

clinical condition for which the DMEPOS is ordered.

(4) *Refills*—(i) *Definitions*. As used in this paragraph (d):

*Date of service* (for refilled items) means either—

(1) The date of delivery for the DMEPOS item; or

(2) For items rendered via delivery or shipping service, the shipping date.

*Refills* mean DMEPOS products that are provided on a recurring basis secondary to a medically necessary DMEPOS order.

*Shipping date* means—

(1) The date the delivery/shipping service label is created; or

(2) The date that the item is retrieved for delivery. These dates must not demonstrate significant variation.

(ii) *Documentation*. The DMEPOS supplier must document contact with the beneficiary or their representative to verify the refill is needed. This documentation must include both of the following:

(A) Evidence of the beneficiary or their representative's affirmative response of the need for supplies, which should be obtained as close to the expected end of the current supply as possible. Contact and affirmative response must be within 30 calendar days from the expected end of the current supply.

(B)(i) For shipped items, the beneficiary name, date of contact, the item requested, and an affirmative response from the beneficiary, indicative of the need for refill, prior to dispensing the product; or

(2) For items obtained in-person from a retail store, the delivery slip signed by the beneficiary or their representative or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

(iii) *Delivery of DMEPOS items provided on a recurring basis*. The date of service for DMEPOS items provided on a recurring basis must be no earlier than 10 calendar days before the expected end of the current supply.

(e) *Suspension of face-to-face encounter and written order prior to delivery requirements*. CMS may suspend face-to-face encounter and written order prior to delivery requirements generally or for a particular item or items at any time and without undertaking rule-

making, except those items for which inclusion on the Master List was statutorily imposed.

[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; 77 FR 69362, Nov. 16, 2012; 84 FR 60802, Nov. 8, 2019; 88 FR 77875, Nov. 13, 2023]

#### § 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.

(b) *Condition for coverage of screening digital rectal examinations.* Medicare Part B pays for a screening digital rectal examination if it is performed by the beneficiary's physician, or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife as defined in paragraphs (a)(4) or (a)(5) of this section who is authorized to perform this service under State law.

(c) *Limitation on coverage of screening digital rectal examinations.* (1) Payment may not be made for a screening digital rectal examination performed for a man age 50 or younger.

(2) For an individual over 50 years of age, payment may be made for a screening digital rectal examination only if the man has not had such an examination paid for by Medicare during the preceding 11 months following the month in which his last Medicare-covered screening digital rectal examination was performed.

(d) *Condition for coverage of screening prostate-specific antigen blood tests.* Medicare Part B pays for a screening prostate-specific antigen blood test if it is ordered by the beneficiary's physician, or by the beneficiary's physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife as defined in paragraphs (a)(4) or (a)(5) of this section who is authorized to order this test under State law.

(e) *Limitation on coverage of screening prostate-specific antigen blood test.* (1) Payment may not be made for a screening prostate-specific antigen blood test performed for a man age 50 or younger.

(2) For an individual over 50 years of age, payment may be made for a screening prostate-specific antigen blood test only if the man has not had such an examination paid for by Medicare during the preceding 11 months following the month in which his last Medicare-covered screening prostate-specific antigen blood test was performed.

[64 FR 59440, Nov. 2, 1999, as amended at 65 FR 19331, Apr. 11, 2000]

**§ 410.40 Coverage of ambulance services.**

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

*Non-physician certification statement* means a statement signed and dated by an individual which certifies that the medical necessity provisions of paragraph (e)(1) of this section are met and who meets all of the criteria in paragraphs (i) through (iii) of this definition. The statement need not be a stand-alone document and no specific format or title is required.

(i) Has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished;

(ii) Who must be employed:

(A) By the beneficiary's attending physician; or

(B) By the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported;

(iii) Is among the following individuals, with respect to whom all Medicare regulations and all applicable State licensure laws apply:

(A) Physician assistant (PA).

(B) Nurse practitioner (NP).

(C) Clinical nurse specialist (CNS).

(D) Registered nurse (RN).

(E) Licensed practical nurse (LPN).

(F) Social worker.

(G) Case manager.

(H) Discharge planner.

*Physician certification statement* means a statement signed and dated by the beneficiary's attending physician which certifies that the medical necessity provisions of paragraph (e)(1) of this section are met. The statement need not be a stand-alone document and no specific format or title is required.

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

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

(c) *Levels of service.* Medicare covers the following levels of ambulance service, which are defined in § 414.605 of this chapter: