

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 **863-644-5991**.

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"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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		SEX 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"/>																
CITY			STATE		7. INSURED'S ADDRESS (No., Street)																
ZIP CODE			TELEPHONE (Include Area Code)		CITY			STATE													
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					10. IS PATIENT'S CONDITION RELATED TO:																
11. INSURED'S POLICY GROUP OR FECA NUMBER					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.																
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					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																
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					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					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. RESERVED FOR LOCAL USE																
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER																
24. DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER DIAGNOSIS CODE \$ CHARGES DAYS OR UNITS EP/SOI Family Plan EMG COB RESERVED FOR LOCAL USE					Enter ConfiCare Provider #: 10-8437																
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 <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Area</th> <th>Locality #</th> <th>Cert</th> <th>Recert</th> </tr> </thead> <tbody> <tr> <td>Florida</td> <td>99</td> <td>\$56.65</td> <td>\$43.13</td> </tr> <tr> <td colspan="4"> Ft. Lauderdale and Miami excluded 2008 Rates </td> </tr> </tbody> </table>					Area	Locality #	Cert	Recert	Florida	99	\$56.65	\$43.13	Ft. Lauderdale and Miami excluded 2008 Rates			
Area	Locality #	Cert	Recert																		
Florida	99	\$56.65	\$43.13																		
Ft. Lauderdale and Miami excluded 2008 Rates																					
25. FEDERAL TAX I.D. NUMBER			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$												
30. BALANCE DUE \$			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.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)													
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					34. SIGNATURE OF PHYSICIAN OR SUPPLIER																
SIGNED					DATE																
PIN#					GRP#																