

Internal Medicine Coding Alert

Increase Care Plan Oversight Revenue with Accurate Coding

As primary health care providers, internists not only see and treat patients, but are often tasked with coordinating and supervising more specialized care when it is needed. Some of the most complex cases involve those patients who need home health, hospice and nursing facility services. Internists must oversee the plan of care for these patients often communicating with several other health care providers and tracking the patients progress.

A confusing issue for many internal medicine practices is coding for this care plan oversight, the difference between the literal definition of care plan oversight and what Medicare will reimburse.

CPT defines care plan oversight as physician supervision of a patient under the care of a home health agency, hospice, or nursing facility requiring complex and multi-disciplinary care modalities involving near regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patients care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month.

The CPT also states, the work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes.

What this means is that if the care is minimal Medicare is not paying (care plan oversight) for it, says **Cynthia C. Thompson, CPC**, senior consultant and coding expert with Gates, Moore & Company. These codes are for intensive, recurrent supervision of care.

Internal medicine practice coders should take special notice of the fact that, although CPT allows for reimbursement for care plan oversight for 15-29 minutes, Medicare is only reimbursing for 30 minutes or more per month. In addition, Medicare is not reimbursing 99380, care plan oversight services delivered to patients in nursing facilities.

These codes are for any payer, but most of the patients that are going to be involved in this are Medicare, Thompson explains.

The American Society of Internal Medicine (ASIM) recently developed a special worksheet to guide internal medicine coders when billing care plan oversight. According to ASIM, the oversight service delivered by the internist must meet the following conditions in order to be billed to Medicare:

Subscriber Benefit: Bound into this issue is a free copy of the ASIM worksheet, if yours is missing please call 800/508-2582 to receive a replacement. If you would like to speak with ASIM directly call their Medicare hotline at 800/338-ASIM.

1. The patient is receiving Medicare-covered home health or hospice benefits. Nursing home services, coordination of care delivered to patients who are not receiving care from a Medicare-covered home health agency, or patients who are not admitted to a Medicare-covered hospice, are not eligible, says Thompson. Practices need to make sure they are not billing codes for patients who are not in the right environments, she states. They cant bill care plan oversight on a diabetes patient that they are monitoring regularly, or something like that.

2. The physician is financially independent from the home health agency and/or hospice. The internist cannot have a significant financial relationship with the agency or hospice and cannot be the medical director or an employee of the agency or hospice.

3. The physician is furnishing a service. This requires a face-to-face encounter with the patient in the six months before the first billing of the service.

4. 30 minutes or more. The care plan oversight services total 30 minutes or more for the calendar month in which the service is billed.

Carefully Track Home Health and Hospice Patients

For each such patient, the practice should have an individual log that tracks the services provided, as well as the date, time and length of the service, and the name of the physician providing the service, Thompson emphasizes.

If the practice is on a computerized records system, she recommends setting up a separate database for the practices patients who are in hospices or who receive home health. If this is not feasible, the patients charts should be kept separately from the rest of the patient records.

You should have a list (of patients charts) to be checked monthly, she explains. Somebody in the office should be designated to pull the charts and check to see whether there is a charge that could be billed.

A care plan oversight encounter log should be kept in each of these patients files, she adds. And, ASIM has a patient encounter form enclosed in its worksheet on care plan oversight that works very well.

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The log should have column headings for the date of service, for detailing the specific services provided, the contact name and organization (if the physician communicated with another health care provider), entry of the start and end times, total minutes, and a monthly subtotal as the last column.

At the bottom of the monthly encounter log would be a monthly total box. The staff person designated to pull the charts, would total all of the times in the monthly subtotal column and write that in the box.

If it adds up to 30 minutes or more, then they can bill it, Thompson says.

Tip: Remember, only one physician per patient per month can bill for care plan oversight. Some practices with more than one physician may have a second one go over the care of the patient while the first is on vacation, explains Thompson. But, you cant have two physicians on one sheet, so you cant bill it.

Complete Documentation is Essential

In its 1996 study, HCFA found that on 13% of claims that were submitted, the physician had no documented record of having seen the patient.

In instances that she has seen, Thompson says, the internist may document that he or she performed some supervision of the patients care, but not documented what that was.

The documentation for care plan oversight must include the physicians name, the patients name, and the calendar month (since only one physician per patient can bill for care plan oversight in a given month), and the length of time spent (i.e., 10 minutes, 15 minutes, or more).

The internist should also document, specifically, what type of service was delivered (regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory or other studies; communication with other health care professionals involved in patients care, integration of new information into

the treatment plan, etc.).

Medicare: Avoid Common Errors With Care Plan Oversight Codes

A 1996 Health Care Financing Administration (HCFA) review of claims from physicians in New York State found that more than two-thirds of Medicare claims for care plan oversight were improperly billed either due to coder mistakes or out and out fraud.

In 1997, HCFA's administrator, **Bruce C. Vladeck, PhD**, testified before the House subcommittee on Health and the Environment, that as many as a quarter of all Medicare claims for home health services were believed to be invalid.

This year, Medicare has increased reimbursement for care plan oversight (from an average \$76.41 in 1997 to \$78.38 before geographic adjustment), but they have also gotten more strict about how these services should be billed and documented.

One of the areas that has been highly investigated by Medicare in their fraud investigations is incorrect billing of care plan oversight, states **Cynthia C. Thompson, CPC**, senior consultant and coding expert with Gates, Moore & Company, a medical practice management consulting firm in Atlanta, GA. The fine can be a very significant amount, particularly in internal medicine, if they have a lot of patients in these areas.

The key to correct coding for care plan oversight is a practice protocol that does three things:

- 1) ensures staff understanding of what does, and does not, meet the Medicare definition of a care plan oversight service;
- 2) ensures adequate documentation to support the billing of these services; and,
- 3) institutes a procedure that tracks which patients are eligible for these services and when these services are provided on their behalf.

Thompson, who often counsels internal medicine practices on management and coding issues, has seen practices that have been fined hundreds of thousands of dollars by Medicare. And this is usually in addition to having to repay the amount they received in reimbursements for incorrectly billing these services.

We don't want to scare practices into not using these codes, stresses Thompson. We just don't want to see them coded improperly. In its 1996 review of care plan oversight claims from New York state providers, HCFA found several common problems.

The three major ones were inaccurate billing of care plan oversight codes 99375-99376 in the following ways:

1. The beneficiary was not in home health or a hospice, a requirement for use of these codes.
2. The physician or biller appeared to be someone who would not provide oversight of complex cases, such as a podiatrist, radiologist, or pathologist.
3. The physician billed for so much care plan oversight that half to three-fourths of his/her practice time would have been devoted to providing oversight services (an unlikely real-world situation).

Additional problems were:

In 13% of claims, the physician had no documented record of ever having seen the patient.

In 33% of claims the dates of service recorded by the physician did not match the dates of service documented by the home health agency or hospice.

33% of claims were invalid because the dates of service billed by the physician were dates when the patient was hospitalized.

Coding for Care Plan Oversight

The CPT codes for care plan oversight are 99374-99380. HCFA will no longer recognize Common Procedure Coding System (HCPCS) codes G0064 and G0065, formerly used for billing these services. CPTs adoption of more specific codes for reporting care plan oversight allowed the administration to delete the HCPCS codes.

Note: HCFA (Medicare) will only pay for care delivered in these settings if the oversight services total 30 minutes or more in the calendar month.

99374 - Physician supervision of a patient under care of a home health agency (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patients care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

99375 - 30 minutes or more. *

99376 - Has been deleted

99377 - Physician supervision of a hospice patient (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patients care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

99378 - 30 minutes or more.*

99379 - Physician supervision of a nursing facility patient (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in patients care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.

99380 - 30 minutes or more. **

* Reimbursed by Medicare

** Not Reimbursed by Medicare

