

## Physician Payment for Home Care Services for Medicare Home Health and Hospice Patients

- **Care Plan Oversight of Home Health and Hospice Patients**
- **Certification/Recertification of Home Health Plans of Care**

Physicians that oversee the complex care needs of Medicare home health and hospice patients can be reimbursed for these services. In addition, physicians can also bill for the services associated with certifying (and recertifying) home health services. The definitions of the proper codes for billing, conditions that must be met for payment, and the documentation requirements for these services are detailed below.

### PHYSICIAN CARE PLAN OVERSIGHT (CPO) FOR HOME HEALTH AND HOSPICE

HCPCS Code	Definition
<b>G0181</b> - Physician supervision of a patient receiving Medicare covered services provided by a participating HHA	(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 related laboratory and other studies, communication (including telephone calls) with other health care professionals involved in 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.
<b>G0182</b> - Physician supervision of a patient under Medicare-approved Hospice	

**To receive payment, the physician:**

- must provide service to Medicare beneficiaries receiving covered home health/hospice services;
- must have had a face-to-face encounter with the patient in the six months prior to the first billing for care plan oversight services;
- may not have a relationship with the home health agency that is prohibited by the Stark II (Physician Self-Referral) regulation. [Note: A home health medical director can bill for CPO]; and
- may not be the medical director or employee of the hospice, nor provide services under arrangement with the hospice.

**In addition:**

- Payment will be made to only one physician per calendar month per patient receiving CPO services.
- Surgeons may bill for post-surgical care plan oversight if documentation shows the care is unrelated to the surgery.
- Payment will be allowed during the 30 days following a hospital discharge, provided all other conditions for payment are met.

**Documentation:**

- Medicare requires the physician to document the CPO services that were furnished, the date, and the length of time associated with those services.
- Documentation may be requested by Medicare as part of post-payment review activities.
- A home health agency may not maintain this documentation for the physician.

**Beneficiary Co-payment:**

- As with all other physician services under Medicare Part B, the beneficiary is responsible for a 20% co-payment.
- Many beneficiaries have supplemental insurance or Medicaid that will cover the additional coinsurance amount.

## CERTIFICATION/RECERTIFICATION SERVICES FOR HOME HEALTH AND HOSPICE

### HCPCS Code and Definitions

**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 Recertification 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.

This code would be used after a patient has received services for at least 60 days (or one certification period) when the physician signs the certification after the initial certification period). \*

**\*Note:** According to CMS, HCPCS code G0179 (recertification) is also reported in the exceptional circumstance when, before a 60-day episode has elapsed, a patient requires a new plan of care. (If a patient is discharged, then subsequently resumes home care prior to the end of the original 60-day episode, the physician certifying the plan of care would report G0179 even though there is a new start of care.)

### Conditions for Payment:

As with CPO services, a physician who has an ownership interest in, or a significant financial or contractual relationship with a home health agency, generally cannot bill these codes for a patient served by that HHA.

Surgeons who refer patients for Medicare-covered home health care and who are certifying (or recertifying) the plan of care will be able to report codes G0179 and G0180 regardless of whether the plan of care is related to surgery.

### Documentation:

Medicare requires that physicians document those services that were furnished. The final rule authorizing physician payment for certification and recertification did not enumerate specific documentation requirements. However, physicians should at least retain a copy of the signed HCFA-485 (home health plan of care), signed interim or telephone orders, or any reports of patient status used to determine the need for certification/recertification of the patient (as noted in the HCPCS definition).

### Some Notes About Billing

- Physicians bill for CPO or certification/recertification using Form HCFA-1500.
- The claim for these services must contain the home health agencies 6-digit Medicare provider number in Locator 23 of the form or the claim will be rejected.
- The date(s) of service should be the date(s) the physician provided the service.
- Locator 32: Facility where services were furnished is the physician's office.

Medicare does not allow nurse practitioners and physician assistants to sign home health plans of care; therefore, they may not bill for Certification/Recertification Services.