PROVIDERS GUIDE TO COMMUNICATING ABOUT LUNG CANCER
# TABLE OF CONTENTS

## Lung Cancer Screening—How and When to Recommend

- About Lung Cancer .................................................................................................................. 3
- How to use this guide ............................................................................................................. 3
- Lung cancer screening guidelines .......................................................................................... 3
- Shared Decision Aids for LDCT Lung Cancer Screening ......................................................... 4
- Tobacco Cessation Services .................................................................................................... 4
- Writing an LDCT Order .......................................................................................................... 4
- Insurance Coverage for Lung Cancer Screening ................................................................. 5
- LDCT Lung Cancer Screening Facility Site Map .................................................................... 7

## Best Practices for Communicating About Lung Cancer

- Helping Patients Assess Risk .................................................................................................. 8
- Long-Term Care and Survivorship ......................................................................................... 8
- Addressing Stigma ................................................................................................................. 9
- Frequently Asked Questions ................................................................................................. 9
- Resources .............................................................................................................................. 11
- References .......................................................................................................................... 12
- Appendix A .......................................................................................................................... 14
- Appendix B .......................................................................................................................... 16
ABOUT LUNG CANCER

Lung cancer is the second most common cancer in both men and women in the United States. Similarly, in West Virginia lung cancer is the second most common cancer type in both men and women and accounts for 18% of all new cancer cases diagnosed. Annually, 2,039 people are diagnosed with the disease while 1,482 will die from lung cancer. More West Virginians will die from lung cancer than colorectal, prostate, and breast cancers combined. Advances in screening have the potential to reduce deaths from lung cancer by identifying the disease in the critical early treatable stages.

HOW TO USE THIS GUIDE

This guide is for primary care providers, advanced practice professionals, oncology providers, and/or cancer treatment teams interested in aiding patients at risk for lung cancer. The guide is designed to assist in implementing the lung cancer screening guidelines, using shared decision making, and making referrals for low-dose computed tomography (LDCT) scans. This resource includes information about the needs of West Virginians who may be at risk for lung cancer including, resources, screening sites, insurance coverage, and tobacco cessation services.

LUNG CANCER SCREENING GUIDELINES

The United States Preventative Services Task Force (USPSTF) found adequate evidence that annual screening for lung cancer with LDCT in a defined population of high-risk persons can prevent a substantial number of lung cancer–related deaths.

High-risk persons are defined as people who: are ages 55-80, have a 30 pack-year * smoking history, and are current smokers or have quit within the past 15 years. Individuals meeting these criteria should receive the LDCT annually.

*Pack-year = packs a day x number of years smoking
(ex: 2 packs a day x 15 years = 30 pack-year smoking history)

In addition to LDCT, new medications and developing treatment pathways demonstrate great promise for lung cancer patients. These significant strides in early stage diagnosis and treatment of lung cancer will continue to increase the number of early stage lung cancer survivors. This population of early stage lung cancer patients is the focus of this toolkit.
Providing shared decision making is a vital part of the lung cancer screening process. Deciding whether or not to go through lung cancer screening is not easy. Patients along with their provider should walk through the benefits and harms of screening as well as how screening can decrease your chances of having lung cancer. Below are some tools to aid in this process.

**Five Easy Steps to Promote a Shared Decision**

1. Seek your patient’s participation in the decision making process.
2. Help your patient explore and compare the potential benefits and harms of lung cancer screening, and assess your patient’s level of understanding.
3. Assess your patient’s values and preferences about lung cancer screening.
4. Reach a decision about lung cancer screening with your patient.
5. Evaluate your patient’s feelings about the decision by having a follow up discussion.

*For a printable aid to shared decision-making and additional resources see the Clinician’s Checklist in Appendix A.

**TOBACCO CESSATION SERVICES**

As a part of the criteria set from Medicare and Medicaid services tobacco cessation must be discussed if applicable during the clinical encounter.

Below are certified tobacco cessation programs. According to the US World news “Smokers who don’t participate in a smoking cessation program fail 95 percent of the time.”

**WRITING AN LDCT ORDER**

To provide a written order when the screening is recommended and the patient is interested, requires the following elements:

- Beneficiary date of birth
- Actual pack-year smoking history
- Current smoking status, and for former smokers, the number of years since quitting smoking
- Statement that the beneficiary is asymptomatic
- National Prover Identifier (NPI) of the ordering practitioner
INSURANCE COVERAGE FOR LUNG CANCER SCREENING

Relaying insurance coverage information can be cumbersome. Utilize the chart below for an overview of the current status of insurance coverage for these services based on current federal laws, regulations, and guidance. Where coverage is not uniform within a particular program, the overview chart states that coverage “varies.” In these situations, individual insurers (e.g., your state Medicaid program) will need to determine coverage.

Effective 1-1-2016, West Virginia Medicaid began coverage of LDCT scans for lung cancer screening for members 55 and over, utilizing the following codes:

- G0296 – Counseling visit to discuss need for lung cancer screening. This code does not require prior authorization and has a one per rolling year limit.
- G0297 – Low dose CT scan (LDCT) for lung cancer screening. This code requires prior authorization for medical necessity using InterQual Criteria that is based on guidelines.

For under or uninsured West Virginians eligible for LDCT screening, the self-pay cost approximately $125.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Coverage (Y/N)</th>
<th>Population Covered</th>
<th>Cost-Sharing</th>
<th>Details / Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid (Traditional)¹</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies²</td>
<td>The USPSTF recognizes the importance of SDM in the context of lung cancer screening. SDM should therefore be covered for the Medicaid expansion population. However, some states/insurers may disagree.</td>
</tr>
<tr>
<td>Medicaid (Expansion)²</td>
<td>Yes</td>
<td>Adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.</td>
<td>No³</td>
<td>LCS is covered under Medicare Part B. Individuals must therefore generally be enrolled in Medicare Part B (or a Medicare Advantage plan) to receive coverage of LCS. Medicare covers SDM for lung cancer screening. SDM is required for the initial screening. SDM can be provided via telehealth if Medicare telehealth requirements are met.</td>
</tr>
<tr>
<td>Original Medicare⁵</td>
<td>Yes</td>
<td>Individuals aged 55 to 77 years with no signs or symptoms of lung cancer who have a 30 pack-year smoking history and currently smoke or have quit within the last 15 years and who receive a written order for screening.</td>
<td>No⁶</td>
<td>Medicare covers SDM for lung cancer screening. SDM is required for the initial screening. SDM can be provided via telehealth if Medicare telehealth requirements are met.</td>
</tr>
<tr>
<td>Medicare Advantage⁶</td>
<td>Yes</td>
<td>Individuals aged 55 to 77 years with no signs or symptoms of lung cancer who have a 30 pack-year smoking history and currently smoke or have quit within the last 15 years and who receive a written order for screening.</td>
<td>No⁷</td>
<td>Medicare covers SDM for lung cancer screening. SDM is required for the initial screening. SDM can be provided via telehealth if Medicare telehealth requirements are met.</td>
</tr>
</tbody>
</table>

² The USPSTF recognizes the importance of SDM in the context of lung cancer screening. SDM should therefore be covered for the Medicaid expansion population. However, some states/insurers may disagree.

³ LCS is covered under Medicare Part B. Individuals must therefore generally be enrolled in Medicare Part B (or a Medicare Advantage plan) to receive coverage of LCS. Medicare covers SDM for lung cancer screening. SDM is required for the initial screening. SDM can be provided via telehealth if Medicare telehealth requirements are met.

⁴ Beginning in 2020, Medicare Advantage plans have additional flexibility in providing telehealth services.
<table>
<thead>
<tr>
<th>Group/ Individual(^{12}) (non-grandfathered)(^{13})</th>
<th>Yes</th>
<th>Adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.</th>
<th>No</th>
<th>The USPSTF recognizes the importance of SDM in the context of lung cancer screening, so it should be covered for the group/individual insurance population, but some insurers may disagree.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Health Insurance Plans</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Short-term health insurance plans are not considered individual health insurance plans and are not subject to the preventive service coverage requirements of the Affordable Care Act.(^{14}) Coverage and cost-sharing for LCS and SDM in these plans therefore may vary greatly.</td>
</tr>
</tbody>
</table>

**Important Caveat Regarding Cost-Sharing:** The chart above indicates when payers may not charge cost-sharing for the screening itself. Patients may face additional charges under certain circumstances (e.g., if the patient receives other services during the visit in addition to the screening or if the health care provider charges a facility fee). To avoid unexpected medical bills, it is important for patients to speak with their health plan and provider prior to screening to understand any charges that may occur.

**Note on Medicare Advantage Plans:** Medicare Advantage plans are prohibited from charging a patient for a facility fee when the only service received is a lung cancer screening.
The web link below covers all facilities whose applications for accreditation are still under review. It provides patients, providers, and third-party payers with information critical to selecting appropriate facilities for imaging needs. The American College of Radiology site below has the most up to date list of accredited facilities. The sites as of 12-11-2019 are shown on the WV state map below.

https://www.acraccreditation.org/accredited-facility-search
BEST PRACTICES FOR COMMUNICATING ABOUT LUNG CANCER

Public Health professionals, cancer control professionals, cancer centers, and providers can use this guide to implement evidence based practices when communicating about lung cancer. The following excerpt is from the George Washington University Social Media Toolkit. To view the document in its entirety visit: https://smhs.gwu.edu/cancercontroltap/sites/cancercontroltap/files/Lung_SocMedia%20Toolkit%202018%20FINAL.pdf
HELPING PATIENTS ASSESS RISK

- Familial history of lung or other cancers may increase risk for lung cancer in nonsmokers. Encourage patient-provider discussions of family history and risk.

- Current and former smokers are not likely to “integrate their family history into their risk perceptions” of developing lung cancer. Provide information about the link between family history and lung cancer risk.

LONG-TERM CARE AND SURVIVORSHIP

- The Center for Disease Control (CDC) recommends that follow-up care for lung cancer survivors should focus on tobacco cessation, increased physical activity, good nutrition, ongoing vaccinations, regular cancer screenings, and pain management. When creating messaging for lung cancer survivors focus on these topics.
  
  - For oncology providers, primary care providers, advanced practice professionals, and/or cancer treatment teams interested in implementing a comprehensive lung cancer survivorship program. The WVU Cancer Institute’s Bridge Program has a resource that includes information about the needs of lung cancer patients following treatment and tools for oncology teams to use in coordinating a multidisciplinary survivorship care program. Use the link below to view this resource.

  - [http://www.wvucancer.org/media/2441/finalilized-toolkit03032020.pdf](http://www.wvucancer.org/media/2441/finalilized-toolkit03032020.pdf)

- The American College of Surgeons requires Commission on Cancer (CoC)-accredited programs to “provide a summary of treatment and follow-up plan to all patients completing lung cancer treatments” for curative intent. Encourage providers to promote survivorship care plans for patients.

- Inform patients and caregivers about available resources they can request, such as survivorship care plans or long-term recommendations about screening and follow-up.

- The introduction of palliative care early in the course of treatment may prolong survival and improve the quality of life and mood for lung cancer survivors with metastatic non-small cell lung cancer. Promote patient-provider discussion of palliative care options.
ADDRESSING STIGMA

- Lung cancer is often socially stigmatized, which can lead to emotional distress and limited illness related disclosure. Providers should avoid stigmatizing the illness and be aware of the pervasive influence of societal stigma on both smokers and nonsmokers with lung cancer.

- Stigmatization can also potentially deter patients from seeking support. Address lung cancer stigma in your messaging to promote early medical help-seeking behavior.

FREQUENTLY ASKED QUESTIONS

What is lung cancer?

- Lung cancer begins when cells that are not normal grow inside the lungs. The lungs are part of the respiratory system, which controls breathing.

What causes lung cancer?

- Smoking (cigarettes, cigars, and pipes) causes 80-90 percent of lung cancers. Also, non-smokers who breathe secondhand smoke (smoke from others) at home or at work increase their lung cancer risk by 20-30 percent.

- Radon (a gas you cannot see or smell) can also cause lung cancer. Radon comes from rocks and soil. It can be found in places with poor airflow, such as mines, and in some homes. The basement is where radon levels are highest in the home, because it is the closest room to the soil.

- Other risk factors include air pollution, a personal or family history of the disease, and exposure to asbestos, arsenic, chromium, nickel, tar and other substances found in some workplaces.

What are symptoms of lung cancer?

- Early lung cancer may not cause any symptoms. Doing all you can to prevent the disease is important. Symptoms may appear after lung cancer develops and grows. These include a cough that does not go away, trouble with breathing, chest pain, coughing up blood, a hoarse voice, lung infections that keep coming back, feeling weak and tired, and loss of appetite. Often, these problems are caused by other health issues. People with any of these symptoms should see their doctor.

What are screening tests?

- Screening tests help doctors find many cancers early, when they are easiest to treat. The only recommended lung cancer screening test is a low-dose CT scan which is a picture that helps your doctor see tumors or growths in your lungs.
FREQUENTLY ASKED QUESTIONS

Do I need to have an LDCT lung screening exam every year?

- Yes. If you are high-risk, an LDCT lung screening exam is recommended every year until you are 80 years old.

How do I determine if I am high risk?

- High-risk persons are defined as people who: are ages 55-80, have a 30 pack-year * smoking history, and are current smokers or have quit within the past 15 years. Individuals meeting these criteria should receive the LDCT annually.

  * Pack-year = packs a day x number of years smoking
    (ex: 2 packs a day x 15 years = 30 pack-year smoking history)

How is the exam performed?

- The exam takes less than 10 minutes using a low-dose CT scan. You will lie on your back on the CT scan table with your hands above your head. The table will move in and out of the machine that takes the images. No medications are given, and no needles are used.

- You can eat before and after the exam. You must, however, be able to hold your breath for at least six seconds while the chest scan is taken.

Are there any risks to LDCT lung screening?

- Your healthcare provider who ordered the screening may want to talk with you about the risks.

- Radiation exposure: LDCT lung screening uses radiation to create images of your lung. Radiation can increase a person's risk of cancer. By using special techniques, the amount of radiation in LDCT lung screening is small – about the normal amount received from the sun in a year. Further, your physician has determined the benefits of the screening outweigh the risks of being exposed to the small amount of radiation from this exam.
RESOURCES

Tobacco Cessation Services

- Certified Tobacco Treatment Specialist Training Programs - [https://ctttp.org/accredited-programs](https://ctttp.org/accredited-programs)
- WVU Cancer Institute - [http://wvucancer.org](http://wvucancer.org)
- WV Tobacco Quitline - [https://wvtobaccoquitline.com](https://wvtobaccoquitline.com)

Shared Decision Making Tools

- Memorial Sloan Kettering Cancer Center - [http://nomograms.mskcc.org/Lung/Screening.aspx](http://nomograms.mskcc.org/Lung/Screening.aspx)
- University of Michigan - [www.shouldiscreen.com](http://www.shouldiscreen.com)

West Virginia Resources

- WVU Cancer Institute Bridge Program (Cancer Survivorship Program) - [http://www.wvucancer.org/cancer-prevention-control/bridge-program/](http://www.wvucancer.org/cancer-prevention-control/bridge-program/)
- WV State Cancer Coalition, Mountains of Hope - [https://moh.wv.gov](https://moh.wv.gov)
- WV Lung Cancer Careline, 1-866-684-2479 - [https://wvlungcancer.pafcareline.org/](https://wvlungcancer.pafcareline.org/)

National Resources

- American Cancer Society - [www.cancer.org](http://www.cancer.org)
- American Lung Association - [www.lung.org](http://www.lung.org)
- Centers for Disease Control and Prevention - [www.cdc.gov/cancer/index.htm](http://www.cdc.gov/cancer/index.htm)
- George Washington Cancer Center and eLearning Series - [https://smhs.gwu.edu/gwci/survivorship/ncsrc/elearning](https://smhs.gwu.edu/gwci/survivorship/ncsrc/elearning)
- Lung Cancer Alliance - [https://lungcanceralliance.org/](https://lungcanceralliance.org/)
- National Cancer Institute - [www.cancer.gov](http://www.cancer.gov)


REFERENCES


Lung Cancer Screening: A Clinician’s Checklist

This checklist was developed to help clinicians meet the Centers for Medicare & Medicaid Services (CMS) criteria for a lung cancer screening counseling and shared decisionmaking visit. All of the criteria listed below must be met for the screening to be covered as a preventive service benefit under Medicare.

**Before...**

**The Clinical Encounter**

Determine patient’s eligibility.

This checklist may be completed with the assistance of a nurse, physician assistant, or other medical assistant.

- Is the patient 55 to 77 years old? (55 to 80 years old for patients with private insurance)
- Yes  No
- Is the patient a current smoker or former smoker who has quit within the past 15 years?
- Yes  No
- Does the patient have at least a 30 pack-year smoking history?
- Yes  No
- Is the patient asymptomatic for lung cancer with no personal history of lung cancer?
- Yes  No
- Is the patient healthy enough to have lung surgery?
- Yes  No
- Is the patient willing to receive potentially curative treatment?
- Yes  No

**During...**

**The Clinical Encounter**

Complete all of the following activities.

- Documented all elements in the patient’s medical chart.
- Used a decision aid
- Discussed potential benefits of lung cancer screening:
  - Reduced mortality from lung cancer
- Discussed potential harms of lung cancer screening, including:
  - False-positive results
  - Followup testing if an abnormality is found (and the possible complications of invasive testing)
  - Overdiagnosis
  - Total radiation exposure (screening and diagnostic testing, cumulative)
- Discussed other issues:
  - The impact of comorbidities on screening (the benefit of screening is reduced in patients with poor health)
  - The patient’s ability or willingness to undergo invasive diagnostic procedures and treatment
- Counseled about:
  - The importance of adherence to annual lung cancer screening
  - The importance of maintaining cigarette smoking abstinence or smoking cessation, as applicable
  - Tobacco cessation interventions (provided information, if appropriate)

**After...**

**The Clinical Encounter**

Establish the next steps.

- If the patient would like screening, provide a written order for the lung cancer screening visit with the following elements:
  - Patient’s date of birth
  - Actual pack-year smoking history
  - Current smoking status; for former smokers, the number of years since quitting
  - Statement that the patient is asymptomatic
  - National Provider Identifier (NPI) of the ordering practitioner
  - If the patient declines screening, document the discussion and the patient’s decision in his or her medical record.
  - If the patient is unsure about screening or wants more time, consider scheduling a followup visit to discuss the patient’s screening decision.
  - For all patients, reinforce the importance of smoking cessation and abstinence.

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*Screening is not recommended. If the patient is a current smoker, encourage smoking cessation and provide resources. If the patient is a former smoker, encourage continued abstinence and provide additional support if needed.*

*Symptomatic patients may need followup and diagnostic testing, but not screening.*

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**Calculate Pack-Years**

(20 cigarettes = 1 pack)

Number of years smoked x Average number of packs smoked per day = Pack-years
The importance of shared decisionmaking

Lung cancer screening with low-dose computed tomography (LDCT) reduces mortality from lung cancer. There are also potential harms associated with lung cancer screening, including a high-false positive rate and the associated need for diagnostic followup, known and unknown risks of additional testing associated with incidental findings, cumulative radiation exposure, and overdiagnosis. Shared decisionmaking is a collaborative patient-centered process in which patients and clinicians make decisions together, within the context of the best evidence and recommendations and based on the patient’s values and preferences.

Tips To Promote a Shared Decision
Below is a five-step process for shared decisionmaking that includes exploring and comparing the possible benefits and harms of each option through meaningful dialogue about what matters most to the patient.

STEP 1: Seek your patient’s participation in the decisionmaking process.
STEP 2: Help your patient explore and compare the potential benefits and harms of lung cancer screening, and assess your patient’s level of understanding. (See the teach-back examples in the box to the far right.)
STEP 3: Assess your patient’s values and preferences about lung cancer screening.
STEP 4: Reach a decision about lung cancer screening with your patient.
STEP 5: Evaluate your patient’s feelings about the decision by having a followup discussion.

Talking Points
Below are specific points to address during the clinical encounter.

- Lung cancer screening can be effective if patients 1) follow the screening protocol, 2) undergo diagnostic followup procedures after a positive screening result, and 3) receive treatment, which has potential harms.
- Screening does not mean that smoking is OK. Smoking still causes lung cancer, cardiovascular disease, and other lung disease.
- Screening can lead to early treatment that can prevent some, but not all, lung cancer deaths.
- False-positive results (“false alarms”) are common, and additional scans or invasive procedures may be needed. Less commonly, major complications of invasive procedures can occur, including bleeding, infection, or a collapsed lung.
- Lung cancer screening may find lung cancer that would not have ever caused symptoms or harmed the patient in his or her lifetime if the cancer had not been found. This could lead to treatment of people who do not really need treatment.
- Screening and followup testing exposes patients to radiation. The harms associated with cumulative radiation exposure are unknown.
- Screening should stop if the patient 1) exceeds the upper age criterion, 2) no longer wants screening, 3) has a worsening health condition that limits their life expectancy or increases the risk of complications from lung surgery, or 4) has not smoked for 15 years.

Teach-Back Examples

“T...
Lung Cancer in West Virginia

Lung Cancer Incidence in West Virginia per 100,000 people: 79.3
Lung Cancer Deaths in West Virginia per 100,000 people: 57.0

Lung cancer is the leading cause of cancer related deaths in West Virginia.
Regular lung cancer screening can detect cancer early when it is easier to treat and cure.

Lung Cancer Risk Factors
- Smoking
- Secondhand smoke
- Radon
- Environmental exposures
- Personal or family history of lung cancer

Average Annual Age-Adjusted Late Stage Lung Cancer Incidence Rates by County, West Virginia, 2012-2016*

Lung Cancer Screening Guidelines:
Low-Dose Computed Tomography (CT)
Yearly CT (low-dose) is recommended for people who:
- Are 55 to 80 years old, and
- Have a 30 pack-year* smoking history, and
- Are either current smokers or smokers who quit in the past 15 years.

* pack-year = packs a day x number of years smoking
(ex: 2 packs a day x 15 years = 30 pack-year smoking history)

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