ACCC 2023
Oncology
Reimbursement
MEETINGS

It Takes a Village: Billing for the Multidisciplinary Cancer Care Team

Association of Community Cancer Centers

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Teri Bedard, BA, RT(R)(T), CPC

Executive Director, Client & Corporate Resources
Revenue Cycle Coding Strategies

Teri.Bedard@RCCSinc.com

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The Multidisciplinary Cancer Care Team

- Surgeon
- Medical oncologist
- Radiation oncologist
- Advanced practice provider
- Genetic counselor
- Dietician/nutritionist
- Social worker
- Psychologist
- Pharmacist
- Patient navigator
- Chaplain/spiritual adviser

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Keys to a Successful Team

Communication

Regular meetings and/or discussions about the patient, progress, and concerns

Shared goals

Everyone understands the patient's wants/needs and their role in developing and executing a plan toward the goal

Trust

- Each member has a role and is respected for what they bring to the plan
- Each member carries out their work timely and as defined by the plan

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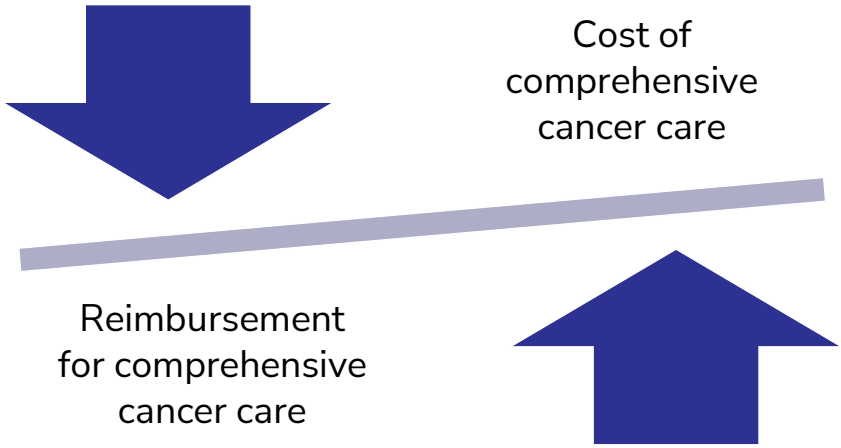
The Crux to Success?



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Common Care & Resources

- Surgery
- Drug therapy
- Radiation therapy
- Patient navigation
- Financial counseling
- Hospice and palliative care
- Survivorship care planning
- Psychosocial (mental health)
- Nutrition
- Smoking cessation
- Dental

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Primary Physician Care

Surgeons

Medical oncologists

Radiation oncologists

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Advanced Practice Providers (APP)

Who *is* an APP?

- Advance practice registered nurses (APRNs), including:
  - Certified registered nurse anesthetists (CRNAs)
  - Nurse practitioners (NPs)
  - Clinical nurse specialists (CNSs)
  - Certified nurse-midwives (CNMs)
- Anesthesiologist assistants (AAs)
- Physician assistants (PAs)

Who *is not* an APP?

- Registered nurses (RNs)
- Licensed practical nurses (LPNs)
- Medical assistants (MAs)
- Ancillary staff

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What Is the Route of an APP?

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- Incident to
- Split/shared
- Direct billing

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State Scope of Practice Nurse Practitioners[1]

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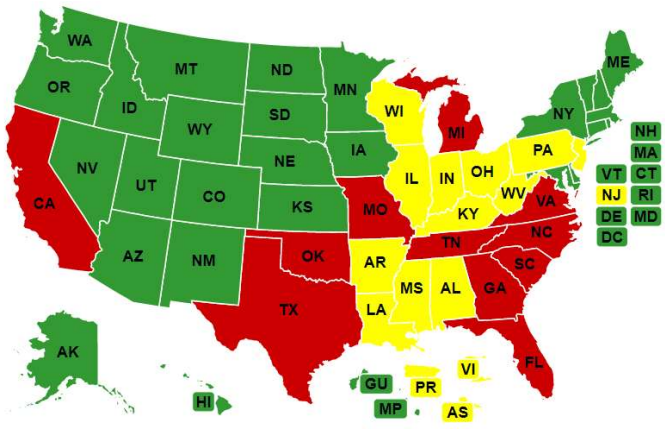

- Full Practice
- Reduced Practice
- Restricted Practice

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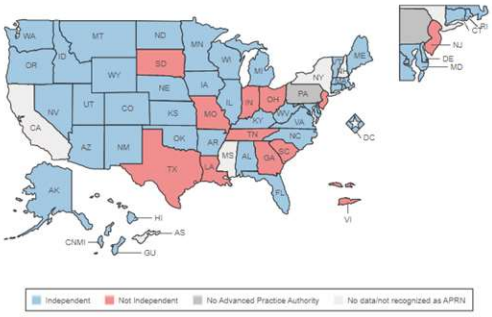
State Scope of Practice Clinical Nurse Specialists[2,3]

- **Map**: National Council of State Boards of Nursing (NCSBN's) APRN campaign for consensus—state progress toward uniformity
- Independent practice – CNS
  - Can CNSs practice independently?



- **Scope of Practice:** References the NCSBN's CNS Independent Practice map from its APRN campaign for consensus: state progress toward uniformity for the most current, available information
  - This resource is continuously updated

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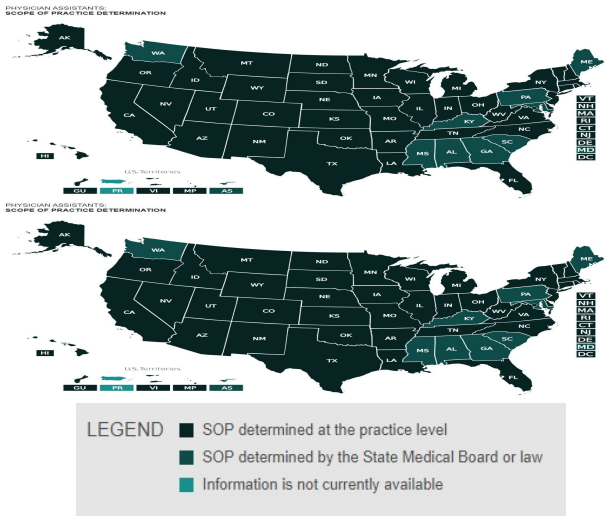
State Scope of Practice (SOP) Determination: Physician Assistants[4]



- SOP determination refers to whether a physician assistant's (PA's) scope of practice is determined at the practice level between the PA and collaborating physician.
- In some states, the state medical board or state law determines a PA's SOP

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Scope of Practice *May Include* the Following:

- Conduct physical exams
- Diagnose and treat illness(es)
- Order and interpret tests
- Counsel on preventative healthcare
- Assist in surgery
- Write prescriptions

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Reminder: Sometimes there is a difference between what a person has been trained to do and what they are **ALLOWED** to do by state and/or Medicare guidelines.

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Incident to

- Only applies in the office setting
- Does not apply to all services
- Oncologist must see patients for new problems and establish the care plan
- Requires supervision of auxiliary personnel, who are working under direction of the oncologist
- APP must be employed, leased, or contracted by the physician group
- Services billed under the national provider identifier (NPI) of the oncologist and paid at full Medicare assigned rate

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Possible Incident to Services

- Chemotherapy and complex drug administrations
  *some exclusions apply
- Therapeutic infusions
- Hydration
- Follow-up visits
- Assist with adverse effects due to radiation

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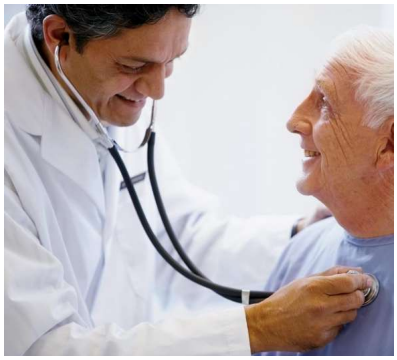
Split (or Shared) Visit Defined

- Evaluation and management (E/M) visit performed:
  - By both a physician and non-physician practitioner (NPP) who are in the same group
  - In a facility setting
  - In accordance with applicable laws and regulations
  - For new and established patient visits

Non-facility (physician office) follows incident to or billed under NPI of rendering provider



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Billing Provider

Provider who performed substantive portion of visit

Revised metrics related to "substantive portion" effective January 1, 2024

"Substantive portion" to mean more than half of the total time spent by the physician or NPP performing the visit

- Recommend documenting time in note, even if medical decision-making method
- Note signed by entity providing substantive portion
- Document should include names/credentials of both entities

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Split (or Shared) Visit Modifier

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New modifier—**FS**—to identify shared (or split) visits

Allow for data collection by the Centers for Medicare & Medicaid Services (CMS)

- Frequency of occurrence
- Quality of visits paid under physician rate

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Direct Billing by APP

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Trained in specialty

- Training, education, and expertise is specific to medical or radiation oncology
- State scope of practice
- Credentialed by payers

E/M visits

- New problems
- Follow-ups
- Outpatient, inpatient, and emergency department (ED)
- Establish plan of care

Other services

- Drug administrations in office setting
- Minor procedures, may include 10-day global surgical procedures

Reimbursement

- Paid at 85% of Medicare physician rate
- Name and NPI of APP listed on claim
- Payer may require modifiers
- Not all payers may credential, verify if necessary

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Supervision[6]

By setting	Supervising physician	Ordering physician	Personally performed
• Current Procedural Terminology (CPT®) manual, the administration of drugs, biologicals, and substances require direct physician supervision in the office or freestanding center. • Physician or qualified non-physician practitioner providing the direct supervision must be able to "furnish assistance and direction throughout the performance of the service." • Hospitals have minimum of general physician supervision required since 2020.	• "In some cases, the physician or non-physician practitioner, who performed an initial service and ordered the service that is subsequently performed by auxiliary personnel, is not the same person [as] who is supervising the service. Then the supervising physician must be identified on both the paper and electronic claim forms."	• "Item 24J: Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion."	• Supervision and personally performed are different. • Most drug administration services are performed incident to and billed under name of the oncologist providing direct supervision. • Procedures, such as intralesional administration of chemotherapy and bone marrow biopsies, are billed in the name of the provider who performed the service.

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Are You Covered?

- ✓State scope of practice
- ✓Risk management insurance
- ✓Written collaboration agreement
  - ✓Between physician/physician practice and APP
  - ✓Outline what is in scope and what is out for those states that allow practice establishment
  - ✓Ensure training, education, and expertise pertains to medical and/or radiation oncology and is maintained and updated
  - ✓Some states require written collaboration to be filed with the state before services can be provided
- ✓Must be credentialed with payers

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E/M Code Selection for Office Visits

Time

Medical decision-making

The extent of history and physical examination is not an element in code selection.

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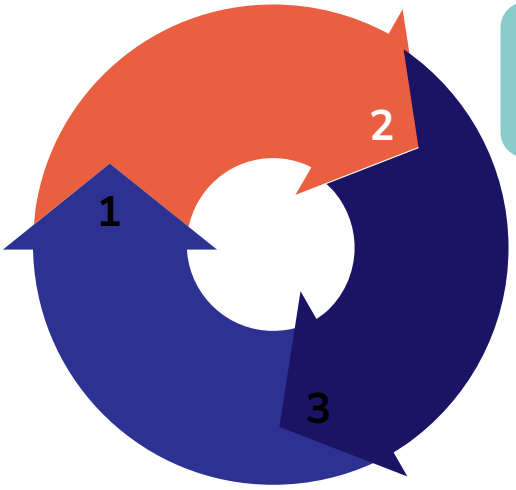
Medical Decision-Making Scoring

Data

Amount and/or complexity of data to be reviewed and analyzed



Problem(s)

Number and complexity of problems addressed at the encounter

Level of medical decision-making is based on 2 out of 3 element levels

Risk

Risk of complications and/or morbidity or mortality of patient management

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Drug Monitoring

- Drugs that require intensive monitoring are therapeutic agents with the potential to cause serious morbidity or death
- Monitoring performed for assessment of adverse effects and not primarily for assessment of therapeutic efficacy
- Monitoring is a generally accepted practice for the agent
- May be long-term or short-term
- Monitoring includes lab tests, physiologic tests, or imaging
- Monitoring by history or examination does not qualify

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Total Time: Activities

- Preparing to see patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic health record
- Independently interpreting results (not separately reported) and communicating results to patient/family/caregiver
- Care coordination (not separately reported)

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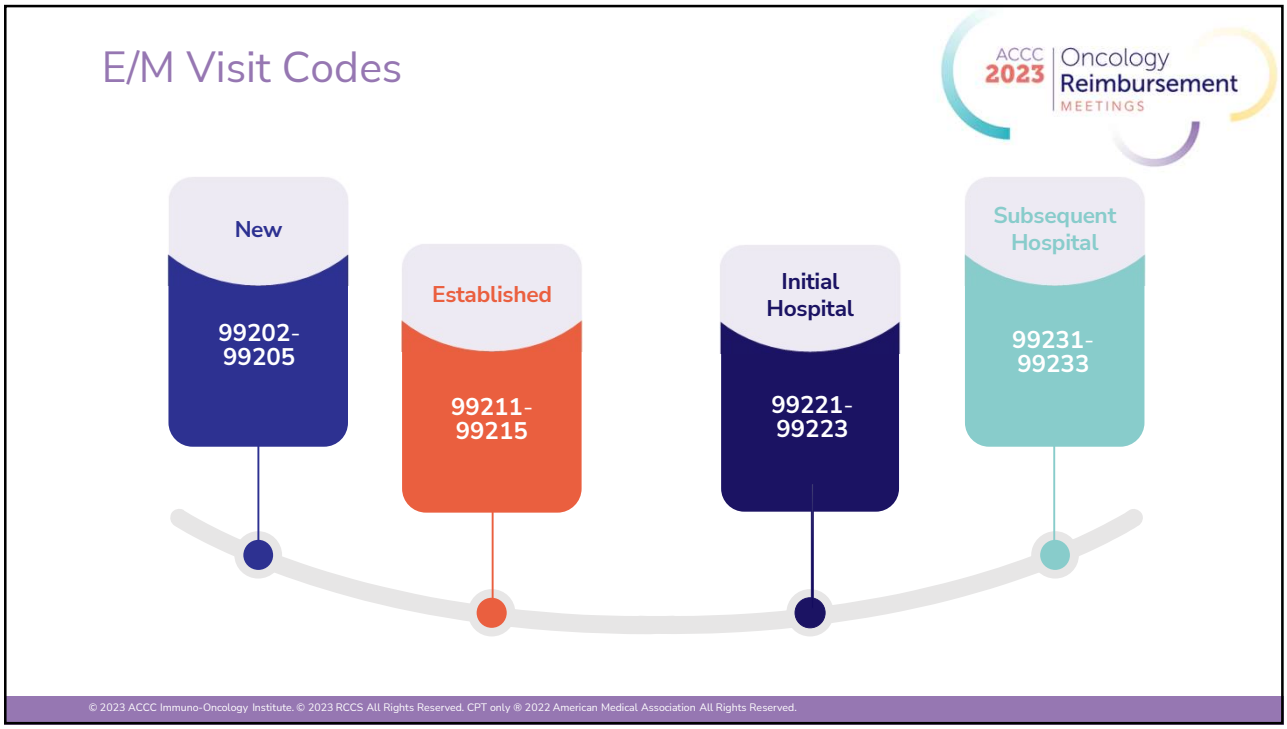
E/M Visit Codes
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New
99202-99205
Established
99211-99215
Initial Hospital
99221-99223
Subsequent Hospital
99231-99233
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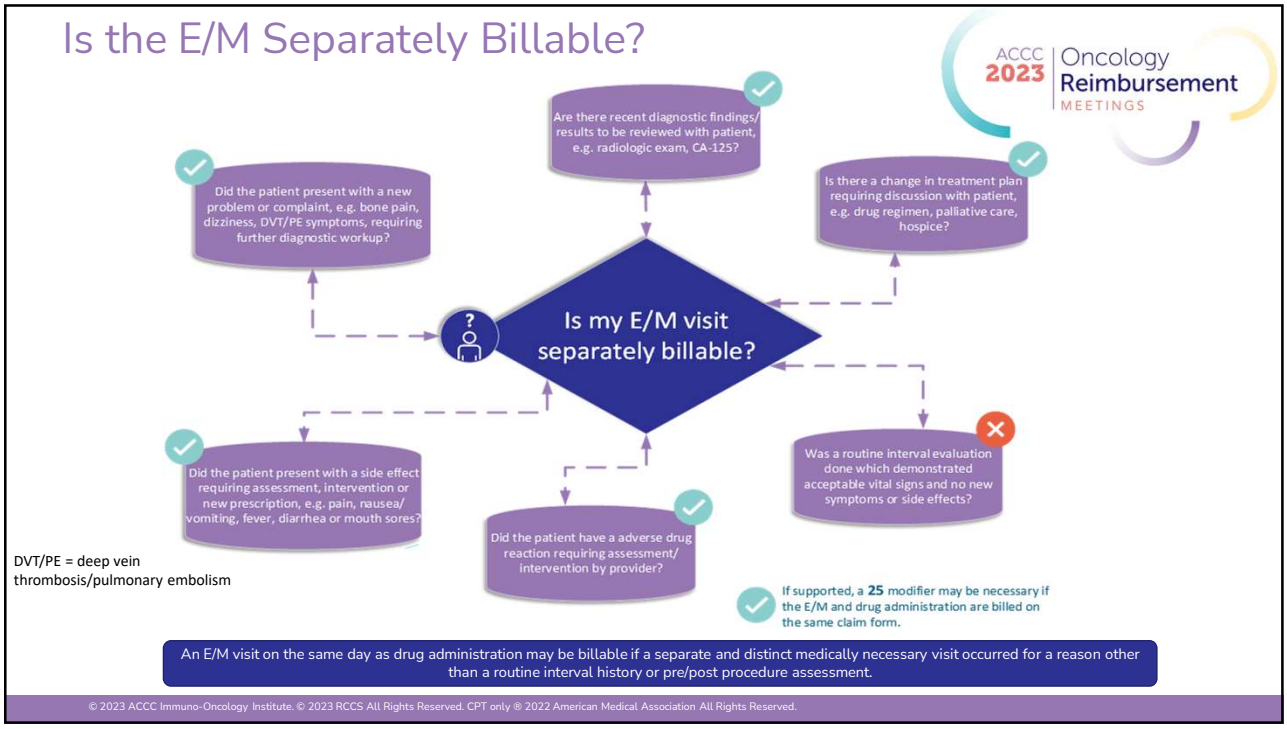
Is the E/M Separately Billable?
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Are there recent diagnostic findings/ results to be reviewed with patient, e.g. radiologic exam, CA-125?
Did the patient present with a new problem or complaint, e.g. bone pain, dizziness, DVT/PE symptoms, requiring further diagnostic workup?
Is there a change in treatment plan requiring discussion with patient, e.g. drug regimen, palliative care, hospice?
Is my E/M visit separately billable?
Did the patient present with a side effect requiring assessment, intervention or new prescription, e.g. pain, nausea/ vomiting, fever, diarrhea or mouth sores?
Was a routine interval evaluation done which demonstrated acceptable vital signs and no new symptoms or side effects?
Did the patient have a adverse drug reaction requiring assessment/ intervention by provider?
DVT/PE = deep vein thrombosis/pulmonary embolism
If supported, a 25 modifier may be necessary if the E/M and drug administration are billed on the same claim form.
An E/M visit on the same day as drug administration may be billable if a separate and distinct medically necessary visit occurred for a reason other than a routine interval history or pre/post procedure assessment.
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CPT Code **99211**

CPT code	Definition
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional

- Should not be billed routinely when the patient presents to the office for a blood draw, injection, or other scheduled service; E/M is inherent to the service
- The following are examples of situations when code **99211** should ***not*** be assigned:
  - The patient comes in to have blood drawn for lab work
  - The patient comes into the office for a flu shot
  - The patient comes into the office to pick up a prescription
  - The provider gives the patient instructions over the telephone
  - The provider calls in a prescription refill to the pharmacy
  - The office calls the patient to reschedule a procedure or appointment
  - The office faxes medical records to a hospital
  - Staff records lab results in a patient's chart and/or calls to inform patient of their lab results

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The drug and chemotherapy administration HCPCS [Healthcare Common Procedure Coding System]/CPT codes **96360-96375**, **96377**, and **96401-96425** have been valued to include the work and practice expenses of CPT code **99211** (evaluation and management service, office, or other outpatient visit, established patient, level I).

–Medicare National Correct Coding Initiative (NCCI) Policy Manual[7]

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Radiation Oncology Bundled Services[8]

- Anesthesia (whatever code billed)
- Care of infected skin (whatever code billed)
- Checking of treatment charts
- Verification of dosage, as needed (whatever code billed)
- Continued patient evaluation, examination, written progress notes, as needed (whatever code billed)
- Final physical examination (whatever code billed)
- Medical prescription writing (whatever code billed)
- Nutritional counseling (whatever code billed)
- Pain management (whatever code billed)
- Review and revision of treatment plant (whatever code billed)
- Routine medical management of unrelated problem (whatever code billed)
- Special care of ostomy (whatever code billed)
- Written reports, progress note (whatever code billed)
- Follow-up examination and care for 90 days after last treatment (whatever code billed)

A portion of list from *Medicare Claims Processing Manual*[8]

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Smoking Cessation

- Effective January 1, 2021, low-dose computed tomography (LDCT) lung cancer screening reported with **71271** and not subject to coinsurance or deductible

CPT code	Definition
71271	Computed tomography, thorax, low-dose for lung cancer screening, without contrast material(s)

- Subsequent at least 11 full months must have elapsed since the date of the last screening
- The following ICD-10-CM diagnosis codes are now covered retroactive to October 1, 2015:
  - **F17.210** Nicotine dependence, cigarettes, uncomplicated
  - **F17.211** Nicotine dependence, cigarettes, in remission
  - **F17.213** Nicotine dependence, cigarettes, with withdrawal
  - **F17.218** Nicotine dependence, cigarettes, with other nicotine-induced disorders
  - **F17.219** Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
  - **Z87.891** Personal history of nicotine dependence

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Nutritional Consult

CPT code	Definition
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes

Medicare pays registered dietitians or nutrition providers for medical nutrition therapy services 85%.
Payment may vary by payer and many times only for specific diagnoses related to diabetes and renal disease.

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Nutritional Consult & Payers

- Medical nutrition therapy (MNT) provided by registered dietitians
  - Recognized for billing by Wisconsin Physician Services (WPS) and National Government Services (NGS) (with limitations)
    - Patient has diabetes or kidney disease, or has had a kidney transplant in the past 36 months
- CMS: G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis.
- Private payers may allow for other diagnoses, head and neck cancer with accepted malnutrition ICD-10-CM codes
- Many cancer programs and practices recognize this need, may need to consider use of alternative monies (i.e., foundation money)
- Establish plan of care and monitor over multiple visits to establish necessary life changes, goals, and adjustments

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Genetic Counseling

CPT code	Definition
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family

- Does Medicare cover genetic counseling?
  - Medicare will, Parts A and B may cover genetic counseling when the procedure is undertaken as the result of a medical necessity in a skilled nursing facility or when counseling has been ordered by a Medicare-approved physician prior to starting a medication that may be covered under Part D. Counseling may also be covered as part of a temporary stay at a skilled nursing facility or hospital under Medicare Part A.
  - ***But***...Though genetic counseling may be covered by Medicare when ordered by a physician, genetic counselor services are not generally covered independently.
- Education/genetic counseling by physician or other qualified healthcare provider to individual; report appropriate E/M code

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Clinical Trials

Modifier	Definition
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study

- **When to use modifier Q1:**
  - When a service is performed outside of the clinical research study
  - The service is used for the direct patient management within the study
  - Does not meet definition of investigational clinical services
- **When *not* to use modifier Q1:**
  - When the service is not part of an approved clinical research study
- Codes will vary based on what was provided, related to the services, while under the clinical trial. Apply **modifier Q1**, **diagnosis code V70.7** for physicians and **modifier Q1, condition code 30, diagnosis code V70.7** for facility.

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Routine Clinical Services

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Items and services covered for Medicare beneficiaries outside of the clinical research study; used for direct patient management within the study; and do not meet the definition of investigational clinical services:

- Services required solely for the provision of the investigational clinical services (e.g., admin of chemotherapeutic agent)
- Clinically appropriate monitoring, whether required by the investigational clinical service (e.g., blood tests to measure tumor markers),
- Items or services required for the prevention, diagnosis, or treatment of research-related adverse events (e.g., blood levels of various parameters to measure kidney function)

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Advance Care Planning/Spiritual Services

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CPT code	Definition
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
+99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)

Voluntary, face-to-face service between a physician or other qualified healthcare professional (QHP) and a patient, family member, caregiver, or surrogate

Advanced directives include living wills, medical orders for life-sustaining treatment, health care proxy, durable power of attorney for healthcare, psychiatric advance directives

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Advance Care Planning Documentation Requirements

- Voluntary nature of visit
- Explanation of advance directives
- Who was present for visit
- Time spent discussing advance care planning during face-to-face encounter
- Any change in health status or healthcare wishes if patient is unable to make their own decisions

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Advance Care Planning: Code Based on Time

- Minimum time requirements per CPT guidelines
- Do not discuss any other active management of patient's issues for the time reported when billing advance care plan codes
- Any concurrent service cannot count the time toward the time-based service
- If less than 15 minutes spent, bill E/M code per guidelines
- A unit of time is billable when midpoint of the allowable unit of time passes
- Billable in facility and non-facility settings paid by Medicare

Advance care planning minutes	CPT code and units
Less than 15	No advance care planning billable
16-45	99497 x 1
46-75	99497 x 1 & 99498 x 1
76-105	99497 x 1 & 99498 x 2

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Comfort Care

Hospice

- Comfort care without curative intent
- Patient chooses whether to elect their hospice benefit
- Patient must have a terminal illness certified by a physician
- Physician certifies the patient's life expectancy is six months or less when the illness runs its normal course
- Medicare claims use modifiers
  - **GV**: physician not employed by hospice
  - **GW**: service does not relate to hospice condition

Palliative

- Comfort care with or without curative intent
- Can be billed by licensed clinical social worker (LCSW) with own NPI
- Palliative services not billable same date as other services
  - Use diagnosis codes for symptom management rather than disease diagnosis codes may ensure not duplicated
- E/M codes for services provided

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Social Worker

- May have limitations on billable services
  - Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may ***not*** bill or receive payment for CPT codes: **90805**, **90807**, and **90809**.
- Modifier **AJ** (clinical social worker)—Medicare administrative Contractors (MACs) instruct not to use for payment, no longer needed
- For most codes, Medicare pays 80% of the allowed amount and the patient pays 20%
  - Reduction from the published Medicare Physician Fee Schedule (MPFS) amount—clinical social workers = 75%

Furnish mental health services for the diagnosis and treatment of mental illness and you're legally authorized to perform them under state law	Coverage requirements: Legally authorized to practice clinical social work in the state where you furnish services	Do not cover services incident to CSW's personal professional services

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Coverage for Mental Health Services

Eligible professionals per CMS

- Physicians (medical doctors [MDs] and doctors of osteopathy [DOs]), particularly psychiatrists
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Certified nurse-midwives (CNMs)
- Independently practicing psychologists (IPPs)
- Certified registered nurse anesthetists (CRNAs) (supervision of diagnostic psychological and neuropsychological tests)

Must be reasonable

- Every service billed must indicate:
  - Specific sign, symptom, or patient complaint showing the service need.
- Even if considered "good medical practice," CMS will not pay without documentation of patient's symptoms, complaints, or specific documentation.
- Payment for multiple mental health services for the same patient on the same day.
- No payment for inappropriate or duplicate services on the same day.
- Check MAC websites.

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Mental Health Services

CPT code	Definition
+90785	Interactive complexity (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
+90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
+90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
+90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)

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Depression Screening

CPT code	Definition
G0444	Annual depression screening, 5 to 15 minutes

- Annually for patients with Medicare Part B—at least 11 months since last screening
- No specific diagnosis code required for NGS
- No co-pay, coinsurance, or deductible
- Must deliver the screening in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up
  - Office – 11, off-campus/outpatient hospital – 19, outpatient hospital – 22, independent clinic – 49, state or local public health clinic – 71
- Does not cover actual treatment options, therapeutic interventions, other interventions for depression, self-help materials, telephone calls, or web-based counseling
- Can be provided by telehealth technology

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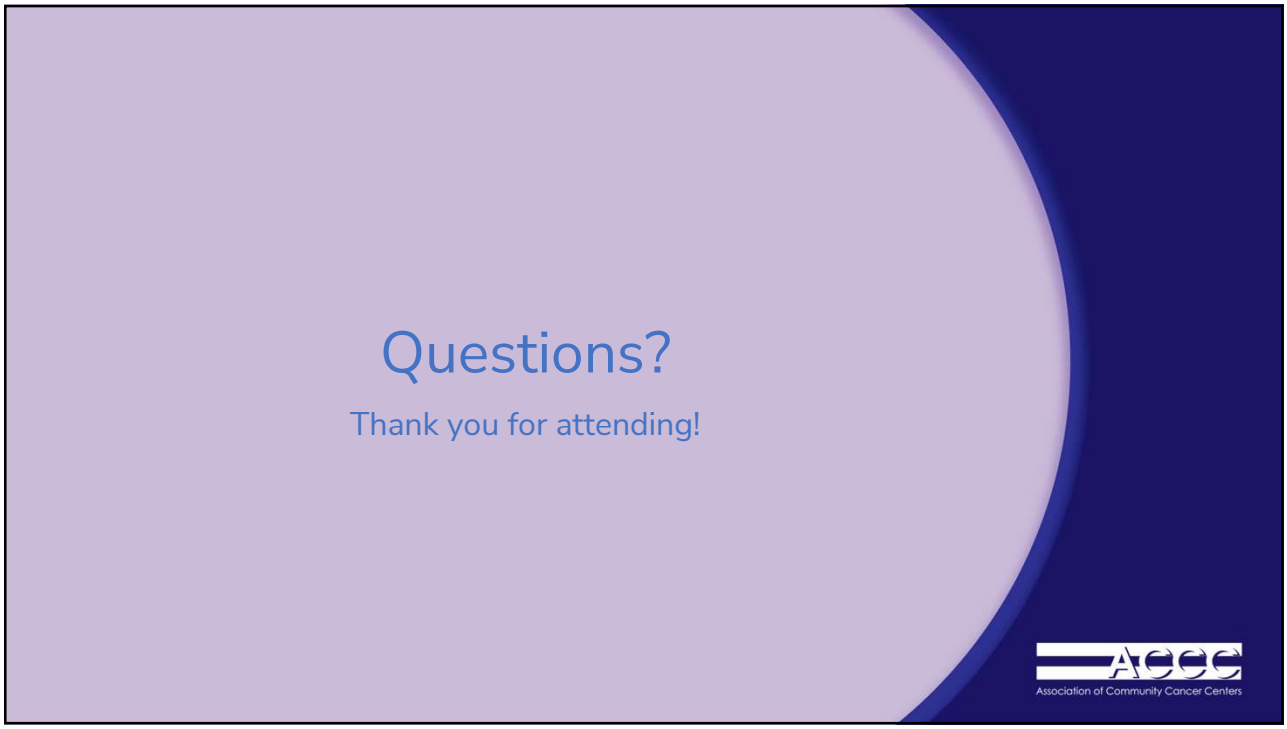
Questions?
Thank you for attending!
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