Medicare Benefit Policy Manual

Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage

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(Rev. 21, 09-24-04)

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(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

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

The purpose of Comprehensive Outpatient Rehabilitation Facility (CORF) is to permit the beneficiary to receive *multidisciplinary* rehabilitation services at a *single* 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.

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, *treatments* involving repetitive *exercises* (i.e., maintenance programs, general conditioning or ambulation) that do not require the skilled services of therapists *or other professional rehabilitation practitioners* are not covered. Nonmedical personnel such as family members *or exercise instructors* could perform these services in the patient's residence. It is not reasonable and necessary for such services to be performed in a *CORF* setting by CORF personnel.

The facility physician must be present in the facility for a sufficient time to provide, in accordance with accepted principles of medical practice, medical direction, medical care services and consultation. (§485.58) All services must be provided within acceptable professional standards and practice and meet the qualifications set forth in §485.70.

20 - Required and Optional CORF Services

(Rev. 1, 10-01-03)

A3-3180, CORF-250

20.1 - Required Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A CORF is defined as a facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of the injured and disabled or to patients recovering from illness. The CORF must provide a comprehensive, coordinated, skilled rehabilitation program for its patients that includes, at a minimum, CORF physicians' services, physical therapy services, and social or psychological services. A physician must certify, as a condition of payment, that CORF services are required because the individual needs skilled rehabilitation services. Skilled rehabilitation services are defined as services requiring the skills of physical therapists, speech-language pathologists, or occupational therapists. In the CORF setting respiratory therapy services can be provided by physical therapists, occupational therapists, respiratory therapists or registered nurses, as recognized by applicable State law.

A CORF is recognized as a provider of services that is paid under the physician fee schedule for all services except for drugs and biologicals. To participate as a CORF, a facility or provider must furnish, as its major services, at least the following to patients requiring skilled rehabilitation services:

- *CORF* physicians' services *(rendered by a physician) - professional services performed by physicians, such as consultation, home, office, and institutional evaluation and management services rendered by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs services (42 CFR 410.100(a)). The physician must have had, subsequent to completing a 1-year hospital internship, at least one year of training in the medical management of patients requiring rehabilitative services; (§485.70) or has had at least 1 year of full-time or part-time experience in a rehabilitation setting providing physician's services similar to those required in a rehabilitation facility. A physician who is specialized only in pulmonary rehabilitation are not likely to have the experience needed to medically manage patients that need skilled rehabilitation services;*

- Physical therapy *- services include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance*

therapy program for an individual whose restoration potential has been reached (42 CFR 410.100(b)); and

- Social or psychological services – *social services include assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, adjustment to care furnished, casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment and assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from the CORF (42 CFR 410.100(h)). Psychological services include assessment, diagnosis and treatment of an individual's mental and emotional functioning as it relates to the individual's rehabilitation, psychological evaluations of the individual's progress under the treatment plan, and assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment (42 CFR 410.100(i));*

In addition to this basic package of *medically necessary comprehensive coordinated skilled rehabilitation* services, the CORF may furnish as many of the other *covered* items and services listed in §20.2 as it *elects, as long as they are consistent with the plan of treatment, necessary to achieve the rehabilitation goals and performed in conjunction with core CORF services*.

To receive Medicare payment for covered services, the CORF must have adequate space and equipment necessary for any of the services provided. *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. 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-language pathology services. There is no restriction on where these services may be furnished with the exception of home evaluations. The home evaluation may be covered if furnished pursuant to the plan of treatment, and it does not duplicate services for which payment has been made under Medicare.* The CORF *must* bill their assigned fiscal intermediary, which makes payment for services provided under this arrangement.

The CORF services are subject to the Medicare Part B deductible and coinsurance provisions*, i.e., the CORF may bill the beneficiary only for the unmet portion of the deductible and 20 percent of the fee schedule amount for covered services, unless the services are subject to the outpatient mental health treatment limitation for psychological therapy.*

20.2 - Optional CORF Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3181, CORF-251

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

- Occupational therapy– *services include assessment of an individual's level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities (42 CFR 410.100(c));*
- Speech-*Language pathology* - *services for the diagnosis and treatment of speech and language disorders that create difficulties in communication or dysphagia (swallowing difficulties). (42 CFR 410.100(d));*
- Respiratory therapy - *services for the functional assessment, diagnosis, and treatment of patients with deficiencies or abnormalities of cardiopulmonary function (42 CFR 410.100(e));*
- Prosthetic and orthotic devices - includes testing, fitting, or training in the use of such devices *(42 CFR 410.100(f) and (g));*
- Nursing *– includes nursing services (e.g., teaching self catheterization) specified in the plan of treatment and any other nursing services necessary for the attainment of the rehabilitation goals which are* provided by or under the supervision of a professional registered nurse *(42 CFR 410.100(j));*
- Drugs and biologicals - which *are not usually* self-administered *by the patient (42 CFR 410.100(k)).*
- Supplies, appliances and equipment, including the purchase or rental of Durable Medical Equipment (DME) from the CORF *(42 CFR 410.100(l)). Effective April 1, 2001, CORFs should not bill for the supplies they furnish. The payment of supplies is included in the payments under the physician fee schedule;* and
- A single home visit - *includes evaluating* the potential impact of the home environment on the rehabilitation goals (*42 CFR* 410.100(m)).

30 - Rules for Provision of Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

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-*language* pathology services. There is no restriction on where these services may be furnished *with the exception of home evaluations*. *The home evaluation* may be covered if furnished pursuant to the plan of treatment, and *it does* 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 484.4 and 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 *survey and certification of* 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 *appropriately* supervised by qualified personnel, the 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 *and must* meet the requirements of Pub 100-01 chapter 5, section 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 *skilled* rehabilitation services.

E - Plan of Treatment

The CORF services must be furnished under a written plan of treatment established *and signed* by a physician *who has recently evaluated the patient*. *It is expected that the*

physician will establish the plan in consultation with the physical therapists, occupational therapists or speech-language pathologists who will provide the actual therapy. The physician wholly establishes the respiratory therapy plan of treatment. 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 *skilled rehabilitation* services to be performed, and the anticipated *skilled* rehabilitation goals. The plan of treatment should be sufficiently detailed to permit an independent evaluation of the patient's specific need for the indicated *skilled rehabilitation* services and of the likelihood that the patient will derive meaningful benefit from them.

The CORF physician *or the referring* physician must review the plan of treatment at least once every 60 days. *The 60-day period begins with the first day of skilled rehabilitation therapy.* Following the review, the physician *must* certify that the plan of treatment is being followed and that the patient is making progress in attaining the established *skilled* rehabilitation goals. When the patient has reached a point where no further progress is being made toward one or more of the *skilled rehabilitation* 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. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.1, B3-2220, CORF-253.1

Certain administrative services provided by the physician associated with the CORF are considered CORF *physician* services. *These services include administrative services provided by the physician associated with the CORF, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility medical and administration activities relating to the comprehensive coordinated skilled rehabilitation service. Examinations for the purpose of establishing and reviewing the plan of care that do not result in a billable service would also represent CORF physician services.*

Physicians' diagnostic and therapeutic services *(e.g., evaluation and management services, debridement),* furnished to an individual patient are not CORF physicians' services. *They are physician services and are billable to the Part B carrier. The physician, not the CORF, bills for and is paid by Medicare for these services. The claim form must be clearly annotated to show the CORF as the place of treatment.*

40.2 - Physical Therapy Services

(Rev.21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.2, CORF-253.2

A qualified physical therapist has the knowledge, training, and experience required to evaluate and reevaluate a patient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function, and recommend to the physician a plan of treatment. However, while the skills of a qualified physical therapist are required to evaluate and reevaluate the patient's level of function and to consult in the development of the plan of treatment, a qualified physical therapist assistant functioning under the general supervision of the qualified physical therapist may also carry out the implementation of the plan, in accordance with applicable State laws. Physical therapist assistants are not allowed to conduct the discharge visit as this visit is viewed as the final reassessment.

Physical therapy is not required to effect improvement or restoration of function when a patient suffers a temporary loss or reduction of function (e.g., temporary weakness resulting from prolonged bed rest after major abdominal surgery) that can reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Accordingly, physical therapy furnished in such situations is not considered reasonable and necessary for the treatment of the individual's illness or injury and the services are excluded from coverage.

40.3 - Occupational Therapy Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.3, CORF-253.3

Occupational therapy is a medically prescribed treatment to improve or restore functions that have been impaired by illness or injury or, when function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Occupational therapy services are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program and performed in conjunction with core CORF services.

A qualified occupational therapist has the knowledge, training, and experience required to evaluate and reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function, and recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate and reevaluate the patient's level of function and consult in the development of the plan of treatment, a qualified occupational therapy assistant functioning under the general

supervision of the qualified occupational therapist may also carry out the implementation of the plan, in accordance with applicable State laws. Occupational therapist assistants are not allowed to conduct the discharge visit as this visit is viewed as the final reassessment.

***NOTE**: General supervision requires initial direction and periodic inspection of the actual activity. However, the supervising therapist need not always be physically present or on the premises when the assistant is providing the services.*

40.4 – Speech-*Language* Pathology Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.4, CORF-253.4

Services related to congenital speech difficulties, such as stuttering or lisping, would not be covered.

A qualified speech-language pathologist has the knowledge, training, and experience required to evaluate and reevaluate a patient's level of function, determine whether a speech-language program could reasonably be expected to improve, restore, or compensate for lost function, and, when appropriate, recommend to the physician a plan of treatment. A qualified speech-language pathologist will evaluate the patient's level of function and provide advice used in the development of the plan of treatment. Speech-language pathology therapy services are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program and performed in conjunction with core CORF services.

Although in other outpatient settings, a speech-*language* pathologist is permitted to establish a plan of treatment, this is not the case with CORF services. However, as with other specialties, it is expected that the physician will *seek and use* advice from the speech-*language* pathologist.

40.5 - Respiratory Therapy Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.5, CORF-253.5

Respiratory therapy services are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician and performed in conjunction with core CORF services.

The facility physician must be present in the facility for a sufficient time to provide, in accordance with accepted principles of medical practice, medical direction, medical care

services and consultation (§485.58). All services must be provided within acceptable professional standards and practice and meet the qualifications set forth in §485.70.

A. Definition

Respiratory therapy (respiratory care) services are those services prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with respiratory deficiencies and abnormalities of function as part of a comprehensive coordinated skilled rehabilitation program.

To qualify for Medicare payment, respiratory therapy must be a covered service and must be reasonable and necessary for the diagnosis or treatment of an illness or injury and performed by respiratory therapists, physical therapists, occupational therapists, or registered nurses, as recognized by applicable State law. Covered services may include:

- *The application of techniques to support oxygenation and ventilation in the acutely ill patient. These techniques include but are not limited to:*

    1. *The establishment and maintenance of artificial airways;*

    2. *The development of ventilator therapy and other means of airway pressure manipulation;*

    3. *The development of techniques to improve the patient's function through delivery of oxygen; and*

    4. *Development of techniques to aid removal of secretions from the pulmonary tree;*

- *The therapeutic use and monitoring of medical gases (i.e., oxygen), active mists and aerosols (to humidify or for other therapeutic effects), and such equipment as nebulizers;*

- *Bronchial hygiene therapy, including deep breathing and coughing exercises, postural drainage, chest percussion and vibration, and nasotracheal suctioning;*

- *Diagnostic tests for evaluation by a physician, e.g., pulmonary function tests, spirometry, and blood gas analyses;*

- *Pulmonary rehabilitation techniques to improve respiratory function:*

    1. *Breathing retraining, including therapeutic procedures specifically targeted at improving the strength and endurance of respiratory muscles.*

2. *Therapeutic activities:*

- *Exercise conditioning, including the performance of graded activity programs to increase strength and endurance of upper body and lower extremities;*

- *Energy conservation strategies to perform tasks with less respiratory effort.*

- *Periodic assessment and monitoring of the acute and chronically ill patient for indications, and the effectiveness of, respiratory therapy services.*

B. Guidelines for Applying Coverage Criteria

There are many conditions for which respiratory therapy may be indicated. However, respiratory therapy performed as part of a standard protocol without regard to the individual patient's actual condition, capacity for improving, and need for such services, is not reasonable and necessary. All respiratory therapy services must meet the test of being "reasonable and necessary" pursuant to §1862(a)(1)(A) of the Act and must be performed in conjunction with core CORF services. Determinations of medical necessity are made based on local contractor decisions on a claim-by-claim basis.

C. Patient Education Programs

Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist.

40.6 - Prosthetic and Orthotic Devices *and Supplies*

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.6, CORF-253.6

Prosthetic devices, other than dental devices and renal dialysis machines, are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician, and performed in conjunction with core CORF services. Prosthetic devices (other than dental) are defined as devices that replace all or part of an internal body organ (including contiguous tissue), or which replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met.

Examples of prosthetic devices include maxillofacial devices and devices which replace all or part of the ear or nose. A urinary collection and retention system is a prosthetic device replacing bladder function in case of permanent urinary incontinence. The Foley catheter is also considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, disposable bed pads, diapers, rubber sheets, etc. are supplies that are not covered under this provision. Colostomy (and other ostomy) bags and necessary equipment required for attachment are covered as prosthetic devices. This coverage also includes irrigation and flushing equipment and other items and supplies directly related to ostomy care, whether or not the attachment of a bag is required.

Payment is made for supplies that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition is covered when ordered by a physician.

Necessary supplies, adjustments, repairs, and replacements are covered even when the device was in use before the user enrolled in Part B of the program, as long as the device continues to be medically required. ***(Note:*** *Initial teaching in use of a prosthetic device is included in the price Medicare pays for these items and cannot be billed for separately.)*

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 leg, arm, back, and neck braces. They are rigid and semi-rigid devices supporting weak or deformed body members or restricting or eliminating motion in a diseased or injured body part. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace. Back braces include, but are not limited to, special corsets, e.g., sacroiliac, sacrolumbar, dorsolumbar corsets and belts.

Prosthetics are artificial legs, arms, and eyes. Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Orthotics and prosthetics are covered when furnished in conjunction with a physician's service or on a physician's order. These devices are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program. As with prosthetic devices, the payment for an orthosis or prosthesis includes its design, materials, measurements, fabrications, testing, fitting, or training in the use of the device.

Adjustments to an artificial limb or other appliance required by a change in the patient's condition are covered when ordered by a physician. Adjustments, repairs and replacements are covered even when the item had been in use before the user enrolled in Part B of the program so long as the device continues to be medically required.

40.7 - Social Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.7, CORF-253.7

Social services *are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician, and performed in conjunction with core CORF services. Social services must* 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. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.8, CORF-253.8

Psychological services provided are covered CORF services if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician, and performed in conjunction with core CORF services. 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 *anyone* 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 reasonable and necessary and* are not covered.

40.9 - Nursing Services

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.9, CORF-253.9

Nursing services provided by or under the supervision of a registered professional nurse are covered CORF services *if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician, and performed in conjunction with core CORF services.*

40.10 - Drugs and Biologicals

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

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

Drugs and biologicals are covered *if they are part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the physician, and performed in conjunction with core CORF services. Drugs and biologicals are covered* when they:

- Are administered by or under the supervision of a physician or registered nurse,
- Are not otherwise excluded from Medicare coverage, such as most injections for immunization, and,
- Are not usually self-administered by the patient.

Base determinations of whether a drug or biological is of a type that cannot be self-administered on the usual method of administration furnished to the patient. If a patient receives an injection of a drug that is not usually self-injected and the drug is also available in oral form, the drug is not subject to the self-administrable drug exclusion because it is not self-administrable in the form furnished to the patient. The FI has the discretion to determine if it was medically necessary in that particular case to administer the injectable form of the drug instead of the oral form. If the FI determines that the oral form was appropriate, then the injectable drug would not be covered. Thus, when a patient is given tablets or other oral medication, the *medications* 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.

Most vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin, or immune globulin. The following three vaccinations are covered if a physician who is a doctor of medicine or osteopathy orders it:

- *Medicare pays for pneumococcal pneumonia vaccine and its administration furnished by a CORF.*
- *Medicare covers hepatitis B vaccine and its administration furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B.*
- *Medicare pays for influenza virus vaccine and its administration.*

<u>High Risk for hepatitis B</u> groups currently identified include:

- *End stage renal disease (ESRD) patients;*
- *Patients with hemophilia who receive Factor VIII or IX concentrates.*
- *Clients of institutions for individuals with mental retardation;*
- *Persons who live in the same household as a hepatitis B Virus (HBV) carrier;*
- *Homosexual men;*
- *Illicit injectable drug abusers.*

<u>Intermediate risk</u> groups currently identified include:

- *Staff in institutions with individuals with mental retardation;*
- *Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.*

<u>Exception</u>: Persons in the above-listed groups would <u>not</u> be considered at high or intermediate risk of contracting hepatitis B if they have laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

For payment allowance limits for drugs and biologicals refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 17, §20.

40.11 - *Home Environment Evaluation*

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

A3-3183.12, CORF-253.12

One *single home environment evaluation visit is a covered CORF service if it is a part of a comprehensive coordinated skilled rehabilitation program, included in the plan of treatment established and signed by the referring physician, and performed in conjunction with core CORF services. The single home visit allows the therapist to evaluate the patient in the home environment and to assess the potential impact on the patient's 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 *either physical or occupational therapist, (whose services are covered by the CORF benefit)* who is selected by the CORF.

50 - Outpatient Mental Health Treatment Limitation

(Rev. 21, Issued: 09-24-04, Effective: 06-30-04, Implementation: 10-25-04)

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 *mental health* condition.

See *Pub. 100-04*, Medicare *Claims Processing* Manual, Chapter *12, "Physicians/Nonphysician Practitioners," §210, for a further description of the outpatient mental health treatment limitation and application of the 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).