

# **Medicare General Information, Eligibility, and Entitlement**

## **Chapter 4 - Physician Certification and Recertification of Services**

### **Table of Contents** *(Rev. 114, 03-16-18)*

#### **Transmittals for Chapter 4**

- 10 - Certification and Recertification by Physicians for Hospital Services - General
  - 10.1 - Failure to Certify or Recertify for Hospital Services
  - 10.2 - Who May Sign Certification or Recertification
  - 10.3 - Certification for Hospital Admissions for Dental Services
  - 10.4 - Inpatient Hospital Services Certification and Recertification
  - 10.5 - Selection by Hospital of Format and Method for Obtaining Statement
  - 10.6 - Criteria for Continued Inpatient Hospital Stay
  - 10.7 - Utilization Review (UR) in Lieu of Separate Recertification Statement
  - 10.8 - Timing of Certifications and Recertifications
    - 10.8.1 - Admissions on or after January 1, 1970 for Non-PPS Hospitals
    - 10.8.2 - Patients Discharged During Hospital Fiscal Years Beginning on or after October 1, 1983 Under PPS
  - 10.9 - Inpatient Psychiatric Facility Services Certification and Recertification
    - 10.9.1 - Delayed/Lapsed Certification and Recertification
- 20 - Certification for Hospital Services Covered by the Supplementary Medical Insurance Program
  - 20.1 - Delayed Certifications and Recertifications
  - 20.2 - Timing for Certification and Recertification for A Beneficiary Admitted Before Entitlement
- 30 - Certification and Recertification by Physicians for Home Health Services
  - 30.1 - Content of the Physician's Certification
  - 30.2 - Method and Disposition of Certifications for Home Health Services
  - 30.3 - Recertifications for Home Health Services
- 40 - Certification and Recertification by Physicians for Extended Care Services
  - 40.1 - Who May Sign the Certification or Recertification for Extended Care Services
  - 40.2 - Certification for Extended Care Services
  - 40.3 - Recertifications for Extended Care Services

- 40.4 - Timing of Recertifications for Extended Care Services
- 40.5 - Delayed Certifications and Recertifications for Extended Care Services
- 40.6 - Disposition of Certification and Recertifications for Extended Care Services
- 50 - Physician's Certification and Recertification for Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology
- 60 - Certification and Recertification by Physicians for Hospice Care
- 70 - DME Certification
- 80 - Summary Table for Certifications/Recertifications

## **10 - Certification and Recertification by Physicians for Hospital Services – General** **(Rev. 1, 09-11-02)**

Payments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the hospital inpatient stay. Appropriate supporting material may be required. The physician certification or recertification statement must be based on a current evaluation of the patient's condition.

For patients admitted to a general hospital, regardless of whether the patients are under PPS, a physician certification is not required at the time of admission for patient services. For services continued over a period of time or for a day outlier case (i.e., an appropriately admitted case results in an extraordinarily long stay) or for a PPS cost outlier case (i.e., an appropriately admitted case results in the expenditure of extraordinary resources), a physician must certify or recertify the continued need for the services at specified intervals. (See § 80 for timing of physician certification and recertification.) Psychiatric and tuberculosis hospitals (which are excluded from PPS) are required to obtain a physician certification on admission.

Hospitals do not transmit physician certification and recertification statements to the A/B MAC (A) or to CMS. The hospital must itself certify on the appropriate billing form that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements are retained in the hospital's file where they are available for verification if needed.

A hospital must also have available in its files a written description of the procedure it adopts on the timing of certifications and recertifications, i.e., the intervals at which the necessary certification statements are required and whether review of long stay cases by the utilization review committee may serve as an alternative to recertification by a physician in the case of the second or subsequent recertification.

### **10.1 - Failure to Certify or Recertify for Hospital Services** **(Rev. 1, 09-11-02)**

If a hospital fails to obtain the required certification or recertification statements in an individual case, program payments may not be made in that case.

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he/she objects in principle to the concept of certification and recertification), the hospital may not bill the program or the beneficiary for covered items or services. The provider agreement precludes the hospital from charging the patient for covered items and services.

## **10.2 - Who May Sign Certification or Recertification** (Rev. 1, 09-11-02)

A certification or recertification statement must be signed by the attending physician responsible for the case or by another physician who has knowledge of the case and is authorized to do so by the attending physician, or by a member of the hospital's medical staff with knowledge of the case.

Ordinarily for purposes of certification and recertification, a "physician" must meet the definition in Chapter 5, §70 and §70.3.

## **10.3 - Certification for Hospital Admissions for Dental Services** (Rev. 1, 09-11-02)

The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status or the severity of the dental procedure requires the patient to be admitted to the hospital for the performance of the dental procedure; and to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered.

## **10.4 - Inpatient Hospital Services Certification and Recertification** (Rev. 1, 09-11-02)

A certification or recertification statement must contain the following information:

- An adequate written record of the reason for either;
  - Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or
  - Special or unusual services for cost outlier cases for hospitals under the prospective payment system (PPS);
- The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and
- Any plans for posthospital care.

## **10.5 - Selection by Hospital of Format and Method for Obtaining Statement** (Rev. 1, 09-11-02)

The individual hospital determines the method by which certifications and recertifications are to be obtained and the format of the statement. Thus, the medical and administrative

staffs of each hospital may adopt the form and procedure they find most convenient and appropriate.

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the A/B MAC (A) to determine that the certification and recertification requirements are, in fact, met. The certification or recertification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate form could be used. If all the required information is included in progress NOTES, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary.

### **10.6 - Criteria for Continued Inpatient Hospital Stay** (Rev. 94, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. In accordance with the regulations at 42 CFR 424.13(c), a physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available. Coverage of these additional, "alternate placement" days in the hospital can continue until the earliest of the following events occurs:

- A bed becomes available in a participating SNF;
- The beneficiary's care needs drop below SNF-level; or
- The beneficiary has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period.

### **10.7 - Utilization Review (UR) in Lieu of Separate Recertification Statement** (Rev. 1, 09-11-02)

For cases not subject to PPS and for PPS day outlier cases, a separate recertification statement is not necessary where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's UR plan. However, it is necessary to satisfy the certification and recertification content standards. It would be sufficient if records of the UR committee show that consideration was given to the three items required for certifications and recertifications: the reasons for continued hospitalization (e.g., consideration was given to the need for special or unusual care in cost outlier status under PPS), estimated time the patient will

need to remain in the hospital (e.g., the time period during which such special or unusual care would be needed), and plans for posthospital care.

## **10.8 - Timing of Certifications and Recertifications** **(Rev. 1, 09-11-02)**

The timing of certifications and recertifications is described in the following subsections.

### **10.8.1 - Admissions On or After January 1, 1970 for Non-PPS Hospitals** **(Rev. 1, 09-11-02)**

For services furnished to beneficiaries admitted on or after January 1, 1970, the initial certifications are required no later than as of the 12th day of hospitalization. A hospital may at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. The first recertification is required no later than as of the 18th day of hospitalization. Subsequent recertifications must be made at intervals established by the UR committee (on a case-by-case basis), but in no event may the interval between recertifications exceed 30 days.

The UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician recertifications with the process of review by the UR committee of longstay cases not subject to PPS, and for PPS day-outlier cases. At the option of the hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the second and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended case by the UR committee.)

Where review of an extended stay case by the UR committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification; however, no explanation for the normal delay is required.

### **10.8.2 - Patients Discharged During Hospital Fiscal Years Beginning On or After October 1, 1983 Under PPS** **(Rev. 1, 09-11-02)**

For cases subject to the prospective payment system (PPS), certification is not required at the time of admission for inpatient services. The admission is reviewed by a hospital review organization upon discharge of the patient. For outlier cases certification is required as follows:

- For day-outlier cases (now discontinued), certification was required no later than 1 day after the hospital reasonably assumes that the case meets the established outlier criteria, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the utilization review committee, on a case-by-case basis if it so chooses, but not less than every 30 days.
- For cost-outlier cases, if possible, certification must be made before the hospital incurs cost for which it will seek cost outlier payment. However, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. For cost-outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee, on a case-by-case basis if it chooses.

As previously stated the UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed. Review by the UR committee used in place of recertification for PPS day outlier cases is considered timely if performed within 7 days after the physician recertification would have been required.

## **10.9 - Inpatient Psychiatric Facility Services Certification and Recertification**

**(Rev. 98, Issued: 05-13-16, Effective: 08-15-16, Implementation: 08-15-16)**

The requirements for physician certification and recertification for inpatient psychiatric facility services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification requirement. In accordance with 42 CFR 424.14, all IPFs (distinct part units of acute care hospitals, CAHs, and psychiatric hospitals) are required to meet the following certification and recertification requirements.

At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. The first recertification is required as of the 12th day of hospitalization. Subsequent recertifications will be required at intervals established by the hospital's utilization review committee (on a case-by-case basis), but no less frequently than every 30 days.

There is also a difference in the content of the certification and recertification. In certification the physician is required to document that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The physician's recertification should satisfy all of the requirements noted below:

1. That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
  - a. Treatment which could reasonably be expected to improve the patient's condition; or,
  - b. Diagnostic study;
2. The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services, and
3. Effective July 1, 2006, physicians will also be required to recertify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

The format of all certifications and recertifications and the method by which they are obtained is determined by the individual facility. No specific procedures or forms are required. The provider may adopt any method that permits verification of all the IPFs requirements to continue treatment. For example, the recertification may be entered on provider generated forms, in progress notes, or in the records (relating to the stay in question) and must be signed by a physician.

Claim denials may not be made for failure to use a certification or recertification form or failure to use particular language or format, provided that the medical record demonstrates that the content requirements given at Pub. 100-02, Medicare Benefit Policy Manual, Chapter 2, §30.2.1 are met.

For convenience, the period covered by the physician's certification and recertification is referred to a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his/her benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

### **10.9.1 - Delayed/Lapsed Certification and Recertification (Rev 98, Issued: 05-13-16, Effective: 08-15-16, Implementation: 08-15-16)**

IPFs are expected to obtain timely certifications and recertifications. However, delayed certifications and recertifications will be honored where, for instance, there have been an oversight or lapse, and a legitimate reason for the delay as noted in Pub. 100-01, §20.1. Denial of payment for lack of the required certification and recertification is considered a

technical denial, which means a statutory requirement has not been met. Consequently, if an appropriate certification is later produced, the denial shall be overturned. Reopenings of technical denial decisions may be initiated by the contractor or the provider.

In addition to compliance with the appropriate certification and recertification content requirements, delayed certification and recertification must include an explanation for the delay and any medical or other evidence which the IPF considers relevant for purposes of explaining the delay. The IPF will determine the format of the delayed certifications and recertifications, and the method by which they are obtained. A delayed certification may be included with one or more recertifications on a single signed document. Separate signed documents for each delayed certification and recertification are not required as they would be if timely certification and recertification had been completed. For all IPF services, a delayed certification may not extend past discharge. IPF certification or recertification documentation may only be signed by a physician.

## **20 - Certification for Hospital Services Covered by the Supplementary Medical Insurance Program**

**(Rev. 50; Issued: 12-21-07; Effective: 09-17-07; Implementation: 01-07-08)**

A physician must certify that medical and other health services covered by medical insurance which were provided by (or under arrangement made by) the hospital were medically required.

Physician certification is not required for the following outpatient services furnished on or after January 3, 1968:

- Hospital services and supplies incident to physicians' services rendered to outpatients; and
- Diagnostic services furnished by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff.

Hospitals must obtain a physician's certification with respect to other services furnished to outpatients.

Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff, e.g., services obtained from an independent laboratory.

This certification requires a brief description of the services and the signature of the physician. It needs to be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the A/B MAC (A) to determine that the certification requirement is in fact met. Therefore, the certification could be entered or pre-printed on a form the physician already has to sign; or a separate certification form could be used.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see §70), outpatient therapy, i.e., physical therapy, occupational therapy and speech-language pathology services (see Pub. 100-02, Chapter 15, §220).

The Physician Certification Statement requirements for all ambulance providers (hospital-owned and operated) and suppliers (independently-owned and operated) are located at 42 CFR §410.40 (d) (2) and §410.40 (d) (3).

## **20.1 - Delayed Certifications and Recertifications** **(Rev. 1, 09-11-02)**

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

## **20.2 - Timing for Certification and Recertification for a Beneficiary Admitted Before Entitlement** **(Rev. 1, 09-11-02)**

If an individual is admitted to a hospital (including a psychiatric hospital) before he/she is entitled to hospital insurance benefits (for example, before attainment of age 65), no certification is required as of the date of admission or entitlement. Certifications and recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he/she became entitled. (The time limits for certification and recertification are computed from the date of entitlement instead of the date of admission.)

## **30 - Certification and Recertification by Physicians for Home Health Services** **(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)**

In addition to the content below, refer to Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5 for a complete description of the requirements that must be met in order to certify and recertify patient eligibility for Medicare home health services.

### **30.1 - Content of the Physician's Certification**

**(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)**

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services that a home health agency (HHA) provides unless a physician certifies that:

- Home health services are needed because the individual is confined to his/her home;
- The individual needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services. Where a patient's sole skilled service need is for skilled oversight of unskilled services, the physician must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician;
- The services are or were furnished while the individual was under the care of a physician; and
- The individual had a face-to-face encounter with an allowed provider type no more than 90 days prior to or within 30 days after the start of home health care and the encounter was related to the primary reason the patient requires home health services in accordance with requirements described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5.1.1. The certifying physician must also document the date of the encounter.

Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible.

The physician must sign and date the plan of care (POC) and the certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The plan of care may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC, oral order, or certification via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

Home health agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the Medicare contractor, state surveyor, or other authorized personnel, in the event of a system breakdown.

See §10.1 for the effects of failure to certify or recertify.

### **30.2 - Method and Disposition of Certifications for Home Health Services**

**(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)**

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the Medicare contractor can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician must be retained by the HHA.

The following instructions pertain to required documentation of the certification and recertification period.

The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the start of care (SOC) date. The "through" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "through" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

Example: Initial certification "From" date 10012000; Initial certification "through" date 11292000; Re-certification "From" date 11302000; Re-certification "through" date 01282001.

**NOTE:** Services delivered on 11292000 are covered in the initial certification episode.

### **30.3 - Recertifications for Home Health Services**

**(Rev. 92, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)**

Under both the hospital insurance and supplementary medical insurance programs, when services are continued past an initial 60-day episode of care, the physician must recertify at intervals of at least once every 60 days that there is a continuing need for services in accordance with requirements described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.5.2. The recertification should be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.

The physician must include an estimate of how much longer the skilled services will be required and must certify that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 40.1.2.2), the physician must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;
3. A plan of care has been established and is periodically reviewed by a physician; and
4. The services are or were furnished while the patient is or was under the care of a physician.

Recertifications must be signed by the physician who reviews the plan of care. The form of the recertification and the manner of obtaining timely recertifications are up to the individual agency.

## **40 - Certification and Recertification by Physicians for Extended Care Services**

**(Rev. 101, Issued: 09-16-16, Effective: 10-18-16, Implementation: 10-18-16)**

Payment for covered posthospital extended care services may be made only if a physician (or, as discussed in §40.1 of this chapter, a physician extender) makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required certification and recertification statements and for retaining them in file for verifications, if needed, by the A/B MAC (A). The skilled nursing facility determines the method by which the certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and recertification statements may be entered on or included in forms, NOTES, or other records that would normally be signed in caring for a patient, or a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed. See Pub. 100-08,

Medicare Program Integrity Manual, chapter 6, section 6.3 regarding medical review of certification and recertification in SNFs.

If the facility's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's or physician extender's refusal to certify based on other grounds (e.g., an objection in principle to the concept of certification and recertification), the facility may not bill the program or the beneficiary for covered items or services. The provider agreement, which the facility files with the Secretary, precludes it from charging the patient for covered items and services.

If a physician or physician extender refuses to certify because, in his/her opinion, the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition), the services are not covered and the facility can bill the patient directly. The reason for the refusal to make the certification must be documented in the facility records. For such documentation to be adequate, there must be some statement in the facility's records, signed by a physician or a responsible facility official, indicating that the patient's physician or physician extender feels that the patient does not, as a practical matter, require daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition).

#### **40.1 - Who May Sign the Certification or Recertification for Extended Care Services**

*(Rev. 114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)*

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a physician extender (that is, a nurse practitioner, a clinical nurse specialist or, effective with items and services furnished on or after January 1, 2011, a physician assistant) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician. *See Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §40.1, for a discussion of "direct" and "indirect" employment relationships in this context.*

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in Chapter 5, §70 of this manual.

#### **40.2 - Certification for Extended Care Services**

*(Rev. 114, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)*

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a *daily* basis for *an ongoing condition* for which he/she was receiving inpatient hospital services prior to transfer to the SNF (*or for a new condition that arose while in the SNF for treatment of that ongoing condition*). *Alternatively, under the regulations at*

*42 CFR 424.20(a)(1)(ii), the initial certification can simply affirm that the individual has been correctly assigned one of the case-mix classifiers that CMS designates as representing the required SNF level of care, as provided in the regulations at 42 CFR 409.30 (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, §30.1, for a discussion of the administrative level of care presumption under the SNF PPS).*

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

### **40.3 - Recertifications for Extended Care Services** (Rev. 1, 09-11-02)

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress.

**NOTE:** In such a case, the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he/she had received inpatient hospital services.

### **40.4 - Timing of Recertifications for Extended Care Services** (Rev. 1, 09-11-02)

The first recertification must be made no later than the 14th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan (if a UR review plan is in place), may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

#### **40.5 - Delayed Certifications and Recertifications for Extended Care Services**

**(Rev. 1, 09-11-02)**

Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

#### **40.6 - Disposition of Certification and Recertifications for Extended Care Services**

**(Rev. 1, 09-11-02)**

Skilled nursing facilities do not have to transmit certification and recertification statements to the A/B MAC (A); instead, the facility must itself certify, in the admission and billing form that the required physician certification and recertification statements have been obtained and are on file.

#### **50 - Physician's Certification and Recertification for Outpatient Physical Therapy Occupational Therapy and Speech-Language Pathology**

**(Rev. 28; Issued: 08-12-05; Effective/Implementation: 09-12-05)**

For certification and recertification of outpatient physical therapy, occupational therapy and speech-language pathology services see Pub. 100-02, Chapter 15, §220.1.3.

#### **60 - Certification and Recertification by Physicians for Hospice Care** **(Rev. 68, Issued: 04-22-11, Effective: 01-01-11, Implementation: 05-12-11)**

The hospice must obtain written certification of terminal illness for each period of hospice care received by an individual. For the initial 90-day period, the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the hospice interdisciplinary group, and the individual's attending physician (if the individual has one). The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. Recertification for subsequent periods only requires the written certification by the hospice medical director or the physician member of the hospice interdisciplinary group. Certifications and recertifications must be dated and signed by the physician and must include the benefit periods to which they apply. Certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.

If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained within the 2 days. A written certification from the medical director of the hospice or the physician member of the interdisciplinary group must be on file in the beneficiary's record prior to the submission of a claim to the Medicare contractor. If these requirements are not met, no payment may be made for the days prior to certification. Instead payment will begin with the day certification is obtained, i.e., the date verbal certification is obtained.

Certifications and recertifications may be completed up to 15 days before the next benefit period begins.

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1, Timing and Content of Certification.

## **70 - DME Certification**

**(Rev. 1, 09-11-02)**

The DME supplier must retain a copy of the physician's order for DME in its files; and in some cases must furnish a Certificate of Medical Necessity to the DME MAC.

## **80 - Summary Table for Certifications/Recertifications**

**(Rev. 84, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)**

The following is a table summarizing the certification/recertification signature requirements and timeframes for various provider types. Please review sections above for more detailed information on Certifications/Recertifications and their required content:



<b>Provider Type</b>	<b>Who Signs Certification</b>	<b>Certification Timeframe</b>	<b>Recertification</b>
Hospital Inpatient	Attending physician or by another physician with knowledge of the case with authorization from attending physician or by a member of hospital's medical staff with knowledge of the case.	No later than the 12th day of hospitalization	Interval between recertifications not to exceed 30 days
SNF	Attending physician or physician on staff at SNF with knowledge of case, or physician extender as discussed in §40.1 of this chapter	Obtain at time of admission or shortly thereafter	First recertification no later than the 14th day of inpatient extended care services. Subsequent at intervals not exceeding 30 days.
HHA	Attending physician	Obtain at time POC is established or shortly thereafter	Physician must recertify at least once every 60 days
Hospice	For initial 90-day period, must obtain written certification statements from medical director of hospice or physician member of the hospice interdisciplinary group and the attending physician.	If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained.	Must be obtained for each period of hospice care; written certification by hospice medical director or physician member of interdisciplinary group.

## Transmittals Issued for this Chapter

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<b><u>R114GI</u></b>	03/16/2018	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	06/19/2018	10512
<b><u>R101GI</u></b>	09/16/2016	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF)	10/18/2016	9748
<b><u>R98GI</u></b>	05/13/2016	Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification	08/15/2016	9522
<b><u>R94GI</u></b>	10/16/2015	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (2015)	11/16/2015	9336
<b><u>R92GI</u></b>	04/22/2015	Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services	05/11/2015	9119
<b><u>R91GI</u></b>	04/10/2015	Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services – Rescinded and replaced by Transmittal 92	05/11/2015	9119
<b><u>R84GI</u></b>	04/04/2014	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions	05/05/2014	8669
<b><u>R76GI</u></b>	01/13/2012	Allowing Physician Assistants to Perform Skilled Nursing Facility (SNF) Level of Care Certifications and Recertifications	02/13/2012	7701
<b><u>R68GI</u></b>	04/22/2011	Physician Certification and Recertification of Services Manual Changes	05/12/2011	7377
<b><u>R50GI</u></b>	12/21/2007	Revision to Certification for Hospital Services Covered by the Supplementary Hospital Insurance Program as it Pertains to Ambulance Services	01/07/2008	5833
<b><u>R47GI</u></b>	08/17/2007	Revision to Certification for Hospital Services Covered by the Supplementary Medical Insurance Program as it Pertains to Ambulance Services	09/17/2007	5684
<b><u>R39GI</u></b>	06/09/2006	Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Rate Year 2007	07/03/2006	5129

<u>R28GI</u>	08/12/2005	Conforming Changes for Change Request 3648 to Pub. 100-01	09/12/2005	3912
<u>R01MGI</u>	09/11/2002	Initial Publication of Manual	NA	NA

[Back to top of Chapter](#)