Medicare Benefit Policy Manual

Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

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10 - Comprehensive Outpatient Rehabilitation Facility (CORF) Services Provided by Medicare

(Rev. 1, 10-01-03)

A3-3180, A3-3181, and CORF-251

The purpose of Comprehensive Outpatient Rehabilitation Facility (CORF) coverage is to permit the beneficiary to receive a variety of rehabilitation services at a central location in a coordinated fashion.

The statute specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service if provided to a hospital patient. This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care. This provision merely requires that the service, if otherwise covered, would be covered if provided in a hospital.

The CORF services are not covered if not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. Thus, there must be potential for restoration or improvement of lost or impaired functions. For example, services involving repetitive services that do not require the skilled services of nurses or therapists, such as maintenance programs or general conditioning or ambulation, are not covered. Nonmedical personnel such as family members could perform these services in the patient's residence. It is not reasonable and necessary for such services to be performed in an ambulatory care setting by CORF personnel.

20 - Required and Optional CORF Services

(Rev. 1, 10-01-03)

A3-3180, CORF-250

20.1 - Required Services

(Rev. 1, 10-01-03)

The CORF must provide at least the following three services:

- Physicians' services;
- Physical therapy; and

- Social or psychological services.

In addition to this basic package of services, the CORF may furnish and receive payment for as many of the other items and services listed in §20.2 as it wishes.

The facility must have adequate space and equipment necessary to provide any of the services it elects to provide. Additionally, in order to accept a patient, the CORF must be able to provide all of the services required by the patient, as established in the plan of treatment. If the CORF does not have personnel to provide the service, it must arrange for the services to be provided at the CORF, as needed, by outside practitioners. Assigned intermediaries process claims.

The CORF services are subject to the Medicare Part B deductible and coinsurance provisions. The CORF may bill the beneficiary only the unmet portion of the deductible and the coinsurance.

20.2 - Optional CORF Services

(Rev. 1, 10-01-03)

A3-3181, CORF-251

The CORF may provide any or all of the following services:

- Physicians' services related to administrative functions;
- Physical therapy, occupational therapy, speech pathology services, and respiratory therapy;
- Social and psychological services;
- Nursing care provided by or under the supervision of a registered professional nurse;
- Prosthetic and orthotic devices, including testing, fitting, or training in the use of such devices;
- Drugs and biologicals which cannot be self-administered;
- Supplies, appliances and equipment, including the purchase or rental of Durable Medical Equipment (DME) from the CORF; and
- A single home visit to evaluate the potential impact of the home environment on the rehabilitation goals.

30 - Rules for Provision of Services

(Rev. 1, 10-01-03)

A3-3182

A - Place of Treatment

In general, all services must be furnished on the premises of the CORF. The only exceptions are the home evaluation, physical therapy, occupational therapy, and speech pathology services. There is no restriction on where these services may be furnished. They may be covered if furnished pursuant to the plan of treatment, and they do not duplicate services for which payment has been made under Medicare.

B - Personnel Qualification Requirements

Services must be furnished or supervised by personnel determined to be qualified in accordance with CMS regulations 42 CFR 485.70.

Determinations regarding whether services are furnished by or under the supervision of qualified personnel are primarily the responsibility of the State agency responsible for certifying the facility. In the absence of evidence to the contrary, Medicare assumes that the services of a participating CORF are furnished or supervised by qualified personnel. Refer any questions in this regard to the regional office. If there is evidence that services are not being furnished or supervised by qualified personnel, the carrier or intermediary will withhold payment until the matter is resolved.

C - Services Furnished Under Arrangements

Any CORF service defined in §§20 or 40 may be furnished under arrangement.

Must meet the requirements of Pub 100-1 chapter 5-10.3.

D - Referral for Treatment

To become a patient of a CORF, the beneficiary must be under the care of a physician who certifies that the beneficiary needs skilled rehabilitation services.

The referring physician must advise the CORF of the beneficiary's medical history, current diagnosis and medical findings, desired rehabilitation goals, and any contraindications to specific activity or intensity of rehabilitation services.

E - Plan of Treatment

CORF services must be furnished under a written plan of treatment established by a physician. The physician may be either a physician associated with the CORF, or the referring physician if the physician provides a detailed plan of treatment that meets the following requirements.

The plan of treatment must contain the diagnosis, the type, amount, frequency, and duration of services to be performed, and the anticipated rehabilitation goals.

The plan of treatment should be sufficiently detailed to permit an independent evaluation of the patient's specific need for the indicated services and of the likelihood that the patient will derive meaningful benefit from them.

The CORF physician must review the plan of treatment at least once every 60 days. Following the review, the physician should certify that the plan of treatment is being followed and that the patient is making progress in attaining the established rehabilitation goals. When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends with respect to that aspect of the plan of treatment.

40 - Specific CORF Services

(Rev. 1, 10-01-03)

A3-3183, CORF-253

40.1 - Physicians' Services

(Rev. 1, 10-01-03)

A3-3183.1, B3-2220, CORF-253.1

Certain administrative services provided by the physician associated with the CORF are considered CORF services and are paid to the CORF. These services include: examinations for the purpose of establishing and reviewing the plan of treatment, consultation with and medical supervision of nonphysician staff, and other medical and facility administration activities.

Physicians' diagnostic and therapeutic services furnished to an individual patient are not CORF physicians' services. If covered, payment for these services is made by the carrier based on the Medicare physician fee schedule subject to the same limitations applicable to physicians' services furnished in outpatient hospital settings.

40.2 - Physical Therapy Services

(Rev. 1, 10-01-03)

A3-3183.2, CORF-253.2

The coverage guidelines in the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §80, apply to physical therapy services provided by CORFs. Note that under those guidelines, maintenance physical therapy, i.e., repetitive services required to maintain a level of functioning, would not be covered. However, the establishment of a maintenance program for a patient whose restoration potential has been reached would be a covered service. This could include examinations, evaluations

of the patient's condition, preparation of the maintenance program, and the training of nonskilled persons to carry out the program.

40.3 - Occupational Therapy Services

(Rev. 1, 10-01-03)

A3-3183.3, CORF-253.3

The coverage guidelines in the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §90, also apply to occupational therapy services furnished by a CORF.

Services involving vocational or prevocational assessment are not covered when they are related solely to vocational rehabilitation; that is, to prepare the patient to qualify for specific employment opportunities, achieve certain work skills, or accommodate a certain work setting. Such services are not considered reasonable and necessary for the diagnosis or treatment of illness or injury.

40.4 - Speech Pathology Services

(Rev. 1, 10-01-03)

A3-3183.4, CORF-253.4

Speech pathology services are subject to the guidelines in the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §110.

Services related to congenital speech difficulties, such as stuttering or lisping, would not be covered unless such services are incident to the treatment of otherwise covered CORF services.

Although in other outpatient settings, a speech pathologist is permitted to establish a plan of treatment, this is not the case with CORF services. Under the statute, all CORF services must be provided under a plan established by a physician. However, as with other specialties, it is expected that the physician will rely heavily on advice from the speech pathologist.

40.5 - Respiratory Therapy Services

(Rev. 1, 10-01-03)

A3-3183.5, CORF-253.5

Respiratory therapy services furnished by a CORF are covered under the guidelines in the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §100.

40.6 - Prosthetic and Orthotic Devices

(Rev. 1, 10-01-03)

A3-3183.6, CORF-253.6

Prosthetic devices, other than dental devices and renal dialysis machines, are covered CORF services. Prosthetic devices are defined as devices that replace all or part of an internal body organ or external body member (including contiguous tissue), or that replace all or part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Coverage of a prosthetic device includes all services necessary for formulating its design, material, and component selection; measurement, fittings, static and dynamic alignments; and instructing the patient in its use. Such coverage is included as an integral part of the fabrication of the device.

Orthotic devices are those orthopedic appliances or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. As with prosthetic devices, the coverage of an orthosis includes its design, materials, measurements, fabrications, testing, fitting, or training in the use of the orthosis.

40.7 - Social Services

(Rev. 1, 10-01-03)

A3-3183.7, CORF-253.7

Social services are covered CORF services if they are included in the plan of treatment and contribute to the improvement of the individual's condition. Such services include:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the CORF;
- Assessment of the relationship of the patient's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from the CORF; and
- Counseling and referral for casework assistance in resolving problems in these areas.

40.8 - Psychological Services

(Rev. 1, 10-01-03)

A3-3183.8, CORF-253.8

Covered services include:

- Assessment, diagnosis, and treatment of the beneficiary's mental and emotional functioning as it relates to his or her rehabilitation;
- Psychological evaluations of the individual's response to and rate of progress under the treatment plan; and
- Assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment.

Although everyone who has a serious illness or injury may suffer from some degree of anxiety, the coverage of psychological services does not automatically extend to every CORF patient. For example, diagnostic testing for a mental problem is covered for a cardiac patient who exhibits excessive anxiety or fear following the acute phase of a cardiac problem. However, the routine testing or treatment of all cardiac rehabilitation patients for mental, psychoneurotic, or personality disorders is not covered.

Family counseling services are covered only when the primary purpose of that counseling is the treatment of the patient's condition, that is, when there is a need to observe the patient's interaction with family members or to assess the capability of family members to aid in the rehabilitation of the patient. Family counseling services that are primarily directed toward the treatment of a family member's problem with respect to the patient's condition are not covered.

40.9 - Nursing Services

(Rev. 1, 10-01-03)

A3-3183.9, CORF-253.9

Nursing services provided by or under the supervision of a registered professional nurse are covered CORF services.

40.10 - Drugs and Biologicals

(Rev. 1, 10-01-03)

A3-3183.10, CORF-253.10, AB-02-072

Drugs and biologicals are covered when they are not usually self-administered, are administered by or under the supervision of a physician or registered nurse, and are not otherwise excluded from Medicare coverage, such as most injections for immunization.

Thus, when a patient is given tablets or other oral medication, they are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a patient is given an injection that is usually self-injected, such as insulin, this drug is excluded from coverage even in an emergency situation. However, if a patient receives an injection of a drug that is not usually self-injected and that is also available in oral form, that drug is not subject to the self-administrable drug exclusion, since it is not self-administrable in the form in which it was furnished to the patient.

40.11 - Supplies, Appliances, and Equipment

(Rev. 1, 10-01-03)

A3-3183.11, CORF-253.11

Covered services include:

- Nonreusable supplies, such as oxygen, bandages, or ceramic tiles, used in the various therapeutic modalities;
- Medical equipment and appliances for the use of patients at the facility; and
- Durable medical equipment (DME) for use outside the CORF, whether furnished at the CORF or delivered to the beneficiary's home. The beneficiary may obtain DME from the CORF or from a DME supplier. The guidelines in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§110, apply to DME furnished by the CORF. Exercise appliances and other self-help devices that can be used for general conditioning do not qualify as DME.

40.12 - Home Environment Evaluation

(Rev. 1, 10-01-03)

A3-3183.12, CORF-253.12

One off-site service is permitted (a single home visit to evaluate the potential impact of the home environment on the rehabilitation goals). The purpose of the evaluation is to permit the plan of treatment to be tailored to take into account the patient's home environment. The Medicare program does not pay for physical alterations to the home that facilitates the patient's rehabilitation.

The home evaluation is not covered as a routine service for all CORF patients. It is covered only if, in establishing or carrying out the plan of treatment, there is a clear indication that the home environment might adversely affect the patient's rehabilitation. Coverage is limited to the services of one professional who is selected by the CORF.

50 - Outpatient Mental Health Treatment Limitation

(Rev. 1, 10-01-03)

A3-3185, CORF-255

Regardless of the actual expenses a beneficiary incurs for treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital, the amount of those expenses for CORF services that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the allowable amount for those services. This limitation is called the outpatient mental health treatment limitation.

Expenses for diagnostic services (e.g., psychiatric testing and evaluation to diagnose the patient's illness) are not subject to this limitation. This limitation applies only to therapeutic services and to services performed to evaluate the progress of a course of treatment for a diagnosed condition.

Carriers use line item diagnoses and HCPCS codes to administer the limitation. Intermediaries use the revenue code. See the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage," §50, for a further description of the outpatient mental health treatment limitation.

50.1 - Outpatient Mental Health Limit Not Applicable for Hospital Inpatients

(Rev. 1, 10-01-03)

A3-3185.A, CORF-255.A

The limitation is applicable to expenses incurred in connection with the treatment of an individual who is not an inpatient of a hospital. Thus, the limitation applies to mental health services furnished to a CORF patient in a physician's office, in the patient's home, in a skilled nursing facility, as an outpatient, and so forth. The term "hospital" in this context means an institution which is primarily engaged in providing to inpatients the following services, by or under the supervision of a physician(s):

- Diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons;
- Rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill patients.

50.2 - Disorders Subject to Outpatient Mental Heath Limitation

(Rev. 1, 10-01-03)

A3-3185.B, CORF-255.B

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Revised (DSM-IV-R)."

50.3 - Diagnostic Services

(Rev. 1, 10-01-03)

A3-3185.C, CORF-255.C

The limitation is not applied to tests and evaluations performed to establish or confirm the patient's diagnosis. Diagnostic services include psychiatric or psychological tests and interpretations, diagnostic consultations, and initial evaluations. However, testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.

50.4 - Application of Outpatient Mental Heath Limitation

(Rev. 1, 10-01-03)

A3-3185.1, CORF-255.1.A

If the CORF treatment services rendered are for both a psychiatric condition and one or more nonpsychiatric conditions, the charges for the psychiatric aspects of treatment are billed under a separate revenue code from the charges for the nonpsychiatric services. See the Medicare Claims Processing publication for specific instructions.

See 100-1, the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, for general policy about the mental health limitation.

50.5 - Computation of Limitation

(Rev. 1, 10-01-03)

A3-3185.1.B, CORF-255.1.C

The intermediary will determine the allowed amount for CORF services subject to the limitation. The allowed amount is the lower of the charge or the Medicare Physician Fee Schedule (MPFS) fee amount. The intermediary multiplies the allowed amount by 0.625 to obtain the limitation amount. This limitation amount is subject to the Part B deductible and 20 percent coinsurance.

The beneficiary is responsible for both the 37.5 percent reduction and the deductible and coinsurance applied to the reduced charges. Once the deductible has been satisfied, a

beneficiary is responsible for 50 percent of the customary charges, which is the sum of 37.5 percent plus 12.5 percent (20 percent of 0.625).