Ask Dr. Miller

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The following questions were posed by NBCCEDP grantees:

Question #1: We have a previous client who is now insured and has a $500 deductible. We spent quite a bit of time navigating her through her insurance details, so that she would get her mammogram. She did, and now needs additional views. After calling her 3 times, she finally scheduled her tests. She later cancelled her appointments because it would cost her $145 out of pocket. Because cost is her barrier to completing the tests that she needs, would this make her eligible for our program? Can we set "under-insured" amounts within our program, or are there CDC standards to follow? Is there a set CDC definition for "under-insured"?

Answer: CDC has allowed grantees to set their own definition and eligibility criteria for under-insured. Grantees can cover out-of-pocket costs (e.g., deductible balance), but not the cost that would be covered by her insurance. We are currently evaluating this policy and will develop more guidance for grantees on this issue. However, grantees will continue to have some flexibility in determining whether to serve the under-insured and how they define under-insured with eligibility criteria.

Question #2: Our primary care association stated that the NBCCEDP screens males now and that the treatment act can be used to treat males. Is this true?

Answer: The NBCCEDP does not screen males. Some years back the Treatment Act underwent a legal analysis determining that males could be covered because the legislation uses the terminology "individuals". At that time they also noted that the NBCCEDP legislation uses the terminology "women" so males could not be served through the NBCCEDP. Grantees would need to check with their local Medicaid staff to find out their state eligibility criteria under the Treatment Act. Medicaid programs did receive communication regarding this issue from CMS.

Question #3: If a provides counsels a high-risk patient on BRCA testing and chemoprophylaxis, can the provider be reimbursed by the BCCP for the counseling?

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Answer: No, the NBCCEDP does not cover genetic counseling or testing. While they may influence screening behavior, genetic counseling and testing are not screening or diagnostic services.

Question #4: In the past, the policy was that we only reimburse providers the conventional mammogram rate even if they performed a digital mammogram. Is this rule still in effect? We have some providers that are wondering why our rate for digital mammogram is lower than CMS published rates.

Answer: That rule is no longer in effect. As of 2009, the NBCCEDP approved for reimbursement of digital mammography at the actual CMS rate.

Question #5: We have a few providers who are billing for both CPT code 19083 and 19285 for the same procedure. Is it permissible to do so?

Answer: 19083 cannot be used with 19285. 19083 is placement of localization device with a breast biopsy whereas 19285 is the placement of localization device without a breast biopsy. Please refer to note #9 on the CPT allowable list. As per the CPT guidance, if a provider is charging for an ultrasound localization procedure followed by a biopsy in radiology then he/she would code 19083. Otherwise if the localization is done in radiology followed by an open breast biopsy in surgery, then they should be coding 19285 with 19101.