

(ii) The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

(iii) The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are beyond the general scope of SNF comprehensive care plans, as required under § 483.20 of this chapter); or

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the day of departure.

(q) *Assisted suicide.* Any health care service used for the purpose of causing, or assisting to cause, the death of any individual. This does not pertain to the withholding or withdrawing of medical treatment or care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.

(r) A home health service (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) as defined in section 1861(m) of the Act furnished to an individual who is under a plan of care of an HHA, unless that HHA has submitted a claim for payment for such services.

[54 FR 41734, Oct. 11, 1989; 55 FR 1820, Jan. 19, 1990, as amended at 55 FR 22789, June 4, 1990; 55 FR 31185, Aug. 1, 1990; 57 FR 33897, July 31, 1992; 57 FR 36015, Aug. 12, 1992; 58 FR 30669, May 26, 1993; 59 FR 49834, Sept. 30, 1994; 60 FR 48424, Sept. 19, 1995; 60 FR 63188, Dec. 8, 1995; 62 FR 46037, Aug. 29, 1997; 62 FR 59101, Oct. 31, 1997; 63 FR 26308, May 12, 1998; 63 FR 35066, June 26, 1998; 64 FR 41682, July 30, 1999; 64 FR 59441, Nov. 2, 1999; 65 FR 18537, Apr. 7, 2000; 65 FR 41211, July 3, 2000; 65 FR 46796, July 31, 2000; 66 FR 32778, June 18, 2001; 66 FR 39600, July 31, 2001; 66 FR 48078, Sept. 17, 2001; 66 FR 55331, Nov. 1, 2001; 66 FR 58786, Nov. 23, 2001; 68 FR 46070, Aug. 4, 2003; 69 FR 66423, Nov. 15, 2004; 70 FR 45055, Aug. 4, 2005]

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

### § 411.20 Basis and scope.

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

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

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

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

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

(i) Workers' compensation.

(ii) Liability insurance.

(iii) No-fault insurance.

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

[60 FR 45361, Aug. 31, 1995]

### § 411.21 Definitions.

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

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

*Coverage* or *covered services*, when used in connection with third party payments, means services for which a