Ask Dr. Miller

September 2020

The following questions were posed by NBCCEDP grantees:

Question #1: The USPSTF recommendations state there isn't enough evidence to recommend breast cancer screening for women over the age 75 years. We have an 83-year-old woman referred to our program who has never had a mammogram. She does not have Medicare, but she does a social security number. Is there CDC guidance addressing breast screening for women over age 75 years?

Answer: Per the USPSTF guidelines, there is not enough evidence to recommend for or against breast cancer screening among women over the age of 75. Screening women in this age group is up to the provider and the patient. The provider will often consider the woman's medical history and life expectancy. Women who qualify for Medicare should be encouraged to apply. CDC does allow women over the age of 64 to be enrolled in the NBCCEDP if they cannot afford the Medicare premium or are not eligible for Medicare. Refer to the manual section entitled "Breast Cancer Screening for Women 65 Year of Age and Older".

Question #2: A 22-year-old female with a painless, supraclavicular mass was referred to our program. The mass was noticed about 2 ago and is increasing in size. Patient denies any breast mass or edema. Primary provider assessment notes normal breasts, large non-tender mass in right supraclavicular space with supraclavicular adenopathy, and no axillary or pectoral adenopathy. She was referred to a surgeon for evaluation. They are requesting a CT scan of the chest, an MRI, a biopsy, and any other services that our program can offer. I see nothing that related to the breast. Can this client be enrolled in our program?

Answer: Why was this patient referred to your program? Does her primary care physician or surgeon suspect breast cancer? Did they provide a differential diagnosis that includes breast cancer? This description does not appear to be related to assessing for breast cancer. It is more concerning for lymphoma. This client can only be enrolled in your program if they are working her up for breast cancer. You will need to determine that in order to decide if she can be enrolled. The program is authorized to provide screening and diagnostic services for breast and cervical cancer. It is not authorized to work up other potential malignancies. Therefore, you should discuss with the referring provider to determine if it is appropriate or not to enroll this patient.

Question #3: We have a patient who went to the emergency room for unrelated to breast complaints, that resulted in a full body CT scan. The CT identified a breast issue. Would the CT scan be something that could be covered with program funds?

Answer: No. That CT scan was not for breast cancer screening, so it would not be covered by the program. Even though a breast issue was identified, a CT scan is not considered breast cancer screening. Your program can proceed with covering the patient's subsequent evaluation for breast cancer.

Question #4: We received a call from one of our partner clinics asking if we can authorize a needle localization biopsy for a patient that was diagnosed with intraductal papilloma via core needle biopsy. They stated that they still need to rule out cancer. Can we authorize a second biopsy for the same lesion? Also, can we cover this procedure for other diagnoses like phyllodes tumor, radial scar, and sclerosing adenosis?

Answer: There are some breast diagnoses that have a higher risk of being associated invasive cancer. Therefore, excisional biopsy (with or without needle localization) is often recommended after core needle biopsy to be sure that invasive cancer is not somewhere within that breast lesion. The provider will also consider the specific pathological findings of the biopsy specimen, patient's other breast findings, family and personal history, and risk of cancer. All these things together go into deciding if a patient needs a follow-up excisional biopsy. Programs may cover a repeat biopsy for when indicated based on the original pathologic finding.

Question #5: We have a facility who is requesting that our program cover a breast biopsy for a patient with private insurance and the facility is out of her insurance network. Upon checking with her insurance, they will cover 70% of the fee if the patient goes to an in-network facility. The insurance will not cover any of the fee is she stays with the out-of-network facility. Since her insurance is not accepted to this facility, can our program cover her procedure?

Answer: No. The NBCCEDP cannot cover charges because a patient is out of her network. The law that established the program states that we can only cover for procedures when the woman has no other source of coverage. That means the NBCCEDP is legally the payor of last resort when it comes to insurance. Since her insurance does cover the procedure, she has a payment source. The program cannot cover for convenience because the patient has chosen to go out of network. The only way your program could assist with payment is to cover her out-of-pocket expense once they insurance has paid their portion at an in-network facility. That also means that you only cover the patient's responsible amount as indicated by her insurance. This amount still cannot be higher than the Medicare rate. You may also assist the patient with transportation assistance through patient navigation services if you find that this is a barrier to her getting services at an appropriate facility.