

Reimbursement for Preventive Counseling Services

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Introduction

The ASCO Cancer Prevention Committee (CAPC) defines cancer 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.”¹ A recent survey of ASCO members in the United States indicated that despite the significance placed on cancer prevention, the most significant barrier to integration into clinical practice is insufficient reimbursement.² Therefore, understanding the payment environment for cancer prevention counseling services is a critical step for oncologists to integrate cancer prevention into clinical practice.

To provide practical information regarding the types of cancer prevention counseling services that are covered by payers and how these services should be billed, ASCO commissioned Avalere Health, LLC, to conduct a study of Medicare and private payer reimbursement policies. The research focused on prevention scenarios that typically occur during patient encounters, including counseling for smoking cessation, breast cancer or colorectal cancer screening and chemoprevention in high-risk populations, genetics, and the prevention of secondary cancers in cancer survivors.

Methods

The study involved both secondary and primary research. Secondary research consisted of a review of published private payer and Medicare policies and guidelines for billing and reimbursement of cancer prevention counseling services. Source documents included publicly available clinical policy bulletins, coverage policies, claims editing procedures, and descriptions of disease management services related to cancer prevention counseling services.

Primary research included telephone interviews with six private payer and four Medicare carrier medical directors. Interview subjects were chosen to ensure good representation across geographic locations and plan sizes. Four private payer medical directors were recruited from the top 15 national plans in the United States, and two from smaller, regional plans. Three Medicare carrier medical directors represented carriers with jurisdiction over multiple states, and one had jurisdiction over a single state. While 10 interviews do not provide information on every health plan and local Medicare policy, they provide a good overview of the types of policies and procedures that are in place across the country for cancer

prevention counseling services. Self-insured private payer plans were not included in the survey.

To ensure consistency across medical director interviews, written discussion guides were used. These guides included questions about the types of cancer prevention counseling services covered, criteria for coverage, and guidelines for coding and medical record documentation.

Results

Private Payers

The private payers surveyed cover a range of preventive services, including services recommended by the Health Plan Employer Data and Information Set and the U.S. Preventive Services Task Force.³ Most of the payers do not have formal coverage policies for preventive counseling but pay for a wide range of cancer prevention counseling services delivered to patients with a precancerous condition or personal or family history of cancer (Table 1). Some of the payers interviewed offer specific policies for preventive services, including smoking cessation, genetic counseling, and weight loss.

Overall, the medical directors believe the primary responsibility for most standard preventive services rests with a patient’s primary care physician (PCP). Oncologists are expected to provide cancer prevention counseling services to patients who already are diagnosed with cancer or are at a high risk of developing cancer. Based on the plan benefit design, the PCP also may serve as a “gatekeeper” with the discretion to refer patients to medical oncologists or other oncologists with relevant expertise for advice on management of cancer risks.

Medicare

By law, Medicare provides coverage only for products and services that are considered “reasonable and necessary” for the treatment of illness or injury. Screening and prevention services generally are not covered.⁴ However, due to statutory requirements, coverage for cancer screening services has increased over time. Coverage now exists for colorectal cancer screening, mammography, Papanicolaou tests and pelvic examinations, and prostate cancer screening.

Few formal Medicare coverage policies on cancer prevention counseling services exist at either the national or local levels. The only relevant national coverage policy is for the smoking cessation counseling benefit that was implemented recently. However, this policy is limited to beneficiaries with an illness caused or complicated by tobacco use or to beneficiaries taking medications whose effectiveness is complicated by tobacco use.⁵ Almost no local policies exist for cancer

Table 1. Coverage of Oncology Preventive Counseling Services for Specific Patient Conditions

Patient Condition	Examples of Preventive Counseling Services	Covered Benefit (No. of plans)	Covered for Medical Oncologist? (No. of plans)
Individual has cancer or personal history of cancer	• Smoking cessation counseling for patient with diagnosis of lung cancer or breast cancer	6*	6
	• Counseling on ultraviolet radiation exposure for patient with history of skin cancer	6	6
	• Counseling on obesity for individual with personal history of cancer	5†	4
Individual has precancerous condition	• Colorectal cancer preventive counseling for patient with colon polyps	5‡	5
	• Breast cancer preventive counseling for patient with atypical hyperplasia	5‡	5
Individual has personal history of precancerous condition	• Breast cancer preventive counseling for patient with history of ductal carcinoma in situ or lobular carcinoma in situ	6	6
	• Colorectal cancer preventive counseling for patient with history of colon polyps	6	6
Individual has family history of cancer but no cancer-related condition	• Breast cancer preventive counseling for patient with family history of breast cancer	6	6
	• Genetic counseling for patient with family history of cancer	5§	5§
Individual has either family history of gene mutation (unknown if patient is carrier) or family history of precancerous conditions	• Colorectal cancer preventive counseling for patient with family history of colon polyps	6	6
	• Breast/ovarian cancer preventive counseling for patient with known family history of BRCA-1 gene mutation	5§	5§

* One plan covers smoking cessation only with the purchase of an additional benefit option. A second plan covers smoking cessation only if it is a part of managing the patient's condition.

† One plan limits nutritional counseling to three times per year. Another requires the purchase of an additional benefit option. A third plan only allows obesity counseling as part of treatment of the underlying condition for which the patient is being seen.

‡ The sixth plan said that there was insufficient information on familial risk to determine if the service would be covered.

§ Five plans cover genetic counseling; the sixth plan does not cover genetic counseling under any circumstances.

prevention counseling services. A local coverage decision on genetic testing was issued by Noridian Administrative Services, which specifies the tests for cancer susceptibility that are covered and the criteria under which they are covered.⁶

Despite the lack of formal policy and the statutory exclusion of most preventive services from coverage, the Medicare carrier medical directors interviewed believe that cancer prevention counseling services would be covered if provided to a patient with an established cancer diagnosis, a precancerous condition, or a high risk of familial cancer (Table 2).

Claims Submission for Specific Oncology Preventive Counseling Scenarios

Both Medicare and private payer medical directors expect the majority of cancer prevention counseling services provided by

a medical oncologist to be billed using established evaluation and management (E/M) codes as these services typically are provided as part of the usual patient assessment and treatment planning. Such services could be provided within the context of the two subcategories of office visits: new or established patient encounter. The appropriate level E/M code reported would reflect the decision-making complexity and time the oncologist spent providing the prevention service.

Medicare carrier medical directors indicated that an exception to the billing guidance presented here would be for services that have specific codes, such as the two new codes that were established to report intermediate and intensive smoking cessation counseling services provided to Medicare beneficiaries.

Table 2. Medicare Carrier Coverage of Oncology Preventive Services for Specific Patient Conditions

Patient Condition	Covered (No. of carriers)
Individual has cancer or personal history of cancer	4
Individual has precancerous condition	3*
Individual has personal history of precancerous condition	3*
Individual has family history of cancer but no cancer-related condition	3†
Individual has either family history of gene mutation (unknown if patient is carrier) or family history of precancerous conditions	3†

* One carrier would cover preventive counseling only in certain cases.
 † Two of the medical directors who would cover these scenarios indicated the scenarios would not be covered if the sole purpose of the visit is preventive. The third medical director was very liberal in his interpretation of what constituted a covered Medicare benefit and believed the risk factors were reasonable and necessary to justify counseling as part of an evaluation and management visit. One medical director indicated these claims would automatically be denied if the only diagnosis code listed on the claim was for family history.

Some private payers would allow oncology preventive services to be billed using the individual counseling series of codes, *Current Procedural Terminology (CPT) 9940X*, if a patient has a precancerous condition or a high risk of familial cancer. However, they would not allow medical oncologists to bill using group counseling CPT codes (99411 and 99412). Billing both a counseling CPT 9940X code and an established patient E/M code on the same day of service may require a modifier code that will be payer specific. Medicare does not cover either the individual or group counseling CPT codes.

Both Medicare and private payer medical directors reported that they do not have specific patient medical record documentation requirements for cancer prevention counseling services. Both Medicare and private payers referenced American Medical Association (AMA) CPT guidelines for reporting E/M services, which must justify the level of E/M service billed.⁷

Table 3. Elements of Decision Making

Type of Decision Making	No. of Diagnoses or Treatment Options	Amount and/or Complexity of Data Reviewed	Risk of Significant Complications, Morbidity and/or Mortality
Straightforward	Minimal	Minimal or none	Minimal
Low complexity	Limited	Limited	Low
Moderate complexity	Multiple	Moderate	Moderate
High complexity	Extensive	Extensive	High

With the AMA guidelines, the complexity of medical decision making is determined by the:

- Number of possible diagnoses and/or the number of management options considered
- Amount and/or complexity of medical records; diagnostic tests; and other information that must be obtained, reviewed, and analyzed
- Risk of significant complications, morbidity, mortality, and comorbidities associated with the patient’s presenting problems, diagnostic procedures, and management options

The elements for each level of medical decision making are summarized in Table 3. To qualify for a given type of medical decision-making, two of the three elements in each category must either be met or exceeded.

The specific times included in the definitions of levels of E/M services represent the average time the physician spends face-to-face with the patient and/or family. This face-to-face time is a proxy for the total work done before, during, and after the patient encounter and should assist the practicing oncologist in selecting the most appropriate level of E/M services.

According to Medicare’s policy,⁸ when more than 50% of the face-to-face physician/patient/family encounter is dedicated to counseling, time is considered the key or controlling factor to qualify for a particular level of E/M service. Documentation required for a patient encounter dominated by counseling includes capturing the total length of time of the encounter and describing the counseling services provided in the patient’s medical record.

A summary of the billing guidance provided by payers on several specific prevention counseling services is presented in Table 4. These scenarios addressed two broad categories of prevention counseling services delivered by medical oncologists—prevention counseling of patients with and without an established cancer diagnosis. While some of the specific coding recommendations varied, the general consensus was to follow the AMA guidelines with regard to decision-making complexity or time the oncologist spent providing the prevention service.

Table 4. Private Payer Coding Recommendations for Prevention Counseling in Context of Entire Patient Encounter

Scenario	Coding Recommendation	Documentation
<p>30-year-old, premenopausal woman diagnosed with high-risk, lymph node–positive (11/25 positive) breast cancer is seen for usual E/M visit with history, review of systems, physical examination, and review of laboratory results for ongoing chemotherapy.</p> <ul style="list-style-type: none"> • Currently receiving adjuvant chemotherapy • New complaint of hip pain • Family history positive for multiple second degree relatives with ovarian and breast cancer <p><i>Discussion addresses potential genetic predisposition for cancer and need for counseling.</i></p>	<ul style="list-style-type: none"> • Six payers recommended appropriate level of established patient E/M code that reflects complexity of medical decision making and/or counseling time • Two payers recommended individual counseling codes, <i>CPT</i> 9940X 	<ul style="list-style-type: none"> • Medical record documentation appropriate for E/M code selected; include complexity of medical decision making and/or time spent and counseling services provided
<p>69-year-old woman with breast cancer is seen for routine follow-up with history, review of systems, physical examination, laboratory review, and assessment/plan.</p> <ul style="list-style-type: none"> • Currently on anastrozole • Smokes but no diagnosed lung or cardiac disease attributable to smoking <p><i>Discussion addresses smoking as a risk factor for a variety of cancers and options for smoking cessation.</i></p>	<ul style="list-style-type: none"> • Five payers recommended appropriate level of established patient E/M code that reflects complexity of medical decision-making and/or counseling time • One payer recommended individual counseling codes, <i>CPT</i> 9940X and appropriate level of established patient E/M code 	<ul style="list-style-type: none"> • Medical record documentation appropriate for E/M code selected; include complexity of medical decision-making and/or time spent and counseling services provided
<p>53-year-old patient is seen for new patient evaluation.</p> <ul style="list-style-type: none"> • Patient has family history suggestive of possible cancer syndrome <p><i>Discussion addresses recent finding of colon polyp.</i></p>	<ul style="list-style-type: none"> • Five payers recommended appropriate level of new patient E/M code that reflects complexity of medical decision-making and/or counseling time • One payer recommended individual counseling codes, <i>CPT</i> 9940X AND appropriate level of established patient E/M code 	<ul style="list-style-type: none"> • Medical record documentation appropriate for E/M code selected; include complexity of medical decision-making and/or time spent and counseling services provided

Abbreviations: E/M, evaluation and management; *CPT*, *Current Procedural Terminology*.

Conclusion

Both Medicare and private payer medical directors believe cancer prevention counseling services are valuable and should be covered. Additional reimbursement for cancer prevention counseling services is available when provided to patients with an established cancer diagnosis, a precancerous condition, or a high risk of familial cancer, and if the time and complexity justify a higher-level E/M code. Overall, billing and documentation requirements are consistent with AMA guidelines for reporting E/M services.

References

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The current thoughts on defining prevention services at the clinical practice level and acknowledging reimbursement concerns for these services were discussed in this article, by Zon and colleagues. Recently, an ASCO member survey exploring attitudes and interest in prevention services confirmed that insufficient reimbursement is a barrier to implementing prevention activities in clinical practice (Ganz PA. J Clin Oncol 24:2948–2957, 2006). To address these concerns, the Reimbursement Subcommittee of ASCO's Cancer Prevention Committee (CAPC) was charged with exploring methods for documentation and reimbursement for these services and assisted ASCO in commissioning Avalere Health LLC to investigate public and private payer coverage for these services. The research of Zon et al reports the findings as they apply to practical information on services covered and billing strategies for these services.

In addition to this survey, the CAPC will continue to explore strategies for prevention services to become financially feasible within clinical practices. The CAPC recognizes that broader issues beyond clinical practice reimbursement exist and must be addressed in order to effectively implement these services. Barriers requiring our attention include lack of coverage for proven interventions; lack of resources to access care; and lack of financial resources in minority, uninsured, and underinsured populations. To attend to these barriers, the CAPC is exploring collaboration with ASCO's Clinical Practice Committee (CPC) to ensure that prevention is a priority consideration in the CPC's strategies. Finally, the CAPC will assist ASCO in becoming a leading advocate for health care expenditures, to reflect equivalent value of proven prevention interventions to proven cancer therapies.



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