DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-21

DATE: **January 16, 2009**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: 2009 Physician Fee Schedule Changes Affecting the Survey & Certification of Rehabilitation Programs

Memorandum Summary

On November 19, 2008, the Centers for Medicare & Medicaid Services (CMS) published revisions and updates to payment policies as well as conditions of participation (CoPs) under the Physician Fee Schedule. These changes affected the following CoPs and conditions for coverage (CfCs):

Comprehensive Outpatient Rehabilitation Facilities (CORFs):
42 CFR 485.58 CoP: Comprehensive rehabilitation program
42 CFR 485.70 CoP: Personnel qualifications
Rehabilitation Agencies (OPTs):
42 CFR 485.703 Definitions
42 CFR 485.711 CoP: Plan of care and physician involvement
42 CFR 485.717 CoP: Rehabilitation program
Critical Access Hospitals (CAHs):
42 CFR 485.635 CoP: Provision of services (Critical Access Hospitals)

Background

The CMS annually publishes the Revision to Payment Policies under the Physician Fee Schedule. Generally the changes affect coverage and payment rules for Medicare providers and suppliers. This year (2009) the Revision to Payment Policies included several changes that directly affect the CoPs/CfCs related to rehabilitation services. As the Physician Fee Schedule was published November 19, 2008 (73 FR 69726), the changes are not available in the current hard copy version of 42 CFR 430 to End publication. These changes can only be found in the e-CFR which continually updates the various 42 CFR publications.

In the meantime, we are highlighting the changes to the regulations here. These changes will affect the survey process and we don't want facilities to be found deficient in certain practices because our guidance is not current.

Discussion

42 CFR Chapter IV is amended as set forth below:

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

§ 485.58 Condition of participation: Comprehensive rehabilitation program.

The introductory paragraph was modified to add the personnel qualifications set forth in **§ 484.4.**

§ 485.58(a)(1)(i) adds the supervision of non-physician staff to Comprehensive Outpatient Rehabilitation Facilities (CORF) physician responsibilities.

§ 485.58(e)(2) adds the patient's home as a location for the provision of outpatient physical occupational therapy or speech-language pathology services. Also, the single home evaluation visit now requires the presence of the patient as well as the appropriate therapist.

§ 485.70 Personnel qualifications.

§ 485.70(c) and **(e)** now refer to qualifications set forth in § 484.4.

§ 485.70(j) defines the new qualifications for a respiratory therapist. A respiratory therapist must (1) be licensed by the State in which practicing, if applicable; (2) have successfully completed a nationally-accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exams, and have passed the registry examination administered by the NBRC, or (3) have equivalent training and experience as determined by the NBRC and passed the registry examination administered by the NBRC.

§ 485.70(k), the definition of a respiratory therapy technician has been removed.

The January 1, 2009 regulation revision will mean that some CORFs may not have respiratory therapists on staff who meet the requirements under the definition of qualified personnel. Because of the new requirements for respiratory therapists, and the removal of respiratory therapy technicians as (recognized) qualified personnel, CMS is contemplating further revision to this regulation.

If a surveyor discovers during an inspection that respiratory therapy 1) is not being provided by respiratory therapists who meet the new requirements, and/or 2) is being provided by a respiratory therapy technician, the surveyor may cite the CORF at the standard level for these requirements. The CORF would be required to write a plan of

correction for either of these deficiencies that addresses how it will come into compliance with the personnel requirements. However, this may not preclude surveyors from citing condition level deficiencies **if warranted,** but that scenario would likely be more serious. For example, if the surveyor identifies an adverse patient outcome or potential adverse outcome related to the skill and competence of the therapist rendering the care, then the CORF would be cited at the Condition level.

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

§ 485.635 *Provision of services.* A technical correction was made to the regulatory language at §485.635(e) to remove language that erroneously required CAHs to offer rehabilitation services as a direct service only. The regulatory text now reads:

§ 485.635(e) Standard: Rehabilitation Therapy Services. Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 of this subpart.

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

§ 485.703 Definitions.

Extension locations are now defined.

The definition of a rehabilitation agency has been changed to an agency that provides at least physical therapy or speech-language pathology services. Social or vocational adjustment services are no longer required.

§ 485.711 Condition of participation: Plan of care and physician involvement.

The introductory paragraph was changed to delete the need for a physician to be available to furnish necessary medical care in case of an emergency.

§ 485.711(b)(3) was changed by dropping the requirement for the plan of care to be reviewed every 30 days for Medicare patients. Now, the plan of care is to be reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken. The reference to § 410.61 has been deleted.

The payment rules indicated the plan of care must be reviewed at least every 90 days.

§ 485.711(c) was changed by dropping the requirement that one or more doctors of medicine or osteopathy be available on call to furnish necessary medical care in case of emergency.

§ 485.717 Condition of participation: Rehabilitation program.

The introductory paragraph was changed to delete social or vocational adjustment services.

§ 485.717(a) was completely revised. It no longer refers to social or vocational adjustment services but instead refers to therapy services furnished by qualified individuals as direct services and services provided under contract.

§ 485.717(b) was also revised to remove all references to social or vocational adjustment services and was renumbered.

Forms CMS-1893, CMS-360, and CMS-1880 are being updated and changes in Automated Survey Processing Environment (ASPEN) will be entered as soon as possible. State Operations Manual (SOM) Appendices E and K are also being updated.

In the meantime, please note the following:

Form CMS-1893

- Tag I-47 will continue but the last sentence ("The organization has a physician available to furnish necessary medical care in case of emergency") is no longer applicable and should not be cited after January 1, 2009.
- Tag I-50 (b)(3). Ignore the 30-day timeframe. The plan of care is reviewed at least every 90 days or as often as the patient's condition requires.
- Tag I-54 will continue; however, ignore the first part of the tag that states, "The organization provides for one or more doctors of medicine or osteopathy to be available on call to furnish necessary medical care in case of emergency." This section is no longer applicable and should not be cited.
- Tags I-67 will continue; however, all sections referring to social or vocational adjustment services are no longer applicable and should not be cited.
- Tag I-68 will continue but will be revised. The current language pertaining to social or vocational adjustment services is no longer applicable. Do not cite after January 1, 2009.
- Tag I-72 is currently not applicable as it relates only to social or vocational adjustment services. This tag will be revised. Do not cite this tag until the revised Form CMS-1893 is available.

Form CMS-360

- Tag I-533 will continue with the following addition to (a)(1)(i): *Provide medical supervision of nonphysician staff.*
- Tag I-549 will continue with the addition of *"qualifications of § 485.70 and 484.4"* Also, the surveyor would cite this tag if a respiratory therapist doesn't meet the new qualifications defined above.
- Tag I-553 will remain - (e)(2) will allow the CORF to provide therapy services in the patient's home. It will be revised to include (e)(3) indicating a single home environment evaluation requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

Contact Georgia Johnson at 410-786-6859 or Georgia.Johnson@cms.hhs.gov if you have questions or concerns about rehabilitation agencies or CORFs and contact Cindy Melanson at 410-786-0310 or Cindy.Melanson@cms.hhs.gov if you have questions or concerns regarding the CAHs.

Effective Date: January 1, 2009. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: The information contained in this letter should be shared with all appropriate survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments:
Regulatory Excerpts from 2009 Physician Fee Schedule
Summary of new Federal regulations for OPTs (Rehabilitation Agencies), CORFs and CAHs
Identification of new Federal regulations for OPTs (Rehabilitation Agencies), CORFs and CAHs

conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined that the provider or supplier was no longer operational.

(h) *Submission of claims for services furnished before revocation.* A physician organization, physician, nonphysician practitioner or independent diagnostic testing facility must submit all claims for items and services furnished within 60 calendar days of the effective date of revocation.

■ 47. Section 424.565 is added to read as follows:

§ 424.565 Overpayment.

A physician or nonphysician practitioner organization, physician or nonphysician practitioner that does not comply with the reporting requirements specified in § 424.516(d)(1)(ii) and (iii) of this subpart is assessed an overpayment back to the date of the final adverse action or change in practice location. Overpayments are processed in accordance with Part 405 Subpart C of this chapter.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ 48. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

■ 49. Section 485.58 is amended by revising the introductory text and paragraphs (a)(1)(i) and (e)(2) to read as follows:

§ 485.58 Condition of participation: Comprehensive rehabilitation program.

The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. These services must be furnished by personnel that meet the qualifications set forth in §§ 485.70 and 484.4 of this chapter and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

(a) * * *

(1) * * *

(i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of nonphysician staff;

* * * * *

(e) * * *

(2) *Exceptions.* Physical therapy, occupational therapy, and speech-language pathology services may be furnished away from the premises of the CORF including the individual's home when payment is not otherwise made under Title XVIII of the Act. In addition, a single home environment evaluation is covered if there is a need to evaluate the potential impact of the home environment on the rehabilitation goals. The single home environment evaluation requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

* * * * *

■ 50. Section 485.70 is amended by:

■ A. Revising paragraphs (c), (e), (j) introductory text, (j)(2) and (j)(3).

■ B. Reletting paragraph (k) and redesignating paragraphs (l) and (m) as paragraphs (k) and (l) respectively.

The revisions read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in § 484.4 of this chapter.

* * * * *

(e) A physical therapist and a physical therapist assistant must meet the qualifications in § 484.4 of this chapter.

* * * * *

(j) A respiratory therapist must—

(1) * * *

(2) Have successfully completed a nationally—accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exams, and have passed the registry examination administered by the NBRC, or

(3) Have equivalent training and experience as determined by the National Board for Respiratory Care (NBRC) and passed the registry examination administered by the NBRC.

* * * * *

Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)

■ 51. Section 485.635 is amended by revising paragraph (e) to read as follows:

§ 485.635 Conditions of participation: Provision of services.

* * * * *

(e) *Standard: Rehabilitation Therapy Services.* Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in § 409.17 of this subpart.

Subpart H—Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services

■ 52. Section 485.703 is amended by—

■ A. Adding the definition of ''extension location'' in alphabetical order.

■ B. Revising paragraph (2) of the definition of ''rehabilitation agency.''

The addition and revision read as follows:

§ 485.703 Definitions.

* * * * *

Extension location. A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the rehabilitation agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

* * * * *

Rehabilitation agency * * *

(2) Provides at least physical therapy or speech-language pathology services.

* * * * *

■ 53. Section 485.711 is amended by revising the introductory text and paragraphs (b)(3) and (c) to read as follows:

§ 485.711 Condition of participation: Plan of care and physician involvement.

For each patient in need of outpatient physical therapy or speech pathology services, there is a written plan of care established and periodically reviewed by a physician, or by a physical therapist or speech pathologist respectively.

* * * * *

(b) * * *

(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken.

* * * * *

(c) *Standard: Emergency care.* The rehabilitation agency must establish procedures to be followed by personnel

in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

■ 54. Section 485.717 is revised to read as follows:

§ 485.717 Condition of participation: Rehabilitation program.

This condition and standards apply only to a rehabilitation agency's own patients, not to patients of hospitals, skilled nursing facilities (SNFs), or Medicaid nursing facilities (NFs) to which the agency furnishes services. The hospital, SNF, or NF is responsible for ensuring that qualified staff furnish services for which they arrange or contract for their patients. The rehabilitation agency provides physical therapy and speech-language pathology services to all of its patients who need them.

(a) *Standard: Qualification of staff.* The agency's therapy services are furnished by qualified individuals as direct services and/or services provided under contract.

(b) *Standard: Arrangements for services.* If services are provided under contract, the contract must specify the term of the contract, the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

■ 55. The authority citation for part 486 continues to read as follows:

Authority: Secs. 1102, 1138, and 1871 of the Social Security Act (42 U.S.C. 1302, 1320b–8, and 1395hh) and section 371 of the Public Health Service Act (42 U.S.C. 273).

Subpart C—Conditions for Coverage: Portable X-Ray Services

■ 56. Section 486.104 is amended by—

■ A. Revising the introductory text of paragraph (a).

■ B. Revising paragraph (a)(1).

■ C. Adding paragraph (a)(4).

The revision and addition read as follows:

§ 486.104 Condition for coverage: Qualifications, orientation and health of technical personnel.

* * * * *

(a) *Standard-qualifications of technologists.* All operators of the portable X-ray equipment meet the requirements of paragraphs (a)(1), (2), (3), or (4) of this section:

(1) Successful completion of a program of formal training in X-ray technology in a school approved by the Joint Review Committee on Education in Radiologic Technology (JRCERT), or have earned a bachelor's or associate degree in radiologic technology from an accredited college or university.

* * * * *

(4) For those whose training was completed prior to January 1, 1993, successful completion of a program of formal training in X-ray technology in a school approved by the Council on Education of the American Medical Association, or by the American Osteopathic Association is acceptable.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

■ 57. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

Subpart B—Essentials of Provider Agreements

■ 58. Section 489.20 is amended by—

■ A. Redesignating paragraphs (s)(12), (13), (14), and (15) as (s)(13), (14), (15), and (16), respectively.

■ B. Adding new paragraph (s)(12).

The addition reads as follows:

§ 489.20 Basic commitments.

* * * * *

(s) * * *

(12) Services described in paragraphs (s)(1) through (6) of this section when furnished via telehealth under section 1834(m)(4)(C)(ii)(VII) of the Act.

* * * * *

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: October 21, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2008.

Michael O. Leavitt,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2009. Addendum B contains the RVUs for work, non-facility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

• An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the non-facility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.

• Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier–26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier–26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier–53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for

SUMMARY OF
NEW FEDERAL REGULATIONS FOR OPTs, CORFs, and CAHs

Effective January 1, 2009

CHANGES	**ADDITIONAL INFORMATION found in "Identification of New Federal Regulations for OPTs, CORs, and CAHs at numbers:**
A. OPT Regulations	
1. There is a <u>new definition</u> of "Extension Location."	#1–pg 1
2. The section "Rehabilitation Agency" has <u>eliminated</u> "Social or vocational adjustment services."	#1–pg 1; #5–pg 2-3; #6–pg 3; #7– pg 3
3. The requirement to "have a physician available to furnish necessary medical care in case of emergency" has been <u>eliminated.</u>	#2–pg 1; #4–pg 2
4. The requirement to have plan of care reviewed every 30 days for Medicare patients has been <u>eliminated</u>. The Medicare Fee Schedule will require a 90–day review.	#3–pg 1-2
B. CORF Regulations	
1. <u>Expanded</u> the qualifications of therapy staff.	#1–pg 3-4; #5–pg 5
2. Included "medical supervision of non–physician staff" as part of physician services.	#2–pg 4
3. Has NOT changed the requirements for a 60–day review of the Plan of Treatment.	#3–pg 4
4. Allows payment for treatments and an evaluation in the client's home.	#4–pg 4-5
C. CAH Regulations	
1. Changes the requirement that rehabilitation therapy be provided by staff of the hospital and can now be a contracted service.	#1, pg 6

IDENTIFICATION OF NEW FEDERAL REGULATIONS FOR OPTs, CORFs, and CAHs
November 2007 – December 10, 2008

A search of the Federal Register from November 27, 2007 to December 10, 2008, was conducted. Whenever Centers for Medicare & Medicaid Services (CMS) published "Rules and Regulations," they were checked for new regulations related to OPT, CORF and CAHs. The findings were cross-referenced with the Electronic Code of Federal Regulations (e-CFR), December 4, 2008 and the appropriate SOM Appendix.

New OPT Regulations:

1. One new definition has been added and in paragraph (2) the definition of "rehabilitation agency was revised in the CFR under **§ 485.703,** effective January 1, 2009

   Extension location. A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site.

   The extension location is part of the rehabilitation agency.

   The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.

   Rehabilitation agency (part two has been shortened)
   (2) Provides at least physical therapy or speech-language pathology services.

   Deleted: (2) (ii) Social or vocational adjustment services.

2. The CFR indicates a change in the wording of **§ 485.711 COP:** Plan of care and physician involvement effective January 1, 2009

   For each patient in need of outpatient physical therapy or speech pathology services, there is a written plan of care established and periodically reviewed by a physician, or by a physical therapist or speech pathologist respectively.

   This re-wording eliminates the following:

   Deleted: The organization has a physician available to furnish necessary medical care in case of emergency.

3. The CFR indicates a change in the wording of **§ 485.711(b)(3)** effective January 1, 2009.

   (b)(3) The plan of care and results of treatment are reviewed by the physician or by the individual who established the plan at least as often as the patient's condition requires, and the indicated action is taken.

   This re-wording eliminates the following:

Deleted: (For Medicare patients, the plan must be reviewed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant at least every 30 days, in accordance with §410.61(e) of this chapter.)

Note:

- "Highlights of 2009 Physician Fee Schedule final Rule" APTA Staff, November 4, 2008 states: . . .the 2008 Medicare Fee Schedule final rule- which mandates that the outpatient therapy plan of care be recertified every 90 days.

- **§ 424.24(c)(2)** Timing. The initial certification must be obtained as soon as possible after the plan is established. This means the surveyor should find a physician's signature in the clinical record at least once within the 90-day certification period or as often as the patient's condition changes. The signature indicates the doctor is aware of the plan of care and s/he approves of the services being provided. The physician does not need to sign the actual plan of care but a plan of care must be located in the clinical record. If the physician's signature is not in the clinical record at least once within the 90-day certification/recertification period, the surveyor should cite the facility. (CMS S&C Memo 08-30, August 1, 2008. pg 2-3)

- This impacts **§ 485.711(b)(3)** which currently says for Medicare patients, the plan will be reviewed every 30 days by the physician, nurse practitioner, clinical nurse specialist, or physician assistant. Any therapy services provided prior to January 1, 2008 require a 30-day certification/ recertification period. (CMS S&C Memo 08-30, August 1, 2008. pg 2-3)

4. The CFR eliminates some of the wording of **§ 485.711(c)** effective January 1, 2009.

   (c) *Standard: Emergency care.* The rehabilitation agency must establish procedures to be followed by personnel in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared

   This re-wording eliminates/changes the following:

   Deleted: The organization provides for one or more doctors of medicine or osteopathy to be available on call to furnish necessary medical care in the case of emergency.

   Re-worded: The established procedures to be followed by personnel . . .

5. The CFR eliminates some of the wording in the third sentence & eliminates the fourth sentence of **§ 485.717, COP:** Rehabilitation program, effective January 1, 2009

   This condition and standards apply only to a rehabilitation agency's own patients, not to patients of hospitals, skilled nursing facilities (SNFs), or Medicaid nursing facilities (NFs) to which the agency furnishes services.

   The hospital, SNF, or NF is responsible for ensuring that qualified staff furnish services for which they arrange or contract for their patients.

   The rehabilitation agency provides physical therapy and speech-language pathology services to all of its patients who need them.

This re-wording eliminates/changes the following:

Deleted: The rehabilitation agency provides, in addition to physical therapy and speech-language pathology services, social or vocational adjustment services to all of its patients who need them.

Deleted: The agency provides for special qualified staff to evaluate the social and vocational factors, to counsel and advise on the social or vocational problems that arise from the patient's illness or injury, and to make appropriate referrals for needed services.

6. The CFR eliminates some of the wording of **§ 485.717(a)**, effective January 1, 2009.

(a) *Standard: Qualification of staff.* The agency's therapy services are furnished by qualified individuals as direct services and/or services provided under contract.

This re-wording eliminates/changes the following:

Deleted: (a) *Standard: Qualification of staff.* The agency's social or vocational adjustment services are furnished as appropriate, by qualified psychologists, qualified social workers, or qualified vocational specialists. Social or vocational adjustment services may be performed by a qualified psychologist or qualified social worker. Vocational adjustment services may be furnished by a qualified vocational specialist.

7. The CFR eliminates some of the wording of **§ 485.717(b)**, effective January 1, 2009.

(b) *Standard: Arrangements for services.* If services are provided under contract, the contract must specify the term of the contract, the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

This re-wording eliminates/changes the following:

Deleted: (b) *Standard: Arrangements for social or vocational adjustment services.* (1) If a rehabilitation agency does not provide social or vocational adjustment services through salaried employees, it may provide those services through a written contract with others who meet the requirements and responsibilities set forth in this subpart for salaried personnel.
(2) The contract must specify the term of the contract and the manner of termination or renewal and provide that the agency retains responsibility for the control and supervision of the services.

Note: The word "written" as in written contract has also been deleted. This may pose a problem in the future.

New CORF Regulations:

1. The CFR added requirements to § **485.58**, **COP**: Comprehensive rehabilitation program, effective January 1, 2009.

The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. These services must be furnished by personnel that meet the qualifications set forth in §§485.70 and 484.4 of this chapter and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

The current regulation does not include the reference to 484.4.

The facility must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services. The services must be furnished by personnel that meet the qualifications set forth in §485.70 and must be consistent with the plan of treatment and the results of comprehensive patient assessments.

2. The CFR added requirements to § **485.58(a)(1),** effective January 1, 2009.

(a) *Standard: Physician services.* (1) A facility physician must be present in the facility for a sufficient time to—

(i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, consultation, and medical supervision of non-physician staff;

The current regulation does not include mention of non-physician staff.

(a) *Standard: Physician services.* (1) A facility physician must be present in the facility for a sufficient time to—

(i) Provide, in accordance with accepted principles of medical practice, medical direction, medical care services, and consultation;

3. CFR has **NOT** changed the requirements for a 60-day review of the Plan of Treatment in § **485.58(b)(4).**

(b) *Standard: Plan of treatment.* For each patient, a physician must establish a plan of treatment before the facility initiates treatment. The plan of treatment must meet the following requirements:

(4) It must be reviewed at least every 60 days by a facility physician who, when appropriate, consults with the professional personnel providing services. The results of this review must be communicated to the patient's referring physician for concurrence before treatment is continued or discontinued.

Note:

- § 410.105(c)(2) has changed the time that a plan of treatment must be reviewed. The plan must be reviewed every 60 days for respiratory therapy and every 90 days for PT, OT, and SLP services effective January 1, 2008. (CMS S&S Memo 08-30, August 1, 2008) In order for the facility to meet § 485.58 (b)(4) the plan of treatment must be recertified every 60 days. (CMS S&C Memo 08-30, August 1, 2008)
- The surveyor will be the one who must explain that the provider must meet all CoPs regardless of the newly instituted timeframes (CMS S&C Memo 08-30, August 1, 2008)

4. The CFR expanded the requirements addressing home treatment in § **485.58(e)(2),** effective January 1, 2009

(e) * * *

- (2) *Exceptions.* Physical therapy, occupational therapy, and speech-language pathology services may be furnished away from the premises of the CORF including the individual's home when payment is not otherwise made under Title XVIII of the Act. In addition, a single home environment evaluation is covered if there is a need to evaluate the potential impact of the home environment on the rehabilitation goals. The single home environment evaluation requires the presence of the patient and the physical therapist, occupational therapist, or speech-language pathologist, as appropriate.

This re-wording eliminates/changes the following:

(e) *Standard: Scope and site of services* - (1) *Basic requirements.* The facility must provide all the CORF services required in the plan of treatment and, except as provided in paragraph (e)(2) of this section, must provide the services on its premises.

(2) *Exceptions.* Physical therapy, occupational therapy, and speech pathology services furnished away from the premises of the CORF may be covered as CORF services if Medicare payment is not otherwise made for these services. In addition, a single home visit is covered if there is need to evaluate the potential impact of the home environment on the rehabilitation goals.

5. The CFR expanded the requirements addressing personnel requirements in § **485.70,** effective January 1, 2009

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in §484.4 of this chapter.

(e) A physical therapist and a physical therapist assistant must meet the qualifications in §484.4 of this chapter.

(j) A respiratory therapist must—

(1) * * *

(2) Have successfully completed a nationally—accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exams, and have passed the registry examination administered by the NBRC, or

(3) Have equivalent training and experience as determined by the National Board for Respiratory Care (NBRC) and passed the registry examination administered by the NBRC.

This re-wording changes the reference to 484 in the current regulation to 484.4 for (c) and (e) and changes the requirement for a respiratory therapist in the new regulation:

(c) An occupational therapist and an occupational therapy assistant must meet the qualifications in part 484 of this chapter.

(e) A physical therapist and a physical therapist assistant must meet the qualifications in part 484 of this chapter.

(j) A *respiratory therapist* must—

(1) Be licensed by the State in which practicing, if applicable;

(2) Have successfully completed a training program accredited by the Committee on Allied Health Education and Accreditation (CAHEA) in collaboration with the Joint Review Committee for Respiratory Therapy Education; and

New CAH Regulations:

1. The CFR revised requirements to § **485.635 Standard (e)** under Provision of services**,** effective January 1, 2009.

(e) *Standard: Rehabilitation Therapy Services.* Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 of this subpart.

This re-wording eliminates the requirement that the services be direct services:

(e) *Standard: Rehabilitation Therapy Services.* Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided as direct services by staff qualified under State law, and consistent with the requirements for therapy services in 409.17.

References:

1. "Highlights of 2009 Physician Fee Schedule final Rule" APTA Staff, November 4, 2008 (E-mail from Lynn Steffes, November 19, 2008)
2. CMS S&C Memo 08-30, 2008 Physician Fee Schedule Changes Affecting Survey & Certification, August 1, 2008
3. Electronic Code of Federal Regulations, December 4, 2008
4. Federal Register / Vol. 73, No. 224 / Wednesday, November 19, 2008 / Rules and Regulations http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf Pages 69941 – 69943
5. Federal Register / Vol. 73, No. 10 / Tuesday, January 15, 2008 / Rules and Regulations http://edocket.access.gpo.gov/2008/pdf/E8-561.pdf Pages 2432- 2433
6. Federal Register / Vol. 72, No. 227 / Tuesday, November 27, 2007 / Rules and Regulations http://edocket.access.gpo.gov/2007/pdf/07-5506.pdf Pages 66406 – 66409