FUNDING AND REIMBURSEMENT SURVEY RESULTS
SEPTEMBER 14, 2001

KEY FINDINGS

REPORTED PROBLEMS:
- Pre-authorization for services is unreliable
- Levels of reimbursement are variable, but consistently low
- Justifying need for services requires significant amounts of time
- Reimbursement practices are not standard throughout insurance industry
- Navigating insurance system is difficult and time consuming
- Genetic counseling is rarely reimbursed

SUGGESTED SOLUTIONS:
- Education on importance of genetic services for
  --Payors
  --Primary care providers
- Insurance industry regulation
  --Require pre-certification of genetic services
  --Require review of disputed claims (no denial without review)
- Research on medical utility of genetic services
- Legislation
  --License genetic counselors
  --Mandate payment for genetic services
- Create a genetics standard of care

METHODS

The following is a report of findings from a telephone survey conducted in August and September 2001 to gather qualitative information about reimbursement for genetic services by third party payors.

Members of the Genetics Advisory Committee suggested appropriate personnel to interview. Geneticists, genetic counselors, and billing specialists from five Oregon genetics centers were interviewed. Kaiser Permanente was not included in the survey because their authorization and reimbursement policies differ significantly from the other organizations interviewed. Interviews followed a loose script of open-ended questions developed and approved by the Genetics Plan
Advisory Council. Open-ended questions were chosen over categorical questions in order to collect the broadest possible range of issues and problems of concern to interviewees. Items discussed included general and specific concerns about pre-authorization and reimbursement for genetic services, ideas for handling these concerns, and ways the state or the DHS/CDRC Genetics program could help. Interviews were taped and transcribed. Transcripts were reviewed for content, details, and themes.

RESULTS

AUTHORIZATION & REIMBURSEMENT

All respondents reported problems getting pre-authorization for genetic services, but the frequency of problems varied. Some reported experiencing problems daily, others reported only occasional difficulties. A concern voiced by many is that pre-authorization is not a guarantee of payment and in many situations, patients end up responsible for paying for pre-authorized services.

Interviewees reported that some services are routinely pre-authorized. These services include diagnostic testing for symptomatic patients, inpatient services, and consults. Additionally, diagnostic DNA testing is more often pre-authorized than predictive DNA testing.

Participants report that many services are routinely refused pre-authorization. These include predictive testing based on family history and diagnosis in asymptomatic persons. Carrier screening tests and pre-conceptual services related to family planning are also often refused.

All participants reported having to spend time justifying to third party payors, either before or after seeing a patient, why it was necessary to provide a patient with genetic services. For one genetic counselor, 60% of work hours were spent justifying the necessity of genetic services; another clinician estimated over 1 hour per day spent. Still another clinic reported spending one hour per patient justifying the need for services. The times spent by each interviewee varied and the variation may reflect differences in job responsibilities. However, working with insurance companies to arrange payment for services is a common activity for these genetics service providers.

Compared to other types of medical services, reimbursement for genetic services is more difficult to obtain. Because some clinics only provide genetic services, certain respondents could not discuss the differences between reimbursement for genetics vs. non-genetic services. Respondents indicated it is harder to get referrals, pre-authorization, and reimbursement for genetic services. For at least one interviewee, billing for genetics required more “creativity” to find an effective billing strategy.

When companies refuse pre-authorization or reimbursement, reasons include:

- Service is excluded from all plans
- Service is not covered in the employer plan
- Service is not medically necessary
- Service or diagnosis billed is unknown
- Experimental procedures (tests) are not covered
- Clinic or provider is out of plan
- Tests performed out of state are not covered
- “Bundling (a single procedure billed as separate procedures)” is not allowed
Respondent estimates of reimbursement rates for genetic services varied from a low of 10-15% to a high of 100% for some services. Most estimates were in the range of 50-65%, depending on the type of service, the insurance company, and the employer group. One participant indicated that even within one insurance company, reimbursement rates for similar services vary dramatically depending on the employer group plan.

Genetic counseling is almost universally refused payment and most interviewees report that if they bill for genetic counseling at all, they bill using the provider number of the attending physician (see box in “Strategies”).

In several instances, respondents reported conflicting experiences. For example, some providers report difficulty obtaining pre-authorization and reimbursement for breast cancer mutation testing in symptomatic and presymptomatic patients; others report a good record of reimbursement for the test regardless of symptom status. Some providers report general success for clinical consults but not lab testing; another provider reports that lab tests are often covered but consults are not. Some providers report successful claims for presymptomatic DNA testing for Huntington’s disease while others report that claims for this test are routinely denied. These inconsistencies show that provider experiences with reimbursement for genetic services differ markedly. They may also suggest that other factors, such as provider billing practices, may interact with payor policies to influence reimbursement success.

**Strategies**

Respondents reported a variety of strategies used in an attempt to maximize reimbursement. Efforts include verifying benefits (with specific CPT codes) prior to the office visit, double-checking coverage, and seeking pre-authorization even if the plan doesn’t require it. Some inform patients ahead of time if insurance isn’t going to cover a service so that the patient knows that he or she will be responsible for the bill. Several reported that genetic counselor services are billed using the supervising physician’s provider code, even though a genetic counselor actually does the counseling. Some organizations employ reimbursement and billing specialists to handle difficult claims or to review billing. Less routine efforts include presenting educational materials to insurance company personnel, and turning denied breast cancer mutation testing claims over to the Myriad Reimbursement Assistance Program to facilitate second-level review.
One genetic counselor in Oregon is able to bill – and is reimbursed for – limited genetic services. This counselor has an agreement with a single insurance company that allows billing for cognitive services related to breast cancer mutation testing. This is an unusual situation and a more detailed interview with this counselor may provide new insights on how to improve reimbursement for counseling services.

**SOLUTIONS: THE ROLE OF THE STATE IN ADDRESSING PROBLEMS**

Possible projects for the DHS/CDRC Genetics program:

- Work toward licensure of genetic counselors.
- Draft recommendations on genetics standards of care.
- Create a manual for navigating insurance pre-authorization and reimbursement and educate clinic and billing staff in how to use it.
- Help coordinate communication between genetic service providers so that providers can share information and strategies.
- Provide education to insurance companies to clarify need and explain medical necessity of services.
- Work cooperatively with the insurance commissioner and insurance companies to create a streamlined, centralized method of managing complaints and claim review.
- Conduct a study to provide evidence of the medical necessity and utility of genetic services.

Possible legislative approaches:

- License genetic counselors.
- Mandate adequate payment for genetic services.
- Standardize insurance industry to:
  - Ensure predictable and fair reimbursement for services
  - Require pre-authorization that guarantees payment
  - Require review of disputed claims and forbid denial without review.

“...I’m unsure if things can really change without some kind of law or change in the procedures of insurance companies. The problem is, genetics is moving along so quickly that insurance companies and lawmakers are left behind in the dust. They don’t understand what’s going on and it makes it difficult to convince them that changes are needed...”
CONCLUSIONS

It is unclear whether reimbursement issues stem from billing policies and practices among genetic service centers or if the problems are related to the reimbursement policies and practices of third party payors.

The problems experienced by Oregon’s genetics service providers are not consistent.

Some providers may be more successful than others in obtaining reimbursement. This conclusion is supported by the conflicting reports of services that are refused reimbursement. For example, the clinics that are being reimbursed for presymptomatic breast cancer testing may have a more effective billing strategy.

Many providers think that licensing genetic counselors is important for improving reimbursement of genetic services.

There is general support among providers for licensing genetic counselors.

Genetic service providers feel they could benefit from standardization of reimbursement practices within insurance companies.

Many providers agree that insurance companies need education to understand the place of genetics in clinical medicine.

These results represent the views of those interviewed and do not necessarily reflect the views of all genetic services providers in Oregon.

This survey provides some general information on perceptions of problems by providers. To confirm the existence and extent of reported problems, a more structured, quantitative study is needed.

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