

CORF – The New Contender

by

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Introduction

New APC codes and provider-based regulations issued by CMS furnish strong reasons for both non-hospital and hospital-based providers to consider using the CORF structure for delivery of rehabilitative services. For non-hospital-owned providers, the CORF structure, with the ability to bill directly for respiratory therapy, social services, and nursing services, offers a distinct advantage over the rehabilitation agency structure. For hospital-owned providers, the new provider-based regulations give the CORF structure much greater administrative ease and flexibility than the hospital outpatient department.

CORFs vs. Rehabilitation Agencies

Unlike a rehabilitation agency with limited reimbursable services of physical therapy, occupational therapy, speech therapy, social services, and vocational adjustment services; a CORF has the ability to bill Medicare directly for nursing, psychology, DME, drugs and biologicals, immunizations, and respiratory therapy in addition to social services, physical therapy, occupational therapy, and speech therapy. Effective November 30, 2001, this advantage over the rehabilitation agency structure is strengthened by new G codes for respiratory therapy instituted for both CORFs and hospital outpatient departments. CORFs now provide a convenient vehicle for the delivery of such respiratory services as chest wall manipulation and aerosol or vapor inhalations to increase strength or endurance of respiratory muscles. There is also provision for group therapy to improve muscle function.¹ For joint ventures and other non-hospital-owned venues, this gives the CORF structure a clear advantage over the rehabilitation agency structure.

CORFs also enjoy a key medical management advantage over rehabilitation agencies. CMS regulations applied to rehabilitation agencies require physicians to review the patient's plan of care at least every 30 days, whereas a CORF requires a physician to review the plan of care every 60 days thereby permitting planning for a longer range, complex care program.

CORFs vs. Hospital Outpatient Departments

Because the new Medicare provider-based regulations specifically exclude CORFs from their coverage, for hospital-based venues, the CORF structure now enjoys a considerable administrative advantage over the hospital outpatient department. The

¹ 66 Fed. Reg. 59856 (Nov. 30, 2001).

new provider-based requirements, which went into effect on November 30, 2001, are applicable to most hospital outpatient departments regardless of where they are located. Recent communications from the Centers for Medicare and Medicaid Services Region VI have indicated that all entities or departments, unless specifically exempted from the requirement of obtaining provider-based designation, must meet provider-based requirements and file applications for provider-based designations in order to be reimbursed by Medicare as part of a hospital. Thus most hospital outpatient departments—even if they are located on the hospital's campus—will now have to comply with the provider-based requirements. Since the regulations exempt from the provider-based requirements facilities that furnish only physical occupational, or speech therapy to ambulatory patients as long as the \$1,500 annual cap on coverage of physical, occupational, and speech therapy remains suspended, some hospital outpatient departments / facilities will not be required to obtain a provider-based designation if their services are limited to physical therapy, occupational therapy and / or speech therapy. However, any outpatient department providing therapy services other than those specifically excluded, such as respiratory therapy, will have to comply with the provider-based requirements.

The new provider-based requirements will add considerable complexity to outpatient department administration. The provider-based designation application forms now being developed by CMS will require outpatient departments to prove to CMS's satisfaction, among other things, that outpatient departments generally be located on the main hospital campus or within 35 miles of it, that the appropriate reporting relationships exist between the outpatient department staff and the main hospital's administration, (this can become very complicated if the outpatient department is run under a management contract), that the medical director of the outpatient department maintains the appropriate reporting relationship with the chief medical officer of the main hospital, that the outpatient department can be separately identified in the main hospital's Medicare cost report, that the patient records of the outpatient department and the main hospital are fully integrated, and that, in its advertising, billing, and correspondence, the outpatient department is held out to the public as part of the main hospital and not as a separate entity. Because CORFs are explicitly excluded from provider-based coverage, they are not subject to these compliance requirements.

Moreover, the new provider-based regulations add a host of new obligations to hospital outpatient departments that need not concern CORFs. These obligations include:

- Compliance with the anti-dumping rules of the Emergency Medical Treatment and Active Labor Act;
- Ensuring that physician services are billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied;
- Compliance with all the terms of the main hospital's provider agreement;
- Ensuring that all patients are treated, for billing purposes, as hospital outpatients;

- In the case of patients admitted to the hospital after receiving treatment in the hospital outpatient department, subjecting the patients' bills to the 3-day window (72-hour rule) applicable to the main hospital's PPS; and
- Compliance with *all* of the main hospital's health and safety rules.²

Perhaps most onerously, under the new provider-based regulations, that all off-campus hospital outpatient departments will be required to furnish their patients with an *advance* notice of the patient's Medicare coinsurance liability. According to the regulation, if the exact type of care and extent of service that the patient is to receive are known before the visit—as it generally is with physical, occupational, speech, or respiratory therapy—the notice must include the potential *amount* of the coinsurance liability. Even if the exact type or care and extent of service are not known beforehand, the notice must still explain to the patient that he or she will incur a coinsurance liability that he or she would not have incurred if the outpatient department were not provider-based.³

The CORF structure also provides additional administrative advantages over the hospital outpatient department. Because services are reimbursed on a fee schedule, CORFs will not be required to prepare Medicare cost reports for cost reporting periods ending on or after June 30, 2001.⁴ Also, while the outpatient department's plan of care must be reviewed every 30 days, a CORF plan of care need be reviewed only every 60 days.

Conclusion

While additional comparisons may be drawn between CORFs, rehabilitation agencies, and hospital outpatient departments, as we have seen, in this new age of prospective payment systems and much closer CMS scrutiny of provider-based facilities, CORFs remain a very viable and attractive option for the delivery of rehabilitation services.

(The following chart summarizes the key characteristics of CORFs, rehabilitation agencies and hospital outpatient departments.)

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² 42 C.F.R. § 413.65(g).

³ 42 C.F.R. § 413.65(g)(7).

⁴ Provider Reimbursement Manual, Part II, § 1800 as amended by CMS-Pub. 15-2-18 Medicare Transmittal Number 5, September 2001.

OUTPATIENT VENUE CROSSWALK

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	CORF	Rehabilitation Agency	Hospital Outpatient Department
Purpose	To provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons.	To provide an integrated multidisciplinary rehabilitation program to upgrade the physical functioning of disabled individuals.	To Provide hospital services and supplies to outpatients.
Medicare Reimbursement	Physician Fee Schedule (Non-Facility Rate)	Physician Fee Schedule (Non-Facility Rate)	<ul style="list-style-type: none"> ➤ Outpatient PPS ➤ OT, PT, ST on Physician Fee Schedule (Non-Facility Rate) ➤ Physician Services (Facility Rate)
Minimum Services Required	<ul style="list-style-type: none"> ➤ Physician Services ➤ Physical Therapy ➤ Social or Psychological Services 	<ul style="list-style-type: none"> ➤ PT or ST ➤ Social or vocational adjustment services 	Under supervision of a physician unless service is: <ul style="list-style-type: none"> ➤ PT ➤ OT ➤ ST (subject to state licensing requirements)
Other Covered Services	<ul style="list-style-type: none"> ➤ Respiratory therapy ➤ Occupational therapy ➤ Speech therapy ➤ Nursing care ➤ Prosthetic and orthotic devices ➤ Drugs and biologicals (non-self-administered) ➤ Supplies, appliances, and equipment ➤ Single home evaluation visit 	<ul style="list-style-type: none"> ➤ OT 	<ul style="list-style-type: none"> ➤ Respiratory therapy
Recertification of Plan of Care	Plan of Treatment must be reviewed by a facility physician at least every 60 days.	The Plan of Care must be reviewed as often as the patient's condition requires but at least every 30 days.	Plan of treatment must be recertified at least every 30 days for physical therapy and speech-language pathology services.
Cost Report	No	No	Yes
Provider-Based Requirements applicable	No	No	Yes, if any services beyond PT, OT and ST are provided.

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