DEPARTMENT OF HEALTH
AND HOSPITALS

Health Standards Section
Initial Medicare Certification
(CORF) COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

PLEASE READ ALL INFORMATION CAREFULLY

Enclosed is a list of forms to be completed and sent to the DHH Health Standards Section State Office. Contact this office if forms identified on the list are missing.

DHH Health Standards Section
Attention: CORF Program Manager
P.O. Box 3767
Baton Rouge, Louisiana 70821
225-342-0138 or 225-342-0523 (phone) 225-342-0157 (fax)
http://new.dhh.louisiana.gov/index.cfm/page/248/n/24

This application packet is designed to direct an applicant through the initial process as it relates to State Licensing & Medicare/Medicaid Certification.

The Department of Health and Hospitals (DHH) shall not process any application until all completed forms, required applicable accompanying information and the application fee (where required) is received.

The application **process will be terminated** for applicants who have **not completed** the submission of all the required forms and supplemental information **within 90 days** of the initial application date. Applicants who are still interested in applying must begin the initial process with the submission of a new application.

When all of the required forms, fees, and information have been received, the State Office will notify you in writing, how to proceed. The forms, fees, and information should be submitted to HSS State Office approximately **six (6)** weeks **prior to your anticipated opening date**.

Federal regulations at 42 CFR 485.62(a)(3) requires your building to have a fire alarm system. At a minimum, this system needs a pull station which activates an internally audible alarm that can be heard throughout the building. You will need to submit documentation of either its existence or an invoice for its installation. If a system has to be installed, the office of State Fire Marshal must approve your plans for installation. In that event, you will need to contact them at (225) 925-4920.

Your facility must have an on-site inspection by the Office of State Fire Marshal. Please submit a copy of that inspection report.

In accordance with 42 CFR 485.62 (d), a CORF must ensure safe access and adequate space to maneuver in waiting areas, treatment areas and toilet facilities for all physically impaired patients including those on stretchers or in wheelchairs. Therefore, applicants will need to submit

architectural plans to the Office of State Fire Marshal for review and approval concerning access for the physically impaired.

For participation in the Medicare program, all providers/suppliers must complete the CMS 855 form, Medicare Federal Health Care Provider/Supplier Application for Health Care Providers or Suppliers. The application must be obtained from the provider/supplier's chosen fiscal intermediary or carrier. The Centers for Medicare and Medicaid Services (CMS) website located @ http://www.cms.hhs.gov/MedicareProviderSupEnroll/ , contains a list of FIs and carriers by state and specialty. The FI/Carrier will answer any inquiries concerning completion of the enrollment application.

Please note that an initial certification survey of a new provider/supplier will be conducted only after the state agency has received notice from the FI or Carrier that the CMS 855 form has been approved.

New providers/suppliers must be in operation and providing services to patients when surveyed for certification. This means that at the time of the survey, the institution must have opened its doors to admissions, be furnishing all services necessary to meet the applicable provider/supplier definition and demonstrate the operational capability of all facets of its operations.

Current regulations require that the effective date of the provider agreement can be no earlier than the completion date of the survey, assuming all requirements are met. In the event that a deficiency is cited at the initial survey, the effective date will be no earlier than the date that the facility provides an acceptable Plan of Correction.

You are cautioned about accepting Medicare beneficiaries prior to confirmation by the Department of Health and Human Services Regional Office, in Dallas, Texas, of the effective date of the Health Insurance Benefits Agreement. You should notify the beneficiary or his representative, in writing, of beneficiary's financial responsibility in the program.

This agency is responsible for determining compliance with Medicare/Medicaid regulations and certifying its findings to the CMS Regional Office, which will make the decision as to whether you qualify for participation in the Medicare/Medicaid program. A provider/supplier participating in the Medicare/Medicaid program under this approval will continue to be eligible to participate until a determination of non-compliance is made.

For information regarding enrollment as a Medicaid Provider or if you need a Provider Enrollment Application, you should contact the Medicaid Provider Enrollment office at (225)-237-3370.

If you have any additional questions, you may contact this office at (225)342-0138. You may call 1-800-553-6847 to request the Federal Regulations and Interpretive Guidelines for your program.

Please Note: At the direction of the Dallas Regional office of the CMS, the Louisiana State Agency will no longer be making recommendations or inquiring about provider-based

designation status. Prospective providers and/or suppliers that have questions as to whether they meet the criteria for provider-based designation are instructed to contact: Patty Rawlings with the CMS at (214) 767-4423.

Information/forms included in this packet:
Initial Provider Memorandum
CMS 359 - CORF Report for Certification/Participation in the Medicare Program
CMS 1561 - Health Agreement (2)
Fiscal Intermediary Preference/Fiscal year end date
Federal Conditions of Participation Specialized Providers
HSS-1513L - Disclosure of Ownership and Control Interest Statement
Office for Civil Rights Forms Memo

The following forms/fees/information are to be <u>returned</u> to state office if requesting participation in Medicare:
Letter of Intent (anticipated date of opening)
CMS 359 - CORF Report for Certification/Participation in the Medicare Program
CMS 1561 - Health Agreement (2 signed originals)
Fiscal Intermediary Preference/Fiscal year end date
HSS-1513L - Disclosure of Ownership and Control Interest Statement
Fire approval from office of State Fire Marshal
Documentation of existence of fire alarm system
Office for Civil Rights Forms Memo

Form Approved
OMB No. 0938-0267

INSTRUCTIONS FOR COMPLETING THE COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REQUEST FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM

The filing of this request for certification will initiate the process of obtaining a decision as to whether the Conditions of Participation are (continue to be) met.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. Return the form to the State agency in the envelope provided; retain a copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security District Office.

Question I. **Identifying Information**

Insert the full name under which the CORF operates, its address and telephone number.

Medicare/Medicaid provider number - Leave blank on all initial certifications. On all recertifications, insert the facility's six digit provider number.

State/County/Region code - Leave blank. CMS Regional Office will complete.

Question II. **Eligibility**

All applicants are to check block #1 (Medicare). CORF services are covered only under the Medicare program, hence, blocks #2 and #3 are for future use only. No entry for related provider number. State agency will complete.

Question III. **Type of Control**

Check the one category that is most descriptive of the type of organization operating the facility. Use the following as a guide:

Proprietary - For profit corporation.

Non-profit church - A church affiliated facility governed by a board of directors and financed by contributions and earnings.

Non-profit other than church - A facility which is generally governed by a community based board of directors and financed by contributions and earnings.

Government - A facility primarily administered by the State, county, city or other local unit of government.

Question IV. **Services Provided**

Please indicate in each block how services are provided, using the following figures:

1. Employees
2. Under Arrangement
3. Independent Contractor

These terms are defined below. Note that more than one figure may be used for each block. Blocks #1, #2 and either #3 or #4 must be completed for the facility to be eligible for participation since these are mandatory services.

Employee - An individual who is paid a salary per unit time of work (i.e., hourly, yearly), is covered under Social Security and Workmen's Compensation and accrues benefits (i.e., sick leave, vacation).

Under Arrangement - The facility has an agreement with an organization to use their personnel. The facility pays the organization and not the individuals providing the services.

Independent Contractor - An individual who is paid a sum of money based upon services rendered or units of time. However, the independent contractor is not covered under Social Security through the facility and does not accrue benefits. The individual generally has a contract with the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0267

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REPORT FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM

(Please read instructions on back before completing form)

I. IDENTIFYING INFORMATION

NAME OF FACILITY		STREET ADDRESS	MEDICARE/MEDICAID PROVIDER NUMBER RD01	
CITY, COUNTY, STATE	ZIP CODE	TELEPHONE NO. *(Area Code)* RD02	STATE/COUNTY RD03	STATE REGION RD04

II. ELIGIBILITY

REQUEST TO ESTABLISH ELIGIBILITY IN:

☐ 1. MEDICARE ☐ 2. MEDICAID ☐ 3. BOTH RD05

RELATED PROVIDER NUMBER RD06

III. TYPE OF CONTROL *(Check one)*

PROPRIETARY ☐

NON-PROFIT
☐ CHURCH
☐ OTHER

GOVERNMENT

RD07

Does your organization currently participate in Medicare as a provider of Outpatient Physical Therapy/Speech Pathology (e.g., Rehabilitation Agency)?

☐ YES ☐ NO RD08

If yes, list Provider No. _____ RD09

IV. SERVICE PROVIDED:

Indicate in each block how services are provided using the following numbers.

NOTE: More than one number may be used for each block.

1. Employees
2. Under Arrangement
3. Independent Contractor

These terms are defined in the instructions on the reverse side of this form.

☐ 1. PHYSICAL THERAPY ☐ 4. PSYCHOLOGICAL SERVICES ☐ 7. SPEECH PATHOLOGY

☐ 2. PHYSICIAN SERVICES ☐ 5. OCCUPATIONAL THERAPY ☐ 8. ORTHOTIC/PROSTHETIC SERVICES

☐ 3. SOCIAL SERVICES ☐ 6. RESPIRATORY THERAPY ☐ 9. NURSES

Blocks #1, #2, and either #3 or #4 must be completed for the facility to be eligible for participation.

RD10

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable Federal or State law. In addition, knowingly and willfully failing to fully and accurately disclose this requested information may result in denial of a request to participate, or where the entity already participates, a termination of its agreement of contract with the State agency or the Secretary as appropriate.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE RD11

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between

THE SECRETARY OF HEALTH AND HUMAN SERVICES

and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____

D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

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Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

DEPARTMENT OF HEALTH
AND HOSPITALS

HEALTH STANDARDS SECTION

Fiscal Year End Date

In order to be assured that your Fiscal Year End Date is currently and correctly recorded, please complete the information in the space provided below. Be sure to sign this form and return it along with any other requested documents.

Name of Provider: _____

Address: _____

_____

_____

_____

_____

Fiscal Year Ending Date

_____

Signature

HSS-ALL-21 (revised 07/24/09; 8/11; 02/12)

Health Standards Section
• P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 •http://dhh.louisiana.gov/

PART 485—CONDITIONS OF PARTICIPATION AND CONDITIONS FOR COVERAGE: SPECIALIZED PROVIDERS AND SUPPLIERS

Authority: Secs. 1102, 1124, 1138, 1820, 1861(aa), and (cc) and 1871 of the Social Security Act; (42 U.S.C. 1302, 1320a-3, 1320b-8, 1395i-4, 1395x(aa) and (cc) and 1395hh); and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

Subpart A—[Reserved]

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

[¶ 22,165.50]

§ 485.50 Basis and scope.

This subpart sets forth the conditions that facilities must meet to be certified as comprehensive outpatient rehabilitation facilities (CORFs) under section 1861(cc)(2) of the Social Security Act and be accepted for participation in Medicare in accordance with Part 489 of this chapter.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.50 (formerly § 488.50) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.51]

§ 485.51 Definition.

As used in this subpart, unless the context indicates otherwise, *"comprehensive outpatient rehabilitation facility"*, *"CORF"*, or *"facility"* means a nonresidential facility that—

(a) Is 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; and

(b) Meets all the requirements of this subpart.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.51 (formerly § 488.51) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.54]

§ 485.54 Condition of participation: Compliance with State and local laws.

The facility and all personnel who provide services must be in compliance with applicable State and local laws and regulations.

(a) *Standard: Licensure of facility.* If State or local law provides for licensing, the facility must be currently licensed or approved as meeting the standards established for licensure.

(b) *Standard: Licensure of personnel.* Personnel that provide service must be licensed, certified, or registered in accordance with applicable State and local laws.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.54 (formerly § 488.54) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.56]

§ 485.56 Condition of participation: Governing body and administration.

The facility must have a governing body that assumes full legal responsibility for establishing and implementing policies regarding the management and operation of the facility.

(a) *Standard: Disclosure of ownership.* The facility must comply with the provisions of Part 420, Subpart C of this chapter that require health care providers and fiscal agents to disclose certain information about ownership and control.

(b) *Standard: Administrator.* The governing body must appoint an administrator who—

(1) Is responsible for the overall management of the facility under the authority delegated by the governing body;

(2) Implements and enforces the facility's policies and procedures;

(3) Designates, in writing, an individual who, in the absence of the administrator, acts on behalf of the administrator; and

(4) Retains professional and administrative responsibility for all personnel providing facility services.

(c) *Standard: Group of professional personnel.* The facility must have 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.

(d) *Standard: Institutional budget plan.* The facility must have an institutional budget plan that meets the following conditions:

(1) It is prepared, under the direction of the governing body, by a committee consisting of representatives of the governing body and the administrative staff.

(2) It provides for—

(i) An annual operating budget prepared according to generally accepted accounting principles;

(ii) A 3-year capital expenditure plan if expenditures in excess of $100,000 are anticipated, for that period, for the acquisition of land; the improvement of land, buildings, and equipment; and the replacement, modernization, and expansion of buildings and equipment; and (iii) Annual review and updating by the governing body.

(e) *Standard: Patient care policies.* The facility must have written patient care policies that govern the services it furnishes. The patient care policies must include the following:

(1) A description of the services the facility furnishes through employees and those furnished under arrangements.

(2) Rules for and personnel responsibilities in handling medical emergencies.

(3) Rules for the storage, handling, and administration of drugs and biologicals.

(4) Criteria for patient admission, continuing care, and discharge.

(5) Procedures for preparing and maintaining clinical records on all patients.

(6) A procedure for explaining to the patient and the patient's family the extent and purpose of the services to be provided.

(7) A procedure to assist the referring physician in locating another level of care for—patients whose treatment has terminated and who are discharged.

(8) A requirement that patients accepted by the facility must be under the care of a physician.

(9) A requirement that there be a plan of treatment established by a physician for each patient.

(10) A procedure to ensure that the group of professional personnel reviews and takes appropriate action on recommendations from the utilization review committee regarding patient care policies.

(f) *Standard: Delegation of authority.* The responsibility for overall administration, management, and operation must be retained by the facility itself and not delegated to others.

(1) The facility may enter into a contract for purposes of assistance in financial management and may delegate to others the following and similar services:

(i) Bookkeeping.

(ii) Assistance in the development of procedures for billing and accounting systems.

(iii) Assistance in the development of an operating budget.

(iv) Purchase of supplies in bulk form.

(v) The preparation of financial statements.

(2) When the services listed in paragraph (f)(1) of this section are delegated, a contract must be in effect and:

(i) May not be for a term of more than 5 years;

(ii) Must be subject to termination within 60 days of written notice by either party;

(iii) Must contain a clause requiring renegotiation of any provision that HCFA finds to be in contravention to any new, revised or amended Federal regulation or law;

(iv) Must state that only the facility may bill the Medicare program; and

(v) May not include clauses that state or imply that the contractor has power and authority to act on behalf of the facility, or clauses that give the contractor rights, duties, discretions, or responsibilities that enable it to dictate the administration, management, or operations of the facility.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.56 (formerly § 488.56) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.58]

§ 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. 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.

(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;

(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.

(2) The facility must provide for emergency physician services during the facility operating hours.

(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:

(1) It must delineate anticipated goals and specify the type, amount, frequency and duration of services to be provided.

(2) It must be promptly evaluated after changes in the patient's condition and revised when necessary.

(3) It must, if appropriate, be developed in consultation with the facility physician and the appropriate facility professional personnel.

(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.

(5) It must be revised if the comprehensive reassessment of the patient's status or the results of the patient case review conference indicate the need for revision.

(c) *Standard: Coordination of services.* The facility must designate, in writing, a qualified professional to ensure that professional personnel coordinate their related activities and exchange information about each patient under their care. Mechanisms to assist in the coordination of services must include—

(1) Providing to all personnel associated with the facility, a schedule indicating the frequency and type of services provided at the facility;

(2) A procedure for communicating to all patient care personnel pertinent information concerning significant changes in the patient's status;

(3) Periodic clinical record entries, noting at least the patient's status in relationship to goal attainment; and

(4) Scheduling patient case review conferences for purposes of determining appropriateness of treatment, when indicated by the results of the initial comprehensive patient assessment, reassessment(s), the recommenda-

tion of the facility physician (or other physician who established the plan of treatment), or upon the recommendation of one of the professionals providing services.

(d) *Standard: Provision of services.*

(1) All patients must be referred to the facility by a physician who provides the following information to the facility before treatment is initiated:

(i) The patient's significant medical history.

(ii) Current medical findings.

(iii) Diagnosis(es) and contraindications to any treatment modality.

(iv) Rehabilitation goals, if determined.

(2) Services may be provided by facility employees or by others under arrangements made by the facility.

(3) The facility must have on its premises the necessary equipment to implement the plan of treatment and sufficient space to allow adequate care.

(4) The services must be furnished by personnel that meet the qualifications of § 488.70 and the number of qualified personnel must be adequate for the volume and diversity of services offered. Personnel that do not meet the qualifications specified in § 488.70 may be used by the facility in assisting qualified staff. When a qualified individual is assisted by these personnel, the qualified individual must be on the premises, and must instruct these personnel in appropriate patient care service techniques and retain responsibility for their activities.

(5) 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.

(6) 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. At least one qualified professional must be on the premises during the facility's operating hours.

(7) All services must be provided consistent with accepted professional standards and practice.

(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.

(f) *Standard: Patient assessment.* Each qualified professional involved in the patient's care, as specified in the plan of treatment, must—

(1) Carry out an initial patient assessment; and

(2) In order to identify whether or not the current plan of treatment is appropriate, perform a patient reassessment after significant changes in the patient's status.

(g) *Standard: Laboratory services.* (1) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(2) If the facility chooses to refer specimens for laboratory testing, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.58 (formerly § 488.58) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985), and amended at 56 F.R. 8832 (Mar. 1, 1991, effective Apr. 1, 1991), and at 57 F.R. 7002 (Feb. 28, 1992, effective Sept. 1, 1992).

[¶ 22,165.60]

§ 485.60 Condition of participation: Clinical records.

The facility must maintain clinical records on all patients in accordance with accepted professional standards and practice. The clinical records must be completely, promptly, and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

(a) *Standard: Content.* Each clinical record must contain sufficient information to identify the patient clearly and to justify the diagnosis and treatment. Entries in the clinical record must be made as frequently as is necessary to insure effective treatment and must be signed by personnel providing services. All entries made by assistant level personnel must be countersigned by the corresponding professional. Documentation on each patient must be consolidated into one clinical record that must contain—

(1) The initial assessment and subsequent reassessments of the patient's needs;

(2) Current plan of treatment;

(3) Identification data and consent or authorization forms;

(4) Pertinent medical history, past and present;

(5) A report of pertinent physical examinations if any;

(6) Progress notes or other documentation that reflect patient reaction to treatment, tests, or injury, or the need to change the established plan of treatment; and

(7) Upon discharge, a discharge summary including patient status relative to goal achievement, prognosis, and future treatment considerations.

(b) *Standard: Protection of clinical record information.* The facility must safeguard clinical record information against loss, destruction, or unauthorized use. The facility must have procedures that govern the use and removal of records and the conditions for release of information. The facility must obtain the patient's written consent before releasing information not required to be released by law.

(c) *Standard: Retention and preservation.* The facility must retain clinical record information for 5 years after patient discharge and must make provision for the maintenance of such records in the event that it is no longer able to treat patients.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.60 (formerly § 488.60) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.62]

§ 485.62 Condition of participation: Physical environment.

The facility must provide a physical environment that protects the health and safety of patients, personnel, and the public.

(a) *Standard: Safety and comfort of patients.* The physical premises of the facility and those areas of its surrounding physical structure that are used by the patients (including at least all stairwells, corridors and passageways) must meet the following requirements:

(1) Applicable Federal, State, and local building, fire, and safety codes must be met.

(2) Fire extinguishers must be easily accessible and fire regulations must be prominently posted.

(3) A fire alarm system with local (in-house) capability must be functional, and where power is generated by electricity, an alternate power source with automatic triggering must be present.

(4) Lights, supported by an emergency power source, must be placed at exits.

(5) A sufficient number of staff to evacuate patients during a disaster must be on the premises of the facility whenever patients are being treated.

(6) Lighting must be sufficient to carry out services safely; room temperature must be maintained at comfortable levels; and ventilation through windows, mechanical means, or a combination of both must be provided.

(7) Safe and sufficient space must be available for the scope of services offered.

(b) *Standard: Sanitary environment.* The facility must maintain a sanitary environment and establish a program to identify, investigate, prevent, and control the cause of patient infections.

(1) The facility must establish written policies and procedures designed to control and prevent infection in the facility and to investigate and identify possible causes of infection.

(2) The facility must monitor the infection control program to ensure that the staff implement the policies and procedures and that the policies and procedures are consistent with current practices in the field.

(3) The facility must make available at all times a quantity of laundered linen adequate for proper care and comfort of patients. Linens must be handled, stored, and processed in a manner that prevents the spread of infection.

(4) Provisions must be in effect to ensure that the facility's premises are maintained free of rodent and insect infestation.

(c) *Standard: Maintenance of equipment, physical location, and grounds.* The facility must establish a written preventive maintenance program to ensure that—

(1) All equipment is properly maintained and equipment needing periodic calibration is calibrated consistent with the manufacturer's recommendations; and

(2) The interior of the facility, the exterior of the physical structure housing the facility, and the exterior walkways and parking areas are clean and orderly and maintained free of any defects that are a hazard to patients, personnel, and the public.

(d) *Standard: Access for the physically impaired.* The facility must ensure the following:

(1) Doorways, stairwells, corridors, and passageways used by patients are—

(i) Of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs); and

(ii) In the case of stairwells, equipped with firmly attached handrails on at least one side.

(2) At least one toilet facility is accessible and constructed to allow utilization by ambulatory and nonambulatory individuals.

(3) At least one entrance is usable by individuals in wheelchairs.

(4) In multi-story buildings, elevators are accessible to and usable by the physically impaired on the level that they use to enter the building and all levels normally used by the patients of the facility.

(5) Parking spaces are large enough and close enough to the facility to allow safe access by the physically impaired.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.62 (formerly § 488.62) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.64]

§ 485.64 Condition of participation: Disaster procedures.

The facility must have written policies and procedures that specifically define the handling of patients, personnel, records, and the public during disasters. All personnel associated with the facility must be knowledgeable with respect to these procedures, be trained in their application, and be assigned specific responsibilities.

(a) *Standard: Disaster plan.* The facility's written disaster plan must be developed and maintained with assistance of qualified fire, safety, and other appropriate experts. The plan must include—

(1) Procedures for prompt transfer of casualties and records;

(2) Procedures for notifying community emergency personnel (for example, fire department, ambulance, etc.);

(3) Instructions regarding the location and use of alarm systems and signals and fire fighting equipment; and

(4) Specification of evacuation routes and procedures for leaving the facility.

(b) *Standard: Drills and staff training.*

(1) The facility must provide ongoing training and drills for all personnel associated with the facility in all aspects of disaster preparedness.

(2) All new personnel must be oriented and assigned specific responsibilities regarding the facility's disaster plan within two weeks of their first workday.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.64 (formerly § 488.64) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.66]

§ 485.66 Condition of participation: Utilization review plan.

The facility must have in effect a written utilization review plan that is implemented at least each quarter, to assess the necessity of services and promotes the most efficient use of services provided by the facility.

(a) *Standard: Utilization review committee.* The utilization review committee, consisting of the group of professional personnel specified in § 488.56(c), a committee of this group, or a group of similar composition, comprised by professional personnel not associated with the facility, must carry out the utilization review plan.

(b) *Standard: Utilization review plan.* The utilization review plan must contain written procedures for evaluating—

(1) Admissions, continued care, and discharges using, at a minimum, the criteria established in the patient care policies;

(2) The applicability of the plan of treatment to establish goals; and

(3) The adequacy of clinical records with regard to—

(i) Assessing the quality of services provided; and

(ii) Determining whether the facility's policies and clinical practices are compatible and promote appropriate and efficient utilization of services.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.66 (formerly § 488.66 at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985).

[¶ 22,165.70]

§ 485.70 Personnel qualifications.

This section sets forth the qualifications that must be met, as a condition of participation, under § 485.58, and as a condition of coverage of services under § 410.100 of this chapter.

(a) A facility physician must be a doctor of medicine or osteopathy who—

(1) Is licensed under State law to practice medicine or surgery; and

(2) Has had, subsequent to completing a 1-year hospital internship, at least 1 year of training in the medical management of patients requiring rehabilitation services; or

(3) Has had at least 1 year of full-time or part-time experience in a rehabilitation setting providing physicians' services similar to those required in this subpart.

(b) A licensed practical nurse must be licensed as a practical or vocational nurse by the State in which practicing, if applicable.

(c) An occupational therapist and an occupational therapist assistant must meet the qualifications set forth in § 405.1202(f) and (g) of this chapter.

(d) An *orthotist* must—

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

(2) Have successfully completed a training program in orthotics that is jointly recognized by the American Council on Education and the American Board for Certification in Orthotics and Prosthetics; and

(3) Be eligible to take that Board's certification examination in orthotics.

(e) *A physical therapist* and a *physical therapist assistant* must meet the qualifications set forth in § 405.1702(d) and (e) of this chapter.

(f) A *prosthetist* must—

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

(2) Have successfully completed a training program in prosthetics that is jointly recognized by the American Council on Education and the American Board for Certification in Orthotics and Prosthetics; and

(3) Be eligible to take that Board's certification examination in prosthetics.

(g) A *psychologist* must be certified or licensed by the State in which he or she is practicing, if that State requires certification or licensing, and must hold a masters degree in psychology from an educational institution approved by the State in which the institution is located.

(h) A *registered nurse* must be a graduate of an approved school of nursing and be licensed as a registered nurse by the State in which practicing, if applicable.

(i) A *rehabilitation counselor* must—

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

(2) Hold at least a bachelor's degree; and

(3) Be eligible to take the certification examination administered by the Commission on Rehabilitation Counselor Certification.

(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

(3) Either—

(i) Be eligible to take the registry examination for respiratory therapists administered by the National Board for Respiratory Therapy, Inc.; or

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Therapy, Inc.

(k) A *respiratory therapy technician* must—

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

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

(3) Either—

(i) Be eligible to take the certification examination for respiratory therapy technicians administered by the National Board for Respiratory Therapy, Inc.; or

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Therapy, Inc.

(l) A *social worker* must—

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

(2) Hold at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education; and

(3) Have 1 year of social work experience in a health care setting.

(m) A *speech-language pathologist* must meet the qualifications set forth in § 405.1702(j) of this chapter.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.70 (formerly § 488.70) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985), and amended at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985), and at 51 F.R. 41332 (Nov. 14, 1986, effective Dec. 15, 1986) (cross-reference change only).

[¶ 22,165.74]

§ 485.74 Appeal rights.

The appeal provisions set forth in Part 498 of this chapter, for providers, are applicable to any entity that is participating or seeks to participate in the Medicare program as a CORF.

.01 Source:

As adopted, 47 F.R. 56282 (Dec. 15, 1982); redesignated as § 485.74 (formerly § 488.74) at 50 F.R. 33027 (Aug. 16, 1985, effective Sept. 16, 1985); and amended at 52 F.R. 22444 (June 12, 1987) (cross-reference change only).

Louisiana Department of Health and Hospitals
Health Standards Section

Disclosure of Ownership & Controlling Interest Statement

I. Identifying Information

Legal Entity/Corp. Name:	
D/B/A Name:	
Employer ID Number (EIN):	
Street Address:	
City:	State :
Parish/County:	Zip Code:
Phone Number:	Email :

II. (a) List names, addresses and phone numbers for persons or group of persons, or the Employer Identification Number (EIN) for organizations having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity.

Name	Address	EIN #

II. (b) Type of Entity:

For-Profit Entity	Non-Profit Entity	Government Entity
☐ Individual/Sole Proprietorship	☐ Individual/Sole Proprietorship	☐ Federal
☐ Corporation	☐ Corporation	☐ State
☐ Partnership	☐ Partnership	☐ Parish
☐ Group Practice	☐ Religious Affiliate	☐ City/Parish
☐ Religious Affiliate	☐ Unincorporated Association	☐ City
☐ Unincorporated Association	☐ Limited Liability Corporation	☐ Hospital District
☐ Limited Liability Corporation	☐ Other :	☐ Combination Gov/Non-Profit
☐ Other :		☐ Human Services District
		☐ Other :

II. (c) If the disclosing entity is a corporation, list names, addresses, and phone numbers of the Directors and attach.

II. (d) Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ **Yes** ☐ **No**
(proprietorship, partnership, or Board Members). If yes, list names, addresses, and phone numbers of individuals and facility provider numbers.

Name	Address	Provider Number

III. Has there been a change in ownership or control within the last year?

☐ **NO** change of ownership.	☐ **YES**, ownership has changed. **Date** of Ownership Change:

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS, IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE LOUISIANA STATE AGENCY

Print Name and Title of Authorized Representative:	
Signature:	**Date:**
Notes/Remarks:	

Form HSS-1513L (7/11; 01/12; 02/12; 3/12, 3/13)

Instructions

Required Office of Civil Rights (OCR) forms must be completed and submitted with each Change of Ownership (CHOW) and/or Initial Provider Certification Packet. These provider completed forms are used by the OCR to process clearance for the facilities undergoing CHOWS and Initial Certification. The role of this agency (Health Standards Section of the Louisiana Department of Health and Hospitals) is limited to collecting and forwarding the civil rights data to Center for Medicare and Medicaid Services (CMS), who will then forward to the OCR. The OCR Civil Rights Information Request for Medicare Certification Form (OMB No. 0990-0243), and the Form HHS-690 for Assurance of Compliance are included as a part of the state agency packet. All other information that is required by OCR and that must be submitted is described on the OCR website at:

http://www.hhs.gov/ocr/civilrights/clearance/index.html

Carefully read the information on this website regarding Civil Rights Certification for Medicare Provider Applicants (that is located on the above website) for a complete listing of the documents required for submission by OCR.

Any questions concerning the forms must be directed to the regional HHS Office for Civil Rights **(Phone #214-767-4056).**

Please be aware that completed CHOW or Initial Certification packets will not be forwarded to the CMS for processing until all completed OCR forms have been returned to this agency.

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