

counted against the number of inpatient care days available to the beneficiary under Medicare Part A.

(b) *Deductibles.* Expenses for Medicare covered services that are paid for by primary payers are credited toward the Medicare Part A and Part B deductibles.

**§ 411.31 Authority to bill primary payers for full charges.**

(a) The fact that Medicare payments are limited to the DRG amount, or the reasonable charge, reasonable cost, capitation or fee schedule rate, does not affect the amount that a primary payer may pay.

(b) With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than title XVIII of the Act or by agreements with the primary payer.

**§ 411.32 Basis for Medicare secondary payments.**

(a) *Basic rules.* (1) Medicare benefits are secondary to benefits payable by a primary payer even if State law or the primary payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in § 411.33, to supplement the primary payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under § 411.33(e).

(b) *Exception.* Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a primary payment that is less than its charges.

(c) *General limitation: Failure to file a proper claim.* When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced primary payment because of failure to file a proper claim,

the Medicare secondary payment may not exceed the amount that would have been payable under § 411.33 if the primary payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

**§ 411.33 Amount of Medicare secondary payment.**

(a) *Services for which CMS pays on a Medicare fee schedule or reasonable charge basis.* The Medicare secondary payment is the lowest of the following:

(1) The actual charge by the supplier (or the amount the supplier is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the primary payer.

(2) The amount that Medicare would pay if the services were not covered by a primary payer.

(3) The higher of the Medicare fee schedule, Medicare reasonable charge, or other amount which would be payable under Medicare (without regard to any applicable Medicare deductible or coinsurance amounts) or the primary payer's allowable charge (without regard to any deductible or co-insurance imposed by the policy or plan) minus the amount actually paid by the primary payer.

(b) *Example:* An individual received treatment from a physician for which the physician charged \$175. The primary payer allowed \$150 of the charge and paid 80 percent of this amount or \$120. The Medicare fee schedule for this treatment is \$125. The individual's Part B deductible had been met. As secondary payer, Medicare pays the lowest of the following amounts:

(1) Excess of actual charge minus the primary payment:  $\$175 - \$120 = \$55$ .

(2) Amount Medicare would pay if the services were not covered by a primary payer:  $.80 \times \$125 = \$100$ .

(3) Primary payer's allowable charge without regard to its coinsurance (since that amount is higher than the Medicare fee schedule in this case) minus amount paid by the primary payer:  $\$150 - \$120 = \$30$ .

The Medicare payment is \$30.

(c)-(d) [Reserved]

(e) *Services reimbursed on a basis other than fee schedule, reasonable charge, or monthly capitation rate.* The Medicare secondary payment is the lowest of the following:

(1) The gross amount payable by Medicare (that is, the amount payable without considering the effect of the Medicare deductible and coinsurance or the payment by the primary payer), minus the applicable Medicare deductible and coinsurance amounts.

(2) The gross amount payable by Medicare, minus the amount paid by the primary payer.

(3) The provider's charges (or the amount the provider is obligated to accept as payment in full, if that is less than the charges), minus the amount payable by the primary payer.

(4) The provider's charges (or the amount the provider is obligated to accept as payment in full if that is less than the charges), minus the applicable Medicare deductible and coinsurance amounts.

(f) *Examples:* (1) A hospital furnished 7 days of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's charges for Medicare-covered services totaled \$2,800. The primary payer paid \$2,360. No part of the Medicare inpatient hospital deductible of \$520 had been met. If the gross amount payable by Medicare in this case is \$2,700, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare inpatient hospital deductible:  $\$2,700 - \$520 = \$2,180$ .

(ii) The gross amount payable by Medicare minus the primary payment:  $\$2,700 - \$2,360 = \$340$ .

(iii) The provider's charges minus the primary payment:  $\$2,800 - \$2,360 = \$440$ .

(iv) The provider's charges minus the Medicare deductible:  $\$2,800 - \$520 = \$2,280$ . Medicare's secondary payment is \$340 and the combined payment made by the primary payer and Medicare on behalf of the beneficiary is \$2,700. The \$520 deductible was satisfied by the primary payment so that the beneficiary incurred no out-of-pocket expenses.

(2) A hospital furnished 1 day of inpatient hospital care in 1987 to a Medicare beneficiary. The provider's

charges for Medicare-covered services totalled \$750. The primary payer paid \$450. No part of the Medicare inpatient hospital deductible had been met previously. The primary payment is credited toward that deductible. If the gross amount payable by Medicare in this case is \$850, then as secondary payer, Medicare pays the lowest of the following amounts:

(i) The gross amount payable by Medicare minus the Medicare deductible:  $\$850 - \$520 = \$330$ .

(ii) The gross amount payable by Medicare minus the primary payment:  $\$850 - \$450 = \$400$ .

(iii) The provider's charges minus the primary payment:  $\$750 - \$450 = \$300$ .

(iv) The provider's charges minus the Medicare deductible:  $\$750 - \$520 = \$230$ . Medicare's secondary payment is \$230, and the combined payment made by the primary payer and Medicare on behalf of the beneficiary is \$680. The hospital may bill the beneficiary \$70 (the \$520 deductible minus the \$450 primary 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 primary 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 primary payment:  $\$1,048 - \$1,024 = \$24$ .

(iii) The provider's charges minus the primary 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 primary 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 primary payer as payment in full. The primary payer paid \$2,900 due to a deductible requirement under the primary 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 primary payment:  $\$3,500 - \$2,900 = \$600$ .

(iii) The provider's charge minus the primary 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 primary payer and Medicare on behalf of the beneficiary is \$3,000. The beneficiary has no liability for Medicare-covered services since the primary payment satisfied the \$520 deductible.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45362, Aug. 31, 1995; 71 FR 9470, Feb. 24, 2006]

**§ 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 primary 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 bene-

ficiary 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 primary 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 primary 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 primary payment made or due to the beneficiary or to the provider or supplier for the medical services.

(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 primary 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 primary 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 primary payer.* If CMS seeks recovery from the primary payer, in accordance with § 411.24(i), the recovery amount will be