

## Care Plan Oversight

Care Plan Oversight (CPO) is a service that helps with the physician supervisions of patients in a hospice setting where the patient needs care from many different trained professional healthcare providers. Medicare does not reimburse CPO services for nursing facility patients, but hospices may be eligible. Check the links below for CPO resources.

Effective January 1, 2001 the new billing code for physician care plan oversight is HCPCS Code G0182 for hospice patients. All other codes that may be mentioned in the references below have expired.

Hospice Bulletin 95-3 Issued by Independence Blue Cross, Medicare Fiscal Intermediary Medicare Provider Bulletin January 13, 1995 Physician Payment for Medicare Care Plan Oversight.

Memo FKA 43 HHS/HCFA June 21, 1995 from: Director, Office of Physician and Ambulatory Care Policy, BPD To: All Regional Administrators, Division of Medicare Q/A Related to Care Plan Oversight – Information

### **Hospice Bulletin 95-3 IBC Government Services \* Fiscal Intermediary**

To: Chief Executive Officers of Providers for which IBC Government Services is Medicare Intermediary From: Robert A. McKeown Senior Vice President Provider Contracting & Medicare Operations Date: January 13, 1995 Subject: Physician Payment for Medicare Care Plan Oversight.

The Health Care Financing Administration (HCFA) recently announced changes in its payment policy for physician care plan oversight services furnished in 1995. This change was initiated to pay for extensive physician oversight of the care delivered by home health agencies and hospices to Medicare beneficiaries. These services are to be billed to the Medicare Part B Carrier by the physician.

In 1994, the CPT added two codes for care plan oversight services, 99375 and 99376. These codes were included in the 1994 Medicare fee schedule as codes that were bundled into the payment for visits and other procedures; separate payment for the care plan oversight codes was not allowed in 1994.

In general, Medicare continues to consider care plan oversight services to be included in the payment for other services. However, Medicare will allow separate payment for care plan oversight services furnished on or after January 1, 1995 under the following conditions:

1. The services are furnished by a physician to a beneficiary receiving Medicare-covered home health or hospice services;

2. The physician has furnished a service requiring a face-to-face encounter with the patient at least once in the 6 months prior to the first billing for the service; and
3. The physician does not have a significant financial relationship with the home health agency, is not the medical director or employee of the hospice and does not provide services under arrangement with the hospice.

If the above conditions are met, Medicare will:

1. Allow payment to one physician per patient per month for care plan oversight if it involves 30 or more minutes of the physician's time per calendar month.
2. Allow payment for 30 or more minutes of care plan oversight to a physician providing post-surgical care during the post-operative period only if the care plan oversight is documented to be unrelated to the surgery and billed with modifier 24.
3. Allow payment under CPT code 99375 only. CPT code 99376 will remain bundled since payment for care plan oversight services beyond 60 minutes per month is included in the payment for CPT code 99375.
4. Base Payment on 1.61 total relative value units (RVU) for payment in 1995 (1.06 work RVUs, 0.51 practice expense RVUs, and 0.04 malpractice expense RVUs).

Some physicians have raised the following questions concerning care plan oversight services.

**Q1. What physician activities are considered care plan oversight services for which separate payments is allowed?**

A1. Care plan oversight includes the following physician activities: development or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy. Care plan oversight does not include the routine pre-and-post-service work associated with visits and procedures. Also, telephone calls with patients and/or their families is not included.

**Q2. What documentation is required?**

A2. Physicians claiming payment for care plan oversight services must document in their records the care plan oversight services they furnish, including the dates and exact duration of time spent on the services for which payment is claimed. Care plan oversight is recognized by Medicare as a physician service and must be provided and documented only by the responsible physician.

**Q3. How will beneficiaries know that they may be responsible for additional coinsurance payments for care plan oversight services?**

A3. Since care plan oversight services do not typically involve a face-to-face encounter between

the patient and the physician, the patient may not be aware that the services were provided. Physicians can help by informing their patients that Medicare will pay for these services when the specified conditions are met. Beneficiaries will also be notified regarding allowed care plan oversight services in the Explanation of your Medicare Part B benefits messages. Questions from Home Health and Hospice Providers may be directed to (215)241-2500. Questions that physicians' offices may have should be directed to the appropriate Carrier.

## **Memo FKA 43 Department of Health & Human Services/HCFCA**

Date: June 21, 1995 From: Director, Office of Physician and Ambulatory Care Policy, BPD  
Subject: Questions and Answers Related to Care Plan Oversight Information To: All Regional Administrators ATTN: All Regional Administrators, Division of Medicare  
Over the course of the past few months we have received numerous inquiries from regions, carriers, and physicians regarding Medicare policy as related to physician care plan oversight (code 99375).

Below is a collection of some of the more frequently asked questions and our response to these questions. We believe that a question and answer document, sent to carriers, will assist in educating carrier personnel and physicians about the guidelines associated with care plan oversight. In addition to the questions below we have received calls regarding whether certain activities are countable toward the 30 minute requirement. The end of this document lists the activities about which we have received inquiries.

The responses to these questions are based on national policies governing when care plan oversight could be billed by a physician and when it would be appropriate for the carriers to pay separately for these services. The responses should not be construed as claims processing requirements. The Bureau of Program Operations has issued claims processing requirements for care plan oversight. Any addition to or modifications of those instructions would be implemented through the regular systems change cycle.

### **Questions and Answers for Care Plan Oversight**

**Question 1:** Can a physician other than the physician who signed the plan of care (i.e. attending physician) bill for care plan oversight?

The physician who bills for care plan oversight must be the same physician who signs the plan of care.

**Question 2:** Under what conditions can the medical director of a home health agency sign the plan of care for the Medicare beneficiary?

Physicians may sign the plan of care for a home health agency if: they do not have significant ownership in or a significant financial relationship with the home health agency.

Significant ownership is defined as: a) having direct or indirect ownership interest of 5 percent or more in the capital, stock, or the profits of the home health agency. b) having an ownership interest of 5 percent or more in any mortgagee, deed of trust, note, or other obligation that is secured by the agency, if that interest equals 5 percent or more of the agency's assets.

Significant financial or contractual relationship is defined as: a) receiving any compensation as an officer or director (i.e., board of directors) of the HHA. b) having direct or indirect business transactions with the HHA that, in any year, amount to more than \$25,000 or 5 percent of the agency's total operating expenses, agreements, purchase orders, or leases to obtain services, supplier, equipment, and space.

**Question 3:** Can a volunteer medical director of a hospice bill for care plan oversight?

No. According to Section 418.3 of the Code of Federal Regulations a volunteer within a hospice is considered an employee of the hospice. Payments to the hospice already include payment for services of the hospice physicians in establishing and overseeing the plans of care. Separate Part B payments are limited to physicians who are not affiliated with the hospice (see CFR 418.304). Thus, the volunteer medical director is considered an employee of the hospice and cannot bill separately for care plan oversight under the physician fee schedule.

**Question 4:** Can a carrier determine care plan oversight not medically necessary although the Regional Home Health Intermediary (RHHI) has approved payment for either home health or hospice care?

Although the RHHI has approved payment for either home health or hospice care, this does not automatically mean that payment for care plan oversight is warranted. As for all services paid for by Medicare, the care plan oversight services for which Medicare will pay must be medically necessary. Further, for those care plan oversight services for which we will recognize separate payment, the patient must require complex or multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, or review of related laboratory and/or other studies. Participation of a beneficiary in covered home health or hospice care does not alone qualify the beneficiary's physician for separate payment for care plan oversight.

**Question 5:** If a group of physicians are members of a group practice in which one of the members of the group practice has either significant ownership or financial interest in an HHA, can the other physicians in the group practice sign the plan of care and bill for care plan oversight?

YES. If the group itself has no ownership interest in the Home Health Agency, the other members of the group can sign the plan of care and be paid for care plan oversight services.

**Question 6:** Will we pay for care plan oversight for a hospice patient who resides in a SNF/NF?

Under normal circumstances, we do not pay for both SNF care and hospice care. However, if the hospice beneficiary is in the SNF receiving respite or general inpatient care under the hospice benefit, or is a dually entitled beneficiary, or is a private paying resident, Medicare will pay for care plan oversight related to the hospice services if all other conditions for payment are met. The attending physician can not be an employee of the hospice. Care plan oversight is included in the prospective rate of the hospice if the physician is an employee of the hospice. We will pay for care plan oversight services if the attending physician is not an employee of the hospice, the care plan oversight services are document to be related to the hospice plan of care and the duration of time spent by the attending physician overseeing the hospice plan of care during the month is 30 minutes or more.

**Question 7:** Can a home health agency's records serve as documentation of the physician's care plan oversight activities?

NO. We require that the physician who furnishes the services document which services were furnished and the date and length of time associated with those services.

**Question 8:** Can the attending physician's time spent discussing, with his/her nurse, conversations his/her nurse had with the home health agency count toward the 30 minute requirement?

NO. Such time spent with his/her nurse does not count toward the 30 minute threshold. However, the time spent by the physician working on the care plan, after the nurse has conveyed the pertinent information to the physician, is countable toward the 30 minutes.

**Question 9:** Can care plan oversight be reported and paid when furnished by nurse practitioners and physician assistants?

NO. Section 1851(m) of the Act provides coverage of home health services where those services are furnished under a plan of care established and periodically reviewed by a physician. Further, sections 1814(a) (2) © and 1835 (a) (2) (A) of the Act require physicians to certify the need for home health services. Thus, physicians are required by current law to perform certain functions (such as signing the plan of care) and, therefore, only physicians may be paid for care plan oversight.

**Question 10:** Can the time another physician spends working on the patient's care with the attending physician who actually signed the care plan be counted toward the 30 minute requirement?

NO. Only the time the attending physician spends on care plan oversight is countable. The time spent by other physicians is not countable toward the 30 minute requirement. Payment for care plan oversight is for the time spent by one physician (i.e., th4 physician providing the service).

**Question 11:** Why does HCFA require the physician billing for care plan oversight services to have seen the patient at least once in the 6 months prior to the first billing for care plan oversight?

We believe that the medical management of patients with complex health care needs should be linked with a face to face evaluation of the patient. We do not believe that it is unreasonable to specify that a physician be required to see a patient within the 6 months prior to the initial billing for care plan oversight.

**Question 12:** Do physicians need to see their patient every 6 months in order to bill for care plan oversight?

NO. HCFA does not require physicians to see beneficiaries at regular 6 month intervals after the initial encounter 6 months prior to the first billing of care plan oversight.

**Question 13:** Will HCFA permit payment for care plan oversight services during the same month that a physician bills for hospital discharge day management?

YES. We have decided to allow payment for care plan oversight services for patients receiving covered home health and hospice services during the month following hospital discharge if the other conditions for payment are met.

**Question 14:** What site of service should be indicated on the claim form for care plan oversight?

The physician should indicate the location where the majority of the services were furnished. Since care plan oversight is not necessarily a face-to-face service and the physician is likely to perform countable activities in the office setting, the site of service is likely to be the physician's office. However, if the majority of time spent on care plan oversight activities is at a site other than the physician's office that other site of service should be identified.

**Question 15:** Does the physician need to send in his/her documentation requirements when they submit billing to care plan oversight?

NO. The documentation requirements are to kept by the physician unless requested by the Medicare carrier.

**Question 16:** Can rural health clinic (RHC) physicians receive a separate payment for physician care plan oversight services?

NO. RHC physicians do not receive separate payments for services provided to RHC patients at the RHC or other medical facilities. Medicare pays the RHC for the RHC services provided to Medicare patients. RHC services include physicians' services. The RHC is paid only on per visit

basis for the face-to-face encounters the physician may have with the Medicare patient. If the RHC incurs any additional costs as a result of the physician providing this service, (in addition to the compensation paid by the RHC to the physician), the RHC may include the cost in its cost report to determine the RHC's all inclusive payment rate.

**Question 17:** Will Medicare pay for overseeing the care of a patient who is not receiving Medicare covered home health or hospice benefits?

NO. Medicare will pay separately for care plan oversight services only for patients who receive Medicare covered home health or hospice benefits.

**Question 18:** If Medicare will not pay for overseeing the care of a patient who does not receive Medicare covered home health or hospice benefits, can the physician charge the beneficiary for those services?

NO. This service is covered and payment is bundled into the payment for other visits and procedures.

### **CARE PLAN OVERSIGHT (COUNTABLE SERVICES)**

The following activities are countable toward the 30-minute requirement for care plan oversight.

Countable (physicians' time dedicated toward an individual patient):

- review of charts, reports, treatment plans, or lab or study results except for the initial interpretation or review of lab or study results that were ordered during or associated with a face to face encounter.
- telephone calls with other health care professionals (not employed in the same practice) involved in the care of the patient.
- team conferences (must document time spent per individual patient).
- telephone or face to face discussions with a pharmacist about pharmaceutical therapies.
- medical decision making
- activities to coordinate services (if the coordination activities require the skills of a physician).
- documenting the service provided which includes writing a note in the patient chart describing services provided, decision-making performed, and amount of time spent performing the countable services.

### **CARE PLAN OVERSIGHT (NOT-COUNTABLE SERVICES)**

The following activities are not countable toward the 30 minute requirement for care plan oversight.

Not Countable (covered; bundled into other services and separately countable; some activities included in practice expense).

- time the nurse, NP, PA, CNS, or other staff spends getting or filing charts, calling HHAs, patients, etc.
- physician telephone call to patient or family, even to adjust medication or treatment.
- physician time spent telephoning prescriptions into the pharmacist; not a physician service, does not require a physician to perform.
- physician time getting and/or filing the chart, dialing the phone, or time on hold (these activities do not require physician work or meaningfully contribute to the treatment of the illness or injury).
- travel time
- time spent preparing claims and for claims processing
- initial interpretation or review of lab or study results that were ordered during or associated with a face-to-face encounter.
- low intensity services included as part of other E & M services.
- informal consults with health professionals not involved in the patient's care.