§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) Basic rule. Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in § 484.4 of this chapter and only under the following conditions:

(1) They are furnished to a beneficiary while he or she is under the care of a physician who is a doctor of medicine or osteopathy.

(2) They are furnished under a written plan of treatment that meets the requirements of § 410.61.

(3) They are furnished by one of the following:

(i) A provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider.

(ii) A speech-language pathologist in private practice as described in paragraph (c) of this section.

(iii) Incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

(4) Claims submitted for furnished services contain prescribed information on patient functional limitations.

(b) Condition for coverage of outpatient speech-language pathology services furnished to certain inpatients of a hospital or a CAH or SNF. Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) Special provisions for services furnished by speech-language pathologists in private practice—(1) Basic qualifications. In order to qualify under Medicare as a supplier of outpatient speech-language pathology services, each individual speech-language pathologist in private practice must meet the following requirements:

(i) Be legally authorized (if applicable, licensed, certified, or registered) to engage in the private practice of speech-language pathology by the State in which he or she practices, and practice only within the scope of his or her license and/or certification.

(ii) A speech-language pathologist in private practice as described in paragraph (c) of this section.

(iii) Incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services.
§ 410.63 Hepatitis B vaccine and blood clotting factors: Conditions.

Notwithstanding the exclusion from coverage of vaccines (see §405.310 of this chapter) and self-administered drugs (see §410.29), the following services are included as medical and other health services covered under §410.10, subject to the specified conditions:

(a) Hepatitis B vaccine: Conditions. Effective September 1, 1984, hepatitis B vaccinations that are reasonable and necessary for the prevention of illness for those individuals who are at high or intermediate risk of contracting hepatitis B as listed below:

(i) High risk groups. (i) End-Stage Renal Disease (ESRD) patients;
(ii) Hemophiliacs who receive Factor VIII or IX concentrates;
(iii) Clients of institutions for individuals with intellectual disabilities;
(iv) Persons who live in the same household as a hepatitis B carrier;
(v) Homosexual men;
(vi) Illicit injectable drug abusers;
(vii) Pacific Islanders (that is, those Medicare beneficiaries who reside on Pacific islands under U.S. jurisdiction, other than residents of Hawaii); and
(viii) Persons diagnosed with diabetes mellitus.

(b) Blood clotting factors: Conditions. Effective July 18, 1984, blood clotting factors to control bleeding for hemophilia patients competent to use these factors without medical or other supervision, and items related to the administration of those factors. The amount of clotting factors covered under this provision is determined by the carrier based on the historical utilization pattern or profile developed by the carrier for each patient, and based on consideration of the need for a reasonable reserve supply to be kept in the home in the event of emergency or unforeseen circumstance.

(c) Blood clotting factors: Furnishing Fee. (1) Effective January 1, 2005, a furnishing fee of $0.14 per unit of clotting factor is paid to entities that furnish blood clotting factors unless the costs associated with furnishing the clotting