

**§ 422.108**

**42 CFR Ch. IV (10–1–00 Edition)**

(1) Payment of a portion or all of the M+C basic and supplemental premiums.

(2) Payment of a portion or all of other cost-sharing amounts approved for the M+C plan.

(3) Other employer-sponsored benefits that may require additional premium and cost-sharing, or other benefits provided by the organization under a contract with the State Medicaid agency.

[65 FR 40320, June 29, 2000]

**§ 422.108 Medicare secondary payer (MSP) procedures.**

(a) *Basic rule.* HCFA does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the M+C organization.* The M+C organization must, for each M+C plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Identify the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Collecting from other entities.* The M+C organization may bill, or authorize a provider to bill, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Collecting from other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may bill, or authorize a provider to bill any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

(e) *Collecting from group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may bill a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may bill the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

(f) *MSP rules and State laws.* Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C plans only to the extent that those State laws are inconsistent with the standards established under this part. A State cannot take away an M+C organization's right under Federal law and the MSP regulations to bill, or to authorize providers and suppliers to bill, for services for which Medicare is not the primary payer. Section 1852(a)(4) of the Social Security Act does not prohibit a State from limiting the amount of the recovery; thus, State law could modify, but not negate, an M+C organization's rights in this regard.

[63 FR 35077, June 26, 1998, as amended at 65 FR 40320, June 29, 2000]

**§ 422.109 Effect of national coverage determinations (NCDs).**

(a) If HCFA determines and announces that an NCD meets the criteria for "significant cost" described in paragraph (c) of this section, an M+C organization is not required to assume risk for the costs of that service until the contract year for which the annual M+C capitation rate is determined on a basis that includes the cost of the NCD service.

(b) The M+C organization must furnish, arrange or pay for an NCD "significant cost" service before the adjustment of the annual M+C capitation rate. The following rules apply to these services:

(1) Medicare payment for the service is:

(i) In addition to the capitation payment to the M+C organization; and

(ii) Made directly by the fiscal intermediary and carrier to the M+C organization in accordance with original