(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=1010.40. 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.

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

§ 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.

(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