Ask Dr. Miller

August 2024

The following questions were posed by NBCCEDP recipients:

Question #1: One of our providers is asking if our program will cover Automated Breast Ultrasound (ABUS). They were referring to a new recommendation for women that have heterogeneously dense or extremely dense breasts should have an ABUS yearly as well as a screening mammogram. It's an optional ultrasound that is alternated every 6 months with the mammogram. If covered, what CPT code should we use?

Answer: There are no national recommendations to provide routine ABUS (or any other testing) with mammograms for those with dense breast tissue. Some institutions may be recommending this. Having any additional testing for dense breast tissue is something that should be done with shared decision-making discussion between the provider and the patient. It is also important to have a risk assessment to determine if the patient is at high risk independent of the dense breast tissue. If a provider then orders an ABUS after making an informed decision, it can be reimbursed by the program using the CPT code 76641 for breast ultrasound. CPT code 76642 would not be appropriate as that covers for a limited examination of the breast, whereas ABUS would be a complete examination of the breast.

Question #2: Providers are asking if there is a CPT code that would allow them to bill for assessing personal history, family history, risk assessment, benefits and risks of screening, etc. over the phone when making referrals for mammogram screenings without a CBE. As we understand it, CPT codes 99211 and 99202 require in-office/in-person visits.

Answer: These could be billed as telehealth visits. CMS actually allows for the 9920x and 9921x office visit CPT codes to be used as telehealth visits. However, CMS now requires that these telehealth office visit codes use both audio and video technology. Please see my newsletter from February this year with the list of CPT codes approved to use as telehealth.

Question #3: We have a client that needs to have a LEEP. The facility where the doctor normally provides this service is no longer enrolled in our program. We are having difficulty getting them to resubmit the required paperwork. Her doctor can perform the procedure in the

operating room at a nearby hospital that is enrolled with our program. Can we pay for this procedure in the operating room? Our only other option is to have the patient travel to see another provider at a different clinic.

Answer: Yes, due to these extenuating circumstances that are beyond the control of the program and the patient. The procedure can be covered if performed in an operating room as long as it is done as an outpatient procedure since the program is not allowed to cover any inpatient procedures. The CPT codes are the same. The hospital may have additional charges like anesthesia and other supplies that can also be covered.

Question #4: We had a provider perform a breast biopsy on a patient with a left breast mass. The provider also requested ER/PR/HER2 assays as these tests are believed to be crucial for the patient's treatment. Can our program cover these tests?

Answer: It is now standard of care to perform the ER/PR/HER2 testing on the breast tissue sample when breast cancer is identified. It is usually done as part of the initial diagnostic pathology testing. Because it is a part of the initial diagnostic testing, CDC allows for this testing to be reimbursed by the program. The CPT codes for immunohistochemical testing and FISH testing are already listed on CDC's CPT list.

Question #5: Our state is adding the new FDA requirements to our state regulations for mammography providers to include breast tissue density in the report to the patient. Does CDC have any guidance on possible impact to our program?

Answer: CDC does not have any specific guidance on implementation or how this notification will impact the program. There are more than 30 states that already have this notification requirement in place. We have not noticed any specific differences in these states. This may be because there is no guidance in the national recommendations for specific testing due to breast density. Because of the notification requirement, providers should have further discussions with patients about their density, breast cancer risk, and potential additional testing options. If the provider orders additional testing, programs are allowed to cover this testing as long as it is included on our CPT list.