Ask Dr. Miller

April 2018

The following questions were posed by NBCCEDP grantees:

1. ***We have a 59 year old women who presented with vaginal bleeding. Her pelvic exam found significant blood in her vault and an "ulcerative-type fungating mass" on the cervix. Her Pap test result is Carcinoma NOS. The attending physician recommended a transvaginal ultrasound and CT abdomen/pelvis or MRI. Should our program cover these tests?***
   Since this patient has a diagnosis of carcinoma, she needs to be referred to Medicaid Treatment Act. Transvaginal ultrasound and CT/MRI are needed to evaluate the extent of the disease for treatment planning purposes. Those tests are not covered by the NBCCEDP as they are not being done to determine if the woman has cancer.

2. ***Is a clinical breast exam (CBE) a required part of the breast cancer screening process? Does a woman need to have a CBE before her mammogram?***
   It is not a requirement for every woman to have a CBE. There are no clinical guidelines stating that a CBE needs to be done before a mammogram. The CBE received an 'I recommendation' by USPSTF because there is not enough scientific evidence to determine if it does or does not reduce breast cancer mortality. Therefore, we allow reimbursement for an office visit to perform a CBE, but do not require it. The decision to have a CBE should be between the woman and her provider. That is one reason why providers should do risk assessments to help determine what examinations a woman should undergo.

3. ***What is the appropriate and recommended interval for a pelvic exam? Is this an annual practice supported by the program? We've had some pushback from providers about the necessity of the pelvic exam as an annual screening.***
   An annual pelvic exam alone is not covered by the program, as this exam does not screen for cervical cancer. A pelvic exam is usually done in conjunction with the Pap test or other invasive diagnostic procedures looking for cervical cancer. Some groups think a pelvic exam should be done as part of an annual well woman visit, but the NBCCEDP does not cover well woman visits. The NBCCEDP only covers services related to screening and diagnostic evaluation for breast and cervical cancer.

4. ***We have a Federally Qualified Health Center (FQHC) that uses the T1015 CPT code to bill for their office visits when they bill our program. This code is not on our CPT code list. Therefore, we deny the claims. Under Medicare reimbursements, FQHC***

providers are reimbursed an encounter rate that is established by Medicaid and includes all services provided during the encounter regardless of actual charges. Would CDC be ok with us adding this CPT code to our list of allowable codes?
T1015 is an all-inclusive code that covers everything done during a comprehensive office visit, much like the preventive medicine codes 993XX. The NBCCEDP only covers services related to breast and cervical cancer assessments, not an entire comprehensive encounter. Therefore, use of the T1015 code would not be appropriate for the NBCCEDP. The FQHC should bill the appropriate CPT codes to your program. The codes billed to your program should be for the specific services rendered for your clients.

5. ***We have a 56 year old female who has bilateral lesions on diagnostic mammogram. There is a persistent 11 x 9mm lobulated density in the left breast and a possible 4 mm focal asymmetry in the right breast. The bilateral ultrasound showed no sonographic correlation. Breast Cancer Risk Model for this patient is normal at 0.9% (5-Year risk) and 4.4% (lifetime risk). The radiologist recommended bilateral breast MRI for complete assessment. Is it okay for our program to cover the MRI?***
In this is a situation, the recommendation for the bilateral breast MRI is based on the mammographic findings, not the woman's breast cancer risk. The recommended MRI would be a diagnostic exam not a screening exam. Therefore, the lifetime risk for breast cancer is not a factor is this case and the women should follow the radiology recommendation to complete her assessment.

6. ***If a woman under the age of 65 years has disability Medicare (SSDI) and meets all other program eligibility requirements, can we pay for any part of the service that is not covered by her insurance? For example, a 51 year old woman needs a mammogram, but doesn't want to get one because she can't afford the co-pay/deductible charged by her SSDI.***
It appears that this woman may have Medicare Part A, but not Medicare Part B. If this is the case, she would be considered underinsured and could have her cost sharing covered by the grantee. If she has Medicare Part B, there should be no co-pay/deductible. You should clarify exactly what type of coverage the woman has in order to determine what assistance she qualifies to receive. Some individuals with disabilities may not get Medicare Part B because they cannot afford the premium.

7. ***Is our program allowed to cover HPV vaccination? We are developing a campaign to increase HPV vaccination rates and it seems odd that we tell our providers to do the vaccinations without actually paying for them. I know there is a federal vaccination program for kids under 19, but we're looking to reach adults (<26) who have never been vaccinated. We want to check with CDC first since it feels more like prevention than detection.***
NBCCEDP cannot pay for HPV vaccinations. This was addressed with CDC attorneys and determined that it does not fit under the program's authorization for screening. Therefore, we can only educate about the benefits of HPV vaccine. That is why the FOA specifically reads "educating" women about the benefits of HPV vaccine.