



Physician Care Plan Oversight for hospice

Since 1995, the Centers for Medicare and Medicaid Services has allowed separate payment for physician care plan oversight services rendered to hospice patients. Physicians, not the hospice, must bill for physician care plan oversight services, and after Jan. 1, 2001, they are billed under code G0182 (hospice).

Services that may be included as physician care plan oversight:

- Ongoing review of reports, orders, treatment plans, changes in patient status, lab/study results (except for the initial review associated with previous face-to-face encounter)
- Telephone calls with other healthcare professionals involved in the patient's care
- Development and/or revision of healthcare plan
- Team conferences (time spent per individual patient must be documented.)
- Medical decision-making:
- Integration of new information into the medical treatment plan
- Adjustment of medical therapy
- Coordination of services that require the skills of a physician
- Time spent on revision of care plan after pertinent information has been conveyed

Services that may not be included as physician care plan oversight:

- PCPO services rendered to non-medical patients
- Post-surgical services within one month of surgery
- Initial interpretation of lab/study results ordered during a face-to-face encounter
- Services provided incident to office visits
- Telephone calls to patient, family or pharmacy, even to adjust medication or treatment
- Travel time, time spent preparing claims, time spent on claims processing
- Low-intensity services included as part of other evaluation and management services

- Informal consults with health professionals not involved with the patient's care
- Time spent discussing the patient with office staff

To qualify for physician care plan oversight payment, the patient must:

- Be receiving Medicare-covered hospice services;
- Have been seen face-to-face by the physician within the six months prior to billing for the care plan oversight service;
- Require complex or multidisciplinary care modalities involving frequent physician development or revision that necessitate a high level of decision-making and go beyond administrative functions; and
- Have complex medical conditions requiring intensive treatments, frequent determinations of responses to therapies and reassessments of the plan of care.

To receive physician care plan oversight payments, the physician must:

- Spend at least 30 minutes rendering care plan oversight services to each patient in a calendar month period;
- Not have a significant ownership interest or significant financial or contractual relationship with the hospice;
- Not be the medical director of the hospice or contract with the hospice to provide medical services; and
- Not be a physician providing services to rural healthcare clinic patients.

Documentation

Medicare requires that physicians who furnish care plan oversight services document those services that were furnished, the date

and the length of time associated with those services. No pre-
 assumptions are allowed to support a claim that sufficient time has
 been spent within a calendar month to satisfy the conditions for
 payment. The Medicare program may conduct post-payment
 reviews of claims for reimbursement of this service.

Where documentation is inadequate to support a claim that
 services in excess of 30 minutes have been provided in a calendar
 month, reimbursements may be denied.

The physician must be able to demonstrate, through documenta-
 tion in the patient's record, that at least 30 minutes were spent on
 oversight of the home care plan of care during the calendar month.
 The documentation must include the dates and amount of time
 associated with each encounter.

The responsibility for documentation of care plan oversight
 activities lies with the physician. **Although hospice care provid-
 ers may provide educational information to inform physicians
 of this benefit, those who engage in activities such as the
 development of detailed monthly reports for physicians run
 the risk of being viewed as engaging in cost report or referral
 kickback violations.**

Billing for PCPO

Physicians should bill these services on the CMS form 1500.
 Nothing except CPO services are to be billed on the claim.

- CPO services are to be billed only once per calendar month with
 one month's services per line item.
- Claim must not be submitted until after the end of the month in

which services are performed.

- Dates of service entered on the claim form must be the first and
 the last date during which documented CPO services were
 actually provided during the calendar month, not just the first and
 last days of the calendar month in which the claim is submitted.
- Medical records for those dates must have documented that 30
 minutes or more of time have been spent by physicians perform-
 ing included activities; the services that were furnished; and the
 date and length of time associated with the services.
- The appropriate HCPCS Code must be used: G0182 (hospice
 patient).
- All claims for CPO must contain the six-digit Medicare provider
 number of the hospice rendering covered Medicare services
 during the period in which the care planning was furnished.
- As with other Part B services, the patient is liable for a 20
 percent co-payment when he or she is billed.
- Claims must be completed and submitted by the physician's
 office staff and not the hospice agency.

Form 1500

Common mistakes on the form 1500 that result in denials:

- Item 23: Prior authorization number (The hospice six-digit
 Medicare provider number)
- Item 32: Facility where services were furnished
- The physician's office (When the name and address of the facility
 where the services were furnished is the same as the biller's
 name and address shown in item 33, enter the word "SAME.")

Hospice Physician Care Plan Oversight Guide for Billing – Form 1500

"Date(s) of Service": Actual dates of physician's service in a calendar month

"Place of Service": Office 11

"Type of Service": 01

"CPT Code": G0182

Hospice Agency Provider Number:

"Modifier": "GV" (attending physician)

"Q5" (covering physician; used in conjunction with "GV")

"Q6" (locum tenens physician; used in conjunction with "GV")

"GW" (service not related to terminal condition)

See Payment Rate Guide

"Charge": G0182 (Care Plan Oversight — Hospice)

"Diagnosis": Found on CMS-1450 Data Set

Physician's Office