§ 409.85 Skilled nursing facility (SNF) care coinsurance.

(a) General provisions. (1) SNF care coinsurance is the amount chargeable to a beneficiary after the first 20 days of SNF care in a benefit period.

(2) For each day from the 21st through the 100th day, the coinsurance is 1⁄8 of the applicable inpatient hospital deductible.

(3) For coinsurance days before January 1, 1982, the coinsurance amount is based on the deductible applicable for the year in which the benefit period began. The coinsurance amounts do not change during a beneficiary’s benefit period even though the coinsurance days may fall in a subsequent year for which a higher deductible amount has been determined.

(4) For coinsurance days after December 31, 1981, the coinsurance amount is based on the deductible applicable for the calendar year in which the services were furnished.

(b) Specific coinsurance amounts. The specific SNF coinsurance amounts for each calendar year are published in the FEDERAL REGISTER no later than October 1 of the preceding year.

(c) Exception to published amounts. If the actual charge to the patient is less than the coinsurance amount applicable for the calendar year in which the services were furnished, the actual charge per day is the daily coinsurance.

§ 409.87 Blood deductible.

(a) General provisions. (1) As used in this section, packed red cells means the red blood cells that remain after plasma is separated from whole blood.

(2) A unit of packed red cells is treated as the equivalent of a unit of whole blood.

(3) Medicare does not pay for the first 3 units of whole blood or units of packed red cells that a beneficiary receives, during a calendar year, as an inpatient of a hospital or CAH or SNF, or on an outpatient basis under Medicare Part B.

(4) The deductible does not apply to other blood components such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin, or to the cost of processing, storing, and administering blood.

(5) The blood deductible is in addition to the inpatient hospital deductible and daily coinsurance.

(b) Beneficiary’s responsibility for the first 3 units of whole blood or packed red cells—(1) Basic rule. Except as specified in paragraph (b)(2) of this section, the beneficiary is responsible for the first 3 units of whole blood or packed red cells. He or she has the option of paying the hospital’s or CAH’s charges for the blood or packed red cells or arranging for it to be replaced.

(2) Exception. The beneficiary is not responsible for the first 3 units of whole blood or packed red cells if the provider obtained that blood or red cells at no charge other than a processing or service charge. In that case,
the blood or red cells is deemed to have been replaced.

(c) **Provider’s right to charge for the first 3 units of whole blood or packed red cells**—(1) **Basic rule.** Except as specified in paragraph (c)(2) of this section, a provider may charge a beneficiary its customary charge for any of the first 3 units of whole blood or packed red cells.

(2) **Exception.** A provider may not charge the beneficiary for the first 3 units of whole blood or packed red cells in any of the following circumstances:

(i) The blood or packed red cells has been replaced.

(ii) The provider (or its blood supplier) receives, from an individual or a blood bank, a replacement offer that meets the criteria specified in paragraph (d) of this section. The provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

(iii) The provider obtained the blood or packed red cells at no charge other than a processing or service charge and it is therefore deemed to have been replaced.

(d) **Criteria for replacement of blood.** A blood replacement offer made by a beneficiary, or an individual or a blood bank, a replacement offer that meets the criteria specified in paragraph (d) of this section. The provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

(i) The blood or packed red cells at no charge other than a processing or service charge and it is therefore deemed to have been replaced.

(ii) The provider (or its blood supplier) receives, from an individual or a blood bank, a replacement offer that meets the criteria specified in paragraph (d) of this section. The provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

(iii) The provider obtained the blood or packed red cells at no charge other than a processing or service charge and it is therefore deemed to have been replaced.

§ 409.89 Exemption of kidney donors from deductible and coinsurance requirements.

The deductible and coinsurance requirements set forth in this subpart do not apply to any services furnished to an individual in connection with the donation of a kidney for transplant surgery.