

## § 424.27

- (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 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

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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.)

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(u) 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

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(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 circumstances precluding submission of electronic claims.

(5) *Effective date.* This paragraph (d) is effective October 16, 2003, and applies

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to claims submitted on or after October 16, 2003.

[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; 68 FR 48813, Aug. 15, 2003; 70 FR 71020, Nov. 25, 2005; 71 FR 48143, Aug. 18, 2006; 72 FR 66405, Nov. 27, 2007]

#### § 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.

[53 FR 6634, Mar. 2, 1988, as amended at 59 FR 10299, Mar. 4, 1994; 59 FR 26740, May 24, 1994]

#### § 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 of the individuals specified in paragraph (b)(1), (2), (3), or (4) of this section.

(6) An ambulance provider or supplier with respect to emergency or non-emergency ambulance transport services, if the following conditions and documentation requirements are met.

(i) None of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section was available or willing to sign the claim on behalf of the beneficiary at the time the service was provided;

(ii) The ambulance provider or supplier maintains in its files the following information and documentation for a period of at least four years from the date of service:

(A) A contemporaneous statement, signed by an ambulance employee present during the trip to the receiving facility, that, at the time the service was provided, the beneficiary was physically or mentally incapable of signing the claim and that none of the individuals listed in paragraph (b)(1), (2), (3), or (4) of this section were available or willing to sign the claim on behalf of the beneficiary, and

(B) Documentation with the date and time the beneficiary was transported, and the name and location of the facility that received the beneficiary, and

(C) Either of the following:

(I) A signed contemporaneous statement from a representative of the facility that received the beneficiary, which documents the name of the beneficiary and the date and time the beneficiary was received by that facility; or

(2) The requested information from a representative of the hospital or facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment. Secondary forms of verification include a copy of any of the following:

- (i) The signed patient care/trip report;
- (ii) The facility or hospital registration/admission sheet;
- (iii) The patient medical record;
- (iv) The facility or hospital log; or
- (v) Other internal facility or hospital records.

(c) *Who may sign if the beneficiary was not present for the service.* If a provider, nonparticipating hospital, or supplier files a claim for services that involved

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no personal contact between the provider, hospital, or supplier and the beneficiary (for example, a physician sent a blood sample to the provider for diagnostic tests), a representative of the provider, hospital, or supplier may sign the claim on the beneficiary's behalf.

(d) *Claims by entities that provide coverage complementary to Medicare.* A claim by an entity that provides coverage complementary to Medicare Part B may be signed by the entity on the beneficiary's behalf.

(e) *Acceptance of other signatures for good cause.* If good cause is shown, CMS may honor a claim signed by a party other than those specified in paragraphs (a) through (c) of this section.

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988, as amended at 53 FR 28388, July 28, 1988; 72 FR 66406, Nov. 27, 2007; 73 FR 2432, Jan. 15, 2008; 73 FR 66938, Nov. 19, 2008]

### § 424.37 Evidence of authority to sign on behalf of the beneficiary.

(a) *Beneficiary incapable.* When a party specified in § 424.36(b) signs a claim or request for payment statement, he or she must also submit a brief statement that—

(1) Describes his or her relationship to the beneficiary; and

(2) Explains the circumstances that make it impractical for the beneficiary to sign the claim or statement.

(b) *Beneficiary not present for services.* When a representative of the provider, nonparticipating hospital, or supplier signs a claim or request for payment statement under § 424.36(c), he or she must explain why it was not possible to obtain the beneficiary's signature. (For example: "Patient not physically present for test.")

[53 FR 6640, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

### § 424.40 Request for payment effective for more than one claim.

(a) *Basic procedure.* A separate request for payment statement prescribed by CMS and signed by the beneficiary (or by his or her representative) may be included in claims by reference, in the circumstances specified in paragraphs (b) through (d) of this section.

(b) *Claims filed by a provider or nonparticipating hospital—(1) Inpatient services.* A signed request for payment

statement, included in the first claim for Part A services furnished by a facility (a participating hospital or SNF, or a nonparticipating hospital that has elected to claim payment) during a beneficiary's period of confinement, may be effective for all claims for Part A services the facility furnishes that beneficiary during that confinement.

(2) *Home health services and outpatient physical therapy or speech pathology services.* A signed request for payment statement, included in the first claim for home health services or outpatient physical therapy or speech pathology services furnished by a provider under a plan of treatment, may be effective for all claims for home health services or outpatient physical therapy or speech pathology services furnished by the provider under that plan of treatment.

(c) *Signed statement in the provider record—(1) Services to inpatients.* A signed request for payment statement in the files of a participating hospital or SNF may be effective for all claims for services furnished to the beneficiary during a single inpatient stay in that facility—

(i) By the hospital or SNF;

(ii) By physicians, if their services are billed by the hospital or SNF in its name; or

(iii) By physicians who bill separately, if the services were furnished in the hospital or SNF.

(2) *Services to outpatients: Providers and renal dialysis facilities.* A signed request for payment statement retained in the provider's or facility's files may be effective indefinitely, for all claims for services furnished to that beneficiary on an outpatient basis—

(i) By the provider or facility;

(ii) By physicians whose services are billed by the provider or facility in its name; or

(iii) By physicians who bill separately, if the services were furnished in the provider or facility.

(3) *Services to outpatients: Independent rural health clinics and Federally qualified health centers.* A signed request for payment statement retained in the clinic's or center's files may be effective indefinitely for all claims for services furnished to that beneficiary by the clinic.

(d) *Signed statement in the supplier's record.* A signed request for payment statement retained in the supplier's file may be effective indefinitely subject to the following restrictions:

(1) This policy does not apply to unassigned claims for rental of durable medical equipment (DME).

(2) With respect to assigned claims for rental or purchase of DME, a new statement is required if another item of equipment is rented or purchased.

[53 FR 6634, Mar. 2, 1988, as amended at 57 FR 24982, June 12, 1992]

#### § 424.44 Time limits for filing claims.

(a) *Time limits.* (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) Except as provided in paragraphs (b) and (e) of this section and except for services furnished during the last 3 months of 2009, for services furnished before January 1, 2010, the claim must be filed—

(i) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(ii) On or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year.

(3) For services furnished during the last 3 months of CY 2009 all claims must be filed no later than December 31, 2010.

(b) *Exceptions to time limits.* Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet

the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(4) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.

(ii) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.

(iii) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(5) *Extension of time.* (i) If CMS or one of its contractors determines that a failure to meet the deadline specified in paragraph (a) of this section was caused by error or misrepresentation of

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an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification that the error or misrepresentation referenced in paragraph (b)(1) of this section was corrected. No extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

(iv) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(4) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

(c) *Extension of period ending on a nonworkday.* If the last day of the period allowed under paragraph (a) or (b) of this section falls on a Federal nonworkday (a Saturday, Sunday, legal

holiday, or a day which by statute or Executive Order is declared to be a nonworkday for Federal employees), the time is extended to the next succeeding workday.

(d) *Outpatient diabetes self-management training.* CMS makes payment in half-hour increments to an entity for the furnishing of outpatient diabetes self-management training on or after the approval date CMS approves the entity to furnish the services under part 410, subpart H of this chapter.

(e) As specified in §§ 424.520 and 424.521 of this subpart, there are restrictions on the ability of the following newly-enrolled suppliers to submit claims for items or services furnished prior to the effective date of their Medicare billing privileges:

- (1) Physician or nonphysician practitioner organizations.
- (2) Physicians.
- (3) Nonphysician practitioners.
- (4) Independent diagnostic testing facilities.

[53 FR 6634, Mar. 2, 1988, as amended at 65 FR 83153, Dec. 29, 2000; 73 FR 69939, Nov. 19, 2008; 75 FR 73627, Nov. 29, 2010]

### Subpart D—To Whom Payment Is Ordinarily Made

#### § 424.50 Scope.

(a) This subpart specifies to whom Medicare payment is ordinarily made for different kinds of services.

(b) Subpart E of this part sets forth provisions applicable in special situations.

(c) Subpart F of this part specifies the exceptional circumstances under which payment may be made to an assignee or reassignee.

#### § 424.51 Payment to the provider.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare pays the provider for services furnished by a provider.

(b) *Exception.* Medicare pays the beneficiary for outpatient hospital services if the hospital has collected an amount in excess of the unmet deductible and coinsurance, as specified in § 489.30(b)(4) of this chapter.