A large health system's approach to utilization of the genetic counselor CPT® 96040 code

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Purpose: In 2007, CPT® code 96040 was approved for genetic counseling services provided by nonphysician providers. Because of professional recognition and licensure limitations, experiences in direct billing by genetic counselors for these services are limited. A minority of genetics clinics report using this code because of limitations, including perceived denial of the code and confusion regarding compliant use of this code. We present results of our approach to 96040 billing for genetic counseling services under a supervising physicians National Provider ID number in a strategy for integration of genetics services within nongenetics specialty departments of a large academic medical center. **Methods:** The 96040 billing encounters were tracked for a 14-month period and analyzed for reimbursement by private payers. Association of denial by diagnosis code or specialty of genetics service was statistically analyzed. Descriptive data regarding appointment availability are also summarized. **Results:** Of 350 encounters January 2008 to February 2009, 289 (82%) were billed to private payers. Of these, 62.6% received some level of reimbursement. No association was seen for denial when analyzed by the diagnosis code or by genetics focus. Through this model, genetics appointment availability minimally doubled. **Conclusion:** Using 96040 allowed for expanding access to genetics services, increased appointment availability, and was successful in obtaining reimbursement for more than half of encounters billed. ***Genet Med*** **2011:13(12):1011–1014.**

Key Words: *genetic counseling, 96040, billing, reimbursement*

Genetic counseling has long been supported by many professional medical organizations as essential to the healthcare of patients concerned about the predisposition to, occurrence or recurrence of disease.[1–4] However, billing for genetic counseling services (GCS) is inconsistent nationally.[5]

Common challenges in developing a reimbursement strategy have included the lack of consistent state and federal recognition of genetic counselors. State governments regulate healthcare practitioners and standards of medical services in a state through licensure laws. Currently, only 13 states have passed legislation for licensure of certified genetic counselors, with eight states actively issuing licenses and additional states actively pursuing this.[6] The Federal Social Security Act of 1935, regulated by the Center for Medicare and Medicaid Services (CMS) and the US Congress, defined which nonphysician healthcare providers (NPPs) can provide and bill Medicare directly under their own National Provider ID (NPI) number, for healthcare services.[7] This act was passed before the existence of genetic counseling as a healthcare field, and thus, genetic counselors, although now approved to obtain an NPI, are not recognized as billable NPPs by Medicare. Private health insurance payers (participating provider organizations) or Health Management Organizations are not required to follow these CMS guidelines to determine which services they will or will not reimburse; nonetheless, CMS often serves as a guide even for the former.

In 2007, the American Medical Association (AMA) approved the Current Procedural Terminology (CPT®) code 96040, for services provided by a trained nonphysician genetic counselor and included obtaining and constructing of a structured family health history, analysis of available medical information for genetic risk analysis, genetic education, and psychosocial assessment of the patient and family.[8] When these services are performed by a physician provider, an Evaluation and Management CPT® code (E&M) is used. Before this date, no accurate medical billing code specifically for GCS provided by a genetic counselor was available. Although this signifies the recognition by the AMA of GCS as important and separate services, Medicare does not reimburse this code as a separately billable service due to the above discussed lack of recognition of genetic counselors as NPPs by CMS and that these services are also bundled into the E&M services of a CMS-approved physician. The relative value of professional provider work performed with this code as available in the published Medicare fee schedule is low, as genetic counselors are not yet CMS-recognized professional providers. A survey performed among the National Society of Genetic Counselors revealed only 24% of genetic counselors, who reported billing for their services, used this code with varied strategies and reimbursement.[5]

The Center for Personalized Genetic Healthcare (CPGH) is the clinical component of the Genomic Medicine Institute within the Cleveland Clinic (CC). CPGH first began providing clinical patient care in the Fall of 2005, and at the time of study, study was staffed by four MD geneticists, for a total of 1.8 clinical full time equivalents (FTE) dedicated to clinical care and 10 genetic counselors with 6.5 clinical FTE. Clinical foci span all medical genetics and subspecialties, but at the time of this study initiation, primarily consisted of cancer, pediatric, and general genetic services.

From 2005 to 2008, all clinical patients were seen using the paired MD-genetic counselor model, where all patient encounters involved active patient face-to-face contact by both the genetic counselor and the attending MD geneticist. Family history and medical history were primarily collected by the genetic counselor, focused differential diagnosis-seeking history and physical examination performed by the MD, and counseling on the diagnosis, suspected diagnosis, and possible testing would be performed by the genetic counselor, the MD, or both providers as a team. Within this service delivery model, all encounters were billed using the appropriate E&M CPT® codes, namely, 99201–99205; 99241–99245; 99212–99215, or the preventative services codes 99401–99404, as appropriate, for the

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MD geneticists' time only. Time spent by the genetic counselor was not billed.

In response to increasing demand for GCS across a wide array of specialties within the CC health system (CCHS), an effort to improve access was initiated. The main goals of this initiative included decreasing patient wait time; increasing financial support for the genetic counseling staff; and increasing the integration of GCS into as many as possible nongenetics specialty departments within the hospital system while maintaining compliant reporting of the services rendered. Currently (first quarter, 2011), we have integrated our genetics services into 25 different nongenetics clinic locations belonging to the Taussig Cancer Institute, Heart Vascular Institute, Pediatrics Institute, Obstetrics/Gynecology and Women's Health Institute, Digestive Diseases Institute, Head and Neck Institute, Wellness Institute, etc. CCHS is unusual in that it recently (from 2007 onward) switched to an institute's model and both medical and surgical (and other relevant) departments/services reside within a single clinical institute. For example, we service both the medical gastroenterology and surgical gastroenterology services within the Digestive Diseases Institute.

The compliance department was consulted to determine the most accurate strategy for and is a crucial element for attempting to establish an approach to GCS billing model within our large academic medical center. An analysis by the CCHS compliance team determined that the 96040 CPT® code clearly defines the services described as being provided by a nonphysician genetic counselor. Within the CCHS, GCS could be then provided at the request of a CCHS physician, with a supervising (genetics or nongenetics) physician on location, using the 96040 code under the NPI of the supervising physician. The supervising physician's NPI number was used to reflect supervision of these services, whereas 96040 was selected as the most transparent coding that most accurately reflects the services provided by a NPP genetic counselor. A model of service was developed providing GCS within requesting departments, in collaboration with the requesting physicians using this code. This plan allowed for the physical separation of genetic counselor and the MD geneticist and also allowed for billing of the genetic counselor time.

Use of E&M CPT® codes is available for use by NPPs; however, these codes are limited in the ability to accurately portray GCS provided. For this reason, 96040 was selected as the most accurate description of the services being rendered under this model. A rate deemed customary and reasonable for the region, based on comparable services for this time-based code was determined with the assistance of CCHS's compliance and contracting departments.

Encounters billed in this manner to third party private payers were then left to the payer to determine whether the services were a covered benefit. For payers, the definition of the 96040 code made it clear that the services were provided by a NPP genetic counselor. Use of the supervising physician NPI number communicated supervision of services and an avenue for initial inclusion into the payer system for review of coverage. Incorporation of this model required notification of all incoming patients of the possibility that the requested GCS may not be a covered service by their payer, with the provision of options to prepay for the appointment if preferred. For all Medicare patients, it was already known that the GCS billed under the 96040 code would not be considered as covered services.[9] For GCS, as part of a bundled service, the institution absorbed the costs. For Medicare patients seen for noncovered preventive reason, such as family history, the patients are asked to complete an Advance Beneficiary Notice, confirming acceptance of uncovered expenses.

In this study, we sought to describe our approach of using the AMA's CPT-defined code for genetic counseling when performed by genetic counselors, CPT-96040, and under the onsite supervision of a physician, whether geneticist or nongeneticist.

MATERIALS AND METHODS

This model was strategically incorporated across the CPGH and CCHS, targeting departments that may experience a higher proportion of patients who would benefit from GCS, and where a nongenetics MD provider had indicated a strong interest in championing the incorporation of GCS. Patient encounters within the initial 14 months of building this model where 96040 was billed were tracked using Compass software and analyzed for third party private payer reimbursement. All encounters, where the patient chose to self-pay or where Medicare/Medicaid was the sole coverage and thus 96040 had no reimbursement, were removed from analysis.

A designated billing specialist (and a CPGH employee) who reviewed denials and coordinated appeals for all cases where this was necessary also assisted in collection of data. All data analyzed were from closed accounts, after completion of all appeals for payment had concluded. Data obtained included date of service, insurance carrier, type of encounter (cancer genetics or general genetics evaluation), associated diagnosis code, total charges, total payment, percentage of charges paid, and in some cases minimal details regarding reason for denial of coverage were available. Because of limitations of contract protection, detailed financial return including payer breakdown or monetary value returned cannot be provided.

Data were analyzed using Graph Pad Software[10] for aggregate categorical and descriptive statistics. Fisher's two-tailed exact test was used to evaluate for potential association of reimbursement and type of diagnosis code, or type of genetic services provided. Comparison of average GCS encounters per week pre- and postincorporation of this model was performed as a descriptive measure of access to GCS.

RESULTS

In the analyzed 14-month period from January 2008 to February 2009, 350 patient encounters could be agnostically (i.e., if we ignored who the payer is) viewed as in alignment with CPT® 96040. For 61 encounters, the patient self-paid ($N = 10$) or had Medicare/Medicaid ($N = 51$), and these encounters were removed before analysis. This allows for evaluation of third party private payer reimbursement for the remaining eligible 289 encounters that were actually billed to third party private payers. Of these 289 encounters, 181 (62.6%) encounters received some level of financial reimbursement by the third party private payer for 96040; and 108 encounters received no reimbursement for the services coded with 96040 by the third party payer. Of the denied encounters, 87 included comments regarding reason for denial. The limited descriptions or reason for denial included "coding concerns," "policy limitations," "bundling of services," and "registration or preauthorization" problems (Table 1).

There was no significant difference in reimbursement for encounters by active diagnosis ICD-9 code or a preventive services ICD-9 V code ($P = 0.39$; Table 2). There were also no differences in reimbursement or denial of 96040 by the third party private payer by clinical specialty of the genetic risk assessment performed (cancer genetic risk analysis versus general genetics evaluation) ($P = 0.14$; Table 2).

Table 1 Reasons for denial of 96040 encounters by third party private payers

Reason for denial	No. encounters denied	Percentage	90% CI
Coding concern	30	37.4% (0.3448)	0.2667–0.4323
Policy limitation	21	24.1% (0.2414)	0.1741–0.3243
Bundling of services	29	33.3% (0.3333)	0.2562–0.4205
Registration/ preauthorization issue	7	8.0% (0.0805)	0.0426–0.1436
Total	87	100% (1.0000)	

Table 2 Evaluation of reimbursement by genetics specialty and ICD-9 code

	96040 reimbursement	
	None	Some
Genetic specialty ($P = 0.14$[a])		
General genetic assessment	19	46
Cancer genetic risk assessment	89	135
Primary diagnosis code ($P = 0.39$[a])		
Preventive services V-code	57	85
Active diagnosis	51	96

[a]Fisher's two-tailed exact test.

Under this model, an average of three patients/clinical FTE were seen per week at the beginning of the study compared with 6.5 patients/clinical FTE per week at the end of the study period. At the end of 2010 (approximately 1 year 10 months after closure of the study), genetic counselors see an average of seven encounters/clinical FTE per week, with capacity to triple this volume, while holding FTE stable. With this model, CPGH has expanded to comprehensive genetic services, which have added cardiovascular genetics, obstetrics genetics, and many other subspecialty services to our core of general, pediatric, and cancer genetics, on main campus and the regional practice. With this accessability, CPGH is able to see referrals on a "same day" basis.

DISCUSSION

Establishing an approach or first-pass model of GCS delivery that enabled increased access to genetics expertise in a timely and reimbursable manner was necessary for the CPGH to respond to increasing demand for these services across a wide range of specialty departments within the CCHS. Analysis of this approach to billing using the 96040 code under the NPI of a supervising physician for a 14-month period (January 2008 to February 2009, inclusive) was promising in that more than half (62.6%) of the encounters billed to third party private payers received some level of reimbursement. A detailed analysis breaking down reimbursement by payer or rate of reimbursement for encounter could not be provided due to concerns for contract protection; however, it is notable that eight different third party private payers were represented in our patient population.

Although the particular billing approach used clearly defined CPT® codes for GCS provided by NPP genetic counselors, CMS does not recognize genetic counselors as billable healthcare professionals, and genetic counseling is valued as an unreimbursed preventative service. For these reasons, Medicare patients seen for preventive reasons were prenotified that these services were not a covered benefit and provided the opportunity to self-pay. GCS provided to Medicare patients with medical conditions are considered bundled into the physician's evaluation and management service and, therefore, were not billed to Medicare or to the patient. Patient self-pay encounters were not analyzed in this dataset. We hope that recent federal healthcare initiatives to encourage an increase in preventive healthcare and evaluation of the value added by genetic healthcare will increase recognition for these valuable preventive services for Medicare patients.

Of encounters where information on the reason for denial was obtained, only one third of these were due to concerns regarding the particular 96040 code, and another one third of these denials were due to limitations of the particular policy. Unfortunately, specific details regarding these were not available. These could be hypothesized to include a lack of awareness by the payers, selection of a particular policy excluding coverage of GCS, or a lack of the new code within these payers' billing systems. These are issues that could be addressed through educational initiatives targeting these payers. Approximately one third of these denials were due to bundling of services. GCS and "counseling and coordination of care services" included in the E&M service codes have been interpreted as one and the same by some payers, and thus, E&M codes billed on the same date of services as a 96040 service may be interpreted as a repetition of the same services. Further education for payers regarding the unique and complex services provided by trained and certified genetics professionals may assist in reducing this confusion. The minority of denials for 96040 were reported due to registration or preauthorization error; these are easily avoidable at the front end and likely unrelated to the particular code used.

No significant difference was seen in reimbursement when analyzed for type of GCS provided or when analyzed for active or preventive diagnosis code. This is promising for the future as federal healthcare initiatives further stress the importance of preventive care and the use of predictive genetic testing to tailor management become more and more prevalent, the ability to support the increasing demand for GCS by healthy individuals will be needed.

One argument against this particular model is that the reimbursement levels for 96040 are lower than those received for the E&M codes. However, when examining the ratio of professional time used and access, before the installment of this model, each patient spent approximately 45–60 minutes with the GC and 10–30 minutes with the MD geneticist, of which only the MD time was billable and the number of encounters per week were limited by MD availability. Following establishment of this model, each patient spent approximately 45–60 minutes with the GC with services provided reflective of the defined genetic counselor scope of practice.[11,12] Complex cases necessitating a full medical genetics evaluation including a physical examination were prioritized and triaged to the MD geneticist, resulting in more judicious use of the limited MD clinical time. All GC and MD time was billable, and the number of available patient encounters per week increased and continue to increase while

holding FTE stable. This type of approach may also be amenable to extending GCS to regional and community practices.

Another benefit of our approach involves the anecdotal experience that this model contributed to the greater genetics education of the collaborating CCHS physicians. Within this particular model, a genetic counselor was available in the requesting specialty departments to serve as a consulting genetics expert for their providers and patients. Marketing of this model and the services provided also included provider-directed presentations regarding the benefits of GCS often in the environment of grand rounds, case reviews, and staff meetings.

A challenge against this particular approach lies in the definition of the 96040 code. This approach bills for GCS under the NPI of the supervising physician as "services provided as an extension of the referring providers care plan." The exact definition of 96040 states that this code is "for services provided by a trained nonphysician genetic counselor," and thus, use of this code under the NPI of a physician provider may be questioned by some. The ideal use for 96040 would be for genetic counselors to bill under their own NPI number as uniquely trained, credentialed, and contracted healthcare providers. Additionally, the 96040 code does not recognize the professional education obtained by certified genetic counselors, as the published value assigned for professional GCS is limited by the lack of CMS recognition for genetic counselors as individual health professionals. Relative values assigned to the 96040 code do not accurately reflect the professional expertise involved in GCS. One option to address these points is for CCHS clinical institutes to develop contracted relationships with their private payers for direct genetic counselor billing with inclusion of fair value rates which reflect the services provided. However, without contracting negotiations or until Federal recognition for GCS is established, institutional compliance and coding departments will be the best resource to provide guidance and interpretation on the use of these codes.

As ongoing initiatives for adoption of the 96040 CPT® code occur and to expand access to genetic expertise through genetic counselor state licensure and advocacy to initiate federal CMS inclusion of genetic counselors as nonphysician providers, demand for our colleagues to further investigate and share their experiences in developing models of care is necessary. Although no single model will likely work for all organizations, we advocate for the sharing of each achievement or failure to fully appreciate and develop strengths, challenges, opportunities, and tactics to assist our colleagues in medical genetics to adapt to the increasing demand for broad genetics expertise as genetics knowledge paves the way for personalized healthcare.

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