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.

(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.

(b) The prescribed forms for claims are the following:

CMS–1450—Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)