§ 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.

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

(d) Submission of electronic claims—(1) Definitions. For purposes of this paragraph, the following terms have the following meanings:

(i) Claim means a transaction defined at 45 CFR 162.1101(a).

(ii) Electronic claim means a claim that is submitted via electronic media. A claim submitted via direct data entry is considered to be an electronic claim.

(iii) Direct data entry is defined at 45 CFR 162.103.

(iv) Electronic media is defined at 45 CFR 160.103.

(v) Initial Medicare claim means a claim submitted to Medicare for payment under Part A or Part B of the Medicare Program under title XVIII of the Act for initial processing, including claims sent to Medicare for the first time for secondary payment purposes. Initial Medicare claim excludes any adjustment or appeal of a previously submitted claim, and claims submitted for payment under Part C of the Medicare program under title XVIII of the Act.

(vi) Physician, practitioner, facility, or supplier is a Medicare provider or supplier other than a provider of services.

(vii) Provider of services means a provider of services as defined in section 1861(a) of the Act.

(viii) Small provider of services or small supplier means—

(A) A provider of services with fewer than 25 full-time equivalent employees; or

(B) A physician, practitioner, facility, or supplier with fewer than 10 full-time equivalent employees.

(2) Submission of electronic claims required. Except for claims to which paragraph (d)(3) or (d)(4) of this section applies, an initial Medicare claim may be paid only if submitted as an electronic claim for processing by the Medicare fiscal intermediary or carrier that serves the physician, practitioner, facility, supplier, or provider of services. This requirement does not apply to any other transactions, including adjustment or appeal of the initial Medicare claim.

(3) Exceptions to requirement to submit electronic claims. The requirement of paragraph (d)(2) of this section is waived for any initial Medicare claim when—

(i) There is no method available for the submission of an electronic claim. This exception includes claims submitted by Medicare beneficiaries and situations in which the standard adopted by the Secretary at 45 FR 162.1102 does not support all of the information necessary for payment of the claim. The Secretary may identify situations coming within this exception in guidance.

(ii) The entity submitting the claim is a small provider of services or small supplier.

(4) Unusual cases. The Secretary may waive the requirement of paragraph (d)(2) of this section in unusual cases as the Secretary finds appropriate. Unusual cases are deemed to exist in the following situations:

(i) The submission of dental claims.

(ii) There is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of the interruption.

(iii) The entity submitting the claim submits fewer than 10 claims to Medicare per month, on average.

(iv) The entity submitting the claim only furnishes services outside of the U.S. territory.

(v) On demonstration, satisfactory to the Secretary, of other extraordinary
§ 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
(b) Signed by the provider, supplier, or hospital unless CMS instructions waive this requirement.

§ 424.34 Additional requirements: Beneficiary's claim for direct payment.

(a) Basic rule. A beneficiary's claim for direct payment for services furnished by a supplier, or by a nonparticipating hospital that has not elected to claim payment for emergency services, must include an itemized bill or a “report of services”, as specified in paragraphs (b) and (c) of this section.

(b) Itemized bill from the hospital or supplier. The itemized bill for the services, which may be receipted or unpaid, must include all of the following information:

(1) The name and address of—
   (i) The beneficiary;
   (ii) The supplier or nonparticipating hospital that furnished the services; and
   (iii) The physician who prescribed the services if they were furnished by a supplier other than the physician.

(2) The place where each service was furnished, e.g., home, office, independent laboratory, hospital.

(3) The date each service was furnished.

(4) A listing of the services in sufficient detail to permit determination of payment under the fee schedule for physicians' services; for itemized bills from physicians, appropriate diagnostic coding using ICD–9–CM must be used.

(5) The charges for each service.

(c) Report of services furnished by a supplier. For Medicare Part B services furnished by a supplier, the beneficiary claims may include the “Report of Services” portion of the appropriate claims form, completed by the supplier in accordance with CMS instructions, in lieu of an itemized bill.

§ 424.36 Signature requirements.

(a) General rule. The beneficiary’s own signature is required on the claim unless the beneficiary has died or the provisions of paragraphs (b), (c), or (d) of this section apply. For purposes of this section, “the claim” includes the actual claim form or such other form that contains adequate notice to the beneficiary or other authorized individual that the purpose of the signature is to authorize a provider or supplier to submit a claim to Medicare for specified services furnished to the beneficiary.

(b) Who may sign when the beneficiary is incapable. If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on his or her behalf by one of the following:

(1) The beneficiary’s legal guardian.

(2) A relative or other person who receives social security or other governmental benefits on the beneficiary’s behalf.

(3) A relative or other person who arranges for the beneficiary’s treatment or exercises other responsibility for his or her affairs.

(4) A representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary.

(5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished if the provider or nonparticipating hospital is unable to have the claim signed in accordance with paragraph (b)(1), (2), (3), or (4) of this section after making reasonable efforts to locate and obtain the signature of one