

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. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

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

Section 1861(cc) of the Social Security Act 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 requires a hospital level of care or meets 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 covered only if they relate directly to the rehabilitation for the treatment of injured, disabled, or sick patients. CORF services are not covered if not reasonable and medically 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 physical therapists, occupational therapists, speech-language pathologists or respiratory therapists are not covered. Nonmedical personnel such as family members or exercise instructors could perform these activities in the patient's residence. It is not reasonable and medically necessary for such activities to be performed in a CORF setting by CORF personnel. See 42CFR 410.100 and sections 20.1 and 20.2 of this chapter for the list of required and optional services provided in a CORF.

CORF services do not include the following: a) provision of hyperbaric oxygen services, b) infusion therapy services, c) cardiac rehabilitation services, or d) diagnostic sleep studies. They do not meet the definition of a CORF services and/or they do not relate to the rehabilitation plan of treatment. These services, and other services not specifically listed as CORF services, may be covered under another Medicare benefit category, such as physician services, incident-to physician services, and diagnostic services.

Physical therapy, occupational therapy, and speech-language pathology services may be furnished in the patient's home, as CORF services, when payment for these therapy services is not otherwise made under the Medicare home health benefit. However, since the CORF premise is the primary location for furnishing these services, it is expected that a clear majority of the physical therapy, occupational therapy and speech-language pathology services delivered will be provided on the CORF premises for all CORF patients.

In addition to the above noted services, which may be provided in the home, a single home environment evaluation visit is a covered CORF service if it is included in the

rehabilitation plan of treatment. The patient must be present during the home environment evaluation that is performed by the physical therapist, occupational therapist, or speech-language pathologist, as appropriate. The patient's presence is necessary to assess the patient's current or future ability to function safely in the home environment and to determine the potential impact the home situation will have on the patient's rehabilitation goals.

Services provided under the "incident to" benefit may not be recognized as CORF services. Services furnished by CORF personnel, including registered nurses, physical therapists, occupational therapists, speech-language pathologists, respiratory therapists, social workers and psychologists are not considered as furnished incident-to physician services.

The CORF physician must be present in the facility for a sufficient time to ensure that CORF services are provided in accordance with accepted principles of medical practice. All CORF services must be provided within acceptable professional standards and practice (§§42CFR485.70, and 410.100).

20 - Required and Optional CORF Services

(Rev. 1, 10-01-03)

A3-3180, CORF-250

20.1 - Required Services

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Section 1861(cc) of the Act defines a CORF as a facility that is primarily engaged in providing outpatient rehabilitation to the injured and disabled or to patients recovering from illness. The CORF must provide the following core CORF services: a) CORF physicians' services, b) physical therapy services, and c) social and/or psychological services. Physical therapy services should comprise a clear majority of the total CORF services provided when the CORF offers the three core CORF services. A physician must certify, as a condition of payment, that all 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 addition, respiratory therapists are recognized to provide skilled respiratory therapy services only under the CORF benefit.

A CORF is recognized as a provider of rehabilitation services. It is paid under the physician fee schedule for all CORF services and items except for CORF physician services (which are administrative in nature), drugs and biologicals and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). To participate in Medicare, a CORF must furnish at least the following:

- CORF physicians' services - includes professional services performed by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs services. These services are administrative in

nature, such as consultation with, and medical supervision of, CORF qualified personnel, patient case review conferences, utilization review, and review of the rehabilitation plan of treatment, as appropriate. The physician must ensure that CORF services are provided in accordance with accepted principles of medical practice, medical direction and medical supervision. Subsequent to completing a 1-year hospital internship, the physician must have completed at least 1-year of training in the medical management of patients requiring rehabilitative services (42CFR485.70) or at least 1 year of full-time or part-time experience in a rehabilitation setting providing physician services similar to those required in a rehabilitation facility. A physician who specializes only in pulmonary rehabilitation does not meet these requirements as he/she is not likely to have the experience needed to medically manage patients that need physical therapy, occupational therapy and speech-language pathology services. Diagnostic or therapeutic services provided to a CORF patient by the CORF physician or other physician are not CORF physician services. Such services are separately payable to the physician and not the CORF under the physician fee schedule at the non-facility payment amount. These services should be billed as if they were provided in the physician's office. (See 42CFR410.100(a) and section 40.1.)

- 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 (See 42CFR410.100(b) and section 40.2); and
- Social and/or psychological services – are covered only if the patient's physician or the CORF physician establishes that the services directly relate to the patient's rehabilitation plan of treatment and are needed to achieve the goals in the rehabilitation plan of treatment. Social and/or psychological services include only those services that address the patient's response and adjustment to the rehabilitation treatment plan; rate of improvement and progress towards the rehabilitation goals, or other services as they directly relate to the physical therapy, occupational therapy, speech-language pathology, or respiratory therapy plan of treatment being provided to the patient. CORF social and/or psychological services do not include services for mental health diagnoses (See 42CFR410.100(h) and section 40.7.)

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 rehabilitation plan of treatment. If the CORF does not have the necessary qualified personnel to provide the service(s), it must arrange for the service(s) to be provided at the CORF, as needed.

Functional reporting is required on claims for CORF physical therapy, occupational therapy, and speech-language pathology services by section 3005(g) of the Middle Class

Tax Relief and Jobs Creation Act (MCTRJCA) of 2012. (See 42CFR410.105 and 42CFR410.59, 60, and 62.) ***NOTE: Functional reporting and its associated documentation requirements are no longer applicable for claims or medical records for dates of service on and after January 1, 2019. See the NOTE at the beginning of subsection F in Section 30 below for more information.***

The CORF services are subject to the Medicare Part B deductible and coinsurance provisions. 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.

20.2 - Optional CORF Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

In addition to the three required core CORF services, the CORF may furnish any of the other covered and medically necessary items and services listed in §20.2. These optional services must directly relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the patient's rehabilitation goals. When a CORF provides occupational therapy, speech-language pathology and/or respiratory therapy services in addition to the required physical therapy services, the physical therapy services shall represent the predominate rehabilitation service provided. For discussion of payment rules see section 30.1. The CORF may provide any or all of the following rehabilitation 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 (See 42CFR410.100(c) and section 40.3);
- Speech - Language pathology - services for the diagnosis and treatment of speech and language disorders that create difficulties in communication or dysphagia (swallowing difficulties). (See 42CFR410.100(d) and section 40.4);
- Respiratory therapy - services includes only those services that can be appropriately provided to CORF patients by a qualified respiratory therapist (42CFR485.70(j)) under a physician-established respiratory therapy plan of treatment in accordance with current medical and clinical standards (See 42CFR410.100(e) and section 40.5);
- Prosthetic and orthotic devices - includes testing, fitting, or training in the use of such devices (See 42CFR410.100(f) and (g) and section 40.6);
- Nursing – includes nursing services (e.g., teaching self catheterization) that directly relate to and are specified in the rehabilitation plan of treatment, are necessary for the attainment of the rehabilitation goals and are provided by a

registered nurse as defined in 42CFR485.70(h). (See 42CFR410.100(i) and section 40.8);

- Drugs -and biologicals – which are not excluded from Part B payment, including those that are self-administered, specified at 42CFR410.29, however, there are no drugs identified which can be provided in a CORF (Calendar Year (CY) 2008 Physician Fee Schedule (PFS) Rule 72 FR 66293). (See 42CFR410.100(j) and section 40.9);
- Supplies and Durable Medical Equipment (DME) – CORFs may not bill separately for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding Current Procedural Terminology code. (See 42CFR410.100(k) and section 40.6); and
- A single physical therapy, occupational therapy, or speech-language pathology home environment evaluation visit as appropriate – this includes evaluating the potential impact of the home environment on the rehabilitation goals (See 42CFR410.100(l) and section 40.10).

30 - Rules for Provision of Services

(Rev. 255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

A. Place of Treatment

In general, CORF services, except for physical therapy, occupational therapy, speech-language pathology services, and the single home environment evaluation, must be furnished on the premises of the CORF. Physical therapy, occupational therapy, and speech-language pathology services provided in the home are not covered as CORF services if payment for such services is made under the Medicare home health benefit. Although, physical therapy, occupational therapy, and speech-language pathology services can be furnished in the patient's home, a majority of these services must be provided on the CORF premises for all CORF patients.

A single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment.

A CORF cannot provide items or services that are not included in the definition of CORF services at 42CFR410.100 other than vaccines (CY 2008 PFS Rule 72 FR 66293). Those services included in the definition of CORF services are covered only to the extent that they support or further the rehabilitation plan of treatment.

B. Personnel Qualification Requirements

Services must be furnished or supervised by qualified personnel in accordance with regulation 42CFR485.70. Payment for social and/or psychological services, nursing services and respiratory therapy services is made when provided as specified in sections 40.7, 40.8 and 40.5 respectively of this chapter, as appropriate.

Determinations regarding whether services are furnished in accordance with the conditions of participation and under the supervision of qualified personnel as noted at section 20.2 are primarily the responsibility of the State survey agency responsible for survey and certification of the facility. If services are not being furnished or appropriately supervised by qualified personnel, the Medicare contractor will withhold payment until the matter is resolved, as appropriate.

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 rehabilitation services. If the rehabilitation goals for physical therapy, occupational therapy, speech-language pathology or respiratory therapy services are not specified by the referring physician, the CORF physician must establish them.

E. Plan of Treatment

The CORF services must be furnished under a written rehabilitation plan of treatment established and signed by a physician who has recently evaluated the patient. It is expected that the physician will establish the rehabilitation plan of treatment in consultation with the physical therapist, occupational therapist or speech-language pathologist who will provide the actual therapy. The physician wholly establishes the respiratory therapy plan of treatment. The physician may be either a CORF physician or the patient's referring physician if the physician provides a detailed rehabilitation plan of treatment that meets the following requirements.

The rehabilitation plan of treatment must be established and signed by a physician prior to the commencement of treatment in the CORF setting and contain the diagnosis, the type, amount, frequency, and duration of skilled rehabilitation services to be performed, and the anticipated skilled rehabilitation goals. The services furnished under the rehabilitation plan of treatment must be reasonable and medically necessary and relate directly to the rehabilitation of injured, disabled, or sick patients. The skilled

rehabilitation goals for physical therapy, occupational therapy, and speech-language pathology plans of treatment must be consistent with those used for the Functional reporting pursuant to 410.105(d). For related documentation requirements, see subsection F below. For more details on documentation requirements, refer to chapter 15, section 220.3, of this manual. **NOTE: Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after January 1, 2019. For more information, refer to the NOTE in subsection F below.**

The CORF physician or the referring physician for physical therapy, occupational therapy and speech-language pathology services, must review the plan of treatment at least once every 90 days certifying that the patient needs or continues to need skilled rehabilitation services, the rehabilitation plan of treatment is being followed and that the patient is making progress in attaining the established rehabilitation goals. The 90-day period begins with the first day of rehabilitation therapy. For respiratory therapy services, the CORF physician or the patient's referring physician must review the rehabilitation plan of treatment at least every 60 days. The 60-day period begins with the first day of respiratory therapy treatment. (For survey and certification the plan of treatment review must meet the requirements at 42CFR 485.58(b)). When the patient has reached a point where no further progress is being made toward one or more of the rehabilitation goals, or the skills of a therapist are no longer required, Medicare coverage ends with respect to that aspect of the rehabilitation plan of treatment.

F. Functional Reporting and Documentation Requirements for Physical Therapy, Occupational Therapy, and Speech-language Pathology Services.

NOTE: In the calendar year (CY) 2019 Physician Fee Schedule (PFS) final rule, CMS-1693-F, after consideration of stakeholder comments for burden reduction, a review of all of the requirements under section 3005(g) of Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA), and in light of the statutory amendments to section 1833(g) of the Act, via section 50202 of Bipartisan Budget Act of 2018 to repeal the therapy caps, CMS concluded that continued collection of functional reporting data through the same or reduced format would not yield additional information to inform future analyses or to serve as a basis for reforms to the payment system for therapy services. To reduce the burden of reporting for providers of therapy services, the CY 2019 PFS final rule ended the requirements of reporting the functional limitation nonpayable HCPCS G-codes and severity modifiers on claims for therapy services and the associated documentation requirements in medical records, effective for dates of service on and after January 1, 2019. The rule also revised regulation text at 42 CFR 410.59, 410.60, 410.61, 410.62, 410.105, accordingly.

The instructions below apply only to dates of service when the functional reporting requirements were effective, January 1, 2013 through December 31, 2018.

Functional reporting is required on claims for CORF physical therapy, occupational therapy, and speech-language pathology services by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012. (See 42CFR410.105 and 42CFR410.59, 60, and 62.)

The regulations implementing Section 3005(g) of the MCTRJCA require that nonpayable G-codes and severity modifiers be used to report the functional status of CORF patients receiving physical therapy, occupational therapy, and speech-language pathology services. This functional reporting is required to be included on claims at the beginning of treatment/outset of therapy, at specified reporting intervals which are consistent with those for progress reporting, and at discharge from therapy. In addition, functional reporting is required when an evaluative procedure, including a re-evaluative one, is billed. The functional G-codes and severity modifiers used in reporting the patient's functional status shall be documented in each patient's medical record. Refer to chapter 15, section 220 of this manual for instructions on selecting and documenting these functional G-codes and severity modifiers in the patient's medical record.

For details about the functional reporting requirements for G-codes and severity modifiers on claims for therapy services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6.

30.1 – Rules for Payment of CORF Services

(Rev. 255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

The payment basis for CORF services is 80 percent of the lesser of: (1) the actual charge for the service or (2) the physician fee schedule amount for the service when the physician fee schedule establishes a payment amount for such service. Payment for CORF services under the physician fee schedule is made for physical therapy, occupational therapy, speech-language pathology and respiratory therapy services, as well as the nursing and social and/or psychological services, which are a part of, or directly relate to, the rehabilitation plan of treatment.

Payment for covered durable medical equipment, orthotic and prosthetic (DMEPOS) devices and supplies provided by a CORF is based upon: the lesser of 80 percent of actual charges or the payment amount established under the DMEPOS fee schedule; or, the single payment amount established under the DMEPOS competitive bidding program, provided that payment for such an item is not included in the payment amount for other CORF services.

If there is no fee schedule amount for a covered CORF item or service, payment should be based on the lesser of 80 percent of the actual charge for the service provided or an amount determined by the local Medicare contractor.

The following conditions apply to CORF physical therapy, occupational therapy, and speech-language pathology services;

- Claims must contain the required functional reporting. (Reference: Sections 42 CFR 410.105.) Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6. ***NOTE: Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after***

January 1, 2019. For more information, refer to subsection F in section 30 above.

- The functional reporting on claims must be consistent with the functional limitations identified as part of the patient's therapy plan of care and expressed as part of the patient's therapy goals; effective for claims with dates of service on and after January 1, 2013. (Reference: 42 CFR 410.105.) See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6. ***NOTE: Functional reporting and documentation requirements are no longer applicable for claims for dates of service on and after January 1, 2019. For more information, refer to subsection F in section 30 above.***
- The National Provider Identifier (NPI) of the certifying physician identified for a CORF physical therapy, occupational therapy, and speech-language pathology plan of treatment must be included on the therapy claim. This requirement is effective for claims with dates of service on or after October 1, 2012. (See Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.3.)

Payment for CORF social and/or psychological services is made under the physician fee schedule only for HCPCS code G0409, as appropriate, and only when billed using revenue codes 0560, 0569, 0910, 0911, 0914 and 0919.

Payment for CORF respiratory therapy services is made under the physician fee schedule when provided by a respiratory therapist as defined at 42CFR485.70(j) and, only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment, when billed using revenue codes 0410, 0412 and 0419. Separate payment is not made for diagnostic tests or for services related to physiologic monitoring services which are bundled into other respiratory therapy services appropriately performed by a respiratory therapist, such as HCPCS codes G0237, G0238 and G0239.

Payment for CORF nursing services is made under the physician fee schedule only when provided by a registered nurse as defined at 42CFR485.70(h) for nursing services only to the extent that these services support or are an adjunct to the rehabilitation plan of treatment. In addition, payment for CORF nursing services is made only when provided by a registered nurse. HCPCS code G0128 is used to bill for these services and only with revenue codes 0550 and 0559.

For specific payment requirements for CORF items and services see Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services.

40 - Specific CORF Services

(Rev. 1, 10-01-03)

A3-3183, CORF-253

40.1 - Physicians' Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

Certain administrative services provided by a qualified physician, as defined at 42CFR485.70(a), associated with the CORF are considered CORF physician services, which are not billable by the CORF. These services include administrative services provided by the physician associated with the CORF, such as:

- consultation with and medical supervision of nonphysician staff,
- team conferences,
- case reviews, and
- other facility medical and administration activities necessary to the provision of skilled rehabilitation services, and
- Other services that directly relate to the rehabilitation plan of treatment.

Examinations for the purpose of establishing and reviewing the rehabilitation 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, electrocardiography (ECG)), furnished to an individual CORF patient are not CORF physicians' services. They are physician services and are billable to the Medicare contractor, as appropriate. The physician, not the CORF, bills for and is paid by Medicare for these services. The physician claim must be clearly annotated to show the CORF as the place of treatment, which is paid at the nonfacility physician fee schedule rate.

40.2 - Physical Therapy Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

A qualified physical therapist, as defined at 42CFR485.70(e), has the knowledge, training, and experience required to evaluate and reevaluate, as appropriate, 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. The skills of a qualified physical therapist are required to evaluate and reevaluate the patient's level of function and to develop, in consultation with the physician as appropriate, the physical therapy plan of treatment. A qualified physical therapist assistant (PTA), as defined at 42CFR485.70(e), functioning under the supervision of the qualified physical therapist may carry out certain procedures of the physical therapy plan of treatment, in accordance with applicable State laws. Only the physical therapist, not the PTA can conduct the discharge visit as this visit is viewed as the final assessment of the patient's progress toward attaining the goals of the physical therapy plan of treatment.

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.

All therapy coverage and documentation guidelines (except for development of plan of treatment) noted in Pub. 100-02, Benefit Policy Manual, chapter 15, sections 220-220.3(E) apply to the CORF setting.

NOTE: Supervision of CORF physical therapy services requires that the physical therapist must be on the premises of the CORF or must be available to the physical therapy assistant through direct telecommunications for consultation and assistance during the CORF's operating hours. (See 42CFR485.58(d)(6)).

40.3 - Occupational Therapy Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

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 physical therapy services are the predominate rehabilitation services provided in the CORF.

A qualified occupational therapist, as defined at 42CFR485.70(c), 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. The skills of a qualified occupational therapist are required to evaluate and reevaluate the patient's level of function and to develop, in consultation with the physician as appropriate, the occupational therapy plan of treatment. A qualified occupational therapy assistant, as defined at 42CFR485.70(c), functioning under the supervision of the qualified occupational therapist may also carry out various aspects, as appropriate, of the occupational therapy plan of treatment, 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 assessment of the patient's progress toward attaining the goals of the occupational therapy plan of treatment.

NOTE: Supervision of CORF occupational therapy services requires that the occupational therapist either must be on the premises of the CORF or must be available to the occupational therapy assistant through direct telecommunications for consultation and assistance during the CORF's operating hours. (See 42CFR485.58(d)(6)).

40.4 – Speech-Language Pathology Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

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

A qualified speech-language pathologist, as defined at 42CFR485.70(m), has the knowledge, training, and experience required to evaluate and reevaluate, as appropriate, 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 to recommend to the physician a plan of treatment. A qualified speech-language pathologist must evaluate and reevaluate the patient's level of function to develop, in consultation with the physician as appropriate, the speech-language pathology plan of treatment. Speech-language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services provided in the CORF.

40.5 - Respiratory Therapy Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

A respiratory therapy plan of treatment is wholly established and signed by the referring physician before the respiratory therapist initiates the actual treatment.

A. Definition

Respiratory therapy services include only those services that can be appropriately provided to CORF patients by a qualified respiratory therapist, as defined at 42CFR485.70(j), under a physician-established respiratory therapy plan of treatment. 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. Respiratory therapy services include the physiological monitoring necessary to furnish these services. Payment for these services is bundled into the payment for respiratory therapy services and is not payable separately. Diagnostic and other medical services provided in the CORF setting are not considered CORF services, and therefore may not be included in a respiratory therapy plan of treatment because these are covered under separate benefit categories.

The respiratory therapist assesses the patient to determine the appropriateness of pursed lip breathing activity and may check the patient's oxygen saturation level (via pulse oximetry). If appropriate, the respiratory therapist then provides the initial training in order to ensure that the patient can accurately perform the activity. The respiratory therapist may again check the patient's oxygen saturation level, or perform peak respiratory flow, or check other respiratory parameters. These types of services are considered "physiological monitoring" and are bundled into the payment for HCPCS

codes G0237, G0238 and G0239. Physiological monitoring also includes the provision of a 6-minute walk test that is typically conducted before the start of the patient's respiratory therapy activities. The time to provide this walk "test" assessment is included as part of the HCPCS code G0238. When provided as part of a CORF respiratory therapy plan of treatment, payment for these monitoring activities is bundled into the payment for other services provided by the respiratory therapist, such as the three respiratory therapy specific G-codes.

B. Guidelines for Applying Coverage Criteria

There are some conditions for which respiratory therapy services 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 the need for such services as established, is not reasonable and medically necessary. All respiratory therapy services must meet the test of being "reasonable and medically necessary" pursuant to §1862(a)(1)(A) of the Act. Determinations of medical necessity are made based on local contractor decisions on a claim-by-claim basis.

The three HCPCS codes G0237, G0238, and G0239 are specific to services provided under the respiratory therapy plan of treatment and, as such, are not designated as subject to the therapy caps.

C. Patient Education Programs

Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary to the patient's respiratory therapy plan of treatment and can usually be given to a patient during the course of treatment by the respiratory therapist. These educational instructions are bundled into the covered service and separate payment is not made.

40.6 - Prosthetic and Orthotic Devices and Supplies

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

Prosthetic devices, other than dental devices and renal dialysis machines, are covered CORF services if they are included in the rehabilitation plan of treatment. 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 patient's medical record, including the judgment of the physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met.

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

Examples of prosthetic devices include artificial legs and arms. Residual limb stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

In general, 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 included as part of the rehabilitation plan of treatment. The payment for an orthosis or prosthesis includes its design, materials, measurements, fabrications, testing, fitting, adjustments and 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 the patient's referring or CORF physician. Adjustments, repairs and replacements in these cases are covered even when the item had been in use before the beneficiary enrolled in Medicare Part B so long as the device continues to be medically required.

CORFs may not bill separately for the supplies they furnish except for those cast and splint supplies that are used in conjunction with the corresponding Current Procedural Terminology code.

40.7 - Social and/or Psychological Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

Social and psychological services are covered CORF services if physical therapy services represent the predominate rehabilitation services provided in the CORF. Social and psychological services must be included as part of, or directly relate to, the rehabilitation plan of treatment. Social and psychological services must contribute to the improvement of the individual's rehabilitation condition and may not relate to a mental health diagnosis. Social and psychological services include the assessment and treatment of a CORF patient's mental health and emotional functioning and the response to, and rate of progress of the patient's rehabilitation plan of treatment including physical therapy services, occupational therapy services, speech-language pathology services and respiratory therapy services.

- CORF social and/or psychological covered services are the same, regardless of whether they are provided by a qualified social worker, as defined at 42CFR485.70(l), or a psychologist, as defined at 42CFR485.70(g). Therefore, a

CORF may elect to provide these services when they are indicated. Qualifications for individuals providing CORF social and psychological services are, at a minimum, a Bachelors of Science Degree for a social worker and a Masters-level degree for a psychologist.

40.8 - Nursing Services

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

CORF nursing services may only be provided by an individual meeting the qualifications of a registered nurse, as defined at 42CFR485.70(h). They must relate to, or be a part of, the rehabilitation plan of treatment.

CORF nursing services must be reasonable and medically necessary and are provided as an adjunct to the rehabilitation plan of treatment. For example, a registered nurse may perform or instruct a patient, as appropriate, in the proper procedure of “in and out” urethral catheterization, tracheostomy tube suctioning, or the cleaning for ileostomy or colostomy bags.

Nursing services may not substitute for or supplant the services of physical therapists, occupational therapists, speech-language pathologists and respiratory therapists, but instead must support or further the services and goals provided in the rehabilitation plan of treatment.

CORF nursing services must be provided by a registered nurse and may only be coded as HCPCS code G0128 indicating that CORF “nursing services” were provided.

40.9 - Drugs and Biologicals

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

There are no drugs and biologicals currently identified as appropriate for a therapy rehabilitation plan of treatment, CORFs may not submit claims for drugs and biologicals. If a drug or biological is identified in the future, the administration of such shall be consistent with the limitations established at 42CFR410.29.

40.10 - Home Environment Evaluation

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

One single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment. The single home environment evaluation visit allows the evaluation of the patient in the home environment and the assessment of the potential impact on the patient’s rehabilitation goals. The purpose of the home environment evaluation is to permit the rehabilitation plan of treatment to be tailored to take into account the patient’s

home environment. However, Medicare does not pay for physical alterations to the home that facilitates the patient's rehabilitation. The patient must be present during the home environment evaluation visit, which must be performed by the physical therapist, occupational therapist or speech-language pathologist, as appropriate. The patient's presence is necessary to fully evaluate the potential impact of the home situation on the rehabilitation goals as specified in the plan of treatment.

The home environment evaluation visit is not covered as a routine service for all CORF patients. It is covered only if, in establishing or carrying out the physical therapy, occupational therapy, or speech-language pathology 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 a physical therapist, occupational therapist, or a speech-language pathologist who provides the therapy services established in the corresponding plan of treatment that identifies the necessity for the home environment evaluation visit.

40.11 - Vaccines

(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

A CORF may provide pneumococcal pneumonia, influenza virus, and hepatitis B vaccines to its patients. While not included as a service under the CORF benefit, Medicare will make payment to the CORF for certain vaccines and their administration provided to CORF patients (CY 2008 PFS Rule 72 FR 66293).

The following three vaccinations are covered in a CORF if a physician who is a doctor of medicine or osteopathy orders it for a CORF patient:

- Pneumococcal pneumonia vaccine and its administration;
- Hepatitis B vaccine and its administration furnished to a beneficiary who is at high or intermediate risk of contracting hepatitis B; and
- Influenza virus vaccine and its administration

Payment for covered pneumococcal pneumonia, influenza virus, and hepatitis B vaccines provided in the CORF setting is based on 95 percent of the average wholesale price. The CORF registered nurse provides administration of any of these vaccines using HCPCS codes G0008, G0009 or G0010 with payment based on CPT code 90471.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R255BP</u>	01/25/2019	Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018	02/26/2019	11120
<u>R165BP</u>	12/21/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012	01/07/2013	8005
<u>R163BP</u>	11/30/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 165	01/07/2013	8005
<u>R158BP</u>	08/24/2012	Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services -- Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 163	01/07/2013	8005
<u>R111BP</u>	09/25/2009	Comprehensive Outpatient Rehabilitation Facility (CORF) Services	10/26/2009	6005
<u>R21BP</u>	09/24/2004	Medicare Comprehensive Outpatient Rehabilitation Facility Coverage	10/25/2004	3315
<u>R1BP</u>	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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