# Society for Maternal-Fetal Medicine
# White Paper for Billing and Reimbursement
# For Genetics Counseling Services

## Introduction:

Genetic Counseling is an integral part of all perinatal practices. This type of counseling service may be provided by the Perinatologist or a Certified Genetic Counselor. Members of the SMFM have questioned the Coding Committee about the proper way to bill and receive reimbursed for these services when the complete genetic history and counseling is done by a Genetic Counselor and the physician does not spend time with, or spends a minimal amount of time with the patient.

This White Paper will deal with this subject and give, to the best of this Committee's knowledge, what the appropriate and "legal" ways of billing and obtaining reimbursement for Genetic Counseling services are. It will discuss the usual and customary situation when there are no specific contractual arrangements dealing with this situation as well as the situation in which a special contract has been executed.

**Per CPT Guidelines:**

***The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of Evaluation and Management Services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate Evaluation and Management code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with Modifier 26 appended.***

To emphasize, if an Evaluation and Management Service is performed during the same encounter that antepartum/diagnostic testing is performed (i.e. ultrasound studies, amniocentesis, CVS, etc.), other than to explain the risks and benefits of the procedure, it would be appropriate to bill the Evaluation and Management Service in addition to the procedure.

When the patient's condition required a significant, separately identifiable Evaluation and Management Service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed, it is strongly recommended that you attach the Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service) to the appropriate Evaluation and Management Service.

A significant, separately identifiable Evaluation and Management Service is defined or substantiated by documentation that satisfies the relevant criteria for the respective Evaluation and Management Service to be reported.

**Payment for Genetic Counseling when no specific contractual terms have been agreed upon with a specific payer (all government payers follow these rules as well as most commercial payers unless a specific contract with that payer that addresses this issue is executed)**

1. **Genetic Counseling Performed by the Perinatologist-(Consultation)**

When the Genetic Counseling is performed by the Perinatologist, then the physician should be reporting the standard E&M coding. If this is done as a consult, the appropriate codes (99241-99245) should be reported. Since time-based coding is more appropriate for counseling reimbursement, the code selected would be based on the total **face-to-face** time the **physician** spends with the patient. **Face-to-face time refers to the time with the physician only.**

***Per CMS Transmittals 1776BR and 178CP:***
***In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.***

The total Physician time must be based on the actual total time that is spent doing the Genetic Counseling, not time spent doing other tasks such as ultrasounds or providing any other service.

Appropriate coding for these services would be:

99241- 15 minutes
99242- 30 minutes
99243- 40 minutes
99244- 60 minutes
99245- 80 minutes

By coding in this fashion you are stating that there was a written or verbal request for a consultation from another physician or appropriate source, the consultation was performed by the Physician, not Genetic Counselor, the consultation note will clearly state the approximate physician face-to-face time spent with the patient and a separate distinct written report was sent back to the requesting physician. When the physician face-to-face time is used as the controlling factor in selecting your level of Evaluation and Management Service, your documentation must include the following key phrase or similar:

*The majority time (>50%) was spent on counseling and coordination of care with this patient and/or family member. The approximate physician face-to-face _______ minutes.*

**2. Genetic Counseling by the Perinatologist Providing Global Obstetrical Care**

When the Perinatologist will be billing for global obstetrical care (CPT Codes 59400, 59510, 59610, 59618) and providing the Genetic Counseling for that patient, he/she may not be able to separately bill for these services since they may be considered as included in the global Obstetrical Care Package. Since we believe that this counseling is clearly separate from routine Obstetrical Care, it is suggested that you bill for this using the appropriate time-based E&M codes and attach Modifier 25. Time must be based on the actual time that is spent doing the Genetic Counseling, not time spent performing other tasks such as an ultrasound or other procedures.

Appropriate coding for these services would be:

99211- 5 minutes
99212- 10 minutes
99213- 15 minutes
99214- 25 minutes
99215- 40 minutes

By coding in this fashion you are stating that this was a separate service provided to the patient by a physician independent of routine obstetrical care. There should be a separate note with details of this counseling **and** the note should clearly state that the face-to-face time the physician spent with the patient for counseling is consistent with the code used. When the physician face-to-face time is used as the controlling factor in selecting your level of Evaluation and Management Service, your documentation must include the following key phrase or similar:

*The majority time (>50%) was spent on counseling and coordination of care with this patient and/or family member. The approximate physician face-to-face _______ minutes.*

3. **Genetic Counseling performed by a Genetic Counselor**
   Effective January 1, 2007, a new CPT code was released specifically for genetic counseling provided by a non-physician, 96040 (Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family). A physician should not report this CPT Code.

   According to CPT Guidelines, these services are provided by Certified Genetic Counselors and may include obtaining a structured family genetic history, pedigree construction, analysis for genetic risk assessment, and counseling of the patient and family. This code should be reported when a Genetic Counselor is performing the session.

   When the genetic counseling session is provided by a physician to an individual, you would report the appropriate Evaluation and Management codes.

   In order to receive reimbursement for this CPT Code, it is strongly recommended that your Genetic Counselor obtain a National Provider ID Number. The payers must have your Genetic Counselor added as a "provider" for this specific CPT Code. You need to negotiate a payment rate for the service with each payer. Until you have this specific code added to your existing fee schedule, if no contractual arrangements have been made with the payers, no physician encounter took place and the counseling session was solely performed by the Genetic Counselor, you may not get reimbursed or you may only bill using CPT Code 99211, for an established patient.

   Since the CPT Code 96040 is a time based code, when reporting genetic counseling services under this code, it is required that the total Genetic Counselors face-to-face time with the patient and/or family member be noted in the documentation.

   *The majority time (>50%) was spent on counseling with this patient and/or family member. The approximate Genetic Counselors face-to-face _______ minutes.*

   **Combined Perinatal Counseling - Genetic Counseling and Counseling Related to an Independent Medical or Obstetrical Complication**

   In certain circumstances, some patients who undergo genetic counseling will have additional medical or obstetrical complications of pregnancy that will require additional time with the physician. In these circumstances, if additional time is spent with the patient, and if counseling and coordination of care accounts for greater than 50% of the service, then the time component can be used for billing purposes for the physicians face-to-face time, independent of the Genetic Counselors face-to-face time.

**Example**:

1. Genetic Counseling performed by Genetic Counselor in Perinatologist's office. The Genetic Counselor spends 30 minutes face-to-face with the patient discussing risk factors, etc. due to the patient's Advanced Maternal Age. During the same visit, the physician performs a 30-minute consultation in regards to a treatment plan for her chronic hypertension and diabetes.

    a. 96040 for Genetic Counselor, 30 minutes (if contracted with payers)
    b. 99242 for Physician consultation, 30 minutes (time independent from GC)
    c. If Genetic Counselor is not contracted with the payers, only the Physician's face-to-face time can be reported.

Another option in cases where there are concomitant medical problems would be the use of the history, physical and medical decision-making route in assigning an E & M code but this would not then be time dependent. Obviously all components of the exam must be included. Under these circumstances, when using the three components, information obtained by the genetics counselor in terms of the history component can be included as part of the required components. In addition, care should be taken so as not to up code or perform unnecessary examinations so as to increase reimbursement.

**Payment for Genetic Counseling for Patients who have Commercial Insurance who do not follow the CMS "Incident to" Billing Guidelines**

Commercial insurers will usually default to the CMS Guidelines for reimbursement and will not reimburse for services provided by non-contracted or credentialed providers, such as Genetic Counselors. Therefore these payers will reimburse as described above. Some Payers though, will participate in contractual relationships that will specifically identify Genetic Counseling by Genetic Counselors as a reimbursable service.

Genetic Counseling and/or Perinatal Centers must negotiate specific contracts with these commercial insurers that detail the understanding reached to provide reimbursement for services provided by a Genetic Counselor. The agreement must include the circumstances under which coverage is deemed appropriate, i.e. advanced maternal age, abnormal multiple serum screening, previous chromosomal abnormality in a prior pregnancy, a suspected fetal anomaly on ultrasound, repetitive pregnancy loss etc. The contract should specifically state not only those services are reimbursable, but also what codes need to be used to be reimbursed for these services. A specific detailed list of CPT codes, and their definitions, should be written into the contract that can be used for Genetic Counseling. These codes will usually be linked with specific ICD-9 codes or the V26.3x (Genetics Counseling for Appropriative Management) code.

If a specific contract states that a code such as 99244 can be used to bill for these services rendered by a Genetic Counselor or Perinatologist, then even if the use of that code does not conform to the definitions in the CPT book, the code can be used for this specific contracted carrier without being considered illegal. Remember though, the code can't be used for other commercial carriers or government insurers in the same way.

Negotiations for these codes that can be used for reimbursement when services are provided by Genetic Counselors should be done by practices with individual insurers when the practice pays for Genetic Counselors. Because of the complexity of this service, and the fact that it is not a "reimbursable" service for CMS, it is suggested that the negotiations be done by someone familiar with the situation and the details be clear in the contract.

**Examples**:

2. Genetic Counseling performed by Genetic Counselor in Perinatologist's office. Genetic Counselor spends 35 minutes with the patient and physician cosigns the letter. No other services provided by the physician.

    a. 96040, (if contracted with payers)
    b. 99211 for established patient (if not contracted for CPT Code 96040)
    c. 99211-25 for established patient receiving Global Obstetric Care from this office

3. Genetic Counseling performed by Genetic Counselor in Perinatologist's office totaling 60 minutes. Perinatologist spends an additional 15 minutes reviewing an abnormality found on ultrasound.

    a. 96040 twice, for 60 minutes of genetic counseling, (if contracted with payors) plus if there was a request for a consultation, the physician would be reporting 99241 for the 15 minutes of face-to-face time.

4. Genetic Counseling performed by Genetic Counselor in Perinatologist's office for Commercial Payer with a negotiated contract.
    a. Code according to guidelines established in contract and use predetermined code.

**Summary**:

For billing and reimbursement purposes, the Genetic Counselor is not considered an independent practitioner who can be reimbursed unless specific contractual agreements are made with a specific payer, which would include contracting for CPT Code 96040.
As always, we strongly recommend that you contact your local payers for their preferred method of reporting genetic counseling services.

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