Care Plan Oversight (CPO) Services

Policy Number: PG0229
Last Review: 05/09/2017

PARAMOUNT

ADVANTAGE | ELITE | HMO
INDIVIDUAL MARKETPLACE |
PROMEDICA MEDICARE
PLAN | PPO

GUIDELINES

This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE

X Professional
_ Facility

DESCRIPTION

Care Plan Oversight (CPO) is physician supervision of patients under either the home health or hospice benefit where the patient requires complex or multi-disciplinary care requiring ongoing physician involvement. Care Plan Oversight services are reported separately from codes for office/outpatient, hospital, or home services. Code selection for Care Plan Oversight Services is determined by the complexity and approximate time spent by the physician or other health care professional within a 30-day period. Care plan oversight services is not for nursing facility or skilled nursing facility patients.

POLICY

Care Plan Oversight Services (G0179, G0180, G0181, G0182) do not require prior authorization for Elite/ProMedica Medicare Plan.

Care Plan Oversight Services (G0179, G0180, G0181, G0182) are non-covered for HMO, PPO, Individual Marketplace, & Advantage.

COVERAGE CRITERIA

Elite/ProMedica Medicare Plan

Applicable Codes

HCPCS Code	Short Description	Notes
G0179	MD re-certification HHA PT	May be submitted per certification period
G0180	MD certification HHA patient	May be submitted per certification period
G0181	Home health care supervision	Requires 30 minutes or more of physician or NPP's time within a calendar month
G0182	Hospice care supervision	Requires 30 minutes or more of physician or NPP's time within a calendar month

Note: the types of services that are included in CPO are included in the narrative descriptions for each HCPCS code.

Criteria for Coverage

- The beneficiary requires complex or multi-disciplinary care modalities requiring the physician's ongoing involvement in the beneficiary's plan of care.
- CPO services are furnished during the period in which the beneficiary was receiving covered home health agency (HHA) or hospice services.
- The physician who submits the claim for CPO must be the same physician that signed the home health or hospice plan of care.
- The physician furnished at least 30 minutes of CPO within the calendar month. Time counted toward CPO may not include time spent by a nurse or time spent consulting with a nurse.
- Time counted toward hospital discharge management (CPT codes 99238-99239) or discharge from observation (CPT code 99217) may not also be counted toward CPO. Services that are separately documented and that are provided after the patient is physically discharged may be counted toward CPO.
- The physician provided a covered service that required a face-to-face encounter (i.e., Evaluation & Management (E/M) service) with the beneficiary within the 6 months immediately preceding the CPO service. EKG, lab, and surgical services do not meet this face-to-face encounter requirement.
- The CPO service may not be routine post-operative care provided during the global surgery period by the surgeon.
- For home health CPO, the physician may not have a "significant financial or contractual interest in the home health agency." For hospice CPO, the physician may not be employed by or volunteer as medical director of the hospice.
- CPO services must be submitted by the same physician that provided the services.
- Services provided "incident to" a physician's service may not be counted toward the 30-minute requirement for CPO.
- The same physician may not submit a claim for both CPO and end stage renal disease (ESRD) capitation payment for the same beneficiary during the same month.
- The physician must document, in the patient's medical record, the services furnished to the patient and date and length of time associated with these services.

CPO: Home Health

Paramount pays separately for the services involved in physician certification/re-certification and development of a plan of care for covered home health services when certain criteria are met.

- Submit HCPCS code G0180 when the patient has not received covered home health services for at least 60 days. The initial certification (HCPCS code G0180) cannot be submitted for the same date of service as the supervision service HCPCS code (G0181).
- Submit HCPCS code G0179 for re-certification after a patient has received services for at least 60 days (or one certification period).
    - HCPCS code G0179 may be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.
- Special notes regarding certification and re-certification of home health care:
    - Physicians play a key role in determining and documenting the medical necessity for home health care for beneficiaries. As a physician, you are responsible for providing appropriate, accurate supporting documentation of your face-to-face encounters (FTF) with your patients regarding home health care.
    - For more information about required documentation for home health certification and re-certification, please refer to the CGS web article "Face to Face Documentation for Home Health Certification: Important Information for Certifying Physicians and Non-physician Practitioners (NPPs)."

CPO: Hospice

Submit HCPCS code G0182 for CPO services provided to patients that have elected hospice benefits and who are in an approved hospice.

Claim submission:

- The patient does not have to be present in order for CPO services to be provided and claims submitted.
- The HHA or Hospice Provider Number is required on claims for CPO (HCPCS codes G0181 and G0182).
- Dates of service:
    - For HCPCS codes G0181 and G0182, submit the first and last date during which documented care planning services were actually provided during the calendar month.
    - Do not submit the first and last calendar date of the month unless services were provided on those dates
    - Submit the claim after the end of the month in which the service is performed
    - Report care planning only once per calendar month
    - Report only one month of services per line item
    - For HCPCS codes G0179 and G0180, submit the date physician signed the certification or re-certification.
- Place of service: submit the place of service code that corresponds to where the CPO services were provided.
- Submit CPT codes 99201-99263 and 99281-99357 only when there has been a face-to-face meeting/encounter.

Documentation:

- Claims for care plan oversight services will be denied when review of the beneficiary's claims history shows that there was no covered physician service requiring a face-to-face encounter by the same physician during the six months preceding the provision of the first care plan oversight service.
- Medical records for these services must indicate:
    - For HCPCS codes G0181 and G0182, the physician spent 30 minutes or more for countable care planning activities
    - The specific service furnished, including the date and length of time

HMO, PPO, Individual Marketplace, Advantage

Care Plan Oversight Services (G0179, G0180, G0181, G0182) are non-covered for these product lines.

CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

HCPCS CODES	
G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period
G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) 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, within a calendar month, 30 minutes or more
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other

	studies, communication (including telephone calls) 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, within a calendar month, 30 minutes or more

REVISION HISTORY EXPLANATION
ORIGINAL EFFECTIVE DATE: 03/15/2009
05/09/17: Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
12/16/2020: Medical policy placed on the new Paramount Medical Policy Format

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid
American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.