MEDICARE LIENS IN LIABILITY LITIGATION
(AND WORKERS' COMPENSATION)
for the
PACIFIC NORTHWEST BRAIN INJURY CONFERENCE
March 6, 2009

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I. WHAT IS MEDICARE?

A. History. Enacted 1965, signed by Lyndon Johnson. First beneficiary Harry Truman. In 2007, it's 13% of the U.S. Budget, covers 43 million Americans; 27% of MD income, 47% of hospital income, 61% of nursing home income.

B. Benefits: For "medically necessary" care

1. Part A is hospitalization (incl Skilled Nursing Facility). Premium paid by employers, workers in FICA

2. Part B is outpatient care, doctors, physical therapy, etc. Premium paid by member (unless Medicaid pays it)

3. Part C is "Medicare Advantage", private insurance, with Medicare paying the premium for hospitalization, member paying the rest

4. Part D is prescription drugs (began 1/1/06). Member pays premium.

C. Who gets it?

1. Worker or worker spouse age 65

2. Workers disabled for 2 years and five months

3. Amyotrophic lateral sclerosis (Lou Gehrig's disease) or end stage renal disease (dialysis)

D. Medic<u>aid</u> is a state-run program with federal funds for very low income medical care, governed by state eligibility rules.

II. MEDICARE "SECONDARY PAYER — SOURCES

A. The Statute -- 42 USC 1395y(b)

1. Sec. 1395y(b)(1) — Medicare is secondary to group health plans

2. Sec. 1395y(b)(2) — Medicare is secondary to "primary plans":

a. "Workmen's"(sic) compensation law or plan

b. Auto insurance

c. Liability insurance policy or plan, including self-insurance and failure to insure

d. No fault insurance (e.g. PIP)

B. The Regulations — 42 CFR 411

1. General Secondary Payer provisions, 42 CFR 411.20-.37

2. Workers' compensation, 42 CFR 411.40-.47

3. Liability and No-fault insurance, 42 CFR 411.50-.54

C. The Agency — Center for Medicare and Medicaid Services (CMS, formerly HCFA) in Department of Health and Human Services DHHS

D. The Manual — "Medicare Secondary Payer (MSP) Manual", Chapter 7, "Contractor MSP Recovery Rules" (Revision 59, 2/22/08) — http://www.cms.hhs.gov/manuals/downloads/msp105c07.pdf

(February, 2008 revision still has many October, 2003 provisions.)

III. HOW IT WORKS

A. How it used to work:

1. Original 1965 statute made Medicare secondary to workers' compensation. Private health insurance made its coverage secondary to Medicare.

2. Amendments in 1980 made Medicare secondary to private coverage. 1989 HHS study found Medicare paying claims it shouldn't in 90% of non-retirement cases.

3. 2001 HHS memorandum required all WC "commutation" settlement agreements to include Medicare set-aside language and be submitted to CMS for approval if claimant on Medicare or 30 month/$250,000 threshold met.

4. 2003 amendments to change definitions of "promptly" and "primary plan" to reverse court decisions. See U.S. v. Baxter Int'l, 345 F3d 866, 892 (11th Cir. 2003) for cases construing pre-amendment language to avoid Medicare liens. "Primary plan" now includes simple failure to insure, overruling Thompson v. Goetzmann, 315 F3d 487 (5th Cir. 2002, withdrawn and reissued 337 F3d 489 (5th Cir. 2003). 42 USC 1395y(b)(2)(A)(ii).

4. 2007 amendments to require primary payers to notify Medicare as of July 1, 2009. 42 USC 1395y(b)(8).

B. How it's supposed to work now:

1. Past Payments. Medicare payments made before third party settlement

a. "Conditional payments" by Medicare where "primary plan" not expected to pay "promptly". 42 USC 1395y(b)(2)(B) "Promptly" means 120 days from date of claim. (So Medicare will pay except where covered by PIP or Group Health Plan.)

b. Medicare has direct right of action and subrogation right. MSP ch. 7, 50.1.

i. May recover against any party, including against primary payer where it has already paid plaintiff, plaintiff (42 CFR 411.24(i)(1)), since 1984.

"CMS 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 primary payment." 42 CFR 411.24 (g).

ii. Double damages if "primary payer" refuses to pay, and Medicare has to sue. 42

CFR 411.24(c)(2). Appears not to apply to other possible payers.

iii. Collection methods — offset against social security benefits (42 USC 1395gg); 31 USC 3716 (collection of federal debts by administrative offset)

iv. Tough to get around. Merrifield v. U.S., 2008 US Dist Lexis 25877 (March 2008)(New Jersey statute providing no right to recover against tortfeasor for medical expenses paid by Medicare, so payment could not "reasonably be expected" from liability insurer. Dismissed for lack of exhaustion.)

c. Medicare's right to reimbursement does not exist until plaintiff receives recovery in liability case. MSP Manual, ch. 7, 50.4.1; 42 USC 1395y(b)(2)(B)(ii).

i. No Medicare demand before settlement.

ii. "Settlement proceeds should not be disbursed until Medicare's claim has been satisfied." MSP Manual Ch. 7, 50.4.1. As a practical matter, this means defendant will insist on indemnity against Medicare lien

in settlement agreement.

d. Negotiating Medicare lien

i. Only CMS Regional Offices (not contractors like Blue Cross) can negotiate. Contractors also known as MAC (Medicare Administrative Contractor) or FI(fiscal intermediary) MSP Manual, Ch. 7, 50.4.2.

ii. Reduce lien by proportionate share of costs of recovery (fees and costs). 42 CFR 411.37(a)(1); MSP Manual, Ch. 7, 50.5.2.2.

iii. No negotiating before settlement, so no reducing Medicare lien to facilitate settlement

iv. Medicare ignores any characterization of damages in settlement agreement, assumes full payment for medicals paid by Medicare; honors characterizations only in formal court orders. MSP Manual, Ch. 7, 50.4.4. Medicare will ignore attempts to exclude preexisting conditions. Id. 50.4.5.

v. Contractor keeps liability case file for at least five years after initial contact with primary payer or plaintiff. MSP Manual 50.5.1.1

-Contractors' "Documentation Checklist" includes requests to negotiate, as if negotiation were a real possibility.

vi. Medicare payments are an "overpayment" in the Social Security sense, can be waived or reduced if

- plaintiff not "at fault" in causing overpayment

- payback would cause "hardship" or "unfairness" — can plaintiff pay "ordinary and necessary living expenses?", including food, shelter, medical expenses (not if hardship would have existed anyway).

Waiver standards at MSP Manual ch. 7, 50.6 ff. (Under Social Security Act and Federal Claims Collection Act). Administrative and judicial review under Social Security Act, 42 USC 405(g).

vii. Interest – At T-Bill or private funds rate from date of demand if not paid in 60 days from receipt of settlement. MSP Manual Ch. 7, 50.5.2.3, same as any federal debt. 45 CFR 30.18.

2. Future medicals. "There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement." MSP Manual, ch. 7, sec. 50.5. (Rev. 10/1/03).

a. Medicare payment "may not be made ... with respect to any item or service <u>to the extent that payment has been made, or can reasonably be expected to be made</u>" by workers' compensation or liability insurance. Section 1395y(b)(2)(A)

b. Standard Recovery Letter (MSP Manual ch. 7, 50.5.2.1, Ex. 2) is all about "reimbursement" for past expenses paid

c. Standard Release (MSP Manual ch. 7, 50.5.2.4.1, Ex. 7) discharges plaintiff "from any and all claims, etc, ... whatsoever, which Medicare now has or which may hereafter accrue related to the incident above" (referring to date of "accident")

BUT, the standard release also provides that plaintiff releases Medicare from "any liability for payment for claims

related to the incident above". ASSUME MEDICARE WILL STOP PAYING ACCIDENT-RELATED MEDICAL EXPENSES.

3. Medicare Set-asides (The nice thing about WC Claims Disposition Agreements)

a. Apply only to "commutation" of WC benefits (not "compromise"). MSP Manual, ch. 7, sec. 40.3.5. Argue that CDAs are "commutation" but don't settle medicals, DCS is "compromise".

b. Require separate Medicare set-aside fund from which medical expenses will be paid and which must be exhausted before Medicare will pay further medicals for covered condition. Can be used only for Medicare-covered expenses covered in the agreement.

c. Not mentioned in third party section of MSP Manual

d. Cottage Industry: National Alliance of Medicare Set Aside Professionals. Delay is the problem.

THE STATUTE: 42 USC 1395y(b): Medicare as secondary payer:

(1) [Group health plan requirements]
(2) Medicare secondary payer.

(A) In general. Payment under this title [42 USCS §§ 1395 et seq.] may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that--

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(B) Conditional payment.

(i) Authority to make conditional payment. The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(ii) Repayment required. A primary plan, and an entity that receives

payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title [42 USCS §§ 1395 et seq.] with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

(iii) Action by United States. In order to recover payment made under this title [42 USCS §§ 1395 et seq.] for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity. The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

(iv) Subrogation rights. The United States shall be subrogated (to the extent of payment made under this title [42 USCS §§ 1395 et seq.] for such an item or service) to any right under this subsection of an individual or any other entity to payment with respect to such item or service under a primary plan.

(v) Waiver of rights. The Secretary may waive (in whole or in part) the provisions of this subparagraph in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title [42 USCS §§ 1395 et seq.].

(vi) Claims-filing period. Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

(C) Treatment of questionnaires. The Secretary may not fail to make payment under subparagraph (A) solely on the ground that an individual failed to complete a questionnaire concerning the existence of a primary plan.

(3) Enforcement.

(A) Private cause of action. There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

(B) Reference to excise tax with respect to nonconforming group health plans. For provision imposing an excise tax with respect to nonconforming group health plans, see section 5000 of the Internal Revenue Code of 1986 [26 USCS § 5000].

(C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan. It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title [42 USCS §§ 1395 et seq.] not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)). Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $ 5,000 for each such violation. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(4) Coordination of benefits. Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full, payment may be made under this title [42 USCS §§ 1395 et seq.] (without regard to deductibles and coinsurance under this title [42 USCS §§ 1395 et seq.]) for the remainder of such charge, but--

(A) payment under this title [42 USCS §§ 1395 et seq.] may not exceed an amount which would be payable under this title [42 USCS §§ 1395 et seq.] for such item or service if paragraph (2)(A) did not apply; and

(B) payment under this title [42 USCS §§ 1395 et seq.], when combined with the amount payable under the primary plan, may not exceed--

(i) in the case of an item or service payment for which is determined under this title [42 USCS §§ 1395 et seq.] on the basis of reasonable cost (or other cost-related basis) or under section 1886 [42 USCS § 1395ww], the amount which would be payable under this title [42 USCS §§ 1395 et seq.] on such basis, and

(ii) in the case of an item or service for which payment is authorized under this title [42 USCS §§ 1395 et seq.] on another basis--

(I) the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan), or

(II) the reasonable charge or other amount which would be payable under this title [42 USCS §§ 1395 et seq.] (without regard to deductibles and coinsurance under this title [42 USCS §§ 1395 et seq.]),

whichever is greater.

(5) Identification of secondary payer situations.

(A) Requesting matching information.

(i) Commissioner of Social Security. The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of medicare beneficiaries (as defined in section 6103(1)(12) of the Internal Revenue Code of 1986 [26 USCS § 6103(l)(12)]) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) Administrator. The Administrator of the Centers for Medicare & Medicaid Services shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986 [26 USCS § 6103(l)(12)(B)].

(B) Disclosure to fiscal intermediaries and carriers. In addition to any other information provided under this title [42 USCS §§ 1395 et seq.] to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for purposes of carrying out this subsection.

(C) Contacting employers.

(i) In general. With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 [26 USCS § 6051] by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code [26 USCS § 6103(l)(12)(E)(iii)]), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group

health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) Employer response. Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $ 1,000 for each individual with respect to which such an inquiry is made. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(D) Obtaining information from beneficiaries. Before an individual applies for benefits under part A [42 USCS §§ 1395c et seq.] or enrolls under part B [42 USCS §§ 1395j et seq.], the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.

(6) Screening requirements for providers and suppliers.

(A) In general. Notwithstanding any other provision of this title [42 USCS §§ 1395 et seq.], no payment may be made for any item or service furnished under part B [42 USCS §§ 1395j et seq.] unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) Penalties. An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $ 2,000 for each such incident. The provisions of section 1128A [42 USCS § 1320a-7a] (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)].

(7) Required submission of information by group health plans.

(A) Requirement. On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph [enacted Dec. 29, 2007], an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan

administrator or fiduciary, shall--

(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title [42 USCS §§ 1395 et seq.]; and

(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Enforcement.

(i) In general. An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $ 1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A [42 USCS § 1320a-7a] shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)]. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

(ii) Deposit of amounts collected. Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817 [42 USCS § 1395i].

(C) Sharing of information. Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary--

(i) shall share information on entitlement under Part A [42 USCS §§ 1395c et seq.] and enrollment under Part B under this title [42 USCS §§ 1395j et seq.] with entities, plan administrators, and fiduciaries described in subparagraph (A);

(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(D) Implementation. Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

(8) Required submission of information by or on behalf of liability insurance (including self-insurance), no fault insurance, and workers' compensation laws and plans.

(A) Requirement. On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph [enacted Dec. 29, 2007], an applicable plan shall--

(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title [42 USCS §§ 1395 et seq.] on any basis; and

(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

(B) Required information. The information described in this subparagraph is--

(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

(C) Timing. Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

(D) Claimant. For purposes of subparagraph (A), the term "claimant" includes--

(i) an individual filing a claim directly against the applicable plan; and

(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

(E) Enforcement.

(i) In general. An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $ 1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A [42 USCS § 1320a-7a] shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) [42 USCS § 1320a-7a(a)]. A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title [42 USCS §§ 1395 et seq.] with respect to an individual.

(ii) Deposit of amounts collected. Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

(F) Applicable plan. In this paragraph, the term "applicable plan" means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

(i) Liability insurance (including self-insurance).

(ii) No fault insurance.

(iii) Workers' compensation laws or plans.

(G) Sharing of information. The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

(H) Implementation. Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

MEDICARE SECONDARY PAYER REGULATIONS

§ 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 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.

§ 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 primary payments, means services for which a primary payer would pay if a proper claim were filed."**Monthly capitation payment**" means a comprehensive monthly payment that covers all physician services associated with the continuing medical management of a maintenance dialysis patient who dialyses at home or as an outpatient in an approved ESRD facility."**Plan**" means any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness."**Primary payer**" means, when used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans."**Primary payment**" means, when used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare."**Primary plan**" means, when used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance."**Prompt**" or "**promptly**", when used in connection with primary payments, except as provided in § 411.50, for payments by liability insurers, means payment within 120 days after receipt of the claim.**"Proper claim**" means a claim that is filed timely and meets all other claim filing requirements specified by the plan, program, or insurer."**Secondary**", when used to characterize Medicare benefits, means that those benefits are payable only to the extent that payment has not been made and cannot reasonably be expected to be made under other coverage that is primary to Medicare."**Secondary payments**" means payments made for Medicare covered services or portions of services that are not payable under other coverage that is primary to Medicare.

§ 411.22 Reimbursement obligations of primary payers and entities that received payment from primary payers. (a) A primary payer, and an entity that receives payment from a primary payer, must reimburse CMS for any

payment if it is demonstrated that the primary payer has or had a responsibility to make payment.(b) A primary payer's responsibility for payment may be demonstrated by --(1) A judgment;(2) A payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary payer or the primary payer's insured; or(3) By other means, including but not limited to a settlement, award, or contractual obligation.(c) The primary payer must make payment to either of the following:(1) To the entity designated to receive repayments if the demonstration of primary payer responsibilities is other than receipt of a recovery demand letter from CMS or designated contractor.(2) As directed in a recovery demand letter.

§ 411.23 Beneficiary's cooperation. (a) If CMS takes action to recover conditional payments, the beneficiary must cooperate in the action.(b) If CMS's recovery action is unsuccessful because the beneficiary does not cooperate, CMS 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 CMS. This information will be used only for Medicare claims processing and for coordination of benefits purposes.(b) Right to initiate recovery. CMS may initiate recovery as soon as it learns that payment has been made or could be made under workers' compensation, any liability or no-fault insurance, or an employer group health plan.(c) Amount of recovery -- (1) If it is not necessary for CMS to take legal action to recover, CMS recovers the lesser of the following:(i) The amount of the Medicare primary payment.(ii) The full primary payment amount that the primary payer is obligated to pay under this part without regard to any payment, other than a full primary payment that the primary payer has paid or will make, or, in the case of a primary payment recipient, the amount of the primary payment.(2) If it is necessary for CMS to take legal action to recover from the primary payer, CMS may recover twice the amount specified in paragraph (c)(1)(i) of this section.(d) Methods of recovery. CMS may recover by direct collection or by offset against any monies CMS owes the entity responsible for refunding the conditional payment.(e) Recovery from primary payers. CMS has a direct right of action to recover from any primary payer.(f) Claims filing requirements. (1) CMS 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, CMS 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 a primary plan 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 primary payments. CMS 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 primary payment.(h) Reimbursement to Medicare. If the beneficiary or other party receives a primary payment, the beneficiary or other party must reimburse Medicare within 60 days.(i) Special rules. (1) In the case of liability insurance settlements and disputed claims under employer group health plans, workers' compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, the primary 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 primary 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 primary payment is made to a State Medicaid agency and that agency does not reimburse Medicare, CMS 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 primary 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, CMS 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 primary payer, and Medicare is unable to recover from the primary 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) CMS will not recover from providers or suppliers that are in compliance with the requirements of § 489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.(m) Interest charges. (1) With respect to recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision -"-(i) CMS may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by CMS that payment has been or could be made under a primary plan;(ii) Interest may accrue from the date when that notice or other information is received by CMS, is charged until reimbursement is made, and is applied for full 30-day periods; and(iii) The rate of interest is that provided at § 405.378(d) of this chapter.

§ 411.25 Primary payer's notice of primary payment responsibility. (a) If it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment, it must provide notice about primary payment responsibility and information about the underlying MSP situation to the entity or entities designated by CMS to receive and process that information.(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in § 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.(c) The primary payer must provide additional information to the designated entity or entities as the designated entity or entities may require this information to update CMS' system of records.

§ 411.26 Subrogation and right to intervene. (a) Subrogation. With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a primary payer.(b) Right to intervene. CMS 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) CMS 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 § 405.376 of this chapter.(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

§ 411.30 Effect of primary payment on benefit utilization and deductibles. (a) Benefit utilization. Inpatient psychiatric hospital and SNF care that is paid for by a primary 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 primary payers are credited toward the Medicare Part A and Part B deductibles.

§ 411.31 Authority to bill primary 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 primary 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 primary payer.

§ 411.32 Basis for Medicare secondary payments. (a) Basic rules. (1) Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary 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 primary 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 primary 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 primary 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 primary payer had paid on the basis of a proper claim.The provider, supplier, or beneficiary must inform CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

§ 411.33 Amount of Medicare secondary payment. (a) Services for which CMS pays on a Medicare fee schedule or reasonable charge basis. The Medicare secondary payment is the lowest of the following:(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer.(2) The amount that Medicare would pay if the services were not covered by a primary payer.(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the primary 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 primary payer.(b) Example: An individual received treatment from a physician for which the physician charged $ 175. The primary payer allowed $ 150 of the charge and paid 80 percent of this amount or $ 120. The Medicare fee schedule for this treatment is $ 125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:(1) Excess of actual charge minus the primary payment: $ 175 - 120=$ 55.(2) Amount Medicare would pay if the services were not covered by a primary payer: .80 X $ 125 = $ 100.(3) Primary payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the primary payer: $ 150 - 120 = $ 30.The Medicare payment is $ 30.(c)-(d) [Reserved](e) Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate. The Medicare secondary payment is the lowest of the following:(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the primary payer), minus the applicable Medicare deductible and coinsurance amounts.(2) The gross amount payable by Medicare, minus the amount paid by the primary 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 primary 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 primary 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 primary payment: $ 2,700 - $ 2,360 = $ 340.(iii) The provider's charges minus the primary 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 primary payer and Medicare on behalf of the beneficiary is $ 2,700. The $ 520 deductible was satisfied by the primary 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 primary payer paid $ 450. No part of the Medicare inpatient hospital deductible had been met previously. The primary 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 primary payment: $ 850 - $ 450 = $ 400.(iii) The provider's charges minus the primary 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 primary payer and Medicare on behalf of the beneficiary is $ 680. The hospital may bill the beneficiary $ 70 (the $ 520 deductible minus the $ 450 primary 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 primary payer paid $ 1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is $ 131 or $ 1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $ 1,048 - $ 75 - $ 194.60 = $ 778.40. (The coinsurance is calculated as follows: $ 1,048 composite rate - $ 75 deductible = $ 973 X .20 = $ 194.60).(ii) The gross amount payable by Medicare minus the primary payment: $ 1,048 - $ 1,024 = $ 24.(iii) The provider's charges minus the primary payment: $ 1,280 - $ 1,024 = $ 256.(iv) The provider's charge minus the Medicare deductible and coinsurance: $ 1,280 - $ 75 - $ 194.60 = 1010.40. Medicare pays $ 24. The beneficiary's Medicare deductible and coinsurance were met by the primary 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 primary payer as payment in full. The primary payer paid $ 2,900 due to a deductible requirement under the primary 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 primary payment: $ 3,500 - $ 2,900=$ 600.(iii) The provider's charge minus the primary 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 primary payer and Medicare on behalf of the beneficiary is $ 3,000. The beneficiary has no liability for Medicare-covered services since the primary 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 primary 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 primary 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 primary 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 primary 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 primary 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 primary 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 CMS seeks to recover.(2) Special rule. If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery amount is as set forth in paragraph (e) of this section.(b) Recovery against the primary payer. If CMS seeks recovery from the primary 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) CMS incurs procurement costs because of opposition to its recovery. If CMS must bring suit against the party that received payment because that party opposes CMS'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.

WORKERS' COMPENSATION MSP REGULATIONS

§ 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 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) A conditional Medicare payment may be made under either of the following circumstances:(1) 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.(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.(b) Any conditional payment that CMS makes is conditioned on reimbursement to CMS in accordance with subpart B of this part.

§ 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= 1/3), the workers' compensation compromise settlement is considered to have paid for one-third of the total medical expenses (1/3 $ 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.

MEDICARE MSP REGULATIONS FOR AUTO AND 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. This term includes a plan of an individual or other entity

engaged in a business, trade, or profession, a plan of a non-profit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade, or profession is 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.

§ 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.

§ 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.

§ 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) 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 co-insurance 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 services) or under 489.32 of this chapter (when services are partially covered).