Statute

TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 7. SOCIAL SECURITY ACT
TITLE XVIII. HEALTH INSURANCE FOR THE AGED AND DISABLED
PART D. MISCELLANEOUS PROVISIONS

42 USCS § **1395y** (2002)

§ **1395y.** Exclusions from coverage and medicare as secondary payer

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(b) Medicare as secondary payer.

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(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 promptly (as determined in accordance with regulations) 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.

(B) Conditional payment.

(i) Repayment required. Any payment under this title [42 USCS §§ 1395 et seq.] with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title [42 USCS §§ 1395 et seq.] when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice 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).

(ii) Action by United States. In order to recover payment under this title [42 USCS §§ 1395 et seq.] for such an item or service, the United States may bring an action against any entity which is required or responsible (directly, as a third-party administrator, or

otherwise) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. 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.

(iii) 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.

(iv) 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.].

(v) 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 such 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.

Code of Federal Regulations

TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE

& MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 411--EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

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

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Sec. 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.

Sec. 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 third party payment recipient, the amount of the third party 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 third parties. CMS 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) 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 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. 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 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 disputed claims under employer group health plans and no-fault insurance, 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 Sec. 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, 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 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, 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 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) CMS will not recover from providers or suppliers that are in compliance with the requirements of Sec. 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 and is charged until reimbursement is made; and

(iii) The rate of interest is that provided at 42 CFR 405.376(d).

Sec. 411.25 Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in Sec. 411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to CMS. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

Sec. 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 third party 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.

Sec. 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 Sec. 405.376 of this chapter.
(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

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Sec. 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 Sec. 413.35 of this chapter when cost limits are applied to the services, or under Sec. 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 Sec. 424.64 of this chapter.

Subpart C--Limitations on Medicare Payment for Services Covered Under Workers' Compensation

Sec. 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 Sec. 411.32 and Sec. 411.33.

Sec. 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 Sec. 411.45(a), Medicare does not pay until the beneficiary has exhausted his or her remedies under workers' compensation.

(c) Except as specified in Sec. 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.

Sec. 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.

Sec. 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 Sec. 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.

Sec. 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\ x $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).