

What is Care Plan Oversight?

Care Plan Oversight is a mechanism to allow your practice to bill for supervision or non-face-to-face services you provide for Medicare patients receiving home health care. The service can be performed by a physician, nurse practitioner, clinical nurse specialist or physician assistant in your practice.

In order to bill Medicare for these services you provide, there are some guidelines and documentation requirements. We have summarized many of these requirements. You can also visit your Medicare intermediary's website to find out more information on CPO and how much the reimbursement is for each service.

Requirements

- The physician cannot have a significant financial relationship with the HHA providing care for the patient (i.e. medical director, employee of HHA)
- Only 1 physician per month can bill CPO
- Physicians billing for ESRD under a capitation agreement nor a physician who is providing surgical follow-up may bill for CPO
- The physician who bills for CPO must be the same physician who signed the certification for the HHA
- The physician must have had a face-to-face service with the patient within 6 months of billing for the CPO
- The physician must have personally provided at least 30 minutes of service in 1 calendar month
- The beneficiary must be receiving Medicare covered home health services during the period in which CPO is billed
- The beneficiary must require complex or multidisciplinary care modalities requiring ongoing physician involvement in the patient's plan of care

Codes Used for CPO

G0180 – Used for certification of a home care patient's treatment plan.

G0179 – Used for recertification of a home care patient's treatment plan.

G0181 – Used for non face-to-face supervision of a home care patient requiring complex and multidisciplinary care. Time spent must equal or exceed 30 minutes per calendar month.

Contact Conficare®

To learn more about Care Plan Oversight, contact Conficare®. One of our professionals would be more than happy to provide an educational in-service to you and your staff. Let our trusted knowledge and resources work for you.

Call Conficare® at **772-225-5474** ♦ Medicare Certified ♦ HHA 299991911



Or, visit <http://www.conficare.com> for additional information and to complete a referral form to begin the assessment process.

Can bill for time spent for:

- Time reviewing reports, treatment plans and charts
- Team conferences
- Review of diagnostic studies if the review is not part of an E/M service
- Phone conversations with other health care professionals who are not employees of the practice and are involved in the patient's care
- Care coordination if physician or non-physician practitioner is required
- Discussion of drug treatment/ interactions (not routine prescription renewals) with a pharmacist
- Making changes to the treatment plan.

Cannot bill for time spent for:

- Discussions with fellow employees at the practice
- Travel
- Renewal of prescriptions
- Time spent working on discharge services
- Interpreting test results at a E/M visit
- Preparing or submitting claims
- Discussions with a patient's family, even if discussing treatment plan changes
- Informal consults with physicians who are not treating the patient
- CPO work performed by staff who are not physicians or non-physician practitioners.

Suggestions for Your Office:

- Establish a monthly routine
- Log all patients for whom CPO is provided to use at the end of the month during billing
- Keep a CPO log in each patients chart with documentation
- Use the census list from HHA to make sure they do not miss anyone





Initial Certification (485) Billing Code **GO180**

Recertification Billing Code **GO179**

Below is the information you will need in order to bill for the review and signature of home health plans of care.

HEALTH INSURANCE CLAIM FORM																								
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																	
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																			
7. INSURED'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)																			
CITY		STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE															
ZIP CODE		TELEPHONE (Include Area Code)			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																			
11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. EMPLOYER'S NAME OR SCHOOL NAME					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. INSURANCE PLAN NAME OR PROGRAM NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
SIGNED Signature on file DATE _____					SIGNED Signature on file DATE _____																			
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																			
19. RESERVED FOR LOCAL USE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
1. _____ 3. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
2. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER Enter ConfiCare Provider #: 10-8274																			
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE					24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																			
Enter Dates of Service including the SOC date.					Reimbursement will be dependent upon the HCPC code used in box 24D <ul style="list-style-type: none"> ▪ GO180 (Initial Certification) = Level 3 Established Patient Visit ▪ GO179 (Recertification) = Level 2 Established Patient Visit ▪ GO181 (Home Health Care Plan Oversight) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Area</th> <th style="text-align: left;">Locality #</th> <th style="text-align: left;">Cert</th> <th style="text-align: left;">Recert</th> <th style="text-align: left;">CPO</th> </tr> </thead> <tbody> <tr> <td>Florida</td> <td>99</td> <td>\$53.17</td> <td>\$40.50</td> <td>\$105.45</td> </tr> <tr> <td colspan="5"> <ul style="list-style-type: none"> ▪ Ft. Lauderdale and Miami excluded ▪ 2011 Rates </td> </tr> </tbody> </table>					Area	Locality #	Cert	Recert	CPO	Florida	99	\$53.17	\$40.50	\$105.45	<ul style="list-style-type: none"> ▪ Ft. Lauderdale and Miami excluded ▪ 2011 Rates 				
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Florida	99	\$53.17	\$40.50	\$105.45																				
<ul style="list-style-type: none"> ▪ Ft. Lauderdale and Miami excluded ▪ 2011 Rates 																								
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																			
SIGNED _____ DATE _____					28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$																			
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) Enter Name & Address where services were rendered.					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																			
PIN# _____					GRP# _____																			