

(2) The certifying nurse practitioner (as defined at § 484.2 of this chapter), certifying clinical nurse specialist (as defined at § 484.2 of this chapter), or a nurse practitioner or a clinical nurse specialist who is working in accordance with State law and in collaboration with a physician or in collaboration with an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(3) A certified nurse midwife (as defined in section 1861(gg) of the Act) as authorized by State law, under the supervision of a physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(4) A certifying physician assistant (as defined at § 484.2 of this chapter) or a physician assistant under the supervision of a physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(B) The face-to-face patient encounter may occur through telehealth, in compliance with section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

(C) The face-to-face patient encounter must be performed by the certifying physician or allowed practitioner unless the encounter is performed by:

(1) A certified nurse midwife as described in paragraph (a)(1)(v)(A)(4) of this section.

(2) A physician, physician assistant, nurse practitioner, or clinical nurse specialist with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

(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 or allowed practitioner who establishes the plan.

(b) *Recertification*—(1) *Timing and signature of recertification.* Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed, and must be signed and dated by the physician or allowed practitioner who reviews the plan of care. Recertification is required at least every 60 days unless there is a—

(i) Beneficiary elected transfer; or

(ii) Discharge with goals met and/or no expectation of a return to home health care.

(2) *Content and basis of recertification.* As a condition for payment of home health services under Medicare Part A or Medicare Part B, if there is a continuing need for home health services, a physician or allowed practitioner must recertify the patient's continued eligibility for the home health benefit as outlined in sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, as set forth in paragraph (a)(1) of this section, and as specified in paragraphs (b)(2)(i) and (ii) of this section.

(i) 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.

(ii) 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 or allowed practitioner must include a brief narrative describing the clinical justification of this need. If the narrative—

(A) Is part of the recertification form, then the narrative must be located immediately prior to the physician or allowed practitioner's signature.

(B) Exists as an addendum to the recertification form, in addition to the physician or allowed practitioner's signature on the recertification form, the physician or allowed practitioner must

sign immediately following the narrative in the addendum.

(c) *Determining patient eligibility for Medicare home health services.* (1) Documentation in the certifying physician or allowed practitioner's medical record or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) or both must be used as the basis for certification of the patient's eligibility for home health as described in paragraphs (a)(1) and (b) of this section. Documentation from the HHA may also be used to support the basis for certification of home health eligibility, but only if the following requirements are met:

(i) The documentation from the HHA can be corroborated by other medical record entries in the certifying physician or allowed practitioner's medical record for the patient or the acute/post-acute care facility's medical record for the patient or both, thereby creating a clinically consistent picture that the patient is eligible for Medicare home health services.

(ii)(A) The certifying physician or allowed practitioner signs and dates the HHA documentation demonstrating that the documentation from the HHA was considered when certifying patient eligibility for Medicare home health services.

(B) HHA documentation can include, but is not limited to, the patient's plan of care required under § 409.43 of this chapter, or the initial or comprehensive assessment of the patient required under § 484.55 of this chapter.

(2) The documentation must be provided upon request to review entities or CMS or both. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment is not rendered for home health services provided.

(d) *Limitation of the performance of physician or allowed practitioner's 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 or allowed practitioner

who has a financial relationship as defined in § 411.354 of this chapter, with that HHA, unless the physician or allowed practitioner'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 or allowed practitioner has a financial relationship as defined in § 411.354 of this chapter, with an HHA, the physician or allowed practitioner 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)(1) if the nonphysician practitioner were a physician.

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§ 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) or (4), (d)(1), 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) *Intensive outpatient services: Content of certification and plan of treatment requirements*—

(1) *Content of certification.* (i) The individual requires such services for a minimum of 9 hours per week.

(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 (d)(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.* Recertifications are required at intervals established by the provider, but no less frequently than every 60 days.

(iii) *Content.* The recertification must specify that the patient continues to require at least 9 hours of intensive outpatient services and describe the following:

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

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

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

(e) *Partial hospitalization services: Content of certification and plan of treatment requirements*—(1) *Content of certification.*

(i) The individual requires such services for a minimum of 20 hours per week and would require inpatient psychiatric care if the partial hospitalization services were not provided.