2011 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:

- Screening services should include CBE, pelvic exam, mammogram, and a Pap smear.
- Reimbursement for treatment services is not allowed.
- Programs are required to detail in their application the procedures and reimbursement rates that they will be routinely using to provide these services.
- The suggested CPT codes are not all-inclusive and Programs 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 Program's application, the Program's local medical advisory board or consultant should be consulted to determine if the procedure is warranted given the overall intent of the CDC funding and amount of resources the program has 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, Programs are required to be responsible stewards of the NBCCEDP funds and use screening and diagnostic dollars in an efficient and appropriate manner.

OFFICE VISITS		FOOT NOTE	Medicare 2011	Mod 26	Mod TC
99201	New Patient; history, exam, straightforward decision-making; 10 minutes		45.33		
99202	New Patient; *expanded* history, exam, straightforward decision-making; 20 minutes		77.59		
99203	New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes		111.34		
99204	New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	1	169.32		
99205	New Patient; comprehensive history, exam, high complexity decision-making; 60 minutes	1	210.05		
99211	Established Patient; evaluation and management, may not require presence of physician; 5 minutes		22.22		
99212	Established Patient; history, exam, straightforward decision-making; 10 minutes		45.73		
99213	Established Patient; *expanded* history, exam, straightforward decision-making; 15 minutes		74.88		
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	NA		
99386	Same as 99385, but 40-64 years of age	2	NA		

Note: This Revised 2011 NBCCEDP Allowable Procedures and Relevant CPT® Codes is effective from June 30, 2011 to June 29, 2012.

99387	Same as 99385, but 65 years and older	2	NA		
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	NA		
99396	Same as 99395, but 40-64 years of age	2	NA		
99397	Same as 99395, but 65 years and older	2	NA		

BREAST SCREENING & DIAGNOSTIC PROCEDURES			Medicare 2011	Mod 26	Mod TC	Facility Fee
77057	Screening Mammogram, Bilateral (2 view film study of each breast)		$91.7	36.52	55.18	
77055	Mammography, Diagnostic Follow-up, Unilateral		98.21	36.52	61.7	
77056	Mammography, Diagnostic Follow-up, Bilateral		125.8	45.38	80.42	
77031	Stereotactic localization guidance for breast biopsy or needle placement		180.79	83.27	97.51	
77032	Mammographic guidance for needle placement, breast		62.7	29.09	33.61	
76098	Radiological examination, surgical specimen		21.78	8.52	13.26	
76645	Ultrasound, breast(s), unilateral or bilateral, B-scan and/or real time with image documentation		102.55	28.23	74.31	
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation		231.92	35.09	**196.83**	
19000	Puncture aspiration of cyst of breast		122.68			80.99
19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*		28.05			11.16
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance		188.17			157.07
19101	Breast biopsy, open, incisional		354.5			1050.42
19102	Breast biopsy, percutaneous, needle core, using imaging guidance; *for placement of localization clip use 19295*		237.52			333.96
19103	Breast biopsy, percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance		621.73			621.73

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		499.69			1050.42
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion		553.42			1050.42
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; *each additional lesion separately identified by a preoperative radiological marker*		161.43			1050.42
19290	Preoperative placement of needle localization wire, breast		180.27			
19291	Preoperative placement of needle localization wire, breast; each additional lesion		75.89			
19295	Image guided placement, metallic localization clip, percutaneous, during breast biopsy		108.1			
10021	Fine needle aspiration without imaging guidance		158.17			64.46
10022	Fine needle aspiration with imaging guidance		152.65			188.17
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)		56.26	31.61	24.65	
88173	Cytopathology, evaluation of fine needle aspirate; *interpretation and report*		154.63	71.77	82.86	
88305	Surgical pathology, gross and microscopic examination		121.6	38.33	83.27	
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins		259.52	83.85	175.67	
G0202	Screening Mammogram, Digital, Bilateral	3	162.53	36.52	126.01	
G0204	Diagnostic Mammogram, Digital, Bilateral	3	194.18	44.97	149.21	
G0206	Diagnostic Mammogram, Digital, Unilateral	3	153.57	36.52	117.05	

00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3	4	21.01/unit			
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.					

CERVICAL SCREENING & DIAGNOSTIC PROCEDURES			Medicare 2011	Mod 26	Mod TC
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision		14.87		
88141	Cytopathology (conventional Pap test), cervical or vaginal, any reporting system, *requiring interpretation by physician*		31.25		
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	5	28.51		
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	6	28.51		
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	6	28.51		
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	6	37.28		
87621	Papillomavirus, Human, Amplified Probe • Hybrid Capture II from Digene - HPV Test [High Risk Typing, only] • Cervista HPV HR	7	49.39		
57452	Colposcopy of the cervix		116.38		
57454	Colposcopy of the cervix, with biopsy and endocervical curettage		162.9		
57455	Colposcopy of the cervix, with biopsy		153.04		
57456	Colposcopy of the cervix, with endocervical curettage		144.97		
57460	Endoscopy with loop electrode biopsy(s) of	9	323.05		

	the cervix				
57461	Endoscopy with loop electrode conization of the cervix	9	361.06		
57500	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)		145.15		
57505	Endocervical curettage (not done as part of a dilation and curettage)		111.03		
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	9	329.27		
57522	Loop electrode excision procedure	9	282.63		
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)		117.46		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	10	50.93		
88305	Surgical pathology, gross and microscopic examination		121.6	38.33	83.27
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen		101.14	63.05	38.09
88332	Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen		44.12	30.86	13.26
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)	8			

PROCEDURES SPECIFICALLY NOT ALLOWED

Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.	
Any	HPV testing for screening purposes	
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics	
Any	Magnetic Resonance Imaging (MRI) in breast cancer screening or diagnostics	

END NOTES

1	Effective January 1, 2010; CMS eliminated all consultation codes, which included codes that had been on this list: 99241, 99242, 99243, and 99244. As of that date, 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, and 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. [Source: NBCCEDP Blast Email, Dated 2/9/06 and NBCCEDP Blast Email, Dated 12/11/07.]
3	Effective July 1, 2009, the NBCCEDP the digital mammography policy is revised to allow payment for digital screening and diagnostic mammography up to the applicable rates approved by Medicare. [Source: Full Field Digital Mammography Policy Implementation Plan, dated November 4, 2008] Until July 1, 2009, digital mammography is approved for reimbursement at the conventional film mammography rate. [Source: Digital Mammography Policy Statement, Dated 10/6/05]
4	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
5	Effective July 2007, reimbursement for liquid-based cytopathology may be made at the appropriate Medicare rate (or less) for these CPT code(s). Programs are expected to provide the following: 1) a budget which incorporates the costs of using LBT on a biennial basis; 2) capability of using CPT codes and MDE codes which reflect which technology was utilized; 3) a method of ensuring that patients are not over screened; and 4) a patient and/or provider reminder system which prevents the loss of patients to follow-up, and ensures that women return biennially for cervical cancer screening. [Source: NBCCEDP Blast Email, Dated 12/20/2005]
6	These procedures must be reimbursed at the applicable 88142 Medicare reimbursement rate (or less). [Source: NBCCEDP Blast Email, Dated 9/27/06]
7	HPV DNA testing is a reimbursable procedure if used in the follow-up of an ASC-US result from the screening exam, or for surveillance at one year following an LSIL Pap test and no CIN2,3 on colposcopy-directed biopsy. 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 ≥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. [Source: 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests] The CDC will allow for reimbursement of Cervista HPV HR, however, only at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. CDC funds cannot be used for reimbursement of Cervista HPV 16/18. [Source: Ask Dr Miller Letter, June 2009]
8	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.
9	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations and according to their algorithm on the management of women with HSIL. 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 committee or designated clinical representative(s) review these cases in advance, and on an individual basis. [Source: NBCCEDP Blast Email, dated 5/27/04 and the NBCCEDP Policy & Procedures]
10	Added subsequent to "Ask Dr Lawson #9" correspondence: November 2007.

Prepared by:

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