(e) Eligible risk factors. Individuals with the following risk factors are eligible to receive the benefit:

1. Hypertension.
2. Dyslipidemia.
3. Obesity, defined as a body mass index greater than or equal to 30 kg/m².
4. Prior identification of impaired fasting glucose or glucose intolerance.
5. Any two of the following characteristics:
   i. Overweight, defined as body mass index greater than 25, but less than 30 kg/m².
   ii. A family history of diabetes.
   iii. 65 years of age or older.
   iv. A history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.

[69 FR 66421, Nov. 15, 2004]

§ 410.19 Ultrasound screening for abdominal aortic aneurysms: Condition for and limitation on coverage.

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

Eligible beneficiary means an individual who—

1. Has received a referral for an ultrasound screening for an abdominal aortic aneurysm as a result of an initial preventive physical examination (as defined in section 1861(ww)(1) of the Act);
2. Has not been previously furnished an ultrasound screening for an abdominal aortic aneurysm under Medicare program; and
3. Is included in at least one of the following risk categories:
   i. Has a family history of an abdominal aortic aneurysm.
   ii. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime.
   iii. Is an individual who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding abdominal aortic aneurysms, as specified by the Secretary through a national coverage determination process.

Ultrasound screening for abdominal aortic aneurysms means the following services furnished to an asymptomatic individual for the early detection of an abdominal aortic aneurysm:

1. A procedure using soundwaves (or other procedures using alternative technologies of commensurate accuracy and cost, as specified by the Secretary through a national coverage determination process) provided for the early detection of abdominal aortic aneurysms.
2. Includes a physician’s interpretation of the results of the procedure.

(b) Conditions for coverage of an ultrasound screening for abdominal aortic aneurysms. Medicare Part B pays for one ultrasound screening for an abdominal aortic aneurysm provided to eligible beneficiaries, as described in this section, after a referral from a physician or a qualified nonphysician practitioner as defined in §410.16(a), when the test is performed by a provider or supplier that is authorized to provide covered ultrasound diagnostic services.

(c) Limitation on coverage of ultrasound screening for abdominal aortic aneurysms. Payment may not be made for an ultrasound screening for an abdominal aortic aneurysm that is performed for an individual that does not meet the definition of “eligible beneficiary” specified in this section.

[71 FR 69783, Dec. 1, 2006]

§ 410.20 Physicians’ services.

(a) Included services. Medicare Part B pays for physicians’ services, including diagnosis, therapy, surgery, consultations, and home, office, and institutional calls.

(b) By whom services must be furnished. Medicare Part B pays for the services specified in paragraph (a) of this section if they are furnished by one of the following professionals who is legally authorized to practice by the State in which he or she performs the functions or actions, and who is acting within the scope of his or her license:

1. A doctor of medicine or osteopathy, including an osteopathic practitioner recognized in section 1101(a)(7) of the Act.
2. A doctor of dental surgery or dental medicine.
3. A doctor of podiatric medicine.
4. A doctor of optometry.
5. A chiropractor who meets the qualifications specified in §410.22.
(c) Limitations on services. The Services specified in paragraph (a) of this section may be covered under Medicare Part B if they are furnished within the limitations specified in §§410.22 through 410.25.

(d) Prior determination of medical necessity for physicians’ services—(1) Definitions. (i) A “Prior Determination of Medical Necessity” means an individual decision by a Medicare contractor, before a physician’s service is furnished, as to whether or not the physician’s service is covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity.

(ii) An “eligible requester” includes the following:

(A) A participating physician (or a physician that accepts assignment), but only with respect to physicians’ services to be furnished to an individual who is entitled to receive benefits under this part and who has consented to the physician making the request under this section for those physicians’ services.

(B) An individual entitled to benefits under this part, but only with respect to physicians’ services for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a) of the Act.

(2) General rule. Each Medicare contractor will, through the procedures established in CMS manual instructions, allow requests for prior determinations of medical necessity from eligible requesters under this section for those physicians’ services.

(B) An individual entitled to benefits under this part, but only with respect to physicians’ services for which the individual receives, from a physician, an advance beneficiary notice under section 1879(a) of the Act.

(3) Services with local coverage determinations (LCDs) or national coverage determinations (NCDs). In instances where an LCD or an NCD exists that has sufficiently specific reasonable and necessary criteria addressing the particular clinical indication for the procedure for which the prior determination is requested, the contractor will send a copy of the LCD or NCD to the requester along with an explanation that the LCD or NCD serves as the prior determination and that no further determination will be made.

(4) Identification of eligible services. CMS will identify the number of services that are eligible for a prior determination through manual instructions consistent with the criteria established in the regulation.

(5) Statutory procedures. Under sections 1869(h)(3) through (h)(6) of the Act, the following procedures apply:

(i) Request for prior determination—(A) In general. An eligible requester may submit to the contractor a request for a determination, before the furnishing of a physician’s service, as to whether the physician’s service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) of the Act (relating to medical necessity).

(B) Accompanying documentation. CMS may require that the request be accompanied by a description of the physician’s service, supporting documentation relating to the medical necessity of the physician’s service, and other appropriate documentation. In the case of a request submitted by an eligible requester who is described in section 1869(h)(1)(B)(ii) of the Act, the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

(ii) Response to request—(A) General rule. The contractor will provide the eligible requester with written notice of a determination as to whether—
§ 410.21 Limitations on services of a chiropractor.

(a) Qualifications for chiropractors. (1) A chiropractor licensed or authorized to a determination of non-coverage).