

# CMS requirements for Physician Oversight Billing for Medicare Home Health:

## I. Initial certification of Medicare Home Health

- Applies to new orders for Medicare “skilled” home health care (no DME only)
- Submitted under Medicare part B, which requires physician to bill co-pay to patient
- Bill once per patient per 60-day episode of care

## II. Re-certification of Medicare Home Health

- Applies to new orders for Medicare “skilled” home health care (no DME only)
- Submitted under Medicare part B, which requires physician to bill co-pay to patient
- Not for “change orders”

## III. Care Plan Oversight (CPO)

- REQUIREMENTS:**
- Patient must be receiving Medicare reimbursed home health “skilled” services
  - Physician has spent 30 minutes or more time in supervision of care within a given month
  - Physician has seen patient within 6 months before first oversight billing
  - Physician who bills CPO is same physician who signed home health “plan of care” and personally furnished the services
  - Only one physician per month may bill for CPO
  - Post-Op Care not related to surgery when patient is post-surgical
  - No financial or contractual relationships with home care agency caring for patient

- BILLING/REIMBURSEMENT:**
- Documentation of time spent on oversight must be maintained by physician and will be reviewed randomly and periodically by Medicare
  - JHHCG offers a sample tracking log for charting time spent\*
  - HCPC code G0181 and “place of service” is your **office**, not the home
  - Submitted under Medicare part B, which requires physician to bill co-pay to patient
- \*According to Medicare regulations, home care agencies may *not* maintain oversight documentation for the physician.

- APPLICABLE ACTIVITIES:**
- Review of charts, reports, treatment plans, or lab/other test results
  - Medical decision-making
  - Documenting the services provided; e.g., charting in patient record
  - Telephone calls to other health care professionals (not employed by same practice) does include home health services
  - Team conferences (only time spent discussing relevant patient counts)
  - Telephone or other contact with pharmacist regarding patient’s therapies

- NOT APPLICABLE ACTIVITIES:**
- Staff time (Time by others in MD practice)
  - Telephone call to patient, family, pharmacy
  - Travel time
  - Preparation or processing of claims
  - Retrieving / filing chart, dialing the phone, time on hold
  - Informal consultations with clinicians not involved in patient’s care
  - Patient visit to MD office.

## Definitions of Care Plan Oversight codes according to the 2015 HCPC guidebook:

### 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

### 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

### 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

Certification  
(HCPC code G0180)  
\$56.96-Baltimore

Care plan oversight  
(HCPC code G0181)  
\$114.17-Baltimore

Re-certification  
(HCPC code G0179)  
\$44.14-Baltimore

## WHAT ARE MEDICARE CRITERIA FOR ADMISSION TO HOME HEALTH CARE SERVICES?

- Skilled need
  - Assessment, teaching, and treatments to meet goals of patient self-care related to new diagnoses or changes in the medical plan of treatment
- Home bound (required only by Medicare)
  - Unable to leave home without significant assistance for purposes other than medical care
- Intermittent needs
  - Has caregiver or self-care ability; generally visits are about one hour and provided 1-3 times weekly for an acute, not chronic, care need

## HOW DO I MAKE A HOME CARE REFERRAL TO JHHCG?

- If you are based in one of the JH institutions, call (410) 288-8100 - JHHCG Central Intake. They will arrange to have a hospital-based home care coordinator contact you to assist in development of the patient's plan of care.
- If you are not hospital-based, Central Intake nursing staff will assist you directly. You will be asked for patient demographics including address, phone, insurance, primary diagnosis, orders for care, specific supplies or equipment, and the name, address, and phone number of physician who will be following the patient and responsible for ongoing care.

IF YOU HAVE ANY QUESTIONS REGARDING CPO, PLEASE CALL (410) 288-8003.  
THANK YOU FOR USING JOHNS HOPKINS HOME CARE GROUP

- Home Health Services   ▪ Pediatrics at Home
- Pharmaquip Infusion, Home Medical Equipment and Outpatient Pharmacy
- Gilchrist Hospice Affiliation