

behalf of the beneficiary is \$680. The hospital may bill the beneficiary \$70 (the \$520 deductible minus the \$450 third party payment). This fully discharges the beneficiary's deductible obligation.

(3) An ESRD beneficiary received 8 dialysis treatments for which a facility charged \$160 per treatment for a total of \$1,280. No part of the beneficiary's \$75 Part B deductible had been met. The third party payer paid \$1,024 for Medicare-covered services. The composite rate per dialysis treatment at this facility is \$131 or \$1,048 for 8 treatments. As secondary payer, Medicare pays the lowest of the following:

(i) The gross amount payable by Medicare minus the applicable Medicare deductible and coinsurance: $\$1,048 - \$75 - \$194.60 = \778.40 . (The coinsurance is calculated as follows: $\$1,048 \text{ composite rate} - \$75 \text{ deductible} = \$973 \times .20 = \$194.60$).

(ii) The gross amount payable by Medicare minus the third party payment: $\$1,048 - \$1,024 = \$24$.

(iii) The provider's charges minus the third party payment: $\$1,280 - \$1,024 = \$256$.

(iv) The provider's charge minus the Medicare deductible and coinsurance: $\$1,280 - \$75 - \$194.60 = \$1,010.40$. Medicare pays \$24. The beneficiary's Medicare deductible and coinsurance were met by the third party payment.

(4) A hospital furnished 5 days of inpatient care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services were \$4,000 and the gross amount payable was \$3,500. The provider agreed to accept \$3,000 from the third party as payment in full. The third party payer paid \$2,900 due to a deductible requirement under the third party plan. Medicare considers the amount the provider is obligated to accept as full payment (\$3,000) to be the provider charges. The Medicare secondary payment is the lowest of the following:

(i) The gross amount payable by Medicare minus the Medicare inpatient deductible: $\$3,500 - \$520 = \$2,980$.

(ii) The gross amount payable by Medicare minus the third party payment: $\$3,500 - \$2,900 = \$600$.

(iii) The provider's charge minus the third party payment: $\$3,000 - \$2,900 = \$100$.

(iv) The provider's charges minus the Medicare inpatient deductible: $\$3,000 - \$520 = \$2,480$. The Medicare secondary payment is \$100. When Medicare is the secondary payer, the combined payment made by the third party payer and Medicare on behalf of the beneficiary is \$3,000. The beneficiary has no liability for Medicare-covered services since the third party payment satisfied the \$520 deductible.

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§ 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.

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(3) 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 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 §424.64 of this chapter.

§411.37 Amount of Medicare recovery when a third party payment is made as a result of a judgment or settlement.

(a) *Recovery against the party that received payment—*(1) *General rule.* Medicare reduces its recovery to take account of the cost of procuring the judgment or settlement, as provided in this section, if—

(i) Procurement costs are incurred because the claim is disputed; and

(ii) Those costs are borne by the party against which CMS seeks to recover.

(2) *Special rule.* If CMS must file suit because the party that received payment opposes CMS's recovery, the recovery amount is as set forth in paragraph (e) of this section.

(b) *Recovery against the third party payer.* If CMS seeks recovery from the third party payer, in accordance with §411.24(i), the recovery amount will be no greater than the amount determined under paragraph (c) or (d) or (e) of this section.

(c) *Medicare payments are less than the judgment or settlement amount.* If Medicare payments are less than the judgment or settlement amount, the recovery is computed as follows:

(1) Determine the ratio of the procurement costs to the total judgment or settlement payment.

(2) Apply the ratio to the Medicare payment. The product is the Medicare share of procurement costs.

(3) Subtract the Medicare share of procurement costs from the Medicare payments. The remainder is the Medicare recovery amount.

(d) *Medicare payments equal or exceed the judgment or settlement amount.* If

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Medicare payments equal or exceed the judgment or settlement amount, the recovery amount is the total judgment or settlement payment minus the total procurement costs.

(e) *CMS incurs procurement costs because of opposition to its recovery.* If CMS must bring suit against the party that received payment because that party opposes CMS's recovery, the recovery amount is the lower of the following:

(1) Medicare payment.

(2) The total judgment or settlement amount, minus the party's total procurement cost.

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

§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 §411.32 and §411.33.