AMA CPT® Coding Update for Oncology Navigation Services and The Cancer Moonshot

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Revenue Cycle Coding Strategies
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Cancer Moonshot

- Launched 2016
- Part of 21st Century Cares Act – Law signed 12/2016
- Reignited in 2022
- 2 main goals established
- 2/2023 outlined cancer-navigation services

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2 Main Goals of Cancer Moonshot - 2022

- 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.
- Support and center patients and their caregivers living with and surviving cancer.
- Increasing the use of effective cancer-navigation services is an important tool not only to boost support for patients but also to reduce cancer disparities and improve health outcomes.

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Oncology Navigation Standards of Professional Practice

- Cancer leading cause of death worldwide, ~10 million deaths in 2020
- Significant burden
- Disproportionate impact on some communities
- Patient navigation created from 1989 American Cancer Society National Hearings on Cancer in the Poor
- First program initiated in 1990 in Harlem, NY

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Goals

- Enhance the quality of professional navigation services provided to people impacted by cancer
- Advocate with and on behalf of people at risk for cancer, cancer patients, survivors, families, and caregivers to protect and promote the needs and interests of people impacted by cancer
- Encourage navigator participation in the creation, implementation, and evaluation of best practices and quality improvement in oncology care
- Promote navigator participation in the development, analysis, and refinement of public policy at all levels to best support the interests of people impacted by cancer and to protect and promote the profession of navigation
- Educate all stakeholders about the essential role of navigators in oncology systems

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Defined Roles and Standards

Defined Roles

- Professional Navigator
- Oncology Patient Navigator
- Clinical Navigator/Oncology Nurse Navigator
- Clinical Navigator/Oncology Social Work Navigator
- Oncology Navigation
- Patient

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- Ethics; Qualifications; Knowledge; Cultural and Linguistic Humility; Interdisciplinary and Interorganizational Collaboration; Communication; Professional Development; Supervision; Mentorship and Leadership; Self-Care; Prevention, Screening, and Assessment; Treatment, Care Planning, and Intervention; Psychosocial Assessment, and Intervention; Survivorship; End of Life; Advocacy; Operational Management; Practice Evaluation and Quality Improvement; and Evidence-Based Care

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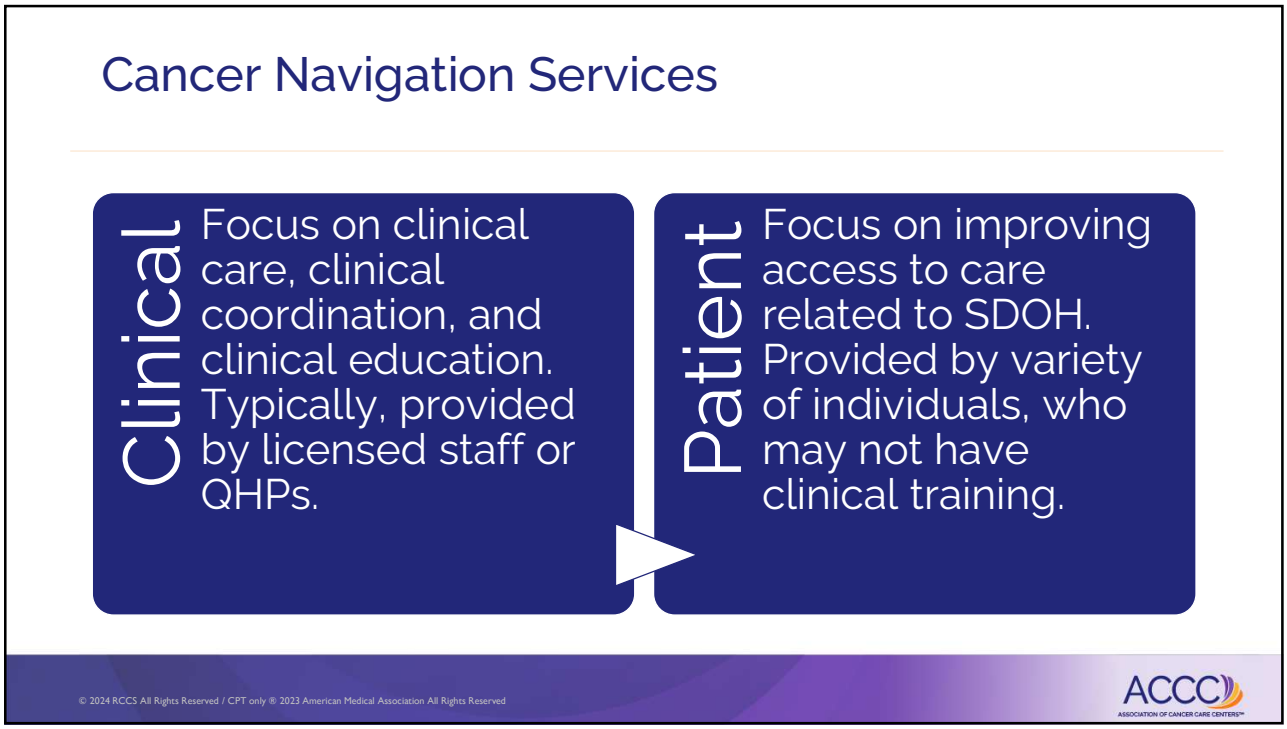
Cancer Navigation Services
Clinical
Focus on clinical care, clinical coordination, and clinical education. Typically, provided by licensed staff or QHPs.
Patient
Focus on improving access to care related to SDOH. Provided by variety of individuals, who may not have clinical training.
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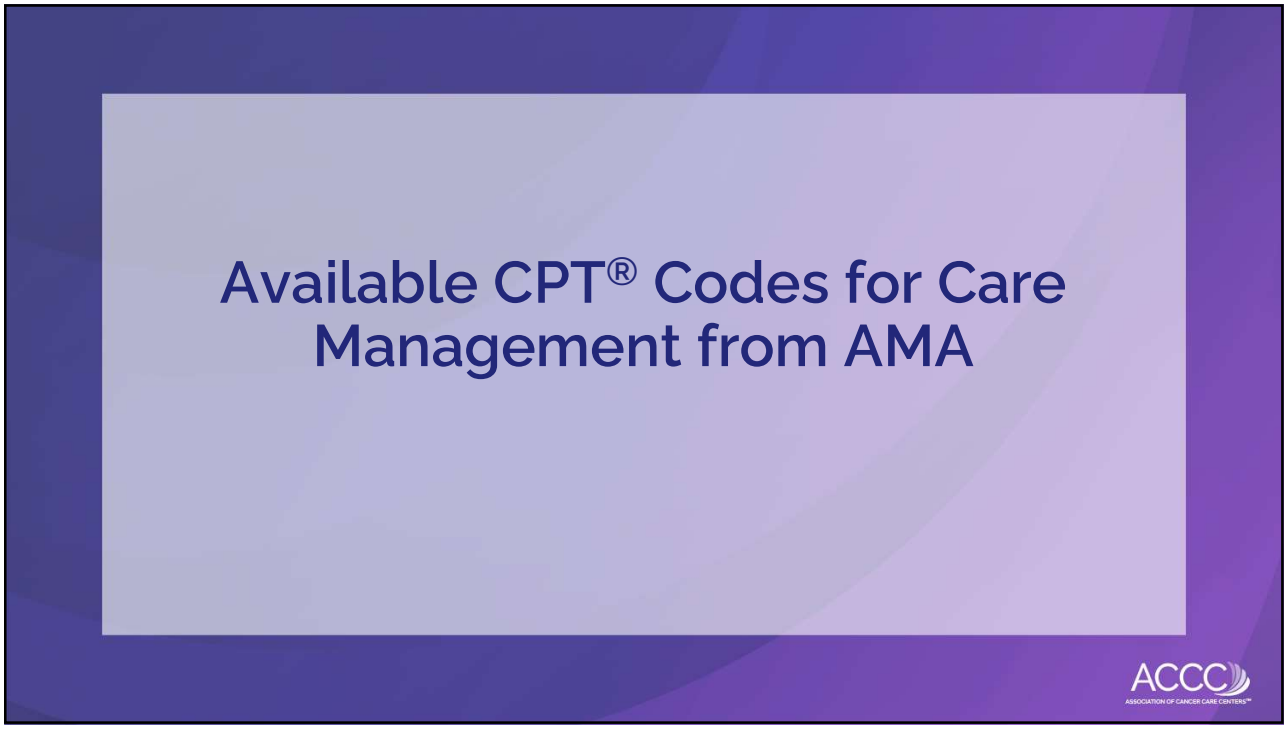
Available CPT® Codes for Care Management from AMA
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CPT® Care Management Services

	Principal Care Management (99424/99426)	Complex Chronic Care Management (99487)	Chronic Care Management (99490/99491)
Threshold Time (minutes)	30	60	20/30**
Expected Duration	At least 3 months	At least 12 months	At least 12 months
Staff Type	MD/QHP/Clinical Staff	Clinical Staff	MD/QHP/Clinical Staff
Patient Conditions	Serious high-risk condition & 1 complex chronic condition	2 or more chronic conditions	2 or more chronic conditions
Care Plan	Disease specific	Comprehensive	Comprehensive

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Chronic Conditions – Examples, Not Limited To

Alcohol abuse	Heart failure
Alzheimer's disease and related dementia	Hepatitis (chronic viral B & C)
Arthritis (osteoarthritis and rheumatoid)	HIV and AIDS
Asthma	Hyperlipidemia (high cholesterol)
Atrial fibrillation	Hypertension (high blood pressure)
Autism spectrum disorders	Ischemic heart disease
Cancer (breast, colorectal, lung, and prostate)	Osteoporosis
Cardiovascular disease	Schizophrenia and other psychotic disorders
Chronic kidney disease	Stroke
Chronic obstructive pulmonary disease (COPD)	Substance use disorders
Depression	
Diabetes	

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Physician or Other QHP PCM

CPT® code	Definition
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes **provided personally by a physician or other qualified health care professional**, per calendar month.
+99425	…each additional 30 minutes **provided personally by a physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)

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Clinical Staff Directed PCM

CPT® code	Definition
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of **clinical staff** time directed by physician or other qualified health care professional, per calendar month.
+99427	…each additional 30 minutes of **clinical staff** time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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Care Management Services Coding Examples		
Principal Care Management (PCM)		
Unit Duration (Time Spent)	Staff Type	Code & Unit Max per Month
Less than 30 minutes	Not separately reported	Not separately reported
30-59 minutes	Physician or other qualified healthcare professional	99424 x 1
	Clinical staff	99426 x 1
60-89 minutes	Physician or other qualified healthcare professional	99424 x 1 and 99425 x 1
	Clinical staff	99426 x 1 and 99427 x 1
90-119 minutes	Physician or other qualified healthcare professional	99424 x 1 and 99425 x 2
	Clinical staff	99426 x 1 and 99427 x 2
120 minutes or more	Physician or other qualified healthcare professional	99424 x 1 and 99425 x 3
	Clinical staff	99426 x 1 and 99427 x 2 (not billable more than 2x per month)

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Clinical Staff Directed CCM

CPT® code	Definition
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of **clinical staff** time directed by a physician or other qualified health care professional, per calendar month
+99439	…each additional 20 minutes of **clinical staff** time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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Physician or Other QHP CCM

CPT® code	Definition
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes **provided personally by a physician or other qualified health care professional**, per calendar month
+99437	…each additional 30 minutes **by a physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)

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Complex Chronic Care Management (CCCM)

CPT® code	Definition
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of **clinical staff** time directed by a physician or other qualified health care professional, per calendar month.
+99489	…each additional 30 minutes of **clinical staff** time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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Care Management Services Coding Examples		
Chronic Care Management (CCM)		
Unit Duration (Time Spent)	Staff Type	Code & Unit Max per Month
Less than 20 minutes	Clinical staff	Not separately reported
20-39 minutes	Clinical staff	99490 x 1
40-59 minutes	Clinical staff	99490 x 1 and 99439 x 1
60 or more minutes	Clinical staff	99490 x 1 and 99439 x 2
Less than 30 minutes	Physician or other qualified healthcare professional	Not separately reported
30-59 minutes	Physician or other qualified healthcare professional	99491 x 1
60-89 minutes	Physician or other qualified healthcare professional	99491 x 1 and 99437 x 1
90 minutes or more	Physician or other qualified healthcare professional	99491 x 1 and 99437 x 2
Complex Chronic Care Management (CCCM)		
Less than 60 minutes	Not separately reported	
60-89 minutes	99487 x 1	
90-119 minutes	99487 x 1 and 99489 x 1	
120 minutes or more	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes	

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Utilization of Services – 2022 Medicare Claims

Top Specialty	Principal Care Management (99424)	Principal Care Management (99426)	Chronic Care Management (99490)	Chronic Care Management (99491)	Complex Chronic Care Management (99487)
Top Specialty #1	Neurology 25.1%	Cardiology 32.1%	Internal Medicine 34.7%	Internal Medicine 30.8%	Internal Medicine 38.0%
Top Specialty #2	Internal Medicine 22.8%	Interventional Cardiology 11.1%	Family Medicine 26.6%	NPs 29.7%	Family Medicine 25.2%
Top Specialty #3	PAs 13.5%	Urology 8.8%	NPs 9.3%	Family Medicine 25.4%	NPs 15.5%
Top Specialty #4	Cardiology 10.8%	Ophthalmology 7.6%	Cardiology 5.6%	PAs 5.5%	Cardiology 3.6%
Highest Oncology	**#6 - Hem/Onc 3.4%**	**#5 - Hem/Onc 6.5%**	**#14 – Hem/Onc 0.9%**	**#12 – Hem/Onc 0.3%**	**-**

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Why Are Services Not Being Billed?

- Administrative guidelines for documentation
- Added co-pays for patients
- Reward not worth the work
- Lack of understanding the available codes
- Not aware separate codes exist

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Why Care Management Services?

Providers

- Payment for the work
- More cohesive care
- Utilizing skills of clinical staff

Patients

- Integrated approach to care – holistic, proactive, strengths-based
- Fewer ER visits and/or hospital stays
- Potentially lower out-of-pocket costs

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Implementation

Start with small subset of most ill patients

Establish core group of providers

Build resources, toolkits, referral sources, partners for nutrition, transportation etc.

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Qualifying to Provide Services

Practitioners

- Physicians
- Non-Physician Practitioners (NPPs)

Sites of Service

- Rural Health Clinics (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital Outpatient Department (HOPD)
- Physician Office/Freestanding Center

Clinical Staff

- Services provided incident to
- Under **General** Supervision

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Initiating Visit

Required when…	Types of initiating visits…	Discussion…	Excluded visits…
• Patient is a new patient or not seen by billing practitioner within a year prior to the beginning of the care management services	• Comprehensive E/M (99212-99205) • Annual Wellness Visit (AWV) • Initial Preventative Physical Exam (IPPE)	• Must discuss the care management services with the patient during the initiating visit or it does not count • Must obtain consent from patient prior to start of care management services	• Low level E/M visits able to be performed by staff, emergency department (ED), inpatient or observation, skilled nursing facility (SNF)

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Patient Consent

Patient's written or verbal consent is required to be documented in the medical record.

Must also inform the patient of the following:

- The availability of CCM services
- Their possible cost sharing responsibilities
- That only 1 practitioner can provide and bill CCM services during a calendar month
- The patient's right to stop CCM services at any time (effective at the end of the calendar month)
- That the practitioner explained the required information and whether the patient accepted or declined services

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Care Plan Development

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Laundry List for Care Plan

- A problem list,
- Expected outcome and prognosis,
- Measurable treatment goals,
- How symptoms will be managed, who is responsible for any planned interventions,
- Management of medication(s) management,
- Any ordered social services, and
- How any services provided by outside organizations will be coordinated and managed in support of the care plan

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Must be Capable to do the Following

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff
- Provide continuity of care with a designated member of the care team
- Utilize an electronic health record system so that care providers have timely access to clinical information
- Use a standardized methodology to identify patients who require chronic complex care coordination services
- Have an internal care coordination process/function so patients identified as meeting the requirements start receiving in a timely manner
- Use a form and format in the medical record that is standardized within the practice
- Able to engage and educate patients and caregivers and coordinate care among all service professionals, as appropriate for each patient

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Applying in the Real World

55-year-old male diagnosed with base of tongue cancer, has a history of and mentions current substance abuse while also on medication for depression. They are currently employed in custodial services department of nearby school, they have an aunt who lives in the area, but she lives in a nursing home with dementia, they may have some assistance from friends from time-to-time but are unsure how they will manage everything.

A care plan begins to manage the following 3 chronic conditions

- Cancer
- Depression
- Substance Abuse

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Assessing Needs of the Patient

Questions asked during the visit	What does the patient feel are their immediate needs?
	Will they or do they plan to work while undergoing treatment?
	Before they were diagnosed with cancer were they experiencing any financial difficulties that may increase if they are not able to work or must reduce work?
	What causes them stress and/or how do they manage stress and or factors related to their depression?
	Do they have any concerns related to their home environment or health, anything regarding their substance abuse?
	Do they understand everything discussed and explained about their cancer, how it will be treated and the potential side effects?

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Identified Immediate Needs

Patient does not understand what side effects of treatment will be, confused about ability to work → Do not have regular dentist, not sure what insurance covers and if the dentist would know how to manage them → Home is paid off, passed to them after mom died 2 years ago, still dealing with grief and drink alcohol to numb – want to try 12-step program but hesitant to go not sure what to expect → Dealing with stress means just doing whatever needs to be done. They eat when they feel like it but have been losing weight last year due to cancer and depression

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Patient's Care Plan

Learning Materials	Dentist	12-Step Program	Nutrition
Explaining head and neck cancer, chemotherapy and radiation treatments are specifically selected and personally reviewed with the patient to explain the process and "what to expect"	An appointment is made with a local dentist who is in network and familiar with head and neck cancer patients preparing for radiation treatments	The clinic has a staff member who actively attends alcoholics anonymous (AA) and spends some time with the patient explaining how it works and setups to attend a meeting that evening together	Local business has pre-made meals, minimal cooking and tailored to dietary needs. Patient is set up with a few vouchers to try out. Patient has a food log they will complete weekly to monitor nutrition

A clinical staff member meets with patient and documents in the medical record over the month. As a time-based service documentation must include time spent, even when non-face-to-face, to appropriately bill.

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Compare and Contrast

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Billing PIN and Other Care Management Codes

CMS.gov

Can CHI and PIN be billed with other care management codes?

a. Care management services are focused heavily on clinical aspects of care rather than social circumstances that impact clinical care and are generally performed by auxiliary personnel who may not have lived experience or training in the specific illness being addressed. You can furnish CHI services in addition to other care management services if you don't count time and effort more than once, you meet the requirements to bill the other care management services, and the services are reasonable and necessary.

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Code Comparison

	Principal Care Management (99424/99426)	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	60	60
Expected Duration	At least 3 months	At least 12 months	At least 12 months	At least 3 months	At least 3 months	At least 3 months
Staff Type	MD/QHP/Clinical	Clinical	MD/QHP/Clinical	Clinical Health Worker (CHW) certified or trained	Certified or trained Navigator	Peer support, State guidelines or SAMSHA*
Patient Conditions	Serious high-risk condition & 1 complex chronic condition	2 or more chronic conditions	2 or more chronic conditions	Social Determinants Of Health	1 Serious high-risk condition	Behavioral health condition
Care Plan	Disease specific	Comprehensive	Comprehensive	Address SDOH	Disease specific	Disease specific

*SAMSHA – Substance Abuse and Mental Health Services Administration
**20-minute threshold clinical staff time per month for CPT 99490, or 30-minute threshold physician/QHP time per month for CPT® 99491

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Medicare Rates and Patient Responsibility

Type of Visit	2024 MPFS Nonfacility Rate	2024 MPFS Facility Rate	2024 HOPPS Rate
Community Health Integration (CHI)	G0019 = $80.56 +G0022 = $50.26	G0019 = $49.60 +G0022 = $34.62	G0019 = $84.93 +G0022 = packaged
Social Determinants of Health (SDOH)	G0136 = $18.97	G0136 = $8.99	G0136 = $27.34
Principal Illness Navigation (PIN)	G0023 = $80.56 +G0024 = $50.26	G0023 = $49.60 +G0024 = $34.62	G0023 = $84.93 +G0024 = packaged
Principal Illness Navigation – Peer Support (PIN-PS)	G0140 = $79.24 +G0146 = $49.45	G0140 = $48.79 +G0146 = $34.05	G0140 = $84.93 +G0146 = packaged
Principal Care Management	99424 = $82.55 +99425 = $59.92 99426 = $61.91 +99427 = $47.27	99424 = $73.57 +99425 = $50.60 99426 = $48.93 +99427 = $34.29	99424 = N/A +99425 = N/A 99426 = $84.93 +99427 = packaged
Complex Chronic Care Management	99487 = $134.15 +99489 = $72.23	99487 = $89.21 +99489 = $49.60	99487 = $151.91 +99489 = packaged
Chronic Care Management	99490 = $62.58 +99439 = $47.93 99491 = $84.55 +99437 = $59.58	99490 = $49.60 +99439 = $34.62 99491 = $74.56 +99437 = $49.93	99490 = $84.93 +99439 = packaged 99491 = N/A +99437 = N/A

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CMS Focus of Efforts for Beneficiaries

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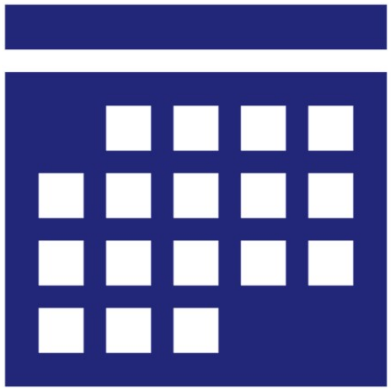
Join Us For A Deeper Dive!

- **9/5/2024** – CHI services, SDOH Risk Assessment, and Principal Illness Navigation Peer Support (PIN-PS) Documentation, Coding, and Billing for Oncology Providers and Administrators



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Association of Cancer Care Centers

Leading education and advocacy for the cancer care community

ACCC translates clinical findings into "how-to" action

Designing quality and process improvement programs to help the cancer team accelerate the integration of effective practices, guidelines, new treatment paradigms, and technical solutions into practice.

ACCC is a community of cancer centers

Representing more than 1,700 private practices, hospital-based cancer programs, large healthcare systems, and major academic centers across the country.

ACCC is a multidisciplinary association

Representing 40,000+ practitioners from clinicians to researchers, hospital executives, administrators, advanced practitioners, financial advocates, supportive care staff, and more.

*ACCC has changed its name in 2024 from "Association of Community Cancer Centers" to the "Association of Cancer Care Centers." The change is a step forward to better align with the dynamic landscape of cancer care, while assuring our members, stakeholders, and the broader community that the values and principles we stand for remain unchanged.

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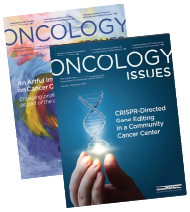

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