

barium enema or screening flexible sigmoidoscopy was performed.

(2) In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed.

[62 FR 59100, Oct. 31, 1997]

§ 410.38 Durable medical equipment: Scope and conditions.

(a) Medicare Part B pays for the rental or purchase of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home.

(b) An institution that is used as a home may not be a hospital or a CAH or a SNF as defined in sections 1861(e)(1), 1861(mm)(1) and 1819(a)(1) of the Act, respectively.

(c) Wheelchairs may include a power-operated vehicle that may be appropriately used as a wheelchair, but only if the vehicle—

(1) Is determined to be necessary on the basis of the individual's medical and physical condition;

(2) Meets any safety requirements specified by HCFA; and

(3) Except as provided in paragraph (c)(2) of this section, is ordered in writing by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology, the written order is furnished to the supplier before the delivery of the vehicle to the beneficiary, and the beneficiary requires the vehicle and is capable of using it.

(4) A written prescription from the beneficiary's physician is acceptable for ordering a power-operated vehicle if a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology is not reasonably accessible. For example, if travel to the specialist would be more than one day's trip from the beneficiary's home or if the beneficiary's medical condition precluded travel to the nearest available specialist, these circumstances would satisfy the "not reasonably accessible" requirement.

(d) Medicare Part B pays for medically necessary equipment that is used for treatment of decubitus ulcers if—

(1) The equipment is ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to the supplier before the delivery of the equipment; and

(2) The prescribing physician has specified in the prescription that he or she will be supervising the use of the equipment in connection with the course of treatment.

(e) Medicare Part B pays for a medically necessary seat-lift if it—

(1) Is ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to the supplier before the delivery of the seat-lift;

(2) Is for a beneficiary who has a diagnosis designated by HCFA as requiring a seat-lift; and

(3) Meets safety requirements specified by HCFA.

(f) Medicare Part B pays for transcutaneous electrical nerve stimulator units that are—

(1) Determined to be medically necessary; and

(2) Ordered in writing by the beneficiary's attending physician, or by a specialty physician on referral from the beneficiary's attending physician, and the written order is furnished to the supplier before the delivery of the unit to the beneficiary.

(g) As a requirement for payment, HCFA may determine through carrier instructions, or carriers may determine that an item of durable medical equipment requires a written physician order before delivery of the item.

[51 FR 41339, Nov. 14, 1986, as amended at 57 FR 57688, Dec. 7, 1992; 58 FR 30668, May 26, 1993]

§ 410.40 Coverage of ambulance services.

(a) *Basic rules.* Medicare Part B covers ambulance services if the following conditions are met:

(1) The supplier meets the applicable vehicle, staff, and billing and reporting requirements of § 410.41 and the service

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meets the medical necessity and origin and destination requirements of paragraphs (d) and (e) of this section.

(2) Medicare Part A payment is not made directly or indirectly for the services.

(b) *Levels of services.* Medicare covers ambulance services within the United States at the following levels of services:

(1) Basic life support (BLS) services.

(2) Advanced life support (ALS) services.

(3) Paramedic ALS intercept services described in paragraph (c) of this section.

(c) *Paramedic ALS intercept services.* Paramedic ALS intercept services must meet the following requirements:

(1) Be furnished in a rural area (as defined in § 412.62(f) of this chapter).

(2) Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

(i) Are certified to furnish ambulance services as required under § 410.41.

(ii) Furnish services only at the BLS level.

(iii) Be prohibited by State law from billing for any service.

(3) Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

(i) Is certified to furnish ALS services as required in § 410.41(b)(2).

(ii) Bills all the recipients who receive ALS intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

(d) *Medical necessity requirements—(1) General rule.* Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. For nonemergency ambulance transportation, the following criteria must be met to ensure that ambulance transportation is medically necessary:

(i) The beneficiary is unable to get up from bed without assistance.

(ii) The beneficiary is unable to ambulate.

(iii) The beneficiary is unable to sit in a chair or wheelchair.

(2) *Special rule for nonemergency, scheduled ambulance services.* Medicare

covers nonemergency, scheduled ambulance services if the ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.

(3) *Special rule for nonemergency, unscheduled ambulance services.* Medicare covers nonemergency, unscheduled ambulance services under the following circumstances:

(i) For a resident of a facility who is under the care of a physician if the ambulance supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.

(ii) For a beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required.

(e) *Origin and destination requirements.* Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary's illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.

(2) From a hospital, CAH, or SNF to the beneficiary's home.

(3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

(4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

(f) *Specific limits on coverage of ambulance services outside the United States.* If services are furnished outside the United States, Medicare Part B covers ambulance transportation to a foreign hospital only in conjunction with the beneficiary's admission for medically

necessary inpatient services as specified in subpart H of part 424 of this chapter.

[64 FR 3648, Jan. 25, 1999]

§ 410.41 Requirements for ambulance suppliers.

(a) *Vehicle.* A vehicle used as an ambulance must meet the following requirements:

(1) Be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle.

(2) Be equipped with emergency warning lights and sirens, as required by State or local laws.

(3) Be equipped with telecommunications equipment as required by State or local law to include, at a minimum, one two-way voice radio or wireless telephone.

(4) Be equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment as required by State or local laws.

(b) *Vehicle staff—(1) BLS vehicles.* A vehicle furnishing ambulance services must be staffed by at least two people, one of whom must meet the following requirements:

(i) Be certified as an emergency medical technician by the State or local authority where the services are furnished.

(ii) Be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

(2) *ALS vehicles.* In addition to meeting the vehicle staff requirements of paragraph (b)(1) of this section, one of the two staff members must be certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.

(c) *Billing and reporting requirements.* An ambulance supplier must comply with the following requirements:

(1) Bill for ambulance services using HCFA-designated procedure codes to describe origin and destination and indicate on claims form that the physician certification is on file.

(2) Upon a carrier's request, complete and return the ambulance supplier form designated by HCFA and provide the Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws.

(3) Upon a carrier's request, provide additional information and documentation as required.

[64 FR 3648, Jan. 25, 1999]

§ 410.43 Partial hospitalization services: Conditions and exclusions.

(a) Partial hospitalization services are services that—

(1) Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(2) Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and

(3) Include any of the following:

(i) Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law.

(ii) Occupational therapy requiring the skills of a qualified occupational therapist.

(iii) Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.

(iv) Drugs and biologicals furnished for therapeutic purposes, subject to the limitations specified in § 410.29.

(v) Individualized activity therapies that are not primarily recreational or diversionary.

(vi) Family counseling, the primary purpose of which is treatment of the individual's condition.

(vii) Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment.

(viii) Diagnostic services.

(b) The following services are separately covered and not paid as partial hospitalization services:

(1) Physicians' services that meet the criteria of part 405, subpart F of this chapter for payment on a fee schedule basis in accordance with part 414 of this chapter.