

(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 statements are required at least every 30 days and must be signed by the physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment.

(ii) *Content*. The recertification statement must indicate the continuing need for physical therapy or speech-language pathology services and an estimate of how much longer the services will be needed.

(iii) *Signature*. Recertifications must be signed by the physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment.

(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) *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 practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case.

(3) *Timing*. The physician, nurse practitioner, 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]

§ 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, based on review by a facility 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.

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 a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP). 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.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 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 the beneficiary's representative (in accordance with § 424.36(b)).

(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.)

CMS-1490S—Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

CMS-1490U—Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)

CMS-1491—Request for Medicare Payment—Ambulance. (For use by an organization requesting payment for ambulance services.)

CMS-1500—Health Insurance Claim Form. (For use by physicians and other suppliers to request payment for medical services.)

CMS-1660—Request for Information—Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) *Where claims forms are available.* Excluding forms CMS-1450 and CMS-1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The CMS-1450 and CMS-1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from CMS or any Social Security branch or district office, or from Medicare intermediaries or carriers. The CMS-1490S is also available at local Social Security Offices.

[53 FR 6639, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998; 66 FR 39601, July 31, 2001]

§ 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.

All claims for services of providers and all claims by suppliers and nonparticipating hospitals must be—

(a) Filed by the provider, supplier, or hospital; and