Allowable CPT Codes for the Illinois Breast and Cervical Cancer Program

FOR INTERNAL USE ONLY

Effective February 2022 rev. 07/12/2022

- Screening services should include CBE, pelvic exam, mammogram, Pap/HPV test, breast and cervical cancer risk assessment and MRI for high risk breast cancer (if applicable).
- Every PA30 (screening cycle) initiated (breast or cervical), must have at least one paid service reimbursed using Federal or State funds with BCCP/S selected as the payer on SV01.
- Providers must accept the CPT rate as full payment for services. Balances may not be billed to the client.
- IBCCP clients are responsible for paying the bills for CPT codes not included on this list or not reimbursed by IBCCP. A written estimate of the additional charges must be provided to the client by the provider/hospital/clinic prior to being rendered. Providers are encouraged to write-off the charges not reimbursed by IBCCP.
- All services must be provided on an outpatient basis. CDC does not allow for payment of inpatient services.
- The reimbursement rates are based on the highest allowable Medicare rates for Illinois. Total payment is not to exceed these approved rates. If a provider bill is less than the approved rates only reimburse the amount of the bill.
- Payment amounts **CANNOT** be entered into Cornerstone until the bill is received.
- Reimbursement for these codes are according to the established technical and professional components described below:
  - ◎ **TC** = Technical Component or the cost of performing the test or procedure at the hospital or outpatient surgery center or clinic and reimbursed to those sites.
  - ◎ **26** = Professional Component or the cost of interpretation of the test or procedure by a physician including radiologists or pathologists when that person is not an employee of the hospital or free standing surgery center.

  Each fee component rate is established individually by Medicare; therefore, the TC and 26 fees may not add up to equal the total fee.
- Refer to Current Procedural Terminology (CPT) Standard Edition, American Medical Association, for detailed explanation of codes.
- Remember, when entering “split” codes into Cornerstone, **both** results codes need to match.
- For women enrolled in Category XP (women with incomes above 250% of FPL), only "State" or "Other" may be entered as Payor Codes in Cornerstone, even for CPT Codes listed as "F."
- If the Medical Provider deviates from CDC approved standards, contact the Quality Assurance Nurse for prior approval.
- Refer to page 14 for Global Billing information.

CPT Code	Global Billing Info	Office Visits- Description and Payers Federal/BCCP=F, State=S		Fee TC	Fee 26	Fee Total	Instructions For Use
99202	XXX	New patient; medically appropriate history/exam – 15-29 minutes (Breast or Cervical)	F S			$ 78.83	
99203	XXX	New patient; medically appropriate history/exam – 30-44 minutes (Breast and Cervical)	F S			$ 121.90	
99204	XXX	New patient; medically appropriate history/exam or Detail Risk Assessment, Moderate, 45-59 minutes	F S			$ 180.93	
99205	XXX	New patient; medically appropriate history/exam or Detail Risk Assessment, Comprehensive, 60-74 minutes	F S			$ 239.28	
99212	XXX	Established patient; medically appropriate history/exam – 10-19 minutes (Breast or Cervical) **Repeat CBE** (Considered a Dx Procedure) – 10-19 minutes	F S			$ 61.18	
99213	XXX	Established patient; medically appropriate history/exam – 20-29 minutes (Breast and Cervical)	F S			$ 97.48	

Instructions For Use (office visits):

Paying for an office visit with another procedure, such as a colposcopy, is not allowed.
Payment of CBEs
* **Federal and State Funds –** All women 35-64 (21-39 receiving a CBE **MUST** have cervical services)

When a **repeat CBE** is performed during the same screening cycle it should be paid as a 99212 Office Visit and coded as a BCD even if the same physician is performing the repeat CBE. The PA30 should be completed as "F1" Diagnostic Work-up Complete. If a repeat CBE is performed as a 6 month follow up, it should also be paid as a 99212 and coded as a BCS. If the original CBE was done by an NP or PA, it is preferred that the repeat CBE is done by a physician.
When a **CBE is performed following an ultrasound** in the same screening cycle, the CBE must be coded as a BCD.
A **post- op visit** must be billed as 99212 and coded as a BCD to incur the least expensive of the office visit codes. IBCCP only pays for 1 post op visit for those CPT codes when a visit is not included. The visit must be completed within the 60 days of screening cycle to avoid an MDE error. Post op visits due to surgical complications are the responsibility of the surgeon and should be written off.
99204 and 99205 are typically not appropriate for a screening visit but may be used when a Provider spends extra time to complete a detailed risk assessment. The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow up.**

CPT Code	Global Billing Info	ConsulatationVisits - Descriptions and Payers Federal/BCCP = F, State = S		Fee TC	Fee 26	Fee Total	Instructions For Use
99202	XXX	Office Consultation Visit - (Considered a Dx Procedure) 15-19 minutes	F S			$ 78.83	Usually, the presenting problem(s) are of low complexity.
99203	XXX	Office Consultation Visit - (Considered a Dx Procedure) 30-44 minutes	F S			$ 121.90	Usually, the presenting problem(s) are of low complexity.
99204	XXX	Office Consultation Visit – (Considered a Dx Procedure) 45-59 minutes	F S			$ 180.93	If used for breast or cervical follow-up visits, the presenting problem(s) must be of moderate complexity.
99205	XXX	Office Consultation Visit - (Considered a Dx Procedure) 60-70 minutes	F S			$ 239.28	If used for breast or cervical follow-up visits, the presenting problem(s) must be of moderate complexity.

CPT Code	Global Billing Info	BREAST - Radiology Codes - Mammography Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
77063	XXX	Screening digital breast tomosynthesis, bilateral *(add-on code to 77067, cannot be used as a stand-alone code.)*	F S	$ 25.29	$ 31.53	$ 56.82	If a diagnostic mammogram is the ONLY mammogram done for short term follow-up and CBE is normal, the SV01 screen must be completed as a BCS and the PA30 must be completed as "P2" diagnostic work-up not planned. If a diagnostic mammogram is the only diagnostic procedure done following an abnormal CBE, additional diagnostics must be completed. (Refer to the Breast algorithms).
77067	XXX	Screening Mammogram, Digital, Bilateral	F S	$100.00	$ 38.94	$ 138.94	
77066	XXX	Diagnostic Mammogram, Bilateral (includes CAD) REMEMBER if a client has a discrete palpable mass (B3) further diagnostic work-up is required, either breast ultrasound or office consult visit or repeat CBE (99212).	F S	$120.96	$ 51.23	$ 172.19	
77065	XXX	Diagnostic Mammogram, Unilateral (includes CAD) REMEMBER if a client has a discrete palpable mass (B3) further diagnostic work-up is required, either breast ultrasound or office consult visit or repeat CBE (99212).	F S	$ 94.94	$ 41.41	$ 136.35	
G0279	XXX	Diagnostic digital breast tomosynthesis, unilateral or bilateral *(add-on code to 77066 or 77065, cannot be used as a stand-alone code)*	F S	$ 25.29	$ 31.53	$ 56.82	

CPT Code	Global Billing Info	BREAST - Radiology Codes - DIAGNOSTICS Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
76098	XXX	Radiological exam, surgical specimen	F S	$ 27.74	$ 16.48	$ 44.22	
76641	XXX	Ultrasound breast, **complete** examination of breast including axilla, unilateral	F S	$ 75.07	$ 37.52	$ 112.60	For bilateral ultrasound use 2 units
76642	XXX	Ultrasound breast, **complete** examination of breast including axilla, unilateral	F S	$ 57.37	$ 35.05	$ 92.42	
76942	XXX	Ultrasonic guidance for needle placement (e.g., biopsy aspiration or localization device); imaging supervision and interpretation	F S	$ 29.91	$ 32.90	$ 62.81	Can be used with CPT Codes, 19000, 19081-19086, 19281-19288.

CPT Code	Global Billing Info	Additional BREAST - Radiology Codes Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
77053	XXX	Mammary ductogram or galactogram, single duct	F S	$ 39.31	$ 18.59	$ 57.89	Reimbursed in conjunction with mammogram when a client has a BRCA mutation: a first-degree relative who is a BRCA carrier **and** has a lifetime risk of 20% or greater as defined by risk assessment models that are largely dependent on family history. Breast MRI can be used to better assess areas of concern on mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should <u>**never**</u> be done alone as a breast cancer screening tool. Breast MRI <u>**cannot**</u> be reimbursed to assess the extent of disease in a woman who already diagnosed with breast cancer.
77046	XXX	Magnetic Resonance Imaging, breast, without contrast, unilateral	F S	$168.93	$ 74.70	$ 243.63	
77047	XXX	Magnetic Resonance Imaging, breast, without contrast, bilateral	F S	$168.21	$ 81.75	$ 249.96	
77048	XXX	Magnetic Resonance Imaging (MRI), breast, including CAD, with and without contrast, unilateral	F S	$277.68	$ 107.04	$ 384.73	
77049	XXX	Magnetic Resonance Imaging (MRI), breast, including CAD, with and without contrast, bilateral (prior approval needed with the exception of a screening MRI for high risk clients)	F S	$275.51	$ 117.22	$ 392.73	

For radiological lesion codes, IBCCP will pay for no more than 3 lesions per breast.

CPT Code	Global Billing Info	BREAST - Surgical Codes Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
10004	XXX	Fine needle aspiration biopsy without imaging guidance, each additional lesion	FS			$ 56.79	Surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Codes 19281, 19282, 19081, 19082, 19283, 19284, and 76942.
10005	XXX	Fine needle aspiration biopsy including ultrasound guidance, first lesion	FS			$ 151.69	
10006	XXX	Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	FS			$ 66.03	
10007	XXX	Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	FS			$ 329.54	
10008	XXX	Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	FS			$ 179.56	
10009	XXX	Fine needle aspiration biopsy including CT guidance, first lesion	FS			$ 493.98	
10010	XXX	Fine needle aspiration biopsy including CT guidance, each additional lesion	FS			$ 289.71	
10011	XXX	Fine needle aspiration biopsy including MRI guidance, first lesion	FS			$ 493.98	
10012	XXX	Fine needle aspiration biopsy including MRI guidance, each additional lesion lesion	FS			$ 289.71	
10021	XXX	Fine Needle Aspiration (FNA) without imaging guidance	FS			$ 111.37	
19000	000	Puncture aspiration of breast cyst	FS			$ 113.18	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Code 19281, 19282, 19081, 19082, 19283, 19284, 76942.
19001	ZZZ	Puncture aspiration of breast cysts, <u>each additional cyst</u>	FS			$ 29.49	Must be used with 19000.
19081	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	FS			$ 559.90	Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging specimen. These codes should not be used in conjunction with 19281-19288. Can be used with 76942, 19000 and 19101. May be paid to physician and outpatient facility.
19082	XXX	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	FS			$ 437.25	
19083	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	FS			$ 566.70	
19084	XXX	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	FS			$ 431.81	
19085	XXX	Breast biopsy, placement of localization device and imaging of biopsy specimen, percutaneous, MRI guidance, 1st lesion	FS			$ 867.11	
19086	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; MRI guidance; each additional lesion	FS			674.65	
19100	000	Breast biopsy, percutaneous, needle core, not using imaging guidance	FS			$ 175.42	Preoperative testing and surgical supplies are allowed. May be

CPT Code	Global Billing Info	Descriptions and Payers	Federal/BCCP = F, State = S	TC	26	Total	Instructions For Use
19101	010	Breast biopsy, open incisional	FS			$ 379.64	paid to physician and outpatient facility.
19120	090	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	FS			$ 595.61	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility. Cannot be billed with 19125 unless a **separate** lesion.
19125	090	Excision of breast lesion identified by preoperative placement of radiological marker	FS			$ 659.12	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility.
19126	ZZZ	Excision of breast lesion identified by preop placement of radiological marker; each additional lesion separately identified by preop markers.	FS			$ 189.88	Must be used with CPT Code 19125. Limit 2 additional lesions.

CPT Code	**Global Billing Info**	**BREAST - Surgical Codes Descriptions and Payers Federal/BCCP = F, State = S**		**Fee**			**Instructions For Use**
				TC	**26**	**Total**	
19281	XXX	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	FS			$ 261.91	Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086. May be paid to physician and outpatient facility.
19282	XXX	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	FS			$ 186.05	
19283	000	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	FS			$ 285.97	
19284	XXX	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	FS			$ 213.36	
19285	000	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	FS			$ 417.32	
19286	XXX	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	FS			$ 343.75	
19287	000	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	FS			$ 720.26	
19288	XXX	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	FS			$ 559.16	

For surgical biopsy codes, IBCCP will pay for no more than 3 lesions per breast.

CPT Code	**Global Billing Info**	**CERVICAL - Screening Codes Descriptions and Payers Federal/BCCP = F, State = S**		**Fee**			**Instructions For Use**
				TC	**26**	**Total**	
88141	XXX	Cytopathology, cervical or vaginal, requiring interpretation by physician	FS			$ 23.47	**ONLY allowed every 3 or 5 years.** If provider chooses to do annually, IBCCP will not reimburse. CPT codes 88143, 88174, 88175 must be reimbursed at the applicable 88142 Medicare reimbursement rate (or less based on bill received). **See exceptions in Section 5.6.**
88142	XXX	Pap Test, cervical or vaginal, Liquid Based, thin prep, manual screening under physician supervision	FS			$ 20.26	
88164	XXX	Pap Test, Conventional slides, cervical or vaginal, reported in the Bethesda System, under physician supervision	FS			$ 15.92	

87624	XXX	HPV (Human Papillomavirus), high risk types	FS			$ 35.09	*HPV high risk testing is allowed as a primary HPV and in conjunction with PAP testing or for follow-up of an abnormal Pap result or surveillance and reimbursed by IBCCP per ASCCP guidelines. *Not reimbursable as a primary screening test for women under 30 yrs. or as an adjunctive screening test to the Pap for women under 30 yrs. *Providers should specify the high-risk HPV DNA panel only. *Reimbursement of screening for low-risk HPV types is not permitted. *CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.
87625	XXX	Human Papillomavirus, **types 16 and 18 <u>only</u>**	FS			$ 40.55	IBCCP funds may be used for reimbursement of HPV genotyping. To be used in conjunction with 87624 as per ASCCP guidelines.

CPT Code	Global Billing Info	CERVICAL - Diagnostic Codes Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
57452	000	Colposcopy of cervix including upper/adjacent vagina **<u>without</u>** biopsy or Endocervical Curettage (ECC)	FS			$ 142.08	Follow the ASCCP guidelines for appropriate screening and follow-up to abnormals. May be paid to physician and outpatient facility. Paying for an office visit with another procedure, such as a colposcopy, is not allowed. Surgical supplies are allowed. DO NOT REPORT 57452 in addition to 57454-57456. DO NOT REPORT 57456 with 57461.
57454	000	Colposcopy of the cervix **<u>with</u>** biopsy **<u>and</u>** endocervical curettage	FS			$ 191.67	
57455	000	Colposcopy of the cervix **<u>with</u>** biopsy	FS			$ 181.75	
57456	000	Colposcopy of the cervix **<u>with</u>** endocervical curettage	FS			$ 170.21	
57460	000	Colposcopy with Loop Electrode biopsy(s) of the cervix	FS			$ 355.11	
57461	000	Colposcopy with Loop Electrode Conization biopsy of the cervix	FS			$ 397.97	
57500	000	Biopsies or Local Excision of Cervical Lesion, single or multiple	FS			$ 174.16	Polypectomies are covered.
57505	010	Endocervical Curettage (ECC)	FS			$ 174.73	CPT code 57505 is not reimbursable if done as a part of a dilation and curettage.
57520	090	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser **(prior approval needed)**	FS			$ 397.52	**Follow the ASCCP guidelines. The below information is for coverable diagnostic code guidance. Please see Cervical treatment codes for further guidance on coverable CPT codes related to treatment. IBCCP funds (state and federal based on income) can be used when procedure 57460, 57461, 57520, 57522 are done as diagnostic for the following: *HSIL Pap Test but negative CIN1 on colposcopy or biopsy, *AGC cytology but negative colposcopy, *positive ECC-upgrades,**

57522	090	Loop Electrode Excision Procedure (LEEP) **(prior approval needed)**	FS			$ 342.48	***biopsy read as CIN/dysplasia of indeterminate grade *micro-invasive cancer on biopsy (LEEP to diagnosis deeply invasive cancer, if present). The LEEP would be entered as diagnostic. Only in the above situations, if results from the LEEP are HSIL, CIN2, CIN3 and no further treatment will be needed the procedure would be entered as treatment and state funds should be used. If LEEP is completed without colposcopy/biopsy, follow the ASCCP guidelines for expedited treatment. Either state or federal funds may be used based on income.**
58100	000	Endometrial Sampling (Biopsy) **with** or **without** endocervical sampling (Biopsy), without cervical dilation	FS			$ 115.26	May be paid to physician and outpatient facility. Preoperative testing and surgical supplies are allowed. Abnormal bleeding alone is not justification for endometrial biopsy per CDC. **Criteria for Endometrial Sampling:** **IBCCP will pay for the following:** *AGC Pap for women age 35 and over → endometrial biopsy covered *AGC Pap for women under 35 but abnormal bleeding/anovulation → endometrial biopsy covered *Post-menopausal women with a negative Pap, but endometrial cells are present (enter this result as AGC in Cornerstone). **IBCCP CANNOT pay for the following:** *Post-menopausal bleeding and a negative Pap (required to explore for endometrial hyperplasia/cancer). *Abnormal Pap (Not AGC) with abnormal bleeding at any age. Use 58110 in conjunction with 57452, 57454, 57455, 57456, 57460, and 57461.
58110	000	Endometrial Sampling (Biopsy) performed in conjunction with colposcopy	FS			$ 56.03	
58558	000	Hysteroscopy with Endometrial Biopsy	S			$ 1,516.29	
76856	XXX	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	FS	$ 80.13	$ 35.76	$ 115.89	Only allowable after diagnosis of cervical cancer to determine metastasis in the pelvic region.
CPT Code	**Global Billing Info**	**CERVICAL - Treatment Codes Descriptions and Payers Federal/BCCP = F, State = S**		**Fee**			**Instructions For Use**
				TC	**26**	**Total**	
57460	000	Endoscopy with Loop Electrode Biopsy(s) of the cervix **(prior approval needed)**	FS			$ 355.11	Follow the ASCCP guidelines. May be paid to physician and outpatient facility. Preoperative testing and surgical supplies are allowed. **State Funding:** Treatment for CIN 2. IBCCP funds (state and federal based on income) can be used when procedure 57460, 57461, 57520, 57522 are done as diagnostic for the following: *HSIL Pap Test but negative CIN1 on colposcopy or biopsy, *AGC cytology but negative colposcopy, *positive ECC-upgrades, *biopsy read as CIN/dysplasia of indeterminate grade
57461	000	Endoscopy with Loop Electrode Conization biopsy of the cervix **(prior approval needed)**	FS			$ 397.97	

57511	010	Cryocautery of the cervix **(prior approval needed)**	FS			$ 225.87	*micro-invasive cancer on biopsy (LEEP to diagnosis deeply invasive cancer, if present). The LEEP would be entered as diagnostic. Only in the above situations, if results from the LEEP are HSIL, CIN2, CIN3 and no further treatment will be needed the procedure would be entered as treatment and state funds should be used. If LEEP is completed without colposcopy/biopsy, follow the ASCCP guidelines for expedited treatment. Either state or federal based on income. Precancerous cervical conditions eligible for Treatment Act: *CIN 3 *Severe dysplasia of the cervix *HSIL *AGC with a suspicion of AIS Federal Funding (BCCP): Pays for least expensive Service. Medicaid: Pays all other procedures. Data enter all diagnostic services into Cornerstone including those paid by Medicaid.
57520	090	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser **(prior approval needed)**	FS			$ 397.52	
57522	090	Loop Electrode Excision Procedure (LEEP) **(prior approval needed)**	FS			$ 342.48	

CPT Code	Global Billing Info	BREAST & CERVICAL - Pathology Fees Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
88172	XXX	Evaluation of FNA of Breast(s) to determine specimen adequacy	FS	$ 20.88	$ 36.35	$ 57.23	
88173	XXX	Interpretation and report of FNA of Breast(s)	FS	$ 94.36	$ 72.90	$ 167.26	
88177	XXX	Evaluation of FNA of Breast(s) to determine specimen adequacy; each separate additional evaluation episode	FS	$ 7.59	$ 22.57	$ 30.16	
88305	XXX	Surgical pathology, breast **(does not evaluate surgical margins)** or cervical biopsy specimens	FS	$ 36.42	$ 38.45	$ 74.86	IBCCP will pay up to 3 specimens from each breast or 3 cervical specimens
88307	XXX	Surgical pathology, breast **(evaluates surgical margins)**	FS	$218.64	$ 85.32	$ 303.96	Can now be billed to Federal for cervical biopsies for LEEP specimens documented as a **diagnostic** procedure**.** Must still be billed to State for conization of the cervix for treatment of **CIN 2.**
88331	XXX	Frozen section, first tissue block, single specimen (cervical)	FS	$ 43.64	$ 63.88	$ 107.53	**State Funding:** Breast **Federal Funding (IBCCP):** Cervical
88332	XXX	Frozen section, each additional specimen **(Limit 2)** (cervical)	FS	$ 25.94	$ 31.41	$ 57.34	
88341	XXX	Immunohistochemistry or immunocytochemistry, per specimen; each additional stain **(cervical only)**	FS	$ 64.31	$ 28.91	$ 93.22	Only allowable after a diagnosis of CIN2. Other special requests require prior approval.
88342	XXX	Immunohistochemistry or immunocytochemistry, per specimen; 1st stain (cervical only)	FS	$ 71.10	$ 35.62	$ 106.71	
88360	XXX	Morphometric analysis, tumor immunochemistry, per specimen; manual (**breast only**)	FS	$ 84.83	$ 42.67	$ 127.50	
88361	XXX	Morphometric analysis, tumor immunochemistry, per specimen; using CAD (**breast only**)	FS	$ 82.30	$ 44.72	$ 127.02	

CPT Code	Global Billing Info	BREAST & CERVICAL - Preoperative Testing Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
36415		Venipuncture	FS			$ 3.00	These codes may be used only in conjunction with the following procedures: 19000, 19100, 19101, 19081-19086, 19120, 19125, 10021, 57460, 57461, 57520, 57522, 58100, 58110 and 58558. A pregnancy test may be reimbursed prior to colposcopy procedures, only when there is concern that the client may be pregnant. The test should not be routinely performed on every client scheduled for colposcopy. Codes 82565 and 84520 should only be billed in conjunction with 77059 (MRI) based on specified criteria for women who qualify for MRI.
71045		Chest x-ray, 1 view	FS	$ 18.71	$ 9.47	$ 28.19	
71046		Chest x-ray, 2 views	FS	$ 25.22	$ 11.24	$ 36.45	
80048		Basic metabolic panel	FS			$ 8.46	
80053		Comprehensive metabolic panel	FS			$ 10.56	
81001		Urinalysis	FS			$ 3.17	
81025		Pregnancy test	FS			$ 8.61	
82565		Creatinine Assay	FS			$ 5.12	
84520		BUN (Assay of Urea Nitrogen)	FS			$ 3.95	
85014		Hematocrit	FS			$ 2.37	
85018		Hemoglobin	FS			$ 2.37	
85025		CBC with differential WBC count	FS			$ 7.77	
85027		CBC without differential	FS			$ 6.47	
87635		COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative, (Can only be used when COVID-19 testing is **required by a provider prior to a diagnostic procedure).** **(BCD/CCD)**	FS			$ 51.31	
93000		EKG	FS			$ 15.55	

CPT Code	Global Billing Info	BREAST & CERVICAL - Additional Procedures Descriptions and Payers Federal/BCCP = F, State = S	Fee			Instructions For Use
			TC	26	Total	

99156		Conscious Sedation (Limited to $200, 10-22 minutes)	FS			$ 200.00	Conscious Sedation is a drug induced depression of consciousness. Patients will still respond to verbal and tactile stimulation. No artificial airway or ventilation is required. This code can be used with CPT codes 57454, 57455, 57456, 57460, 57461, 57500, 57505, 57520, 57522, 58100, 58110 and 58558. When both a Certified Registered Nurse Anesthetist (CRNA) and an Anesthesiologist bill for the procedure, the amount must be split between the two. This amount is **NOT** reimbursed to the hospital unless the CRNA or anesthesiologist is a hospital employee and will not be submitting a separate bill.
99157		Conscious Sedation (Limited to $200For each additional 15 minutes)	FS			$ 200.00	
00400		General Anesthesia (Limited to $300)	FS			$ 300.00	General anesthesia is unconscious sedation rendered by administration of intravenous medication and/or gas inhalation. This code can be used with CPT codes 19101, 19081-19086, 19120, or 19125. When both a Certified Registered Nurse Anesthetist (CRNA) and an Anesthesiologist bill for the procedure, the amount must be split between the two. This amount is **NOT** reimbursed to the hospital unless the CRNA or anesthesiologist is a hospital employee and will not be submitting a separate bill.

CPT Code	Global Billing Info	BREAST & CERVICAL - Additional Procedures Descriptions and Payers Federal/BCCP = F, State = S		Fee			Instructions For Use
				TC	26	Total	
99070		Surgical Supplies (Limited to $500)	FS			$ 500.00	This code is used to reimburse facilities when procedures are performed in an outpatient setting. Allowable charges include surgical supplies and pharmacy supplies. This code may be used in conjunction with the following procedures: 10021, 19000, 19100, 19101, 19081-19086, 19120, 19125, 57460, 57461, 57520, 57522, 58100, 58110 or 58558. Surgical supply fees should be reimbursed to the hospital or freestanding surgical clinic where the procedure was performed. A separate line item indicating surgical supplies, operating room supplies or similar language should be noted on the bill received. Reimbursement of $50.00 is allowed for minor procedures including CPT Codes 57454, 57455, 57456, 57500, 57505 and 57511. The charge must be listed on the bill received. It is not an automatic payment to the facility or provider. This charge should be used with caution to ensure that programs do not reimburse for supplies, the cost of which, has already been accounted for in another clinical charge. IBCCP funds can be used to pay for estrogen vaginal cream for **postmenopausal women prior to colposcopy** (limited to 6 weeks prior to colposcopy) in those instances when the cream is necessary to ensure adequate visualization for diagnostic purposes. **State Funding:** When the procedure can only be paid using state funds, reimbursement for surgical supplies **MUST** be paid with state funds as well.

GLOBAL BILLING INFORMATION CODE	
Code	**Explanation** The global period is the number of days following a procedure during which all services furnished by the physician are included in the reimbursement for that procedure. This includes postoperative visits and complications following a procedure including all additional medical and/or surgical services required of the physician (not resulting in a return trip to the operating room) during the designated global period.
XXX	The global period concept does not apply to the code.
ZZZ	These represent add-on codes. This code is related to another service and is always included in the global period of the primary service.
0 days	Endoscopic or minor procedure without an associated global period.
10 days	Minor procedure that has an associated 10 day global period, where any postoperative office visit is included in the procedure fee.
90 days	Major surgery with a 1-day preoperative period and a 90-day postoperative period included in the procedure fee.

CORNERSTONE PROGRAM CODES FOR REFERRAL TO TREATMENT ACT – RTTA		
		Fee
RTAA	Referral to Treatment Act – Approved	$50.00
RTAD	Referral to Treatment Act – Denied	$50.00

CORNERSTONE PROGRAM CODES FOR CLINICAL NAVIGATED INSURED - CNI		
		Fee
CNIB/CNIC	Clinical Navigated Insured (Can be paid for both a CNIB and CNIC in same screening cycle)	$75.00

PROCEDURES SPECIFICALLY NOT ALLOWED	
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
77054	Mammary ductogram or galactogram, multiple duct
77061	Breast Tomosynthesis, unilateral
77062	Breast Tomosynthesis, bilateral
87623	Human Papillomavirus, low risk types