

## 12 Comprehensive Outpatient Rehabilitation Facility (CORF)

Rehabilitative services are specialized services for the restoration of people with chronic physical or disabling conditions to useful activity. These services will be provided to recipients on the basis of medical necessity.

### 12.1 Enrollment

CORFs are enrolled only for services provided to QMB eligible recipients (crossover claims).

HP enrolls CORF providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

#### **National Provider Identifier, Type, and Specialty**

A provider who contracts with Alabama Medicaid as a CORF provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for rehabilitation-related claims.

#### **NOTE:**

The 10-digit NPI is required when filing a claim.

CORF providers are assigned a provider type of 01 (Hospital). The valid specialty for CORF providers is Rehabilitation Hospital (012).

### 12.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/Medically Necessary Care.

CORF providers are limited to Medicare-related claims billed on the UB-04 claim form.

Added: [Refer to Chapter... Medically Necessary Care.](#)

### 12.3 Prior Authorization and Referral Requirements

CORF procedures do not require prior authorization or referrals since they are limited to Medicare crossovers only.

## 12.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by CORF providers.

## 12.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➤ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

CORF providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

### NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

### 12.5.1 Time Limit for Filing Claims

Medicaid requires all claims for CORF to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

### 12.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM)* manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

**NOTE:**  
 ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

**12.5.3 Revenue Codes**

CORF providers use the revenue codes identified by Medicare.

**12.5.4 Place of Service Codes**

Place of service codes do not apply when filing the UB-04 claim form.

**12.5.5 Required Attachments**

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

**NOTE:**  
 When an attachment is required, a hard copy Institutional Medicaid/Medicare-related claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

**12.6 For More Information**

This section contains a cross-reference to other relevant sections in the manual.

| Resource   | Where to Find It        |
|--|-------------------------|
| UB-04 Claim Filing Instructions  | Section 5.3             |
| Institutional Medicaid/Medicare-related Claim Filing Instructions                              | Section 5.6.2           |
| Medical Necessity/Medically Necessary Care Electronic Media Claims (EMC) Submission Guidelines | Chapter 7<br>Appendix B |
| AVRS Quick Reference Guide   | Appendix L              |
| Alabama Medicaid Contact Information   | Appendix N              |

Added: Medical Necessity/Medically Necessary Care, Chapter 7

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