

## § 411.21

apply to group health plans are set forth in subpart E of this part.

[60 FR 45361, Aug. 31, 1995]

### § 411.21 Definitions.

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

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

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

*Prompt* or *promptly*, when used in connection with third party 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.

*Third party payer* means an insurance policy, plan, or program that is primary to Medicare.

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*Third party payment* means payment by a third party payer for services that are also covered under Medicare.

[54 FR 41734, Oct. 11, 1989, as amended at 60 FR 45361, Aug. 31, 1995]

### § 411.23 Beneficiary's cooperation.

(a) If HCFA takes action to recover conditional payments, the beneficiary must cooperate in the action.

(b) If HCFA's recovery action is unsuccessful because the beneficiary does not cooperate, HCFA 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 HCFA. This information will be used only for Medicare claims processing and for coordination of benefits purposes.

(b) *Right to initiate recovery*. HCFA 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 HCFA to take legal action to recover, HCFA 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 HCFA to take legal action to recover from the primary payer, HCFA may recover twice the amount specified in paragraph (c)(1)(i) of this section.