Internal Medicine Coding Alert

Experts' Advice: Stop Giving Away Care Plan Oversight Services for Free

Don't let payers undervalue your physician's time performing CPO

Your internist can earn up to $140 for some care plan oversight services, but many practices are throwing this reimbursement away by not properly billing for their physician's work performing the oversight. For a quick care plan oversight refresher, check out our expert advice.

Example: Suppose the internist spends 40 minutes setting up a home health plan of care for an elderly diabetic Medicare patient who fell outside of her home, sprained her right wrist and right ankle and suffered multiple abrasions on her right lower leg.

Due to the wrist injury, she cannot ambulate with crutches or a walker, so she is confined to a wheelchair while her injuries heal. However, the lack of flexibility and movement could bar the patient from performing her foot care to prevent peripheral neuropathy.

The internist writes up a plan of care outlining the patient's home healthcare requirements, but because the physician does not spend this time face-to-face with the patient, you write off the 40 minutes as nonbillable time -- and in the process, you forfeit about $80, the amount that Medicare designates for code G0180 (Physician certification for 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 patients needs, per certification period).

Face-to-Face Not Required for CPO

Care plan oversight (CPO) services are time-based, non-face-to-face E/M services that include many tasks that internists regularly perform for the long-term management of home health agency, hospice, or nursing facility patients under their care.

Although preauthorization is sometimes required, most payers will recognize these codes. Remember that Medicare only accepts G0179-G0182 for CPO, while private ayers usually require codes from the 99374-99380 series for home health, hospice or nursing facility patients. If you perform CPO for a home, domiciliary or rest home patient who has non-Medicare insurance, use a code from the 99339-99340 series.

Remember: When the physician performs his monthly review of the home healthcare plan, you should not report G0180, because this code applies only to the certification. Instead, for monthly care, report G0181 (Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency [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 healthcare professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more).

Spend at Least 30 Minutes on CPO

The internist must spend at least 30 minutes performing CPO before you can report these services. If your practice frequently reports CPO, you should consider stapling a time documentation sheet to the forms that your home health agencies send to you. This form allows the physician to document the time that he spends on the patient's PO.

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Practitioners who use CPO codes should keep not only documentation of the time they spend performing the services but also details about what transpired with each contact. Without this documentation, it may be difficult to defend the complexity and time required to manage the patient.

Challenge Frequency Limitations

Some internal medicine practices find that Medicare carriers limit coverage for the physician's services performing monthly hospice CPO, for which they report 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 healthcare professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more).

"We find that insurers will reimburse for the first two submissions of G0182," says **Peggy Lore,** coder at Franklin Medical Group in Franklin, Penn. "However, coverage is apparently intended for care up to six months only."

Keep in mind: Some carriers have very specific requirements to maintain billing CPO after six months. For example, Empire Medicare's policy states, "Documentation of an E/M visit within six months of each Care Plan Oversight service must be maintained by the provider in the patient's medical record or in the appropriate in-patient medical record."

Other payers don't outline any frequency requirements in their policies, so if your physician follows the rules but still faces denials, be prepared to appeal. (To review Medicare policies, visit www.cms.hhs.gov/mcd and enter your search terms or your carrier's information.)

Confirm Medical Necessity

"Most insurers, including Medicare, do not publish their frequency limitations," says **Kathy Pride, CPC, CCS-P,** director of government services for QuadraMed in Reston, Va. "However, this does not mean that it is not reimbursable; it just means that it has exceeded the frequency limitations within the insurance company's automated system.

"Practices should appeal their cases," she says. "The insurance carrier is probably looking for proof of medical necessity, so the appeal should include documentation to support medical necessity."

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