



Physician Care Plan Oversight for home health

Since 1995, the Centers for Medicare and Medicaid Services has allowed separate payment for physician care plan oversight services rendered to home health patients. Physicians, not the home health agency, must bill for physician care plan oversight services, and after Jan. 1, 2001, they are billed under code G0181 (home health).

Services that may be included as physician care plan oversight:

- Ongoing review of reports, orders, treatment plans, changes in patient status, lab/study results (except for the initial review associated with previous face-to-face encounter)
- Telephone calls with other healthcare professionals involved in the patient's care
- Development and/or revision of healthcare plan
- Team conferences (Time spent per individual patient must be documented.)
- Medical decision-making:
 - Integration of new information into the medical treatment plan
 - Adjustment of medical therapy
- Coordination of services that require the skills of a physician
- Time spent on revision of care plan after pertinent information has been conveyed

Physician Certification/ Recertification

Since Jan. 1, 2001, the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, will reimburse physicians who initially certify or recertify plans of care for patients receiving Medicare-covered home health services.

The tasks that are included in physician certification and recertification include:

- Creation and review of the plan of care
- Verification that the home health agency is complying with the POC
- Review of data collected in the home health agency's patient assessment, including the Outcome and Assessment Information Set data.

Initial Certification

Physician certification of Medicare-covered services under a home health plan of care (patient not present), including contacts with home health agencies and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period. The appropriate billing code for this service is G0180 and can only be used when the patient has not received Medicare-covered home health services for at least 60 days.

(Service billable once for a patient's home health certification period. This code will be used when the patient has not received Medicare-covered home health services for at least 60 days. In the exceptional circumstance when the patient requires a new plan of care to start a new episode before a 60-day episode has elapsed, the physician certifying the plan of care would report code G0179.)

Recertification

Physician recertification of Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period. The appropriate billing code for this service is G0179.

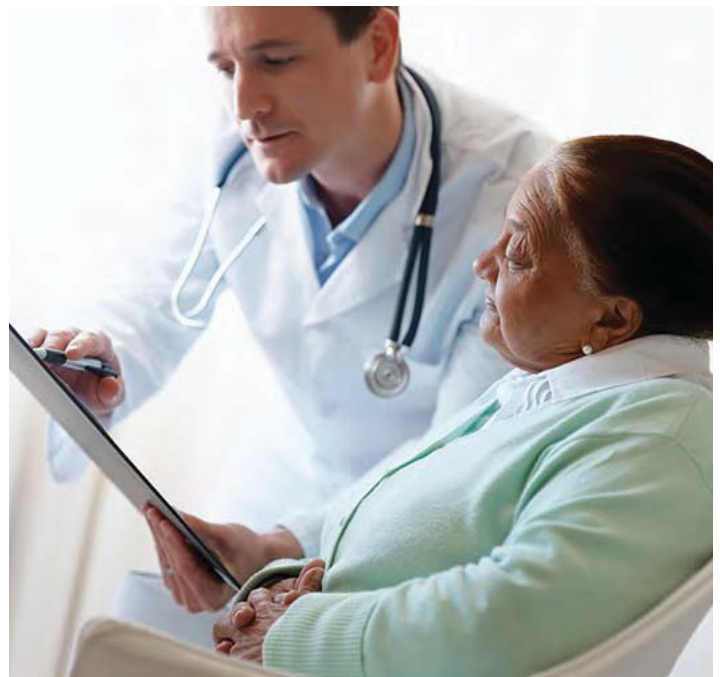
(Service billable once for a patient's home health certification period. This code would be used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period. If a patient is discharged, then subsequently resumes home care prior to the end of the original 60-day episode, the physician certifying the plan of care would report G0179 even though there is a new start of care.)

Services that may not be included as physician care plan oversight:

- PCPO services rendered to non-medical patients
- Post-surgical services within one month of surgery
- Initial interpretation of lab/study results ordered during a face-to-face encounter
- Services provided incident to office visits
- Telephone calls to patient, family or pharmacy, even to adjust medication or treatment
- Travel time, time spent preparing claims, time spent on claims processing
- Low-intensity services included as part of other evaluation and management services
- Informal consults with health professionals not involved with the patient's care
- Time spent discussing the patient with office staff

To qualify for physician care plan oversight payment, the patient must:

- Be receiving Medicare-covered home care services;
- Have been seen face-to-face by the physician within the six months prior to billing for the care plan oversight service;
- Require complex or multidisciplinary care modalities involving frequent physician development or revision that necessitate a high level of decision-making and go beyond administrative functions; and
- Have complex medical conditions requiring intensive treatments, frequent determinations of responses to therapies and reassessments of the plan of care.



To receive physician care plan oversight payments, the physician must:

- Spend at least 30 minutes rendering care plan oversight services to each patient in a calendar month period;
- Not have a significant ownership interest or significant financial or contractual relationship with the home health agency;
- Not be the medical director of the home health agency who contracts with the home health agency to provide medical services; and
- Not be a physician providing services to rural health care clinic patients.

Note:

- A home health medical director with an appropriate arrangement under the Stark law can bill for services provided to his/her own patients on which he/she has signed the plan of care (ie, is the "attending physician").
- A non-physician practitioner (nurse practitioner, clinical nurse specialist or physician's assistant) can bill for services, but may not certify a patient as needing home health.
- CPO may be billed only if the physician who signs the plan of care provides regular ongoing care under the same plan of care as the NPP billing for care plan oversight, and
 - the physician and NPP are part of the same group practice; or
 - the physician and NPP have a collaborative agreement (or if the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of PA services for the practice.)

Documentation

Medicare requires that physicians who furnish care plan oversight services document those services that were furnished, the date and the length of time associated with those services. No presumptions are allowed to support a claim that sufficient time has been spent within a calendar month to satisfy the conditions

for payment. The Medicare program may conduct post-payment reviews of claims for reimbursement of this service. Where documentation is inadequate to support a claim that services in excess of 30 minutes have been provided in a calendar month, reimbursements may be denied. The physician must be able to demonstrate, through documentation in the patient's record, that at least 30 minutes were spent on oversight of the home care plan of care during the calendar month. The documentation must include the dates and amount of time associated with each encounter. The responsibility for documentation of care plan oversight activities lies with the physician. **Although home care providers may provide educational information to inform physicians of this benefit, those who engage in activities such as the development of detailed monthly reports for physicians run the risk of being viewed as engaging in cost report or referral kickback violations.**

Billing for Certification, Recertification and PCPO

Physicians should bill these services on the CMS form 1500. Nothing except CPO services are to be billed on the claim.

- CPO services are to be billed only once per calendar month with one month's services per line item.
- Claim must not be submitted until after the end of the month in which services are performed.
- Dates of service entered on the claim form must be the first and the last date during which documented CPO services were

actually provided during the calendar month, not just the first and last days of the calendar month in which the claim is submitted.

- Medical records for those dates must have documented that 30 minutes or more of time was spent by physicians performing included CPO activities, the CPO services that were furnished, and the date and length of time associated with the services.
- The appropriate HCPCS Code must be used: G0181 (home care patient).
- All claims for CPO must contain the six-digit Medicare provider number of the home health agency rendering covered Medicare services during the period in which the care planning oversight was furnished.
- As with other Part B services, the patient is liable for a 20 percent co-payment when he or she is billed.
- Claims must be completed and submitted by the physician's office staff and not the home health agency.

Form 1500

Common mistakes on the form 1500 that result in denials:

- Item 23: Prior authorization number
- The home health agency six-digit Medicare provider number
- Item 32: Facility where services were furnished
- The physician's office (When the name and address of the facility where the services were furnished is the same as the biller's name and address shown in item 33, enter the word "SAME.")

Home Health Physician Care Plan Oversight Guide for Billing – Form 1500

"Date(s) of Service": Actual dates of physician's service in a calendar month

"Place of Service": Office 11

"Type of Service": 01

"CPT Code": G0179, G0180 or G0181

Home Health Agency Provider Number:

"Modifier": None necessary

See Payment Rate Guide

"Charge": G0181 (Care Plan Oversight)
G0180 (Certification)
G0179 (Recertification)

"Diagnosis": Found on 485 Plan of Care

Physician's Office

NOTE: Remember to retain a copy of the signed HCFA-485 (Home Health Plan of Care), signed interim or telephone orders or any reports of patient status used to determine the need for certification/recertification of patient as noted in the HCPCS definition.