2017 NBCCEDP Allowable Procedures and Relevant CPT® Codes

Listed below are allowable procedures and the corresponding suggested CPT codes for use in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) under these general conditions:

- New codes indicated in bold, deleted codes are indicated with double strikethrough.
- Reimbursement for treatment services is not allowed.
- The suggested CPT codes are *not* all-inclusive and grantees may utilize other, including temporary, CPT codes for an approved procedure.
- When questions arise regarding the appropriateness to utilize a procedure not listed in a grantee's application, the grantee's local medical advisory board should be consulted to determine if the procedure is warranted given the overall intent of the CDC funding and amount of resources available.
- However, the use of procedures not listed in the application should be an exception (used in less than 5% of the screening population) and not the rule.
- As always, grantees are required to be responsible stewards of the NBCCEDP funds and use screening and diagnostic dollars in an efficient and appropriate manner.

OFFICE VISITS		END	MEDICARE	MOD 26	TC
99201	New Patient; history, exam, straightforward decision-making; 10 minutes		$47.77		
99202	New Patient; *expanded* history, exam, straightforward decision-making; 20 minutes		$80.77		
99203	New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes		$115.68		
99204	New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	1	$174.25		
99205	New Patient; comprehensive history, exam, high complexity decision-making; 60 minutes	1	$218.56		
99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes		$22.43		
99212	Established Patient; history, exam, straightforward decision-making; 10 minutes		$47.55		
99213	Established Patient; *expanded* history, exam, straightforward decision-making; 15 minutes		$78.67		
99214	Established Patient; *detailed* history, exam, moderately complex decision- making; 25 minutes		$115.38		
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	2			

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99386	Same as 99385, but 40-64 years of age	2			
99387	Same as 99385, but 65 years and older	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	2			
99396	Same as 99395, but 40-64 years of age	2			
99397	Same as 99395, but 65 years and older	2			
99420	**Administration and interpretation of health risk**	**15**			

BREAST SCREENING & DIAGNOSTIC PROCEDURES		END	MEDICARE	MOD 26	TC
77065	Diagnostic mammography, unilateral, includes CAD	14			
77066	Diagnostic mammography, bilateral, includes CAD	14			
77067	Screening mammography, bilateral	14			
77063	Screening digital breast tomosynthesis, bilateral	11	$61.17	$31.77	$29.41
76098	Radiological examination, surgical specimen		$18.21	$8.46	$9.75
76641	Ultrasound, complete examination of breast including axilla, unilateral		$121.37	$38.32	$83.05
76642	Ultrasound, limited examination of breast including axilla, unilateral		$99.28	$35.69	$63.59
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation		$66.39	$33.87	$32.53
19000	Puncture aspiration of cyst of breast		$125.82		
19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*		$28.63		
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance		$164.73		
19101	Breast biopsy, open, incisional		$370.02		
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		$524.41		
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion		$579.52		

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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		$164.52		
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	9	$788.31		
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	9	$658.68		
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	9	$765.49		
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	9	$633.71		
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	9	$1,171.57		
19086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	9	$945.56		
19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	10	$268.07		
19282	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	10	$188.70		
19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	10	$303.93		
19284	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	10	$232.02		
19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	10	$595.01		
19286	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	10	$523.33		
19287	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	10	$998.21		
19288	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	10	$808.85		
10021	Fine needle aspiration without imaging guidance		$133.50		
10022	Fine needle aspiration with imaging guidance		$156.22		

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88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study		$62.75	$39.75	$23.00
88173	Cytopathology, evaluation of fine needle aspirate; *interpretation and report*		$171.20	$77.57	$93.63
88305	Surgical pathology, gross and microscopic examination		$75.68	$41.49	$34.18
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins		$301.61	$92.02	$209.59
G0202	Screening Mammogram, Digital, Bilateral		$154.34	$38.57	$115.77
G0204	Diagnostic Mammogram, Digital, Bilateral		$190.75	$50.54	$140.21
G0206	Diagnostic Mammogram, Digital, Unilateral		$150.15	$40.59	$109.56
G0279	Diagnostic Digital Breast Tomosynthesis, Unilateral or Bilateral	12	61.17	31.77	29.41
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3	3	$22.07		
77053	Mammary ductogram or galactogram, single duct		$66.21	$19.19	$47.02
77058	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral	8	$577.72	$85.87	$491.85
77059	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral	8	$577.72	$85.87	$491.85
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.				

CERVICAL SCREENING & DIAGNOSTIC PROCEDURES		END	MEDICARE	MOD 26	TC
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision		$14.49		
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision		$14.49		
88141	Cytopathology, cervical or vaginal, any reporting system, *requiring interpretation by physician*		$35.43		
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision		$27.79		

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88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	4	$27.79		
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	4	$29.31		
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	4	$36.34		
87624	Human Papillomavirus, high-risk types	5	$48.14		
87625	**Human Papillomavirus, types 16 and 18 only**	**5**	$48.14		
57452	Colposcopy of the cervix		$116.34		
57454	Colposcopy of the cervix, with biopsy and endocervical curettage		$161.63		
57455	Colposcopy of the cervix, with biopsy		$152.05		
57456	Colposcopy of the cervix, with endocervical curettage		$143.67		
57460	Colposcopy with loop electrode biopsy(s) of the cervix	6	$309.32		
57461	Colposcopy with loop electrode conization of the cervix	6	$348.21		
57500	Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)		$140.48		
57505	Endocervical curettage (not done as part of a dilation and curettage)		$110.52		
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	6	$328.38		
57522	Loop electrode excision procedure	6	$280.69		
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)		$116.37		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)		$50.39		

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88305	Surgical pathology, gross and microscopic examination		$75.68	$41.49	$34.18
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen		$106.63	$69.13	$37.50
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)		$58.10	$34.28	$23.83
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure		$120.68	$38.87	$81.81
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)		$103.19	$31.13	$72.06
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, rays, supplies, or materials provided)	7			
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.				

Ambulatory Surgical Center (ASC) Payment Rates			
		End Note	**MEDICARE 2017**
19000 SG	Aspiration of cyst		$79.18
19125 SG	Excision		$987.46

PROCEDURES SPECIFICALLY NOT ALLOWED		END NOTE
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.	
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics	
77061	**Breast tomosynthesis, unilateral**	13
77062	**Breast tomosynthesis, bilateral**	13
87623	**Human Papillomavirus, low-risk types**	

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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 typically 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.
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. CDC allows 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.**
6	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Grantees are strongly encouraged to develop policies to closely monitor these procedures and should pre-authorize this service for reimbursement by having it medical advisory board or designated clinical representative(s) review these cases in advance, and on an individual basis.
7	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.
8	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 a women who is already diagnosed 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.
11	List separately in addition to code for primary procedure G0202.
12	List separately in addition to G0204 or G0206
13	These procedures have not been approved by coverage by Medicare.

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14	Due to Medicare claims processing issues, CMS will not be able to process the new CPT codes. Therefore no reimbursement fees have been assigned to these codes. Grantees should use only G0202, G0204 and G0206 until this has been resolved. It is expected that these codes will be operationalized by 2018.
15	Appropriate for use of breast risk assessment tools during an office visit. The modifier -25 should be added to the appropriate office visit CPT to indicate a separate service done on same day.

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