

## Physician's Quick Guide to Care Plan Oversight (CPO) and Medicare Billing

- **Physicians can be reimbursed by Medicare for a minimum of 30 minutes per calendar month of time spent on home care orders and communications for patient receiving home health services.**
- **Medicare Part B physician reimbursement is subject to 20% co-payments. The beneficiary is responsible for the copay. A supplemental insurance policy may cover this amount.**
- **Bill Medicare CPO under code GO181.**

### **12 Criteria for CPO Billing**

1. Patients must receive home health services that are covered by Medicare and require complex or multi-disciplinary modalities requiring physician involvement.
2. Physician must devote and document 30 minutes or more of his/her time to supervision of patient's care plan and include documentation in the patient record.
3. The physician who bills CPO must be the same as the physician who signs the treatment plan and personally provides the service.
4. A nurse practitioner, nurse clinical specialist or a physician assistant may bill for CPO if they have been providing patient evaluation and management as a "physician service" while acting within the scope of state laws.
5. Only one physician per month can bill.
6. The physician must have furnished a service requiring a face-to-face encounter with the patient in the 6 month period before CPO is billed.
7. The physician cannot have a significant financial contract with the agency (5% ownership or salary amounting to more than \$25,000 or 5% of agency total operating expenses).
8. Cannot bill for CPO if billing for Medicare ESRD capitation payment in the same month.
9. Any work included in hospital stay discharge management or discharge from hospital observation is not countable towards CPO.
10. To bill separately for CPO in the post-operative period, the physician must document that CPO services are unrelated to the surgery.
11. HHA Medicare # must be on claim.
12. Billing must be for 30 minutes within calendar month.

## **Activities that Do Count towards 30 minutes monthly of CPO**

- Review of charts, reports, treatment plans, lab and other test results that were not ordered during the face-to-face encounter qualifying patient for CPO
- Telephone calls to other health care professionals involved in care of patient (not in office)
- Team conferences
- Telephone call/discussions with pharmacist about medication therapies
- Medical decision making
- Activities to coordinate services requiring the skills of a physician
- Documenting the services provided (includes time to write a note about service provided, decision making performed, amount of time spent on countable services)
- Time spent on activities undertaken on day of hospital discharge separately documented as occurring after physical discharge from hospital.

## **Activities that Do Not Count for 30 minutes of CPO**

- Office staff time spent getting/filing charts, calling Home Health Agencies or patients/families
- Physician telephone calls to patient/family, even to adjust medication or treatment
- Physician time spent to call in prescriptions to pharmacy
- Physician time getting/filing chart, dialing phone, or on hold waiting
- Travel time
- Time spent preparing/processing claims
- Initial time spent reviewing results of tests ordered during face-to-face encounter
- Informal consultations with health professionals not involved in the patient's care
- Time spent on day of hospital discharge to manage the discharge plan

## **Common Reasons for Denial of CPO Payment**

- Dates of service don't match agency billing
  - Start of Care 6/20, CPO billing 6/1/08 – 6/30/08
  - CPO bill for 7/1/08 – 7/30/08 when patient discharged from homecare on 7/14/07
- Agency Medicare number not on HCFA1500; VNS agency number is 41-7023
- Location of service identified as 12 (home) when MD did not go to the home so should be 11 (office)
- Home Health Agency has not submitted their bill yet (should be rare if your office has received a 485)