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Getting to the truth in internal investigations

an interview with Michael Johnson
CEO, Clear Law Institute

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Care plan oversight—More than meets the eye

» Care plan oversight (CPO) is the non–face-to-face supervision of a patient under the care of a home health agency (HHA) or hospice.

» CPO is a time-based service, requiring a minimum of 30 minutes per month.

» The two Medicare codes used to bill these services are G0181 in HHA and G0182 in hospice; these services can only be billed once per month.

» To avoid False Claims Act liability, practices must ensure that all requirements are met prior to billing.

» Monitoring and auditing processes should be implemented to ensure continued compliance.

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Care plan oversight (CPO) is not a new concept. For many years, providers and non-physician providers have furnished these non–face-to-face services to patients, often outside of traditional work hours. However, some providers have refrained from billing these services because the complexity of regulatory and documentation requirements were onerous and burdensome. The rules are specific: which provider can bill, which beneficiaries are eligible, which components make up CPO, and the minimum time requirement.

Is billing for CPO worth the effort? Per the Medicare Physician Fee Schedule, the 2016 national payment pricing for CPO is $108.34 for a home health patient and $108.85 for a hospice patient. Providers who are already performing this service may find that the revenue potential is valuable enough to warrant taking the time to understand and comply with the requirements. Risk management and compliance professionals have interceded to sort through the myriad requirements and put them in a palatable and digestible format. False claims and billing error risks are mitigated through education to providers and billing staff, and through appropriate monitoring.

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What is a CPO?

Care plan oversight is the physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare-covered services provided by a participating home health agency (HHA) or Medicare approved hospice.[1]

There are five types of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System Level (HCPCS) II codes as listed in Table 1 (on page 64). However, only the first two are reimbursed by Medicare.

G0181 – "[P]hysician supervision of a patient receiving Medicare-covered services provided by a

Table 1: CPT and HCPCS Billing codes

CPT/HCPCS	Description of Procedure
G0181	**Supervision of a patient under the care of an HHA in a home or equivalent area**
G0182	**Supervision of a hospice patient**
99380	Supervision of a nursing facility patient
99340	Supervision of a patient in a home or equivalent area not under the care of an HHA
94005	Home ventilator management supervision

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 patient care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more."[2]

G0182 – "[P]hysician supervision of a patient receiving 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 patient care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more."[3]

The CPO services require recurrent physician supervision of a patient involving 30 or more minutes of the physician's time per month. The services must include complex or multidisciplinary care modalities which may include:

- Regular physician development and/or revision of care plans,
- Review of subsequent reports of patient status,
- Review of related laboratory and other studies,
- Communication with other health professionals not employed in the same practice who are involved in the patient's care,
- Integration of new information into the medical treatment plan, and/or
- Adjustment of medical therapy.[4]

Now that we know what counts toward the 30-minute threshold as part of CPO, let's turn our attention to what is not included. Medicare has outlined specific examples of services that do not count toward the 30-minute threshold that must be provided in order to bill for CPO. They include but are not limited to:

- Time associated with discussion with the patient, his/her family or friends to adjust medication or treatment;
- Time spent by staff getting or filing the chart;
- Travel time; and/or
- Physician's time spent telephoning prescriptions into the pharmacist, unless the telephone conversation involves discussion of pharmaceutical therapies.[5]

Requirements

Four main categories of requirements must be met to satisfy the Medicare rules for CPOs.

1. Provider requirements

CPO services must be personally furnished by a physician or non-physician practitioner. CMS recently clarified that a non-physician practitioner may bill for CPO services.[6] Thus, nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of state law, may bill CPO codes. These non-physician practitioners must have been providing ongoing care for the beneficiary through evaluation and management (E/M) services. These non-physician practitioners may not bill for CPO if they have been involved only with delivery of the Medicare-covered home health or hospice service.[7] In addition, these non-physician practitioners must have a collaborative agreement with the physician who signed the initial hospice or home health agency plan of care.

2. Patient eligibility requirements

Patients qualify for CPO services if they require complex treatment, are under the care of a multidisciplinary team, and under the care of a Medicare-approved home health agency or hospice. The patient must have complex conditions that require intensive treatments, frequent determinations of responses to therapies, and periodic reassessment of the plan of care. This patient must have had an E/M service within the last 6 months immediately preceding the first CPO service. The CPO claim may be denied if this E/M was provided under a Medicare Advantage plan or prior Medicare coverage, necessitating the provision of additional documentation to support the claim. Services such as diagnostic testing, surgical procedures, etc. do not meet this requirement. The care plan oversight should not be post-operative care provided in the global period of a surgical procedure.

Services provided as incident-to the physician's services are not eligible for CPO reimbursement.

3. Billing requirements

When billing for CPO, it is important to meet the specific requirements set out by the Medicare Claims Processing Manual.[8] As the description in the CPT code suggests, these services do not have to be provided face-to-face in order to submit a claim for CPO to Medicare. However, the HHA or hospice National Provider Number (NPI) must be entered on the claim when the CPO services are billed. CPO cannot be billed on the same date as any other service. The claim is submitted at the end of the month, with the first and last date of documented planning services provided during the month noted. Only one unit of service may be billed per calendar month. Assigning the correct place of service (POS) code that corresponds to where the CPO services were provided is crucial to the submission of an accurate claim. The place of service code should indicate the location where the physician was providing the care plan oversight, not necessarily the place that the patient is located. This code should either be the office or outpatient hospital (POS 11, 22). It would be incorrect to assign home (POS 12, 13) or hospice (POS 34).

4. Documentation requirements
Medicare requires that the physician who furnishes the care plan oversight services must properly and accurately document those services. If documentation does not provide evidence of at least 30 minutes of CPO services, reimbursement will be denied. The physician must be able to prove, through documentation in the patient record, that at least 30 minutes were spent on oversight of the care plan during the calendar month. The documentation must include the dates and amount of time associated with each patient encounter. The responsibility of documentation lies with the provider.

Compliance considerations

As with any other services provided to Medicare & Medicaid beneficiaries, great care is needed in monitoring and auditing of CPO to prevent compliance issues from occurring. Some of the more common issues are discussed below.

Physician ownership or board members
It is important that the physician does not have a significant ownership or financial or contractual relationship with the home health agency. In addition, the physician may not be the medical director or employee of the hospice and may not furnish these services under an arrangement with the hospice.[9] Violation of either one of these rules would possibly invoke the referral prohibition of the Stark Law or the Anti-Kickback Statute. (There are exceptions to this rule, as explained in 42 CFR 411.355 through 42 CFR 411.357, but that is not within the scope of this article.)

Lack of documentation
Currently, billing under the home health prospective payment system (PPS) is high on the 2016 OIG Work Plan. Per the OIG Work Plan, "we will review compliance with various aspects of the home health PPS, including the documentation required in support of the claims paid by Medicare."[10] A prior OIG report found that one in four home health agencies had questionable billing including fraud, waste, and abuse. In fact, since 2010, nearly $1 billion in improper Medicare payments have been identified. Providers billing CPO codes must ensure that they understand and are compliant with the various requirements to ensure that the documentation supports the code.

Billing
As specified above, accurately coding and billing these codes is crucial. This means the medical coder must correctly abstract physician documentation to track the cumulative time. The medical coder must have a good knowledge of what is allowable and not allowable under CMS guidelines when coding these procedures. Without properly scrutinizing the physician note, the medical coder could possibly overstate the time and code/bill this monthly procedure, even though during the course of the month, certain activities should not have been counted. Even though this could be a "simple human error," this is considered a false claim and would violate the False Claims Act. If the coder willingly and knowingly allows these time events to be included, the medical coder would be committing healthcare fraud.

Auditing and Monitoring

As a fairly new service, CPO auditing and monitoring methods are usually "'home-grown" templates that are fairly easy to create. There are 17 required elements that must be met for billing CPO services and another element for collaboration agreements, if applicable. A checkbox template is easiest and allows the auditor to determine at a glance whether or not the requirements have been fulfilled. Continued monitoring,

Table 2: Template for CPO billing audit

Date of Audit_____ Auditor_____ Month of Service_____ MRN_____ Provider _____		
		Required Element
		Physician or NPP documented at least 30 minutes of CPO care in a calendar month Total time documented_____ Auditor recalculated time_____
		Complex multidisciplinary modalities were documented & supported
		CPO notes are signed and dated
N/A		Presence of NPP-Physician Collaborative Agreement, if applicable, is signed by physician who signed the HHA or hospice Plan of Care
		Patient requires complex treatment
		Care provided by multidisciplinary team
		Medicare-approved HHA or hospice (verify online or request copy of approval)
		E/M service documented within last 6 months (prior to first CPO service)
		Patient is a Medicare beneficiary (not Medicare Advantage)
		Care provided by HHA or hospice is NOT related to surgical service during global period
		Service provided by HHA or hospice in NOT diagnostic testing
		Claim form includes NPI of HHA or hospice
		No other service were provided on same date
		Claim form includes first & last date of CPO service provided in calendar month
		Only one unit of CPO was billed
		Place of Service code on claim form matches location of physician or NPP providing CPO POS 11_____ POS 22_____
		Physician is NOT the medical director or employee of HHA or hospice
		Physician signed financial conflict of interest statement declaring no significant financial interest, significant ownership, or contractual relationship with the HHA or hospice
		_____**/17 supported =** _____**% (**ex: 16/17 supported = 94%)
		Follow - up
		CPO requirements met — re-audit annually CPO requirements not met — check remediation method(s) ____ Education & re-audit in 3 months ____ Re-education & place on 100% pre-bill review ____ Restrict from billing CPO services

remediation via education, and sanctions for repeated errors should be implemented. A sample audit template is provided in Table 2.

All 17 (or 18) boxes should have a check mark. Education should concentrate on areas that did not meet the requirements. However, all elements should be included in the re-audit. The organization should develop a policy on an acceptable compliance rate and record the results in the physician file as well as report to the audit or compliance committee.

Recent case law

In 2014, a physician and two other individuals received lengthy prison sentences for fraud convictions stemming in part from billing for CPO when the physician was out of the country and on a cruise. The trio billed $1.4 million in fraudulent claims.[11] The indictment noted several occasions of CPO billing while the physician was unavailable, including billing for 184 Medicare patients while he was in Peru for several weeks and billing for 76 patients while on a cruise.[12]

In another case law, indictments were handed out to a physician and his conspirators for allegedly submitting $12 million in false and fraudulent claims for CPO and other services that were never provided, including claims for these services rendered to deceased patients. The defendants are also accused of concealment attempts by back dating records and creating false documentation.[13]

Conclusion

As home health and hospice billing in general are fraught with waste, fraud, and abuse, providers can expect scrutiny. Before billing CPO codes, the provider is responsible for ensuring that the code is appropriate and supported by documentation. Compliance professionals can assist with accurate billing by providing education before using this code, and implementing monitoring and auditing processes to ensure that all requirements are met. Monitoring and auditing should focus not only on the physician's documentation, but also the elements of the claim.

With careful attention to compliance, providers caring for home health and hospice patients may be able to generate an additional source of revenue by billing for the care plan oversight services they provide to their patients.

1. CMS: Medicare Benefit Policy Manual, Chapter 15, Section 180. Available at http://go.cms.gov/2bzGCJi
2. CMS.gov: 2016 Alpha-Numeric HCSPCS File. Available at http://go.cms.gov/2caOKkb
3. Idem.
4. Ibid, Ref #1
5. Ibid, Ref #1
6. CMS: Medicare Claims Processing Manual (Pub. 100-04), Transmittal 999, July 14, 2006. Available at http://go.cms.gov/2bfKUoA
7. Ibid, Ref #1
8. Ibid, Ref #4, Ch. 12, Section 180.
9. 42 CFR 414.39 – Special rules for payment of care plan oversight. Available at http://bit.ly/2bDB9Qx
10. US Department of Health and Human Services, Office of Inspector General: 2016 OIG Work Plan. Available at http://bit.ly/2biVkzg
11. Department of Justice, press release: "Father and Son, Who Owned/Operated A Physician House Call Company and Billed Services Not Rendered, Are Convicted On Conspiracy and Health Care Fraud Charges" October 17, 2013. Available at http://bit.ly/2btlkeS
12. *United States of America vs. Lawrence Dale St. John, Jeffry Dale St. John, and Nicolas Alfonso Padron*. Indictment available at http://bit.ly/2bDBBy3
13. *United States of America vs. Rick Brown, Dr. Roger Lucero, and Mary Talaga*. Indictment available at http://bit.ly/2btli6J