

Centers for Medicare & Medicaid Services, HHS

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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)

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of developing cervical cancer or vaginal cancer, as determined in accordance with the following risk factors:

(i) High risk factors for cervical cancer:

(A) Early onset of sexual activity (under 16 years of age).

(B) Multiple sexual partners (five or more in a lifetime).

(C) History of a sexually transmitted disease (including HIV infection).

(D) Absence of three negative or any Pap smears within the previous 7 years.

(ii) High risk factor for vaginal cancer: DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

(3) *More frequent screening for women of childbearing age.* 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 as specified in paragraph (a) of this section for a woman of childbearing age who has had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding 3 years. The term “woman of childbearing age” means a woman who is premenopausal, and has been determined by a physician, or a qualified practitioner, as specified in paragraph (a) of this section, to be of childbearing age, based on her medical history or other findings.

(4) *Limitation applicable to women at high risk and those of childbearing age.* Payment is not made for a screening pelvic examination for women considered to be at high risk (under any of the criteria described in paragraph (b)(2) of this section), or who qualify for coverage under the childbearing provision (under the criteria described in paragraph (b)(3) of this section) more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

[62 FR 59101, Oct. 31, 1997; 63 FR 4596, Jan. 30, 1998, as amended at 66 FR 55329, Nov. 1, 2001]

42 CFR Ch. IV (10–1–24 Edition)

§ 410.57 Preventive vaccines.

(a) Medicare Part B pays for the pneumococcal vaccine and its administration.

(b) Medicare Part B pays for the influenza virus vaccine and its administration.

(c) Medicare Part B pays for the COVID-19 vaccine (or monoclonal antibodies used for pre-exposure prophylaxis of COVID-19) and its administration.

(d) Medicare Part B pays for the Hepatitis B vaccine and its administration, as defined in § 410.63(a).

[63 FR 35066, June 26, 1998, as amended at 85 FR 71197, Nov. 6, 2020; 87 FR 70223, Nov. 18, 2022; 88 FR 79527, Nov. 16, 2023]

§ 410.58 Additional services to HMO and CMP enrollees.

Services not usually covered under Medicare Part B may be covered as medical and other health services if they are furnished to an enrollee of an HMO or a CMP and the following conditions are met:

(a) The services are—

(1) Furnished by a physician assistant or nurse practitioner as defined in § 491.2 of this chapter, or are incident to services furnished by such a practitioner; or

(2) Furnished by a clinical psychologist as defined in § 417.416 of this chapter to an enrollee of an HMO or CMP that participates in Medicare under a risk-sharing contract, or are incident to those services.

(b) The services are services that would be covered under Medicare Part B if they were furnished by a physician or as incident to a physician's professional services.

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in part 484 of this chapter for an occupational therapist or an appropriately supervised occupational therapy assistant but only under the following conditions: