

§411.25

until reimbursement is made, and is applied for full 30-day periods; and

(iii) The rate of interest is that provided at §405.378(d) of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995; 69 FR 45607, July 30, 2004]

§411.25 Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that CMS has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in §411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self-insured and self-administered, the employer must give the notice to CMS. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

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

§411.26 Subrogation and right to intervene.

(a) *Subrogation.* With respect to services for which Medicare paid, CMS is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) *Right to intervene.* CMS may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

§411.28 Waiver of recovery and compromise of claims.

(a) CMS may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and §405.376 of this chapter.

42 CFR Ch. IV (10–1–05 Edition)

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 61 FR 63749, Dec. 2, 1996]

§411.30 Effect of third party payment on benefit utilization and deductibles.

(a) *Benefit utilization.* Inpatient psychiatric hospital and SNF care that is paid for by a third party payer is not 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 third party payers are credited toward the Medicare Part A and Part B deductibles.

§411.31 Authority to bill third party 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 third party 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 third party payer.

§411.32 Basis for Medicare secondary payments.

(a) *Basic rules.* (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party 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 third party 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 third party 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 third party 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 third party 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 third party payer.

(2) The amount that Medicare would pay if the services were not covered by a third party 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 third party payer's allowable charge (without regard to any deductible or coinsurance imposed by the policy or plan) minus the amount actually paid by the third party payer.

(b) *Example:* An individual received treatment from a physician for which the physician charged \$175. The third party 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 third party payment: $\$175 - 120 = \55 .

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

(3) Third party 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 third party 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 third party payer), minus the applicable Medicare deductible and coinsurance amounts.

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