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reconditioning of this equipment. Dialysis equipment includes, but is not limited to, artificial kidney and automated peritoneal dialysis machines, and support equipment such as blood pumps, bubble detectors, and other alarm systems.

(2) Items and supplies required for dialysis, including (but not limited to) dialyzers, syringes and needles, forceps, scissors, scales, sphygmomanometer with cuff and stethoscope, alcohol wipes, sterile drapes, and rubber gloves.

(3) Home dialysis support services furnished by an approved ESRD facility, including periodic monitoring of the patient's home adaptation, emergency visits by qualified provider or facility personnel, any of the tests specified in paragraphs (b) through (d) of § 410.50, personnel costs associated with the installation and maintenance of dialysis equipment, testing and appropriate treatment of water, and ordering of supplies on an ongoing basis.

(4) On or after July 1, 1991, erythropoiesis-stimulating agents for use at home by a home dialysis patient and, on or after January 1, 1994, by a dialysis patient, if it has been determined, in accordance with § 494.90(a)(4) of this chapter, that the patient is competent to use the drug safely and effectively.

(b) Home dialysis support services specified in paragraph (a)(3) of this section must be furnished in accordance with a written treatment plan that is prepared and reviewed by a team consisting of the individual's physician and other qualified professionals. (Section 494.90 of this chapter contains details on patient plans of care).

[51 FR 41339, Nov. 14, 1986, as amended at 56 FR 43709, Sept. 4, 1991; 59 FR 26959, May 25, 1994; 73 FR 20474, Apr. 15, 2008]

§ 410.53 Marriage and family therapist services.

(a) *Definition: marriage and family therapist.* For purposes of this part, a marriage and family therapist is defined as an individual who -

(1) Possesses a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which such individual fur-

nishes the services defined as marriage and family therapist services;

(2) After obtaining such degree, has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice, or clinic; and

(3) Is licensed or certified as a marriage and family therapist by the State in which the services are performed.

(b) *Covered marriage and family therapist services.* Medicare Part B covers marriage and family therapist services.

(1) *Definition: marriage and family therapist services* means services furnished by a marriage and family therapist (as defined in paragraph (a) of this section) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished. The services must be of a type that would be covered if they were furnished by a physician or as an incident to a physician's professional service and must meet the requirements of this section.

(2) *Exception.* The following services are not marriage and family therapist services for purposes of billing Medicare Part B under the MFT and MHC statutory benefit category:

(i) Services furnished by a marriage and family therapist to an inpatient of a Medicare-participating hospital.

(ii) [Reserved]

(c) *Prohibited billing.* (1) A marriage and family therapist may not bill Medicare for the services specified in paragraph (b)(2) of this section.

(2) A marriage and family therapist or an attending or primary care physician may not bill Medicare or the beneficiary for the consultation that is required under paragraph(b)(2) of this section.

[88 FR 79526, Nov. 16, 2023]

§ 410.54 Mental health counselor services.

(a) *Definition: mental health counselor.* For purposes of this part, a mental

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health counselor is defined as an individual who—

(1) Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, professional counselor under the State law of the State in which such individual furnishes the services defined as mental health counselor services;

(2) After obtaining such a degree, has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice, or clinic; and

(3) Is licensed or certified as a mental health counselor, clinical professional counselor, professional counselor by the State in which the services are performed.

(b) *Covered mental health counselor services.* Medicare Part B covers mental health counselor services.

(1) *Definition: Mental health counselor services* means services furnished by a mental health counselor (as defined in paragraph (a) of this section) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished. The services must be of a type that would be covered if they were furnished by a physician or as an incident to a physician's professional service and must meet the requirements of this section.

(2) *Exception.* The following services are not mental health counselor services for purposes of billing Medicare Part B:

(i) Services furnished by a mental health counselor to an inpatient of a Medicare-participating hospital.

(ii) [Reserved]

(c) *Prohibited billing.* (1) A mental health counselor may not bill Medicare for the services specified in paragraph (b)(2) of this section.

(2) A mental health counselor or an attending or primary care physician may not bill Medicare or the beneficiary for the consultation that is re-

quired under paragraph(b)(2) of this section.

[88 FR 79527, Nov. 16, 2023]

§ 410.55 Services related to kidney donations: Conditions.

Medicare Part B pays for medical and other health services covered under this subpart that are furnished in connection with a kidney donation—

(a) If the kidney is intended for an individual who has end-stage renal disease and is entitled to Medicare benefits; and

(b) Regardless of whether the donor is entitled to Medicare.

§ 410.56 Screening pelvic examinations.

(a) *Conditions for screening pelvic examinations.* Medicare Part B pays for a screening pelvic examination (including a clinical breast examination) if it is performed by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act), or by a certified nurse midwife (as defined in section 1861(gg) of the Act), or a physician assistant, nurse practitioner, or clinic nurse specialist (as defined in section 1861(aa) of the Act) who is authorized under State law to perform the examination.

(b) *Limits on coverage of screening pelvic examinations.* The following limitations apply to coverage of screening pelvic examination services:

(1) *General rule.* Except as specified in paragraphs (b)(2) and (b)(3) of this section, payment may be made for a pelvic examination performed on an asymptomatic woman only if the individual has not had a pelvic examination paid for by Medicare during the preceding 23 months following the month in which her last Medicare-covered screening pelvic examination was performed.

(2) *More frequent screening based on high-risk factors.* Subject to the limitation as specified in paragraph (b)(4) of this section, payment may be made for a screening pelvic examination performed more frequently than once every 24 months if the test is performed by a physician or other practitioner specified in paragraph (a) of this section, and there is evidence that the woman is at high risk (on the basis of her medical history or other findings)