

§ 410.25 Limitations on services of a podiatrist.

Medicare Part B pays for the services of a doctor of podiatric medicine, acting within the scope of his or her license, if the services would be covered as physicians' services when performed by a doctor of medicine or osteopathy.

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

(a) Medicare Part B pays for services and supplies incident to a physician's professional services, including drugs and biologicals that cannot be self-administered, if the services or supplies are of the type that are commonly furnished in a physician's office or clinic, and are commonly furnished either without charge, or included in the physician's bill.

(b) Drugs and biologicals are also subject to the limitations specified in § 410.29.

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

(i) By or under arrangements made by a participating hospital, except in the case of an SNF resident as provided in § 411.15(p) of this chapter;

(ii) As an integral though incidental part of a physician's services; and

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter; and

(2) In the case of partial hospitalization services, also meet the conditions of paragraph (d) of this section.

(b) Drugs and biologicals are also subject to the limitations specified in § 410.168.

(c) Rules on emergency services furnished to outpatients by nonparticipating hospitals are specified in § 410.168.

(d) Medicare Part B pays for partial hospitalization services if they are—

(1) Prescribed by a physician who certifies and recertifies the need for the services in accordance with subpart B of part 424 of this chapter; and

(2) Furnished under a plan of treatment as required under subpart B of part 424 of this chapter.

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.42(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter must be under the direct supervision of a physician. "Direct supervision" means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

[56 FR 8841, Mar. 1, 1991, as amended at 63 FR 26307, May 12, 1998; 65 FR 18536, Apr. 7, 2000]

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

(a) Medicare Part B pays for hospital or CAH diagnostic services furnished to outpatients, including drugs and biologicals required in the performance of the services (even if those drugs or biologicals are self-administered), if those services meet the following conditions:

(1) They are furnished by or under arrangements made by a participating hospital or participating CAH, except in the case of an SNF resident as provided in § 411.15(p) of this chapter.

(2) They are ordinarily furnished by, or under arrangements made by, the hospital or CAH to its outpatients for the purpose of diagnostic study.

(3) They would be covered as inpatient hospital services if furnished to an inpatient.

(b) Drugs and biologicals are also subject to the limitations specified in § 410.29(b) and (c).

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.42(a).

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(d) Rules on emergency services furnished to outpatients by nonparticipating hospitals are set forth in subpart G of part 424 of this chapter.

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic services furnished at a facility (other than an RHC or an FQHC) that HCFA designates as having provider-based status only when the diagnostic services are furnished under the appropriate level of physician supervision specified by HCFA in accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii). Under general supervision at a facility accorded provider-based status, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the facility.

[51 FR 41339, Nov. 14, 1986, as amended at 58 FR 30668, May 26, 1993; 63 FR 26307, May 12, 1998; 65 FR 18536, Apr. 7, 2000]

§ 410.29 Limitations on drugs and biologicals.

Medicare part B does not pay for the following:

(a) Except as provided in § 410.28(a) for outpatient diagnostic services and § 410.63(b) for blood clotting factors, and except for EPO, any drug or biological that can be self-administered.

(b) Any drug product that meets all of the following conditions:

(1) The drug product was approved by the Food and Drug Administration (FDA) before October 10, 1962.

(2) The drug product is available only through prescription.

(3) The drug product is the subject of a notice of opportunity for hearing issued under section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the FEDERAL REGISTER on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.

(4) The drug product is presently not subject to a determination by FDA, made under its efficacy review program, that there is a compelling justification of the drug product's medical need. (21 CFR 310.6 contains an explanation of the efficacy review program.)

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(c) Any drug product that is identical, related, or similar, as defined in 21 CFR 310.6, to a drug product that meets the conditions of paragraph (b) of this section.

[51 FR 41339, Nov. 14, 1986, as amended at 55 FR 22790, June 4, 1990; 56 FR 43709, Sept. 4, 1991]

§ 410.30 Prescription drugs used in immunosuppressive therapy.

(a) *Scope.* Payment may be made for prescription drugs used in immunosuppressive therapy that have been approved for marketing by the FDA and that meet one of the following conditions:

(1) The approved labeling includes the indication for preventing or treating the rejection of a transplanted organ or tissue.

(2) The approved labeling includes the indication for use in conjunction with immunosuppressive drugs to prevent or treat rejection of a transplanted organ or tissue.

(3) Have been determined by a carrier (in accordance with part 421, subpart C of this chapter), in processing a Medicare claim, to be reasonable and necessary for the specific purpose of preventing or treating the rejection of a patient's transplanted organ or tissue, or for use in conjunction with immunosuppressive drugs for the purpose of preventing or treating the rejection of a patient's transplanted organ or tissue. (In making these determinations, the carriers may consider factors such as authoritative drug compendia, current medical literature, recognized standards of medical practice, and professional medical publications.)

(b) *Period of eligibility.* Coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who receives an organ or tissue transplant for which Medicare payment is made, for the following periods:

(1) For drugs furnished before 1995, for a period of up to 1 year beginning with the date of discharge from the hospital during which the covered transplant was performed.

(2) For drugs furnished during 1995, within 18 months after the date of discharge from the hospital during which the covered transplant was performed.