CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BCCS OFFICE VISITS	
99201	**Office Visit - New Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes**	**$44.61**
99202	**Office Visit - New Patient; *expanded problem focused* history, exam, straightforward decision-making; 20 minutes**	**$76.20**
99203	**Office Visit - New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes**	**$110.25**
99204	**Office Visit - New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes.**	**$168.36**
99205	**Office Visit - New Patient; *comprehensive* history, exam, high complexity decision-making; 60 minutes.**	**$211.17**
99211	**Office Visit - Established Patient; *evaluation and management*, may not require physician; 5 minutes**	**$20.33**
99212	**Office Visit - Established Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes**	**$44.27**
99213	**Office Visit - Established Patient; *expanded problem focused* history, exam, low-complexity decision-making; 15 minutes**	**$74.42**
99214	**Office Visit - Established Patient; *detailed* history, exam, moderate complexity decision-making; 25 minutes**	**$109.65**

- Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN
- The CPT code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making
- 99204, 99205, and 99214 are uncommon office visits for the typical services provided through the BCCS program. Utilization review is performed on office visits
- No more than 1 BCCS office visit is billable on the same day
- 99204 and 99205 must meet the criteria for the code. These codes are not appropriate for screening visits
- 99211 does not require physician presence, although client evaluation and/or management are required; 99211 cannot be billed for client phone calls or patient navigation.
- Consultation visits are billed using office visit codes and may be billed on the same day as the BCCS office visit
- Global fee periods apply to certain diagnostic surgical procedures. Office visits are not allowed to be billed separately during the global fee periods
- Global fee periods do not apply to consultations with a breast or cervical specialist
- See specific diagnostic CPT codes for any global fee periods that may apply
- Mammography facilities cannot bill for office visits
- Neither the program, nor the patient, can be billed for "no show" visits

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
77053	**Mammary ductogram or galactogram, single duct, Global Fee**	**$59.50**
• May be billed with 77065, 77066, 76641, 76642 • Billable for clients with spontaneous nipple discharge and BI-RADS 1-3 after diagnostic mammogram • May not be billed with screening mammograms (77067, B7067) or MRI (77058, B7058, 77059, B7059) • BCCS performs utilization review on this service		
77058	**Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral, Global Fee**	**$543.98**
77059	**Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral, Global Fee**	**$543.98**
• May only be reimbursed for clients with one or more of the following: -BRCA mutation; -a first-degree relative who is a BRCA carrier; -a lifetime risk of 20% or greater, as defined by risk assessment models such as BRCAPRO/Gail Model; -radiation therapy to the chest between the ages of 10-30 years; -Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes. • May not be used alone as a breast cancer screening tool • May not be billed with B7058, B7059 • May be billed with diagnostic mammograms used for additional views • Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy • 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. • Preauthorization is required		

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES	
B7058	**AGES 40-49 Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral**	**$543.98**
B7059	**AGES 40-49 Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral**	**$543.98**

- May only be reimbursed for clients with one or more of the following:
  -BRCA mutation;
  -a first-degree relative who is a BRCA carrier;
  -a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model;
  -radiation therapy to the chest between the ages of 10-30 years;
  -Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes.
- May not be used alone as a breast cancer screening tool
- May not be reimbursed with 77058, 77059
- May be billed with diagnostic mammograms used for additional views
- Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy
- 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.
- Preauthorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
77067	**Screening Mammogram, Bilateral, including computer-aided detection (CAD) when performed, Global Fee**	**$139.92**
77065	**Diagnostic Mammogram, Unilateral, including computer-aided detection (CAD) when performed, Global Fee**	**$136.55**
77066	**Diagnostic Mammogram, Bilateral, including computer-aided detection (CAD) when performed, Global Fee**	**$173.24**

- A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants and/or a history of breast cancer/lumpectomy
- A screening mammogram, on occasion, may precede the Clinical Breast Exam, i.e. mobile mammograms
- An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided
- Bundled codes are reimbursed at CMS G-code mammogram rates

CPT CODE	CODE DESCRIPTIONS	RATE
B7067	**AGES 40-49 Screening Mammogram, Bilateral, including computer-aided detection (CAD) when performed, Global Fee**	**$139.92**

- Must be used to bill screening mammograms for women 40 to 49 years of age
- Women in this age group may receive a mammogram every two (2) years or annually if high risk per risk assessment tool – see breast clinical guidelines
- The guidelines for 77067 apply to B7067. The guidelines for 77067 apply to B7067

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
G0279	**Diagnostic digital breast tomosynthesis, unilateral or bilateral**	**$57.07**
77063	**Screening digital breast tomosynthesis, bilateral**	**$57.07**

- G0279 can be billed with 77066 or 77065
- 77063 can be billed with 77067

19000	**Puncture Aspiration of Breast Cyst**	**$116.38**

- 19000 may be billed once per breast regardless of the number of lesions
- 19000 may be billed with 76942
- Pathology (88305 or 88173) may not be reimbursed with 19000
- Office visit codes on the day of the procedure are not payable (Global Fee Period 000)

19100	**Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Office)**	**$154.91**
F9100	**Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Facility)**	**$72.94**
100FX	**Facility fee for needle core biopsy**	**$526.74**

- 19100 and F9100 may only be billed once per breast, regardless of the number of specimens
- 19100 cannot be billed with 00400 or 100FX
- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 100FX may be billed with F9100; but only once
- 00400 may be billed with F9100 and 100FX for the total anesthesia units provided, up to the 8 unit maximum
- 88305 may be billed for up to 6 biopsy specimens per breast
- Office visit codes on the day of the procedure are not payable (Global Fee Period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19101	**Incisional Breast Biopsy; one or more lesions (Physician in Office)**	**$351.34**
F9101	**Incisional Breast Biopsy; one or more lesions (Physician in Facility)**	**$230.20**
101FX	**Facility fee for incisional breast biopsy**	**$1,223.47**

- 19101 and F9101 may be billed only once (per breast) regardless of the number of lesions
- 76098 (if indicated) may be billed for each lesion, up to the maximum of 3 per breast
- 88305 may be billed for up to 6 biopsy specimens per breast
- 101FX may be billed once with F9101
- 19101 cannot be billed with 00400
- 00400 may be billed with F9101 for the total anesthesia units provided, up to the 8 unit maximum
- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammogram or MRI codes
- May be billed with image guided preoperative placement of breast localization devices 19281-F9288 and their associated facility codes
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19120	**Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Office)**	**$510.13**
F9120	**Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Facility)**	**$429.61**
120FX	**Facility fee for excisional breast biopsy**	**$1,223.47**
• May be billed only once per breast regardless of the number of lesions • 120FX may be billed once with F9120. 76098 may be billed if indicated for each lesion up to the maximum of 3 per breast • 88305 may be billed for up to 6 biopsy specimens per breast • 00400 cannot be billed with 19120 • 00400 may be billed with F9120 for the total anesthesia units provided, up to the maximum of 8 • May not be used with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes • May be billed with imaging guided preoperative wire placement (19281-F9288 and associated facility codes) • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)		
19125	**Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (Physician in Facility)**	**$477.58**
125FX	**Facility fee for excision of abnormal breast tissue, duct, nipple or areolar lesion/preoperative placement of radiological marker, single lesion.**	**$1,223.47**
19126	**Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (Physician in Facility)**	**$168.92**
• 19125 may be billed only once per breast, regardless of the number of lesions • 19126 may only be billed for up to 2 additional lesions. • 125FX may be billed once with 19125 • 76098 may be billed if indicated for each lesion, up to the maximum of 3 • 88305 may be billed for up to 6 biopsy specimens per breast • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum	• May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI • 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed • For 19125-Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) • For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ)	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *first lesion*; Global Fee (Physician in Office)**	**$714.41**
F9081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *first lesion*; Global Fee (Physician in Facility)**	**$177.62**
19082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *each additional lesion* (Physician in Office)**	**$591.13**
F9082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *each additional lesion* (Physician in Facility)**	**$88.82**
812FX	**Facility fee for percutaneous breast biopsy using *stereotactic guidance; one or more lesions***	**$526.74**

- 19081 and F9081 can only be billed once per breast, regardless of the number of lesions
- 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast
- May not be billed with 19281-F9288 or associated facility codes
- 88305 may be billed for up to 6 biopsy specimens per breast
- 76098 may be billed for each lesion up the maximum of 3, if indicated
- 000400 cannot be billed with 19081 or 19082. May be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 812FX may be billed with once with F9081 and F9082
- Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance; first lesion* (Physician in Office)**	**$690.90**
F9083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance; first lesion* (Physician in Facility)**	**$166.44**
19084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance; each additional lesion* (Physician in Office)**	**$568.75**
F9084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance; each additional lesion* (Physician in Facility)**	**$83.40**
834FX	**Facility fee for percutaneous breast biopsy using *ultrasound guidance; one or more lesions***	**$526.74**
• 19083 and F9083 may only be billed once per breast regardless of the number of lesions • 19084 and F9084 may be billed up to the maximum of 2 additional lesions per breast • May not be billed with 19281-F9288 or associated facility codes • 88305 may be billed for up to 6 biopsy specimens per breast • 76098 may be billed for each lesion up the maximum of 3, if indicated	• 00400 cannot be billed with 19083 or 19084 • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum • Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes • 834FX may be billed once with F9083 and F9084 • Office visits not reimbursable on day of procedure	
F9085	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance; first lesion* Global Fee (Physician in Facility)**	**$195.45**
F9086	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance; each additional lesion* Global Fee (Physician in Facility)**	**$96.88**
856FX	**Facility fee for percutaneous breast biopsy using *MRI guidance, one or more lesions***	**$790.85**
• F9085 may only be billed once per breast regardless of the number of lesions • May only be performed in a facility with dedicated breast MRI equipment. • Preauthorization is required • F9086 may be billed up to the maximum of 2 additional lesions per breast • May not be billed with 19281-F9288 or associated facility codes • 88305 may be billed for up to 6 biopsy specimens per breast	• 76098 may be billed for each lesion up the maximum of 3, if indicated • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum • Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes • 856FX may be billed once with F9085 • Office visits not reimbursable on day of procedure	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19281	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *first lesion* (Physician in Office)**	**$246.69**
F9281	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *first lesion* (Physician in Facility)**	**$106.33**
19282	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *each additional lesion* (Physician in Office)**	**$172.65**
F9282	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *each additional lesion* (Physician in Facility)**	**$53.32**

- May only be billed with incisional/excisional biopsy and their associated facility codes
- Facility fees are included with the primary procedure code
- 19281 and F9281 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 00400 cannot be billed with 19281 or 19282
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES	
19283	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *first lesion* (Physician in Office)**	**$277.46**
F9283	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *first lesion* (Physician in Facility)**	**$106.99**
19284	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *each additional lesion* (Physician in Office)**	**$209.24**
F9284	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *each additional lesion* (Physician in Facility)**	**$54.01**

- May only be billed with incisional/excisional biopsies and their associated facility codes
- Facility fees are included with the primary procedure code
- 19283 and F9283 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 00400 cannot be billed with 19283 or 19284
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
19285	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *first lesion* (Physician in Office)**	**$530.71**
F9285	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *first lesion* (Physician in Facility)**	**$90.69**
19286	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *each additional lesion* (Physician in Office)**	**$467.07**
F9286	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *each additional lesion* (Physician in Facility)**	**$45.70**

- May only be billed with incisional/excisional biopsies and their associated facility codes
- Facility fees are included with the primary procedure code
- 19285 and F9285 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 00400 cannot be billed with 19283 or 19284
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
F9287	**Preoperative placement of breast localization device, percutaneous; *magnetic resonance* guidance; *first lesion* (Physician in Facility)**	**$136.04**
F9288	**Preoperative placement of breast localization device, percutaneous; *magnetic resonance* guidance; *each additional lesion* (Physician in Facility)**	**$67.87**
• Codes using magnetic resonance imaging may only be performed in a facility with dedicated breast MRI equipment • Facility fees are included with the primary procedure code • Preauthorization is required • May only be billed with incisional/excisional biopsies and their associated facility codes • F9287 may only be billed once per breast regardless of the number of lesions	• Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-F9086 or their associated facility codes • Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes • 00400 may be billed with to reflect anesthesia units provided, up to the 8 unit maximum • Office visits not reimbursable on day of procedure	
00400	**Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified.**	**$22.88**
• Bill for the total number of units provided up to the maximum of 8 units • Total Units = (3 base units plus time units)	• One time unit equals 15 minutes • 00400 may only be billed with allowable BCCS facility codes	
76098	**Radiological examination, surgical specimen**	**$17.04**
• May be billed to reflect each lesion present, up to the maximum of 3 per breast		
76641	**Ultrasound, *complete* examination of breast including axilla, unilateral**	**$110.31**
76642	**Ultrasound, *limited* examination of the breast including axilla, unilateral**	**$90.72**
• May not be billed with 76942. • 76641 used when four quadrants of the breast are examined	• 76642 used when fewer than four quadrants of the breast are examined • May be billed to reflect each breast examined	
76942	**Ultrasonic guidance for needle placement, imaging supervision and interpretation**	**$62.42**
• May be billed to reflect each lesion present, up to the maximum of 3 per breast	• May only be billed with 19000.May not be billed with 76641, 76642.	

CPT CODE	CODE DESCRIPTIONS		
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES			
10022	**Fine Needle Aspiration, with imaging guidance**		**$145.08**
• FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer. May be reimbursed for evaluation of abnormal lymph nodes for breast cancer staging and may not be reimbursed to evaluate a breast mass		• 10022 may be billed with 88173 • BCCS performs utilization review on this service	
88173	**Cytopathology Interpretation and Report of Fine Needle Aspiration**		**$157.61**
• FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer • 88173 may be billed to evaluate the aspirate of each abnormal lymph node for the purpose of breast cancer staging		• 88173 may only be billed with 10022 • 88173 requires cytologic expertise	
88305	**Surgical pathology, gross and microscopic examination of breast biopsy not requiring microscopic evaluation of surgical margins**		**$75.18**
• 88305 may be billed for up to 6 biopsy specimens per breast			

CPT CODE	CODE DESCRIPTIONS		RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES			
87624	**HPV, high-risk type**		**$47.80**
• Used for cytology and HPV co-testing every 5 years for women ages 30 and over and management of specific abnormal Pap tests • Must be ordered by a provider and not done as part of lab protocol • When a conventional Pap test result is ASC-US, a follow-up office visit may be billed to collect the reflex HPV test		• When a liquid based Pap test result is ASC-US, the HPV test can be done on the original specimen and a follow-up visit for HPV testing cannot be billed • Refer to cervical algorithms for indications for HPV testing • HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
88141	**Pap Test – physician's interpretation (Bethesda System)**	**$33.42**
	• Each laboratory may develop their own policy for indications for the pathologist's review of Pap slides • 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 test service • The BCCS program monitors utilization. No greater than 5% of Pap tests provided by a contractor should require physician (pathologist) review	
88142	**Pap Test – liquid based, cytologist's interpretation (Bethesda System)**	**$27.60**
	• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines	
88143	**Pap Test-cytopathology, cervical, collected in preservative fluid, automated thin layer prep; manual screening and rescreening under physician supervision**	**$27.60**
	• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines	
88164	**Pap Test – cytologist's interpretation (Bethesda System)**	**$14.39**
	• As indicated. Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines	
88174	**Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system under physician supervision**	**$29.11**
	• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines	
88175	**Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system and manual rescreening under physician supervision**	**$36.09**
	• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines	
88305	**Surgical pathology, gross and microscopic examination of cervical biopsy**	**$75.18**
	• May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy	
88307	**Surgical Pathology, gross and microscopic examination (cervix, conization)**	**$316.52**
	• May be billed with 57461, 57520, 57522 and their associated facility codes • May be billed for up to 4 specimens per cervical conization procedure	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57452	**Colposcopy of the cervix**	**$111.98**
• May be billed only once regardless of the number of lesions	• Office visit codes on the day of the procedure are not payable (Global fee period 000)	
57454	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)**	**$156.97**
F7454	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)**	**$139.92**
454FX	**Facility fee for colposcopy with cervical biopsy(s) and endocervical curettage**	**$61.58**
• 57454 and F7454 may be billed only once regardless of the number of lesions • 88305 may be billed for up to 5specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy • May not be billed with 88307 • May not be billed with colposcopy: 57452, 57455, 57456, 57460, 57461 or their associated facility codes • 00940 cannot be billed with 57454	• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum • 454FX may be billed once with F7454 • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review of F7454 and 454FX. Preauthorization is required	
57455	**Colposcopy with biopsy(s) of the cervix (Physician in Office)**	**$146.44**
F7455	**Colposcopy with biopsy(s) of the cervix (Physician in Facility)**	**$114.16**
455FX	**Facility fee for colposcopy with biopsy(s) of the cervix**	**$64.81**
• May be billed only once, regardless of the number of lesions • 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on cervix • May not bill with 88307 • May not be billed with colposcopy: 57452, 57454, 57456, 57460, 57461 or their associated facility codes • F7455 may be billed once with 455FX	• 00940 cannot be billed with 57455 • 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review of F7455 and 455FX. Preauthorization is required	

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES</th></tr>
<tr><td>57456</td><td colspan="2">Colposcopy with endocervical curettage (Physician in Office)</td><td>$138.11</td></tr>
<tr><td>F7456</td><td colspan="2">Colposcopy with endocervical curettage (Physician in Facility)</td><td>$106.19</td></tr>
<tr><td>456FX</td><td colspan="2">Facility fee for colposcopy with endocervical curettage</td><td>$61.94</td></tr>
<tr><td colspan="2">• May be billed only once regardless of the number of lesions
• 88305 may only be billed once
• May not be billed with 88307
• 00940 cannot be billed with 57456
• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</td><td colspan="2">• May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes
• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• F7456 may be billed once with 456FX
• BCCS performs utilization review of F7456 and 456FX. Preauthorization is required</td></tr>
<tr><td>57460</td><td colspan="2">Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)</td><td>$289.68</td></tr>
<tr><td>F7460</td><td colspan="2">Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)</td><td>$167.81</td></tr>
<tr><td>460FX</td><td colspan="2">Facility fee for colposcopy with loop electrode biopsy(s)</td><td>$172.58</td></tr>
<tr><td colspan="2">• May be billed only once, regardless of the number of lesions
• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes
• 00940 cannot be billed for 57460
• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum
• 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix</td><td colspan="2">• May not bill with 88307
• F7460 may be billed once with 460FX
• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• BCCS performs utilization review of F7460 and 460FX. Preauthorization is required</td></tr>
</table>

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES</th></tr>
<tr><td>57461</td><td colspan="2">Colposcopy with loop electrode conization of the cervix (Physician in Office)</td><td>$327.36</td></tr>
<tr><td>F7461</td><td colspan="2">Colposcopy with loop electrode conization of the cervix (Physician in Facility)</td><td>$193.52</td></tr>
<tr><td>461FX</td><td colspan="2">Colposcopy with loop electrode conization of the cervix (Facility Fee)</td><td>$185.82</td></tr>
<tr><td colspan="2">• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460 and their associated facility codes
• 57461 may be billed only once and may not be billed with F7461, 461FX or anesthesia
• 88307 may be billed for up to 4 specimens
• 88305 may not be billed with 57461 or F7461</td><td colspan="2">• F7461 may be billed once with 461FX. Preauthorization is required
• 00940 may not be billed with 57461
• 00940 may be billed for the total units of anesthesia provided, up to the 8 unit maximum
• No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility</td></tr>
<tr><td>57500</td><td colspan="2">Biopsy(s) of cervix (Physician in Office)</td><td>$130.88</td></tr>
<tr><td colspan="2">• 88305 may be billed with 57500 for up to 4 specimens to reflect multiple biopsy sites on cervix
• May not be billed with 88307</td><td colspan="2">• Office visit codes on the day of the procedure are not payable (Global fee period 000)</td></tr>
<tr><td>57505</td><td colspan="2">Endocervical curettage (Physician in Office)</td><td>$104.74</td></tr>
<tr><td colspan="2">• May be billed only once
• 88305 may be billed once with 57505
• May not be billed with 88307</td><td colspan="2">• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</td></tr>
</table>

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57520	**Conization of the cervix; excision by cold knife or laser (Physician in Facility)**	**$283.65**
520FX	**Facility fee for conization of the cervix (excision by cold knife or laser method)**	**$1,040.74**
• 57520 may be billed only once • 88307 may be billed with 57520 for up to 4 specimens • May not be billed with 88305 • 00940 may be billed for the units of anesthesia provided, up to the 8 unit maximum • 57520 must be performed in a certified ambulatory surgery center or day surgery facility	• 520FX may be billed once with 57520 • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) • BCCS performs utilization review of this service	
57522	**Conization of cervix (LEEP); (Physician in office)**	**$270.02**
F7522	**Conization of cervix (LEEP); (Physician in Facility)**	**$250.44**
522FX	**Facility fee for Conization of cervix (excision by LEEP method)**	**$1,040.74**
• 57522 may be billed only once and may not be billed with F7522, 522FX or anesthesia • May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or associated facility codes • 88307 may be billed for up to 4 specimens • May not be billed with 88305 • F7522 may be billed only once with 522FX. Preauthorization is required	• 00940 may be billed with F7522 for the total units of anesthesia provided, up to the 8 unit maximum • No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090). BCCS performs utilization review of this service	
00940	**Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.**	**$22.88**
• Bill for the total number of units provided up to a maximum of 8 units • Total Units = (3 base units plus time units). One time unit equals 15 minutes	• 00940 may only be billed with allowable BCCS procedures performed in a facility	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)**	**$49.31**
F8110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)**	**$42.05**

- Must be billed with a colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or their associated facility codes
- 00940 may not be billed with 58110
- 00940 may be billed to reflect anesthesia, up to the maximum of 8 units
- F8110 requires preauthorization
- Code related to another service and is always included in the global period of the other service (Global fee period ZZZ)
- Utilization review is performed on this service

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES		
93000	**ECG**	**$17.40**

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions.(ASA Grade 2 or 3)
- For BCCS diagnostic services only
- Refer to the American Society of Anesthesiologists for (ASA) grades.
- Utilization review is performed on this service

CPT CODE	CODE DESCRIPTIONS	RATE
80048	**Basic Metabolic Panel (Chem 6)**	**$11.52**
80053	**Comprehensive Metabolic Panel (Chem 12)**	**$14.39**

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3)
- For BCCS diagnostic services only
- 88048 may not be billed with 88053
- No greater than 7% clients receiving anesthesia should undergo these tests. Utilization review is performed on these services

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES</th></tr>
<tr><td>81025</td><td colspan="2">Urine Pregnancy Test</td><td>$8.61</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for women of child-bearing age. May not be used as routine pregnancy screening</td><td colspan="2">• For BCCS diagnostic services only
• BCCS performs utilization review on this service
• Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline.</td></tr>
<tr><td>85025</td><td colspan="2">CBC, automated with differential</td><td>$10.59</td></tr>
<tr><td>85027</td><td colspan="2">CBC, automated</td><td>$8.81</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grade 2 or 3)
• For BCCS diagnostic services only</td><td colspan="2">• 85025 cannot be billed with 85027
• No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</td></tr>
<tr><td>85610</td><td colspan="2">Prothrombin Time (PT)</td><td>$5.36</td></tr>
<tr><td>85730</td><td colspan="2">Partial Thromboplastin Time (PTT)</td><td>$8.18</td></tr>
<tr><td>85384</td><td colspan="2">Fibrinogen</td><td>$11.57</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3)
• For BCCS diagnostic services only</td><td colspan="2">• 8610, 85730 and 85384 may be billed together
• No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</td></tr>
<tr><td>71010</td><td colspan="2">Chest X-Ray, AP (1 View)</td><td>$22.85</td></tr>
<tr><td>010FX</td><td colspan="2">Facility fee for Chest X-Ray, AP (1 view)</td><td>$12.89</td></tr>
<tr><td>71020</td><td colspan="2">Chest X-Ray, AP and Lateral (2 views)</td><td>$28.30</td></tr>
<tr><td>020FX</td><td colspan="2">Facility fee for Chest X-Ray, AP and Lateral (2 views)</td><td>$16.47</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3)
• For BCCS diagnostic services only</td><td colspan="2">• 71010 and 010FX cannot be billed with 71020 or 020FX
• No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</td></tr>
</table>

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
44410	**Medicaid for Breast and Cervical Cancer (MBCC) Comprehensive Visit**	**$122.31**
• 44410 may only be billed for a client diagnosed with breast or cervical cancer by a non-BCCS provider who is referred to your agency for completion of the MBCC application • No BCCS screening or diagnostic funds were used for the cancer diagnosis • 44410 may only be billed by one BCCS contractor, **one time only per cancer diagnosis**, upon completion of the MBCC assessment, service plan, and application • Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT • 44410 reimbursement requires completion of the Med-IT patient navigation module	• 44410 may only be billed with 44413 and may not be billed with any other codes, including patient navigation codes: 99910, 99913, 88810, and 88813 • May not be billed for a reinstatement, renewal, or client transferring from another state • **If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, HHSC may withhold or recover payment** • May not be billed with SC100	
44413	**Medicaid for Breast and Cervical Cancer (MBCC) Telephone call (or in-person visit)**	**$29.36**
• May be billed up to a maximum of 3 follow-up phone calls • Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT • May not be billed with SC100		
99910	**Patient Navigation for abnormal breast cancer screening (abnormal CBE or mammogram, diagnostic tests required)**	**$122.31**
• 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan • 99910 reimbursement requires completion of Med-IT patient navigation module	• May not bill with 44410, 44413, 88810 or 88813 • May not be billed for a reinstatement, renewal, or client transferring from another state	
99913	**BCCS Follow-up Visit (telephone)**	**$29.36**
• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities • May not bill with 44410, 44413, 88810 or 88813		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
SC100	**Service Coordination**	**$50.00**
	• SC100 reimbursement requires insurance assessment with Marketplace referral and Med-IT documentation in *Cycle Initiation -> Insurance Referral* • 'Marketplace Referral' types are variable by contractor and may include handouts, on-site assistance, counselor referrals, etc. • May only be billed by one BCCS contractor, one time per year • May not be billed for clients that are BCCS ineligible • May not be billed for MBCC referred-in clients - 44410	
88810	**Patient Navigation for abnormal cervical cancer screening (diagnostic test required)**	**$122.31**
	• 88810 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan • 88810 reimbursement requires completion of Med-IT patient navigation module • May not bill with 44410, 44413, 99910 or 99913 • May not be billed for a reinstatement, renewal, or client transferring from another state	
88813	**Follow-up Visit (telephone)**	**$29.36**
	• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities • May not bill with 44410, 44413, 99910 or 99913	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD202	**Office Visit - New Patient; *expanded problem focused* history, exam, straightforward decision-making; 20 minutes**	**$76.20**
CD203	**Office Visit - New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes**	**$110.25**
CD204	**Office Visit - New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes.**	**$168.36**
CD211	**Office Visit - Established Patient; *evaluation and management*, may not require physician; 5 minutes**	**$20.33**
CD212	**Office Visit - Established Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes**	**$44.27**
CD213	**Office Visit - Established Patient; *expanded problem focused* history, exam, low-complexity decision-making; 15 minutes**	**$74.42**
CD214	**Office Visit - Established Patient; *detailed* history, exam, moderate complexity decision-making; 25 minutes**	**$109.65**

- Office visits may only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN
- The "CD" code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making
- CD204 & CD214 are uncommon office visits for typical services provided under Title V dysplasia
- Utilization review is performed on office visits
- No more than 1 office visit s billable on the same day
- CD211 does not require physician presence, although client evaluation and/or management are required; CD211 is not billable for client phone calls.
- Global fee periods apply to certain management and treatment procedures. Office visits are not allowed to be billed separately during some global fee periods
- See specific CD, FCD and FCX management & treatment procedure codes for any global fee periods that may apply
- Neither BCCS, nor the patient, can be billed for "no show" visits

NOTE:
CD202 corresponds to 99202
CD203 corresponds to 99203
CD204 corresponds to 99204
CD212 corresponds to 99212
CD213 corresponds to 99213
CD214 corresponds to 99214

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>CD810</td><td colspan="2">Patient Navigation for “Referred-In” to Dysplasia Treatment Services</td><td>$122.31</td></tr>
<tr><td colspan="2">• CD810 may be billed for patient navigation services for a client who was referred-in for cervical dysplasia management & treatment
• CD810 may not be billed with 88810 or 88813</td><td colspan="2">• CD810 may only be billed by one BCCS contractor, one time only, per problem, and upon completion of the assessment and service plan
• NOTE: CD810 corresponds to 88810</td></tr>
<tr><td>CD624</td><td colspan="2">HPV, high-risk types</td><td>$47.80</td></tr>
<tr><td colspan="2">• Use for management of dysplasia per dysplasia algorithms
• Must be ordered by a provider and not done as part of lab protocol</td><td colspan="2">• HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated
• NOTE: CD624 corresponds to 87624</td></tr>
<tr><td>CD141</td><td colspan="2">Pap Test – Physician’s interpretation</td><td>$33.42</td></tr>
<tr><td colspan="2">• May be billed as the professional component with CD142 and CD164 as applicable
• Each laboratory may develop their own policy for pathologist review of cervical Pap slides</td><td colspan="2">• No greater than 5% of Pap tests provided should require pathologist review
• BCCS performs utilization review of this service</td></tr>
<tr><td>CD142</td><td colspan="2">Pap Smear – liquid based</td><td>$27.60</td></tr>
<tr><td colspan="4">• Use for management of dysplasia per cervical dysplasia algorithms
• NOTE: CD142 corresponds to 88142</td></tr>
<tr><td>CD164</td><td colspan="2">Pap Smear– conventional</td><td>$14.39</td></tr>
<tr><td colspan="4">• Use for management of dysplasia per dysplasia algorithms
• NOTE: CD164 corresponds to 88164</td></tr>
</table>

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD452	**Colposcopy**	**$111.98**
• May be billed only once • Office visit codes on the day of the procedure are not payable (Global fee period 000). • NOTE: CD452 corresponds to 57452		
CD455	**Colposcopy with biopsy(s) of the cervix (Physician in Office)**	**$146.44**
FCX55	**Colposcopy with biopsy(s) of the cervix (Physician in Facility)**	**$114.16**
FCD55	**Facility fee for colposcopy with biopsy(s) of the cervix**	**$64.81**
• May be billed only once • CD305 may be billed with CD455 and FCX55 up to 4 times to reflect multiple biopsy sites on the cervix • Cannot be billed with colposcopy codes • FCD55 may be billed once with FCX55 • CD940 cannot be billed with CD455	• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review on FCX55/FCD55. Preauthorization is required • NOTE: CD455 corresponds to 57455 FCX55 corresponds to F7455 FCD55 corresponds to 455FX	
CD456	**Colposcopy with endocervical curettage (Physician in Office)**	**$138.11**
FCX56	**Colposcopy with endocervical curettage (Physician in Facility)**	**$106.19**
FCD56	**Facility fee for colposcopy with endocervical curettage**	**$61.94**
• May be billed only once • CD305 may be billed only once with CD456 and FCX56. • Cannot be billed with colposcopy codes • CD940 cannot be billed with CD456 • CD940 can be billed to reflect anesthesia provided, up to the maximum of 8	• FCD56 may be billed once with FCX56 • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review on FCX56/FCD56. Preauthorization is required • NOTE: CD456 corresponds to 57456 FCX56 corresponds to F7456 FCD56 corresponds to 456FX	

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>CD460</td><td colspan="2">Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)</td><td>$289.68</td></tr>
<tr><td>FCX60</td><td colspan="2">Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)</td><td>$167.81</td></tr>
<tr><td>FCD60</td><td colspan="2">Facility fee for colposcopy with loop electrode biopsy(s) of the cervix</td><td>$172.58</td></tr>
<tr><td colspan="2">• May be billed only once
• CD305 may be billed with CD460 and FCS60 up to 4 times to reflect multiple biopsy sites on the cervix
• May not be billed with colposcopy codes
• FCD60 may be billed once with FCX60
• CD940 cannot be billed with CD460</td><td colspan="2">• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units
• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• BCCS performs utilization review on FCX60/FCD60. Preauthorization is required
• NOTE: CD460 corresponds to 57460
FCX60 corresponds to F7460
FCD60 corresponds to 460FX</td></tr>
<tr><td>CD461</td><td colspan="2">Colposcopy with loop electrode conization of the cervix (Physician in Office)</td><td>$327.36</td></tr>
<tr><td>FCX61</td><td colspan="2">Colposcopy with loop electrode conization of the cervix (Physician in Facility)</td><td>$193.52</td></tr>
<tr><td>FCD61</td><td colspan="2">Facility fee for colposcopy with loop electrode conization of the cervix</td><td>$185.82</td></tr>
<tr><td colspan="2">• May be billed only once
• CD307 may be billed up to 4 times to reflect multiple biopsy sites on the cervix
• May not be billed with colposcopy codes
• FCD61 may be billed once with FCX61
• CD940 cannot be billed with CD461</td><td colspan="2">• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units
• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• NOTE: CD461 corresponds to 57461
FCX61 corresponds to F7461
FCD61 corresponds to 461FX
• BCCS performs utilization review of FCX61 AND FCD61. Pre-authorization is required</td></tr>
</table>

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<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>CD454</td><td colspan="2">Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)</td><td>$156.97</td></tr>
<tr><td>FCX54</td><td colspan="2">Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)</td><td>$139.92</td></tr>
<tr><td>FCD54</td><td colspan="2">Facility fee for colposcopy with biopsy(s) and endocervical curettage</td><td>$61.58</td></tr>
<tr><td colspan="2">• May be billed only once
• May not be billed with colposcopy codes
• CD305 may be billed up to 5 times to reflect 4 biopsy sites on the cervix and one (1) ECC biopsy
• CD940 cannot be billed with CD454
• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.</td><td colspan="2">• FCD54 may be billed once with FCX54
• Office visit codes on the day of the procedure are not payable (Global fee period 000)
• BCCS performs utilization review on FCX54/FCD54. Preauthorization is required
• NOTE: CD454 corresponds to 57454
FCX54 corresponds to F7454
FCD54 corresponds to 454FX</td></tr>
<tr><td>CD505</td><td colspan="2">Endocervical curettage (Physician in Office)</td><td>$104.74</td></tr>
<tr><td colspan="2">• May be billed only once.
• CD305 may be billed once with CD505.
• May not be billed with CD307.</td><td colspan="2">• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010).</td></tr>
<tr><td>CD511</td><td colspan="2">Cryotherapy: cryocautery, initial or repeat</td><td>$148.65</td></tr>
<tr><td colspan="2">• There is no pathology associated with CD511 because a biopsy is not performed with this procedure
• Decision to repeat is based upon provider medical decision-making and adherence to algorithms</td><td colspan="2">• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)
• NOTE: CD511 corresponds to 57511
• BCCS performs utilization review of this service</td></tr>
<tr><td>CD513</td><td colspan="2">Cervical Cautery with laser ablation</td><td>$148.91</td></tr>
<tr><td colspan="2">• There is no pathology associated with CD513 because a biopsy is not performed with this procedure
• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</td><td colspan="2">• NOTE: CD513 corresponds to 57513
• BCCS performs utilization review of this service</td></tr>
</table>

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<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>FCX20</td><td colspan="2">Cervical Conization with cold knife or laser (Physician in Facility)</td><td>$ 283.65</td></tr>
<tr><td>FCD20</td><td colspan="2">Facility fee for Cervical Conization with cold knife or laser</td><td>$1,040.74</td></tr>
<tr><td colspan="2">• FCX20 must be performed in a certified ambulatory surgical center or a day surgery facility
• FCX20 may be billed only once
• FCD20 may be billed with FCX20 for the facility fee
• CD307 may be billed with FCX20for up to 4 specimens per cervical conization procedure
• Cannot be billed with CD305</td><td colspan="2">• CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum
• Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)
• NOTE: FCX20 corresponds to 57520
FCD20 corresponds to 520FX
• BCCS performs utilization review of this service</td></tr>
<tr><td>CD522</td><td colspan="2">Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Office)</td><td>$270.02</td></tr>
<tr><td>FCX22</td><td colspan="2">Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Facility)</td><td>$250.44</td></tr>
<tr><td>FCD22</td><td colspan="2">Facility fee for Cervical Conization with Loop Electrode Excision (LEEP)</td><td>$1,040.74</td></tr>
<tr><td colspan="2">• CD522 may be billed only once and cannot be billed with FCX22, FCD22, or CD940
• CD522 and FCX22 may not be billed with CD452, CD454, CD455, CD456, CD460, CD461 or their associated facility codes
• CD307 may be billed with CD522 or FCX22for up to 4 specimens
• May not be billed with CD305
• FCD22 may be billed once with FCX22.
• CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum
• No greater than 20% of conization LEEPs should be done in a certified, ambulatory surgical center or a day surgery facility</td><td colspan="2">• Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)
• NOTE: CD522 corresponds to 57522
FCX22 corresponds to F7522
FCD22 corresponds to 522FX
• BCCS performs utilization review of this service</td></tr>
</table>

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<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>CD811</td><td colspan="2">Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)</td><td>$49.31</td></tr>
<tr><td>FCX81</td><td colspan="2">Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)</td><td>$42.05</td></tr>
<tr><td colspan="2">• May be billed only once
• CD811 must be billed with a colposcopy
• Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater if:
○ Client 35 or more years of age, or
○ At risk for endometrial neoplasia (see BCCS algorithms).
• CD940 cannot be billed with CD811
• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units</td><td colspan="2">• Code related to another service and is always included in the global period of the other service (Global fee period ZZZ).
• Utilization review is performed on this service
• Pre-authorization is required for FCX81</td></tr>
<tr><td>CD940</td><td colspan="2">Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.</td><td>$22.88</td></tr>
<tr><td colspan="2">• Bill for the total number of units provided, up to the 8 unit maximum.
• Total Units= (3 base units plus time units). One time unit equals 15 minutes</td><td colspan="2">• CD940 may only be billed with allowable facility codes FCD20 or FCD22.
• NOTE: CD940 corresponds to 00940</td></tr>
<tr><td>CD305</td><td colspan="2">Surgical Pathology - cervical biopsy</td><td>$75.18</td></tr>
<tr><td colspan="4">• May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix and 1 ECC biopsy
• May only be billed once with CD505
• NOTE: CD305 corresponds to 88305</td></tr>
<tr><td>CD307</td><td colspan="2">Surgical Pathology – cervical conization</td><td>$316.52</td></tr>
<tr><td colspan="4">• May be billed for up to 4 specimens per cervical conizations procedure.
• NOTE: CD307 corresponds to 88307</td></tr>
<tr><td>CD930</td><td colspan="2">ECG</td><td>$17.40</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grade 2 or 3)
• For CD treatment services only</td><td colspan="2">• Utilization review is performed on this service
• CD930 corresponds to 93000</td></tr>
</table>

<table>
<tr><th>CPT CODE</th><th colspan="2">CODE DESCRIPTIONS</th><th>RATE</th></tr>
<tr><th colspan="4">BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</th></tr>
<tr><td>CD048</td><td colspan="2">Basic Metabolic Panel (Chem 6)</td><td>$11.52</td></tr>
<tr><td>CD053</td><td colspan="2">Comprehensive Metabolic Panel (Chem 12)</td><td>$14.39</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)
• CD048 cannot be billed with CD053
• For CD treatment services only</td><td colspan="2">• Utilization review is performed on this service
• CD048 corresponds to 80048
• CD053 corresponds to 88053</td></tr>
<tr><td>CD125</td><td colspan="2">Urine Pregnancy Test</td><td>$8.61</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)
• For CD treatment services only</td><td colspan="2">• Utilization review is performed on this service
• CD125 corresponds to 81025
• Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline.</td></tr>
<tr><td>CD025</td><td colspan="2">CBC, automated with differential</td><td>$10.59</td></tr>
<tr><td>CD027</td><td colspan="2">CBC, automated</td><td>$8.81</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)
• For CD treatment services only
• CD025 corresponds to 85025</td><td colspan="2">• CD025 cannot be billed with CD027
• CD027 corresponds to 85027</td></tr>
<tr><td>CD610</td><td colspan="2">Prothrombin Time (PT)</td><td>$5.36</td></tr>
<tr><td>CD730</td><td colspan="2">Partial Prothrombin Time (PTT)</td><td>$8.18</td></tr>
<tr><td>CD384</td><td colspan="2">Fibrinogen</td><td>$11.57</td></tr>
<tr><td colspan="2">• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)
• For CD treatment services only
• CD610, CD730 and CD384 may be billed together
• BCCS performs utilization review on this service</td><td colspan="2">• CD610 corresponds to 85610
• CD730 corresponds to 85730
• CD384 corresponds to 85384</td></tr>
</table>

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD710	**Chest X-Ray, AP (1 view)**	**$22.85**
FCD01	**Facility fee for Chest X-Ray, AP (1 view)**	**$12.89**
CD720	**Chest X-Ray, AP and Lateral (2 views)**	**$28.30**
FCD02	**Facility fee for Chest X-Ray, AP and Lateral (2 views)**	**$16.47**

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)
- For CD treatment services only
- CD710 and FCD01 cannot be billed with CD720 or FCD02
- BCCS performs utilization review of these services

- CD710 corresponds to 71010
- FCD01 corresponds to 010FX
- CD720 corresponds to 71020
- FCD02 corresponds to 020FX