

## Prevention Counseling and Associated Reimbursement Come Closer to Policy Reality, Part 1

ASCO's Cancer Prevention Committee (CAPC) was established in November 2002. The issues surrounding prevention were defined in a Comments and Controversies article published in the October 1, 2004, issue of the *Journal of Clinical Oncology*, Vol 22, No 19. Since the publication of that article, progress in medical science has continued to add urgency to the issue, and changes in reimbursement policy have reinforced that urgency. Further, the CAPC commissioned a survey of ASCO members to explore their attitudes and interest in prevention services.

In this first of two articles, *JOP* examines progress made since the Comments and Controversies piece in defining prevention and prevention counseling at the clinical practice level. We review the current thoughts on reimbursement. A second article on this subject will be published in the November 2005 issue of *JOP*, and will provide guidance to the practicing oncologist for coding, billing and reimbursement for prevention counseling.

For this article we talked to **Robin Zon, MD**, chair of the Reimbursement for Cancer Prevention Services Subcommittee of the CPAC, and **Patricia Ganz, MD**, principal author of the survey. Zon is a practicing medical oncologist at Michiana Hematology and Oncology in northern Indiana, and Ganz is a medical oncologist at UCLA involved in research on quality of life and cancer prevention, as well as teaching and patient care.



Robin Zon, MD, FACP



Patricia Ganz, MD

As chair of the Reimbursement Subcommittee of the Cancer Prevention Committee, Zon has helped sort out some of the barriers that US medical oncologists have faced in implementing the typical prevention services of counseling and education. The committee defined prevention as “a reduction in the risk of developing clinically evident cancer, whether first or second primary cancer, or of developing intraepithelial neoplasia (IEN), a frequent cancer precursor.” Inherent in this definition is the early detection and treatment of IEN. Zon's subcommittee began its work by defining the goals and elements of prevention services, and then identified the topics that might typically come up in a prevention encounter with a practicing oncologist. That subcommittee is also identifying current ways for reimbursement of these services.

### Prevention Counseling of the Cancer Patient and Family Members

Most medical oncologists begin patient care after the cancer diagnosis is established. The patients are usually accompanied by family members when they come for the initial consultation. Once the conversation about treatment and prognosis is completed, questions about familial risk and prevention usually arise.

According to Zon, “The primary ways that oncologists deliver prevention are through counseling and educating the patient, and potentially other family members. We make recommendations for screening or other testing, and then follow up on those recommendations.” In large centers, other professionals may also be involved in this encounter. The M.D. Anderson Cancer Center, for example, has an entire division of prevention that includes family practice doctors. In a typical community setting, counseling is more likely to involve just the oncologist, and perhaps an advanced nurse practitioner.

The prevention topics most likely to be covered are smoking cessation, breast cancer or colorectal screening in high-risk populations, genetics, and the prevention of secondary cancers in cancer survivors. The conversations might also include discussion of UV radiation exposure and obesity, although Zon says that these topics are somewhat “softer,” so they are less likely to come up.

The counseling oncologist would also consider the patient's comorbidities, and here a sense of proportion is important. The 85-year-old with significant comorbidities such as cardiovascular disease and dementia would be an unlikely candidate for genetic counseling.

A related subset is the patient who arrives with no diagnosis of cancer. A woman having a breast biopsy does not necessarily have cancer, but may still be at high risk for breast cancer, for ovarian cancer, or other cancer, and therefore warrant consultation. Primary care physicians (PCPs) often turn to the medical oncologist for advice on patients at high risk of familial cancer or for advice on a patient who has a family member with cancer, who want advice on their own risks.

### Interface With the Primary Care Provider

Meanwhile, oncologists have voiced some concern over the possibility, however remote, of being seen as interfering in primary care—even though that is not the case. Says Zon, “Primary care physicians see patients at all risks for developing cancers, whereas we see patients either at high risk of developing cancer, or already diagnosed with cancer, and possibly at high risk of developing second cancers. Prevention issues in the typical oncology practice are therefore separate and

distinct from the world of primary care.” Nevertheless, the issue is sensitive because oncologists receive referrals from PCPs.

Ganz amplified this point. “There are also many people out there who have survived cancer, but remain at risk for secondary cancers,” she said. “For example, people with hereditary susceptibility genes. Few of these patients are being followed by primary care physicians for their secondary cancer risks. That’s a targeted area where ASCO members could really make a difference.” The issue of the patient population’s not being taken care of adequately by the primary care physicians was considered in the Comments and Controversies article, she noted. “Those patients seem to be in our venue; yet, our members don’t seem to be as well trained or haven’t conceptualized how they’re going to take care of those patients,” said Ganz.

The issue seems to be not whether, but where oncologists should get into prevention. “Should we be out on the street doing primary care, and making sure people get pap smears, and mammograms, and colon cancer screening?” said Ganz. “Or should that be the primary doctor’s role, and we’re just advisors to them as community resources?”

One thing is certain: after the diagnosis of cancer is made, the patient will likely be seen indefinitely by his or her oncologist. “Once a patient comes under the care of an oncologist, the primary care doctor often expects the oncologist to do everything,” said Zon. “It’s not uncommon for me to see a woman of 55 or 60 who’s had a diagnosis of breast cancer, who’s currently disease-free, and whose primary care doctor has never mentioned colorectal screening or smoking cessation.”

Zon sees her primary care doctors as typically having no more than 15 minutes with a patient, and they must use that time to gauge the areas of greatest immediate risk, such as hypertension, cardiovascular disease and diabetes. However, once a patient is diagnosed with cancer and put under the oncologist’s care, she observed that many functions previously performed by the PCP were implicitly presumed to belong to the oncologist. It is also assumed that the patient will be the oncologist’s forever, even though consults may happen only once a year.

“The oncologist won’t be taking typical, average, at-risk patients away from the primary care arena,” said Zon. “Individuals will continue to be referred to an oncologist’s office based on newly-diagnosed disease or elevated risk for developing cancer.”

### Reimbursement Concerns

Reimbursement and documentation of these services is complex. An example is counseling a breast cancer survivor who is also a smoker and is at high risk for developing a second primary lung cancer. “Many physicians now do this sort of counseling without reimbursement, either because they don’t know how to bill, or were turned down [for reimbursement] in the past,” said Zon. In fact, she says, it is happening in medical oncologist’s offices across the country.

The reimbursement subcommittee is exploring methods for documentation, reimbursement and follow-up with these sometimes time-consuming, but important, tasks.

The reimbursement outlook has recently improved. According to Ganz, Medicare just approved smoking cessation counseling. “We all see people with smoking-related cancers, and can provide smoking cessation counseling, which is a billable service.” The same is true for breast cancer, she says. “A few years ago, after tamoxifen was approved, I began to see a lot of women and do high-risk counseling. I was being fully reimbursed...[as for] a new patient consult,” she said.

The subcommittee is exploring ways to facilitate reimbursement for all of these and for other case scenarios as well. “We’re exploring the mechanisms to get reimbursed by using appropriate diagnostic and billing codes to reflect the decision-making complexity or time that the oncologist has spent providing the prevention service,” said Zon. How to use the codes will be the subject of Part 2 in this series.

Until recently, margins on chemotherapy administration covered prevention and other services. Oncologists didn’t worry about lack of reimbursement for prevention counseling, if provided, because the other sources of revenue covered these uncompensated costs. Rather than deal with the headaches of diagnostic coding and billing and supporting documentation, they simply didn’t worry about it. Now, however, with the changing reimbursement climate, all legitimate revenue is relevant.

### ASCO’s Role

Ganz said that curriculum development is one way for ASCO to play a leading role, citing the cancer genetics curriculum as a good example. “That [genetics curriculum] has now been integrated into many oncologist’s practices, especially if they see a lot of breast or colon cancer patients. By virtue of the dissemination of this information, people are thinking about risk reduction and prevention,” she said. Additionally, Otis Brawley, MD, is currently directing a committee to develop a cancer prevention curriculum that will be similar in scope to ASCO’s genetics curriculum.

To Ganz, the point is that oncologists are already seeing and counseling patients. “They’re seeing high-risk patients. They’re seeing patients who are survivors who need risk reduction strategies and preventive strategies, so they’ve got in their waiting rooms, in their offices, a community of patients who are primed and ready for prevention strategies for whom we are, in fact, by default and by expertise, the acknowledged resources in the community. We have to find better ways to deliver this care within our practice settings. We need to think about new models of care, in order to be able to deliver these services. We need to provide the education to our members to have them feel confident. Clearly the genetics curriculum has done this; we are now working on a prevention curriculum. Education sessions within the meeting are going to be important to give our members the tools and strategies to be confident in doing this,” she concluded.