Medicare
Outpatient Physical Therapy
Comprehensive Outpatient Rehabilitation Facility, and Community Mental Health Center

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 12 **Date: JUNE 2000**

REFER TO: CHANGE REQUEST 931

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter I	1-1 (1 p.)	1-1 (1 p.)
118 - 120	1-7 - 1-8 (2 pp.)	1-7 - 1-10 (4 pp.)
Table of Contents - Chapter V	5-1 (1 p.)	5-1 (1 p.)
500 - 500	5-3 (1 p.)	5-3 - 5-16 (14 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: N/A
IMPLEMENTATION DATE: NA

Sections 118 - 118.3 Fraud and Abuse - General, have been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Section 500, Medical Review of Comprehensive Outpatient Rehabilitation Facility (CORF) Claims, Section 500.1, Focused Medical Review, and Section 501, Intermediary Medical Review (MR) of Part B OPT Bills, have been **deleted** and moved to the Program Integrity Manual to avoid duplication.

The Program Integrity Manual can be found at the following Internet address: **www.hcfa.gov/pubforms/83_pim/pimtoc.htm**.

DISCLAIMER: ...The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

Section

Administration of Medicare Program

Provider Participation in Medicare

Disclosure of Information

D. State Agency as a Medical Insurance Intermediary.--Where a State enters into an agreement with the Federal government to pay medical insurance premiums on behalf of its aged welfare recipients, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

116. DISCRIMINATION PROHIBITED

Participating providers of services must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provision of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin in the treatment of patients, the use of equipment and other facilities, and the assignment of personnel to provide services.

The Office of Civil Rights in DHHS is responsible for investigating complaints of noncompliance.

118. FRAUD AND ABUSE - GENERAL

Sections 118 - 118.3 have been moved to the Provider Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

Provider Participation in Medicare

120. DEFINITION OF PROVIDER

A. Providers of Services.--A provider of services (also called a "provider") is defined as a hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, or a comprehensive outpatient rehabilitation facility (CORF). For purposes of this manual, the term also includes:

- A clinic, rehabilitation agency, or public health agency that meets the applicable conditions of participation, but only for the limited purpose of furnishing outpatient physical therapy, outpatient speech pathology, or outpatient occupational therapy services; and

- A community mental health center (CMHC), but only for the limited purpose of furnishing partial hospitalization services.

B. Participating Providers.-- To be a participating provider, a provider must be in compliance with applicable provisions of title VI of the Civil Rights Act of 1964. The provider must enter into an agreement under §1866 of the Social Security Act that provides that (l) it does not charge any individual or other person for items and services covered by the health insurance program other than deductibles and coinsurance amounts; and (2) it returns any money incorrectly collected from the individual or other person on their behalf or make such other disposition as required by statue or regulation.

A provider that files an agreement becomes a qualified participating provider after they meet all certification requirements on the date of their onsite survey. If the provider fails to meet any other certification requirements on the date of their onsite survey, the effective date of their agreement is applicable on:

- The date they meet all requirements;

- The date on which the provider submits a correction plan acceptable to HCFA; or

- The date on which the provider submits an approvable waiver request.

For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a sufficient record-keeping capability to determine the costs of services furnished to Medicare beneficiaries. (This is not applicable to hospitals under the Prospective Payment System (PPS)).

122. NOMINATION OF INTERMEDIARY

A. Newly Participating Provider.--You may elect to be served by any intermediary already authorized to serve other providers of the same type in its area. Your RO reviews requests. Requests are usually approved unless special or temporary limitations are placed on the requested intermediary's availability, or it is determined that an addition to the requested intermediary's workload at the time is undesirable. Direct questions regarding the availability of an intermediary to the RO.

CHAPTER V

MEDICAL REVIEW

Medical Review of Comprehensive Outpatient Rehabilitation Facility (CORF) Claims

500. MEDICAL REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) CLAIMS

Sections 500-501 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.