Part B Insider (Multispecialty) Coding Alert

Care Plan Oversight: Stop Giving Away Your CPO Services for Free

But ensure that a face-to-face visit took place before you bill.

Don't let carriers undervalue your physician's care plan oversight (CPO) services: Start getting paid for CPO with a solid understanding of how and when to report 99374-99380 and G0179-G0180.

Suppose your physician spends 40 minutes setting up a home-health plan of care for an elderly diabetic patient who falls outside of her home and sprains her right wrist and right ankle with multiple abrasions of the right lower leg. Due to her wrist injury, she cannot ambulate with crutches or a walker, so she is confined to a wheelchair while her injuries heal. She requires home care for assistance with activities of daily living, hygiene, and wound care. You write off the 40 minutes as nonbillable time - and in the process, you forfeit about $80 in care plan oversight services.

Physicians supervising home healthcare can often recoup payment for their time by accessing CPO codes 99374-99380 for private payers, and G0179-G0180 for Medicare. Reimbursement for these codes is on par with some of the higher-level E/M codes, so if your documentation supports it, you should charge for CPO. But because auditors have scrutinized CPO services in recent years, it's more important than ever to ensure that your CPO documentation is airtight.

Face-to-Face Time Now Required

CPO services are time-based, E/M services that include many tasks that doctors regularly perform for the long-term management of home-health agency, hospice or nursing-facility patients under their care. Physicians might provide such services for spinal injury patients who are wheelchair-bound or accident victims recovering from multiple traumatic injuries.

Effective Jan. 1, 2011, physicians (or NPPs) who order home health care must personally examine the patient during a face-to-face visit. "The physician must document that the physician or NPP saw the patient, and document how the patient's clinical condition supports a homebound status and need for skilled services," CMS says. "The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care."

Although preauthorization is sometimes required, many payers will recognize these codes. Remember that Medicare only accepts G0179-G0180 for CPO, while private payers usually require the 99374 series. The CPO codes include:

- G0179 -- Physician recertification 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 patient's needs, per recertification period
- G0180 -- Physician certification ... including review of reports of patient status ... to affirm the initial implementation of the plan of care ...
- G0181 -- Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency ...
- G0182 -- Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities...
- 99374 -- Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) 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 related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision

maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's 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
- 99377 -- Physician supervision of a hospice patient ...; 15-29 minutes
- 99378 -- ... 30 minutes or more
- 99379 -- Physician supervision of a nursing facility patient ...; 15-29 minutes
- 99380 -- ... 30 minutes or more.

When You Can Report CPO During Global

Suppose Dr. Jones performs surgery on a patient and decides that the patient requires a month of home healthcare during recovery. To determine whether you can report Dr. Jones' services with a CPO code, you first have to decide whether the patient only needs routine postoperative care. If that's the case, Medicare would not qualify the service as a payable CPO service.

In addition, Section 180 of the Medicare Claims Processing Manual states that you cannot count the following activities toward the CPO time:

- Discussions with the patient, his family, or his friends adjusting medications or treatment
- Staff time getting or filing charts
- Travel time
- Phoning in prescriptions (unless the phone conversation involves discussion of pharmaceutical therapies)

Spend At Least 30 Minutes for Medicare

The physician must spend at least 30 minutes performing CPO for you to be able to report G0181 or G0182 to Medicare. If your practice frequently reports these services, you should consider stapling a "cheat sheet" to the forms that your home-health agencies send to you. The form allows the physician to document the time that he or she spends on the patient's CPO, and reminds him to document the face-to-face encounter.

What the documentation must include: Ensure that your physician thoroughly describes his examination of the patient and the reasons he's requesting home health.

"The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services," notes an article by WPS Medicare, a Part B provider in four states.

"It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type," the document states. "It is also acceptable for the documentation to be generated from a physician's electronic health record. It is unacceptable for the physician to verbally communicate the encounter to the HHA, where the HHA would then document the encounter as part of the certification for the physician to sign."

Although Medicare will deny CPO services that you report with the 99374 series, these carriers do offer second chances. If the practice doesn't do a lot of Medicare business, they probably don't know that Medicare carriers require the HCPCS Level III codes. If Medicare denies your claim because you've reported the CPT codes instead of the G codes, you can file a corrected claim with the correct codes.