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BY AAPC

Eli's Rehab Report

Stop Giving Away Your CPO Services for Free

Correct documentation could earn you an extra $80

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 **CPT 99374 -99380** and G0179-G0180.

Suppose your physiatrist spends 40 minutes setting up a home health plan of care for a hip-replacement patient who falls during her recovery and sprains her left foot and wrist. Because the patient also has vertigo, the potential for another fall is significant, so your physician prescribes home healthcare and creates goals for the patient's progress. 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 the OIG intends to scrutinize CPO services in 2004, it's more important than ever to ensure that your CPO documentation is airtight.

Face-to-Face Time Is Not Required

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

Although preauthorization is sometimes required, many payers will recognize these codes. Remember that Medicare accepts only G0179-G0180 for CPO, while private payers usually require the 99374 series. See the box on page 12 for a list of the CPO codes.

Know 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 have to decide whether the patient requires healthcare because of the surgery.

"If the patient only requires home healthcare because he's recovering from surgery, then the CPO is included in the global surgical package," says **Quinten A. Buechner, MS, MDiv, CPC, CHCO**, president of ProActive Consultants, a healthcare reimbursement consulting firm in Cumberland, Wis. For example, if a surgeon performs a hip replacement and requests that a home health practitioner visit the patient weekly to check for infection and help the patient perform range-of-motion exercises, he cannot report the CPO codes.

Section 15513 of the Medicare Carriers Manual (MCM) states that CPO services are only payable if the service was "not routine postoperative care provided in the global surgical period of a surgical procedure billed by the physician."

"Pain management requiring IV infusion with frequently altered dosage schedules or medications would probably meet the test of 'complex' care and may not be considered routine postoperative care," says **Jean Acevedo, LHRM, CPC, CHC**, president of Acevedo Consulting Inc., a healthcare reimbursement consulting firm in Delray Beach, Fla.

But if the surgeon turns over the patient's care to the rehab physician, he can report the CPO services without regard for

the global period.

Spend at Least 30 Minutes for Medicare

The physician must spend at least 30 minutes performing CPO for you 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 spends on the patient's CPO.

Although Medicare will deny CPO services that you report with the 99374 series, these carriers do offer second chances, Buechner says. "If the practice doesn't do a lot of Medicare business, they probably don't know that Medicare carriers recommend the HCPCS Level III codes," he says. "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."

The only exception is if Medicare denied your charges for 99374, Acevedo says. "Medicare has never reimbursed for this code because it represents CPO services of 15-29 minutes within a calendar month. Medicare only pays if 30 minutes or more of CPO have been provided and documented in a calendar month."

Don't Include Travel Time in CPO

You cannot report all of your physician's home health certification services as CPO, even if they involve much time and effort. You can only count the activities requiring a physician's skill, and anything that does not meaningfully contribute to the treatment of the illness or injury does not count.

According to the MCM, section 15513, you can't report the following services as CPO:

1. physician phone calls to the patient or family
2. travel time
3. time spent preparing claims for processing.

A physician billing CPO must have had a face-to-face encounter with the patient for whom the services are reported within the six months immediately preceding the first reported CPO claim. Qualifying E/M services include 99221-99263 and 99281-99357.