Ask Dr. Miller

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The following questions were posed by NBCCEDP grantees:

Question #1: Sometimes our providers identify women between the ages of 21-35 who have an increased risk for breast cancer due to known family history of genetic mutation, history of radiation to the chest before age 30, or first-degree relative with premenopausal breast cancer. Should we provide annual mammograms and MRIs for these young women?

Answer: Young women who are determined to be high risk for breast cancer should have annual mammograms and MRIs typically beginning at the age of 30 according to the ACS. NCCN recommends annual mammography starting at age 30 and annual screening MRI starting at age of 25. For women who are under 30, NCCN recommends risk reduction, breast cancer awareness, and annual office checks that include clinical breast exams (although they admit that this is to maximize early detection and no studies have been done to show benefit). Please refer to ACS and NCCN guidelines.

Question #2: We have a 26-year-old woman who recently had her first Pap test through a clinic that was not covered by our program. Her provider states that she needs a colposcopy according to ASCCP guidelines. Can we use CDC funds to cover her colposcopy?

Answer: Yes, if she meets your program criteria. She could be referred to and enrolled in your program for her diagnostic work-up. Once enrolled, CDC funds can be used to cover all appropriate diagnostic testing.

Question #3: If women are identified as high risk for cervical cancer, should we provide yearly Pap testing for those aged 21-29 years and co-testing every 3 years for those aged 30-65 years?

Answer: Women who are at high risk for cervical cancer should have more frequent screening than average risk women. Cervical cancer screening for HIV-positive women has been studied extensively and distinct recommendations are provided for these women. Recommendations for other high-risk groups such as women who are immunosuppressed due to organ transplantation or women who were exposed to DES in utero have been mostly extrapolated from HIV studies. In general, the recommendations are annual Pap testing for women 21-29 and co-testing every 3

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years for women 30 and older. HPV-positive women aged 21-29 may transition to Pap testing every 3 years after having 3 consecutive normal Pap results. Women at high risk should also continue screening beyond the age of 65.

Question #4: During cancer surveillance, we are monitoring women for signs of cancer recurrence after completing treatment. Are we limited to what services we can provide, especially if they are not included on the list of approved CPT codes? Are we limited on how frequently we can repeat any service?

Answer: The intent of CDC's guidance is to clarify that cancer survivors can be enrolled in the program for surveillance testing as needed once they no longer have Medicaid coverage for treatment or any other coverage. Grantees may reimburse for any follow-up tests that are recommended for surveillance. NCCN has the most extensive algorithms for follow-up based on the patient's disease status. Because CDC does not make recommendations, we do not provide specific guidance on what testing should or should not be done. If there are questions about surveillance testing requested for a specific patient, grantees should discuss that case with their clinical consultant because the answers usually depend on that specific patient's status.

Remember, the CPT list is not all-inclusive for every potential test for which a grantee could reimburse. It mostly focuses on screening tests. Therefore, a grantee may provide any specific surveillance testing needed. The only limit is that the testing must be specifically related to assessing for recurrence of breast or cervical cancer.