

PRIMER ON BILLING AND REIMBURSEMENT FOR GENETIC COUNSELORS

1. Introduction
2. Terminology and Definitions
3. Billing Process
4. Payers
5. Compliance
6. Creating Contracts
7. Actions to facilitate billing and reimbursement issues

1. INTRODUCTION

There are many different billing strategies currently being employed by GCs. There is great confusion within the genetic counseling community about how to accurately and legally bill for services. In addition, many counselors remain uncertain about the best resources available to help clarify genetic counseling billing options. This primer was designed to help genetic counselors understand the basics of billing and reimbursement for provided services. However, **this does NOT constitute a legal document.** None of the information contained in this web page substitutes for state law or compliance department policies within individual institutions. Each institution must establish its own policies and procedures regarding appropriate billing for genetic counseling services in the context of their own state law.

For more in-depth coverage of billing and reimbursement issues for medical genetics and genetic counseling services, we recommend the following resource:

Manual on Reimbursement for Medical Genetics Services, 2002. Marc Williams, MD, Editor-in-Chief. American College of Medical Genetics. Publisher: Kendall-Hunt Publishing, Dubuque, IA; ISBN: 0-7872-9848-4
<http://www.acmg.net/resources/reimbursement/manual-reimburse.pdf>

2. TERMINOLOGY AND DEFINITIONS:

Accreditation – A process by which a program of study or an institution is recognized by an external body as meeting certain predetermined standards to assure the public of the quality of the accredited institution or program. The state or federal governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals.

Capitation – A method of payment, characteristic in Health Maintenance Organizations, for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time.

Certification – Certification is the principle method by which a profession gives formal recognition to an individual who has demonstrated competence in a defined area of specialization in the professional field. Many times, this consists of passing an examination and/or demonstration of continuing education in the profession.

CMS (Centers for Medicare and Medicaid Services) - Formerly HCFA (Health Care Financing Administration), CMS is an arm of the Health and Human Services branch of the federal government and is responsible for administration of Medicare and Medicaid programs and funding.

CMS (HCFA) 1500 Claim Form - Medicare requires that all physicians submit this form when billing for Medicare patients. It is also usually required for submission of bills to Medicaid. <http://cms.hhs.gov/providers/edi/1500info.asp>

Compliance Office – The responsibility of an institution's compliance office is to ensure that the institution or department is following appropriate steps in billing. The office sets up a series of internal controls and measures to ensure that the institution/department is following federal, state and local statutes and regulations governing federally funded health care programs.

Consumer-directed plans – A new model in which the client sets up a health savings account. The money in this account can be used to pay for traditional health services plus some additional services. These plans generally have a deductible after the savings account is depleted.

CPT codes - <http://www.ama-assn.org/ama/pub/category/3113.html>
Current Procedural Terminology codes (CPT) are copyrighted by the American Medical Association and are used as universal descriptions of services rendered. CPT codes are recognized by virtually all third-party payers. Combined with ICD-9 (diagnosis/condition) codes, CPT codes were designed to easily inform the payer the exact type(s) of services that were provided and why each was provided. Centers for Medicare & Medicaid Services (CMS) require CPT coding; payment is based on Relative Value Units (RVUs) assigned to each code. Other third-party payers typically base fees on these RVU's, although there may be a discrepancy in reimbursement levels. Currently, there are no specific billing codes for genetic counseling; therefore, most genetic counselors have been using existing codes for office visits or consultations.

Credentialing - The process of permitting an individual health care provider to practice in a particular hospital, clinic or other medical practice setting. Credentialing committees are free to establish reasonable criteria which include, at a minimum, a valid professional license and/or valid certification, and verification of undergraduate and graduate medical education. Many third party payers also require credentialing of providers within their plans.

Customary, Prevailing, and Reasonable (CPR) – Current method of paying physicians under Medicare. Payment for a service is limited to the lowest of 1) the physician's billed charge for the service, 2) the physician's customary charge for the service, or 3) the prevailing charge for that service in the community. Similar to the Usual, Customary, and Reasonable system used by private insurers.

Diagnosis Related Groups Groupings of diagnostic categories drawn from the International Classification of Diseases (ICD) that aggregate patients into case types based on diagnosis and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs work by taking the 10,000+ ICD-9-CM codes and grouping these into a more manageable number of meaningful patient categories (close to 500 now). Patients within each category are similar both clinically and in terms of resource use. DRG coding is the system used by Medicare to

pay hospitals since 1983. DRGs are also used to classify a hospital's "case-mix" (i.e. types of patients seen) which is used in Medicare's prospective payment system.

ERISA - Employee Retirement Income Security Act of 1974 - Self-insured, self-funded plans that are exempt from state insurance regulations. They are regulated by the U.S. Department of Labor. Pre-verification or pre-authorization of services is strongly recommended as ERISA-covered benefits may vary considerably from state-regulated plans.

Exclusive provider arrangement (EPA) – An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

Fee for service (FFS) - The traditional model of reimbursement in which practitioners charge separately for each patient encounter or service rendered and are reimbursed based on their submitted fees and according to a percentage set by the third party payer.

Health Care Common Procedure Coding System (HCPCS) codes -

<http://cms.hhs.gov/medicare/hcpcs/default.asp>

The HCPCS was developed in 1983 by the Health Care Financing Administration to standardize the coding systems used to process Medicare claims nationally. It is a three tier coding system that includes (1) CPT codes, (2) spell out(HCPC) national codes defined by Health Care Finance Administration (HCFA), and (3) local or state codes defined by local Medicare/Medicaid intermediaries (Note: as of April 2003 when HIPAA rules went into effect, state-specific codes should be eliminated). These codes must be used when billing Medicare and are typically used in billing Medicaid as well. In addition, most private insurers also allow or mandate the use of these codes. The HCPCS are alphanumeric five digit codes with the first digit a letter from A-Z and can include two digit modifiers. They are revised annually in December; therefore, it is important to obtain a new coding list each year.

Health Maintenance Organization (HMO). Prepaid medical service plans in which members must use contracted service providers.

Health Insurance Portability and Accountability Act (HIPAA) –

US Dept of Health and Human Services: HIPAA <http://www.hhs.gov/ocr/hipaa/>

- CMS- HIPAA web sites <http://www.hipaa.org/>

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule creates national standards to protect individuals' medical records and other personal health information. First passed in 1996 and amended in 2003, HIPAA gives patients more control over their health information, sets boundaries on the use and release of health records, establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information, holds violators accountable, and aims to strike a balance when public responsibility supports disclosure of some forms of data – e.g. to protect public health. It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure and gives patients the right to examine and obtain a copy of their own health records and to request corrections.

ICD-9-CM codes -

<http://www.cdc.gov/nchs/about/otheract/icd9/abtcd9.htm>

<http://www.eicd.com/default.htm/>

The International Classification of Diagnoses, 9th Revision, Clinical Modification (ICD-9-CM) is the coding system used to describe a disease or condition. It is mandatory by law that all physicians use ICD-9-CM codes when reporting patient diagnoses to Medicare. It is advisable to use ICD-9-CM codes for all third party claims.

Licensure – The granting of a license to practice a specific profession, based on the power of a state to protect health, welfare and safety of citizens. Licensure is practice-based. At this time, most states do not have licensure for genetic counselors. However, licensure may allow professionals within a state to become recognized providers and may allow for better billing practices.

Managed Care – A health plan that initiates selective contracting to channel patients to a limited number of providers and requires utilization review to control unnecessary use of health services.

Medicaid - A public program jointly funded by state and federal dollars. It is meant to provide health care benefits for people who meet certain income requirements. It is managed by the state with federal oversight provided by Centers for Medicare & Medicaid Services (CMS, previously called HFCA). Services vary considerably from state to state. Billing requirements are usually the same as those for Medicare.

Medicare - CMS oversees the Medicare program which was first established in 1965 to cover persons 65 and older and those who qualify for disability benefits.

Medicare + Choice plans - CMS contracts with local managed care plans or provider run plans to provide Medicare services. The local managed care organizations are paid monthly by CMS based on a per capita formula. These plans often require less paperwork and provide additional benefits for subscribers.

Point of Service plans (POS) – Allow a choice of receiving services from a participating (In-network) or nonparticipating (out of network) provider, with only a percentage of out-of-network service costs reimbursed.

Pre-Authorization - The third-party payer for each patient should be contacted prior to the visit to confirm eligibility and coverage and to request a referral/preauthorization number if necessary. For some plans, preauthorization may not be necessary.

Preferred Provider Organizations (PPO): A group of hospitals and physicians who provide services to insurance company clients for a set fee paid to the group. Coverage is usually 100% with a minimal co-payment for each office visit or hospital stay.

Superbill - A standardized, preprinted, insurance form that contains all the relevant and necessary billing information regarding the provision of services for a particular clinic. Superbills are usually created by each department and can be modified to include codes that are typically used. They may also include spaces for writing in additional services.

Tricare (previously Civilian Health and Medical Program of the Uniformed Services or CHAMPUS) - Covers medical claims for military employees and their families. Providers must apply for and be approved to receive reimbursement for services. For services not available from Tricare providers, the patient must have an approved “non-availability statement” in order to see and be reimbursed for services from a civilian provider.

Unique Provider Identification Number (UPIN) - CMS establishes a unique identifier for all physicians, called the UPIN, a six-place alpha/numeric identifier, to be used for Medicare and Medicaid billing purposes.

3. BILLING PROCESS OVERVIEW

The appropriate use of CPT codes by genetic counselors and/or the level of CPT codes that should be used for counselor-only sessions remains unclear at this time. Some genetic counselors who bill under their own name tend to use only the lowest level codes because of institutional or compliance department policies, or as a result of the counselor's own discomfort with billing and compliance policies. Some genetic counselors submit bills for service when a physician also sees the patient, but in these instances only the physician's face-to-face time is accounted for when selecting the appropriate CPT code level. In addition, a number of genetic counselors have been informed by their institutions or compliance departments that they are not allowed to bill at all. The reality is that every institution has its own interpretation of what is allowed as far as billing for genetic counseling services. In addition, each insurance plan has its own definition of allowable services and how to bill.

How to use CPT codes

[SEE APPENDIX A: Billing and Reimbursement Codes](#)

According to the CPT 2003 standard edition, with the collaboration of the American Medical Association, the "listing of a service or procedure and its code number in a specific section.....does not restrict its use to a specific specialty group. Any procedure or service in any section...may be used to designate the services rendered by any qualified physician or other qualified health care professional".

CPT codes are graded by the complexity and length of time of the appointment. The complexity is based on the patient's history, physical examination, the severity of the presenting problem and the resulting decision-making. The CPT code determines the level of reimbursement for the health care provider. Thus, there are rules that must be considered when coding for a visit so that it accurately reflects the visit type: "new patient (99201 to 99205)", "established patient (99211 to 99215)" or "consultation (99241-99245)", etc. The key to good reimbursement is to use the highest level CPT code that can be legitimately justified and documented by the length and intensity of the patient visit. It is critical that the summary note or chart support the use of the CPT code. It is medical fraud to inflate CPT codes to collect reimbursement that is not justified by the referral. (Refer to ACMG Manual on Reimbursement, 2002).

Clinics which receive state or federal funds are usually audited annually. There must be adequate documentation to justify all CPT codes or the institution could be fined and ordered to reimburse fees. All codes submitted for reimbursement to Medicaid or Medicare organizations (with the exception of health and behavioral codes and facility fee codes) pertain to services provided by a physician or a Medicare designated provider, of which genetic counselors are not yet recognized. However, some genetic counselors use these codes for billing private third party

payers. Categories of “Evaluation and Management (E&M)” codes applicable to genetics services include:

- Consultation Codes – limited to services provided to a patient who is referred by another physician. Consultation codes should not be used for patients who are self-referred.
99242 -245 Consultation service, new and established patients
 - Reimbursable at a higher rate than office visits. Criteria for using:
 - Written or verbal request must be made by the patient’s physician and documented in the patient’s medical record
 - Consultant’s opinion and services ordered/performed must be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.
 - When counseling and/or coordination of care represent at least half of the time spent on the appointment, it is generally appropriate to use time as the key element to correctly code the service.
- Office Visit Codes – can be used for any patient and should be used for those that are self-referred. Usually results in a lower level of reimbursement than consultation codes.

99201-205 Office/Outpatient service, new patient (self-referred)

99211-215 Office/Outpatient service, established patient

- Preventive Medicine/Risk Reduction Codes –may be less likely to be reimbursed by third party payers. However, some genetic counselors have reported good success in using these codes.

Preventive medicine codes are used to report services provided to patients in order to promote health and prevent illness or injury. They are not to be used to report counseling and risk factor reduction intervention provided to patients with symptoms or established illness. These may be appropriate for patients with a family history of cancer seen for cancer genetic risk assessment and counseling.

- Preventive medicine, individual counseling 99401-99404
- Preventive medicine, group counseling 99411-99412

- Group Counseling 99078
- Health and Behavioral Assessment Codes for non-physicians - These codes describe services associated with an acute or chronic illness, prevention of a physical illness or disability and maintenance of health (not meeting criteria for a psychiatric diagnosis or representing a

preventive medicine services). Can include modification in a patient's behavior towards prevention, treatment or management of physical health problem or other factors that do not directly treat a diagnosed illness but affect recovery or its progression.

- Health and Behavior Assessment 96150
- Health and Behavior Intervention 96152
- Group (2 or more patients) 96153
- Family (w/patient present) 96154
- Family (w/out patient present) 96155

Each code is for a 15-minute face-to-face encounter

Health and Behavior assessment code (96150) is used to identify the psychological, behavior, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.

The health and behavior codes may be reported by, but are not limited to psychologists, advanced practice nurses, clinical social workers, and other non-physician healthcare professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessment/intervention procedures. At this time, it is unclear how these codes fit into the genetic counseling setting.

CPT codes most often used by genetic counselors:

Many medical geneticists and some genetic counselors bill for their services using either consultation codes (#9924X - 9925X, 9926X - 9927X) series (last digits entered depend on level of complexity), office visit codes (#9920X - 9921X), or counseling and risk factor reduction/intervention codes (#994XX). Each of these codes is defined in the CPT manual and is distinguished from one another by subtle yet distinct criteria (e.g., new or established patient, inpatient or outpatient, etc.). In addition, other considerations determine which codes to use. For example, consultation codes are limited to services provided to a patient who has been referred by another provider and **should not be used for patients who are self-referred**. In the case of a self-referred patient, the CPT manual restricts you to using an office visit code, which typically generates a much lower level of reimbursement. The risk reduction codes are the only ones available for group counseling.

Facility Fees: What are they and how do you use them?

Genetic counselors who are employees of a hospital may pursue billing as part of the "facility fee". Facility fees are typically negotiated with third-party payers, including state Medicaid programs, and are intended to allow reimbursement for costs associated with providing medical services. Genetic counselors who are employed by hospitals should consider initiating a discussion with the hospital administration department to discuss the option of "facility fee" billing, since use of this strategy will vary between institutions.

This billing strategy has been reported to be highly successful. However, facility fee codes are still linked to a physician name within the hospital (i.e. the supervising medical geneticist, perinatologist, or oncologist). The remuneration is typically smaller than allowed with office visit or consultation codes. Codes are facility-specific so the genetic counselor must see patients within the walls of the facility under which the services are being billed.

FACILITY FEE CODES: These may be state-specific so investigate appropriate codes with your particular institution.

99201 – 99205 (new patients)
99121 – 99215 (repeat patients)
99242 – 99245 (consultations)

“Incident to” billing – what is it and why can’t you use it?

“Incident to” billing enables certain categories of non-physician health care providers to bill through a supervising physician. Medicare permits this type of billing for the following non-physician practitioners: Clinical Psychologists, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists. Genetic Counselors are not included.

Since these categories of allied health care providers are determined by Congress, and genetic counselors are not included, CMS has ruled that it is inappropriate for Master’s level trained genetic counselors to bill as “incident to” the physician.

Rules regulating “incident to” billing are Medicare rules. While other payers often follow Medicare regulations, some third-party payers may be more flexible. Individual institutions may consider discussing genetic counseling services with contracted third-party payers in order to contract for reimbursement for genetic counseling services.

HCPCS codes - <http://cms.hhs.gov/medicare/hcpcs/default.asp>.

A three tier coding system that includes (1) CPT codes, (2) HCPC national codes defined by CMS, and (3) local or state codes defined by local Medicare/Medicaid intermediaries (Note: as of April 2003 when HIPAA rules went into effect, state specific codes should be eliminated). These codes must be used when billing Medicare and are typically used in billing Medicaid as well. This system is meant to be a uniform method for health care providers and medical suppliers to report professional services.

Some examples of HCPCS code additions for 2003 include:

S3820: Complete BRCA1 and BRCA2 gene sequence analysis for susceptibility to breast and ovarian cancer

Short Description: Comp BRCA1/BRCA2

S3822: Single-mutation analysis (in individual with a known BRCA1 or BRCA2

- mutation in the family) for susceptibility to breast and ovarian cancer
Short Description: Sing mutation brst/ovar
- S3823: Three-mutation BRCA1 and BRCA2 analysis for susceptibility to breast and ovarian cancer in Ashkenazi individuals
Short Description: 3 mutation brst/ovar
- S3828: Complete gene sequence analysis; MLH1 gene
Short Description: Comp MLH1 gene
- S3829: MSH2 gene
Short Description: Comp MSH2 gene

How to use ICD-9-CM codes*

[SEE APPENDIX A: Billing and Reimbursement Codes](#)

[*In addition: see the ACMG Manual on Reimbursement for more in-depth information on use of ICD-9-CM codes]

The ICD-9-CM code is a 4-5 digit number that indicates the reason for the referral or diagnosis. Some codes are more likely to generate reimbursement, and it is legitimate to submit more than one code if they apply to the purpose of the visit. It is also appropriate to keep resubmitting a rejected bill to find a code that is acceptable to the insurer, as long as the new codes reflect the referral reason.

Unfortunately, only a small proportion of genetic syndromes have specific codes. It can be difficult to find acceptable codes for preventative care (e.g., pre-conception counseling) versus prenatal care. Another problem is that the code for genetic counseling is a “V” code (V 26.3), which may not be reimbursed by insurers, especially when submitted with the indication of “family history of...”.

V codes are used for patients who are not being seen for a current illness. Services linked to some V codes are reimbursable. For example, Medicare will reimburse for V16.3 (“family history of breast cancer”) and V19.5 (“family history of congenital anomalies”).

Usually, one ICD-9 code is used by the insurer for each CPT code. However, it is appropriate to use as many codes as apply (average is 3).

- **What codes are appropriate for genetics services?**

A list of ICD-9-CM codes that have been used to bill for genetic services has been collected from genetic counselors and medical geneticists and can be found in Appendix A. This list is not comprehensive, nor have the codes been verified. Please use an official ICD-9-CM manual to verify codes and appropriate usage.

- **How to use ICD-9-CM coding when the patient sees more than one health care professional on the same day.** i.e. maternal age counseling then amniocentesis.
 - You must use different ICD codes for each appointment.

3. PAYERS: Private Third Party Payers, HMO's, Managed Care, Medicare/Medicaid, etc.

Private (non-government) Payers: There are currently over 3000 separate private companies and/or organizations that offer third-party payment of medical care for individuals. These constitute traditional insurance companies, HMOs, PPOs, self-funded plans, ERISA plans, consumer-directed plans, etc. It is generally true for all third-party payers that:

1. Covered benefits vary from policy to policy.
2. Many payers have "licensed provider" clauses and do not pay claims submitted by unlicensed providers.
3. Many managed care organizations require each provider to be "credentialed" through their own system with their own credentialing process. Criteria for credentialing often includes licensure. **See Appendix B**

Medicare: CMS (Centers for Medicare & Medicaid Services)

As stated previously, CMS only recognizes select categories of non-MDs as "unique providers" and genetic counselors are not currently recognized as such.

Local insurers or managed care organizations are awarded Medicare contracts and handle operations for their area.

Preventive services are not currently covered by Medicare. This may include many areas of adult genetics services, including cancer genetic counseling and predictive testing. **Private third-party insurers often adopt Medicare guidelines and restrictions for their own policies and procedures.**

State Medicare carriers can be found at <http://cms.hhs.gov/contacts/incardir.asp>

Medicaid: Most Medicaid programs accept CMS-1500 forms. Medicaid eligibility is reviewed and updated monthly for patients; therefore, check the status of your patient's Medicaid eligibility prior to the appointment.

Some states have their own specific Medicaid codes and require you to use these instead of CPT codes. However, as of April 2003, state-specific codes were to be abolished as required by HIPAA, and state-specific codes should be replaced by CPT codes.

Each state has different regulations regarding the use of out-of-state laboratories for diagnostic testing, etc.

How to apply for a UPIN (unique provider identification numbers):

When the HIPAA (Health Information Portability and Accountability Act) was passed several years ago (1996), it included in it a requirement for a National Provider System (NPS) to be established. The initial NPS included a provision that national provider identifiers, like the UPINs currently held by MDs, would be required to facilitate electronic billing/data exchange throughout the U.S. healthcare system. All healthcare providers who bill as part of their service would be expected to be able to obtain a national provider number. The rule outlining how these national provider numbers are applied for and issued was published in the federal registry in 2002. Genetic counselors should be able to apply for UPINs under the new regulations if they “bill as a routine part of their care”.

Some states (e.g. Washington) choose to obtain an “agency provider number” in lieu of the UPIN.

Where to obtain the HCFA (CMS) 1500 Claim Form

Medicare requires that all physicians submit this form when billing for Medicare patients. It is also usually required for submission of bills to Medicaid. Virtually all third-party payers also either require or accept this form. You can download it from <http://cms.hhs.gov/providers/edi/1500info.asp> or buy it from an office supply store. If billing electronically, make sure that the payer will accept an electronic form; if not, you must purchase forms through a supply store.

4. COMPLIANCE

Medicare, Medicaid, Tricare and many private insurers have systems to audit facilities for alleged fraud or undocumented claims. The Social Security Act lists fraud and abuse guidelines for Medicare/Medicaid.

HIPAA (Health Information Portability and Accountability Act of 1996) extends fraud penalties to all payers.

Internal Compliance Programs: Some health care institutions have developed programs or departments to monitor internal compliance to billing regulations. It is important for you to find out if your institution or organization has a compliance program and if so, to learn as much as possible about the program and become active in working with them to create legal and honest billing processes for yourself and your clinic. Creating positive working relationships with your compliance representatives and billing personnel are good ways to remain abreast of the HIPAA and billing/reimbursement regulations.

- 1) If your institution has a compliance officer, he or she usually works closely with the institutional billing department. Check with your billing

- office/department to see if there is a compliance policy for your institution, and, if so, who is in charge.
- 2) Obtain and read your institution's compliance policy and discuss it with your billing department to make sure your current billing system adheres to the policy.

Federal government publications have listed seven criteria necessary for an internal compliance plan:

- 1) A clear commitment to compliance: intent and obligation to comply with established standards by all members of the organization;
- 2) Appointment of a compliance officer with a high level of responsibility and authority;
- 3) Effective training and education programs;
- 4) Auditing and monitoring: including a regular review of the institution's claim development, submission process and a method for employee reporting of suspected fraud;
- 5) Communication, including a "hot line" to facilitate reporting of suspected violations;
- 6) Internal investigation and enforcement;
- 7) Response to identified offenses and application of corrective action initiatives;

5. CREATING CONTRACTS with third-party payers, HMOs, managed care organizations:

Contracts including genetic counseling in the "comprehensive fee". A package of services can include genetic counseling and can be negotiated as a package with managed care organizations or third-party payers. For example, a prenatal genetics package may include pre-amniocentesis counseling, procedure services, cytogenetics lab services and abnormal results counseling when necessary. In this method, the genetic counselor does not have to bill as an individual and the contract formed will pay for all services deemed necessary for amniocentesis.

Preferred Provider Status: Genetic counselors have thus far had limited success in acquiring preferred provider status; insurers may demand physician status and/or licensure may be a requirement. In addition, some insurers have a processing fee to become a provider and/or a yearly administrative fee.

Recommendation: Find the decision-maker in each company and learn the procedure to obtain preferred provider status. Have a referring physician write a letter of support explaining why you are needed in the network. Standardize the documentation of how much time spent with patients, the nature of the patient interaction, and the various services provided. This will make it easier to discuss with your provider status with the payer.

SEE APPENDIX B: [Washington State Credentialing Guideline](#)

SEE APPENDIX C: [“Genetic Counseling and Genetic Testing for Managed Care Organizations”](#)

References: GeneAMP brochure, “What is genetic counseling”? available through NSGC Executive Office.

6. ACTIONS GENETIC COUNSELORS CAN TAKE to FACILITATE BILLING/REIMBURSEMENT ISSUES:

SEE APPENDIX D: [Billing and Reimbursement Issues Matrix](#)

1. Educate large employers in the region about the value of genetic counseling and recommend that it be included in their employee benefits.
2. Determine who is responsible for contracts and make sure that appropriate contract language is used.
3. Work with the state Medicaid office to establish billing practices for genetic counseling.
4. Educate local insurers about genetic counseling services and their benefits.
5. Share the NSGC model health policy for MCOs, HMOs, and other insurers regarding genetic services. (**SEE APPENDIX C: “Genetic Counseling and Genetic Testing for Managed Care Organizations”**)
6. Work with other professional organizations to apply for and lobby the AMA for CPT codes specific to genetic counseling.
7. Obtain state licensure for genetic counselors and/or work with insurers to revise language to reflect “appropriately licensed or credentialed provider”.
8. Provide guidance and information on how genetic counselors can be adequately and safely credentialed within a health plan.
9. Get involved in NSGC committees (Genetic Services and Professional Issues Committees) that are working toward a solution.

References

Genetics and Managed Care: Policy Statement of the American College of Medical Genetics. *Genetics in Medicine*. Nov/Dec 2001, Vol 3, No. 6, pp 430-435.

Manual on Reimbursement for Medical Genetics Services, 2002. Marc Williams, MD, Editor-in-Chief. American College of Medical Genetics.
<http://www.acmg.net/resources/reimbursement/manual-reimburse.pdf>

Glossary of Terms as Commonly Used in Health Care – Alpha Center – Health Policy and Planning. September, 1994.

American Medical Association CPT page
<http://www.ama-assn.org/ama/pub/category/3113.html>

CMS: Centers for Medicare and Medicaid
<http://cms.hhs.gov/>

HHS: HIPAA
<http://www.hhs.gov/ocr/hipaa/>

HIPAA
<http://www.hipaa.org/>

CDC: ICD-9-CM Codes
<http://www.cdc.gov/nchs/about/otheract/icd9/abtcd9.htm>

State Medicare Carriers
<http://cms.hhs.gov/contacts/incardir.asp>

CMS 1500 Claim Form
<http://cms.hhs.gov/providers/edi/1500info.asp>

Social Security Act
<http://www.ssa.gov/>

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APPENDICES

APPENDIX A:

EXAMPLE CPT and ICD-9 CODES USED FOR GENETIC SERVICES

References:

Manual on Reimbursement for Medical Genetic Services (2002)

Marc S. Williams, (Ed). American College of Medical Genetics

Publisher: Kendall-Hunt Publishing, Dubuque, IA

ISBN: 0-7872-9848-4

<http://www.acmg.net/resources/reimbursement/manual-reimburse.pdf>

Genetics and Managed Care: Policy Statement of the American College of Medical Genetics.

Marc S. Williams, MD, FAAP, FACMG, Genetics in Medicine, Vol 3, #6, Nov/Dec, 2001, pp. 430 - 435.

CPT Code Books – examples:

NSGC does not endorse any one coding book or product – these references are to give readers examples of the types of coding manuals available.

CPT 2003: Current Procedural Terminology (CPT Standard Edition, 2003)

Publisher: American Medical Association; 4th edition (November 2002)

ISBN: 1579473024

CPT Plus, 2003

Publisher: Practice Management Information; (November 2003)

ISBN: 1570662568

ICD-9 Codes Books – examples:

NSGC does not endorse any one coding book or product – these references are to give readers examples of the types of coding manuals available.

ICD-9-CM 2004 Volumes 1 & 2: American Medical Association. AMA press.

Aardvark Forms (2003).

customerservice@aardvarkforms.com

ICD-9-CM Coding Handbook 2004

Publisher: Health Forum; (August 2003)

ISBN: 1556483112

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“Free” on-line look-up of basic ICD9 codes: www.icd9coding.com

CPT CODES USED BY GENETIC SERVICES PROVIDERS

The codes below are a compilation of codes that have been collected from NSGC members. They have been used by genetic counselors and/or medical geneticists to bill for genetics services. This document does not endorse the utilization or appropriateness of any of the following codes and does not constitute a legal document. It is recommended that each genetics clinic purchase copies of the most recent CPT and ICD-9 codes books to verify appropriate and accurate codes to use for each genetics encounter.

Rules for using CPT and ICD-9 codes:

- Apply multiple CPT codes with appropriate modifiers to the secondary procedures.
- Modifiers provide a coding shorthand. There is no insurance industry standard for recognizing modifiers.
- Correct level of consultation is determined by the extent of the history, physical exam and complexity of the medical decision-making process for each patient.
- Performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately.
- Learn how to link each service billed with one or more specific ICD-9CM diagnostic codes that specifically justifies the reason for the service.
(ACOG ICD-9-CM Diagnostic Coding in OB/GYN and CPT coding in OB/GYN)

CPT codes

- 99201-205 Office/Outpatient service, new patient (self-referred)
- 99201 – Level 1 - 10 min
 - 99202 – Level 2 - 20 min
 - 99203 – Level 3 - 30 min
 - 99204 – Level 4 - 45 min
 - 99205 – Level 5 – complex, 60 min

These same codes (99201 – 99205) can also be used as facility fee codes.

- 99211-215 Office/Outpatient service, established patient

- 99241-245 Office/Outpatient consultations, new or established patient
- 99241 Limited – 15 min
 - 99242 Limited – 30 min

- 99243 Intermed - 45 min
- 99244 Comprehensive – 60 min
- 99245 Complex – 80 min

- 99251-255 Initial inpatient consultations

- 99261-263 Follow-up inpatient consultations

- 99271-275 Confirmatory consultations - New or established patients

- 99381-387 Preventive medicine – new patient
Level of code used is determined by the age of the patient

- 99391-397 Preventive medicine – established patient
Level of code used is determined by the age of the patient

- 99401-404 Individual counseling of risk factor reduction to healthy individual
 - 99401 – 15 min
 - 99402 – 30 min
 - 99403 – 45 min
 - 99404 – 60 min

- 99411 Preventive Medicine: counseling of risk factor reduction to healthy individuals – group counseling, 30 minutes

- 99412 Preventive Medicine: counseling of risk factor reduction to healthy individuals – group counseling, 60 minutes

- 99420 Administration and interpretation of health risk assessment

- 99361 Medical Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present) – 30 min

- 993362 Medical Conference (patient not present) – 60 minutes

- 99499 “Incident to” MD
As a reminder, these codes cannot be used by genetic counselors as now deemed by CMS. Please see page 8 for a discussion of this topic.

- 99078 Group Education sessions

- 96150-96155 Health and Behavioral Assessment Codes (CPT 2002):
Codes used for “services associated with an acute or chronic illness, prevention of a physical illness or disability, and maintenance of health, not

meeting criteria for a psychiatric diagnosis, or representing a preventive medicine service.”

To be used by “but are not limited to, psychologists, advanced practice nurses, clinical social workers and other non-physician healthcare professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessment/intervention procedures. These codes are not intended to be used by physicians”. These services are face-to-face services and do not include neuropsychological testing.

- “Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.”

- “Health and behavior intervention procedures are used to modify the psychological, behavioral, emotional, cognitive, and social factors identified as important to or directly affecting the patient’s physiological functioning, disease status, health and well-being.”

96150: Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires) each 15 minutes face-to-face with the patient; initial assessment.

96151 Re-assessment

96152 Health and behavior intervention; each 15 minutes, face-to-face; individual

96153 Group (2 or more patients)

96154 Family (with patient present)

96155 Family (without the patient present)

It is not clear whether or how genetic counselors could use the health and behavioral assessment codes.

FACILITY FEE CODES:

99201 – 99205 (new patients)

99121 – 99215 (repeat patients)

99242 – 99245 (consultations)

99272 – 99275 (conference consultations)

EXAMPLES OF ICD-9 CODES USED BY GENETIC SERVICES PROVIDERS

This list has been compiled from examples submitted by NSGC members. The appropriateness and accuracy have not been verified; therefore, all readers are advised to check an official ICD-9 manual before using these codes. For a more comprehensive listing of appropriate ICD-9 codes, see either the ICD-9 manual or the ACMG billing and reimbursement manual

Use diagnostic codes at their highest level of specificity (i.e. fill out to 5 digits when available). Claims can be denied if the codes are not specific enough.

General

V26.3 - Genetic counseling

V16 codes – Screening codes

Cancer Genetics

-ICD-9 codes for cancer, a medical complaint or a family history of cancer varies depending on whether the patient has cancer or not.

-At risk: non-cancer medical complaint (fibrocystic breast disease, polyps)

-V codes used for either family history of cancer or the V code for Genetic Counseling

Active Diagnosis of:

153.9 Primary Colon Cancer
154.0 Colon CA
158.9 Primary malignant neoplasm Peritoneum
172.9 Malignant Melanoma
174.0 Breast CA (female)
175.0 Breast CA (male)
183.0 Malignant Neoplasm Ovary
185.0 Malignant Neoplasm, Prostate
189.0 Kidney CA
193.0 Thyroid CA
193.0 MEN2 - Sipple Syndrome
211.3 Polyposis Colon Adenomatous Or FAP
233.0 DCIS/LCIS
237.71 NF1
237.72 NF2
334.8 Ataxia Telangiectasia
611.1 Benign and atypical hyperplasia
610.1 Fibrocystic Breast Disease
756.6 Von Hippel Lindau
758.3 Li-Fraumeni
759.5 Tuberous Sclerosis
759.6 Cowden syndrome

Special Screening for Malignant Neoplasms:

- V76.1 Breast
- V76.41 Rectum
- V76.43 Skin
- V76.8 Other Neoplasm

Personal History Malignant neoplasm in:

- V10.00 Gastrointestinal tract (unspecified)
- V10.02 Tongue
- V10.03 Esophagus
- V10.04 Stomach
- V10.05 Large intestine
- V10.06 Rectum, rectosigmoid junction, anus
- V10.07 Liver
- V10.09 Other GI tract
- V10.11 Bronchus and lung
- V10.12 Trachea
- V10.20 Respiratory organ, unspecified
- V10.21 Larynx
- V10.29 Other respiratory and intrathoracic organs
- V10.30 Breast
- V10.40 Female genital organs, unspecified
- V10.41 Cervix
- V10.42 Other parts of uterus
- V10.43 Ovary
- V10.42 Uterus
- V10.44 Other female genital organs
- V10.45 Male genital organs, unspecified
- V10.46 Prostate
- V10.47 Testis
- V10.48 Epididymis
- V10.49 Other male genital organs
- V10.50 Urinary organs, unspecified
- V10.51 Bladder
- V10.52 Kidney
- V10.59 Other urinary organs
- V10.60 Leukemia, unspecified
- V10.61 Lymphoid leukemia
- V10.62 Myeloid leukemia
- V10.63 Monocytic leukemia
- V10.79 Other lymphatic or hematopoietic leukemia
- V10.81 Bone
- V10.82 Malignant Melanoma
- V10.83 Other malignant neoplasm of the skin
- V10.84 Eye
- V10.85 Brain

- V10.86 Other parts of nervous system
- V10.88 Other endocrine glands and related structures

Family History of malignant neoplasm in: (screening codes) – office consult

- V16.0 Family hx Malignant Neoplasm, Colon/GI tract
- V16.1 Family hx, trachea, bronchus and lung
- V16.2 Family hx, other respiratory and intrathoracic organs
- V16.3 Family hx Malignant Neoplasm, Breast
- V16.40 Family hx Malignant Neoplasm, Genital Organs
- V16.41 Family hx Malignant Neoplasm, Ovary
- V16.42 Family hx, Prostate
- V16.43 Family hx, Testes
- V16.49 Family hx, other genital organ
- V16.5 Family hx Malignant Neoplasm, Renal/Urinary Organs
- V16.51 Family hx, kidney
- V16.5 Family hx, other urinary organ
- V16.6 Family hx, leukemia
- V16.7 Family hx, other lymphatic and hematopoietic
- V16.8 Other specified malignant neoplasm
- V16.9 Other unspecified
- V18.5 Family hx colorectal polyps
- V19.8 Family hx FAP
- V26.3 Genetic Counseling
- V61.49 Concern regarding family hx

PRENATAL AND PRECONCEPTIONAL GENETICS and PRENATAL DIAGNOSIS

A Fifth digit must be used for subclassification with categories 651-659 to denote the current episode of care. The majority of cases of prenatal genetic counseling will require a “3” in the fifth digit area. Example: 655.03 designates anencephaly found on ultrasound, 659.53 designates prenatal genetic counseling for pregnant elderly primigravida. Always add the appropriate 5th digit to the following codes.

- 0 = unspecified episode of care
- 1 = delivered, with or without mention of antepartum condition
- 2 = delivered with mention of postpartum complication
- 3 = antepartum condition or complication (used for all prenatal diagnosis)**
- 4 = postpartum condition or complication

- V26.3 Genetic Counseling for procreative management (prenatal or pre-pregnancy) counseling

- 629.9 Habitual aborter, not pregnant
- 631.0 Abnormal products of conception
- 648.0 Known or suspected maternal diabetes damage
- 653.7 Other fetal abnormality causing disproportion
- 655.0 Known or suspected fetal abnormality affecting management of mother
- 655.0 Fetal or suspected fetal CNS malformation
 - anencephaly
 - hydrocephalus
 - spina bifida (w/meningomyelocele)
- 655.1 Chromosome abnormality in fetus
- 655.1 Known or suspected fetal abnormality, chromosome abnormality in fetus
- 655.2 Hereditary Disease in family, fetus possibly affected
- 655.3 Suspected damage to fetus from viral disease in mother
- 655.3 Alcohol
- 655.4 Suspected damage to fetus from other disease in mother
- 655.5 Suspected teratogen
- 655.6 Suspected damage to fetus from radiation
- 655.8 Other known or suspected fetal abnormality, not elsewhere classified
- 655.9 Other unspecified agents, fetal anomaly, known or unknown
- 656.4 Intrauterine Death
- 656.5 Poor fetal growth
- 656.8 Other specified fetal and placental problems
- 656.9 Unspecified fetal and placental problems
- 658.0 Oligohydramnios
- 659.53 Elderly primigravida
- 659.63 Elderly multigravida

Male Partner

- 606.0 Azoospermia
- 608.1 Oligospermia
- 659.83 Advanced paternal age
- 758.4 Habitual aborter, male

Perinatal (refers to the delivered baby)

- 760.70 Teratogen exposure, unspecified
- 760.71 Teratogen exposure, alcohol
- 760.76 Fetal embryopathy
- 771.1 Congenital infection, viral (CMV)
- 771.2 Congenital infection
- 775.0 Infant of a diabetic mother
- 779.9 Stillborn
- 780.79 Teratogen exposure, other
- 781.8 Spontaneous abortion

Preconception or Prenatal Family History

- V17.0 Family hx psychiatric disorder

- V17.1 Family hx stroke
- V17.2 Family hx neurologic disease (includes Huntington)
- V17.3 Family hx ischemic heart disease
- V17.4 Family hx other cardiovascular disease (not MI)
- V17.5 Family hx asthma
- V17.6 Family hx other chronic resp condition (not asthma)
- V17.7 Family hx arthritis
- V17.8 Family hx other musculoskeletal disease (not arthritis)
- V18.1 Family hx of other endocrine/metabolic (not diabetes)
- V18.2 Family hx of anemia
- V18.3 Family hx of other blood disorders (not anemia)
- V18.4 Family hx of mental retardation
- V18.5 Family hx digestive disorders
- V18.61 Family hx polycystic kidney disease
- V18.69 Family hx other kidney disorders
- V18.7 Family hx other genitourinary diseases
- V19.0 Family hx of blindness/visual loss
- V19.1 Family hx of other eye disorders
- V19.2 Family hx of deafness/hearing loss
- V19.3 Family hx of other ear disorders
- V19.4 Family hx of skin disorder
- V19.5 Family hx of congenital anomalies
- V19.6 Family hx of allergic disorder
- V19.7 Family hx of consanguinity
- V19.8 Family hx of other conditions
- V23.5 Prior pregnancy with perinatal death
- V23.81 Elderly primigravida
- V23.82 Elderly multigravida

- 655.2 Family hx hereditary disorder (used for women carrier testing only)

Prenatal Screening and Testing

- V28.0 Screening for chromosome abnormalities by amnio
- V28.1 Screening for AFP levels in AF
- V28.2 Other screening based on amnio
- V28.4 Screening for malformations by U/S
- V28.8 Other specified antenatal screening

GENETIC DIAGNOSES – codes refer to the affected patient

Postnatal Screening – follow-up of positive newborn screen , etc.

- V77.3 Special screening for PKU
- V77.4 Special screening for galactosemia
- V77.6 Special screening for cystic fibrosis
- V77.7 Special screening for other inborn errors of metab
- V78.2 Special screening for sickle cell disease/trait
- V78.3 Special screening for other hemoglobinopathies
- V82.4 Maternal postnatal screening for chrom abns
- V82.8 Special screening for other specified conditions

Chromosome abnormalities

- 655.13 Chrom abn, known or suspected
- 758.0 Trisomy 21
- 758.1 Trisomy 13
- 758.2 Trisomy 18
- 758.3 Autosomal deletion syndrome
- 758.4 Normal individual, balanced autosomal translocation
- 758.5 Other conditions autosomal anomaly
- 758.6 Turner syndrome
- 758.7 Klinefelter syndrome
- 758.81 Other conditions sex chromosome anomaly
- 758.9 Conditions due to anomaly of unspecified chromosome
- 759.81 Prader-Willi syndrome

Neurologic / neuromuscular / neurocutaneous conditions

- 237.71 Neurofibromatosis, type 1
- 237.72 NF, type 2
- 330.0 Leukodystrophy
- 330.1 Cerebral lipidoses
- 330.2 Cerebral degeneration in general lipidoses
- 330.3 Cerebral degeneration of childhood in other diseases, classified elsewhere
- 330.8 Other specified cerebral degeneration in childhood
- 330.9 Unspecified cerebral degeneration of childhood
- 331.0 Alzheimer disease
- 331.89 Other cerebral degeneration
- 331.9 Cerebral degeneration, specified
- 332.0 Parkinson's disease
- 333.0 Olivopontocerebellar degeneration
- 333.4 Huntington disease
- 333.99 Abnormal movement disorder
- 334.0 Friedreich's Ataxia
- 334.1 Hereditary spastic paraplegia
- 334.2 SCA (hereditary cerebellar degeneration)

- 334.8 Ataxia-telangiectasia
- 334.9 Spinocerebellar degeneration, unspecified
- 335.0 Spinal Muscular Atrophy type 1
- 335.11 SMA type 2
- 335.19 SMA type 3
- 335.20 ALS
- 337.9 Autonomic nervous system disorder, unspecified
- 340 Multiple sclerosis
- 341.9 Demyelinating disease of CNS, unspecified
- 355.10 Spinal Muscular Atrophy, unspecified
- 356.0 Hereditary and idiopathic peripheral neuropathy
- 356.1 Charcot Marie Tooth
- 359.0 Congenital hereditary muscular dystrophy
- 359.1 DMD/BMD
- 359.1 Facioscapulohumeral muscular dystrophy
- 359.1 Limb/Girdle Muscular Dystrophy
- 359.2 Myotonic dystrophy and other myotonic disorders
- 359.8 Mitochondrial myopathy
- 359.8 Other myopathy, specified
- 359.9 Unspecified myopathy
- 759.5 Tuberous sclerosis
- 781.3 Ataxia, unspecified

Skeletal dysplasias /Connective Tissue disorders

- 756.0 Craniosynostosis
- 756.4 Skeletal dysplasia (includes Achondroplasia)
- 756.51 Osteogenesis Imperfecta
- 756.56 Multiple epiphyseal dysplasia
- 759.82 Marfan syndrome
- 756.83 Ehlers-Danlos

Hematologic conditions – Coagulation defects

- 277.1 Disorder of porphyrin metabolism
- 282.0 Hereditary spherocytosis
- 282.1 Hereditary elliptocytosis
- 282.2 G6PD
- 282.3 Pyruvate Kinase deficiency
- 282.4 Sickle/Thal
- 282.4 Alpha-thal
- 282.4 Beta-thal
- 282.5 Sickle cell trait
- 282.61 Sickle Cell (Hb SS) w/o crisis
- 282.62 Sickle Cell with crisis
- 282.63 Sickle Cell (SC) disease
- 282.7 Other hemoglobinopathies
- 282.9 Hereditary hemolytic anemia (NOS)

- 286.0 Hemophilia A
- 286.1 Hemophilia B
- 286.3 Other clotting factors
- 286.4 Von Willebrand disease

Metabolic Conditions

- 220.8 Leigh's disease
- 270.1 Disturbance of amino acid transport
- 270.1 PKU
- 270.2 Other disturbances of aromatic amino-acid metabolism
- 270.3 Branched chain
- 270.4 Sulfur-bearing
- 270.5 Histidine metabolism
- 270.6 Urea cycle metabolism
- 270.7 Straight-chain
- 270.8 Other specified disorder
- 270.9 Unspecified disorder
- 271.0 Glycogenesis
- 271.1 Galactosemia
- 271.2 Hereditary fructose intolerance
- 271.8 Other specified disorder of carbohydrate transport and metabolism
- 271.9 Unspecified disorder of carbohydrate transport and metabolism
- 272.0 Familial hypercholesterolemia
- 272.7 Gaucher's
- 272.7 Niemann-Pick (lipidoses)
- 272.75 Fabry disease
- 272.8 Other disorder of lipid metabolism
- 272.9 Unspecified disorder of lipid metabolism
- 275.0 Hemochromatosis (disorder of iron metabolism)
- 275.1 Wilson's (disorder of copper metabolism)
- 275.4 Disorder of calcium metabolism
- 276.2 Acidosis
- 277.00 Cystic fibrosis w/out meconium ileus
- 277.01 CF with meconium ileus
- 277.2 Lesch-Nyhan
- 277.5 Mucopolysaccharidoses
- 277.6 Alpha-1-antitrypsin deficiency (deficiency of circulating enzymes)
- 277.8 Other specified disorder of metabolism
- 277.9 Unspecified disorder of metabolism
- 330.0 Krabbe's disease (leukodystrophy)
- 330.0 Metachromatic leukodystrophy
- 330.1 Tay Sachs (cerebral lipidoses)

Developmental/Growth Disorders

- 259.0 Delayed puberty
- 299.00 Autism, infantile or childhood
- 315.31 Language disorder
- 317 Mild mental retardation
- 318.00 Moderate MR
- 318.1 Severe MR
- 318.2 Profound MR
- 319 Unspecified MR
- 783.41 Failure to thrive
- 783.42 Delayed milestones
- 783.43 Short Stature

Other diagnoses

- 368.00 Visual impairment, unspecified
- 389.9 Deafness
- 758.5 Other conditions due to autosomal anomalies
- 759.7 Undiagnosed/unknown syndrome
- 759.7 Multiple congenital anomalies
- 759.89 Other specified anomalies
- 796.4 Dysmorphic syndrome

Physical Features

- 524. Micrognathia
- 709.09 Café au lait spots
- 709.00 Hypopigmentation
- 737.30 Scoliosis
- 744.2 Low set ears
- 750.1 Macroglossia
- 754.81 Pectus excavatum
- 756 Hypotelorism

Malformations /Genetic Syndromes

- 253.0 Sotos syndrome
- 279.11 DiGeorge syndrome
- 728.3 Arthrogyrosis
- 740 Anencephaly
- 741.0 Spina bifida
- 742 Other congenital anomalies of nervous system
- 742.1 Microcephaly
- 742.2 Holoprosencephaly
- 742.3 Hydrocephaly in newborn
- 742.4 Macrocephaly
- 743 Eye anomalies
- 743.0 Anophthalmos
- 743.1 Microphthalmos

- 743.2 Buphthalmos
- 743.3 Congenital cataract, lens anom
- 743.37 Ectopia lentis
- 743.4 Coloboma
- 743.5 Anomalies of posterior segment
- 743.6 Anomalies of lid, lacrimal, orbit
- 744 Anomalies of ear, face, neck
- 747.22 William syndrome
- 748.0 Choanal atresia
- 750.3 Tracheo-esophageal fistula
- 751.8 Congenital GI malformation
- 752.51 Cryptorchidism
- 752.61 Hypospadias
- 752.9 Ambiguous genitalia
- 753.0 Renal agenesis
- 753.10 Cystic kidney disease
- 753.3 Congenital kidney malformation
- 755.01 Polydactyly of fingers
- 755.2 Limb reduction defect – arm
- 755.3 Limb reduction defect - leg
- 756.0 Craniosynostosis
- 756.0 Goldenhar syndrome
- 756.70 Abdominal wall defect
- 756.8 Diaphragmatic hernia
- 756.9 Anomaly, bone, not otherwise specified
- 757.31 Ectodermal dysplasia
- 758.5 Autosomal, other chromosome (includes Angelman syndrome)
- 759.83 Fragile X syndrome
- 759.89 Other known congenital malformation syndrome (Beckwith-Wiedemann syndrome, VATER, etc)
- 778.0 Hydrops fetalis

Cleft lip/palate

- 749 Cleft palate and cleft lip
- 749.0 Cleft palate
- 749.01 Unilateral, complete
- 749.02 Unilateral, incomplete
- 749.03 Bilateral, complete
- 749.04 Bilateral, incomplete
- 749.1 Cleft lip
- 749.10 Cleft lip, unspecified
- 749.11 Unilateral, complete
- 749.12 Unilateral, incomplete
- 749.13 Bilateral, complete
- 749.14 Bilateral, incomplete
- 749.2 Cleft palate with cleft lip

- 749.20 Cleft palate with cleft lip unspecified
- 749.21 Unilateral, complete
- 749.22 Unilateral, incomplete
- 749.23 Bilateral, complete
- 749.24 Bilateral, incomplete
- 749.25 Other combinations

Congenital and structural heart defects

- 424.0 Mitral Valve Prolapse
- 441.0 Aortic aneurysm (dissecting)
- 441.9 Dilated aorta
- 745 Cardiac defects, structural
- 745.4 VSD
- 746.9 Congenital heart disease/anomaly
- 746.89 Other specified anomalies of the heart
- 747.22 Supravalvular aortic stenosis

Neural tube defects

- 741.93 Lumbar spina bifida without hydrocephalus

APPENDIX B: WASHINGTON STATE CREDENTIALING STANDARDS FOR GENETIC COUNSELORS * Printed with permission from Debra Lochner Doyle, Washington State Coordinator for Genetic Services

Minimum Standards

REVIEW ITEM(S)	STANDARD	Genetic Counselor Application
1. License	Valid, current license.	Valid National Certification**
2. DEA Certificate	No DEA revocation.	Not applicable; do not prescribe medications.
3. Hospital Privileges	Unrestricted staff and clinical privileges in good standing.	Scope of practice does not include admitting; privileges needed for in-patient charting only.
4. Washington State Medical Quality Assurance Commission	No current restrictions on prescribing habits or other practice limitations.	Not Applicable regarding prescribing habits but insurer may consider regarding other practice limitations.
5. Board Certification	Listed in the current edition of the ABMG or ABGC <i>Compendium</i> . Certified Genetic Counselors are also posted on the ABGC website: http://www.faseb.org/genetics	Board Certified by the American Board of Medical Genetics (ABMG) and/or Board Certified or Eligible by the American Board of Genetic Counseling (ABGC).
6. Felony conviction	No convictions or guilty pleas within two (2) previous years.	Insurer may consider.
7. Medicaid/Medicare Sanctions	No active sanction activity.	Genetic Clinics do have Medicaid Agency Provider #s so could have complaints filed; Insurer may consider.
8. Alcohol or drug abuse	No evidence of ongoing alcohol or drug abuse.	Insurer may consider.
9. Professional liability claims	No record of successful malpractice suites.	Insurer may require liability cover-age of \$1,000,000/1,000,000 or \$3,000,000 in total.
10. National Practitioner Data Bank	No history of discipline.	Not applicable; NPDB does not include at this time.
11. Patient Complaints (MCO Recredentialing)	Example: Less than three (3) substantiated in past review period.	Insurer may consider.
12. Focused Quality Studies (MCO Recredentialing)	Example: Meets criteria 90% of the time on focused quality studies.	Insurer may consider.
13. Utilization Management (MCO)	Example: Consistent pattern of utilization performance within	Insurer may consider.

Recredentialing)	established UM criteria.	
13. Patient Satisfaction (MCO Recredentialing)	Example: Greater than an 85% rating.	Insurer may consider.

*These review item(s) standards taken from NCQA as applied to M.D./D.O.s.

** The ABGC requires recredentialing every ten years for all certified genetic counselors since 1997. Genetic Counselors who received ABGC or ABMG certification prior to 1997 hold lifetime certificates. Recredentialing will require annual CEUs or re-testing of candidate in order to maintain national credentials.

GENETIC COUNSELING AND GENETIC TESTING FOR MANAGED CARE ORGANIZATIONS

A contract statement regarding
coverage of genetic services and
testing targeted to Managed Care
Organizations

October, 1998

A GeneAMP project funded by the National Society of Genetic Counselors.

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GENETIC COUNSELING AND GENETIC TESTING FOR MANAGED CARE ORGANIZATIONS

Purpose

This document establishes a framework for coverage of genetic services including genetic counseling, medical genetics evaluation and genetics testing.

Definitions of Genetic Services

- A. Genetic Counseling:** The process of providing information, education and support to individuals and families with genetic concerns. Typically provided by an American Board of Genetic Counseling Certified/Eligible Genetic Counselor.
-
- B. Medical Genetics Evaluation:** A formal medical evaluation and diagnostic work-up performed by an American Board of Medical Genetics Certified/Eligible Clinical Geneticist for the purpose of confirming or ruling out a genetic diagnosis in an individual or family.
-
- C. Genetic Testing:** The process of performing specific laboratory testing to confirm a potential genetic diagnosis, or determine if a predisposing genetic alteration is present in an individual or family. Examples include biochemical genetic testing, chromosome analysis, DNA analysis and protein/enzyme studies.
-

Covered Expenses/Professional Services

Genetic Counseling

1. Coverage for genetic risk assessment, including but not limited to family history, to determine appropriate evaluation or testing.
2. Coverage to provide risk assessment and medical intervention for increased genetic risk in pregnancy.
3. Coverage for genetic counseling preceding genetic predisposition or susceptibility testing.
4. Coverage to provide interpretation of genetic test or evaluation results.
5. Coverage for genetic counseling for individuals and families to facilitate decision-making about health maintenance (quality, cost effective care), disease prevention and reproductive matters.

Medical Genetic Evaluation

1. Coverage for diagnostic examinations and evaluations.
2. Coverage for disease-specific anticipatory guidance (preventive care).
3. Coverage for disease-specific management and treatment including periodic re-evaluation.

Genetic Testing

Category 1:

Universal coverage.

A) Genetic testing for symptomatic individuals to confirm a diagnosis and allow appropriate medical management.

B) Genetic testing for asymptomatic individuals at-risk of having a child with a genetic condition.

Category 2:

Coverage of testing is determined by a previous established policy or by committee¹ if no prior policy exists.

Presymptomatic diagnosis in asymptomatic individuals allows preventive measures, alteration of lifestyle, or prophylactic surgeries which may alter the outcome of the condition.

Linkage analysis - testing is being completed to provide appropriate interpretation of genetic testing for other at-risk family members.

DNA banking

Category 3:

Coverage determined by committee¹ only.

Asymptomatic individuals. There are no potential physiological or medical benefits nor treatment or management implications. Information is for patient knowledge/psychological benefit only.

¹ Designated by Health Plan and ideally includes a genetic specialist.

Operating Principles to be used by the Medical Director

Genetic Services

1. Genetic services are necessary for establishing or confirming a diagnosis.
2. Genetic services will potentially influence medical treatment or management.
3. Genetic services will potentially alter an individual's lifestyle choices, relationships, life plans, or family planning.
4. Genetic counseling is necessary for assessing and interpreting genetic risk.

Genetic Testing

1. The requesting health care professional has provided rationale for offering testing.
2. Genetic testing is performed with *fully informed consent* of the individual or guardian. Fully informed consent implies the individual has received complete genetic counseling information regarding the potential benefits, harms, and limitations of the test, including implications of both positive and negative test results.
3. All individuals undergoing genetic testing have *access to* genetic counseling.
 - a) Genetic Counseling should occur *prior to* testing if the individual is asymptomatic, e.g. carriers or presymptomatic individuals.
 - b) *All individuals* should receive genetic counseling following testing for interpretation of a positive or a negative result.

Suggested Diagnostic Protocol for referral for Genetic Services:

The following are examples which warrant *consideration* for genetic services (Any or all of services A, B and C defined under Definitions).

Pediatric

1. Abnormal newborn screening result.
2. Presence of one or more major malformations (e.g. congenital heart defect, cleft lip/palate, spina bifida).
3. Evidence of a potential metabolic condition (e.g. hypotonia, persistent vomiting, lethargy, seizures, abnormal lab tests - i.e. hypercalcemia).
4. Evidence of a potential genetic condition (constellation of features such as minor malformations, sensory loss, developmental delay [DD], family history).
5. Evidence of prenatal teratogen exposure (e.g. alcohol, cocaine, dilantin).
6. Unexplained developmental delay, neurological abnormalities, loss of milestones, mental retardation.
7. Known chromosome abnormality.
8. Significant sensory loss.
9. Abnormal growth parameters.
10. Precocious puberty/lack of secondary sexual development.
11. Stillbirth or neonatal death.

Adult

1. Individual with one or more major malformations, mild malformations or dysmorphic features, DD or mental retardation (MR), significant sensory loss, etc., who was not evaluated or worked-up in childhood, requires re-evaluation or who is requesting recurrence risk information.
2. A medical condition with potential teratogenic implications requiring preconception counseling (e.g. PKU, epilepsy, heavy alcohol use, diabetes).
3. A personal or family history of cancer with a known or suspected genetic predisposition (e.g. early age of onset, multiple affected relatives).

4. A personal or family history of a known or suspected genetic disorder (e.g., cystic fibrosis (CF), adult onset polycystic kidney disease, Marfan syndrome, myotonic dystrophy, Huntington disease, Charcot-Marie-Tooth disease, alpha-1-antitrypsin deficiency, neurofibromatosis, non-dietary hyperlipidemia).

5. A personal or family history of a known chromosome abnormality or a history of a balanced chromosomal translocation or other chromosome rearrangement segregating in the family.

Prenatal

1. Preconception counseling in couples with anxiety concerning reproductive risks.

2. Advanced maternal age.

3. Abnormal maternal serum screening.

4. Abnormal prenatal diagnosis results.

5. Fetus with anomalies suspected on ultrasound.

6. Men or women exposed to a known or suspected reproductive hazard.

7. Either parent with or a family history of a chromosome abnormality/rearrangement.

8. Previous child with a chromosome abnormality.

9. Previous child or family member with a known or suspected inborn error of metabolism (e.g. PKU, Maple Syrup Urine Disease, galactosemia, Hurler syndrome).

10. Previous child/pregnancy/family member with a major structural malformation (e.g. neural tube defect, congenital heart defect, cleft lip/palate).

11. Previous child/ family member with a physical and/or developmental problem (e.g. learning disabilities/DD/MR, hearing loss, seizures, attention deficit hyperactivity disorder, autism).

12. Previous child/family member with a known genetic abnormality (e.g. osteogenesis imperfecta, neurofibromatosis, myotonic dystrophy, tuberous sclerosis).

13. Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities.

14. History of recurrent pregnancy loss.
 15. Consanguinity/incest.
 16. Parent is a known carrier or has a family history of a genetic condition (e.g. Duchenne muscular dystrophy, cystic fibrosis, fragile X syndrome).
 17. Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions (e.g. Ashkenazic Jewish -Tay Sachs, Mediterranean/Asian -thalassemia , African American - sickle cell).
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APPENDIX D: “Billing and Reimbursement Issues Impacting the Genetic Counseling Profession” by Debra Lochner Doyle. Revised 6-03.

The United States health care system is funded through a patchwork of varied payers, each operating under federal and state laws and regulations, which adds to the complexity of the overall system. The following matrix depicts various issues that currently impact the ability of the genetic counseling profession to bill and be reimbursed for their services. While every effort has been made to identify and address all issues, I confess that I do not report myself to be an expert in all arenas of healthcare, merely someone who has worked to improve issues concerning billing and reimbursement for genetic counselors over the past ten years. Any oversights or errors in this matrix should serve to confirm this limitation in my skills and expertise.

The Payer	Billing Issue	Possible Solution
Medicare	<p>CMS (formerly HCFA) historically did not authorize unique providers numbers to non-MDs. New HIPAA regs may revise this.</p> <p>Allied health care professionals as determined by Congress,(1) could bill CMS for services as “physician extenders” subject to “incident to” definition for services provided <i>outside of the hospital</i>. (Because of the latter clause, some university based genetics clinics operate as affiliates to the hospital with GCs paid by the hospital while MD is paid by the professional service affiliate. Incident to, requires that they be W-2’d employees of the same organization, or that the GC is a W-2’d employee of the physician AND supervisor must be on site.)</p> <p>(1) Non-physicians (physician is defined under Medicare as M.D., D.O., Podiatrist, Dentist, and, to a more limited extent, Optometrist and Chiropractor) having their own statutory benefit category are:</p>	<p>GCs should apply for unique provider under new regs if they “bill as a routine part of their care.”</p> <p>Court challenge of the definition of “incident to” OR pressure Congress to revise law to include GCs as non-physician category.</p> <p>Ensure GC is W-2’d employee of MD or they are employed by the same employer if billing “incident to.”</p> <p>Lobby CMS/Congress to</p>

The Payer	Billing Issue	Possible Solution
	<p>Clinical Psychologist Physician Assistant Nurse Practitioner Clinical Nurse Specialist Nurse Midwife Certified Registered Nurse Anesthetist</p> <p>Medicare does not cover preventive services.</p>	<p>include preventive services for Medicare recipients.</p>
<p>Medicaid</p>	<p>Federal and State partnership with federal oversight provided by CMS. It requires some level of state funding in order to leverage federal funds.</p>	<p>Approach state Medicaid offices and request that genetic counseling be added to Medicaid benefits – site WA, OH, and TX experiences and lobby for family planning (10:90) match rate.</p>

The Payer	Billing Issue	Possible Solution
State Contracts	NBS fees, MCH block grant and/or other federal or state funds obtained by the state health agency can be used to support genetic counseling services.	If genetic counselors or their institutions don't have a state contract, they should seek one out.
Indemnity Insurance Products	<p>Fee-for-service style of insurance where covered benefits are determined by health broker or health care purchaser (employer) and may be subject to state benefits mandates (if employer is not self-insured).</p> <p>There is no specific billing code (Current Procedural Terminology or CPT©)² for genetic counseling.</p> <p>These policies frequently have "licensed provider" clauses.</p> <p>⁽²⁾ CPT is a copyright of the American Medical Association)</p>	<p>Know what laws exist in each state re: genetic services.</p> <p>Offer model medical necessity policies re: genetic services to insurers.</p> <p>Work with other professional organizations to apply for and lobby AMA for CPT code.</p> <p>Educate employers/health care brokers about genetic services.</p> <p>Obtain state licensure for genetic counselors (*add CA and UT laws as examples) OR work with insurers to revise language to reflect "appropriately licensed or credentialed provider," language.</p>
HMS/MCO Insurance Products	Same issues as indemnity products, plus... Requires providers to be credentialed within the plan.	Provide guidance on how genetic counselors can be adequately and safely credentialed within a health plan.