

(2) Not covered by the plan for any individuals or spouses who are enrolled by virtue of the individual's current employment status;

(3) Covered under the plan but not available to particular individuals or spouses enrolled by virtue of current employment status because they have exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional Medicare payments: Basic rule.* Except as provided in paragraph (c) of this section, Medicare may make a conditional primary payment if—

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim under the group health plan and the plan has denied the claim in whole or in part; or

(2) The beneficiary, because of physical or mental incapacity, failed to file proper claim.

(c) *Conditional primary payments: Exception.* Medicare does not make conditional primary payments under either of the following circumstances:

(1) The claim is denied for one of the following reasons:

(i) It is alleged that the group health plan is secondary to Medicare.

(ii) The plan limits its payments when the individual is entitled to Medicare.

(iii) The plan covers the services for individuals or spouses who are enrolled in the plan by virtue of current employment status and are under age 65 but not for individuals and spouses who are enrolled on the same basis but are age 65 or older.

(iv) Failure to file a proper claim if that failure is for any reason other than physical or mental incapacity of the beneficiary.

(2) The group health plan fails to furnish information requested by CMS and necessary to determine whether the employer plan is primary to Medicare.

[54 FR 41734, Oct. 11, 1989. Redesignated and amended at 60 FR 45362, 45371, Aug. 31, 1995]

Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans

SOURCE: 60 FR 45371, Aug. 31, 1995, unless otherwise noted.

§ 411.200 Basis.

(a) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(1) Individuals who are entitled to Medicare on the basis of disability; and

(2) Large group health plans (LGHPs) that cover those individuals.

(b) Under these provisions, the LGHP may not take into account the Medicare entitlement of a disabled individual who is covered (or seeks to be covered) under the plan by virtue of his or her own current employment status or that of a member of his or her family. (§ 411.108 gives examples of actions that constitute taking into account.)

§ 411.201 Definitions.

As used in this subpart—

Entitled to Medicare on the basis of disability means entitled or deemed entitled on the basis of entitlement to social security disability benefits or railroad retirement disability benefits. (§ 406.12 of this chapter explains the requirements an individual must meet in order to be entitled or deemed to be entitled to Medicare on the basis of disability.)

Family member means a person who is enrolled in an LGHP based on another person's enrollment; for example, the enrollment of the named insured individual. Family members may include a spouse (including a divorced or common-law spouse), a natural, adopted, foster, or stepchild, a parent, or a sibling.

§ 411.204 Medicare benefits secondary to LGHP benefits.

(a) Medicare benefits are secondary to benefits payable by an LGHP for services furnished during any month in which the individual—

(1) Is entitled to Medicare Part A benefits under § 406.12 of this chapter;

(2) Is covered under an LGHP; and

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(3) Has LGHP coverage by virtue of his or her own or a family member's current employment status.

(b) *Individuals entitled to Medicare on the basis of disability who are also eligible for, or entitled to, Medicare on the basis of ESRD.* If a disabled individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

§ 411.206 Basis for Medicare primary payments and limits on secondary payments.

(a) *General rule.* CMS makes Medicare primary payments for services furnished to disabled beneficiaries covered under the LGHP by virtue of their own or a family member's current employment status if the services are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(2) Not covered under the plan for the disabled individual or similarly situated individuals;

(3) Covered under the plan but not available to particular disabled individuals because they have exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional primary payments: Basic rule.* Except as provided in paragraph (c) of this section, CMS may make a conditional Medicare primary payment for any of the following reasons:

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim with the LGHP and the LGHP has denied the claim in whole or in part.

(2) The beneficiary, because of physical or mental incapacity, failed to file a proper claim.

(c) *Conditional primary payments: Exceptions.* CMS does not make conditional Medicare primary payments if—

(1) The LGHP denies the claim in whole or in part for one of the following reasons:

(i) It is alleged that the LGHP is secondary to Medicare.

(ii) The LGHP limits its payments when the individual is entitled to Medicare.

(iii) The LGHP does not provide the benefits to individuals who are entitled to Medicare on the basis of disability and covered under the plan by virtue of current employment status but does provide the benefits to other similarly situated individuals enrolled in the plan.

(iv) The LGHP takes into account entitlement to Medicare in any other way.

(v) There was failure to file a proper claim for any reason other than physical or mental incapacity of the beneficiary.

(2) The LGHP, an employer or employee organization, or the beneficiary fails to furnish information that is requested by CMS and that is necessary to determine whether the LGHP is primary to Medicare.

(d) *Limit on secondary payments.* The provisions of § 411.172(e) also apply to services furnished to the disabled under this subpart.

Subpart I [Reserved]

Subpart J—Physician Ownership of, and Referral of Patients or Laboratory Specimens to, Entities Furnishing Clinical Laboratory or Other Health Services

SOURCE: 60 FR 41978, Aug. 14, 1995, unless otherwise noted.

§ 411.350 Scope of subpart.

(a) This subpart implements section 1877 of the Act, which generally prohibits a physician from making a referral under Medicare for designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship.

(b) This subpart does not provide for exceptions or immunity from civil or criminal prosecution or other sanctions applicable under any State laws