

service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,

(iv) If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (d)(3)(iii) of this section.

(v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

(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, as amended at 65 FR 13914, Mar. 15, 2000; 67 FR 9132, Feb. 27, 2002]

#### § 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.

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

(1) Bill for ambulance services using CMS-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 CMS 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]

### § 410.42 Limitations on coverage of certain services furnished to hospital outpatients.

(a) *General rule.* Except as provided in paragraph (b) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients. As used in this paragraph, the term "hospital" includes a CAH.

(b) *Exception.* The limitations stated in paragraph (a) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

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(7) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

[65 FR 18536, Apr. 7, 2000]

### § 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) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Qualified psychologist services, as defined in section 1861(ii) of the Act.