

(2) For 2005, the deductible is \$110.

(3) From 1991 through 2004, the deductible was \$100.

(4) From 1982 through 1990, the deductible was \$75.

(5) From 1973 through 1981, the deductible was \$60.

(6) From 1966 through 1972, the deductible was \$50.

(g) *Carryover of Part B annual deductible.* For calendar years before 1982, the Part B annual deductible was reduced by the amount of expenses incurred during the last quarter of the preceding year that was applied to meet the deductible for that preceding year. *Example:* If \$20 of expenses incurred in November 1980 was used to meet the 1980 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 en-

titled 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]

§ 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

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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.

§410.165 Payment for rural health clinic services and ambulatory surgical center services: Conditions.

(a) Medicare Part B pays for covered rural health clinic and Federally qualified health center services if—

(1) The services are furnished in accordance with the requirements of subpart X of part 405 of this chapter and subpart A of part 491 of this chapter; and

(2) The clinic or center files a written request for payment on the form and in the manner prescribed by CMS.

(b) Medicare Part B pays for covered ambulatory surgical center (ASC) services if—

(1) The services are furnished in accordance with the requirements of part 416 of this chapter; and

(2) The ASC files a written request for payment on the form and in the manner prescribed by CMS.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 24981, June 12, 1992]

§410.170 Payment for home health services, for medical and other health services furnished by a provider or an approved ESRD facility, and for comprehensive outpatient rehabilitation facility (CORF) services: Conditions.

Payment under Medicare Part B, for home health services, for medical and other health services, or for CORF services, may be made to the provider or facility only if the following conditions are met:

(a) *Request for payment.* A written request for payment is filed by or on behalf of the individual to whom the services were furnished.

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(b) *Physician certification.* (1) For home health services, a physician provides certification and recertification in accordance with §424.22 of this chapter.

(2) For medical and other health services, a physician provides certification and recertification in accordance with §424.24 of this chapter.

(3) For CORF services, a physician provides certification and recertification in accordance with §424.27 of this chapter.

(c) In the case of home dialysis support services described in §410.52, the services are furnished in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition as required by §494.90 of this chapter.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988; 73 FR 20474, Apr. 15, 2008]

§410.172 Payment for partial hospitalization services in CMHCs: Conditions.

Medicare Part B pays for partial hospitalization services furnished in a CMHC on behalf of an individual only if the following conditions are met:

(a) The CMHC files a written request for payment on the CMS form 1450 and in the manner prescribed by CMS; and

(b) The services are furnished in accordance with the requirements described in §410.110.

[59 FR 6578, Feb. 11, 1994]

§410.175 Alien absent from the United States.

(a) Medicare does not pay Part B benefits for services furnished to an individual who is not a citizen or a national of the United States if those services are furnished in any month for which the individual is not paid monthly social security cash benefits (or would not be paid if he or she were entitled to those benefits) because he or she has been outside the United States continuously for 6 full calendar months.

(b) Payment of benefits resumes with services furnished during the first full