Eli's Rehab Report

Medicare: New Physician Fee Schedule Cracks Down on CORFs

Consider these 3 major compliance checkpoints

The 2008 Medicare **Physician fee schedule** Final Rule brought more than just a heap of drama on the conversion factor and the therapy caps. Comprehensive outpatient rehabilitation facilities (CORFs) now have some careful self-examination to do, thanks to the rule's clarification of what CORFs can -- and can't -- provide.

1. It's Got to Relate to a Rehab POC

This section of the Final Rule had a lot of detailed instructions for CORFs, but the take-home message was, "CORF services that are not skilled rehabilitation services must directly relate to the physical therapy or other rehabilitation plan of treatment and its associated goals."

What this means: Every patient at your CORF had better have a rehab plan of care -- and each service she is receiving there should somehow relate to it. For example, a patient has had depression following a CVA, which is affecting her ability to keep up with her home exercise program. It would be perfectly compliant for a CORF that's rehabilitating this stroke patient with physical therapy, occupational therapy and speech-language pathology to offer psychological services for the depression -- since it relates directly to the stroke and the patient's rehab plan of care.

On the other hand, a CORF couldn't just offer psychological services to a patient with depression and nothing else. Other no-no's for a CORF are hyperbaric oxygen treatments, diagnostic sleep studies, or infusion therapy for cancer treatment, says **Lyndean Lenhoff Brick, JD,** senior vice president of Murer Consultants Inc. in Joliet, Ill., noting that she's actually seen some CORFs offer these services.

Bottom line: "A CORF can't be a mini outpatient hospital department," Brick says. "A CORF is designed for rehabilitating sick, disabled or injured persons, and anything that gets away from that is going to be viewed as suspect."

2. Tread Carefully With Drugs and Biologicals

While the "must be related to rehab" issue is pretty straightforward, CMS managed to stir up some confusion on a separate CORF topic: the use of drugs and biologicals. In the proposed rule, the agency said that drugs and biologicals should not be considered part of a CORF's scope of services. But in the Final Rule, CMS gives CORFs the OK to administer pneumococcal, influenza and hepatitis B vaccines to its patients "even though such vaccines fall outside the scope of CORF services." And CMS decided to allow "drugs and biologicals that are not considered to be self-administered."

Problem: The agency couldn't think of any examples of non-self-administered drugs a CORF would use, which creates a billing catch-22: "As we are not aware of any non-self-administered drugs and biologicals that appropriately may be included as part of a rehabilitation plan of treatment, we intend to closely track the provision of drugs and biologicals in the CORF setting and do not expect CORFs to bill for such drugs and biologicals," CMS said [emphasis added].

In other words, if you do decide to bill for non-self-administered drugs, be prepared to be scrutinized, Brick says. "And make sure you explain to CMS how they're related to the rehab plan of treatment."

3. Say Goodbye to E/Ms, Respiratory Therapists

Perhaps the regs with the biggest impact on CORFs affect the pulmonary rehabilitation arena. Respiratory therapists (RTs) are up in arms about CMS nixing their ability to perform evaluation procedures. "The agency is taking away the RT's ability to do things like spirometry tests and other tests that determine if a patient is appropriate for pulmonary rehabilitation and putting the onus on the physician," says **Darrie Ichilov, PT,** senior consultant for Universal Healthcare Solutions, a healthcare consulting firm in Scottsdale, Ariz.

Why? CMS believes "diagnostic evaluations," "management" and "assessment" are "services performed by the physician to establish the medical and therapy-related diagnoses and the respiratory therapy plan of treatment." In addition, the Final Rule states, "Respiratory therapists are not recognized as independent practitioners in the Act or regulations, and respiratory therapy services are not specifically identified in a statutory benefit category."

But RTs argue that they are nationally accredited and most certainly have the expertise and right to perform these tests. And RT advocates argue that patient care could suffer because physicians don't have time to perform these tests. "A lot of pulmonologists and internists defer to an RT to determine if the patient meets the requirements for pulmonary rehab," Ichilov tells Eli. And "a lot of CORFs provide pulmonary rehab because it is one of the few treatment centers other than a hospital setting that is allowed to provide this service."

Possible solution: "I'm advising my clients [CORFs] to develop relationships with patients' physicians, in which the CORF contracts out its RTs to provide evaluations in the physician office," Ichilov says. "The physician is going to bill for it anyway, and it behooves the CORF to do this because it's still able to maintain relationships and direct patients into their facility."

Note: Before embarking on a business venture as such, be sure to contact a healthcare lawyer or a consultant to help you compliantly handle the details.

To read the full text on CORFs in the Final Rule, go to http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5506.pdf, and read pages 73-83.