis.* Except as specified in paragraph (c) of this section, the Medicare secondary payment will be the lowest of the following:

(1) The actual charge by the supplier 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 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 reasonable charge 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×$125=$100.

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

The Medicare payment is $30.

(c) *Exception.* When an employer plan is primary to Medicare for ESRD beneficiaries, for services paid on a reasonable charge or monthly capitation rate basis, the Medicare secondary payment amount is the lowest of the following:

(1) The actual charge by the supplier, minus the amount paid by the employer plan.

(2) The amount that Medicare would pay if the services were not covered by the employer plan.

(3) The sum of the amounts that would have been paid by Medicare as primary payer and the employer plan as secondary payer, minus the amount actually paid by the employer plan as primary payer.

(d) *Example:* Using the amounts specified in paragraph (b) of this section, the Medicare secondary payment for services furnished to an ESRD beneficiary is the lowest of the following:

(1) Excess of actual charge over the employer plan's payment: $175−$120=$55.

(2) Amount Medicare would pay if the services were not covered by employer plan: .80×$125=$100.

(3) The sum of the amounts that would have been paid by Medicare as primary payer and the employer plan as secondary payer; minus the amount actually paid by the employer plan as primary payer ($100+75=$175−$120=$55. The Medicare payment is $55.

(e) *Services reimbursed on a basis other than 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 amoung 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 composite rate−$75 deductible=$973×20=$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 charges minus the Medicare deductible:
$1,280−$75=$1,205. 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.

§ 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 benefits paid under workers' compensation by releasing the workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, Medicare will not pay for treatment of that condition.

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

(d) *Lump-sum compromise settlement: Effect on payment for services furnished after the date of settlement.*—(1) *Basic rule.* Except as specified in paragraph (d)(2) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment of workers' compensation benefits, medical 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 = ⅓), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (⅓ × $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
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 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 policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law, or is underinsured.

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

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

(2) Services furnished on or after (effective date of final regulations) 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.

§ 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 Furnished to End-Stage Renal Disease Beneficiaries Who Are Also Covered Under an Employer Group Health Plan

§ 411.60 Scope and definitions.

(a) *Scope.* This Subpart E sets forth the policies and procedures for payment for services furnished to beneficiaries who are entitled to Medicare solely on the basis of end-stage renal disease (ESRD) and who are also covered under an employer group health plan.

(b) *Definitions.* As used in this Subpart E—

"Employer" means, in addition to individuals 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.

"Employer group health plan" or *"employer plan"* means a group health plan that—

(1) Is of, or contributed to by, an employer; and

(2) Provides medical care directly or through other methods such as insurance or reimbursement, to current or former employees, or to current or former employees and their families.

It includes a plan that is under the auspices of an employer who makes no financial contribution, a so-called "employee-pay-all" plan.

"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 dialyzes at home or as an outpatient in an approved ESRD facility.

§ 411.62 Medicare benefits secondary to employer group health plan benefits.

(a) *General rules.* (1) Medicare benefits are secondary to benefits payable under an employer plan, for services furnished to an ESRD beneficiary during a period of up to 12 consecutive months as specified in paragraphs (b) and (c) of this section.

(2) If the individual becomes entitled to Medicare after the 12-month period has begun, as set forth in paragraph (c) of this section, Medicare benefits are secondary only for that portion of the 12-month period that begins with the month of entitlement.

(3) During the period in which Medicare benefits are secondary, the following rules apply:

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

(A) Furnished to Medicare beneficiaries who are not enrolled in the employer plan;

(B) Not covered under the employer plan; or

(C) Covered under the employer plan but not available to particular enrollees

because they have exhausted their benefits.

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

(b) *Beginning of 12-month period.* The period of 12 consecutive months specified by law begins with the earlier of the following months:

(1) The month in which the individual initiates a regular course of renal dialysis.

(2) In the case of an individual who receives a kidney transplant, the first month in which the individual could become entitled to Medicare if he or she filed a timely application, that is, the earliest of the following:

(i) The month in which the transplant is performed.

(ii) The month in which the individual is admitted to the hospital in preparation for, or anticipation of, a transplant that is performed within the next two months.

(iii) The second month before the month the transplant is performed, if performed more than 2 months after admission.

(c) *Beginning of period in which Medicare is secondary payer.* The period in which Medicare is secondary payer begins later than the beginning of the 12-month period (and therefore lasts less than 12 months) if the individual—

(1) Is subject to the 3-month waiting period for individuals who initiate renal dialysis but do not begin training for self-dialysis during the first 3 months of dialysis; or

(2) Files the application for Medicare entitlement more than 12 months after the month in which a 12-month period begins. (Under the Act, an application may not be retroactive for more than 12 months).

(d) *Examples.* The following examples illustrate how to determine, in different situations, the number of months during which Medicare is secondary payer.

(1) *Individual filed a timely application and became entitled without a waiting period.* In October 1981, John began a regular course of dialysis and filed an application for Medicare. In December 1981, John began training for self-dialysis. Since John initiated self-dialysis training during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1981, the first month of dialysis. In this situation, the month of entitlement coincides with the beginning of the 12-month period and Medicare is secondary payer during the entire period.

(2) *Individual filed a timely application and became entitled to Medicare after a waiting period.* (i) Janice started a regular course of renal dialysis in October 1981 and filed an application in the same month. The 12-month period begins with October 1981, but the 3-month waiting period doesn't end until December 1981. The month of entitlement for Janice is January 1982. Medicare is secondary payer from January through September 1982.

(ii) Peter started a regular course of dialysis in January 1982, and was hospitalized and received a kidney transplant in March 1982. The 12-month period begins with January 1982. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1982. Medicare is secondary payer from March through December 1982.

(3) *Individual did not file a timely application.* In January 1982, Katherine suffered kidney failure and received a kidney transplant but did not apply for Medicare until July, 1983. Since the application is retroactive for only 12 months, Katherine becomes entitled to Medicare in July 1982. The 12-month period begins in January 1982, the month in which Katherine could have been entitled if she had filed a timely application. Medicare is secondary payer from July through December 1982.

(e) *Effect of changed basis for Medicare entitlement.* If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the 12-month period terminates with the month before the month in which the change is effective.

(f) *Determinations for subsequent periods of ESRD entitlement.* If an individual has more than one period of entitlement based solely on ESRD, a period during which Medicare may be secondary payer will be determined for each period of entitlement, in accordance with this section.

§ 411.65 Basis for conditional Medicare payments.

(a) *General rule.*[2] 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 employer 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.

[2] For services furnished before January 21, 1988, conditional Medicare payments were made unless HCFA determined that the employer plan would pay the particular claims as promptly as Medicare.

(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 employer plan is secondary to Medicare.

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

Subpart F—Limitations on Payment for Services Furnished to Employed Aged and Aged Spouses of Employed Individuals Who Are Also Covered Under an Employer Group Health Plan

§ 411.70 General provisions.

(a) *Basis and scope.* This Subpart F implements section 1862(b)(3) of the Act. It sets forth the limitations that apply to Medicare payment for services furnished to employed aged and to aged spouses of employed individuals who are covered under an employer group health plan of an employer who employs at least 20 employees.

(b) *Applicability.* The rules of this subpart apply only to services furnished after December 1982.

(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.

(d) *Definitions.* As used in this subpart—

"*Employed*" encompasses not only employees but also, subject to the provisions of paragraph (f) of this section, self-employed persons such as

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.

"Employer" means, in addition to individuals 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.

"*Employer group health plan*" or "*employer plan*" means a group health plan that provides medical care, directly or through other methods such as insurance or reimbursement, to current or former employees or to employees and their families, and meets one of the following conditions:

(1) Is of, or contributed to by, a single employer of at least 20 employees.

(2) Is a multiemployer group health plan that includes at least one employer of 20 or more employees.

The term includes a plan that is under the auspices of an employer who makes no financial contribution, a so-called "employee-pay-all" plan.

"*Multiemployer group health plan*" or "*multiemployer plan*" means a "multiple employer plan", which is a plan sponsored by more than one employer, or a "multi-employer plan", which is a plan sponsored jointly by employers and unions.

(e) *Referral of cases to the Equal Employment Opportunity Commission (EEOC).* HCFA refers to the EEOC cases of apparent noncompliance with the Age Discrimination in Employment Act (29 U.S.C. 623). That Act requires employers to provide the same health benefits under the same conditions, to aged employees and their spouses as they provide to younger employees and their spouses.

(f) *Special rules applicable to the self-employed and to members of religious orders.* (1) A self-employed individual is considered "employed" during a particular tax year only if, during the preceding tax year, the individual's net earnings, from work 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.

(2) A member of a religious order is considered employed if the religious order pays FICA taxes on behalf of that member.

§ 411.72 Medicare benefits secondary to employer group health plan benefits.

(a) *Conditions the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by an employer plan 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;

(3) Is not entitled, and could not upon filing an application become entitled, to Medicare on the basis of end-stage renal disease as provided in § 406.13 of this chapter; and

(4) Meets one of the following conditions:

(i) Is employed and covered, by reason of that employment, under an employer plan.

(ii) Is the aged spouse 3 of an employed individual who—

(A) For services furnished before January 1985 was, at the time the services were furnished, age 65 through 69;

(B) For services furnished from January 1, 1985 through April 30, 1986 was, at the time the services were furnished, any age through 69; or

(C) For services furnished after April 30, 1986 was, at the time the services were furnished, any age.

(b) *Exception for multiemployer plans.* If a multiemployer plan can identify particular enrollees as employees of an employer of fewer than 20 employees, Medicare is primary for those enrollees and their spouses.

(c) *Refusal to accept employer 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) *Coverage of reemployed retiree or annuitant.* A reemployed retiree or annuitant who is covered by an employer group health plan is considered covered "by reason of employment".

if the employer provides the same group coverage to retirees as to other employees in the same category. This rule applies even if—

(1) The plan is the same plan that previously provided coverage to that individual when he was a retiree or annuitant; or

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

§ 411.75 Basis for Medicare primary payments.

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

(1) Furnished to employed individuals or spouses who are not enrolled in the employer plan;

(2) Not covered for any of the employed individuals or spouses who are enrolled in that plan; or

(3) Covered under the plan but not available to particular employed individuals or spouses because they have exhausted their benefits.

(b) *Conditional primary 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 employer plan and the plan has denied the claim in whole or in part; or

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

(c) *Conditional primary payments: Exceptions.* 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 employer plan is secondary to Medicare.

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

(iii) The services are covered by the employer plan for younger employees and spouses but not for employees and spouses age 65 or over.

(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 employer plan fails to furnish information requested by HCFA and necessary to determine whether the employer plan is primary to Medicare.

Subparts G–J—[Reserved]

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 funished 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. It 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 is 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.*[4] 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 reasonable 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:

(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 phyician.* 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

[4] For 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.

have known that the services were excluded from coverage on the basis of—

(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 PRO; or

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

III. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENTS UNDER MEDICARE

1. The authority citation continues to read as follows:

Authority: Secs. 1102, 1864, 1866 and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x, 1395aa, 1395cc and 1395hh), unless otherwise noted.

2. Section 489.20 is amended as set forth below:

§ 489.20 [Amended]

a. The undesignated introductory statement is revised to read:

"The provider agrees to the following:"

b. Periods are substituted for the semicolons at the end of paragraphs (a) through (c) and for the "; and" at the end of paragraph (d).

c. New paragraphs (f) through (j) are added to read as follows:

(f) To maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented.

(g) To bill other primary payers before billing Medicare except when the primary payer is a liability insurer and except as provided in paragraph (j) of this section.

(h) If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days.

(i) If the provider receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim—

(1) To bill Medicare for an amount no greater than would have been payable as secondary payment if the primary insurer's payment had been based on a proper claim; and

(2) To charge the beneficiary only: (i) The amount it would have been entitled to charge if it had filed a proper claim and received payment based on such a claim; and

(ii) An amount equal to any third party payment reduction attributable to failure to file a proper claim, but only if the provider can show that—

(A) It failed to file a proper claim solely because the beneficiary, for any reason other than mental or physical incapacity, failed to give the provider the necessary information; or

(B) The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than mental or physical incapacity.

(j) In 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, hospitals may bill liability insurers first. However, if the liability insurer does not pay "promptly", as defined in § 411.50 of this chapter, the hospital must withdraw its claim or lien and bill Medicare for covered services.

3. A new § 489.34 is added, and the table of contents is amended to reflect the addition:

§ 489.34 Allowable charges: Hospitals participating in State reimbursement control systems or demonstration projects.

A hospital receiving payment for a covered hospital stay under either a State reimbursement control system approved under 1886(c) of the Act or a demonstration project authorized under section 402(a) of Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1 (note)) and that would otherwise be subject to the prospective payment system set forth in Part 412 of this chapter may charge a beneficiary for noncovered services as follows:

(a) For the custodial care and medically unnecessary services described in § 412.42(c) of this chapter, after the conditions of § 412.42(c)(1) through (c)(4) are met; and

(b) For all other services in accordance with the applicable rules of this Subpart C.

IV. Technical Amendment

§ 412.42 [Amended]

In paragraph (c) of § 412.42, "§ 405.310(g)" is changed to "§ 411.15(g)", and "§ 405.310(k)" is changed to "§ 411.15(k)".

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program; and No. 13.773, Medicare—Hospital Insurance.)

Dated: September 22, 1989.

Louis B. Hays,

Acting Administrator, Health Care Financing Administration.

Approved: September 25, 1989.

Louis W. Sullivan,

Secretary.

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