CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 999	**Date: JULY 14, 2006**
	Change Request 4374

Transmittal 993, issued on June 23, 2006, is rescinded and replaced by Transmittal 999 because in the Business Requirement 4374.6 the words "home health" should be replaced with "hospice." This is the only correction and all other information remains the same.

SUBJECT: Non-Physician Practitioner (NPP) Payment for Care Plan Oversight

I. SUMMARY OF CHANGES: This Change Request (CR) revises the policy associated with Non-Physician Practitioners billing for physician home health care plan oversight (CPO). Effective January 1, 2005, NPPs who are not the provider who signed the home health plan of care shall also be eligible for payment for physician home health CPO services provided they meet certain conditions. This CR clarifes those conditions. This CR also clarifies the policy associated with Non-Physician Practitioners billing for physician hospice CPO, clarifies HCPCS codes for CPO, and temporarily waives the requirement to include the HHA or hospice provider number on a CPO claim since there is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number. Additionally, this CR clarifies that the physician who bills CPO must be the same physician who signs the plan of care.

New / Revised Material
Effective Date: January 1, 2005
Implementation Date: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	11/40/40.1.3.1/Care Plan Oversight
R	12/180/Care Plan Oversight Services
R	12/180/180.1/Care Plan Oversight Billing Requirements

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 999	Date: July 14, 2006	Change Request 4374

Transmittal 993, issued on June 23, 2006, is rescinded and replaced by Transmittal 999 because in the Business Requirement 4374.6 the words "home health" should be replaced with "hospice." This is the only correction and all other information remains the same.

SUBJECT: Non-Physician Practitioner (NPP) Payment for Care Plan Oversight

I. GENERAL INFORMATION

A. Background: Physician Care Plan Oversight is paid under the Medicare Physician Fee Schedule. Due to a provision in the current manual, Non-Physician Practitioners (NPPs) have been prohibited from billing for this service in a home health setting.

The current manual section provides that the physician who signs the plan of care for home health services must be the same person that bills for physician care plan oversight. Since only a physician can sign the plan of care for home health services, NPPs have been unable to bill for physician home health care plan oversight. As printed in the Final Physician Fee Schedule Rule published in the Federal Register dated November 15, 2004, nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. Our intention, as outlined in later portions of §180 on physician care plan oversight, was to allow NPPs to bill for physician care plan oversight within state scope of practice.

The current inconsistency in §180 will not allow NPPs to be paid for this service. This manual revision effectuates a revision to the policy that states that the same provider that signs the plan of care does not have to be the same provider that bills for physician care plan oversight.

Section 40.1.3.1 of Pub.100-04, Chapter 11 has been revised to clarify CPO billing requirements for beneficiaries who have elected the hospice benefit.

Also, currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a care plan oversight claim. For this reason, the requirement to include the HHA or hospice provider number on a care plan oversight claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for care plan oversight claims.

B. Policy: For services furnished on or after January 1, 2005, the carrier shall allow NPPs to bill for physician home health care plan oversight even though they cannot certify a patient for home health services and sign the plan of care. For beneficiaries who have elected the hospice benefit, physicians or nurse practitioners (NPs), who have been identified by a beneficiary, to be his or her attending physician, may submit claims for CPO. For physicians or NPs who are employed by a hospice agency, CPO is not separately payable.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4374.1	The carrier shall pay for physician home health care plan oversight services (HCPCS code G0181) when billed by an NPP for dates of service on or after January 1, 2005.			X						
4374.2	The carrier shall pay for physician hospice care plan oversight services (HCPCS code G0182 with GV modifier) when billed by a nurse practitioner for dates of service on or after January 1, 2005.			X						
4374.3	The carrier shall reopen and adjust any erroneously denied claims with practitioner CPO services brought to their attention.			X						
4374.4	Effective for dates of service on or after January 1, 2005, contractors shall not require the provider numbers of the home health agency or hospice for care plan oversight claims for claims submitted electronically and on paper.			X			X			
4374.4.1	Contractors shall remove any edits associated with requiring and/or attempting to capture these provider numbers.			X			X			
4374.4.2	For claims with dates of service January 1, 2005, and after, carriers shall follow their return as unprocessable procedures for care plan oversight claims having a home health or hospice provider number.			X			X			
4374.5	The carrier shall pay for physician home health care plan oversight services (HCPCS code G0181) no more than one time per calendar month per patient.			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4374.6	The carrier shall pay for physician hospice care plan oversight services (HCPCS code G0182) no more than one time per calendar month per patient.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4374.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4374.6	GV modifier indicates attending physician.

B. Design Considerations: N\A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Gail Addis, (410)-786-4522, Claudette Sikora ,(410) 786-5618 **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

40.1.3.1 - Care Plan Oversight

(Rev. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

For a physician or NP employed by or under arrangement with a hospice agency, CPO functions are incorporated and are part of the hospice per diem payment and as such may not be separately billed.

For information on separately billable CPO services by the attending physician or nurse practitioner see Chapter 12, §180 of this manual.

180 - Care Plan Oversight Services

(Rev. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

The Medicare Benefit Policy Manual, Chapter 15, contains requirements for coverage *for medical and other health services including those of physicians and non-physician practitioners*.

Care plan oversight (CPO) 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 or Medicare approved hospice.*

CPO services require complex or 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 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.*

The CPO services require recurrent physician supervision of a patient involving 30 or more minutes of the physician's time per month. Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to:

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

Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed. The physician who bills for CPO must be the same physician who signs the plan of care.

Nurse practitioners, physician assistants, and clinical nurse specialists, practicing within the scope of State law, may bill for care plan oversight. These non-physician practitioners must have been providing ongoing care for the beneficiary through evaluation and management services. These non-physician practitioners may not bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service.

A. Home Health CPO

Non-physician practitioners can perform CPO only if the physician signing the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for CPO and either:

- *The physician and NPP are part of the same group practice; or*
- *If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or*
- *If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.*

Billing may be made for care plan oversight services furnished by an NPP when:

- *The NPP providing the care plan oversight has seen and examined the patient;*
- *The NPP providing care plan oversight is not functioning as a consultant whose participation is limited to a single medical condition rather than multidisciplinary coordination of care; and*
- *The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.*

NPPs may not certify the beneficiary for home health care.

B. Hospice CPO

The attending physician or nurse practitioner (who has been designated as the attending physician) may bill for hospice CPO when they are acting as an "attending physician". An "attending physician" is one who has been identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care. They are not employed nor paid by the hospice . The care plan oversight services are billed using Form CMS-1500 or electronic equivalent.

For additional information on hospice CPO, see Chapter 11, §40.1.3.1 of this manual.

180.1 - Care Plan Oversight Billing Requirements

(Rev. 999, Issued: 07-14-06; Effective: 01-01-05; Implementation: 10-02-06)

A. Codes for Which Separate Payment May Be Made

Effective January 1, 1995, separate payment may be made for *CPO oversight services for 30 minutes or more* if the requirements specified in the Medicare Benefits Policy Manual, Chapter 15 are met.

Providers billing for CPO must submit the claim with no other services billed on that claim and may bill only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months and should be submitted (and paid) only for one unit of service.

Physicians may bill and be paid *separately for CPO services* only if all the criteria in the Medicare Benefit Policy Manual, Chapter 15 are met.

B. Physician Certification and Recertification of Home Health Plans of Care

Effective 2001, two new HCPCS codes for the certification and recertification and development of plans of care for Medicare-covered home health services were created. *See the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 4, "Physician Certification and Recertification of Services," §10-60, and the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 7, "Home Health Services", §30.*

The home health agency certification code can be billed only when the patient has not received Medicare-covered home health services for at least 60 days. The home health agency recertification code is 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. The home health agency recertification code will be reported only once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care to start a new episode.

C. Provider Number of Home Health Agency (HHA) or Hospice

For claims for CPO submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider *number of the HHA or hospice providing Medicare-covered services to the beneficiary for the period during which CPO services* was furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the HHA or hospice Medicare provider numbers. Additionally, physicians should provide their UPIN to the HHA or hospice furnishing services to their patient.

> **NOTE:** There is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice provider number required for a care plan oversight claim. For this reason, the requirement to include the HHA or hospice provider number on a care plan oversight claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for care plan oversight claims.