

deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

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 under automobile no-fault insurance.

(2) Services furnished on or after November 13, 1989 for which payment has been made or can reasonably be expected to be made under any no-fault insurance other than automobile no-fault.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 71 FR 9470, Feb. 24, 2006]

§ 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.

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

(1) The beneficiary has filed a proper claim for liability insurance benefits but the intermediary or carrier determines that the liability insurer will not pay promptly for any reason other than the circumstances described in § 411.32(a)(1). This includes cases in which the liability insurance carrier has denied the claim.

(2) The beneficiary has not filed a claim for liability insurance benefits.

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006]

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

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

(1) The beneficiary 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.

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

(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

[71 FR 9470, Feb. 24, 2006]

§ 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

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

(d) *Exception—(1) Prepaid health plans.* If the services were furnished through an organization that has a contact under section 1876 of the Act (that is, 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.

(2) *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 provider or supplier may elect to bill a liability insurer or place a lien against the beneficiary's liability settlement for Medicare covered services, rather than bill only Medicare for Medicare covered services, if the liability insurer pays within 120 days after the earlier of the following dates:

(A) The date the provider or supplier 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 provider or supplier:

(A) Must withdraw its claim with the liability insurer and/or withdraw its lien against a potential liability settlement.

(B) May only bill Medicare for Medicare covered services.

(C) 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 these

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

[54 FR 41734, Oct. 11, 1989, as amended at 68 FR 43942, July 25, 2003]

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

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

§411.100 Basis and scope.

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

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

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

(iii) Large group health plans (that is, plans of employers that employ at least 100 employees) and that cover Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of the individual's or a family member's current employment status with an employer. (Section 1862(b)(1)(B))

(2) Sections 1862(b)(1)(A), (B), and (C) of the Act provide that group health plans and large group health plans may not take into account that the individuals described in paragraph (a)(1) of this section are entitled to Medicare on the basis of age or disability, or eligible for, or entitled to Medicare on the basis of ESRD.