Did you know that MediCare now will pay you for merely certifying or re-certifying a patient for home care. The fact is that: physicians are entitled to bill MediCare part B for their supervision of home health agency including care plan oversight (CPO) by using appropriate CPT codes. This separate payment for CPO was first approved in 1995 by CMAS (previously known as HCFA). The following schedule for payments been raised and updated in 2002 for federal average and Los Angeles geographic areas.

CPT Codes	Types of Service	Average Pay	LA
G0180	Home Health Plan Certification	73.07	89.46
G0181	Home Care Supervision	122.04	146.95
G0179	Home Health Plan Re-certification	61.27	75.30

Los Angeles county rates are 5% for facilities and 8.9% for office visits higher than the average rates. According to above payment schedule, you can earn as much as $370.00 for a single 60-days episode period, which includes fee for certification, re-certification and supervision.

The following are additional guidance to help you for successful reimbursement from CMS:

A - **The most common reasons for CPO payments denial are:**

1- Claim failed to answer "place of service" which should be coded for "office" rather than "home"

2- Because the patient's diagnosis code did not match the diagnosis code on the form 485, (plan of care) submitted by the home health agency.

B- **Nine Criteria for Billing CPO Services**

1- CPO patients must receive home health services that are covered by MediCare and require complex or multi-disciplinary care modalities requiring ongoing physician involvement in their plan of care during the period for which CPO is billed.

2- The physician must devote 30 or more minutes of her/his time per month for supervision of the patient's therapy

3- The physician who bills CPO must be the same physician who signs the home health plan of care (form 485) and must personally furnish the services.

4- Only one physician per patient may bill for services furnished during a calendar month.

5- The physician must have furnished a service requiring a fact-to-face encounter with the patient at least once during the six month period before the month for which CPO payment is first billed.

6- The physician may not have a significant financial or contractual relationship with the home health agency.

7- The physician may not bill for CPO if she/he is billing MediCare ESRD (End Stage Renal Disease) capitation payment for the same month.

8- to bill separately for CPO services provided during a postoperative period, the physician must document in the patient's medical record that the CPO services are Unrelated to surgery.

9- Physician is responsible for obtaining the HHA (home health agency) MediCare provider number to include on claim for CPO services.

C- **Seven COP services Eligible for MediCare Reimbursement**

1- Review of charts, reports, treatment plans, or lab or other test results except for the initial interpretation or review of lab or test results that were ordered during or associate with a face-to-face encounter.
2- Telephone calls with other health care professionals (not employed in same practice) involved in the care of the patient.
3- Team conferences (must document time spent per individual patients).
4- Telephone or face-to-face discussions with a pharmacist about pharmaceutical therapies.
5- Medical decision makings.
6- Activities to coordinate services (if the coordination activities require the skills of a physician).
7- Documenting the services provided, which includes writing a note in the patient's chart describing services provided, decision-making performed and amount of the time spent performing the countable services.

D- **Eight CPO services Not Eligible for MediCare Reimbursement**

These services are covered by MediCare but are either bundled into other services, or included in the practice expenses and therefore can not be paid separately.

1- The time the nurse practitioner, physician, clinical nurse specialist, or other staff spends getting or filling charts, calling HHA, patients, etc.
2- Physician telephone calls to patient or family, even to adjust medication or treatment.
3- Physician time spent telephoning prescriptions into the pharmacist; not a physician.
4- Physician time getting and/or filling the chart, dialing the phone, or time on hold (these activates do not require physician work or meaningfully contribute to the treatment of the illness or injury).
5- Travel time
6- Time spend preparing claims and for claims processing.
7- Initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
8- Informal consultation with health professionals not involved in the patient's care.

E- **Nine Billing Tips**

The following tips is a guide line from CMS, for your billing department

1- Block 23 on the form 1500, "prior authorization number", enter HHA's provider number (agency provider number).
2- Block 24, column B "place of services", enter "11" for office, not "12" for home
3- Dates of service for G0181 should be the first and last dates for CPO services performed during a month.
4- Dates of service for G0180 and G0179 should be the first and last dates of the 60-day certification or re-certification period.
5- HHA must first file MediCare part A, claim for the home care service for patient.

6- Under CMS regulations, reimbursement rules allow providers 15 to 17 months to submit payment request, depending on the month in which the services was performed.
7- Physicians has to visit the patient at-least once every 6 months.
8- Enclosed is a formed confirmed by MediCare, which is designed to track and document the **30** minutes per month of oversight work which MediCare requires a physician to do, in order to qualify for CPO payment. Once form indicates that 30 minutes time requirement is met, the physician and billing staff simply need no longer count minutes for that patient, that month. Simply bill and start all over a new form for next month.
9- At the end of each month, the white top page of the time sheet form should be record in the patient's chart, who have been certified for home care services and will remain in the patient's record.
   The yellow page of the form will be used by biller, to prepare claim for all eligible home health services provided at that month.
   If you need more copy of this form please do not hesitate to call our office.