

§411.51

(1) Services for which payment has been made or can reasonably be expected to be made promptly 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 promptly under any no-fault insurance other than automobile no-fault.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990]

§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.

If HCFA has information that services for which Medicare benefits have been claimed are for treatment of an injury or illness that was allegedly caused by another party, a conditional Medicare payment may be made.

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

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

(a) The beneficiary, or the provider or supplier, 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.

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

§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) *Basic rules—(1) Itemized bill.* A hospital must, upon request, furnish to the beneficiary or his or her representative an itemized bill of the hospital's charges.

(2) *Specific limitations.* Except as provided in paragraph (d) of this section, the provider or supplier—

(i) May not bill the liability insurer nor place a lien against the beneficiary's liability insurance settlement for Medicare covered services.

(ii) May only bill Medicare for Medicare-covered services; and

(iii) May bill the beneficiary only for applicable Medicare deductible and coinsurance amounts plus the amount of any charges that may be made to a beneficiary under §413.35 of this chapter (when cost limits are applied to the services) or under §489.32 of this chapter (when services are partially covered).

(d) *Exceptions—(1) Nonparticipating suppliers.* The limitations of paragraph (c)(2) 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 has not claimed payment for them under §424.64 of this chapter.

(2) *Prepaid health plans.* If the services were furnished through an organization that has a contract under section 1876 of the Act (that is, through an