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Education

Care Plan Oversight Services and Physician Services for Certification and Recertification of Medicare-Covered Home Health Services

TrailBlazer HEALTH ENTERPRISES, LLC℠

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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★★IMPORTANT★★

The information provided in this manual was current as of August 2006. Any changes or new information superseding the information in this book are provided in the Medicare Part B newsletters with publication dates after August 2006. Medicare Part B newsletters are available at: www.trailblazerhealth.com/pubs.asp?

★★IMPORTANT★★

CARE PLAN OVERSIGHT SERVICES AND PHYSICIAN SERVICES FOR CERTIFICATION AND RECERTIFICATION OF MEDICARE-COVERED HOME HEALTH SERVICES

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CARE PLAN OVERSIGHT (CPO) SERVICES (COVERED ONCE PER CALENDAR MONTH)

Care Plan Oversight (CPO) is the supervision of a patient under the care of a Home Health Agency (HHA) or hospice who requires complex and multidisciplinary care modalities involving any of the following:

- Regular physician development and/or revision of care plans.
- Review of subsequent reports of patient status.
- Review of related laboratory and other studies.
- Communication with other health professionals not employed in the same practice who are involved in the patient's care.
- Integration of new information into the care plan.
- Adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for patients of Skilled Nursing Facilities (SNFs), nursing home facilities or inpatient hospitals.

Non-Physician Practitioners

Nurse practitioners, physician assistants and clinical nurse specialists, practicing within the scope of state law, may bill for CPO. The non-physician practitioners must be providing ongoing care for the beneficiary through Evaluation and Management (E/M) services (but not if they are involved only in the delivery of the Medicare-covered home health or hospice service).

Home Health CPO

Non-physician practitioners can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- The physician and NPP are part of the same group practice; or
- If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or
- If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

Providers may bill for CPO furnished by an NPP when:

- The NPP providing the CPO has seen and examined the patient.
- The NPP providing CPO is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care; and
- The NPP providing CPO integrates his/her care with that of the physician who signed the plan of care.

NPPs may not certify the beneficiary for home health care.

Hospice CPO

The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an "attending physician." An "attending physician" is one who has been identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care. They are not employed nor paid by the hospice. The CPO services are billed using Form CMS-1500 or electronic equivalent.

Conditions for Coverage

These services are covered only once per calendar month if all of the following requirements are met:

1. The beneficiary must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care.
2. The CPO services should be furnished during the period in which the beneficiary was receiving Medicare-covered HHA or hospice services.
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care (refer to information under "Non-Physician Practitioners" if provided by an NPP).
4. The physician furnished at least 30 minutes of CPO within the calendar month for which payment is claimed, providing no other physician has been paid for CPO within the calendar month.
5. The physician provided a covered physician service that required face-to-face encounter with the beneficiary within the six months immediately preceding the first CPO service. Only E/M services are acceptable as prerequisite face-to-face encounters for CPO. EKG, lab and surgical services are not sufficient face-to-face services for CPO.
6. The CPO billed by the physician was not routine postoperative care provided in the global surgical period of a surgical procedure billed by the physician.

7. If the beneficiary is receiving HHA services, the physician did not have a significant financial or contractual interest in the HHA. A physician who is an employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice.
8. The physician who bills the CPO services is the physician who furnished them.
9. Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.
10. The physician is not billing for the Medicare End Stage Renal Disease (ESRD) capitation payment for the same beneficiary during the same month.
11. The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.

Which Services Count Toward the 30 Minutes?

- Review of charts, reports, treatment plans, or lab or study results, except for the initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
- Telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
- Team conferences (time spent per individual patient must be documented).
- Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
- Medical decision-making.
- Activities to coordinate services are countable if the coordination activities require the skills of a physician.

Which Services DO NOT Count Toward the 30 Minutes?

Services not countable toward the 30-minute threshold that must be provided in order to bill for CPO include, but are not limited to:

- Time associated with discussions with the patient, his or her family, or friends to adjust medication or treatment.
- Physician's time spent telephoning prescriptions to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.
- Time spent by staff getting or filing charts.
- Travel time.

- Initial interpretation or review of lab or study results that were ordered during or are associated with a face-to-face encounter.
- Low-intensity services included as part of other E/M services.
- Informal consults with health professionals not involved in the patient's care.
- The physician's time spent discussing, with his nurse, conversations the nurse had with the HHA. However, time spent by the physician working on the care plan after the nurse has conveyed the pertinent information to the physician is countable toward the 30 minutes.
- The work included in hospital discharge day management (codes 99238-99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital.

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the HHA or hospice during the month for which CPO services were billed.

CARE PLAN OVERSIGHT SERVICES AND PHYSICIAN SERVICES FOR CERTIFICATION AND RECERTIFICATION OF MEDICARE-COVERED HOME HEALTH SERVICES

Care Plan Oversight Billing Requirements

G0181 Physician supervision of a patient receiving Medicare-covered services provided by a participating HHA (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into medical treatment plan, and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

G0182 Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into medical treatment plan, and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

- No other services may be submitted on the claim with the CPO services.
- These services are covered only once per calendar month after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service.

PHYSICIAN SERVICES FOR CERTIFICATION AND RECERTIFICATION OF MEDICARE-COVERED HOME HEALTH SERVICES

Physician's services involved in physician certification (and recertification) of Medicare-covered home health services may be separately coded and reimbursed. These services include creation and review of a plan of care and verification that the HHA initially complies with the physician's plan of care. The physician's work in reviewing data collected in the HHA's patient assessment would be included in these services. This document defines the coverage for the physician service. For information concerning coverage of home health services, please refer to the *Home Health Agency (HHA) Manual* (**www.cms.hhs.gov/manuals/11_hha/hh200.asp**) and to the appropriate Home Health Intermediary.

The physician services for initial certification of Medicare-covered home health services are billable once for a certification period. This may be billed when the patient has not received Medicare-covered home health services for at least 60 days. (This means that the patient has not received services for 60 days and does not mean that 60 days have elapsed since the previous certification.) Physician services for recertification of Medicare-covered home health services may be billed after a patient has received services for at least 60 days when the physician signs the certification after the initial certification period. **This recertification may be reported only once every 60 days, except in the rare situation when the patient starts a new episode of care requiring a new plan of care before the 60 days elapse.**

Medicare-covered home health services are defined in the *HHA Manual* (Section 203).

Conditions to be Met for Coverage of Home Health Services

Medicare covers HHA services when the following criteria are met:

- The person to whom the services are provided is an eligible Medicare beneficiary.
- The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program.
- The beneficiary qualifies for coverage of home health services as described in Section 204.
- The services for which payment is claimed are covered as described in the *HHA Manual*, Sections 205 and 206.

- Medicare is the appropriate payer.
- The services for which payment is claimed are otherwise excluded from payment.

The physician may bill physician certification for a patient receiving Medicare-covered home health services that require the development of a plan of care. The physician must participate in the development of the plan of care and review of data collected in the HHA's patient assessment in addition to signing the certification statement.

A physician may bill for services for certification of Medicare-covered home health services and for CPO services for the same period of time during which the patient is receiving the home health services. However, the work required for each service must be unique. The work and time spent developing the plan of care for the certification must be separate and apart from the time counted toward CPO. Work performed in revising a plan of care that was previously established is appropriately counted toward the time needed to fulfill the requirements for CPO (assuming that all other criteria, including the patient's need for complex and multidisciplinary care, have been met).

A physician may perform other E/M services during the same month for which he is billing the physician's services for certification/recertification. However, time counted toward the services for certification/recertification should not be included in the work or time counted toward the pre-, post- and intraservice work of the E/M service.

The physician billing for physician certification must be the provider supervising the patient's care. A physician is defined as a Doctor of Medicine (MD), a Doctor of Osteopathy (DO) or a Doctor of Podiatric Medicine (DPM) (as permitted under 42CFR 424.22).

Limitations

Physicians' services for certification/recertification are covered for reimbursement only when performed by physicians (MD/DO) in specialties indicated by one of the following physician specialty codes: 1-18, 20-34, 36-40, 44, 46, 66, 76-79, 81-86, 90-94 and 98; or by podiatric physicians (DPM, specialty code 48). Certification services (services not pertaining to provision of care) provided by other practitioners (including, but not limited to, chiropractors, dentists/oral surgeons, optometrists, clinical psychologists, clinical social workers, physical therapists, occupational therapists, speech therapists, limited licensed practitioners, physician assistants, nurse practitioners and certified clinical nurse specialists) are not Medicare-covered services.

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Physicians in specialties other than those commonly providing primary or comprehensive medical care to patients under the care of HHAs may be subject to review for medical necessity.

Discharge planning for a hospitalized patient is included in the E/M codes 99217, 99238 and 99239 and is not part of the physician certification.

In general, Medicare expects that the physicians certifying a plan of care for a patient receiving home health services must have provided a Medicare-covered face-to-face encounter such as an E/M visit, an encounter with a surgeon during the postoperative period or other similar encounter within the six months prior to the certification. Medicare recognizes that in rare circumstances, this may not always be possible because of practice patterns in certain physician group practices.

CPT/HCPCS Codes

G0179	MD recertification HHA PT
G0180	MD certification HHA patient

Reasons for Denial

- Claims for physician services for certification (or recertification) submitted for beneficiaries not receiving Medicare-covered HHA services at the time of the certification/recertification will be denied.
- Claims for physician services for certification (or recertification) submitted for beneficiaries receiving HHA services paid by Medicaid, by insurance other than Medicare or privately will be denied.
- Claims submitted without an identifying HHA provider number or with place of service codes not specifically listed in these guidelines will be denied.
- Claims for services will be denied if the physician submitting the claim is not the physician signing the HHA plan of care (the primary physician).
- **Only one physician may bill for services for certification/ recertification of Medicare-covered HHA services for a beneficiary in a 60-day period. All other claims will be denied**.
- Claims for services will be denied if the patient's medical record does not document the physician's services. These may include: creation and review of a plan of care, verification that the HHA initially complied with the physician's plan of care, and review of data collected in the HHA's patient assessment.

- Claims for services will be denied when the only documentation of plan development indicates that it was part of the discharge day service of an observation or inpatient stay.
- The services will be denied if the provider's specialty is not listed in the "Limitations" section of this document.
- Since HHA services are usually intermittent, continued physician services to recertify Medicare-covered HHA services occurring for multiple certification periods may be subject to review for medical necessity.
- The medical record does not verify that the service described by the HCPCS code was provided.
- The service does not follow the guidelines of this document.
- The service is never considered medically necessary.

Coding Guidelines

- Use HCPCS code G0180 to bill physician services for initial certification of Medicare-covered HHA services.
- Use HCPCS code G0179 to bill physician services for recertification of Medicare-covered HHA services.
- Enter "1" as the number of services in Box 24 of the CMS-1500 form or, if submitting electronically, in the ANSI format: 2400/SV104 (UN qualifier).
- The place of service code should represent the place where the preponderance of the plan development and review work was performed. This place of service code should be consistent with the policies enumerated above. Appropriate place of service codes are limited to: 11 (office), 12 (home), 22 (outpatient hospital) and 71 (state/local public health clinic).
- Enter the provider number of the HHA from which the beneficiary is receiving Medicare-covered services in comment field on the CMS-1500. For electronic claims submitted in the ANSI-837 format, the HHA Medicare provider information must be entered in 2310D-NM101-77 (service facility or FA (facility)), NM108-24 (EIN) or 34 (SSN), NM109 – input lab/facility ID, REF01-LU (location number), REF02 – input lab/facility. Failure to provide this information may result in the claim being denied because required information was not supplied.
- No other services may be billed on the same claim as the physician services for certification or recertification.

Documentation Requirements

- The physician must maintain documentation supporting the development of a plan of care and data review in the patient's medical records. If the written plan was not prepared by the physician (i.e., it was prepared by the HHA), the medical record must document the physician's contribution to the development of the plan, or document review of the specific items entered into the plan; this documentation may take the form of progress notes and orders, annotations on the HHA orders and plan of care, copies of verbal orders, notes of phone calls, or a variety of other types of documentation.
- It is not sufficient that the HHA maintain documentation in their records for the physician. The physician must maintain his/her own records including periodic summary reports provided by the HHA.
- Documentation of all face-to-face (E/M) visits and any phone communications with the patient or immediate caretakers must be present in the patient's chart. This documentation must indicate an ongoing knowledge of any changes in the patient's condition, drugs or other needs and how they are being met.

Utilization Guidelines

It is expected that HHA services are intermittent and not continuous, and that certification and recertification services would not be billed more than three times a year for most patients. Some patients with complicated medical problems may require more than the average services.

Note: For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an Advance Beneficiary Notice (ABN).

REVISION HISTORY

August 2006	Care Plan Oversight	Added Non Physician Practitioner information and removed requirement for completing Item 23 from CR 4374.