

§411.54 Limitation on charges when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer.

(a) *Definition.* As used in this section, *Medicare-covered services* means services for which Medicare benefits are payable or would be payable except for applicable Medicare deductible and coinsurance provisions. Medicare benefits are payable notwithstanding potential liability insurance payments, but are recoverable in accordance with §411.24.

(b) *Applicability.* This section applies when a beneficiary has received a liability insurance payment or has a claim pending against a liability insurer for injuries or illness allegedly caused by another party.

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

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

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

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

(iii) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under §413.35 of this chapter (when cost limits are applied to the services) or under §489.32 of this chapter (when services are partially covered).

(d) *Exceptions*—(1) *Nonparticipating suppliers.* The limitations of paragraph (c)(2) of this section do not apply if the services were furnished by a supplier that is not a participating supplier and has not accepted assignment for the services or has not claimed payment for them under §424.64 of this chapter.

(2) *Prepaid health plans.* If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through an HMO or CMP), or through an organization that is paid under section 1833(a)(1)(A) of the Act (that is, through an HCPP) the rules of §417.528 of this chapter apply.

(3) *Special rules for Oregon.* For the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, there are the following special rules:

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

(A) The date the hospital files a claim with the insurer or places a lien against a potential liability settlement.

(B) The date the services were provided or, in the case of inpatient hospital services, the date of discharge.

(ii) If the liability insurer does not pay within the 120-day period, the hospital must withdraw its claim or lien and comply with the limitations imposed by paragraph (c)(2) of this section.

Subpart E—Limitations on Payment for Services Covered Under Group Health Plans: General Provisions

SOURCE: 60 FR 45362, Aug. 31, 1995, unless otherwise noted.

§411.100 Basis and scope.

(a) *Statutory basis.* (1) Section 1862(b) of the Act provides in part that Medicare is secondary payer, under specified conditions, for services covered under any of the following:

(i) Group health plans of employers that employ at least 20 employees and that cover Medicare beneficiaries age 65 or older who are covered under the plan by virtue of the individual's current employment status with an employer or the current employment status of a spouse of any age. (Section 1862(b)(1)(A))

(ii) Group health plans (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in §411.163, group health plans are always primary payers throughout the first 18 months of ESRD-based Medicare eligibility or entitlement. (Section 1862(b)(1)(C))