Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN’S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY24

- Reimbursement rates are based on Nevada’s maximum allowable Medicare rates. The total payment is not to exceed the approved rates.
- If the provider bills less than the approved rate for a service, the provider will be reimbursed at the billed amount.
- The provider must accept Medicare’s reimbursement rates as payment in full for services rendered. Balances may not be billed to the patient.
- Providers are encouraged to give WHC patients a written estimate of any additional charges that are not covered under the program prior to the procedure.
- Providers are encouraged to write off charges not reimbursed by WHC.
- A surgical center (modifier SG) is a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization, in which the expected duration of services does not exceed 24 hours following admission.
- A surgical center is not the same as a provider-based outpatient surgery center. Procedures and services performed in a provider-based outpatient surgery center should be billed using the non-facility fee.
- If a provider performs a service or procedure at an ASC, the provider would be entitled to the professional rate (modifier 26), and the surgical center would be entitled to the facility fee (modifier SG).
- If a provider performs a service or procedure in their office, the provider would be entitled to the Global rate.
- Global fees and SG fees cannot be billed together.
- All billing claims must indicate an associated ICD-10 code for reimbursement.

A **new patient** is a patient new to WHC, or a patient who has NOT been seen by a WHC provider or practice within the last 3 years.
An **Established Patient** is a patient who has been seen by the provider or practice within the last three (3) years.
All **consultation visits** should be billed through the standard “new patient” office visit CPT codes, 99201-99205.

CPT CODE	OFFICE VISITS	RATE	END NOTE
99202	**New patient; medically appropriate history/exam; straightforward decision making**; 15-29 minutes	$73.12	
99203	**New patient; medically appropriate history/exam; low level decision making;** 30-44 minutes	$113.41	
99204	**New patient; medically appropriate history/exam; moderate level decision making;** 45-59 Minutes	$168.17	1
99205	**New patient; medically appropriate history/exam; high level decision making;** 60-74 minutes	$221.97	1
99211	**Established patient**; evaluation and management, may not require presence of physician; presenting problems are minimal	$23.42	
99212	**Established patient;** medically appropriate history/exam; straightforward decision making; 10-19 minutes	$57.13	
99213	**Established patient;** medically appropriate history/exam; low level decision making; 20-29 minutes	$91.15	
99214	**Established patient;** medically appropriate history/exam; moderate level decision making; 30-39 minutes	$128.90	
99385	*Initial* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **18 to 39 years of age**	$91.42	2

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99386	*Initial* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures **40 to 64 years of age**	$110.80	2
99387	*Initial* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures **65 years of age or older**	$119.05	2
99395	*Periodic* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **18 to 39 years of age**	$82.84	2
99396	*Periodic* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **40 to 64 years of age** Approval Required	$90.07	2
99397	*Periodic* comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures;**65 years of age or older** Approval Required	$95.02	2

RADIOLOGY		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
77067	**Screening mammography, bilateral, includes CAD**	$130.63	$36.73	$93.90	
77063	**Screening digital breast tomosynthesis, bilateral** Do not report in conjunction with 77065,77066 List separately in addition to code for primary procedure 77067	$53.68	$29.28	$24.40	3
G0279	**Diagnostic digital breast tomosynthesis, unilateral or bilateral** List separately in addition to 77065 or 77066	$53.68	$29.28	$24.40	4
77065	**Diagnostic mammography, unilateral, includes CAD** A diagnostic mammogram can be performed as the initial screening mammogram for a woman with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results	$127.58	$38.76	$88.82	
77066	**Diagnostic mammography, bilateral, includes CAD** A diagnostic mammogram can be performed as the initial screening mammogram for a woman with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results	$160.79	$47.58	$113.22	
76098	**Radiological examination, surgical specimen**	$42.80	$15.32	$27.48	
76641	**Ultrasound, complete examination of breast including axilla, unilateral**	$105.56	$35.38	$70.18	
76642	**Ultrasound, limited examination of breast including axilla, unilateral**	$86.92	$33.00	$53.91	

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CPT CODE	RADIOLOGY CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
76942	**Ultrasonic guidance for needle placement, imaging supervision and interpretation**	$59.13	$30.63	$28.50	
77046	**Magnetic resonance imaging (MRI), breast, without contrast, unilateral**	$224.97	$69.36	$155.61	5
77047	**Magnetic resonance imaging (MRI), breast, without contrast, bilateral**	$233.14	$76.85	$156.29	5
77048	**Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral**	$357.67	$101.01	$256.66	5
77049	**Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral**	$365.16	$110.53	$254.63	5
77053	**Mammary ductogram or galactogram, single duct**	$54.32	$17.35	$36.97	

BREAST DIAGNOSTIC PROCEDURES		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
10004	**Fine needle aspiration biopsy without imaging guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$51.87	$43.06	$47.05	
10005	**Fine needle aspiration biopsy including ultrasound guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$138.49	$74.44	$81.32	
10006	**Fine needle aspiration biopsy including ultrasound guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$60.99	$50.49	$55.16	
10007	**Fine needle aspiration biopsy including fluoroscopic guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$302.23	$89.42	$97.69	
10008	**Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$146.62	$53.09	$58.00	

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CPT CODE	BREAST DIAGNOSTIC PROCEDURES	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
10009	**Fine needle aspiration biopsy including CT guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$443.64	$109.85	$120.01	
10010	**Fine needle aspiration biopsy including CT guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$243.26	$72.47	$79.18	
10011	**Fine needle aspiration biopsy including MRI guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$472.67	$115.53	$126.22	8
10012	**Fine needle aspiration biopsy including MRI guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$277.45	$82.62	$90.26	8
10021	**Fine needle aspiration biopsy without imaging guidance, first lesion** • 88172, 88173 may be billed by the lab/pathology	$103.82	$55.70	$60.85	
19000	**Puncture aspiration of cyst of breast**	$104.06	$43.06	$47.05	
19001	**Puncture aspiration of cyst of breast, each additional cyst, *used with 19000***	$26.57	$20.80	$22.73	
19081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19081 may only be billed once per breast regardless of the number of biopsies • 19082 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once ** No Global Period Office visit codes on the day of the procedure are not payable	$515.54	$164.47	$179.68	6

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19082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19081 may only be billed once per breast regardless of the number of biopsies • 19082 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
		$399.45	$82.94	$90.62	6
19083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19083 may only be billed once per breast regardless of the number of biopsies • 19084 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	$515.44	$154.54	$168.83	6
19084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19083 may only be billed once per breast regardless of the number of biopsies • 19084 may be billed for one additional lesion **(Next Page)**	$393.66	$78.17	$85.40	6

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	• 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable **No Global Period				
19085	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19085 may only be billed once per breast regardless of the number of biopsies • 19086 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • For surgical specimen radiography, use 76098 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable **No Global Period	NON-FACILITY $790.94	26: PROFESSIONAL $179.62	SG: FACILITY $196.23	END NOTE 6
19086	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunctioiun with 19281–19288,76098,76942,77002,77021 for same lesion • 19085 may only be billed once per breast regardless of the number of biopsies • 19086 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • For surgical specimen radiography, use 76098 • ASC codes may only be billed once **No Global Period Office visit codes on the day of the procedure are not payable	$614.94	$90.37	$98.72	6

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19100	**Biopsy of breast, percutaneous, needle core without imaging guidance** • 19100 may only be billed once per breast • 19100 may not be billed with imaging guidance (10022, 19290, 19291, 19295, 77031, 77032) or mammograms • 88305 may be billed for up to 3 biopsy specimens per breast • Office visit codes on the day of the procedure are not payable • SG codes may only be billed once • An SG is a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission • An SG is not the same as a provider-based outpatient surgery center. Procedures and services performed in a provider-based outpatient surgery center should be billed using the non-facility fee • If a provider performs a service or procedure at an SG, the provider would be entitled to the professional fee, the SG would be entitled to the SG fee • If a provider performs a service or procedure in their office, the provider would be entitled to the non-facility fee • Non-facility fees and SG fees cannot be billed together **No global period	NON-FACILITY $154.84	26: PROFESSIONAL $70.47	SG: FACILITY $76.98	END NOTE
19101	**Breast biopsy, open, incisional** • 19101 may be billed only once per breast • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • 00400 may be billed for the total time anesthesia provided • 19101 may not be billed with imaging guidance (10011, 19290, 19291, 19295, 77031, 77032) and mammograms • SG codes may only be billed once Office visit codes on the day of the procedure and during the 10-day post-operative period are not payable 10-day global period	$339.06	$229.94	$251.21	

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19120	**Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions** • 19120 may only be billed once per breast regardless of the number of biopsies • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • 00400 may be billed for the total time anesthesia provided Office visit codes on the day of the procedure and during the 10-day post-operative period are not payable **10-day global period	NON-FACILITY $533.76	26: PROFESSIONAL $429.73	SG: FACILITY $469.48	END NOTE
19125	**Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion** • 19125 may only be billed once per breast, regardless of the number of biopsies • 19126 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • 00400 may be billed for the total anesthesia provided • ASC codes may only be billed once Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day post-operative period are not payable **90-day global period	$588.37	$475.53	$519.52	

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19126	**Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker** • 19125 may only be billed once per breast, regardless of the number of biopsies • 19126 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • 00400 may be billed for the total anesthesia provided • ASC codes may only be billed once • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day post-operative period are not payable **90-day global period	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
		$163.35	$163.35	$178.47	
19281	**Placement of breast localization device, percutaneous; mammographic guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19081 may only be billed once per breast regardless of the number of biopsies • 19082 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	$246.62	$99.21	$108.39	7

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19282	**Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19081 may only be billed once per breast regardless of the number of biopsies • 19082 may be billed for one additional lesion • 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	NON-FACILITY $175.19	26: PROFESSIONAL $50.15	SG: FACILITY $54.79	END NOTE 7
19283	**Placement of breast localization device, percutaneous; stereotactic guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19284\ • Office visit codes on the day of the procedure are not payable ** No Global Period	$266.34	$99.95	$109.20	7
19284	**Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19283 Office visit codes on the day of the procedure are not payable ** No Global Period	$196.23	$50.18	$54.82	7

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19285	**Placement of breast localization device, percutaneous; ultrasound guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19286 Office visit codes on the day of the procedure are not payable ** No Global Period	NON-FACILITY $381.15	26: PROFESSIONAL $85.32	SG: FACILITY $93.21	END NOTE 7
19286	**Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • May be billed in conjunction with 19285 • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion Office visit codes on the day of the procedure are not payable ** No Global Period	$312.77	$43.03	$47.01	7
19287	**Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19288 Office visit codes on the day of the procedure are not payable ** No Global Period Approval Required	$656.79	$126.11	$137.78	7
19288	**Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19288 Office visit codes on the day of the procedure are not payable ** No Global Period Approval Required	$508.33	$63.40	$69.26	7

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	BREAST CYTOLOGY	RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88172	**Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode** • To be used with 10021,10022	$55.98	$34.94	$21.04	
88173	**Cytopathology, evaluation of fine needle aspirate; interpretation and report** • To be used with 10021,10022	$163.20	$68.86	$94.34	
88177	**Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode**	$29.52	$21.38	$8.13	
88360	**Morphometric analysis, tumor immunohistochemistry, per specimen; manual**	$119.35	$41.04	$78.31	
88361	**Morphometric analysis, tumor immunohistochemistry, per specimen; using computer assisted technology**	$119.35	$43.07	$76.28	
38505	**Needle biopsy lymph nodes**	$180.17	$86.64	$94.65	

	CERVICAL CYTOLOGY/SCREENING	RATE			
CPT CODE		NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88164	**Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision** • Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review • Bill with 88142,88143,88164,88174,88175 as the technical pap service	$7.21			
88165	**Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision** • Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review • Bill with 88142,88143,88164,88174,88175 as the technical pap service	$7.21			

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88141	**Cytopathology, cervical or vaginal, any reporting system, requiring interpretation by physician** • Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review • Bill with 88142,88143,88164,88174,88175 as the technical pap service	NON-FACILITY $23.08	26: PROFESSIONAL $23.08	TC: FACILITY $25.21	END NOTE
88142	**Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision** • Pap tests are subject to frequency guidelines. See Provider Manual and Cervical Clinical Guidelines	$16.44			
88143	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening and rescreening under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$13.82			
88174	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system, under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$14.58			
88175	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system and manual rescreening, under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$18.07			
87624	**Human Papillomavirus, high-risk types** • Used for cytology and HPV co-testing every 5 years • When a conventional Pap tests results is ASC-US, a follow up office visit may be billed to complete the HPV test • When a liquid-based pap test results is ASC-US, the HPV test can be done on the original specimen and follow up visit for HPV testing cannot be billed Refer to cervical algorithms for indications for HPV testing	$23.88			9

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87625	**Human Papillomavirus, types 16 and 18 only** • HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. • HPV DNA testing is not reimbursable procedure if used as an adjunctive screening test to the Pap for women under 30 years of age. • Providers should specify the high-risk HPV DNA panel only. • Reimbursement of screening for low-risk HPV types are not permitted. • The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. • CDC funds may be used for reimbursement of HPV genotyping.	NON-FACILITY $23.88	26: PROFESSIONAL	TC: FACILITY	END NOTE 9
	CERVICAL CYTOLOGY/SCREENING				
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
57452	**Colposcopy of the cervix, without biopsy** • May be billed only once Office visit codes on the day of the procedure are not payable **No global period	$130.28	$92.67	$101.24	
57454	**Colposcopy with biopsy of the cervix and endocervical curettage** • 57454 may be billed only once regardless of the number of biopsies performed • 88305 may be billed with 57454 for up to 4 specimens to reflect multiple biopsy sites on the cervix & one (1) ECC biopsy Office visit codes on the day of the procedure are payable **No global period	$173.38	$135.42	$147.95	
57455	**Colposcopy of the cervix with biopsy** • May be billed only once. • 88305 may be billed with 57455 for up to 3 specimens to reflect multiple biopsy sites on cervix Office visit codes on the day of the procedure are payable **No global period	$165.38	$110.49	$120.71	

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57456	**Colposcopy of the cervix with endocervical curettage** • May be billed only once • 88305 may be billed once with 57456 Office visit codes on the day of the procedure are payable **No global period	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
		$156.20	$103.00	$112.52	
57460	**Colposcopy with loop electrode biopsy(s) of the cervix.** • May be billed only once • 57460 may not be billed with colposcopy: 57452, 57454, 57455, or 57456 • 88307 may be billed for up to 4 specimens per cervical procedure • Office visit codes on the day of the procedure are not payable Authorization is required **No global period	$324.13	$162.49	$177.52	
57461	**Colposcopy with loop electrode conization of the cervix.** • May be billed only once • 57461 may not be billed with colposcopy: 57452, 57454, 57455, or 57456 • 88307 may be billed for up to 4 specimens per cervical conization procedure • 88305 may not be billed with 57461 • 00400 may be billed for the total anesthesia provided • Office visit codes on the day of the procedure are not payable Authorization is required **No global period day surgery facility	$361.40	$186.88	$204.17	
57500	**Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)** • 88305 may be billed with 57500 for up to 3 specimens to reflect multiple biopsy sites on cervix Office visit codes on the day of the procedure are not payable **No global period	$158.21	$76.20	$83.25	
57505	**Endocervical curettage (not done as part of a dilation and curettage)** • May be billed only once • 88305 may be billed once with 57505 • Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable 10-day Global period	$159.56	$112.12	$122.49	

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		NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
57520	**Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser** • May be billed only once • 88307 may be billed with 57520 for up to 4 specimens per cervical conization procedure • 00400 may be billed for the units of anesthesia provided • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable Authorization is required **90-day Global period	$363.46	$304.50	$332.67	
57522	**Loop electrode excision procedure (LEEP)** • May be billed only once • 57522 and 57522 Facility may not be billed with colposcopy (57452, 57454, 57455, or 57456) • 88307 may be billed with 57522 or 57522 Facility for up to 4 specimens per cervical conization procedure • 00400 may be billed for the total units of anesthesia provided • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable Authorization is required **90-day Global fee period	$312.03	$261.87	$286.10	
58100	**Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation, any method (separate procedure)** • May be billed only once • Must be billed with a colposcopy • Office visit codes on the day of the procedure are not payable Authorization is required **No global period	$104.33	$64.34	$70.29	

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58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)** • List separately in addition to code for primary procedure	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
	• May be billed only once • 58110 must be billed with a colposcopy: 57452, 57454, 57455, 57456, or 57461 • Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater, if client 35 or more years of age, or at risk forendometrial neoplasia • Code related to another service and is always included in the global period of the other service	$50.89	$40.72	$44.49	
PATHOLOGY		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
VARIOUS	**Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.**				
87426	**COVID-19 infectious agent detection by nuclei acid DNA or RNA; amplified probe technique**	$35.33			
87635	**COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative**	$51.31			
88305	**Surgical pathology, gross and microscopic examination; breast or cervical specimens**	$71.91	$36.63	$35.28	
88307	**Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins; breast or cervical specimens**	$293.05	$81.12	$211.93	
88331	**Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen**	$102.78	$61.06	$41.71	
88332	**Pathology consultation during surgery, each additional tissue block, with frozen section(s)**	$55.30	$30.19	$25.11	
88341	**Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**	$87.12	$27.82	$59.30	
88342	**Immunohistochemistry or immunocytochemistry, per specimen. each additional single antibody stain procedure (List separately in addition to code for primary procedure)**	$101.05	$34.26	$66.79	

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CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88365	**In situ hybridization (eg,FISH), per specimen; initial single probe stain procedure**	$182.41	$42.39	$140.02	
88364	**In situ hybridization (eg,FISH), per specimen; each additional single probe stain procedure**	$137.99	$33.58	$104.41	
88366	**In situ hybridization (eg,FISH), per specimen; each multiplex probe stain procedure**	$281.74	$61.06	$220.67	
88367	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure**	$114.94	$32.90	$82.04	
88373	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each additional probe stain procedure**	$69.13	$24.74	$44.39	
88374	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure**	$306.41	$42.05	$264.35	
88368	**Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure**	$143.78	$41.04	$102.75	
88369	**Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure**	$123.42	$32.57	$90.85	
88377	**Morphometric analysis, in situ hybridization, manual, per specimen, each multiplex stain procedure**	$400.31	$62.73	$337.58	
99070	**Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins**	$15.50			

PREOPERATIVE TESTING		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
71046	**Chest x-ray, 2 view**	$34.29	$10.54	$23.75	
80048	**Basic Metabolic Panel**	$5.77			
80053	**Comprehensive Metabolic Panel** Cannot be billed with 80048	$7.21			
81001	**Urinalysis** Should only be performed when there is concern the client may be pregnant. This should not be routinely performed.	$2.16			
81025	**Pregnancy Test** Should only be performed when there is concern the client may be pregnant. This should routinely perform.	$4.32			

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		NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
85014	**Hematocrit** • Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests. • Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services. Approval Required	$1.62			
85018	**Hemoglobin** • Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests. • Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services. Approval Required	$1.62			
85025	**CBC with differential** • Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests. • Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services. Approval Required	$5.31			
85027	**CBC without differential** • Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests. • Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services. Approval Required	$4.42			

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		NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
93000	**EKG, 12 leads, with interpretation and report** • Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests. • Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services. Approval Required	$14.64			

CPT CODE	ANESTHESIA	END NOTE
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified • Rates for time based codes are calculated using base units plus time spent (15 minutes = 1 unit) • Base unit is 3 x $22.11 = $66.33 + time unit spent - 1 unit (15 minutes) = $22.11	
00940	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified • Rates for time-based codes are calculated using base units plus time spent (15 minutes = 1 unit) • Base unit is 3 x $22.11 = $66.33 + time unit spent - 1 unit (15 minutes) = $22.11	
99156	Moderate anesthesia, 10-22 minutes for individuals 5 years or older $76.51	
99157	Moderate anesthesia for each additional 15 minutes $62.38	**10**

CPT CODE	PROCEDURES SPECIFICALLY NOT ALLOWED	END NOTE
Any	Treatment of breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia and cervical cancer.	
77061	Breast tomosynthesis, unilateral	**11**
77062	Breast tomosynthesis, bilateral	**11**
87623	Human papillomavirus, low-risk types	

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END NOTE	DESCRIPTION
1	All consultations should be billed through the standard “new patient” office visit CPT codes 99201–99205. Consultations billed as 99204 or 99205 must meet the criteria for these codes. These codes (99204–99205) are typically not appropriate for NBCCEDP screening visits. However, they may be used when provider spends extra time to do a detailed risk assessment.
2	The 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate. The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP. While some programs may need to use 993XX-series codes, Preventive Medicine Evaluation visits are not covered by Medicare and not appropriate for the NBCCEDP.
3	List separately in addition to code for primary procedure 77067.
4	List separately in addition to 77065 or 77066.
5	Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models, such as BRCAPRO, that depend largely on family history. Breast MRI also can be used to assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed for by the NBCCEDP to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment plan.
6	Codes 19081–19086 are to be used for breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. They should not be used in conjunction with 19281–19288.
7	Codes 19281–19288 are for image guidance placement of a localization device without image-guided biopsy. These codes should not be used in conjunction with 19081–19086.
8	For CPT 10011 use the reimbursement rate for CPT code 10009. For CPT 10012 use the reimbursement rate for CPT code 10010.
9	HPV DNA testing is not a reimbursable test for women under 30 years of age.
10	Example: If procedure is 50 minutes, code 99156 + (99157 x 2). No separate charge allowed if procedure <10 minutes.
11	These procedures have not been approved for coverage by Medicare.

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