ACCC 41ST NATIONAL ONCOLOGY CONFERENCE

REALIZING INNOVATION

Thank You to our Sponsors

We wish to acknowledge and thank the 2024 ACCC NOC sponsors for their invaluable support and contribution in making the ACCC 40th National Oncology Conference in Minneapolis, Minnesota, a resounding success!

Your participation was instrumental in providing the necessary resources and opportunities to foster collaboration, share expert knowledge, and advance the future of cancer care.

From all of us, to all of you – Thank you!

TO LEARN MORE ABOUT OUR #ACCCNOC SPONSORS, **CLICK HERE**

GOLD

abbvie · Bristol Myers Squibb · eon · LeanTaaS · NOVARTIS · Pfizer

SILVER

AVEO ONCOLOGY · McKESSON · OneOme · rigel

BRONZE

AZRA AI · Eisai · FENNEC PHARMA · Kite A GILEAD Company · KYOWA KIRIN · L'ORÉAL LA ROCHE-POSAY INSTITUTIONAL HEALTH

Nuvation Bio · QUALIFY HEALTH · SMIRTA INNOVATIONS · TEMPUS · varian A Siemens Healthineers Company · veracyte

Patient Care Management Programs in Oncology

BY TERI BEDARD, BA, RT(R)(T), CPC

The Centers for Medicare & Medicaid Services (CMS) implemented 7 new Healthcare Common Procedure Coding System (HCPCS) codes effective for 2024[1] that are meant to address 2 main goals of the Biden Cancer Moonshot:

1. Cut today's age-adjusted death rate from cancer by at least 50% in the next 25 years, preventing more than 4 million cancer deaths by 2047
2. Improve the experiences of people and their families living with and surviving cancer. Cancer Moonshot identified effective cancer navigation services as critical to not only boosting support for patients but also to reducing cancer disparities and improving health outcomes.

Cancer navigation services are divided into 2 camps of focus: clinical navigation and patient navigation. Clinical cancer navigation services focus on clinical care, clinical coordination, and clinical education. Typically, clinical cancer navigation services are provided by licensed staff or qualified health practitioners and services are billed using American Medical Association (AMA) CPT® codes specific to care management, which were established prior to 2024. Patient cancer navigation services focus on improving access to care related to social determinants of health and are provided by a range of individuals—who may not have clinical training—but who have lived experience; these services are billed using HCPCS codes. To assist with differences between the CPT and HCPCS codes available for care management, **Table 1** compares key components to help determine the appropriate service.

AMA CPT Care Management Services

Principal care management (PCM), chronic care management (CCM), and complex chronic care management (CCCM) are time-based services reported once a month; these services address patients with chronic conditions, including those that may be serious and high-risk. To bill PCM CPT codes **99424**, **99425**, **99426**, and **99427**, providers are required to spend 30 minutes with the patient each month, with at least 1 serious high-risk, and chronic condition expected to last at least 3 months. Applicable codes will depend on who performed the services during the month: physicians or clinical staff; the physician or the clinical staff code may bill—not both.

To bill CCM CPT codes **99494**, **99491**, **99437**, and **99439**, clinical staff are required to spend 20 minutes or physicians (or other qualified health care practitioners) are required to spend 30 minutes with the patient each month with 2 or more chronic conditions expected to last at least 12 months. Again, applicable codes will depend on who performed the services during the month (physicians or clinical staff) and either the physician or the clinical staff code may bill—not both.

To bill CCCM codes **99487** and **99489**, providers are required to spend 60 minutes with the patient each month with 2 more chronic conditions expected to last at least 12 months.

CPT care management codes also require:

- Verbal or written consent for care management services by the patient; consent must be updated annually
- Care plans to address all the patient's health problems
- Periodic review and substantial revisions to the care plan for the duration of management
- A comprehensive care plan developed by the billing practitioner for the auxiliary staff to follow in addressing the needs of the patient
- That services provided each month by auxiliary staff are provided under general physician supervision and paid in both the facility and non-facility setting
- That only 1 code series is billed each month. Whether service(s) are billed as clinical staff or as a physician or qualified health practitioner, providers cannot combine the times of the physician/qualified health practitioner and clinical staff to reach the threshold and cannot bill for both even if criteria are met.

For additional information on these CPT care management codes, including more detailed definitions, review Medicare Learning Network booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule.[2]

CMS Care Management Services

These new patient navigation categories include community health integration (CHI) (**G0019** and **G0022**), social determinants of health (SDOH) (**G0136**), principal illness navigation (PIN) (**G0023** and **G0024**), and principal illness navigation-peer support (PIN-PS) (**G0140** and **G0146**). These services focus on understanding how social determinants of health impact the ability to diagnose or treatment patients, how to improve payment accuracy for the additional time and resources, and how to pay for activities most oncology providers are already

Table 1. Key Components Between CPT and HCPCS Care Management Codes

	Principal Care Management (99426)	Complex Chronic Care Management (99487)	Chronic Care Management (99490/99491)	CHI (G0019)	PIN (G0023)	PIN-PS (G0140)
Threshold Time (minutes)	30	60	20/30	60	Separate payment based on hospital's charges adjusted	Separate payment based on hospital's charges adjusted
Expected Duration	At least 3 months	At least 12 months	At least 12 months	At least 3 months	Separate payment based on hospital's charges adjusted	Separate payment based on hospital's charges adjusted
Staff Type	Clinical Staff	Clinical Staff	Clinical Staff	Clinical Health Worker (CHW) certified or trained	Separate payment based on hospital's charges adjusted	Separate payment based on hospital's charges adjusted
Patient Conditions	Serious high-risk condition & 1 complex chronic condition	2 or more chronic conditions	2 or more chronic conditions	Social Determinants of Health	Separate payment based on hospital's charges adjusted	Separate payment based on hospital's charges adjusted
Care Plan	Disease specific	Comprehensive	Comprehensive	Address SDOH	Separate payment based on hospital's charges adjusted	Separate payment based on hospital's charges adjusted

SAMSHA – Substance Abuse and Mental Health Services Administration

*20-minute threshold clinical staff time per month for CPT 99490 or 30-minute threshold physician/qualified health care practitioner time per month for CPT 99491

providing without direct compensation. Auxiliary staff providing the CHI and PIN/PIN-PS services should be trained to provide care to specific diseases and/or conditions; lived experience should not be discounted as training. The physician or qualified health care practitioner must provide an initiating visit and discuss with the patient their plan to provide the ongoing services, and the patient must provide their consent for these management services. All this information must be documented in the patient's medical record.

CHI Codes

These services address any unmet social determinants of health that limit the provider's to diagnose or treat the patient. These unmet needs are expected to impact the patient for a minimum of 3 months. A SDOH assessment can be provided to the patient to better assess identified unmet needs. Once the unmet needs are identified, the billing practitioner will provide a comprehensive care plan for staff to follow each month as they work with the patient to address and assist with the identified needs. As these codes are time-based, it is important that staff document their time and the services provided to the patient. CHI services also require:

- Verbal or written consent by the patient, which must be updated annually
- A SDOH that is limiting the provider's ability to diagnose or treat and that is expected to last a minimum of 3 months
- A comprehensive care plan developed by the billing provider for auxiliary staff to follow in addressing the needs of the patient
- That services provided each month by auxiliary staff are provided under general physician supervision and paid in both the facility and non-facility setting; only 1 practitioner can bill for CHI services per month
- Staff to document their time throughout the month. A threshold of 60 minutes must be met or exceeded to bill **G0019**. For each additional 30 minutes, add-on code **G0022** can be billed.

Full definitions of the CHI service codes, and more information can be found in the MLN Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule.[2]

SDOH Codes

Social determinants of health include a large set of factors: economic stability, education access and quality, health care access and

(Continued on page 56.)

(Continued from page 54.)
quality, neighborhood and build environment, and social and community context (eg, housing, food, nutrition access, transportation needs). To assess social determinants of health, CMS has identified tools such as its Accountable Health Communities (AHC) tool,[3] the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®) tool,[4] and the Instruments Identified for Medicare Advantage Special Needs Population Special Risk Assessment.[5] While this list is not inclusive, any tool used to assess social determinants of health must meet these requirements:

- The standardized tool must include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties; billing providers may choose to assess for additional domains beyond those required if there are other prevalent or culturally salient social determinants in the community
- The SDOH assessment can only be provided once per 6 months and take approximately 5–15 minutes
- This screening is not meant to determine unmet needs but rather to assess already identified unmet needs of patients
- Unmet needs assessed in the SDOH tool may help to support and establish the care plan for CHI services (**G0019** and **G0022**)

Full definitions of the SDOH service codes and more information can be found in the MLN Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule.[1]

PIN and PIN-PS Codes

In the context of health care, navigation refers to providing individualized help to the patient to identify appropriate practitioners and providers for care needs and support, and to access necessary care in a timely manner, especially when the health care landscape is complex and delaying care can be deadly. Medicare established PIN service codes to improve payment accuracy to account for additional resources and time for patients with serious illness (ie, cancer and behavioral health). Staffing includes the physician or qualified health care practitioner who oversees and bills for the services provided and the auxiliary staff who provide the services throughout the month to the patient. The serious, high-risk condition must place the patient at risk for hospitalization, nursing home placement, acute exacerbation or decompensation, functional decline, and/or death. PIN and PIN-PS services also require:

- Verbal or written consent by the patient, which must be updated annually
- A serious high-risk or behavioral health condition that is expected to last a minimum of 3 months
- A disease-specific care plan developed by the billing practitioner for the auxiliary staff to follow in addressing the needs specific to the patient
- That services provided each month by auxiliary staff are provided under general physician supervision and paid in both the facility and non-facility setting.
- Staff to document their time throughout the month due to the time-based nature of these codes. A threshold of 60 minutes must be met or exceeded to bill **G0023** or **G0140**. For each additional 30 minutes, add-on codes **G0024** or **G0146** can be billed.
- That staff providing the work be certified and/or trained, as defined by the state, SAMSHA, or in absence of criteria, by Medicare guidelines.

Full definitions of the PIN and PIN-PS service codes and more information can be found in the MLN Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule.[1]

Going Forward

With CMS' continued focus on access and equity in health care, it is important for providers to engage with the agency to help ensure that policies are not burdensome and support providers and beneficiaries as these policies are introduced and operationalized. OI

Teri Bedard, BA, RT(R)(T), CPC, executive director, Client & Corporate Resources.

Additional Resources

- Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc.: https://public-inspection.federalregister.gov/2023-14624.pdf
- Centers for Medicare & Medicaid Services. Connected Care Toolkit Chronic Care Management Resources for Health Care Professionals and Communities: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf
- *Journal of Oncology Navigation & Survivorship*. Oncology Navigation Standards of Professional Practice, March 2022, Vol 13, No 3: https://www.jons-online.com/issues/2022/march-2022-vol-13-no-3/4399-oncology-navigation-standards-of-professional-practice
- Centers for Medicare & Medicaid Services. Health-Related Social Needs FAQ: https://www.cms.gov/files/document/health-related-social-needs-faq.pdf
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Models Standards for Peer Support Certification: https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf
- Centers for Medicare & Medicaid Services, Connected Care Toolkit, Chronic Care Management Resources for Health Care Professionals and Communities: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf

References

1. Reporting CPT codes for oncology navigation services: the Cancer Moonshot. *CPT Assistant, Special Edition: November Update.* Volume 33, 2023. American Medical Association. https://www.ama-assn.org/system/files/cpt-assistant-oncology-navigation-codes.pdf

2. Health equity services in the 2024 physician fee schedule final rule. MLN Booklet. Centers for Medicare & Medicaid Services. Accessed October 14, 2024. https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

3. The Accountable Health Communities health-related social needs screening tool. Centers for Medicare & Medicaid Services. Accessed October 14, 2024. https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

4. Protocol for responding to and assessing patients' assets, risks and experiences. National Association of Community Health Centers. Published June 26, 2024. Accessed October 14, 2024. https://www.nachc.org/resource/prapare/#:~:text=Protocol%20for%20Responding%20to%20and,Risks%20and%20Experiences%20(PRAPARE%C2%AE)&text=(PRAPARE)%20is%20a%20national%20standardized,drivers%20of%20health%20(SDOH).

5. Medicare Advantage special needs plans: health risk assessment. U.S. Department of Health and Human Services. Accessed October 14, 2024. https://health.gov/foodismedicine/federal-resource-hub/medicare-advantage-special-needs-plans-health-risk-assessment