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meet the definition of “eligible beneficiary” specified in this section.

[71 FR 69783, Dec. 1, 2006, as amended at 78 FR 74810, Dec. 10, 2013]

§ 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.

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(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 its respective jurisdiction for those services identified by CMS (updated annually in conjunction with the update to the MPFS and posted on that specific Medicare contractor’s Web site by the Healthcare Common Procedure Coding System procedure code and code description). Only those services listed on that Medicare contractor’s Web site on the date the request for a prior determination is made are subject to prior determination. Each contractor’s list will consist of the following:

(i) The national list, provided by CMS, of the most expensive physicians’ services (as defined in section 1848(j)(3) of the Act) included in the MPFS which are performed at least 50 times annually.

(ii) The national list, provided by CMS, of plastic and dental surgeries that may be covered by Medicare and that have an amount of at least \$1,000 on the MPFS (not including the adjustment for location by the GPCI).

(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 requestor 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—

(1) The physician's service is covered (the physician's service is covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity); or

(2) The physician's service is not covered (the physician's service is not covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity); or

(3) The contractor lacks sufficient information to make a coverage determination with respect to the physician's service.

(B) *Contents of notice for certain determinations—(1) Coverage.* If the contractor makes the determination described in paragraph (d)(5)(ii)(A)(1) of this section, the contractor will indicate in the prior determination notice that the physician service is covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity.

(2) *Noncoverage.* If the contractor makes the determination described in paragraph (d)(5)(ii)(A)(2) of this section, the contractor will include in the notice a brief explanation of the basis

for the determination, including on what national or local coverage or non-coverage determination (if any) the determination is based, and a description of any applicable rights under section 1869(a) of the Act.

(3) *Insufficient information.* If the contractor makes the determination described in paragraph (d)(5)(ii)(A)(3) of this section, the contractor will include in the notice a description of the additional information required to make the coverage determination.

(C) *Deadline to respond.* The notice described in paragraphs (d)(5)(ii)(A)(1) through (d)(5)(ii)(A)(3) of this section will be provided by the contractor within 45 days of the date the request for a prior determination is received by the contractor.

(D) *Informing beneficiary in case of physician request.* In the case of a request by a participating physician or a physician accepting assignment, the process will provide that the individual to whom the physician's service is to be furnished will be informed of any determination described in paragraph (d)(5)(ii)(A)(2) of this section (relating to a determination of non-coverage). The beneficiary will also be notified that, notwithstanding the determination of non-coverage, the beneficiary has the right to obtain the physician's service in question and have a claim submitted for the physician's service.

(iii) *Binding nature of positive determination.* If the contractor makes the determination described in paragraph (d)(5)(ii)(A)(1) of this section, that determination will be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

(iv) *Limitation on further review—(A) General rule.* Contractor determinations described in paragraph (d)(5)(ii)(A)(2) of this section or paragraph (d)(5)(ii)(A)(3) of this section (relating to pre-service claims) are not subject to administrative appeal or judicial review.

(B) *Decision not to seek prior determination or negative determination does not impact the right to obtain services, seek reimbursement, or appeal rights.* Nothing in this paragraph will be construed as affecting the right of an individual who—

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(1) Decides not to seek a prior determination under this paragraph with respect to physicians' services; or

(2) Seeks such a determination and has received a determination described in paragraph (d)(5)(ii)(A)(2) of this section, from receiving (and submitting a claim for) those physicians' services and from obtaining administrative or judicial review respecting that claim under the other applicable provisions of this part 405 subpart I of this chapter. Failure to seek a prior determination under this paragraph with respect to physicians' services will not be taken into account in that administrative or judicial review.

(C) *No prior determination after receipt of services.* Once an individual is provided physicians' services, there will be no prior determination under this paragraph with respect to those physicians' services.

(e) *Medical record documentation.* The physician may review and verify (sign/date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team including, as applicable, notes documenting the physician's presence and participation in the services.

[51 FR 41339, Nov. 14, 1986, as amended at 73 FR 9678, Feb. 22, 2008; 84 FR 63187, Nov. 15, 2019]

§410.21 Limitations on services of a chiropractor.

(a) *Qualifications for chiropractors.* (1) A chiropractor licensed or authorized to practice before July 1, 1974, and an individual who began studies in a chiropractic college before that date, must have—

(i) Had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

(ii) Graduated from a college of chiropractic approved by the State's chiropractic examiners after completing a course of study covering a period of not less than 3 school years of 6 months each year in actual continuous attendance and covering adequate courses of study in the subjects of anatomy, physiology, symptomatology

and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and

(iii) Passed an examination prescribed by the State's chiropractic examiners covering the subjects specified in paragraph (a)(1)(ii) of this section.

(2) A chiropractor first licensed or authorized to practice after June 30, 1974, and an individual who begins studies in a chiropractic college after that date, must have—

(i) Had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

(ii) Satisfactorily completed 2 years of pre-chiropractic study at the college level;

(iii) Satisfactorily completed a 4-year course of 8 months each year offered by a college or school of chiropractic approved by the State's chiropractic examiners and including at least 4,000 hours in courses in anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, principles and practice of chiropractic, and clinical instruction in vertebral palpation, nerve tracing and adjusting, plus courses in the use and effect of X-ray and chiropractic analysis;

(iv) Passed an examination prescribed by the State's chiropractic examiners covering the subjects specified in paragraph (a)(2)(iii) of this section; and

(v) Attained 21 years of age.

(b) *Limitations on services.* (1) Medicare Part B pays only for a chiropractor's manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment.

(2) Medicare Part B does not pay for X-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor.

[51 FR 41339, Nov. 14, 1986, as amended at 64 FR 59439, Nov. 2, 1999. Redesignated at 66 FR 55328, Nov. 1, 2001]