

#### § 409.85

#### 42 CFR Ch. IV (10-1-24 Edition)

the services were furnished. For example, if an individual starts a benefit period by being admitted to a hospital in 1981 and remains in the hospital long enough to use coinsurance days in 1982, the coinsurance amount charged for those days is based on the 1982 inpatient hospital deductible.

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

(c) *Exceptions to published amounts.* (1) If the actual charge to the patient for the 61st through the 90th day of inpatient hospital or inpatient CAH services 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 amount.

(2) If the actual charge to the patient for the 91st through the 150th day (lifetime reserve days) is less than the coinsurance amount applicable for the calendar year in which the services were furnished, the beneficiary is deemed to have elected not to use the days because he or she would not benefit from using them.

[48 FR 12541, Mar. 25, 1983, as amended at 54 FR 4026, Jan. 27, 1989; 58 FR 30666, 30667, May 26, 1993]

#### § 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  $\frac{1}{3}$  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 ap-

plicable 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.

[48 FR 12541, Mar. 25, 1983, as amended at 54 FR 4026, Jan. 27, 1989]

#### § 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.

(6) The Part A blood deductible is reduced to the extent that the Part B blood deductible has been applied. For example, if a beneficiary had received one unit under Medicare Part B, and later in the same benefit period received three units under Medicare Part A, Medicare Part A would pay for the third of the latter units. (As specified in §410.161 of this chapter, the Part B blood deductible is reduced to the extent a blood deductible has been applied under Medicare Part A.)

(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 on behalf of a beneficiary, discharges the beneficiary's obligation to pay for deductible blood or packed red cells if the replacement blood meets the applicable criteria specified in Food and Drug Administration regulations under 21 CFR part 640, i.e.—

(1) The replacement blood would not endanger the health of a beneficiary; and

(2) The prospective donor's health would not be endangered by making a blood donation.

[48 FR 12541, Mar. 25, 1983, as amended at 56 FR 8840, Mar. 1, 1991; 57 FR 36014, Aug. 12, 1992; 58 FR 30666, 30667, May 26, 1993]

#### **§ 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.

### **Subpart H—Payment of Hospital Insurance Benefits**

SOURCE: 53 FR 6633, Mar. 2, 1988, unless otherwise noted.

#### **§ 409.100 To whom payment is made.**

(a) *Basic rule.* Except as provided in paragraph (b) of this section—

(1) Medicare pays hospital insurance benefits only to a participating provider.

(2) For home health services (including medical supplies described in section 1861(m)(5) of the Act, but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA, payment is made to the HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

(b) *Exceptions.* Medicare may pay hospital insurance benefits as follows:

(1) For emergency services furnished by a nonparticipating hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart G of part 424 of this chapter.

(2) For services furnished by a Canadian or Mexican hospital, to the hospital or to the beneficiary, under the conditions prescribed in subpart H of part 424 of this chapter.

[53 FR 6633, Mar. 2, 1988, as amended at 65 FR 41211, July 3, 2000]

#### **§ 409.102 Amounts of payment.**

(a) The amounts Medicare pays for hospital insurance benefits are generally determined in accordance with part 412 or part 413 of this chapter.

(b) Except as provided in §§ 409.61(d) and 409.89, hospital insurance benefits