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Internal Medicine Coding Alert

Reader Question: Care Plan Oversight

Question: Should I use care plan oversight (CPO) codes on a nursing-home patient?

Illinois Subscriber

Answer: CPT provides codes for CPO of nursing-facility patients, 99379-99380. Unfortunately, Medicare does not pay for these codes because it considers CPO of nursing-facility patients to be bundled into the nursing-facility visit codes. However, other payers may reimburse for this code. CPO codes are divided into three main categories services to patients under the care of home-health agencies, hospice patients and nursing-facility patients. These are non-face-to-face services; the patient is not present for the time being billed for this service. CPO services are time-based services that require a minimum of 15 minutes of physician time be spent directing or coordinating the care of the patient within a 30-day period.

As with all time-based CPT codes, the amount of time spent must be documented in the medical record along with a description of the service provided, i.e., review of laboratory results, or telephone calls to other healthcare providers involved in the patients care. These codes may only be billed once every 30 days and, as indicated in CPT, only by the physician who has the sole or predominant supervisory role for a particular patient.

While Medicare does not pay for care plan oversight for nursing-home patients, it does pay for CPO for patients of home-health agencies and hospice patients. Effective Jan. 1, 2001, Medicare ceased accepting the CPT codes for CPO for these patients and began requiring HCPCS codes. Medicare rewrote some of the descriptions for these CPO codes and created G0181 to bill for CPO of home-health agency patients and G0182 to bill for care plan oversight services for hospice patients. As is often the case, Medicare guidelines are different from and more complex than the CPT guidelines for CPO.

Medicare will not pay for CPO of less than 30 minutes. Medicares guidelines are also more explicit about which services can and cannot be counted toward the 30-minute threshold time. Specifically, Medicare prohibits physicians from including time spent providing the following services as CPO time:

Time spent by the physicians nurse or other employees
Time spent discussing the patient with family members or friends, travel time
Time spent telephoning prescriptions to the pharmacist.

Instead of a 30-day period, Medicare guidelines specify each calendar month. Claims should be submitted after the end of each calendar month and CPO codes should be the only codes reported on the claim. Medicare rules also specify that the physician must have had at least one face-to-face encounter with the patient during the six-month period prior to the time that CPO is being billed. The physician also may not have a financial or ownership interest in the home-health agency or be an employee or medical director of the hospice.

Also, in January 2001, Medicare began covering physician certification and recertification of home-health agency services with two new G codes: G0179 (MD recertification, HHA patient) and G0180 (physician certification services for Medicare-covered services provided by a participating home health agency [patient not present], including review of initial or subsequent reports of patient status, review of patients responses to the Oasis assessment instrument, contact with the home health agency to ascertain the initial implementation plan of care, and documentation in the patients office record, per certification period). To qualify as an initial certification, the patient must not have received Medicare-covered home-health services for the preceding 60 days. Code G0179 should be reported only once every 60 days.

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