

Confusing CORF Concepts

by

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We have previously¹ described the considerable advantages for the Comprehensive Outpatient Rehabilitation Facility (CORF) as a venue for the delivery of outpatient rehabilitation services. Compared to rehabilitation agencies and hospital outpatient departments, CORFs are able to offer a combination of diverse services and administrative ease that other venues simply cannot match.

The CORF's considerable flexibility, however, can sometimes lead to confusion when it comes to providing services for patients and billing Medicare for those services. These confusing CORF concepts include:

- Billing for a physical therapist's services as part of pulmonary rehabilitation program;
- Providing immunizations and infusion therapy services;
- Providing free transportation to patients;
- Making gifts to physicians for marketing purposes, and
- Compensating the CORF's medical director.

Each of the items is a serious matter and must be dealt with in terms of compliance with CORF conditions of participation or the anti-kickback statutes and the Stark physician self-referral laws. The following discussion includes illustrative examples, but should not be construed as legal advice. CORF owners and administrators should consult their legal counsel before implementing the programs discussed in this article.

Billing for the Physical Therapist's Time in Pulmonary Rehabilitation Programs

Pulmonary rehabilitation (PR) is specifically listed in the regulations as a service that may be offered by a CORF,² and, indeed, a CORF is an ideal setting in which to provide such services. The regulations require physician supervision of the PR services, but the physician is not required to be physically present in the facility during PR. Thus, the CORF medical director is, by virtue of his or her position, properly situated to supervise PR. Furthermore, the requirements that

¹ See Cherylyn G. Murer, J.D., C.R.A., "CORFs--The New Contender," *Rehab Management* (March 2002).

² 42 C.F.R. § 410.100(e)(4).

the therapy be administered according to a written plan by a physician-directed multidisciplinary team play directly into the structure of services that the CORF will already have in place.

In the CORF setting, the physical therapist often provides routine rehabilitation services for the patient in the pulmonary rehabilitation program, such as education and training that assist the patient in improving respiratory function, strength, and endurance. These education and training services do not meet the definition of physical therapy as it is defined in CPT codes 97000 – 97799, which are used to bill the actual physical and occupation therapy services administered to the patient during PR. How then may the CORF be reimbursed for these valuable services provided by the physical therapist? The answer lies in the HCPCS “G” codes adopted by CMS effective November 30, 2001.

The “G” codes specifically allow the CORF’s physical therapists to bill for routine pulmonary rehabilitation services and education and training of the patient that do not meet all the requirements to qualify as physical therapy:

- G0237 applies to therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring).
- G0238 applies to therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring).
- G0239 applies to therapeutic procedures to improve respiratory function, other than described by G0237, two or more (includes monitoring).

Thus, the G codes, when properly used in conjunction with the CPT codes for PR, allow the CORF to bill for the full range of time that the CORF’s therapists spend with PR patient, even when that time does not meet all the qualifications for therapy billing.

Immunization and Infusion Therapy Programs in a CORF Setting

Most CORF services are covered by Medicare only if the patient is referred to the CORF by a physician and the services are furnished under a written plan of treatment that is reviewed by a CORF physician at least once every 60 days.³ Medicare, however, provides a specific exception to the referral and plan of treatment requirements for pneumonia, influenza, and hepatitis B vaccinations. Medicare pays CORFs 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines upon request by the Medicare beneficiary without a physician’s order and without physician supervision. Medicare also

³ 42 C.F.R. § 410.105.

covers the reasonable cost of hepatitis B vaccine, but does require that it be ordered by a doctor of medicine or osteopathy and that the patient be at high or intermediate risk of contracting hepatitis B.⁴

Confusion arises when the CORF contemplates providing infusion therapy services such as chemotherapy. Infusion therapy is generally defined by Medicare as the administration of a solution with medication or nutrients through a patient's vein. Infusion therapy depends on gravity for administration. The solution to be administered is contained in sterile plastic or glass bottles. The container is suspended from a pole, and a tube leads from the container to an IV needle placed in the patient. Flow of the solution is controlled by a manually adjusted clamp.

Since infusion therapy services are recognized by CMS as CORF services,⁵ it is easy to assume that the CORF may provide these services to "all comers" in the same manner as immunizations. However, nothing in the regulations, program memoranda, or other CMS publications creates the same kind of exception from the physician referral and written plan of treatment requirements for infusion therapy that exists for immunizations. Therefore, a CORF should provide infusion therapy only to those patients who are admitted as full-fledged CORF patients.

In practical terms, this means that, if a CORF wishes to provide chemotherapy services, it must ensure that the cancer patient is referred to the CORF by a physician who certifies that the patient has rehabilitation potential, and that the chemotherapy is administered as part of the patient's written plan of treatment. In other words, the CORF should not simply take chemotherapy patients "off the street."

Complementary Transportation, Gifts to Physicians, and Compensating the Medical Director

The laws limiting gifts and benefits offered to patients and providers in order to attract business often cause confusion for CORF owners and administrators, just as they do for other health care providers. In the CORF venue, these issues are likely to arise in the context of :

- Complementary transportation offered to patients;
- Gifts to physicians as part of marketing activities; and
- Medical director compensation, in terms of what might be acceptable in light of the CORF's reasonable desire to have the medical director refer the patient's from his or her medical practice to the CORF.

⁴ Medicare Intermediary Manual § 3660.7.

⁵ 42 C.F.R. § 410.100(k).

By the nature of their medical conditions, it would seem that complementary transportation would be a logical service for a CORF to offer its patients, since many of them will have difficulty getting to the facility on their own. Before any such services are offered, however, two points should be kept in mind. The first is that free transportation has been something of a sore point with the Office of the Inspector General, because in earlier days “Medicare mills” would solicit patient business for medically unnecessary procedures by having their drivers “cruise” neighborhoods where many senior citizens lived and offering them free rides to the facility. Second, the Medicare statutes generally prohibit offering a Medicare beneficiary any “remuneration” that is likely to influence the beneficiary’s selection of a particular provider.⁶

Nevertheless, in Special Advisory Bulletin issued last year,⁷ the OIG stated that it is considering proposing a new exception to this prohibition. The new exception would permit complimentary local transportation offered to beneficiaries residing in the provider’s primary catchment area. Some complimentary local transportation of greater than nominal value would be permitted, but not luxury transportation in terms of limousines or ambulances. However, vans specially outfitted to transport wheelchairs would be permitted under the proposal. The OIG has not yet issued a formal proposal in accordance with the Special Advisory Bulletin.

It should be stressed, however, that the exception for complementary transportation has not yet been formally proposed by the OIG, much less put into effect. It is probably a much safer approach to complementary transportation for CORFs in the current regulatory environment would be to approach it programmatically. An example of where this may be permissible may be to make the transportation part of the protocol for the CORF’s bone and joint program that the patients served by the program will be admitted one day post hospital surgery. For patients who will have great difficulty ambulating or driving, providing transportation to and from the CORF program would be a sound part of the protocol. By integrating the transportation into the program, issues of incentive and remuneration may be eliminated.

In regulations issued under the Stark Physician Self-Referral Act,⁸ the OIG has recognized that physicians and their immediate family members are often given non-cash items or services of relatively low value for marketing purposes, such as note pads, coffee mugs, paperweights, etc. In order to allow this practice to continue reasonably without rising to a level where it could influence referrals, the regulation permits a physician or an immediate family member to receive up to \$300 of value in non-monetary compensation from any one entity per year, so long as the compensation is not tied in any way to making referrals or the

⁶ Social Security Act §1128A(a)(5), 42 U.S.C. § 1320a-7a(a)(5).

⁷ OIG Special Advisory Bulletin, *Offering Gifts and Other Inducements to Beneficiaries*, August 30,, 2002.

⁸ Social Security Act § 1877, 42 U.S.C. § 1395nn.

number of referrals, and so long as it is not solicited by the physician or members or employees of the physician's practice.⁹ In other words, reasonable marketing of physicians for referral purposes is permitted so long as it does not rise to the level of actual payment in goods and services for those referrals.

When it comes to compensating the CORF's medical director, it is reasonable for the CORF's owners and administrators to desire to have the medical director refer patients from his or her medical practice to the CORF. The confusion arises in attempting to structure the medical director's contract to get those referrals without violating the Stark Act.

Fortunately, following its Congressional mandate to promulgate regulatory exceptions to the general prohibition on physician self-referrals, the OIG has added a physician employment compensation exception which states that the physician's employer may condition the physician's compensation on making referrals to a particular provider (i.e., the employer), so long as:

- The physician's compensation is fixed in advance for the term of the agreement;
- The compensation is for fair market value, meaning that it does not take into account the volume or value of referrals;
- The arrangement does not otherwise violate the Stark or Anti-Kickback Statutes or regulations;
- The requirement to make referrals is set forth in a written agreement signed by the parties;
- The requirement to make referrals does not apply if the patient expresses a preference for a different provider or the patient's insurer determines the particular provider that the patient must be referred to, or the physician determines that the referral is not in the patient's best medical interests.

Thus, without violating the Stark Act, the CORF may require the medical director to refer rehabilitation patients to the CORF, as long as the requirement is in a contract signed by the CORF owners and the medical director, and the medical director's compensation does not take into account the amount or value of any referrals that the medical director may make to the CORF. The contract also must state that the referrals are not required where the patient expresses a preference for a provider other than the CORF, the patient's insurer will not pay for the CORF's services, or the medical director determines that the CORF's services would not be in the patient's best medical interests.

⁹ 42 C.F.R. § 411.357(k).

Conclusion

These confusing CORF concepts may appear to be difficult and contradictory at first blush, and it is important to stress that the CORF program structure should not be tampered with without first consulting legal counsel. However, if one keeps in mind the basic guiding principles that the CORF's patients, except for immunizations, should be referred by physicians and treated under a written plan of care, and that free services, gifts, and compensation provided to patients and physicians should be dealt with programmatically and under written policies and contracts, much of the confusion will be removed.

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