Ask Dr. Miller

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The following questions were posed by NBCCEDP grantees:

Question #1: CPT Update – We cannot find the CPT 99420 in the fee schedule on the CMS web site. What fee should we use?

Answer: Although there is a CPT code for administration and interpretation risk assessment instrument, Medicare does not reimburse for this service. Essentially this means the Medicare rate is $0. Since by law we are bound to the Medicare rates, we will not be able to reimburse for this code. Please remove this code from your fee schedules.

Question #2: One of our providers is requesting reimbursement for CPT codes 88342 and 88343 for immunohistochemistry. Is it allowable to use 88342 and 88343 interchangeably or in place of codes G0461 and G0462?

Answer: As per AMA updates, CPT codes 88343, G0461, and G0462 were deleted in 2015. Therefore, they no longer exist. That's why those codes were deleted from our 2015 allowable list. The appropriate codes for cervical immunohistochemistry are 88342 and 88341.

Question #3: We have a patient that had a high-grade SIL Pap results. Colposcopy with biopsy results were CINIII. She then underwent had a LEEP with result of CINIII. At her 6-month repeat Pap, she again had a high-grade SIL. Her provider wishes to proceed straight to hysterectomy. Can the program pay for the hysterectomy as a diagnostic procedure?

Answer: CDC cannot pay for this hysterectomy as this procedure would be considered treatment for her persistent high grade neoplasia. Repeat excision or hysterectomy are acceptable options according to the ASCCP guidelines. This patient should be referred to the Medicaid program.

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Question #4: Please provide clarification on when to use non-facility vs facility rates for reimbursement. On the CMS.gov web site I found a quote stating that sometimes hospitals can be paid at the non-facility (higher) rate when the facility is responsible for the cost of providing the staff and supplies. Can you provide an explanation about under what circumstances is a facility (hospital) allowed reimbursement at the higher non-facility rate?

Answer: A facility would be allowed to get the higher rate when the facility is providing the entire service (including physician, supplies, and additional staff) and there would not be a separate provider charge. For instance, a procedure is done at a facility where the providers are employed by that facility and are only paid by the facility as a staff employee. The provider would not be sending a separate bill for the procedure.

Question #5: We have a new mammography van that also provides Pap testing in our state. Can any part of the expense for the mammography van and/or services be supported by the NBCCEDP?

Answer: Grantees can contract with a mobile van to provide screening services to NBCCEDP clients. In this situation, they can reimburse the contractor for the mammography and Pap testing provided to women through the van. The grantee cannot pay for the expense to operate the van.

Question #6: Some of our contractors are using a new high risk HPV mRNA test for cervical cancer screening. While this test is typically more expensive than the HR HPV DNA test, is it permissible for us to reimburse for this test at the same rate as the HR HPV DNA test?

Answer: Yes, this mRNA test may be reimbursed at the same approved rate as DNA test.