

§ 489.31

(2) For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary's deductible status.

(i) If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to \$75.

(ii) If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

(3) In either of the cases discussed in paragraph (b)(2) of this section, the hospital is required to file with the intermediary, on a form prescribed by CMS, information as to the services, charges, and amounts collected.

(4) The intermediary must reimburse the beneficiary if reimbursement is authorized and credit the expenses to the beneficiary's deductible if the deductible has not yet been met.

(5) In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the customary (insofar as reasonable) charge for the services, with the following exception: If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 41350, Nov. 14, 1986]

§ 489.31 Allowable charges: Blood.

(a) *Limitations on charges.* (1) A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished under Medicare Part A during a calendar year, or furnished under Medicare Part B during a calendar year.

(2) The charges may not exceed the provider's customary charges.

(3) The provider may not charge for any whole blood or packed red cells in any of the circumstances specified in § 409.87(c)(2) of this chapter.

(b) *Offset for excessive charges.* If the charge exceeds the cost to the provider,

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that excess will be deducted from any Medicare payments due the provider.

[56 FR 23022, May 20, 1991, as amended at 57 FR 36018, Aug. 12, 1992]

§ 489.32 Allowable charges: Non-covered and partially covered services.

(a) *Services requested by beneficiary.* If services furnished at the request of a beneficiary (or his or her representative) are more expensive than, or in excess of, services covered under Medicare—

(1) A provider may charge the beneficiary an amount that does not exceed the difference between—

(i) The provider's customary charges for the services furnished; and

(ii) The provider's customary charges for the kinds and amounts of services that are covered under Medicare.

(2) A provider may not charge for the services unless they have been requested by the beneficiary (or his or her representative) nor require a beneficiary to request services as a condition of admission.

(3) To avoid misunderstanding and disputes, a provider must inform any beneficiary who requests a service for which a charge will be made that there will be a specified charge for that service.

(b) *Services not requested by the beneficiary.* For special provisions that apply when a provider customarily furnishes more expensive services, see § 413.35 of this chapter.

[45 FR 22937, Apr. 4, 1980, as amended at 51 FR 34833, Sept. 30, 1986]

§ 489.34 Allowable charges: Hospitals participating in State reimbursement control systems or demonstration projects.

A hospital receiving payment for a covered hospital stay under either a State reimbursement control system approved under 1886(c) of the Act or a demonstration project authorized under section 402(a) of Pub. L. 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Pub. L. 92-603 (42 U.S.C. 1395b-1 (note)) and that would otherwise be subject to the prospective payment system set forth in part 412 of this chapter may charge a beneficiary for noncovered services as follows: