

§ 489.31

beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no co-insurance 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, 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.

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(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:

(a) For the custodial care and medically unnecessary services described in § 412.42(c) of this chapter, after the conditions of § 412.42(c)(1) through (c)(4) are met; and

(b) For all other services in accordance with the applicable rules of this subpart C.

[54 FR 41747, Oct. 11, 1989]

§ 489.35 Notice to intermediary.

The provider must inform its intermediary of any amounts collected from a beneficiary or from other persons on his or her behalf.

Subpart D—Handling of Incorrect Collections

§ 489.40 Definition of incorrect collection.

(a) As used in this subpart, “incorrect collections” means any amounts collected from a beneficiary (or someone on his or her behalf) that are not authorized under subpart C of this part.

(b) A payment properly made to a provider by an individual not considered entitled to Medicare benefits will be deemed to be an “incorrect collection” when the individual is found to be retroactively entitled to benefits.