Ask Dr. Miller

June 2015

The following questions were posed by NBCCEDP grantees:

Question #1: <u>UPDATE</u> - Since the new breast ultrasound CPT codes 76641 and 76642 are both unilateral, should we expect to see two CPT codes billed if a bilateral ultrasound exam is needed?

Answer: <u>UPDATED INFORMATION</u> - For bilateral breast ultrasound, a modifier 50 should be added to either 76641 or 76642 to indicate a bilateral procedure. The 2015 National Physician Fee Schedule assigns a "1" bilateral indicator to both CPT codes 76641 and 76442 which means that Medicare will allow 150 percent of the standard reimbursement rate.

Question #2: Can we use federal dollars to pay for a laser vaporization for a woman who had a total hysterectomy for cervical dysplasia and has persistent abnormal vaginal cytology with negative HPV? Her biopsy results have shown VAIN 1 and ASC-US. The gynecologist wants to do a laser vaporization because of the continued abnormal results.

Answer: In this scenario, laser vaporization would be for treatment of her persistent abnormal vaginal pathology. This would not be a diagnostic purposes. Therefore, federal dollars could not be used for a treatment procedure. This woman should be referred to the Medicaid program to see if this abnormality would be covered under the Treatment Act.

Question #3: A woman previously diagnosed with cervical cancer has had surgery and completed her chemotherapy. She is due for her three month follow up and is no longer covered under the Treatment Act. Her physician ordered a CT scan for surveillance. Can our Program cover the cost of the CT scan?

Answer: Yes, the CT scan can be covered through the NBCCEDP as long as the indication is appropriate and she still meets all other eligibility requirements. It depends on her stage of disease and physical examination findings as to what follow-up surveillance she needs. The National Comprehensive Cancer Network (NCCN) provides specific guidelines regarding surveillance following cervical cancer treatment. If she had locally advanced disease then she could be followed with a PET-CT scan at 3-6 months. She can be seen through the program and provided appropriate diagnostic workout to assess for possible recurrence.

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Question #4: We have a woman who is on Medicaid through the ACA expansion, but there are no contracted providers in her area and she does not have a car. She will be charged a large co-pay to see an out-of-network provider in her area. Can we consider her underinsured and enroll her in our Program?

Answer: No, this woman cannot have screening services provided by the NBCCEP since she does have insurance that covers these services. A geographic barrier is not considered underinsured. However, your program can provide patient navigation services and assist this woman with transportation to get to a contracted provider. This also provides an opportunity for you to discuss gaps in coverage with Medicaid so that insured individuals will have appropriate access to medical services.

Question #5: We have a woman who had a LEEP procedure and presented to the ER the following day for vaginal bleeding. She was taken to the operating room for a procedure to stop the bleeding and discharged home the next morning. Can we pay for this procedure since it was needed due to complications from her LEEP?

Answer: Yes, we can cover this cost as long as this was considered outpatient. A 23-hour admission is considered outpatient. By law we cannot reimburse for inpatient care.

Questions #6: One of our providers has a woman who is pregnant and in need of a diagnostic mammogram. She has emergency Medicaid, but it only covers pregnancy care (not mammograms). Otherwise she meets our eligibility criteria. Can we pay for her mammogram through NBCCEDP as underinsured?

Answer: Yes, this woman could be considered underinsured. As per CDC policy, your program should establish a written definition on eligibility requirements for serving underinsured women.