
Incorporating genetic testing and counseling in your practice

Of the 2,000 certified genetic counselors in the United States, there may be as few as 700 who focus on cancer. But genetic testing and counseling are in increasing demand. Here's how to include them in your practice.

Increasingly, genetic counseling services are being incorporated into the community oncology setting using various, and still evolving, models and billing strategies. Frank Senecal, MD, a member of a five-oncologist practice, described for attendees the experience he and his colleagues have had in the South Puget Sound area of Washington State where they offer

cancer genetic testing and counseling, folding them into the evaluation and management (E&M) coding system. "We don't get reimbursed for all the time and effort that goes into it," said Dr. Senecal, "but it's a passion of ours. We love the relationships with the families and want to help them through this process." Dr. Senecal, whose Tacoma-based oncology practice is part of Northwest

Medical Specialties, Inc., said his office is at least 30 miles from any genetic counselors.

One impetus for Dr. Senecal and his colleagues to offer screening and counseling was the 2003 policy statement by the American Society for Clinical Oncology (ASCO) that identified the indications for genetic testing. The ASCO statement called on oncologists to define an informed

consent process and implement pre- and post-test counseling for test results. It followed an earlier statement from ASCO urging oncologists to consider genetics risk assessment, counseling, and management a part of their mission.

Stepping up efforts

Dr. Senecal and his colleagues had been offering some screening and counseling, but to relatively few patients, and not in a systematic way. After 2003, they decided to step up their efforts, first by attending various courses. In 2005, along with other members of their practice, they developed a process by which the nurse coordinator uses the electronic practice management system to identify all new patients who had one of the following “red flags:” breast, colon, or uterine cancer prior to the age of 50; ovarian cancer at any age; multiple primary cancers; a second breast cancer diagnosis; Ashkenazi ancestry; a male relative with breast cancer; or a known family member with a genetic predisposition to cancer.

Red flag forms are placed in each affected patient’s record to alert the physician to the need for counseling and screening. The physicians follow a standardized process for counseling and consent. Laboratory staffers then play a key role in completing docu-

IN A SURVEY he conducted last year of members of the National Society of Genetic Counselors, Eric S. Fowler, MS, CGC, found that some practices where physicians are involved in genetic counseling use the preventive medicine CPT codes 99211-15. Services with no physician involvement sometimes use the CPT codes 99241-45 or the new “Medical Genetics and Genetic Counseling Services” code 96040.

mentation for testing, tracking insurance authorization and securing letters of medical necessity, and communicating the status of testing to patients and physicians. This process, Dr. Senecal said, has served their patients well.

Of 18 patients who tested positive for *BRAC1/2* mutations, all made changes to their medical management based on the results, he said. For example, 10 of the 18 had bilateral mastectomies within an average of 5 months of receiving the test results.

Because of the time and complexity involved, many of the E&M visits that include hereditary cancer counseling—often two to three visits per patient—are coded at a level of 4 or 5, Dr. Senecal said.

Different models

At the Baptist Centers for Cancer Care in Memphis, Tennessee, Eric S. Fowler, MS, CGC, serves as clinical director of genetics. He is one of about 2,000 certified genetic counselors in the US, most of whom work as prenatal counselors. The number of CGCs who focus on cancer totals perhaps 700–800.

Mr. Fowler and two other certified genetic counselors are employed by the Baptist Centers for Cancer Care. They travel to each of the system’s five contracted community clinics to visit with patients. The hospital bills the clinics an hourly rate for the genetic services; since physicians typically join in part of the sessions to provide their perspective, the clinics’ costs can be offset largely by reimbursement for office visits.

Hospitals that bill clinics for the provision of genetics services—as in the Baptist model—charge at least \$60–\$85 an hour, said Mr. Fowler. And a “fair number” of hospitals and institutions that provide services on site—rather than in the community—do not charge at all “because of all the complexities involved,” he said.

Until recently, Pennsylvania Hospital in Philadelphia was one such

institution, with a cancer genetic screening program supported almost entirely by grant funding. However, in 2006, clinicians there implemented a modest fee-for-service model, charging a one-time fee of \$150 for the first family member tested and \$50 for subsequent family members.

At the Baptist Centers’ 10-year-old cancer genetics program, testing is coordinated through the referring clinic. Patients are referred directly to the genetic counselor, who contacts patients to schedule appointments. Patients typically have one or two genetic counseling sessions, in which 45–60 minutes are spent with the visiting genetic counselor followed by a much shorter time with the physician, Mr. Fowler explained.

Referrals have increased steadily over the program’s history, resulting in the identification of 150 women with *BRCA1/2* mutations, approximately a dozen individuals with hereditary non-polyposis colorectal cancer mutations, and others with familial adenomatous polyposis and less common syndromes such as Cowden syndrome and Li-Fraumeni syndrome.

Thus far, most referrals (70.6%) have been for patients with breast cancer. Patients with colon cancer account for 7.9% of referrals, and patients with ovarian cancer, 5.8%, Mr. Fowler said.

However, not all patients follow up on their referrals. Approximately 56% of the patients referred to Mr. Fowler’s program make an appointment, about 28% do not respond, and 16% express a lack of interest in the service.

Similarly, too few family members of affected individuals respond to referrals for testing, said Dr. Senecal. Of his 18 patients who tested positive for *BRAC1/2* mutations, only 3 had family members who were subsequently tested.

“We need to develop a mechanism to ensure that families get more information about their potential risks,” he said. “It’s a moral responsibility.”