

a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. (Nonphysician practitioners may order tests as set forth in § 410.32(a)(3).) The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiary's treating physician. That is, the physician in question had a relationship with the beneficiary prior to the performance of the testing and is treating the beneficiary for a specific medical problem. The IDTF may not add any procedures based on internal protocols without a written order from the treating physician.

(e) *Multi-State entities.* An IDTF that operates across State boundaries must maintain documentation that its supervising physicians and technicians are licensed and certified in each of the States in which it is furnishing services.

(f) *Applicability of State law.* An IDTF must comply with the applicable laws of any State in which it operates.

[62 FR 59099, Oct. 31, 1997]

§ 410.34 Mammography services: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

(1) *Diagnostic mammography* means a radiologic procedure furnished to a man or woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure.

(2) *Screening mammography* means a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure.

(3) *Supplier of diagnostic mammography* means a facility that is certified and responsible for ensuring that all diagnostic mammography services furnished to Medicare beneficiaries meet the conditions for coverage of diag-

nostic mammography services as specified in paragraph (b) of this section.

(4) *Supplier of screening mammography* means a facility that is certified and responsible for ensuring that all screening mammography services furnished to Medicare beneficiaries meet the conditions and limitations for coverage of screening mammography services as specified in paragraphs (c) and (d) of this section.

(5) *Certificate* means the certificate described in 21 CFR 900.2(b) that may be issued to, or renewed for, a facility that meets the requirements for conducting an examination or procedure involving mammography.

(6) *Provisional certificate* means the provisional certificate described in 21 CFR 900.2(m) that may be issued to a facility to enable the facility to qualify to meet the requirements for conducting an examination or procedure involving mammography.

(7) The term *meets the certification requirements of section 354 of the Public Health Service (PHS) Act* means that in order to qualify for coverage of its services under the Medicare program, a supplier of diagnostic or screening mammography services must meet the following requirements:

(i) Must have a valid provisional certificate, or a valid certificate, that has been issued by FDA indicating that the supplier meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(ii) Has not been issued a written notification by FDA that states that the supplier must cease conducting mammography examinations because the supplier is not in compliance with certain critical certification requirements of section 354 of the PHS Act, implemented by 21 CFR part 900, subpart B.

(iii) Must not employ for provision of the professional component of mammography services a physician or physicians for whom the facility has received written notification by FDA that the physician (or physicians) is (or are) in violation of the certification requirements set forth in section 354 of the PHS Act, as implemented by 21 CFR 900.12(a)(1)(i).

(b) *Conditions for coverage of diagnostic mammography services.* Medicare

Part B pays for diagnostic mammography services if they meet the following conditions:

(1) They are ordered by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(2) They are furnished by a supplier of diagnostic mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(c) *Conditions for coverage of screening mammography services.* Medicare Part B pays for screening mammography services if they are furnished by a supplier of screening mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(d) *Limitations on coverage of screening mammography services.* The following limitations apply to coverage of screening mammography services as described in paragraphs (c) and (d) of this section:

(1) The service must be, at a minimum a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of each breast.

(2) Payment may not be made for screening mammography performed on a woman under age 35.

(3) Payment may be made for only 1 screening mammography performed on a woman over age 34, but under age 40.

(4) For an asymptomatic woman over 39 years of age, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

[59 FR 49833, Sept. 30, 1994, as amended at 60 FR 14224, Mar. 16, 1995; 60 FR 63176, Dec. 8, 1995; 62 FR 59100, Oct. 31, 1997; 63 FR 4596, Jan. 30, 1998]

§ 410.35 X-ray therapy and other radiation therapy services: Scope.

Medicare Part B pays for X-ray therapy and other radiation therapy services, including radium therapy and radioactive isotope therapy, and materials and the services of technicians administering the treatment.

[51 FR 41339, Nov. 14, 1986. Redesignated at 55 FR 53522, Dec. 31, 1990]

§ 410.36 Medical supplies, appliances, and devices: Scope.

(a) Medicare Part B pays for the following medical supplies, appliances and devices:

(1) Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

(2) Prosthetic devices, other than dental, that replace all or part of an internal body organ, including colostomy bags and supplies directly related to colostomy care, including—

(i) Replacement of prosthetic devices; and

(ii) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted.

(3) Leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the individual's physical condition.

(b) As a requirement for payment, HCFA may determine through carrier instructions, or carriers may determine, that an item listed in paragraph (a) of this section requires a written physician order before delivery of the item.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 36014, Aug. 12, 1992; 57 FR 57688, Dec. 7, 1992]

§ 410.37 Colorectal cancer screening tests: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

(1) *Colorectal cancer screening tests* means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(i) Screening fecal-occult blood tests.
(ii) Screening flexible sigmoidoscopies.

(iii) In the case of an individual at high risk for colorectal cancer, screening colonoscopies.

(iv) Screening barium enemas.

(v) Other tests or procedures, and modifications to tests under this paragraph, with such frequency and payment limits as HCFA determines appropriate, in consultation with appropriate organizations.