Condition for Payment as of January 1, 2011:

The Affordable Care Act mandates that prior to certifying a patient’s eligibility for the home health benefit, the certifying physician **MUST** document that he or she, or an allowed non-physician practitioners (NP, PA) has a **FACE-TO-FACE** encounter with the patient.

**When must the face-to-face occur?**

**Within the 90 days prior to the start of the home health care**.... **OR**

**Within the 30 days after the start of care**
NOTE:

If a physician orders home health care for a patient based on a **NEW CONDITION** that was not evident during a visit within the 90 days prior to start of care, the certifying physician, NP or PA must see the patient within 30 days after admission.

Exceptions to the rule:

** Medicare will also allow a physician who attended to the patient in an acute or post-acute setting (ex: hospital) to certify the need for home health care based on their contact with the patient, initiate the orders for home health services, and “hand off” the patient to another physician to review and sign off on the plan of care.

Example face-to-face statement:

"The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new COPD medical regimen."
NEWS FLASH!!

In the past, if your physician did not sign the 485 Certification or Re-Certification you could not bill for the Care Plan Oversight.

NOW, you can bill for the Care Plan Oversight regardless if your physician signed the 485 Certification or Re-Certification.

Codes to Bill:
- G0179 – Re-Certification of Home Health Services
- G0180 – Certification of Home Health Services
- G0181 – Care Plan Oversight

Reimbursement

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How many bill for 485 Certs?

How many bill for 485 Re-Certs?

How many bill for Care Plan Oversight?
Keeping Track of Home Health Papers

- You will need a 2" notebook and Colored Tabs
- Make a colored tab for each Home Health Agency
- Delegate an employee to keep track of home health papers
- When the physician is finished signing Home Health Papers, the originals go to this employee. Also, all faxes related to Home Health are given to this employee to log.
- After the papers are logged into the notebook, the papers are put for The Home Health Agencies to pick up.
- The employee will bill the home health charges
Frequently Asked Questions:

• Why keep a log?
• Is it worth the time to bill for the Care Plan Oversight?
• What if I get audited?
• How much time does it take a day to keep the log?

12 Criteria for CPO Billing

1. Patients must receive home health services that are covered by Medicare and requires physician involvement.
2. Physician must devote and document 30 minutes or more of his/her time to supervision of patient’s care plan and include documentation in the patient record.
3. The physician who bills CPO must be the same as the physician who signs the treatment plan and personally provides the service. (Changed as of 2011)
4. A nurse practitioner, nurse clinical specialist or a physician assistant may bill for CPO if they have been providing patient evaluation and management as a “physician service” while acting within the scope of state laws.
5. Only one physician per month can bill.
6. The physician must have furnished a service requiring a face-to-face encounter with the patient in the 6 month period before CPO is billed.
7. The physician cannot have a significant financial contract with the agency (5% ownership or salary amounting to more than $25,000 or 5% of agency total operating expenses).
8. Cannot bill for CPO if billing for Medicare ESRD (End Stage Renal Disease) capitation payment in the same month.
9. Any work included in hospital stay discharge management or discharge from hospital observation is not countable towards CPO.
10. To bill separately for CPO in the post-operative period, the physician must document that CPO services are unrelated to the surgery. (Same for Hospice patient)
11. HHA Medicare # must be on claim.
12. Billing must be for 30 minutes within calendar month.
Activities that Do Count towards 30 minutes monthly of CPO

- Review of charts, reports, treatment plans, lab and other test results that were not ordered during the face-to-face encounter qualifying patient for CPO
- Telephone calls to other health care professionals involved in care of patient (not in office)
- Team conferences
- Telephone call/discussions with pharmacist about medication therapies
- Medical decision making
- Activities to coordinate services requiring the skills of a physician
- Documenting the services provided (includes time to write a note about service provided, decision making performed, amount of time spent on countable services)
- Time spent on activities undertaken on day of hospital discharge separately documented as occurring after physical discharge from hospital.

Activities that Do Not Count for 30 minutes of CPO

- Office staff time spent getting/filing charts, calling Home Health Agencies or patients/families
- Physician telephone calls to patient/family, even to adjust medication or treatment
- Physician time spent to call in prescriptions to pharmacy
- Physician time getting/filing chart, dialing phone, or on hold waiting
- Travel time
- Time spent preparing/processing claims
- Initial time spent reviewing results of tests ordered during face-to-face encounter
- Informal consultations with health professionals not involved in the patient’s care
- Time spent on day of hospital discharge to manage the discharge plan

Common Reasons for Denial of CPO Payment

- Patient was deceased before the end of the month that is being billed.
- Agency Medicare number not on HCFA1500: VNS agency number is 41-7023
- Home Health Agency has not submitted their bill yet (should be rare if your office has received a 485)
Questions ??

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254-629-2747 – office

Specializing in: Medical Billing, Medical Consulting,
Meaningful Use, Organizing the Flow in an Office,
Family Practice Coding, PQRS (formerly called “PQRI”)