Physicians, Practice Managers and Billing Managers — Are You Losing Medicare Reimbursement?

It is estimated that millions of dollars of allowable Medicare fees are left uncollected each year because physician offices are not billing for the time it takes for the doctor to oversee care plans for home health patients.

Did you know that?:

Effective 1-1-01, specific HCPCS codes were developed to facilitate physician billing for the following items related to home care:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Potential Physician Reimbursement effective 1/1/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0180</td>
<td>Certification of a Home Health / Hospice Patient</td>
<td>$50.20</td>
</tr>
<tr>
<td>G0179</td>
<td>Recertification of a Home Health / Hospice Patient</td>
<td>$37.42</td>
</tr>
<tr>
<td>G0181</td>
<td>Home Health Care Plan Oversight</td>
<td>$99.33</td>
</tr>
<tr>
<td>G0182</td>
<td>Hospice Care Plan Oversight</td>
<td>$101.00</td>
</tr>
</tbody>
</table>

**G0180 - CERTIFICATION BILLING REQUIREMENTS**
- Must be billed by the physician that signs the Plan of Care (485)
- Used when a patient has not received any home health services for at least 60 days
- **Copy of admission 485 in the patient’s chart is sufficient documentation to support physician billing**
  - Some intermediaries are requesting that the physician’s office supply a copy of this form with billing
- Date of service: Date physician signs the 485
- Billed on HCFA 1500
- Locator 23: Home Health Agency’s 6-digit Medicare provider number

**G0179 - RECERTIFICATION BILLING REQUIREMENTS**
- Must be billed by the physician that recertifies the patient
- Used after a patient has received home health services for at least 60 days
- **Copy of recertification 485 in the patient’s chart is sufficient documentation to support physician billing**
  - Some intermediaries are requesting that the physician’s office supply a copy of this form with billing
- Date of service: Date physician signs the 485
- Billed on HCFA 1500
- Locator 23: Home Health Agency’s 6-digit Medicare provider number

-- Continued on reverse --
CARE PLAN OVERSIGHT

- G0181 - Reflects oversight of patients in home health plan of care
- G0182 - Reflects oversight of patients in hospice plan of care

**REQUIREMENTS OF CARE PLAN OVERSIGHT INCLUDE**

- The beneficiary must be receiving Medicare covered home health services during the period in which care plan oversight services are furnished
- The physician must have provided a covered physician service that required FACE TO FACE encounter with the beneficiary in the 6 months *prior to the first billing* for care plan oversight services
- The beneficiary must require complex or multi-disciplinary care
  - The physician must furnish **at least 30 minutes of supervision within the calendar month** for which payment is claimed and no other physician has been paid for CPO within that calendar month
- The care plan oversight services must be personally provided by the physician who bills for the services
  - Which services count towards the 30 minutes?
  - The following services are countable towards the 30 minute minimum for care plan oversight:
    - Medical decision-making
    - Integration of new information into the treatment plan
    - Adjustment of medical therapy
    - Activities to coordinate services count if the coordination activities require the skill of the physician
    - Physician development or revision of care plans
    - Time spent working on a care plan after the nurse has conveyed pertinent information to the physician
    - Telephone calls with other health care professionals involved in the care of the patient
    - Review of subsequent reports of patient status
    - Team conferences (time spent per individual patient must be documented)

If you are interested in further information related to Care Plan Oversight, please contact Valerie Perout at Visiting Nurse Service and Affiliates at 330-861-6102 or 800-362-0031, Ext. 6102.

**Reminder:** Please ensure that the physician signs the CMS 485. Timely signatures ensure appropriate care to the patient. *Please note* that the form must be **personally signed** by the treating physician to attest the accuracy of the information. Signature stamps and date stamps are not permissible.