GUIDELINES FOR DEVELOPMENT –

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

These guidelines are for use in development of a **Medicare certified Comprehensive Outpatient Rehabilitation Facility** (CORF). A CORF must meet the Medicare certification requirements specified in 42 CFR 485.50-485.74. **Please review these regulations before proceeding with this process.**

If you wish to participate as a Medicare certified Comprehensive Outpatient Rehabilitation Facility submit the following information to:

Missouri Department of Health and Senior Services
Bureau of Home Care and Rehabilitative Standards
P.O. Box 570
Jefferson City, MO 65102

The application will not be processed until all of these items are received:

1. Letter of Intent for OPT's and/or CORF'S

2. State Disclosure of Ownership and Control Interest Statement – 1 copy

3. Assurance of Compliance (Title VI of Civil Rights Act) – 2 copies

4. Health Insurance Benefit Agreement – 2 copies. On the second line of the Health Insurance Benefits Agreement, after the term Social Security Act: enter the corporate name of the enterprise, followed by the "doing business as" d/b/a name (if different from the corporate name). Ordinarily, the agreement will be completed with the name used on all official correspondence. For example, the XYZ Corporation, owner of the Community General Hospice, would enter on the agreement: "XYZ Corporation, d/b/a Community General Hospice." A partnership of several persons doing business as the Easy Care Hospice would complete the agreement to read: "Robert Johnson, Louis Miller, and Paul Allen, partners., d/b/a Easy Care Hospice." A sole proprietorship would complete the agreement to read: "John Smith, d/b/a Good Care Hospice." The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners to enter into this agreement.

5. Comprehensive Outpatient Rehabilitation Facility Report for Certification to Participate in the Medicare Program - 1 copy

6. Facility policy and procedure manual

7. Proof of current registration with the Missouri Secretary of State. If the facility is using a "doing business as" (d/b/a) name, you will need to provide proof of the fictitious filing. For any questions regarding the registration process or fictitious filing, contact the Secretary of State office at 573- 751-4153. All forms received by the Bureau must list the legal entity name and the d/b/a, if applicable.

Tri-Span will be the Medicare Regional Home Health Intermediary (RHHI) for your freestanding or provider based CORF. You must contact Tri-Span directly at 601-664-5416 to obtain the Medicare Enrollment Application (CMS-855A) or access the enrollment form at Medicare's website www.cms.hhs.gov/MedicareProviderSupEnroll/. This form must be completed and returned to Tri-Span for approval before you can receive Medicare payments. The surveyor assigned to your facility will not review your policy and procedure manual until the Bureau has received notification from Tri-Span that the CMS-855 has been approved.

In developing your policy and procedure manual, refer to the website link for *Intrepretive Guidelines - Comprehensive Outpatient Rehabilitation Facilities (State Operations Manual – Appendix K)*. **Policies and procedures must address all of the conditions and standards listed in the Interpretive Guidelines.** Be sure to include:

- Job descriptions for all disciplines. Qualifications for personnel must meet the requirements at 42 CFR 485.70 – Personnel Qualifications. See website link for *Laws, Regulations & Manuals*.
- Orientation and ongoing inservice for all employees that includes disaster preparedness training.
- A sample Consent for Treatment/Authorization form and a policy regarding its use.

The governing body and a group of professional personnel as specified in the regulations, must approve the policy and procedure manual prior to the initial survey.

After receipt of the required forms and policy manual, a surveyor will be assigned to your facility. The following process will be followed:

1. Surveyor reviews and approves policy manual. If additional information is needed from your facility before the manual can be approved, surveyor will notify facility. **Information needed to complete the manual approval process must be submitted by the CORF within 30 days of request. If timeframe is not met by facility, the application will be withdrawn.**

2. Surveyor gives facility permission to develop a patient caseload.

   - The initial caseload for CORF providers seeking Medicare certification shall be **three (3) patients for a period of at least two (2) weeks for each patient.** These patients do not have to be Medicare beneficiaries.

   - If the CORF provider has not developed the required caseload within sixty (60) days from the date your facility is given permission to develop a caseload, your application will be withdrawn and your policy manual returned.

3. The Bureau will send a confirmation letter to the facility regarding permission to start a patient caseload.

4. The facility notifies the Bureau when the required caseload has been achieved.

5. Surveyor schedules initial survey (preferably within 3 weeks).

The initial survey is unannounced by federal requirements. The exit date of the survey is the earliest that your facility can be Medicare certified as a CORF provider. If deficiencies are cited at the time of the survey, the earliest date of Medicare certification will be the date that the plan of correction has been approved by the Bureau. You will receive your CMS Certification Number (CCN) and be able to bill for Medicare services only after the date of the initial survey if deficiency free, or after the date of the acceptable plan of correction if deficiencies are cited. This process may take 2 – 4 weeks following the initial survey. **Under no circumstance can a facility be reimbursed for services furnished to Medicare patients prior to the date of the initial survey.**

After it has been determined all the requirements for compliance are met, the Health Insurance Benefit Agreement will be countersigned by the Centers for Medicare and Medicaid Services (CMS). One copy of the agreement will be returned to you with the notification your facility has been approved. This notification will establish your official date of Medicare participation.

Those facilities that are denied Medicare certification will be sent notification, indicating the reason for the denial and information about their rights to appeal the decision.

If a facility fails to complete the process within one year of initial application, the Bureau will notify the facility that the application is withdrawn and the facility will need to begin the application process again.

Additional information regarding Medicare certification and current CORF provider issues is available on our website at **http://www.dhss.mo.gov/HomeCare**. All of the website links mentioned are available at the above website by clicking on *OPT/CORF >>Applications and Forms>>CORF Forms and Resources.* Please contact the Bureau of Home Care and Rehabilitative Standards at (573) 751-6336 with any questions.