Billing for Oncology Social Work Services

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Historically, oncology social workers have not billed for their services. Common reasons include:

- Institutional stakeholders' lack of awareness that oncology social work interventions are essential to successful health and business outcomes (e.g., improved quality of care and costs savings)
- Challenges related to understanding which oncology social work services are billable and under what circumstances
- Complexity of implementing billing for oncology social work services and return on investment
- Oncology social workers' concern that billing for services might result in reducing access for those who could not afford their services.

During the past several decades, as healthcare delivery—and cancer care—have advanced and evolved, so has the field of social work. Currently in the United States, social workers comprise the greatest percentage of professionals in the mental health field. In oncology, knowledge of the ways in which biopsychosocial dimensions of a cancer diagnosis affect those living with cancer have led to important changes like the inclusion of distress screening as a component of cancer program accreditation and quality metrics.

As the U.S. continues to grapple with cost, quality, and value in healthcare delivery, the oncology ecosystem—one of the most dynamic areas of healthcare—is undergoing transformative change. Shifting demographics underway in the U.S. include a growing population of cancer survivors and an increasingly diverse and aging population, with growth in patients over the age of 65 and the fastest growing cohort within that population are those who are over the age of 80.

> With increased recognition of the value of oncology social work services for patients, families, and providers, cancer programs and practices may benefit from a fresh consideration of billing for oncology social work services and whether this might be an appropriate next step to sustain or grow supportive care services for patients with cancer.

The Institute for Healthcare Improvement's Triple Aim framework for optimizing the U.S. healthcare system calls for delivery approaches that improve the patient experience of care (including quality and satisfaction) and improve population health, while reducing per capita healthcare costs.[1] During the past two decades, significant policymaking coupled with emerging reimbursement models are transitioning the U.S. healthcare system away from traditional fee-for-service reimburemsent to value-based care payment.

Disruption of the U.S. healthcare system has intensified since March 2020 when the COVID-19 public health emergency was announced. In this tumultuous environment, oncology social workers play a critical role in furthering progress toward the Institute for Healthcare Improvement's Triple Aim.

As such, the versatile skillset of oncology social work is in growing demand in both value-based reimbursement models and fee-for-service models in which the patient experience impacts reimbursement rates. With increased recognition of the value of oncology social work services for patients, families, and providers, cancer programs and practices may benefit from a fresh consideration of billing for oncology social work services and whether this might be an appropriate next step to sustain or grow supportive care services for patients with cancer.

One caveat: medical billing is complicated no matter the provider who is billing. There are ever-changing Medicare and private insurance policies and rules, state laws, and differences in billing for hospital-based programs versus an independent community practice, to name only a few. From the outset, it is important to recognize that determining billing opportunities for oncology social work services in your cancer program or practice will take collaboration between multiple departments and experts.

Climate for Change?

As a starting point to billing, consider the following questions about the climate for change at your cancer program and/or health system:

- Is there a senior leader (e.g., chief operating officer, chief financial officer) willing to partner with oncology social work leadership to navigate culture and operational changes needed for successful innovation?
- Does the oncology social work leadership team have the knowledge and skills to engage stakeholders at multiple levels, connect with values from diverse perspectives, and build trust with stakeholders?
- Is there an understanding that reimbursement rates in current and emerging value-based models are tied to the patient experience, including quality and satisfaction?

With leadership, advocacy, and innovative problem-solving, it is feasible for oncology social work to contribute to an organization by generating revenue. The process is not simple, however. Pursuing any institutional change always requires perseverance and—most important—building trust with stakeholders.

Implementing Billing for Social Work: The City of Hope Experience

At City of Hope, a National Cancer Institute-designated comprehensive cancer center in California, oncology social work has been successfully billing for outpatient services since 2019. The goal was to create a billing roadmap for the oncology social work field. The two-year planning and implementation process (Figure 1, right) required the committed engagement of two teams of essential stakeholders. To bring the "must have" stakeholder teams on board, City of Hope used two tested engagement models.[2,3] To engage institutional stakeholders, a values, benefits, outcomes model was used. For the oncology social work team, City of Hope employed a staff leadership model.[4]

Figure 1. Implementation Timeline in Brief

Years 1-2

- Bring the right people to the table (e.g., chief operating officer, chief financial officer) who care about revenue
- Build relationships (do not be held back by middle managers)
- Collaborate with compliance team, coding review, and revenue cycle approval
- Team-based creative problem-solving

Year 2

- Collaborate with impacted departments (financial clearance and patient financial services)
- Build workflow in electronic health records
- Prepare clinical social workers (obtain NPI numbers, train, engage in hard conversations about change and ethical concerns)

NPI = National Provider Identifier.

Values, Benefits, Outcomes Model

Originally developed to build supportive care programs, this model starts with identifying core *values* that will motivate key stakeholders. Values connect people at their very core—highest quality medical care, patient-centered care, national recognition. *Benefits* tend to be less altruistic and relate to the reality of personal self-interest (e.g., manage a problem for me, save me time, allow physicians to see more new patients). *Outcomes* are what will be achieved together for which all stakeholders can be proud—patients living longer with higher quality of life, increased revenue, higher patient satisfaction scores, and greater levels of staff engagement. At City of Hope, key stakeholders engaged through this model included:

- Executive leadership (chief operating office and chief nursing officer)
- Revenue cycle (chief financial officer and vice president)
- Compliance officer
- Information technology support (senior vice president)
- Coding and data quality (senior manager)
- Financial department (executive director)
- Managed care (senior director)
- Credentialing (manager).

Staff Leadership Model

The underlying premise of this model is that it is the responsibility of leadership to work with their teams to 1) create a shared, long-term vision and 2) create opportunities where all colleagues have the capacity (and obligation) to make significant contributions that ensure the success of the program. In addition, in the staff leadership model, every colleague has a responsibility to openly challenge all aspects of the program. Below is a summary of how each member of the team stepped up and assumed lead-

ership roles in the implementation process for oncology social work billing:

- The oncology social work director created a vision of social work billing, developed leadership skills, and built trust with stakeholders (courage, reliability, communication).
- The oncology social work manager operationalized the vision into sustainable, feasible processes; developed training and implementation plans; and kept billing at the forefront of communication.
- Oncology social work team leads and supervisors developed easily implemented and aligned workflows, revised documentation templates to showcase clinical expertise, and supported teams through change by frontloading necessary information.
- Every oncology social work team member assumed additional responsibilities and learned new processes and talked—openly and honestly—about competing priorities, ethical dilemmas, and adjusting to change.

Billing Using Health Behavioral Codes

Licensed clinical social workers at City of Hope bill for outpatient facility charges (not professional fees) using health behavioral codes.[5] Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems. The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being using psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.

At City of Hope, two years of billing data show that oncology social work can generate revenue; reimbursement rates for these professionals were similar to those of medical providers. Despite anticipated patient complaints about billing for social work services, City of Hope received surprisingly minimal (almost no) complaints from patients.

Pilot data from January 2019 to February 2021 show that City of Hope oncology social workers were responsible for 4,025 billing encounters. Charges generated by oncology social workers during this period totaled $1,576,981. The revenue realized was $297,064. This total reflects $267,374 in line-item reimbursement from insurance providers and $29,690 in patient coinsurance/copays. The oncology social work billing denial ratio was only 26 percent, which is in line with that of medical providers. The above financial outcomes were achieved without quality improvement efforts targeting reimbursement and denial codes, which will be a necessary next step for the team to optimize the billing program.

Key benefits to implementation of oncology social work billing at City of Hope:

- There is an increased likelihood that psychosocial services will continue to be available to patients and families.
- Increased prestige of program due to innovation and ability to overcome barriers (i.e., enhanced awareness of oncology social work skillset and versatility) has been achieved.
- Revenue data have been used strategically (e.g., staffing, benchmarking, productivity).
- Oncology social work was able to hire and recruit during COVID-19 when many institutional divisions and roles were not.
- Oncology social work is now able to access institutional resources with other billing departments.
- The oncology social work team has the opportunity to share experience and learnings with other institutions and contribute to the field of oncology social work.

Oncology social workers are the healthcare professionals with the training and skillset to ensure the delivery of equitable quality cancer care. Oncology social workers' interventions reduce patient and family distress, resulting in improved medical outcomes, quality of life, and patient satisfaction. Exploring innovative strategies for oncology social work services to generate increased revenue can be one way to ensure sustainable delivery of quality comprehensive cancer care as defined by the National Academy of Medicine, National Comprehensive Cancer Network, American Society of Clinical Oncology, American College of Surgeons Commission on Cancer, and other leading oncology organizations.

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Making the Business Case for Hiring Oncology Social Workers

By Krista Nelson, MSW, LCSW, OSW-C, FAOSW; Jennifer Bires, MSW, LCSW, OSW-C; Courtney Bitz, LCSW, OSW-C, ACHP-SW; Barbara Jones, PhD, MSW, FNAP; Vicki Kennedy, LCSW; Shirley Otis-Green, MSW, MA, ACSW, LCSW, OSW-CE, FNAP, FAOSW; Bradley J. Zebrack, PhD, MSW, MPH

Quality cancer care requires a comprehensive approach to addressing the wide range of biopsychosocial-spiritual needs facing oncology patients and their families. Recently, renewed attention has focused on social determinants of health as drivers of improved health outcomes, effective system utilization, and decreased healthcare and operational costs.[1] Oncology social workers are experts who have been identifying and responding to these concerns for more than a century.[2]

Oncology social workers are essential for a cancer program or practice to meet the Institute for Healthcare Improvement's Triple Aim: (1) the provision of evidence-based services that improve patient/family/population outcomes; (2) the improvement of patient and provider satisfaction; (3) the reduction of unnecessary utilization and costs[3]—and in meeting the additional imperative (i.e., the Quadruple Aim) to (4) enhance the well-being of providers in the delivery of quality care.[4]

As the primary providers of psychosocial interventions and a critical linkage to internal and external resources, oncology social workers are among the most versatile members of the healthcare team. Oncology social workers' interventions reduce patient and family distress and improve quality of life thereby increasing patient satisfaction, improving efficiencies, and lessening the burden on physicians and healthcare teams by allowing them to do what they do best—administering innovative medical treatment to more patients.[5]

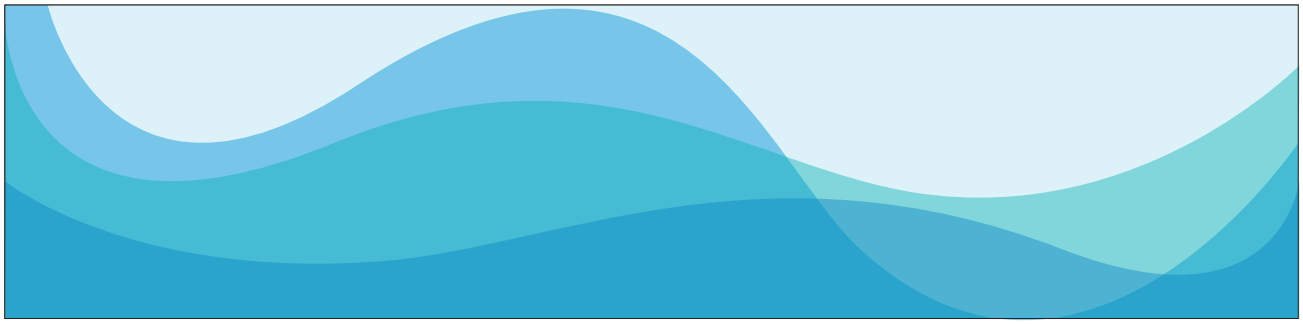
Finally, the importance of the oncology social work role is affirmed by its inclusion as a requisite to meet accreditation and quality standards such as those established by the American College of Surgeons Commission on Cancer (CoC), the American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI), the National Comprehensive Cancer Network (NCCN), and the National Quality Forum (NQF).

THE PROBLEM

Evidence supports that the diagnosis and treatment of cancer results in biopsychosocial-spiritual distress. Research finds that, at a minimum, 30 percent of all newly diagnosed patients with cancer are identified as clinically distressed to the point of requiring psychosocial intervention.[6,7] Other studies have found that many more patients benefit from a social work intervention during their cancer trajectory.[8] Failure to attend to these concerns impacts outcomes, costs, system utilization, and increases moral distress for patients, families, and staff. Despite this, few cancer programs report sufficient oncology social work staffing to meet these critical needs. In fact, results from a recent ACCC survey on comprehensive cancer care revealed that 60 percent of respondents reported they had insufficient or no oncology social work staff.[9]

THE SOLUTION

Investing in the full integration of oncology social work services reflects the highest standard of quality care and is recommended by the National Academy of Medicine.[10] Hiring oncology social work staff is the right thing to do for your patients, their families, and your staff, and it is cost effective.



Oncology social workers are master's-prepared specialists who contribute to your cancer program or practice by:

- Identifying and responding to psychological, social, emotional, practical, and existential distress.
- Increasing adherence to recommended treatment by identifying and reducing barriers to care.
- Facilitating complex goals-of-care conversations to ensure shared treatment decision-making and effective patient-physician communication.
- Advocating for the integration of justice, diversity, equity, and inclusion into cancer care.
- Connecting patients to local, regional, and national resources to overcome practical barriers to care, such as transportation, housing, financial barriers, and lack of adequate health insurance.
- Improving patients' and families' effective coping skills and adjustment during pivotal transition points in the cancer care continuum: diagnosis, treatment, protocol change, clinical trials, palliative care, end-of-life, survivorship, and/or recurrence.
- Addressing social and behavioral barriers to patient enrollment and retention in clinical trials.
- Developing and implementing innovative, evidence-informed programs to address unmet needs.
- Providing education, awareness, and support to mitigate moral distress; burnout; grief and loss; and compassion fatigue among healthcare staff.
- Improving patient safety by ensuring that institutions meet legal, regulatory, and accreditation standards.
- Managing complex (high-risk) psychosocial situations.

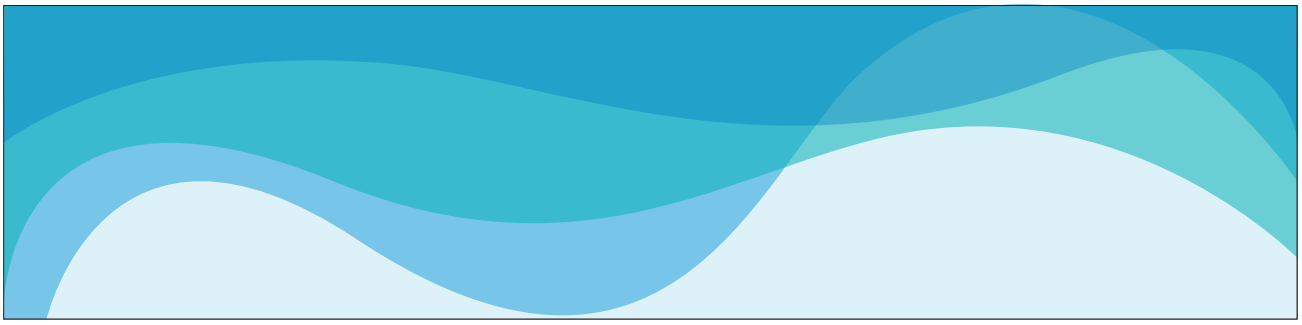
Making a solid business case for a fully integrated oncology social work staff requires a realistic assessment of programmatic and capacity needs. To optimize oncology social work impact, strategic planning and standardization of roles and responsibilities are critical.

BILLING, REIMBURSEMENT & FUNDING CONSIDERATIONS

With leadership, advocacy, and innovative problem solving, it is feasible to expand social work staffing as part of a coordinated care delivery model. Many cancer programs make a successful case for sustainable funding of FTE social work positions through their operations budget, with the understanding that these services will improve patient care and help reduce healthcare costs. Innovative value-based payment agreements that include oncology social work outcomes provide an opportunity to increase revenue and cover the cost of needed staff. It is also possible to bill for some oncology social work services both on outpatient facility charges and professional fees. Data from one National Cancer Institute-Designated Cancer Center's oncology social work team shows reimbursement rates similar to other medical providers and minimal patient billing complaints. (Look for more on the topic of billing for social work services in an upcoming *Oncology Issues*.)

SOCIAL WORK IN ACTION

The U.S. healthcare enterprise acknowledges the importance of responding to social determinants of health as essential to health equity. Increasingly there is recognition that without the delivery of equitable care we are not providing quality care. Oncology social workers are the health professionals best prepared to apply their expertise and knowledge of the social determinants of health to the full biopsychosoical-spiritual spectrum of impact on oncology patients, families, and communities. Regardless of the care delivery model, oncology social workers' versatility supports quality care through their capacity to connect and streamline resources with skill and efficiency. ●



QUALITY & VALUE

Oncology social work staff and faculty help cancer programs prepare for alternative payment model (APM) care delivery transformation. An APM Implementation Checklist developed by ACCC's Alternative Payment Model Coalition outlines three phases of readiness for APM engagement.[11] As oncology clinics, hospitals, and health systems strive to improve outcomes and the delivery of equitable cancer care, oncology social workers are the health professionals best prepared to advance these efforts through community engagement, facilitating patient and family advisory councils, and conducting patient education and outreach.

DISTRESS SCREENING AND SYMPTOM MANAGEMENT REDUCE HEALTHCARE COSTS

Distress screening and response–distress management–have demonstrated effects on cost control and lay primarily within the domain of oncology social work. Since the widespread adoption and implementation of distress screening, several studies are looking at whether screening–coupled with effective distress management–is helping to improve the quality of care and reduce healthcare costs.

A recent study, commissioned by the Association of Oncology Social Work (AOSW), evaluated cancer program adherence to distress management protocols and the association between adherence and patient emergency department (ED) use or hospitalization within two months after the clinic visit that should have included screening.[12] Of 8,409 electronic health records (EHRs) reviewed across 55 CoC-accredited cancer programs in the U.S. and Canada, 5,685 patients (67.6 percent) were identified as screened and subject to appropriate clinical response as per protocol; 2,724 (32.3 percent) were not. The EHRs also indicated that 954 patients (11.3 percent) had used the ED at the institution where they were screened, and 1,398 patients (16.7 percent) had been hospitalized at least once during the two months following the visit at which they were screened for distress.

KEY FINDINGS

Among those who were screened and responded to as per protocol, ED and hospitalization were 18 percent and 19 percent less, respectively, compared to those who were not screened and responded to according to protocol. Study authors concluded that if all patients in the study had been screened for distress and psychosocial issues addressed–a task often carried out by an oncology social worker–there would have been 172 fewer ED visits and 266 fewer hospitalizations.

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