face-to-face patient encounter is related to the primary reason the patient requires home health services, and why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services as defined in §409.42(a) and (c) respectively. The documentation must be clearly titled, dated and signed by the certifying physician.

(2) *Timing and signature.* The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.

(b) *Recertification*—(1) *Timing and signature of recertification.* Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed and dated by the physician who reviews the plan of care. The recertification is required at least every 60 days when there is a—

(i) Beneficiary elected transfer; or

(ii) Discharge and return to the same HHA during the 60-day episode.

(2) *Content and basis of recertification.* The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must sign immediately following the narrative in the addendum.

(c) [Reserved]

(d) *Limitation of the performance of physician certification and plan of care functions.* The need for home health services to be provided by an HHA may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who has a financial relationship as defined in §411.354 of this chapter, with that HHA, unless the physician's relationship meets one of the exceptions in section 1877 of the Act, which sets forth general exceptions to the referral prohibition related to both ownership/investment and compensation; exceptions to the referral prohibition related to ownership or investment interests; and exceptions to the referral prohibition related to compensation arrangements.

(1) If a physician has a financial relationship as defined in §411.354 of this chapter, with an HHA, the physician may not certify or recertify need for home health services provided by that HHA, establish or review a plan of treatment for such services, or conduct the face-to-face encounter required under sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act unless the financial relationship meets one of the exceptions set forth in §411.355 through §411.357 of this chapter.

(2) A Nonphysician practitioner may not perform the face-to-face encounter required under sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act if such encounter would be prohibited under paragraph (d)(i) if the nonphysician practitioner were a physician.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 56 FR 8845, Mar. 1, 1991, as amended at 65 FR 41211, July 3, 2000; 66 FR 962, Jan. 4, 2001; 70 FR 70334, Nov. 21, 2005; 72 FR 51098, Sept. 5, 2007; 74 FR 58133, Nov. 10, 2009; 75 FR 70463, Nov. 17, 2010; 76 FR 9503, Feb. 18, 2011; 76 FR 68606, Nov. 4, 2011]

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

(a) *Exempted services.* Certification is not required for the following:

(1) Hospital services and supplies incident to physicians' services furnished to outpatients. The exemption applies to drugs and biologicals that cannot be self-administered, but not to partial hospitalization services, as set forth in paragraph (e) of this section.

(2) Outpatient hospital diagnostic services, including necessary drugs and biologicals, ordinarily furnished or arranged for by a hospital for the purpose of diagnostic study.

(b) *General rule.* Medicare Part B pays for medical and other health services furnished by providers (and not exempted under paragraph (a) of this section) only if a physician certifies the content specified in paragraph (c)(1), (c)(4) or (e)(1) of this section, as appropriate.

(c) *Outpatient physical therapy and speech-language pathology services*—(1) *Content of certification.* (i) The individual needs, or needed, physical therapy or speech pathology services.

(ii) The services were furnished while the individual was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

(iii) The services were furnished under a plan of treatment that meets the requirements of § 410.61 of this chapter.

(2) *Timing.* The initial certification must be obtained as soon as possible after the plan is established.

(3) *Signature.* (i) If the plan of treatment is established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, the certification must be signed by that physician or nonphysician practitioner.

(ii) If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician or by a nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case.

(4) *Recertification*—(i) *Timing.* Recertification is required at least every 90 days.

(ii) *Content.* When it is recertified, the plan or other documentation in the patient's record must indicate the continuing need for physical therapy, occupational therapy or speech-language pathology services.

(iii) *Signature.* The physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan must recertify the plan by signing the medical record.

(d) [Reserved]

(e) *Partial hospitalization services: Content of certification and plan of treatment requirements*—(1) *Content of certification.* (i) The individual would require inpatient psychiatric care if the partial hospitalization services were not provided.

(ii) The services are or were furnished while the individual was under the care of a physician.

(iii) The services were furnished under a written plan of treatment that meets the requirements of paragraph (e)(2) of this section.

(2) *Plan of treatment requirements.* (i) The plan is an individualized plan that is established and is periodically reviewed by a physician in consultation with appropriate staff participating in the program, and that sets forth—

(A) The physician's diagnosis;

(B) The type, amount, duration, and frequency of the services; and

(C) The treatment goals under the plan.

(ii) The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable expectation of improvement in the patient's condition.

(3) *Recertification requirements*—(i) *Signature.* The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

(ii) *Timing.* The first recertification is required as of the 18th day of partial hospitalization services. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

(iii) *Content.* The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:

(A) The patient's response to the therapeutic interventions provided by the partial hospitalization program.

(B) The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization.

(C) Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program.

(f) *Blood glucose testing.* For each blood glucose test, the physician must certify that the test is medically necessary. A physician's standing order is

not sufficient to order a series of blood glucose tests payable under the clinical laboratory fee schedule.

(g) *All other covered medical and other health services furnished by providers*—(1) *Content of certification.* The services were medically necessary,

(2) *Signature.* The certificate must be signed by a physician, nurse practioner, clinical nurse specialist, or physician assistant who has knowledge of the case.

(3) *Timing.* The physician, nurse practioner, clinical nurse specialist, or physician assistant may provide certification at the time the services are furnished or, if services are provided on a continuing basis, either at the beginning or at the end of a series of visits.

(4) *Recertification.* Recertification of continued need for services is not required.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 56 FR 8845, 8853, Mar. 1, 1991; 63 FR 58912, Nov. 2, 1998; 65 FR 18548, Apr. 7, 2000; 71 FR 69788, Dec. 1, 2006; 72 FR 66405, Nov. 27, 2007]

§ 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

Medicare Part B pays for CORF services only if a physician certifies, and the facility physician recertifies, the content specified in paragraphs (a) and (b)(2) of this section, as appropriate.

(a) *Certification: Content.* (1) The services were required because the individual needed skilled rehabilitation services;

(2) The services were furnished while the individual was under the care of a physician; and

(3) A written plan of treatment has been established and is reviewed periodically by a physician.

(b) *Recertification*—(1) *Timing.* Recertification is required at least every 60 days for respiratory therapy services and every 90 days for physical therapy, occupational therapy, and speech-language pathology services based on review by a facility physician or the referring physician who, when appropriate, consults with the professional personnel who furnish the services.

(2) *Content.* (i) The plan is being followed;

(ii) The patient is making progress in attaining the rehabilitation goals; and,

(iii) The treatment is not having any harmful effect on the patient.

[53 FR 6634, Mar. 2, 1988, as amended at 72 FR 66405, Nov. 27, 2007]

Subpart C—Claims for Payment

§ 424.30 Scope.

This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by an MA organization, or through cost settlement with either a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP), or as part of a demonstration. Therefore, claims must be filed by hospitals seeking IME payment under §412.105(g) of this chapter, and/or direct GME payment under §413.76(c) of this chapter, and/or nursing or allied health education payment under §413.87 of this chapter associated with inpatient services furnished on a prepaid capitation basis by an MA organization. Hospitals that must report patient data for purposes of the DSH payment adjustment under §412.106 of this chapter for inpatient services furnished on a prepaid capitation basis by an MA organization, or through cost settlement with an HMO/CMP, or as part of a demonstration, are required to file claims by submitting no pay bills for such inpatients. Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in subpart E of this part.

[77 FR 53682, Aug. 31, 2012]

§ 424.32 Basic requirements for all claims.

(a) A claim must meet the following requirements:

(1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.

(2) A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM.