Managing Chronic Conditions in Oncology Patients

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

Although providers and oncology programs focus on the latest proven technologies for the effective treatment of cancer, the human body is complex and the task of addressing so many different diagnoses is not easy. To treat the whole patient and to mitigate and manage their response to treatment, oncology providers also must address a patient's other conditions. This requires developing a comprehensive plan of care to heal the mind, body, and soul of the patient.

For many patients, the prevalence of multiple chronic conditions is a significant challenge. At a recent Michigan Society of Hematology and Oncology meeting, a Contractor Medical Director for Wisconsin Physician Services (WPS) Health Solutions gave a presentation on 2021 claims data. It indicated that in the 2 jurisdictions (6 states) that WPS serves, 63% of Medicare patients reported 2 or more chronic conditions. Reviewing other Medicare data available since 2010 supports the prevalence of chronic conditions for Medicare beneficiaries. Consequently, many oncologists find themselves managing more than just their patients' responses to cancer treatment. Instead, oncology providers often become the constant in a patient's ongoing health care routine, which requires them to manage the patient's multiple conditions, some of which may be severe.

It is possible for providers and clinical staff to charge for the work and the resources that are necessary to manage patients with chronic conditions. However, 2021 claims data indicate that very few oncologists actually bill for these services. In 2021, the specialty Hematology/Oncology represented anywhere from 0.1% to 1.1% of the claims submitted using chronic care management codes.[1] Compare this to the internal medicine specialty, which billed for nearly 40% of these services.[1] In my recent discussions with oncology providers, some indicated that the lack of billing was due to the administrative guidelines for documentation and concerns about the added patient co-pays such invoices would generate. Oncology providers agree that this work is routinely being done, and even though cancer is a chronic condition that is often covered by payers, the work required to bill for management of chronic conditions is overly burdensome. Other oncology providers seem unaware of the codes that would allow them to capture and bill payers for this work.

Defining Chronic Care Management

Chronic care management and complex chronic care management are time-based services that can be reported and paid by Medicare once per calendar month. Note: Medicare will only pay for one or the other of these services during a given month. According to the American Medical Association (AMA) manual, *CPT® (Current Procedural Terminology) 2023,* patients who receive chronic care management have "two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."[2]

Both physicians and non-physician practitioners (NPPs) are considered to be eligible providers of these services, but they must be working and billing for the services under their respective National Provider Identifier (NPI) if they are developing the care plan. NPPs or clinical staff working under the direction of the physician must be physically present in the United States and must meet the criteria for incident to; providing the services that they are trained to provide under general supervision of the physician. Typically, services provided incident to the physician require direct supervision, but Medicare has adjusted this for work specific to chronic care management services.

The oncologist must develop a care plan (eg, comprehensive direction for the clinical staff to address all the patient's health problems) and the patient must give written or verbal consent to proceed with this care. It is expected that this plan will require periodic review and may require substantial revisions for the duration of the care. In addition, the plan will include some, if not all, of the following: a problem list; expected outcome and prognosis; measurable treatment goals; a description of how symptoms will be managed; who is responsible for any planned interventions, medication(s) management, and any ordered social services; and how any services provided by outside organizations will be coordinated and managed in support of the care plan.

Per the AMA CPT manual, any cancer program or practice that decides to provide and report this level of care must have the following capabilities to meet the needs of the patient and required work elements:[2]

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients and caregivers with a means to contact health care professionals in the program or practice to address urgent needs, regardless of the time of day or day of the week.
- Provide continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments. Provide timely access and management for the follow-up after an emergency department visit or facility discharge.
- 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 whereby a patient identified as meeting the requirements for these services starts receiving services in a timely manner.
- Use a form and format in the medical record that is standardized within the program or practice.
- Be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

Available CPT Codes

Chronic care management services are billable with 4 CPT codes; 2 are the primary or initial time provided each month (**99490** and **99491**) and 2 that are considered add-on (+) codes (**99439** and **99437**) and are only billable in addition to the primary code when conditions of the code are met. See **Table 1** for full definitions of these codes. The primary codes, **99490** and **99491**, require at least 20 or 30 minutes, respectively, of staff time over the course of 1 calendar month and must be directed by a physician or other qualified health care professional who is carrying out the direction of the care plan.

Complex chronic care management services are billable with 2 CPT codes; 1 is the primary

Table 1. Chronic Care Management CPT Codes

CPT CODE	DEFINITION
99490	Chronic care management services with the following required elements: multiple (2 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	Chronic care management services with the following required elements: multiple (2 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; 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.)
99491	Chronic care management services with the following required elements: multiple (2 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	Chronic care management services with the following required elements: multiple (2 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; 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.)

Table 2. Complex Chronic Care Management CPT Codes

CPT CODE	DEFINITION
99487	Complex chronic care management services with the following required elements: multiple (2 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	Complex chronic care management services with the following required elements: multiple (2 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; 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.)

or initial time provided each month (**99487**) and 1 is an add-on (+) code (**99489**) and is only billable in addition to the primary code when conditions of the code are met. See **Table 2** for full definitions of these codes. Code **99487** represents the first 60 minutes of clinical staff time and add-on code **+99489** represents each additional 30 minutes.

Complex chronic care management requires moderate or high complexity of medical decision-making by the physician. In addition to the previously mentioned eligibility criteria for chronic care management services, complex chronic care management services are typically provided to patients who are being treated with 3 or more prescription medications, require other services such as physical or occupational therapy, and meet at least 1 of the following criteria:

- Require the coordination of a number of specialties and services
- Are unable to perform activities of daily living and/or cognitive impairment, which would result in poor adherence to the treatment plan without substantial assistance from a caregiver
- Have psychiatric and other medical comorbidities
- Need social support or experience difficulty accessing health care

For time-based codes, if the physician personally provides any of the services normally carried out by clinical staff, their time may be counted toward the total time necessary to meet the criteria of the code. Hospital outpatient departments (HOPDs) can report chronic care management codes for the time clinical staff spend in support of the services. Documentation would include identification of the supervising physician and time spent by both physician and clinical staff. Both the HOPD and the physician would bill for their respective services, as is the case for services provided in the inpatient setting.

The *CPT 2023* manual provides a table similar to **Table 3** to assist providers in understanding which of the care management services is billable based on criteria and staff, as they differ between chronic care management and complex chronic care management.

As happens with many of the management codes created by the AMA, the Centers for Medicare & Medicaid (CMS) is not always in agreement and the agency creates its own codes to be used specifically for Medicare beneficiaries. If a patient is new to the physician or practice or the patient has not been seen by the physician within the past year, the physician must provide a face-to-face initial evaluation and management (E/M) visit, annual wellness visit, or the initial preventive physical examination. This service is a separately billable item. If the patient requires extensive face-to-face assessment and care planning for initiation of care management, the provider can report an add-on code to Medicare:

- Healthcare Common Procedure Coding System (HCPCS) **G0506**: Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service).

The code is billable only once, at the outset of chronic care management or complex chronic care management services and only includes the time spent by the provider—no clinical staff time can be counted.

CMS has also created a code specific to rural health clinics and federally qualified health centers to capture and bill for the services provided in many difficult-to-staff facilities:

- HCPCS **G0511**: Rural health clinic (RHC) or federally qualified health center (FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, nurse practitioner, physician assistant, or certified nurse-midwife), per calendar month.

Note: HCPCS code **G0506** is not billed in these settings. Documentation of discussion is not required at initial visit and **G0511** is paid under

Table 3. Care Management Services Coding Examples

CHRONIC CARE MANAGEMENT		
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 health care professional	Not separately reported
30-59 minutes	Physician or other qualified health care professional	99491 x 1
60-89 minutes	Physician or other qualified health care professional	99491 x 1 and 99437 x 1
90 minutes or more	Physician or other qualified health care professional	99491 x 1 and 99437 x 2
COMPLEX CHRONIC CARE MANAGEMENT		
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	

the non-facility rate of the Medicare Physician Fee Schedule (MPFS).[3]

To help providers use and bill these codes correctly, CMS has developed an online informational pamphlet entitled *Connected Care Toolkit, Chronic Care Management Resources for Health Care Professionals and Communities*.[4]

Real-World Application

It is one thing to know the codes for chronic care management and complex chronic care management services, but applying them in the real world can be challenging. Below is a case study that illustrates how providers can ask or discover critical patient needs and concerns. This example includes time spent asking questions, establishing goals for the patient, measuring progress, developing actions to move in the direction of the goal, and assessing and evaluating progress.

Case Study

A man, aged 55 years, is diagnosed with cancer at the base of his tongue. The patient has a history of and mentions current substance abuse while also on medication for depression. The patient is currently employed in the custodial services department of a school. The patient's support is limited. He has an aunt with dementia who lives in a local nursing home. He receives occasional assistance from friends, but he is unsure how

he will manage everything.

The provider begins by developing a care plan to manage the 3 chronic conditions (cancer, depression, and substance abuse). During the initial meeting with the patient, the provider asks the following questions to assess current and future needs, with the understanding that as time progresses and the patient's situation changes, the care plan will need to be updated and revised:

- What does the patient identify as his immediate need(s)?
- Does the patient plan to work while undergoing anti-cancer treatment?
- Before the patient was diagnosed with cancer, was he experiencing any financial difficulties that may be exacerbated if he is not able to work or must reduce the number of hours worked?
- What causes the patient to feel stress? How does he manage stress and/or factors related to his depression?
- Does the patient have concerns related to his home environment, health, or substance abuse?
- Does the patient understand everything that has been explained regarding his cancer? Does he understand how the disease will be treated and the potential adverse effects he may experience?

After talking with the patient, the provider identifies several of the patient's immediate needs, which must be addressed:

- The patient does not fully understand what the treatments will do.
- The patient is unsure whether he will be able to continue working during cancer treatments.
- The patient does not have a regular dentist; he is not well versed in the need for dental care during treatment for tongue cancer. He is not sure whether his insurance covers dental visits.
- The patient does not have a mortgage; he inherited his home after his mother died 2 years ago.
- The patient is still dealing with grief from the loss of his mother and tends to drink alcohol to cope. He would like to try a 12-step program but is hesitant to attend and unsure of what to expect.
- For this patient, dealing with stress means "just doing whatever needs to be done."
- The patient eats when hungry but has been losing weight over the past year due to disease progression and depression.

The provider develops the following care plan to address this patient's needs and concerns:

- The provider gives the patient some materials that explain head and neck cancer, chemotherapy, and radiation treatments. The provider specifically selects and personally reviews them with the patient to explain the process and to give the patient a sense of what to expect.
- A staff member makes an appointment for this patient with a local dentist who is in-network and familiar with what head and neck cancer patients must do to prepare for radiation treatments.
- The clinic has a staff member who actively attends alcoholics anonymous (AA) meetings; this individual spends some time with the patient and explains how the program works and arranges to attend a meeting with the patient that evening.
- A local business creates premade meals that require minimal cooking and can be tailored to certain dietary needs. The patient is given a few vouchers to try out this service. To ensure the patient maintains his weight and calorie intake, he completes a weekly food log to monitor his nutrition.

The clinical staff member meets with the patient and enters everything into the medical record. As this is a time-based service, the documentation will need to include the time spent working with the patient throughout the month, even when the work is not face-to-face, so it can be appropriately billed.

An assessment will be made to gauge how the patient is doing post implementation of the care plan. As he continues through the course of care, the plan will be updated according to any new goals, measurements, or interventions that may be necessary. For any additional needs that may impact his care and the management of his chronic conditions, the care plan will be updated. It will reflect any new goals, specific interventions, metrics for success, and methods of patient assessment. The care plan is ongoing and customized to each patient. Resources and educational materials may be standardized, but no 2 patients are expected to require the exact same management and resources to manage their chronic conditions. OI

Teri Bedard, BA, RT(R)(T), CPC, Executive Director, Client & Corporate Resources at Revenue Cycle Coding Strategies in Des Moines, Iowa.

References

1. Centers for Medicare & Medicaid Services. Medicare Physician & Other Practitioners Datasets. Accessed November 27, 2023. https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners

2. American Medical Association. CPT®, 2023. Accessed November 9, 2023. https://www.ama-assn.org/practice-management/cpt

3. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; CY 2024 payment policies under the Physician Fee Schedule and other changes to Part B payment and coverage policies; Medicare Shared Savings Program requirements; Medicare Advantage; Medicare and Medicaid provider and supplier enrollment policies; Basic health program. CMS-1784-P. Published Accessed August 30, 2023. https://public-inspection.federalregister.gov/2023-14624.pdf

4. CMS. Connected care toolkit: chronic care management resources for health care professionals and communities. Accessed November 9, 2023. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf