Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

CompRehab Wellness Group, Incorporated
Docket No. A-11-62
Decision No. 2406
August 16, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

CompRehab Wellness Group, Incorporated (CompRehab) requests review of the February 4, 2011 decision by Administrative Law Judge (ALJ) Joseph Grow, *CompRehab Wellness Group, Incorporated,* DAB CR2317 (2011) (ALJ Decision). The ALJ sustained CMS's determination to revoke CompRehab's Medicare billing privileges as a comprehensive outpatient rehabilitation facility (CORF), on the basis that CompRehab was not "operational" as a CORF under regulations governing the enrollment of providers and suppliers in the Medicare program and the provision of CORF services.

For the reasons stated below, we sustain the ALJ's conclusion that CMS had the authority to revoke CompRehab's Medicare billing privileges on the ground that CompRehab was not operational.

Applicable Law

A CORF is "a facility which . . . is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons" and that, among other requirements, "provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians . . . who are available at the facility on a full-or part-time basis); (ii) physical therapy; and (iii) social or psychological services[.]" Social Security Act (Act) § 1861(cc)(2) (emphasis added).[1] CORF services covered under Medicare are "furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary)" and may include physicians' services, physical therapy, occupational therapy, speech-language pathology services, respiratory therapy, prosthetic and orthotic devices, social and psychological services, nursing care provided by or under the supervision of a registered professional nurse,

[1] The current version of the Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

drugs and biologicals that cannot be self-administered, and supplies and durable medical equipment. Act § 1861(cc)(1). A CORF "meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities." Act § 1861(cc)(2)(J) (emphasis added). Congress enacted this Medicare benefit to simplify coordination of, and access to, a "broad array of rehabilitation services." H.R. Rep. No. 1167, 96th Cong., 2d Sess. at 375 (1980).

CMS's regulations at 42 C.F.R. Part 485, subpart B define a CORF as a "nonresidential facility that . . . [i]s established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician" (except that a physician need not supervise the administration of vaccines) and meets the specific requirements for CORFs specified in subpart B of Part 485. 42 C.F.R. § 485.51(a). Subpart B states that a CORF "must provide a coordinated rehabilitation program that includes, at a minimum, physicians' services, physical therapy services, and social or psychological services" which "must be furnished by personnel that meet the qualifications set forth in [42 C.F.R.] §§ 485.70 and 484.4 [and] must be consistent with the plan of treatment and the results of comprehensive patient assessments." 42 C.F.R. § 485.58. Section 485.70, as amended in 2007, sets forth the minimum qualifications for some personnel who furnish CORF services (such as physician services) and incorporates by reference the provisions of section 484.4 (relating to home health services) that set forth qualifications for other personnel who furnish CORF services (such as physical therapists).

To be covered under Medicare, CORF services must be furnished on the premises of the CORF, except for certain physical therapy, occupational therapy, and speech-language pathology services and for a home environmental evaluation visit. 42 C.F.R. §§ 410.105, 485.58(e).

The CORF regulations contain further requirements for the provision of physician services and require that the CORF designate a qualified professional to ensure the coordination of its services. We set out those requirements in our analysis below.

A CORF is a "provider" of Medicare services as that term is defined in the Act and regulations. Act § 1861(u); 42 C.F.R. § 400.202. Regulations at 42 C.F.R. Part 424, subpart P specify requirements for providers and suppliers to enroll in the Medicare program. "Providers and suppliers must meet and maintain these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies." 42 C.F.R. § 424.500. One requirement is that a provider or supplier "must be operational to furnish Medicare covered items or services before being

granted Medicare billing privileges." 42 C.F.R. § 424.510(d)(6). The regulations define "operational" as follows:

> *Operational* means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

42 C.F.R. § 424.502 (emphasis added).

The regulations authorize CMS "to perform onsite review of a provider or supplier to verify that the enrollment information submitted to CMS or its agents is accurate and to determine compliance with Medicare enrollment requirements." 42 C.F.R. § 424.517(a); *see also* § 424.510(d)(8) (authorizing "on site inspections" for same purposes). CMS may revoke Medicare billing privileges if "CMS determines, upon on-site review, that the provider or supplier is no longer operational to furnish Medicare covered items or services . . . ." 42 C.F.R. § 424.535(a)(5); *see also* § 424.535(a)(5)(i) (upon on-site review, CMS determines that "A Medicare Part A provider is no longer operational to furnish Medicare covered items or services"). A revocation based on a determination that a provider or supplier is not operational is effective on "the date that CMS or its contractor determined that the provider or supplier was no longer operational." 42 C.F.R. § 424.535(g).

A provider whose Medicare enrollment or billing privileges have been revoked may ask for reconsideration of that revocation by CMS or its contractor. 42 C.F.R. §§ 424.545(a), 498.5(l), 498.22(a). A provider dissatisfied with the reconsideration determination may request a hearing before an ALJ pursuant to 42 C.F.R. Part 498, subpart D, and may request review of the ALJ's decision by the Board. 42 C.F.R. §§ 498.3(b)(17), 498.40, 498.80.

Background[2]

CMS Medicare contractor First Coast Service Options, Inc. (First Coast) notified CompRehab by corrected letter dated April 28, 2010 that its Medicare billing number and billing privileges were being revoked effective March 11, 2010, based on 42 C.F.R. § 424.535(a)(5)(i). ALJ Decision at 1; P. Ex. 1. The revocation followed an on-site visit at CompRehab conducted March 11, 2010 by fraud investigators for SafeGuard Services,

[2] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is intended to provide a context for a discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

LLC, and by a medical review nurse for IntegriGuard, LLC. *Id.* SafeGuard Services had a contract with CMS as a Zone Program Integrity Contractor. CMS Ex. 8, at 2. They interviewed CompRehab's Administrator, who was the only employee on the premises at the time and who was designated as the coordinator of services, and they reviewed records and inspected the physical premises. First Coast determined based on the on-site visit that CompRehab was not in compliance with CORF requirements and was thus not "operational" because: (1) its coordinator of services designated to ensure that professional personnel coordinated their work activities did not hold any medical professional license and was not a qualified professional; (2) the physician who served as CompRehab's Medical Director visited the facility only once a month to sign documents, a level of involvement that did not "allow for providing physician services in accordance with accepted principles of medical practice, direction, consultation and supervision of non-physician staff"; and (3) the physical therapy assistant, occupational therapist, licensed social worker, and speech-language pathologist, who provided services for CompRehab as independent contractors, did not have valid Miami-Dade County tax receipts. P. Ex. 1. The letter stated that CompRehab could submit a corrective action plan (CAP) with "evidence that you are in compliance with Medicare requirements" within 30 days, and could appeal the revocation by requesting reconsideration within 60 days.[3] P. Ex. 1, at 2.

CompRehab simultaneously submitted a CAP and requested reconsideration on May 6, 2010. ALJ Decision at 2; CMS Ex. 4; P. Ex. 2. CompRehab generally did not dispute the factual findings cited in the revocation notice but argued that those findings did not constitute violations of CORF requirements. CompRehab asserted that First Coast had made "no allegation . . . that CompRehab was not operating, only that it was not operating in accordance with certain regulatory requirements." P. Ex. 2, at 2. CompRehab also argued that the cited legal basis for revocation should therefore have been section 424.535(a)(1) (Medicare billing privileges may be revoked if the provider is determined not to be in compliance with enrollment requirements and has not submitted a plan of corrective action). *Id.*

A CMS health insurance specialist denied the CAP in a letter dated July 16, 2010, and then denied both the request for reconsideration and the CAP in a substantively similar

[3] An earlier revocation letter from First Coast dated April 23, 2010 cites the same factual grounds for the revocation as the corrected letter but states that the revocation was based on section 424.535(a)(1), which authorizes revocation where the provider "is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter." CMS Ex. 7. The corrected letter does not cite section 424.535(a)(1).

letter dated August 5, 2010.[4] P. Exs. 3, 4. The health insurance specialist determined "that at the time of the on-site visit . . . CompRehab . . . was not in compliance with multiple regulatory citations required for a CORF in Medicare." P. Ex. 4, at 2. She however changed the regulatory basis for the revocation that First Coast cited in its revocation notice, 42 C.F.R. § 424.535(a)(5), "to reflect that CompRehab . . . was noncompliant with Medicare enrollment requirements per 42 CFR §424.535(a)(1), failed to meet the conditions of participation for a CORF per 42 CFR §485.58 and failed to furnish services required of a CORF per 42 CFR §485.51(a), §485.55, §485.62(a)(7), §485.62(c)(1), §485.70, §410.100." *Id.*

CompRehab appealed the reconsideration decision by requesting a hearing before an ALJ. The ALJ received the parties' briefs and exhibits, including written direct testimony in the form of affidavits. The ALJ denied CMS's motion for summary judgment on the ground that there were material facts in dispute as to whether CompRehab had designated a qualified professional to be its coordinator and had a facility physician to provide the services required of CORF physicians. The ALJ decided the appeal on the written record because neither party had requested the opportunity to cross-examine the other party's witnesses. ALJ Decision at 3.

The ALJ determined that it was "reasonable to require that the qualified professional referenced in 42 C.F.R. § 485.58(c) would at a minimum be qualified by education and experience in the type of services that a CORF provides, namely rehabilitative services." *Id.* at 8. He found that CompRehab "lacked a qualified professional who was coordinating services" because the individual designated as coordinator had no "specialized education or experience that would constitute reasonable professional qualification for a CORF coordinator." *Id.* at 6, 8. He further concluded that CompRehab "lacked a facility physician on staff who was providing the required level of medical direction, medical care services, consultation, and medical supervision of nonphysician staff," as required of CORFs. *Id.* at 8. The ALJ concluded that CMS had the authority under section 424.535(a)(5)(i) to revoke CompRehab's Medicare billing privileges on the ground that CompRehab "was not operational because it had deficient staffing at the time of the inspection, and, therefore, it failed to meet all Medicare conditions of participation of a CORF." *Id.* at 5.[5]

---

[4] In a letter to the CMS health insurance specialist, CompRehab described the letters of July 16 and August 5, 2010 as "virtually identical" and stated that the later letter was "apparently prepared in response to CompRehab's request that CMS clarify whether the July 16 letter was intended to be a response to CompRehab's CAP and its request for reconsideration, or solely to its CAP." P. Ex. 5, at 1 n.1.

[5] The ALJ declined to address CMS's determination that CompRehab had failed to produce valid county business tax receipts for four independent contractors, on the ground that CompRehab's failures to meet CORF requirements relating to coordination of services and physician services were sufficient to support the revocation. ALJ Decision at 10 n.2.

The ALJ rejected CompRehab's arguments that "the notice of revocation was legally insufficient" and "appropriate procedures were not followed for revocation of the provider's number." *Id.* at 10, citing P. Br. at 2, 8. The basis for CompRehab's argument was that the reconsideration notice letter stated that the authority for the revocation was being changed from section 424.535(a)(5) to section 424.535(a)(1). The ALJ rejected this argument because he found it evident from CMS's brief that "CMS chose to revoke [CompRehab's] Medicare billing privileges under 42 C.F.R. § 424.535(a)(5)(i) on the grounds that [CompRehab] was no longer operational." *Id.* at 11. He found from CompRehab's arguments "that it clearly intended to respond to and rebut CMS's determination that it was found nonoperational." *Id.* The ALJ cited Board and court decisions as holding that "after an administrative appeal has commenced, a federal agency may assert and rely on new or alternative grounds for the challenged action or determination as long as the non-federal party has notice of, and a reasonable opportunity to respond to, the asserted new grounds during the administrative proceeding." *Id.* at 10-11(citations omitted). He thus concluded that CMS had afforded due process to CompRehab, and CompRehab does not challenge that conclusion in its request for review.

Finally, the ALJ rejected CompRehab's argument that the revocation should not have been effective until 30 days after CMS rejected its CAP, on the grounds that the opportunity to submit a CAP extended by 42 C.F.R. § 424.535(a)(1) does not apply to the revocation of billing privileges under section 424.535(a)(5), and that he did not have the authority to review CMS's rejection of CompRehab's CAP. *Id.* at 11-12, citing *A To Z DME, LLC*, DAB No. 2303, at 9-10 (2010); *see also DMS Imaging, Inc.*, DAB No. 2313, at 5 (2010) ("[n]either the Social Security Act nor the implementing regulations provide for administrative review of a contractor's refusal to reinstate a supplier's billing privileges on the basis of a CAP."). CompRehab does not challenge that conclusion either.

CompRehab appealed the ALJ Decision and requested an opportunity for oral argument, and the Board, by letter of April 8, 2011, directed CompRehab to state the reason for oral argument no later than in its reply brief, which was due on or about June 7, 2011. CompRehab did not submit a reply brief and did not state the reason for the request for oral argument by that deadline. On July 12, 2011, the Board ordered CompRehab to show cause why the Board should not proceed to decision in this case based on the record as it then existed. CompRehab replied that oral argument would materially assist the Board "to appreciate CompRehab's contention that the revocation of its Medicare provider number has been a disproportionately severe sanction" for the findings supporting the revocation and asserted that the State agency had conducted surveys before and after the on-site review that did not result in revocation or a determination that the Administrator was unqualified to serve as coordinator.

The Board denied the request for oral argument, finding that CompRehab had still provided no reason why it did not meet the deadline for stating the basis for the request and had not responded directly to the order to show cause by stating why the Board should not proceed to decision on the existing record. Denial of Request for Oral Argument, July 20, 2011. The Board also found that CompRehab sought to assert facts not proffered before the ALJ, contrary to regulations prohibiting, in provider or supplier enrollment appeals, the admission of evidence not introduced before the ALJ. *Id.*, citing 42 C.F.R. § 498.86(a). The Board also noted that CompRehab's assertion that had it attained or attempted to attain compliance after the revocation was not relevant to whether there were grounds for the revocation. *Id.* at 2-3.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole and a disputed conclusion of law to determine whether it is erroneous. *See Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program* at http://www.hhs.gov/dab/divisions/appellate/guidelines/prosupenrolmen.html.

Analysis

As an initial matter, we emphasize that "operational" is a term of art specific to Medicare, and that the requirement that a provider be "operational" means it must have a qualified physical practice location and actually be furnishing the types of covered Medicare services that it holds itself out as furnishing. 42 C.F.R. § 424.502; *see also A To Z DME, LLC* at 9-10. This and other Medicare enrollment requirements "protect beneficiaries and the Medicare Trust Funds by preventing unqualified, fraudulent, or excluded providers and suppliers from providing items or services to Medicare beneficiaries or billing the Medicare program or its beneficiaries." 71 Fed. Reg. 20,754 (Apr. 21, 2006). The on-site visits that CMS and its contractors conduct permit the Secretary of HHS "to verify . . . that he is paying an entity that actually exists or that is providing a service that it represented it would provide in its enrollment application." 71 Fed. Reg. at 20,755.

A facility seeking to receive Medicare payments for CORF services thus must actually be primarily engaged in providing comprehensive rehabilitation services to outpatients. The relevant point in time for determining whether a facility is operational as defined in the regulation is the time of the on-site visit that the contractor conducts to determine if the facility is operational. *See A To Z DME, LLC* at 6-7 (reversal of revocation under section 424.535(a)(5) requires showing that the substantive factual findings of the on-site review underlying the revocation determination are incorrect). CompRehab was accordingly required to have been "operational" as a CORF at the time of the on-site visit, meaning that it had to have been "open to the public for the purpose of providing" CORF services,

"prepared to submit valid Medicare claims" as a CORF, and "properly staffed" as a CORF "to furnish [CORF] services[.]" 42 C.F.R. § 424.502 (emphasis added).

An on-site review under the enrollment regulations in 42 C.F.R Part 424, subpart P is distinct from an on-site certification survey pursuant to Parts 488 and 489 to determine compliance with applicable conditions of participation. 42 C.F.R. §§ 424.510(d)(5) and (d)(8), 424.517(a). Determining whether CompRehab was properly staffed to provide Medicare-covered CORF services necessarily required the ALJ (and requires us) to refer to the applicable statutory and regulatory provisions, including the CORF conditions of participation in subpart B of 42 C.F.R. Part 485. The ALJ went further, however, concluding that CompRehab failed to meet those conditions, despite the absence of any certification survey. We do not adopt that conclusion. Instead, we uphold the ALJ's ultimate conclusion that CMS was authorized to revoke CompRehab's Medicare billing privileges under section 424.535(a)(5) because CompRehab was not operational at the time of the on-site review. For the reasons set out below, we conclude that substantial evidence supports the ALJ's finding that CompRehab was not properly staffed to provide Medicare-covered CORF services.

1. CompRehab was not properly staffed because the Administrator, who was designated to coordinate the CORF services, was not a "qualified professional."

CompRehab argues that the ALJ erred in concluding that the lack of a medical license precluded its Administrator, whom CompRehab had designated as coordinator, from holding that position. CompRehab argues that applicable legal provisions requiring that CORF services be coordinated by a "qualified professional" neither define the term "qualified professional" nor require the individual performing that function to hold a medical professional license. CompRehab also states that this individual had been CompRehab's Administrator since May of 2006 and "had the necessary experience to fulfill the position of patient coordinator." CompRehab Request for Review (RR) at 10-11, citing P. Ex. 11 (Fuentes Aff.).

These arguments have no merit. First, the ALJ was not relying on the Administrator's lack of a "medical license" but on her lack of any "specialized education or experience that would constitute reasonable professional qualification for a CORF coordinator." ALJ Decision at 8. The ALJ correctly noted that the issue was not whether the Administrator was qualified to administer the facility but whether she was qualified to coordinate the provision of professional rehabilitative services. *Id.* at 7. While the regulations do not specifically define the term "qualified professional," section 485.70 was clearly intended to meet the statutory requirement for establishing qualifications of CORF personnel and lists the various professionals who furnish services that may be covered as CORF services.

Moreover, other parts of the regulations make clear that the individual designated to coordinate the CORF services must have sufficient experience and/or education or training, to qualify him or her as one of the listed healthcare professionals. The regulations do this in several ways. First, they specify the actual duties required of the qualified professional designated to ensure coordination of services. He or she must "ensure that professional personnel coordinate their related activities and exchange information about each patient under their care." 42 C.F.R. § 485.58(c). The "[m]echanisms to assist in coordinating services must include" activities (such as "[p]eriodic clinical record entries, noting at least the patient's status in relationship to goal attainment") that would require the type of healthcare education, training, and/or experience referred to in section 485.70. *Id.*

Next, the context in which the terms "qualified professional" and "professional" are used in the regulations clearly indicates that they refer to professionals who are qualified to provide rehabilitative services (as stated above, those services include, "at a minimum, physicians' services, physical therapy services, and social or psychological services"). 42 C.F.R. § 485.58. The regulations require that a "qualified professional" must "initiate and coordinate the appropriate portions of the plan of treatment, monitor the patient's progress, and recommend changes, in the plan, if necessary" and that a "qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunication for consultation and assistance during the facility's operating hours." 42 C.F.R. § 485.58(d)(5), (6). The regulations further require that "[e]ach qualified professional involved in the patient's care, as specified in the plan of treatment" must "[c]arry out an initial patient assessment" and "perform a patient reassessment after significant changes in the patient's status." 42 C.F.R. § 485.58(f). There must also be "a group of professional personnel associated with the facility that — (1) Develops and periodically reviews policies to govern the services provided by the facility; and (2) Consists of at least one physician and one professional representing each of the services provided by the facility." 42 C.F.R. § 485.56(c).

The regulations, moreover, distinguish professionals from "assistant level personnel" whose entries in patient clinical records must be countersigned "by the corresponding professional" and from groups of personnel such as simply "staff" (who must be present in sufficient numbers to evacuate patients during a disaster) and "[a]ll personnel associated with the facility" (who must be knowledgeable in the facility's disaster procedures and who must be provided with a schedule indicating the frequency and type of services provided at the facility). 42 C.F.R. §§ 485.60(a), 485.62(a)(5), 485.64, 485.58(c)(1).

CompRehab points to nothing in the statute or regulations based on which it reasonably could have concluded that its Administrator was qualified to ensure coordination of patient care as required by section 485.58(c).

CompRehab cites the Administrator's affidavit in support of its contention that she had the necessary experience to fulfill the role of coordinator. The sole allusions in the affidavit to her qualifications, however, are her attestations that she has been the Administrator of CompRehab since May 2006 and that her "duties as Administrator include insuring that the professional personnel contracted with CompRehab coordinate their related activities and exchange information about each patient under their care." P. Ex. 11 ¶¶ 3, 8 (Fuentes Aff.). She does not claim to have had any education or training that would qualify her to coordinate rehabilitative services nor does she explain how her experience as Administrator made her qualified. We agree with the ALJ that the affidavit is "devoid of any specialized education or experience that would constitute reasonable professional qualification for a CORF coordinator." ALJ Decision at 8.

CompRehab also stated before the ALJ that subsequent to the revocation it designated a licensed physical therapist "to insure that professional personnel coordinate their related activities and exchange information about each patient under their care and to implement the mechanisms set forth in 42 C.F.R. § 485.58(c) to assist in the coordination of services." P. Br. at 13. This does not demonstrate that CompRehab was providing the coordinated services required of CORFs (and was thus operational) at the time of the on-site visit.

2. *CompRehab was not properly staffed to provide the level of physician services required by the regulations.*

Section 1861(cc)(2) of the Act requires a CORF to provide physicians' services "rendered by physicians . . . who are available at the facility on a full-or part-time basis," and the regulations state that "[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 nonphysician staff;
> (ii) Establish the plan of treatment in cases where a plan has not been established by the referring physician;
> (iii) Assist in establishing and implementing the facility's patient care policies; and
> (iv) Participate in plan of treatment reviews, patient case review conferences, comprehensive patient assessment and reassessments, and utilization review.

42 C.F.R. § 485.58(a)(1) (emphasis added).

First Coast found that as of the time of the on-site visit, CompRehab's physician Medical Director appeared at the facility only once a month to sign documents (at no particular

time). CMS Exs. 8-10. First Coast determined that the physician's "level of involvement does not allow for providing physician services in accordance with accepted principles of medical practice, direction, consultation and supervision of non-physician staff – all conditions of participation for operating a [CORF]." P. Ex. 1.

As before the ALJ, CompRehab does not dispute First Coast's finding as to how often the Medical Director appeared at the facility. CompRehab asserts without specificity that the physician "had been available to [CompRehab] and its staff . . . regularly reviewed patient records and assessed patient needs . . . had been available to the facility on [an] as needed basis to see patients who required medical services and consultation" and "had been available telephonically to provide direction and consultation to non-physician staff." RR at 12, citing P. Exs. 11, 12 (Bosch Aff.). The ALJ properly rejected these arguments, which on their face do not allege that CompRehab provided the physician services the statute and regulations require.

CompRehab also argues that the CORF regulations "require only that the facility physician be present for a sufficient time to provide needed services" and "do not require a physician's presence in the facility if the physician's services are not needed." RR at 12. This argument ignores the fact that not only must the CORF provide the listed physician services, but the services must be provided by a physician who is present at the facility on either a full-time or part-time basis. Act § 1861(cc)(2). Moreover, CompRehab presented no evidence that discusses what the service needs of its patients were during the relevant period, much less any evidence that those needs could be met by the facility physician visiting the facility only once a month to sign papers as CompRehab does not dispute was the case here.

CompRehab's assertion that the physician was "available to the facility" on an as-needed basis and by telephone cannot reasonably be read to mean that he was present at the facility for a sufficient time to perform the activities required of CORF physicians, or that he performed those activities while at the facility (or at all). CompRehab does not allege, for example, that the physician participated "in plan of treatment reviews, patient case review conferences, comprehensive patient assessment and reassessments, or utilization review" at the facility. The physician's affidavit similarly does not aver that he was providing physician services required of CORFs on the premises at the time of the on-site review. In his affidavit, the physician states that he has "been available for consultation by telephone at any time," that he "periodically review[s] medical records and consult[s] with professional staff," and that he is "available to visit the facility on an as needed basis to see patients who require medical services, consultation, or to develop or evaluate the plan of treatment for individual patients." P. Ex. 12 ¶¶ 8-10. The physician's affidavit, from October 2010, does not state that he had even this level of involvement as of the on-site visit in March 2010, the relevant point in time for reviewing First Coast's determination that CompRehab was not operational to furnish Medicare covered services. As the ALJ pointed out, the affidavit fails to state how often the physician visited the

facility and does not show that he was there even the one time per month that CompRehab's Administrator reported during the March 11, 2010 on-site visit. ALJ Decision at 9; CMS Exs. 8-10. Thus, the physician's statement that "since March, 2010" CompRehab has adopted and implemented policies including weekly case conferences that he conducts with staff does not provide a basis for the Board to reverse the revocation. P. Ex. 12 ¶ 11.

We also note that, while the physician's affidavit states that his "duties as Medical Director include providing physician services which are in accordance with accepted principles of medical practice," he does not specifically aver that he was, in fact, supervising CompRehab's non-physician practitioners in accordance with accepted principles of medical practice at the time of the on-site review. *Id.* ¶ 8.

CompRehab argues that the physician's availability "on an on-call basis" was sufficient to meet the Medicare requirements because CORF physician services "are primarily administrative in nature." RR at 12. Before the ALJ, CompRehab cited this description of CORF physician services in CMS's State Operations Manual (SOM) containing guidance to surveyors and contractors. ALJ Decision at 9, citing P. Br. at 14. The entire SOM statement is "CORF physician services are administrative in nature: consultation with and medical supervision of non-physician staff, establishment and review of the plan of treatment, and other medical and facility administration activities." SOM App. K, Section 485.58(a) (emphasis in SOM), cited at ALJ Decision at 9. This description of CORF services is consistent with CMS's explanation in a 2007 rulemaking that a physician's diagnostic and therapeutic services would be reimbursed separately under the physician fee schedule, whereas the physician services described in 42 C.F.R. § 410.100(a) as CORF services are administrative in nature and would be reimbursed as such. 72 Fed. Reg. 66,222, 66,294-95 (Nov. 27, 2007). Nothing in this explanation or the related SOM language indicates any intent to relieve CORFs from having to provide the specified CORF physician services at the facility, on a full-time or part-time basis, as the statute and regulations require.

For these reasons, we conclude that the ALJ's finding that CompRehab lacked a facility physician on staff who was providing the required level of medical direction, medical care services, consultation, and medical supervision of nonphysician staff on the premises as required by the CORF statute and regulations was supported by substantial evidence.

Conclusion

For the reasons stated above, we uphold the ALJ Decision sustaining the revocation of CompRehab's Medicare billing privileges on the ground that CompRehab was not "operational" as a CORF as required for it to maintain Medicare billing privileges.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Judith A. Ballard
Presiding Board Member