Coding Quality Review and Education (CQRE)

Survivorship Billing, Coding and Documentation Reference Guide 2024

- ❑ There is **no CPT code** specifically for survivorship services.
- ❑ The term "survivorship" describes the patient's experience of moving beyond the cancer diagnosis and treatment toward maintenance, prophylactic therapy, and wellness.
- ❑ Prior to providing survivorship services, providers typically develop a written cancer treatment summary and follow-up care plan. This document includes:
  - •The survivor's current health status
  - •A summary of the cancer treatment received by the individual patient
  - •Recommended follow-up visits
  - •Necessary services for cancer surveillance
  - •Method(s) to address late and long- term effects of the patient's disease and treatment; symptom management; and psychosocial, spiritual, and financial concerns.

CPT codes 99212-99215 (Used only if <u>above and beyond</u> survivorship planning. Any time spent on survivorship should not count towards E/M leveling.)

- ❑ If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this (survivorship) service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then an appropriate patient visit service may also be reported.

- ❑ The physician or APP can only charge for an E/M visit with established patient codes when the patient has a medically necessary face-to-face visit with documentation of chief complaint, clinically appropriate history and/or exam, and MDM. Established patient E/M services would include ongoing treatment for complications, late effects of therapy or disease, or long-term effects of the neoplastic process.

Are chronic conditions involved? If so, Chronic Care Management Service CPT code 99491 is available. Only billed if patients have 2 or more chronic conditions-see below.

- ❑ Although many survivors feel well when treatment ends, studies have illustrated that a significant percentage of cancer survivors deal with chronic health problems that may be related to their cancer treatment. For example, patients may **experience pain, fatigue, cognitive impairment, or depression** during the survivorship phase of the cancer care continuum.

Chronic Care Management Services Performed by Physician

CPT® Codes	Description
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** …

Make sure you understand the following information:

- ❑ May only be reported once per calendar month by one physician or QHP (or provider group) who assumes the care management role for the patient.
- ❑ The time counted toward reporting this service is typically episodic and can be accumulated on multiple days over the calendar month by one or more physicians and/or QHPs in the group who personally perform the service.
- ❑ **Time allocated to other reportable services** during the same calendar month by these same providers may not be counted toward the 30 minutes required to report this service.
- ❑ CPT 99491 is different from non–face-to-face prolonged service (99358, 99359) because chronic care management service is for a calendar month and **requires documentation of services throughout the calendar month**. See the following clinical examples that describe typical adult and child patients for code 99491.

Clinical example: An 83-year-old female with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the previous 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home-care agency, participates in a remote weight-and-vital-signs monitoring program, and sees a cardiologist and neurologist.

Description of Procedure (99491)

A physician or other QHP personally provides these chronic care management (CCM) services, which are management and support services, to a patient residing at home or in a domiciliary, rest home, or assisted living facility.

These services typically include establishing, implementing, revising, or monitoring the care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other QHP provides and/or oversees the coordination of services as needed for all medical conditions, psychosocial needs, and activities of daily living.

Document and share a plan of care with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements:

- ❑ Problem list;
- ❑ Expected outcome and prognosis;
- ❑ Measurable treatment goals;
- ❑ Cognitive assessment;
- ❑ Functional assessment;
- ❑ Symptom management;
- ❑ Planned interventions;
- ❑ Medication management;
- ❑ Environmental evaluation;
- ❑ Caregiver assessment;
- ❑ Interaction and coordination with outside resources and other health care professionals and others as necessary;
- ❑ Summary of advance directives;
- ❑ Achievable goals for each condition relevant to the patient's well-being and lifestyle (measurable and time bound)

The care management office/practice must have the following capabilities:

- ❑ Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- ❑ Provide 24/7 access to physicians or other QHPs or clinical staff, including providing patients and caregivers with a means to make contact with health care professionals in the practice to address urgent needs, regardless of the time of day or day of week
- ❑ Provide timely access and management for follow-up after an emergency department visit or facility discharge
- ❑ Use an electronic health record system so that care providers have timely access to clinical information
- ❑ Use a standardized methodology to identify patients who require care management services
- ❑ Have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
- ❑ Use a form and format in the medical record that is standardized within the practice; and
- ❑ Engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient
- ❑ Reporting physician or other qualified health care professional oversees activities of the care team
- ❑ All care team members providing services are clinically integrated

Again, Medicare makes only one CCM payment per beneficiary, per month. Prior to the first CCM billing encounter, ***a verbal or written consent from the patient is required.*** *The patient must agree to participate prior to billing any CCM encounter.*

CMS mandates that any provider who bills 99491 ***must personally deliver the service to each patient, which means the service cannot be billed "incident to" and cannot be performed by a member of her or his clinical staff.***

If checking with a payer and they reimburse for survivorship planning, look to the following CPT/HCPCS codes (again not recognized for reimbursement by Medicare or Medicaid)

Option 1 CODES	DESCRIPTION
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure). Because this service is designated as a "separate procedure," it will not be charged if any other service is performed on the same service date. These are time-based codes.
Option 2 CODES	**DESCRIPTION (BC and other payers may reimburse for this code)**
S0220-S0221	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present)