

deductible, the 1981 deductible was reduced to \$40 (\$60–\$20).

(h) *Examples of application of the annual deductible.* (1) Mr. A submitted claims for the following expenses incurred during 1982: \$20 for services furnished in March by physician X; \$30 for services furnished in April by physician Y; \$50 for services furnished in June by physician Z, for a total of \$100. The carrier determined that the charges as submitted were the reasonable charges. The first \$75 of expenses for which claims were processed is applied to meet the \$75 deductible for that year. Medicare Part B pays 80 percent of the remaining \$25, or \$20.

(2) Mr. B submitted a claim that included a \$25 charge by a doctor for an examination to prescribe a hearing aid and an \$80 charge for office surgery. This was the first claim relating to Mr. B's medical expenses processed in the calendar year. The carrier disallowed the \$25 charge because the type of examination is not covered by Medicare. The carrier reduced the \$80 surgery charge to a reasonable charge of \$40. Only the \$40 reasonable charge for covered services will count toward meeting Mr. B's deductible. Since the remainder of the surgery charge constitutes and excess over the reasonable charge, it cannot be applied to satisfy Mr. B's deductible.

(3) Mr. C became entitled to Medicare Part B benefits on July 1, 1982. He incurred expenses of \$200 in July, August, and September. The carrier determined that the charges as submitted were reasonable. Even though Mr. C was entitled to benefits for only half the year, he must meet the full \$75 deductible. Thus, \$75 of this expense constitutes Mr. C's deductible. Medicare would pay \$100, which is 80 percent of the remaining \$125.

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 8842, 8852, Mar. 1, 1991; 57 FR 24981, June 12, 1992; 62 FR 59101, Oct. 31, 1997; 69 FR 66423, Nov. 15, 2004; 71 FR 69785, Dec. 1, 2006; 73 FR 69934, Nov. 19, 2008; 75 FR 73615, Nov. 29, 2010; 77 FR 69363, Nov. 16, 2012; 80 FR 71373, Nov. 16, 2015]

#### § 410.161 Part B blood deductible.

(a) *General rules.* (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 pint of whole blood, which in this section is referred to as 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 are furnished under Part A or Part B in a calendar year. The Part B blood deductible is reduced to the extent that a blood deductible has been applied under Part A.

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

(5) The blood deductible is in addition to the Part B annual deductible specified in § 410.160.

(b) *Beneficiary's responsibility for the first 3 units of blood.* (1) The beneficiary is responsible for the first three units of whole blood or packed red cells received during a calendar year.

(2) If the blood is furnished by a hospital or CAH, the rules set forth in § 409.87 (b), (c), and (d) of this chapter apply.

(3) If the blood is furnished by a physician, clinic, or other supplier that has accepted assignment of Medicare benefits, or claims payment under § 424.64 of this chapter because the beneficiary died without assigning benefits, the supplier may charge the beneficiary the reasonable charge for the first 3 units, to the extent that those units are not replaced.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 56 FR 8852, Mar. 1, 1991; 58 FR 30668, May 26, 1993]

#### § 410.163 Payment for services furnished to kidney donors.

Notwithstanding any other provisions of this chapter, there are no deductible or coinsurance requirements with respect to services furnished to an individual who donates a kidney for transplant surgery.