# Ask Dr. Miller

**October 2024**

## The following questions were posed by NBCCEDP recipients:

***Question #1: As per the information included in the NBCCEDP manual which references the screening guidance for transgender women from the Center of Excellence for Transgender Health and the World Professional Association for Transgender Health, it states that "transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use for 5-10 years, positive family history, BMI > 35)." Are we able to enroll an asymptomatic transgender client for breast cancer screening who is between the ages of 40-50 and has completed hormone usage for 5-10 years prior to turning 40, if requested by the provider?***

Answer: The transgender guidance says to start screening transgender women at the age of 50. However, there may be special circumstances where they may be screened earlier such as length of time on hormones and family history. Therefore, if a provider determines that a transgender woman needs to be screened in their 40s because of length of time on hormones, it is fine to enroll them in your program. See guidelines at link below.
Screening for breast cancer in transgender women | Gender Affirming Health Program (ucsf.edu)

***Question #2: One of our providers is submitting claims with the CPT code 57454 for colposcopy of the cervix, with biopsy and endocervical curettage along with the CPT code 99213 for an office visit both on the same day of service. My understanding is that an office visit can be billed on the same day of a procedure, if the physician reported a separate identifiable evaluation and management service beyond that associated with the actual procedure. In this case, the patient returned for an office visit to discuss abnormal Pap results and the decision was made that a colposcopy was needed. They then proceeded with the colposcopy that day. Can we reimburse for both the colposcopy and the office visit done on the same day?***

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Answer: If the patient was coming in to have a colposcopy, then that would not be considered a separate service because the medical decision-making had already occurred. However, in this case, the office visit is where they reviewed the results and made the medical decision to proceed with a colposcopy. Therefore, it would be considered significant separate E&M service to allow for reimbursement of the office visit in addition to the procedure, since the patient was not coming in to have the procedure. That means that the provider had to take time to discuss the results, provide options, discuss benefits and risks, and decide with the patient on the next step. They then proceeded with the procedure on that same day. This colposcopy was not already planned before the office visit.

***Question #3: We are receiving claims with a new CPT code 99459 for pelvic examination (List separately in addition to code for primary procedure) that is being billed along with office visits codes for Pap testing. Is this an allowable code? If yes, our next issue is that some providers will require an office visit for a mammogram order where they do a pelvic exam that is not related to cervical cancer screening. We assume in this situation that this CPT code should not be covered. Is that correct?***

Answer: This new code is used to provide a nominal additional fee to providers that reflects the cost of pelvic examination packs and in-room chaperones. This CPT code can be reimbursed in addition to the office visit if a provider performs a Pap or HPV test for a program participant. Your assumption is correct in that it would not be appropriate for your program to cover this code if a pelvic exam is done that is not related to cervical cancer screening.

***Question #4: If a provider proceeds to "expedited treatment LEEP" without a colposcopy following the ASCCP guidance for a patient with a cervical cancer screening result of HSIL cytology and HPV 16 Positive or never/rarely screened with HSIL cytology and HPV (any type) positive, can the LEEP be reimbursed by our program? Should we consider this LEEP as diagnostic since no final diagnosis has been obtained or should we consider this as treatment? If treatment, what would be the final diagnosis?***

Answer: Yes, this LEEP can be covered through the program. From the program standpoint, we consider this expedited LEEP as a diagnostic step. As before, a diagnostic LEEP may also end up being treatment. The decision behind the expedited LEEP is that the immediate risk of CIN3 is so high that the patient may proceed to an excisional procedure without undergoing colposcopy and biopsy. The final diagnosis will be the histology results from the LEEP.