

§ 410.38

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screening barium enema or the last screening colonoscopy was performed.

[62 FR 59100, Oct. 31, 1997, as amended at 66 FR 55329, Nov. 1, 2001; 67 FR 80040, Dec. 31, 2002]

§ 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) *Power mobility devices (PMDs)*—(1) *Definitions.* For the purposes of this paragraph, the following definitions apply:

Physician has the same meaning as in section 1861(r)(1) of the Act.

Power mobility device means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

Prescription means a written order completed by the physician or treating practitioner who performed the face-to-face examination and that includes the beneficiary's name, the date of the face-to-face examination, the diagnoses and conditions that the PMD is expected to modify, a description of the item (for example, a narrative description of the specific type of PMD), the length of need, and the physician or treating practitioner's signature and the date the prescription was written.

Treating practitioner means a physician assistant, nurse practitioner, or clinical nurse specialist as those terms are defined in section 1861(aa)(5) of the Act, who has conducted a face-to-face examination of the beneficiary.

Supplier means an entity with a valid Medicare supplier number, including

an entity that furnishes items through the mail.

(2) *Conditions of payment.* Medicare Part B pays for a power mobility device if the physician or treating practitioner, as defined in paragraph (c)(1) of this section meets the following conditions:

(i) Conducts a face-to-face examination of the beneficiary for the purpose of evaluating and treating the beneficiary for his or her medical condition and determining the medical necessity for the PMD as part of an appropriate overall treatment plan.

(ii) Writes a prescription, as defined in paragraph (c)(1) of this section that is provided to the beneficiary or supplier, and is received by the supplier within 45 days after the face-to-face examination.

(iii) Provides supporting documentation, including pertinent parts of the beneficiary's medical record (for example, history, physical examination, diagnostic tests, summary of findings, diagnoses, treatment plans and/or other information as may be appropriate) that supports the medical necessity for the power mobility device, which is received by the supplier within 45 days after the face-to-face examination.

(3) *Exceptions.* (i) Beneficiaries discharged from a hospital do not need to receive a separate face-to-face examination as long as the physician or treating practitioner who performed the face-to-face examination of the beneficiary in the hospital issues a PMD prescription and supporting documentation that is received by the supplier within 45 days after the date of discharge.

(ii) Accessories for PMDs may be ordered by the physician or treating practitioner without conducting a face-to-face examination of the beneficiary.

(4) *Dispensing a power mobility device.* Suppliers may not dispense a PMD to a beneficiary until the PMD prescription and the supporting documentation have been received from the physician or treating practitioner who performed the face-to-face examination of the beneficiary. These documents must be received within 45 days after the date of the face-to-face examination.

(5) *Documentation.* (i) A supplier must maintain the prescription and the supporting documentation provided by the physician or treating practitioner and make them available to CMS and its agents upon request.

(ii) Upon request by CMS or its agents, a supplier must submit additional documentation to CMS or its agents to support and/or substantiate the medical necessity for the power mobility device.

(6) *Safety requirements.* The PMD must meet any safety requirements specified by CMS.

(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 CMS as requiring a seat-lift; and

(3) Meets safety requirements specified by CMS.

(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, CMS may determine through carrier instructions, or carriers may deter-

mine 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; 70 FR 50946, Aug. 26, 2005; 71 FR 17030, Apr. 5, 2006]

§ 410.39 Prostate cancer screening tests: Conditions for and limitations on coverage.

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

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

(i) A screening digital rectal examination.

(ii) A screening prostate-specific antigen blood test.

(iii) For years beginning after 2002, other procedures CMS finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and other factors CMS considers appropriate.

(2) *A screening digital rectal examination* means a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate.

(3) *A screening prostate-specific antigen blood test* means a test that measures the level of prostate-specific antigen in an individual's blood.

(4) A physician for purposes of this provision means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the screening examination or test.

(5) A physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife for purposes of this provision means a physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (as defined in sections 1861(aa) and 1861(gg) of the Act) who is fully knowledgeable about the beneficiary, and who would be responsible for explaining the results of the screening examination or test.