Ask Dr. Miller

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The following questions were posed by NBCCEDP grantees:

Question #1: In the past, we have received guidance indicating that CDC does not allow the reimbursement of the "see and treat" arm of the ASCCP guidelines. For clients with HSIL or AGC favors neoplasia on cytology, where immediate Loop Electrosurgical Excision (LEEP) is recommended by ASCCP, we have required that colposcopy with biopsy confirmation be performed in order to 1) obtain histology diagnosis to ensure proper treatment, 2) avoid over treatment, and 3) enroll women for treatment in the Medicaid Cancer Treatment Program once diagnosis is obtained and not utilize program funds for treatment procedures. Will exclusion of reimbursement for the "see and treat" recommendation continue in light of the new management guidelines?

Answer: CDC does not have specific guidance excluding reimbursement of LEEP and cervical conization procedures. Both procedures allow for pathological confirmation of diagnosis as the tissue sample should always be sent to pathology for review. While these are considered diagnostic procedures for HSIL and AGC favors neoplasia, if the specimen identifies a high-grade neoplasia that has been completely excised, then the diagnostic procedure is considered to have also provided the treatment needed. There has been concern that this form of diagnostic follow-up may lead to "overtreatment" and increased risk of complications in some women. Your program may restrict use of LEEP and cervical conization if approved by your MAB.

Question #2: Where ASCCP provides choices that are equally acceptable for the follow up management of CIN 1 preceded by ASC-H or HSIL cytology, is it acceptable for our MAB to recommend/authorize the reimbursement of the most cost effective option (i.e., co-testing at 12 and 24 months) over the option of diagnostic excisional procedure to preserve screening and diagnostic dollars? Would there be situations, such as an unsatisfactory colposcopy, where a diagnostic excisional procedure should be allowed?

Answer: Your MAB may recommend a specific pathway cervical management, but a diagnostic excisional procedure should not be denied if indicated by the provider. Whenever there is an inadequate colposcopy, steps must be taken to ensure adequate diagnostic work-up and treatment. Most guidelines recommend an excisional procedure if the colposcopy is inadequate. You may consider requiring pre-approval for diagnostic excisional procedures.

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Question #3: Is it acceptable to only recommend/authorize reimbursement for co-testing in one year following a normal cytology with a positive high risk HPV test result rather than reimbursement for HPV genotyping for HPV 16 and 18?
Answer: HPV genotyping is not allowed for reimbursement with CDC funds. Please refer to the endnote #5 on the CPT allowable list.

Question #4: Our state passed legislation approving same sex marriages. Should we start collecting information from the spouse in a same sex marriage for household size and income determination?
Answer: Using same sex marriage partner information for determination of family size and income depends on the language included in the same sex marriage legislation (e.g., eligibility to claim on income tax, ability to include in family coverage on insurance). Grantees should check with their state officials to understand that determination.

Question #5: Can federal funds be used to reimburse for follow-up office visits due to dense breast notification, to perform a breast cancer risk assessment, or for case management related to dense breast?
Answer: The breast density notification laws are created to increase awareness by making sure that women are appropriately informed of their breast density along with any potential risk based on their mammographic findings. There is no scientific evidence to support additional testing solely due to dense breast tissue. Grantees should not create specific guidance for further diagnostic evaluation based on breast density alone. This is an opportune time to remind providers about discussing all risk factors (e.g., obesity, physical inactivity, alcohol consumption, childbirth, breastfeeding, breast density, hormone use, etc.) and possible risk reduction strategies with every woman. Federal funds may be used to reimburse for follow-up visits if a woman has concerns and needs a follow-up assessment. A breast cancer risk assessment should be combined with other services such as a clinical breast exam or cervical cancer screening. The clinical evaluation by her provider, along with her mammographic findings, family history, and risk assessment, should be used to determine appropriate follow-up.

Question #6: Can the BCCP funds pay for an endometrial biopsy for abnormal bleeding without a Pap test?
Answer: As part of the diagnostic evaluation for abnormal bleeding, a Pap test should be done. It could be that the Pap test was done previously and did not need to be repeated. A Pap test does not have to be done in order to obtain an endometrial biopsy. If a recent Pap was done for the abnormal bleeding and was negative with endometrial cells in a postmenopausal woman or had atypical glandular cells, it is okay to reimburse for an endometrial biopsy alone.