



Women's Health Check

A breast and cervical cancer screening program

IDAHO WOMEN'S HEALTH CHECK REIMBURSEMENT RATES 2016			Effective: 1/1/2016		
CPT Codes	Description	Rates	Tech (TC)	Prof (26)	End Notes
*10021	Fine needle aspiration without imaging guidance	\$114.87		\$66.61	
*10022	Fine needle aspiration with imaging guidance	\$131.20		\$63.31	
*19000	Puncture aspiration of cyst of breast	\$104.81		\$42.07	
*19001	Puncture aspiration of cyst of breast, each additional cyst, <i>used with 19000</i>	\$25.61		\$21.11	
*19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	\$693.43		\$163.90	9
*19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	\$526.19		\$82.20	9
*19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	\$618.70		\$154.44	9
*19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	\$506.16		\$76.97	9
*19085	Pre-auth required: Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	\$947.50		\$181.13	8, 9
*19086	Pre-auth required: Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	\$748.45		\$90.18	8, 9
*19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	\$138.29		\$65.58	
*19101	Breast biopsy, open, incisional	\$314.37		\$206.27	
*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	\$456.73		\$385.30	
*19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	\$506.15		\$427.65	
*19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	\$152.00		\$152.00	
*19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	\$222.93		\$98.74	10
*19282	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	\$155.08		\$49.55	10
*19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	\$250.18		\$99.29	10
*19284	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	\$187.30		\$49.92	10
*19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	\$473.25		\$84.27	10
*19286	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	\$413.99		\$42.07	10
*19287	Pre-auth required: Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	\$790.40		\$126.66	8, 10
*19288	Pre-auth required: Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	\$635.67		\$63.31	8, 10
*57452	Colposcopy of the cervix	\$102.42		\$87.30	
*57454	Colposcopy of the cervix, with biopsy and endocervical curettage	\$144.24		\$129.11	
*57455	Colposcopy of the cervix, with biopsy	\$134.08		\$105.45	
*57456	Colposcopy of the cervix, with endocervical curettage	\$126.45		\$98.14	
*57460	Pre-auth required: Colposcopy with loop electrode biopsy(s) of the cervix	\$262.84		\$154.41	6
*57461	Pre-auth required: Colposcopy with loop electrode conization of the cervix	\$297.70		\$178.33	6
*57500	Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	\$118.76		\$71.78	
*57505	Endocervical curettage (not done as part of a dilation and curettage)	\$95.42		\$86.41	
*57520	Pre-auth required: Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	\$287.33		\$258.69	6
*57522	Pre-auth required: Loop electrode excision procedure	\$246.68		\$228.98	6
*58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	\$102.35		\$83.05	
*58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure)	\$45.31		\$39.20	
76098	Radiological examination, surgical specimen	\$15.43	\$7.58	\$7.84	
76641	Ultrasound, complete examination of breast including axilla, unilateral	\$99.78	\$64.21	\$35.57	
76642	Ultrasound, limited examination of breast including axilla, unilateral	\$82.22	\$49.09	\$33.13	
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	\$57.41	\$24.96	\$32.45	

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77053	Mammary ductogram or galactogram, single duct	\$53.66	\$36.22	\$17.44	
77055	Mammography, Diagnostic Follow-up, unilateral	\$83.26	\$49.09	\$34.17	
**G0206	Diagnostic Mammogram, digital, unilateral	\$118.33	\$84.48	\$33.85	
77056	Mammography, Diagnostic Follow-up, bilateral	\$106.90	\$64.53	\$42.38	
**G0204	Diagnostic Mammogram, digital, bilateral	\$150.34	\$107.96	\$42.38	
77057	Screening Mammogram, bilateral (2 view film study of each breast)	\$76.50	\$42.33	\$34.17	
**G0202	Screening Mammogram, digital, bilateral	\$123.15	\$89.30	\$33.85	
77058	Pre-auth required: Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral	\$490.10	\$410.76	\$79.34	8
77059	Pre-auth required: Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral	\$487.85	\$408.51	\$79.34	8
87624	Human Papillomavirus, high-risk type	\$47.80			5
87625	Human Papillomavirus, types 16 and 18 only	\$47.80			5
88141	Cytopathology (conventional Pap test), cervical or vaginal, any reporting system, requiring interpretation by physician	\$30.53			
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	\$27.60			
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	\$27.60			4
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	\$14.39			
88165	Cytopathology (conventional Pap test), slides cervical or vaginal, reported in Bethesda System, manual screening and rescreening under physician supervision	\$14.39			
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	\$54.22	\$17.88	\$36.35	
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	\$144.01	\$72.75	\$71.26	
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	\$29.11			4
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	\$35.40			4
88305	Surgical pathology, gross and microscopic examination	\$68.92	\$30.75	\$38.17	
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	\$285.20	\$201.45	\$83.75	
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	\$90.98	\$28.17	\$62.81	
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)	\$47.88	\$16.91	\$30.97	
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (list separately in addition to code for primary procedure)	\$83.20	\$56.30	\$26.89	
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	\$98.66	\$62.92	\$35.74	
99201	New Patient; history, exam, straightforward decision-making; 10 minutes	\$40.95			
99202	New Patient; <i>expanded</i> history, exam, straightforward decision-making; 20 minutes	\$70.17			
99203	New Patient; <i>detailed</i> history, exam, straightforward decision-making; 30 minutes	\$101.22			
99204	New Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes	\$155.09			1
99205	New Patient; <i>comprehensive</i> history, exam, high complexity decision-making; 60 minutes	\$194.78			1
99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes	\$18.54			
99212	Established Patient; history, exam, straightforward decision-making; 10 minutes	\$40.77			
99213	Established Patient; <i>expanded</i> history, exam, straightforward decision-making; 15 minutes	\$68.52			
99214	Established Patient; <i>detailed</i> history, exam, moderately complex decision-making; 25 minutes	\$101.25			
99385	Initial comprehensive preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 18-39 years of age	\$101.22			2
99386	Same as 99385, but 40-64 years of age	\$101.22			2
99387	Same as 99385, but 65 years and older	\$101.22			2
99395	Periodic comprehensive preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 18-39 years of age	\$68.52			2
99396	Same as 99395, but 40-64 years of age	\$68.52			2
99397	Same as 99395, but 65 years and older	\$68.52			2

00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Maximum Time Units billable is 3. Medicare Base Units = 5/Time Unit.	\$21.48 per base unit	Max of 3 time units allowed per patient	3
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Not to exceed \$100.00		7

* **Healthcare Provider's reduced fee if service performed in facility outside their own office.**
** **Computer-Aided Detection (CAD) is not reimbursed and should not be billed to patient as part of the mammogram.**

PLEASE NOTE:

- **Highlighted procedures require pre-authorization from the Women's Health Check (WHC) State office: contact (208) 334-5971.**
- Allowable CPT codes are procedures that can be reimbursed by United Group Programs (UGP), but they are at the primary CPT rate.
- Reimbursement for treatment services is **not allowed**.
- The Provider shall provide listed services for WHC enrolled clients at no charge to the client. The Provider may not bill the client for any portion of covered services. The Provider must make other arrangements with the client for payment of any services not covered by WHC. The Provider shall refer tobacco users to www.quitnow.net/Idaho.

END NOTES	
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 not appropriate for NBCCEDP screening visits.
2	The type and duration of office visits should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the NBCCEDP. Reimbursement rates should not exceed those published by Medicare. While the use of 993XX-series codes may be necessary in some programs, the 993XX Preventive Medicine Evaluation visits themselves are not appropriate for the NBCCEDP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.
3	Medicare's methodology for the payment of anesthesia services are outlined in the Medicare Claims Processing Manual, Chapter 12, pages 99-107, available here: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf The carrier-specific Medicare anesthesia conversion rates are available here: http://www.cms.hhs.gov/center/anesth.asp
4	These procedures may be reimbursed at their own Medicare rates. They no longer have to be reimbursed at the 88142 rate.
5	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. It is not reimbursable as a primary screening test for women of all ages or 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 is 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 cannot be used for reimbursement of genotyping (e.g., Cervista HPV 16/18).
6	Preauthorization for this service for reimbursement is required. A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Before authorization can be made, Women's Health Check State Office must review these cases in advance, and on an individual basis.
7	This charge should be used with caution to ensure that WHC does not reimburse for supplies, the cost of which, has already been accounted for in another clinical charge.
8	Preauthorization for this service for reimbursement is required. Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history. Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a client with a past 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 women who are already diagnostic with breast cancer.
9	Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.
10	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.

Billing/Claims Submission

Submit complete claim forms within 90 days of service to the WHC Third Party Administrator:

United Group Programs
Attn: Idaho Women's Health Check Program
2500 N Military Trail, Ste 450
Boca Raton, FL 33431
1-800-810-9892 ext 114

Electronic Payer ID: ugp19