Ask Dr. Miller

January 2023
Happy New Year!

The following questions were posed by NBCCEDP recipients:

Question #1: Can we pay for a breast MRI if recommended by the radiologist due to dense breasts?

Answer: If the provider thinks a patient needs and orders a breast MRI after a discussion with the patient considering the pros and cons, then your program can cover the MRI. The typical radiology report language says for the provider to consider additional testing such as an MRI due to breast density.

Question #2: Can NBCCEDP funds be used to pay for translation line services to help communicate with patients who have limited English proficiency?

Answer: You can assist with translation services for individuals enrolled in your program as a means of reducing structural barriers identified through your patient navigation services. Since Medicare does not cover the CPT code available for interpreter services, you will need to set up a reimbursement fee with the clinic or with the translation service.

Question #3: We have a client who was diagnosed with breast cancer in 2019. She underwent a lumpectomy but refused radiation therapy. Her mammograms usually report BI-RADS 4 or BI-RADs 5. She has been getting ultrasounds every 3-6 months since enrolling in our program in June of 2020. However, she has refused to have a follow-up biopsy. Are we permitted to pay for ultrasounds or mammograms in situations where clients refuse the biopsy? Is there a point we must stop covering?

Answer: Your program should continue to cover her imaging as per the recommended follow up even though she does not comply with all recommendations. Your program should provide patient navigation assistance to this client to determine if there are specific barriers for this client

and try to get her to comply with having a biopsy. It is possible that more intense education and assistance with overcoming barriers are needed.

Question #4: When a patient goes to have a colposcopy, the provider usually bills the CPT code 99213 for an office visit combined with the CPT code for the procedure. Can we pay for both codes during the same visit?

Answer: If this is the first visit with that particular provider where technically they are making the decision to perform the colposcopy, then you can reimburse for both the office visit and the procedure. If the provider has already seen the patient related to the finding that requires a colposcopy, then you cannot reimburse for another office visit on the day of the procedure.

Question #5: Can our program cover a urine pregnancy test (CPT 81025) prior to a program participant's colposcopy exam?

Answer: Yes, you can cover urine pregnancy testing. Our CPT list has a line under the pathology section for "various" to cover CPT codes for required pre-operative testing such as CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure. This allows you to cover all necessary pre-procedure testing that providers request.

Question #6: Can we reimburse for an ultrasound as part of the screening mammogram if dense breasts is found on the mammogram?

Answer: Ultrasound is not a part of a screening mammogram. It is a separate test. Ultrasound screening is not currently recommended as a screening procedure by USPSTF or ACS national guidelines for breast density. There should be a discussion between the patient and the provider regarding any additional testing so that the patient is informed about breast density and the balance between the benefits and risks for additional testing. If a provider orders an ultrasound based on patient findings and discussion, your program may reimburse for the ultrasound.