

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BCCS OFFICE VISITS</b>		
99201	Office Visit - New Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$43.67
99202	Office Visit - New Patient; <i>expanded problem focused</i> history, exam, straightforward decision-making; 20 minutes	\$75.10
99203	Office Visit - New Patient; <i>detailed</i> history, exam, straightforward decision-making; 30 minutes	\$109.02
99204	Office Visit - New Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes.	\$167.56
99205	Office Visit - New Patient; <i>comprehensive</i> history, exam, high complexity decision-making; 60 minutes.	\$208.79
99212	Office Visit - Established Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$43.99
99213	Office Visit - Established Patient; <i>expanded problem focused</i> history, exam, low-complexity decision-making; 15 minutes	\$73.67
99214	Office Visit - Established Patient; <i>detailed</i> history, exam, moderate complexity decision-making; 25 minutes	\$108.72
<ul style="list-style-type: none"> <li>• Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN</li> <li>• The CPT code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making</li> <li>• 99204, 99205, and 99214 are uncommon office visits for the typical services provided through the BCCS program. Utilization review is performed on office visits</li> <li>• No more than 1 BCCS office visit is billable on the same day</li> <li>• 99204 and 99205 must meet the criteria for the code. These codes are <u>not</u> appropriate for screening visits</li> <li>• Consultation visits are billed using office visit codes and may be billed on the same day as the BCCS office visit</li> <li>• Global fee periods apply to certain diagnostic surgical procedures. Office visits are not allowed to be billed separately during the global fee periods</li> <li>• Global fee periods do not apply to consultations with a breast or cervical specialist</li> <li>• See specific diagnostic CPT codes for any global fee periods that may apply</li> <li>• Mammography facilities cannot bill for office visits</li> <li>• Neither the program, nor the patient, can be billed for "no show" visits</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>77053</b>	<b>Mammary ductogram or galactogram, single duct, Global Fee</b>	<b>\$60.83</b>
<ul style="list-style-type: none"> <li>• May be billed with 77055, G0206, 77056, G0204, 76641, 76642</li> <li>• Billable for clients with spontaneous nipple discharge and BI-RADS 1-3 after diagnostic mammogram</li> <li>• May not be billed with screening mammograms (77057, G0202, B7057, B0202) or MRI (77058, B7058, 77059, B7059)</li> <li>• BCCS performs utilization review on this service</li> </ul>		
<b>77058</b>	<b>Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral, Global Fee</b>	<b>\$543.11</b>
<b>77059</b>	<b>Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral, Global Fee</b>	<b>\$546.87</b>
<ul style="list-style-type: none"> <li>• May only be reimbursed for clients with one or more of the following:                             <ul style="list-style-type: none"> <li>-BRCA mutation;</li> <li>-a first-degree relative who is a BRCA carrier;</li> <li>-a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model</li> </ul> </li> <li>• May not be used alone as a breast cancer screening tool</li> <li>• May not be billed without breast screening mammogram</li> <li>• May be reimbursed with 77057, G0202</li> <li>• May not be billed with B7059, B7059 or B0202</li> <li>• May be billed with diagnostic mammograms used for additional views.</li> <li>• Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy</li> <li>• Preauthorization is required</li> </ul>		
<b>B7058</b>	<b>Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral (Age 40-49)</b>	<b>\$543.11</b>
<b>B7059</b>	<b>Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral (Ages 40-49)</b>	<b>\$546.87</b>
<ul style="list-style-type: none"> <li>• May only be reimbursed for clients with one or more of the following:                             <ul style="list-style-type: none"> <li>-BRCA mutation;</li> <li>-a first-degree relative who is a BRCA carrier;</li> <li>-a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model</li> </ul> </li> <li>• May not be used alone as a breast cancer screening tool</li> <li>• May not be billed without breast screening mammogram</li> <li>• May be reimbursed with B7057 and B0202</li> <li>• May not be reimbursed with 77058, 77059, 77057 or G0202</li> <li>• May be billed with diagnostic mammograms used for additional views</li> <li>• Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy. Preauthorization is required</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
77057	Screening Mammogram, Bilateral, Global Fee	\$83.48
G0202	Screening Mammogram, Digital, Bilateral, Global Fee	\$136.46
77055	Diagnostic Mammogram, Unilateral, Global Fee	\$91.10
G0206	Diagnostic Mammogram, Digital, Unilateral, Global Fee	\$131.01
77056	Diagnostic Mammogram, Bilateral, Global Fee	\$117.15
G0204	Diagnostic Mammogram, Digital, Bilateral, Global Fee	\$166.51
<ul style="list-style-type: none"> <li>• 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</li> <li>• A screening mammogram, on occasion, may precede the Clinical Breast Exam, i.e. mobile mammograms</li> <li>• An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided</li> <li>• Computer Aided Detection (CAD) in breast cancer screening or diagnostics is specifically not allowed by BCCS</li> </ul>		
B7057	Screening Mammogram, Bilateral, Global Fee (Age 40-49)	\$83.48
B0202	Screening Mammogram, Digital, Bilateral, Global Fee (Age 40-49)	\$136.46
<ul style="list-style-type: none"> <li>• Must be used to bill screening mammograms for women 40 to 49 years of age</li> <li>• 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</li> <li>• The guidelines for 77057 apply to B7057. The guidelines for G0202 apply to B0202</li> </ul>		
19000	Puncture Aspiration of Breast Cyst	\$113.90
<ul style="list-style-type: none"> <li>• 19000 may be billed once per breast regardless of the number of lesions</li> <li>• 19000 may be billed with 76942</li> <li>• Pathology (88305 or 88173) may not be reimbursed with 19000</li> <li>• Office visit codes on the day of the procedure are not payable (Global Fee Period 000)</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Office)	\$152.02
F9100	Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Facility)	\$71.38
100FX	Facility fee for needle core biopsy	\$227.18
<ul style="list-style-type: none"> <li>• 19100 and F9100 may only be billed once per breast, regardless of the number of specimens</li> <li>• 19100 cannot be billed with 00400 or 100FX</li> <li>• Cannot bill with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 100FX may be billed with F9100; but only once</li> <li>• 00400 may be billed with F9100 and 100FX for the total anesthesia units provided, up to the 8 unit maximum</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• Office visit codes on the day of the procedure are not payable (Global Fee Period 000)</li> </ul>		

19101	Incisional Breast Biopsy; one or more lesions (Physician in Office)	\$343.34
F9101	Incisional Breast Biopsy; one or more lesions (Physician in Facility)	\$225.25
101FX	Facility fee for incisional breast biopsy	\$1,090.62
<ul style="list-style-type: none"> <li>• 19101 and F9101 may be billed only once (per breast) regardless of the number of lesions</li> <li>• 76098 (if indicated) may be billed for each lesion, up to the maximum of 3 per breast</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 101FX may be billed once with F9101</li> <li>• 19101 cannot be billed with 00400</li> <li>• 00400 may be billed with F9101 for the total anesthesia units provided, up to the 8 unit maximum</li> <li>• Cannot bill with 76641, 76642, 76942, screening/diagnostic mammogram or MRI codes</li> <li>• May be billed with image guided preoperative placement of breast localization devices 19281-F9288 and their associated facility codes</li> <li>• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
19120	Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Office)	\$499.75
F9120	Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Facility)	\$420.91
120FX	Facility fee for excisional breast biopsy	\$1,090.62
<ul style="list-style-type: none"> <li>• May be billed only once per breast regardless of the number of lesions</li> <li>• 120FX may be billed once with F9120. 76098 may be billed if indicated for each lesion up to the maximum of 3 per breast</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 00400 cannot be billed with 19120</li> <li>• 00400 may be billed with F9120 for the total anesthesia units provided, up to the maximum of 8</li> <li>• May not be used with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• May be billed with imaging guided preoperative wire placement (19281-F9288 and associated facility codes)</li> <li>• 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)</li> </ul>		

19125	Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (Physician in Facility)	\$554.16
125FX	Facility fee for excision of abnormal breast tissue, duct, nipple or areolar lesion/preoperative placement of radiological marker, single lesion.	\$1,090.62
19126	Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (Physician in Facility)	\$165.80
<ul style="list-style-type: none"> <li>• 19125 may be billed only once per breast, regardless of the number of lesions</li> <li>• 19126 may only be billed for up to 2 additional lesions.</li> <li>• 125FX may be billed once with 19125</li> <li>• 76098 may be billed if indicated for each lesion, up to the maximum of 3</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>• May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI</li> <li>• 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed</li> <li>• 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)</li> <li>• For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ)</li> </ul>		

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<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>				
19125	<b>Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (Physician in Facility)</b>	<b>\$554.16</b>		
125FX	<b>Facility fee for excision of abnormal breast tissue, duct, nipple or areolar lesion/preoperative placement of radiological marker, single lesion.</b>	<b>\$1,090.62</b>		
19126	<b>Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (Physician in Facility)</b>	<b>\$165.80</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 19125 may be billed only once per breast, regardless of the number of lesions</li> <li>• 19126 may only be billed for up to 2 additional lesions.</li> <li>• 125FX may be billed once with 19125</li> <li>• 76098 may be billed if indicated for each lesion, up to the maximum of 3</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI</li> <li>• 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed</li> <li>• 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)</li> <li>• For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ)</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• 19125 may be billed only once per breast, regardless of the number of lesions</li> <li>• 19126 may only be billed for up to 2 additional lesions.</li> <li>• 125FX may be billed once with 19125</li> <li>• 76098 may be billed if indicated for each lesion, up to the maximum of 3</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> </ul>	<ul style="list-style-type: none"> <li>• May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI</li> <li>• 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed</li> <li>• 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)</li> <li>• For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ)</li> </ul>
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19081	<b>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; first lesion; Global Fee (Physician in Office)</b>	<b>\$685.62</b>		
F9081	<b>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; first lesion; Global Fee (Physician in Facility)</b>	<b>\$188.44</b>		
19082	<b>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; each additional lesion (Physician in Office)</b>	<b>\$556.37</b>		
F9082	<b>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>stereotactic guidance</u>; each additional lesion (Physician in Facility)</b>	<b>\$89.88</b>		
812FX	<b>Facility fee for percutaneous breast biopsy using <u>stereotactic guidance</u>; one or more lesions</b>	<b>\$387.84</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 19081 and F9081 can only be billed once per breast, regardless of the number of lesions</li> <li>• 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast</li> <li>• May not be billed with 19281-F9288 or associated facility codes</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 76098 may be billed for each lesion up the maximum of 3, if indicated</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 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</li> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 812FX may be billed with once with F9081 and F9082</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• 19081 and F9081 can only be billed once per breast, regardless of the number of lesions</li> <li>• 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast</li> <li>• May not be billed with 19281-F9288 or associated facility codes</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 76098 may be billed for each lesion up the maximum of 3, if indicated</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 812FX may be billed with once with F9081 and F9082</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul>
<ul style="list-style-type: none"> <li>• 19081 and F9081 can only be billed once per breast, regardless of the number of lesions</li> <li>• 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast</li> <li>• May not be billed with 19281-F9288 or associated facility codes</li> <li>• 88305 may be billed for up to 6 biopsy specimens per breast</li> <li>• 76098 may be billed for each lesion up the maximum of 3, if indicated</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 812FX may be billed with once with F9081 and F9082</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul>			

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u> ; <i>first lesion</i> (Physician in Office)	\$681.36
F9083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u> ; <i>first lesion</i> (Physician in Facility)	\$176.58
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u> ; <i>each additional lesion</i> (Physician in Office)	\$548.90
F9084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>ultrasound guidance</u> ; <i>each additional lesion</i> (Physician in Facility)	\$84.47
834FX	Facility fee for percutaneous breast biopsy using <u>ultrasound guidance</u> ; <i>one or more lesions</i>	\$387.84
<ul style="list-style-type: none"> <li>19083 and F9083 may only be billed once per breast regardless of the number of lesions</li> <li>19084 and F9084 may be billed up to the maximum of 2 additional lesions per breast</li> <li>May not be billed with 19281-F9288 or associated facility codes</li> <li>88305 may be billed for up to 6 biopsy specimens per breast</li> <li>76098 may be billed for each lesion up the maximum of 3, if indicated</li> <li>00400 cannot be billed with 19083 or 19084</li> <li>00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>834FX may be billed once with F9083 and F9084</li> <li>Office visits not reimbursable on day of procedure</li> </ul>		
F9085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>magnetic resonance guidance</u> ; <i>first lesion</i> , Global Fee (Physician in Facility)	\$206.16
F9086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; <u>magnetic resonance guidance</u> ; <i>each additional lesion</i> , Global Fee (Physician in Facility)	\$92.32
856FX	Facility fee for percutaneous breast biopsy using <u>MRI guidance</u> , <i>one or more lesions</i>	\$387.84
<ul style="list-style-type: none"> <li>F9085 may only be billed once per breast regardless of the number of lesions</li> <li>May only be performed in a facility with dedicated breast MRI equipment.</li> <li>Preauthorization is required</li> <li>F9086 may be billed up to the maximum of 2 additional lesions per breast</li> <li>May not be billed with 19281-F9288 or associated facility codes</li> <li>88305 may be billed for up to 6 biopsy specimens per breast</li> <li>76098 may be billed for each lesion up the maximum of 3, if indicated</li> <li>00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes</li> <li>856FX may be billed once with F9085</li> <li>Office visits not reimbursable on day of procedure</li> </ul>		

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<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
19281	Preoperative placement of breast localization device, percutaneous; <u>mammographic</u> guidance; <i>first lesion</i> (Physician in Office)	\$241.76
F9281	Preoperative placement of breast localization device, percutaneous; <u>mammographic</u> guidance; <i>first lesion</i> (Physician in Facility)	\$104.03
19282	Preoperative placement of breast localization device, percutaneous; <u>mammographic</u> guidance; <i>each additional lesion</i> (Physician in Office)	\$167.75
F9282	Preoperative placement of breast localization device, percutaneous; <u>mammographic</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$49.99
<ul style="list-style-type: none"> <li>• May only be billed with incisional/excisional biopsy and their associated facility codes</li> <li>• Facility fees are included with the primary procedure code</li> <li>• 19281 and F9281 may only be billed once per breast regardless of the number of lesions</li> <li>• Additional lesions may be billed up to a maximum of 2 per breast</li> <li>• Cannot be billed with 19081-F9086 or their associated facility codes</li> </ul> <ul style="list-style-type: none"> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 00400 cannot be billed with 19281 or 19282</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul>		
19283	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>first lesion</i> (Physician in Office)	\$274.36
F9283	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>first lesion</i> (Physician in Facility)	\$105.08
19284	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>each additional lesion</i> (Physician in Office)	\$201.04
F9284	Preoperative placement of breast localization device, percutaneous; <u>stereotactic</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$50.34
<ul style="list-style-type: none"> <li>• May only be billed with incisional/excisional biopsies and their associated facility codes</li> <li>• Facility fees are included with the primary procedure code</li> <li>• 19283 and F9283 may only be billed once per breast regardless of the number of lesions</li> <li>• Additional lesions may be billed up to a maximum of 2 per breast</li> <li>• Cannot be billed with 19081-F9086 or their associated facility codes</li> </ul> <ul style="list-style-type: none"> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 00400 cannot be billed with 19283 or 19284</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
19285	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>first lesion</i> (Physician in Office)	\$463.08
F9285	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>first lesion</i> (Physician in Facility)	\$89.11
19286	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>each additional lesion</i> (Physician in Office)	\$388.05
F9286	Preoperative placement of breast localization device, percutaneous; <u>ultrasound</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$43.17
<ul style="list-style-type: none"> <li>• May only be billed with incisional/excisional biopsies and their associated facility codes</li> <li>• Facility fees are included with the primary procedure code</li> <li>• 19285 and F9285 may only be billed once per breast regardless of the number of lesions</li> <li>• Additional lesions may be billed up to a maximum of 2 per breast</li> <li>• Cannot be billed with 19081-F9086 or their associated facility codes</li> </ul> <ul style="list-style-type: none"> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes</li> <li>• 00400 cannot be billed with 19283 or 19284</li> <li>• 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>• Office visits not reimbursable on day of procedure. (Global fee period 000)</li> </ul>		
F9287	Preoperative placement of breast localization device, percutaneous; <u>magnetic resonance</u> guidance; <i>first lesion</i> (Physician in Facility)	\$143.51
F9288	Preoperative placement of breast localization device, percutaneous; <u>magnetic resonance</u> guidance; <i>each additional lesion</i> (Physician in Facility)	\$64.61
<ul style="list-style-type: none"> <li>• Codes using magnetic resonance imaging may only be performed in a facility with dedicated breast MRI equipment</li> <li>• Facility fees are included with the primary procedure code</li> <li>• Preauthorization is required</li> <li>• May only be billed with incisional/excisional biopsies and their associated facility codes</li> <li>• F9287 may only be billed once per breast regardless of the number of lesions</li> </ul> <ul style="list-style-type: none"> <li>• Additional lesions may be billed up to a maximum of 2 per breast</li> <li>• Cannot be billed with 19081-F9086 or their associated facility codes</li> <li>• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes</li> <li>• 00400 may be billed with to reflect anesthesia units provided, up to the 8 unit maximum</li> <li>• Office visits not reimbursable on day of procedure</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – BREAST SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>00400</b>	<b>Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified.</b>	<b>\$22.88</b>
<ul style="list-style-type: none"> <li>Bill for the total number of units provided up to the maximum of 8 units</li> <li>Total Units = (3 base units plus time units)</li> </ul>		<ul style="list-style-type: none"> <li>One time unit equals 15 minutes</li> <li>00400 may only be billed with allowable BCCS facility codes</li> </ul>
<b>76098</b>	<b>Radiological examination, surgical specimen</b>	<b>\$19.47</b>
<ul style="list-style-type: none"> <li>May be billed to reflect each lesion present, up to the maximum of 3 per breast</li> </ul>		
<b>76641</b>	<b>Ultrasound, <i>complete</i> examination of breast including axilla, unilateral</b>	<b>\$110.86</b>
<b>76642</b>	<b>Ultrasound, <i>limited</i> examination of the breast including axilla, unilateral</b>	<b>\$91.29</b>
<ul style="list-style-type: none"> <li>May not be billed with 76942.</li> <li>76641 used when four quadrants of the breast are examined</li> </ul>		<ul style="list-style-type: none"> <li>76642 used when fewer than four quadrants of the breast are examined</li> <li>May be billed to reflect each breast examined</li> </ul>
<b>76942</b>	<b>Ultrasonic guidance for needle biopsy, radiological supervision and interpretation</b>	<b>\$74.77</b>
<ul style="list-style-type: none"> <li>May be billed to reflect each lesion present, up to the maximum of 3 per breast</li> </ul>		<ul style="list-style-type: none"> <li>May only be billed with 19000. May not be billed with 76641, 76642.</li> </ul>
<b>10022</b>	<b>Fine Needle Aspiration, with imaging guidance</b>	<b>\$142.09</b>
<ul style="list-style-type: none"> <li>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</li> </ul>		<ul style="list-style-type: none"> <li>10022 may be billed with 88173</li> <li>BCCS performs utilization review on this service</li> </ul>
<b>88173</b>	<b>Cytopathology Interpretation and Report of Fine Needle Aspiration</b>	<b>\$148.46</b>
<ul style="list-style-type: none"> <li>FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer</li> <li>88173 may be billed to evaluate the aspirate of each abnormal lymph node for the purpose of breast cancer staging</li> </ul>		<ul style="list-style-type: none"> <li>88173 may <u>only</u> be billed with 10022</li> <li>88173 requires cytologic expertise</li> </ul>
<b>88305</b>	<b>Surgical pathology, gross and microscopic examination of breast biopsy not requiring microscopic evaluation of surgical margins</b>	<b>\$71.36</b>
<ul style="list-style-type: none"> <li>88305 may be billed for up to 6 biopsy specimens per breast</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>87624</b>	<b>HPV, high-risk type</b>	<b>\$47.76</b>
<ul style="list-style-type: none"> <li>Used for cytology and HPV co-testing every 5 years for women ages 30 and over and management of specific abnormal Pap tests</li> <li>Must be ordered by a provider and not done as part of lab protocol</li> <li>When a conventional Pap test result is ASC-US, a follow-up office visit may be billed to collect the reflex HPV test</li> </ul>	<ul style="list-style-type: none"> <li>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</li> <li>Refer to cervical algorithms for indications for HPV testing</li> <li>HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated</li> </ul>	
<b>88141</b>	<b>Pap Test – physician’s interpretation (Bethesda System)</b>	<b>\$32.14</b>
<ul style="list-style-type: none"> <li>Each laboratory may develop their own policy for indications for the pathologist's review of Pap slides</li> <li>Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review</li> </ul>	<ul style="list-style-type: none"> <li>Bill with 88142, 88143, 88164, 88174, 88175 as the technical Pap test service</li> <li>The BCCS program monitors utilization. No greater than 5% of Pap tests provided by a contractor should require physician (pathologist) review</li> </ul>	
<b>88142</b>	<b>Pap Test – liquid based, cytologist’s interpretation (Bethesda System)</b>	<b>\$27.64</b>
<ul style="list-style-type: none"> <li>Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines</li> </ul>		
<b>88143</b>	<b>Pap Test-cytopathology, cervical, collected in preservative fluid, automated thin layer prep; manual screening and rescreening under physician supervision</b>	<b>\$27.64</b>
<ul style="list-style-type: none"> <li>Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines</li> </ul>		
<b>88164</b>	<b>Pap Test – cytologist’s interpretation (Bethesda System)</b>	<b>\$14.42</b>
<ul style="list-style-type: none"> <li>As indicated. Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
88174	<b>Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system under physician supervision</b>	<b>\$27.64</b>
<ul style="list-style-type: none"> <li>Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines</li> </ul>		
88175	<b>Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system and manual rescreening under physician supervision</b>	<b>\$27.64</b>
<ul style="list-style-type: none"> <li>Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines</li> </ul>		
88305	<b>Surgical pathology, gross and microscopic examination of cervical biopsy</b>	<b>\$71.36</b>
<ul style="list-style-type: none"> <li>May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix &amp; one (1) ECC biopsy</li> </ul>		
88307	<b>Surgical Pathology, gross and microscopic examination (cervix, conization)</b>	<b>\$291.80</b>
<ul style="list-style-type: none"> <li>May be billed with 57461, 57520, 57522 and their associated facility codes</li> <li>May be billed for up to 4 specimens per cervical conization procedure</li> </ul>		
57452	<b>Colposcopy</b>	<b>\$112.52</b>
<ul style="list-style-type: none"> <li>May be billed only once regardless of the number of lesions</li> <li>Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>57454</b>	<b>Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)</b>	<b>\$159.07</b>
<b>F7454</b>	<b>Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)</b>	<b>\$142.51</b>
<b>454FX</b>	<b>Facility fee for colposcopy with cervical biopsy(s) and endocervical curettage</b>	<b>\$61.62</b>
<ul style="list-style-type: none"> <li>• 57454 and F7454 may be billed only once regardless of the number of lesions</li> <li>• 88305 may be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix &amp; one (1) ECC biopsy</li> <li>• May not be billed with 88307</li> <li>• May not be billed with colposcopy: 57452, 57455, 57456, 57460, 57461 or their associated facility codes</li> <li>• 00940 cannot be billed with 57454</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> <li>• 454FX may be billed once with F7454</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review of F7454 and 454FX. Preauthorization is required</li> </ul>		
<b>57455</b>	<b>Colposcopy with biopsy(s) of the cervix (Physician in Office)</b>	<b>\$147.85</b>
<b>F7455</b>	<b>Colposcopy with biopsy(s) of the cervix (Physician in Facility)</b>	<b>\$116.53</b>
<b>455FX</b>	<b>Facility fee for colposcopy with biopsy(s) of the cervix</b>	<b>\$64.12</b>
<ul style="list-style-type: none"> <li>• May be billed only once, regardless of the number of lesions</li> <li>• 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on cervix</li> <li>• May not bill with 88307</li> <li>• May not be billed with colposcopy: 57452, 57454, 57456, 57460, 57461 or their associated facility codes</li> <li>• F7455 may be billed once with 455FX</li> <li>• 00940 cannot be billed with 57455</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review of F7455 and 455FX. Preauthorization is required</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE		
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>				
<b>57456</b>	<b>Colposcopy with endocervical curettage (Physician in Office)</b>	<b>\$139.91</b>		
<b>F7456</b>	<b>Colposcopy with endocervical curettage (Physician in Facility)</b>	<b>\$108.59</b>		
<b>456FX</b>	<b>Facility fee for colposcopy with endocervical curettage</b>	<b>\$61.97</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May be billed only once regardless of the number of lesions</li> <li>• 88305 may only be billed once</li> <li>• May not be billed with 88307</li> <li>• 00940 cannot be billed with 57456</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• F7456 may be billed once with 456FX</li> <li>• BCCS performs utilization review of F7456 and 456FX.</li> <li>• Preauthorization is required</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• May be billed only once regardless of the number of lesions</li> <li>• 88305 may only be billed once</li> <li>• May not be billed with 88307</li> <li>• 00940 cannot be billed with 57456</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> </ul>	<ul style="list-style-type: none"> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• F7456 may be billed once with 456FX</li> <li>• BCCS performs utilization review of F7456 and 456FX.</li> <li>• Preauthorization is required</li> </ul>
<ul style="list-style-type: none"> <li>• May be billed only once regardless of the number of lesions</li> <li>• 88305 may only be billed once</li> <li>• May not be billed with 88307</li> <li>• 00940 cannot be billed with 57456</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> </ul>	<ul style="list-style-type: none"> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• F7456 may be billed once with 456FX</li> <li>• BCCS performs utilization review of F7456 and 456FX.</li> <li>• Preauthorization is required</li> </ul>			
<b>57460</b>	<b>Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)</b>	<b>\$283.64</b>		
<b>F7460</b>	<b>Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)</b>	<b>\$167.63</b>		
<b>460FX</b>	<b>Facility fee for colposcopy with loop electrode biopsy(s)</b>	<b>\$170.87</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May be billed only once, regardless of the number of lesions</li> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes</li> <li>• 00940 cannot be billed for 57460</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> <li>• 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May not bill with 88307</li> <li>• F7460 may be billed once with 460FX</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review of F7460 and 460FX. Preauthorization is required</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• May be billed only once, regardless of the number of lesions</li> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes</li> <li>• 00940 cannot be billed for 57460</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> <li>• 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix</li> </ul>	<ul style="list-style-type: none"> <li>• May not bill with 88307</li> <li>• F7460 may be billed once with 460FX</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review of F7460 and 460FX. Preauthorization is required</li> </ul>
<ul style="list-style-type: none"> <li>• May be billed only once, regardless of the number of lesions</li> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes</li> <li>• 00940 cannot be billed for 57460</li> <li>• 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum</li> <li>• 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix</li> </ul>	<ul style="list-style-type: none"> <li>• May not bill with 88307</li> <li>• F7460 may be billed once with 460FX</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review of F7460 and 460FX. Preauthorization is required</li> </ul>			

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>57461</b>	<b>Colposcopy with loop electrode conization of the cervix (Physician in Office)</b>	<b>\$328.30</b>
<b>F7461</b>	<b>Colposcopy with loop electrode conization of the cervix (Physician in Facility)</b>	<b>\$197.69</b>
<b>461FX</b>	<b>Colposcopy with loop electrode conization of the cervix (Facility Fee)</b>	<b>\$184.13</b>
<ul style="list-style-type: none"> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460 and their associated facility codes</li> <li>• 57461 may be billed only once and may not be billed with F7461, 461FX or anesthesia</li> <li>• 88307 may be billed for up to 4 specimens</li> <li>• 88305 may not be billed with 57461 or F7461</li> <li>• F7461 may be billed once with 461FX</li> <li>• 00940 may not be billed with 57461</li> <li>• 00940 may be billed for the total units of anesthesia provided, up to the 8 unit maximum</li> <li>• No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility</li> </ul>		
<b>57500</b>	<b>Biopsy(s) of cervix (Physician in Office)</b>	<b>\$130.84</b>
<ul style="list-style-type: none"> <li>• 88305 may be billed with 57500 for up to 4 specimens to reflect multiple biopsy sites on cervix</li> <li>• May not be billed with 88307</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> </ul>		
<b>57505</b>	<b>Endocervical curettage (Physician in Office)</b>	<b>\$104.94</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• 88305 may be billed once with 57505</li> <li>• May not be billed with 88307</li> <li>• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>57520</b>	<b>Conization of the cervix; excision by cold knife or laser (Physician in Facility)</b>	<b>\$284.21</b>
<b>520FX</b>	<b>Facility fee for conization of the cervix (excision by cold knife or laser method)</b>	<b>\$1,393.52</b>
<ul style="list-style-type: none"> <li>57520 may be billed only once</li> <li>88307 may be billed with 57520 for up to 4 specimens</li> <li>May not be billed with 88305</li> <li>00940 may be billed for the units of anesthesia provided, up to the 8 unit maximum</li> <li>57520 must be performed in a certified ambulatory surgery center or day surgery facility</li> </ul>		<ul style="list-style-type: none"> <li>520FX may be billed once with 57520</li> <li>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)</li> <li>BCCS performs utilization review of this service</li> </ul>

<b>57522</b>	<b>Conization of cervix (LEEP); (Physician in office)</b>	<b>\$272.97</b>
<b>F7522</b>	<b>Conization of cervix (LEEP); (Physician in Facility)</b>	<b>\$253.52</b>
<b>522FX</b>	<b>Facility fee for Conization of cervix (excision by LEEP method)</b>	<b>\$759.69</b>
<ul style="list-style-type: none"> <li>57522 may be billed only once and may not be billed with F7522, 522FX or anesthesia</li> <li>May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or associated facility codes</li> <li>88307 may be billed for up to 4 specimens</li> <li>May not be billed with 88305</li> <li>F7522 may be billed only once with 522FX</li> </ul>		<ul style="list-style-type: none"> <li>00940 may be billed with F7522 for the total units of anesthesia provided, up to the 8 unit maximum</li> <li>No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility</li> <li>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</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL SCREENING &amp; DIAGNOSTIC SERVICES</b>		
<b>00940</b>	<b>Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.</b>	<b>\$22.88</b>
<ul style="list-style-type: none"> <li>Bill for the total number of units provided up to a maximum of 8 units</li> <li>Total Units = (3 base units plus time units). One time unit equals 15 minutes</li> </ul>		<ul style="list-style-type: none"> <li>00940 may only be billed with allowable BCCS procedures performed in a facility</li> </ul>

58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)	\$49.79
F8110	Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)	\$42.95
811FX	Facility fee for endometrial sampling performed in conjunction with colposcopy	\$48.72
<ul style="list-style-type: none"> <li>• Must be billed with a colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or their associated facility codes</li> <li>• 811FX may be billed once with F8110</li> <li>• 00940 may not be billed with 58110</li> <li>• 00940 may be billed to reflect anesthesia, up to the maximum of 8 units</li> <li>• F8110/811FX require preauthorization</li> <li>• Code related to another service and is always included in the global period of the other service (Global fee period ZZZ)</li> <li>• Utilization review is performed on this service</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES</b>		
93000	ECG	<b>\$16.95</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3)</li> <li>For BCCS diagnostic services only</li> </ul>		<ul style="list-style-type: none"> <li>Refer to the American Society of Anesthesiologists for (ASA) grades.</li> <li>Utilization review is performed on this service</li> </ul>
80048	Basic Metabolic Panel (Chem 6)	<b>\$11.54</b>
88053	Comprehensive Metabolic Panel (Chem 12)	<b>\$14.41</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3)</li> <li>For BCCS diagnostic services only</li> </ul>		<ul style="list-style-type: none"> <li>88048 may not be billed with 88053</li> <li>No greater than 7% clients receiving anesthesia should undergo these tests. Utilization review is performed on these services</li> </ul>
81025	Urine Pregnancy Test	<b>\$8.63</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for women of child-bearing age. <b>May not be used as routine pregnancy screening</b></li> </ul>		<ul style="list-style-type: none"> <li>For BCCS diagnostic services only</li> <li>BCCS performs utilization review on this service</li> </ul>
85025	CBC, automated with differential	<b>\$10.61</b>
85027	CBC, automated	<b>\$8.83</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grade 2 or 3)</li> <li>For BCCS diagnostic services only</li> </ul>		<ul style="list-style-type: none"> <li>85025 cannot be billed with 85027</li> <li>No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES</b>		
85610	Prothrombin Time (PT)	\$5.37
85730	Partial Thromboplastin Time (PTT)	\$8.19
85384	Fibrinogen	\$11.85
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>For BCCS diagnostic services only</li> </ul>		<ul style="list-style-type: none"> <li>8610, 85730 and 85384 may be billed together</li> <li>No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</li> </ul>
71010	Chest X-Ray, AP (1 View)	\$23.59
010FX	Facility fee for Chest X-Ray, AP (1 view)	\$10.48
71020	Chest X-Ray, AP and Lateral (2 views)	\$30.64
020FX	Facility fee for Chest X-Ray, AP and Lateral (2 views)	\$14.41
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>For BCCS diagnostic services only</li> </ul>		<ul style="list-style-type: none"> <li>71010 and 010FX cannot be billed with 71020 or 020FX</li> <li>No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE		
<b>BILLING GUIDELINES – CASE MANAGEMENT SERVICES</b>				
44410	<b>Medicaid for Breast and Cervical Cancer (MBCC) Comprehensive Visit</b>	<b>\$122.31</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 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</li> <li>• No BCCS screening or diagnostic funds were used for the cancer diagnosis</li> <li>• 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</li> <li>• Note: Completed MBCC applications shall not be submitted to DSHS until all client data and case management billing has been entered into Med-IT</li> <li>• 44410 reimbursement requires completion of the Med-IT case management module</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 44410 may only be billed with 44413 and may not be billed with any other codes, including case management codes: 99910, 99913, 88810, and 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> <li>• <b>If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, DSHS may withhold or recover payment</b></li> <li>• A contractor who submitted an application that they presumed eligible for MBCC and was later denied by HHSC will not have to return the fee</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• 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</li> <li>• No BCCS screening or diagnostic funds were used for the cancer diagnosis</li> <li>• 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</li> <li>• Note: Completed MBCC applications shall not be submitted to DSHS until all client data and case management billing has been entered into Med-IT</li> <li>• 44410 reimbursement requires completion of the Med-IT case management module</li> </ul>	<ul style="list-style-type: none"> <li>• 44410 may only be billed with 44413 and may not be billed with any other codes, including case management codes: 99910, 99913, 88810, and 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> <li>• <b>If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, DSHS may withhold or recover payment</b></li> <li>• A contractor who submitted an application that they presumed eligible for MBCC and was later denied by HHSC will not have to return the fee</li> </ul>
<ul style="list-style-type: none"> <li>• 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</li> <li>• No BCCS screening or diagnostic funds were used for the cancer diagnosis</li> <li>• 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</li> <li>• Note: Completed MBCC applications shall not be submitted to DSHS until all client data and case management billing has been entered into Med-IT</li> <li>• 44410 reimbursement requires completion of the Med-IT case management module</li> </ul>	<ul style="list-style-type: none"> <li>• 44410 may only be billed with 44413 and may not be billed with any other codes, including case management codes: 99910, 99913, 88810, and 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> <li>• <b>If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, DSHS may withhold or recover payment</b></li> <li>• A contractor who submitted an application that they presumed eligible for MBCC and was later denied by HHSC will not have to return the fee</li> </ul>			
44413	<b>Medicaid for Breast and Cervical Cancer (MBCC) Telephone call ( or in-person visit)</b>	<b>\$29.36</b>		
<ul style="list-style-type: none"> <li>• May be billed up to a maximum of 3 follow-up phone calls</li> <li>• Note: Completed MBCC applications shall not be submitted to DSHS until all client data and case management billing has been entered into Med-IT</li> </ul>				
99910	<b>Case management for abnormal breast cancer screening (abnormal CBE or mammogram, diagnostic tests required)</b>	<b>\$100.00</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan</li> <li>• 99910 reimbursement requires completion of Med-IT case management module</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• May not bill with 44410, 44413, 88810 or 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan</li> <li>• 99910 reimbursement requires completion of Med-IT case management module</li> </ul>	<ul style="list-style-type: none"> <li>• May not bill with 44410, 44413, 88810 or 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> </ul>
<ul style="list-style-type: none"> <li>• 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan</li> <li>• 99910 reimbursement requires completion of Med-IT case management module</li> </ul>	<ul style="list-style-type: none"> <li>• May not bill with 44410, 44413, 88810 or 88813</li> <li>• May not be billed for a reinstatement, renewal, or client transferring from another state</li> </ul>			
99913	<b>BCCS Follow-up Visit (telephone)</b>	<b>\$29.36</b>		
<ul style="list-style-type: none"> <li>• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct case management activities</li> <li>• May not bill with 44410, 44413, 88810 or 88813</li> </ul>				

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CASE MANAGEMENT SERVICES</b>		
88810	<b>Case management for abnormal cervical cancer screening (diagnostic test required)</b>	<b>\$100.00</b>
<ul style="list-style-type: none"> <li data-bbox="109 358 1041 418">• 88810 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan</li> <li data-bbox="109 418 1041 479">• 88810 reimbursement requires completion of Med-IT case management module</li> <li data-bbox="1056 370 1955 402">• May not bill with 44410, 44413, 99910 or 99913</li> <li data-bbox="1056 402 1955 462">• May not be billed for a reinstatement, renewal, or client transferring from another state</li> </ul>		
88813	<b>Follow-up Visit (telephone)</b>	<b>\$29.36</b>
<ul style="list-style-type: none"> <li data-bbox="109 587 1507 620">• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct case management activities</li> <li data-bbox="109 620 716 652">• May not bill with 44410, 44413, 99910 or 99913</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
CD202	Office Visit - New Patient; <i>expanded problem focused</i> history, exam, straightforward decision-making; 20 minutes	\$74.99
CD203	Office Visit - New Patient; <i>detailed</i> history, exam, straightforward decision-making; 30 minutes	\$109.02
CD204	Office Visit - New Patient; <i>comprehensive</i> history, exam, moderate complexity decision-making; 45 minutes.	\$167.56
CD212	Office Visit - Established Patient; <i>problem focused</i> history, exam, straightforward decision-making; 10 minutes	\$43.99
CD213	Office Visit - Established Patient; <i>expanded problem focused</i> history, exam, low-complexity decision-making; 15 minutes	\$73.67
CD214	Office Visit - Established Patient; <i>detailed</i> history, exam, moderate complexity decision-making; 25 minutes	\$108.72
<ul style="list-style-type: none"> <li>Office visits may only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN</li> <li>The "CD" code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making</li> <li>CD204 &amp; CD214 are uncommon office visits for typical services provided under Title V dysplasia</li> <li>Utilization review is performed on office visits</li> <li>No more than 1 office visit s billable on the same day</li> </ul> <ul style="list-style-type: none"> <li>Global fee periods apply to certain management and treatment procedures. Office visits are not allowed to be billed separately during some global fee periods</li> <li>See specific CD, FCD and FCX management &amp; treatment procedure codes for any global fee periods that may apply</li> <li>Neither BCCS, nor the patient, can be billed for "no show" visits</li> </ul> <p>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</p>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
CD810	Case management for “Referred-In” to Dysplasia Treatment Services	\$50.00
<ul style="list-style-type: none"> <li>CD810 may be billed for case management services for a client who was referred-in for cervical dysplasia management &amp; treatment</li> <li>CD810 may not be billed with 88810 or 88813</li> </ul> <ul style="list-style-type: none"> <li>CD810 may only be billed by one BCCS contractor, one time only, per problem, and upon completion of the assessment and service plan</li> <li>NOTE: CD810 corresponds to 88810</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD624</b>	<b>HPV, high-risk types</b>	<b>\$47.76</b>
<ul style="list-style-type: none"> <li>Use for management of dysplasia per dysplasia algorithms</li> <li>Must be ordered by a provider and not done as part of lab protocol</li> </ul>	<ul style="list-style-type: none"> <li>HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated</li> <li>NOTE: CD624 corresponds to 87624</li> </ul>	
<b>CD141</b>	<b>Pap Test – Physician’s interpretation</b>	<b>\$32.14</b>
<ul style="list-style-type: none"> <li>May be billed as the professional component with CD142 and CD164 as applicable</li> <li>Each laboratory may develop their own policy for pathologist review of cervical Pap slides</li> </ul>	<ul style="list-style-type: none"> <li>No greater than 5% of Pap tests provided should require pathologist review</li> <li>BCCS performs utilization review of this service</li> </ul>	
<b>CD142</b>	<b>Pap Smear – liquid based</b>	<b>\$27.64</b>
<ul style="list-style-type: none"> <li>Use for management of dysplasia per cervical dysplasia algorithms</li> <li>NOTE: CD142 corresponds to 88142</li> </ul>		
<b>CD164</b>	<b>Pap Smear– conventional</b>	<b>\$14.42</b>
<ul style="list-style-type: none"> <li>Use for management of dysplasia per dysplasia algorithms</li> <li>NOTE: CD164 corresponds to 88164</li> </ul>		
<b>CD452</b>	<b>Colposcopy</b>	<b>\$112.52</b>
<ul style="list-style-type: none"> <li>May be billed only once</li> <li>Office visit codes on the day of the procedure are not payable (Global fee period 000).</li> <li>NOTE: CD452 corresponds to 57452</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD455</b>	<b>Colposcopy with biopsy(s) of the cervix (Physician in Office)</b>	<b>\$147.85</b>
<b>FCX55</b>	<b>Colposcopy with biopsy(s) of the cervix (Physician in Facility)</b>	<b>\$116.53</b>
<b>FCD55</b>	<b>Facility fee for colposcopy with biopsy(s) of the cervix</b>	<b>\$64.12</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• CD305 may be billed with CD455 and FCX55 up to 4 times to reflect multiple biopsy sites on the cervix</li> <li>• Cannot be billed with colposcopy codes</li> <li>• FCD55 may be billed once with FCX55</li> <li>• CD940 cannot be billed with CD455</li> </ul>		<ul style="list-style-type: none"> <li>• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review on FCX55/FCD55. Preauthorization is required</li> <li>• NOTE: CD455 corresponds to 57455 FCX55 corresponds to F7455 FCD55 corresponds to 455FX</li> </ul>

<b>CD456</b>	<b>Colposcopy with endocervical curettage (Physician in Office)</b>	<b>\$139.91</b>
<b>FCX56</b>	<b>Colposcopy with endocervical curettage (Physician in Facility)</b>	<b>\$108.59</b>
<b>FCD56</b>	<b>Facility fee for colposcopy with endocervical curettage</b>	<b>\$61.97</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• CD305 may be billed only once with CD456 and FCX56.</li> <li>• Cannot be billed with colposcopy codes</li> <li>• CD940 cannot be billed with CD456</li> <li>• CD940 can be billed to reflect anesthesia provided, up to the maximum of 8</li> </ul>		<ul style="list-style-type: none"> <li>• FCD56 may be billed once with FCX56</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review on FCX56/FCD56. Preauthorization is required</li> <li>• NOTE: CD456 corresponds to 57456 FCX56 corresponds to F7456 FCD56 corresponds to 456FX</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD460</b>	<b>Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)</b>	<b>\$283.64</b>
<b>FCX60</b>	<b>Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)</b>	<b>\$167.63</b>
<b>FCD60</b>	<b>Facility fee for colposcopy with loop electrode biopsy(s) of the cervix</b>	<b>\$170.87</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• CD305 may be billed with CD460 and FCS60 up to 4 times to reflect multiple biopsy sites on the cervix</li> <li>• May not be billed with colposcopy codes</li> <li>• FCD60 may be billed once with FCX60</li> <li>• CD940 cannot be billed with CD460</li> </ul>		<ul style="list-style-type: none"> <li>• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review on FCX60/FCD60. Preauthorization is required</li> <li>• NOTE: CD460 corresponds to 57460 FCX60 corresponds to F7460 FCD60 corresponds to 460FX</li> </ul>

<b>CD461</b>	<b>Colposcopy with loop electrode conization of the cervix (Physician in Office)</b>	<b>\$328.30</b>
<b>FCX61</b>	<b>Colposcopy with loop electrode conization of the cervix (Physician in Facility)</b>	<b>\$197.69</b>
<b>FCD61</b>	<b>Facility fee for colposcopy with loop electrode conization of the cervix</b>	<b>\$184.13</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• CD307 may be billed up to 4 times to reflect multiple biopsy sites on the cervix</li> <li>• May not be billed with colposcopy codes</li> <li>• FCD61 may be billed once with FCX61</li> <li>• CD940 cannot be billed with CD461</li> </ul>		<ul style="list-style-type: none"> <li>• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• NOTE: CD461 corresponds to 57461 FCX61 corresponds to F7461 FCD61 corresponds to 461FX</li> <li>• BCCS performs utilization review of FCX61 AND FCD61. Pre-authorization is required</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD454</b>	<b>Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)</b>	<b>\$159.07</b>
<b>FCX54</b>	<b>Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)</b>	<b>\$142.51</b>
<b>FCD54</b>	<b>Facility fee for colposcopy with biopsy(s) and endocervical curettage</b>	<b>\$61.62</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• May not be billed with colposcopy codes</li> <li>• CD305 may be billed up to 5 times to reflect 4 biopsy sites on the cervix and one (1) ECC biopsy</li> <li>• CD940 cannot be billed with CD454</li> <li>• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.</li> </ul>		<ul style="list-style-type: none"> <li>• FCD54 may be billed once with FCX54</li> <li>• Office visit codes on the day of the procedure are not payable (Global fee period 000)</li> <li>• BCCS performs utilization review on FCX54/FCD54. Preauthorization is required</li> <li>• NOTE: CD454 corresponds to 57454 FCX54 corresponds to F7454 FCD54 corresponds to 454FX</li> </ul>
<b>CD511</b>	<b>Cryotherapy: cryocautery, initial or repeat</b>	<b>\$150.36</b>
<ul style="list-style-type: none"> <li>• There is no pathology associated with CD511 because a biopsy is not performed with this procedure</li> <li>• Decision to repeat is based upon provider medical decision-making and adherence to algorithms</li> </ul>		<ul style="list-style-type: none"> <li>• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</li> <li>• NOTE: CD511 corresponds to 57511</li> <li>• BCCS performs utilization review of this service</li> </ul>
<b>CD513</b>	<b>Cervical Cautery with laser ablation</b>	<b>\$149.64</b>
<ul style="list-style-type: none"> <li>• There is no pathology associated with CD513 because a biopsy is not performed with this procedure</li> <li>• Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)</li> </ul>		<ul style="list-style-type: none"> <li>• NOTE: CD513 corresponds to 57513</li> <li>• BCCS performs utilization review of this service</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>FCX20</b>	<b>Cervical Conization with cold knife or laser (Physician in Facility)</b>	<b>\$284.21</b>
<b>FCD20</b>	<b>Facility fee for Cervical Conization with cold knife or laser</b>	<b>\$1,393.52</b>
<ul style="list-style-type: none"> <li>FCX20 must be performed in a certified ambulatory surgical center or a day surgery facility</li> <li>FCX20 may be billed only once</li> <li>FCD20 may be billed with FCX20 for the facility fee</li> <li>CD307 may be billed with FCX20 for up to 4 specimens per cervical conization procedure</li> <li>Cannot be billed with CD305</li> <li>CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum</li> <li>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)</li> <li>NOTE: FCX20 corresponds to 57520 FCD20 corresponds to 520FX</li> <li>BCCS performs utilization review of this service</li> </ul>		
<b>CD522</b>	<b>Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Office)</b>	<b>\$272.97</b>
<b>FCX22</b>	<b>Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Facility)</b>	<b>\$253.32</b>
<b>FCD22</b>	<b>Facility fee for Cervical Conization with Loop Electrode Excision (LEEP)</b>	<b>\$759.69</b>
<ul style="list-style-type: none"> <li>CD522 may be billed only once and cannot be billed with FCX22, FCD22, or CD940</li> <li>CD522 and FCX22 may not be billed with CD452, CD454, CD455, CD456, CD460, CD461 or their associated facility codes</li> <li>CD307 may be billed with CD522 or FCX22 for up to 4 specimens</li> <li>May not be billed with CD305</li> <li>FCD22 may be billed once with FCX22.</li> <li>CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum</li> <li>No greater than 20% of conization LEEPs should be done in a certified, ambulatory surgical center or a day surgery facility</li> <li>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)</li> <li>NOTE: CD522 corresponds to 57522 FCX22 corresponds to F7522 FCD22 corresponds to 522FX</li> <li>BCCS performs utilization review of this service</li> </ul>		

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD811</b>	<b>Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)</b>	<b>\$49.79</b>
<b>FCX81</b>	<b>Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)</b>	<b>\$42.95</b>
<b>FCD81</b>	<b>Facility fee for endometrial sampling (biopsy) performed in conjunction with colposcopy</b>	<b>\$48.72</b>
<ul style="list-style-type: none"> <li>• May be billed only once</li> <li>• CD811 must be billed with a colposcopy</li> <li>• Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater if:                             <ul style="list-style-type: none"> <li>○ Client 35 or more years of age, or</li> <li>○ At risk for endometrial neoplasia (see BCCS algorithms).</li> </ul> </li> <li>• CD940 cannot be billed with CD811</li> <li>• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units</li> </ul>		<ul style="list-style-type: none"> <li>• FCD81 may be billed once with FCX81</li> <li>• Code related to another service and is always included in the global period of the other service (Global fee period ZZZ).</li> <li>• Utilization review is performed on this service</li> <li>• Pre-authorization is required for FCX81/FCD81</li> </ul>
<b>CD940</b>	<b>Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.</b>	<b>\$22.88</b>
<ul style="list-style-type: none"> <li>• Bill for the total number of units provided, up to the 8 unit maximum.</li> <li>• Total Units= (3 base units plus time units). One time unit equals 15 minutes</li> </ul>		<ul style="list-style-type: none"> <li>• CD940 may only be billed with allowable facility codes FCD20 or FCD22.</li> <li>• NOTE: CD940 corresponds to 00940</li> </ul>
<b>CD305</b>	<b>Surgical Pathology - cervical biopsy</b>	<b>\$71.36</b>
<ul style="list-style-type: none"> <li>• May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix and 1 ECC biopsy</li> <li>• NOTE: CD305 corresponds to 88305</li> </ul>		
<b>CD307</b>	<b>Surgical Pathology – cervical conization</b>	<b>\$291.80</b>
<ul style="list-style-type: none"> <li>• May be billed for up to 4 specimens per cervical conizations procedure.</li> <li>• NOTE: CD307 corresponds to 88307</li> </ul>		
<b>CD930</b>	<b>ECG</b>	<b>\$16.95</b>
<ul style="list-style-type: none"> <li>• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grade 2 or 3)</li> <li>• For CD treatment services only</li> </ul>		<ul style="list-style-type: none"> <li>• Utilization review is performed on this service</li> <li>• CD930 corresponds to 93000</li> </ul>

CPT CODE	CODE DESCRIPTIONS	RATE
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>		
<b>CD048</b>	<b>Basic Metabolic Panel (Chem 6)</b>	<b>\$11.54</b>
<b>CD053</b>	<b>Comprehensive Metabolic Panel (Chem 12)</b>	<b>\$14.41</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>CD048 cannot be billed with CD053</li> <li>For CD treatment services only</li> </ul>	<ul style="list-style-type: none"> <li>Utilization review is performed on this service</li> <li>CD048 corresponds to 80048</li> <li>CD053 corresponds to 88053</li> </ul>	
<b>CD125</b>	<b>Urine Pregnancy Test</b>	<b>\$8.63</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>For CD treatment services only</li> </ul>	<ul style="list-style-type: none"> <li>BCCS performs utilization review on this service</li> <li>CD125 corresponds to 81025</li> </ul>	
<b>CD025</b>	<b>CBC, automated with differential</b>	<b>\$10.61</b>
<b>CD027</b>	<b>CBC, automated</b>	<b>\$8.83</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>For CD treatment services only</li> <li>CD025 corresponds to 85025</li> </ul>	<ul style="list-style-type: none"> <li>CD025 cannot be billed with CD027</li> <li>CD027 corresponds to 85027</li> </ul>	
<b>CD610</b>	<b>Prothrombin Time (PT)</b>	<b>\$5.37</b>
<b>CD730</b>	<b>Partial Prothrombin Time (PTT)</b>	<b>\$8.19</b>
<b>CD384</b>	<b>Fibrinogen</b>	<b>\$11.85</b>
<ul style="list-style-type: none"> <li>Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>For CD treatment services only</li> <li>CD610, CD730 and CD384 may be billed together</li> <li>BCCS performs utilization review on this service</li> </ul>	<ul style="list-style-type: none"> <li>CD610 corresponds to 85610</li> <li>CD730 corresponds to 85730</li> <li>CD384 corresponds to 85384</li> </ul>	

CPT CODE	CODE DESCRIPTIONS	RATE		
<b>BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)</b>				
CD710	Chest X-Ray, AP (1 view)	<b>\$23.59</b>		
FCD01	Facility fee for Chest X-Ray, AP (1 view)	<b>\$10.48</b>		
CD720	Chest X-Ray, AP and Lateral (2 views)	<b>\$30.64</b>		
FCD02	Facility fee for Chest X-Ray, AP and Lateral (2 views)	<b>\$14.41</b>		
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>• For CD treatment services only</li> <li>• CD710 and FCD01 cannot be billed with CD720 or FCD02</li> <li>• BCCS performs utilization review of these services</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• CD710 corresponds to 71010</li> <li>• FCD01 corresponds to 010FX</li> <li>• CD720 corresponds to 71020</li> <li>• FCD02 corresponds to 020FX</li> </ul> </td> </tr> </table>			<ul style="list-style-type: none"> <li>• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>• For CD treatment services only</li> <li>• CD710 and FCD01 cannot be billed with CD720 or FCD02</li> <li>• BCCS performs utilization review of these services</li> </ul>	<ul style="list-style-type: none"> <li>• CD710 corresponds to 71010</li> <li>• FCD01 corresponds to 010FX</li> <li>• CD720 corresponds to 71020</li> <li>• FCD02 corresponds to 020FX</li> </ul>
<ul style="list-style-type: none"> <li>• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3)</li> <li>• For CD treatment services only</li> <li>• CD710 and FCD01 cannot be billed with CD720 or FCD02</li> <li>• BCCS performs utilization review of these services</li> </ul>	<ul style="list-style-type: none"> <li>• CD710 corresponds to 71010</li> <li>• FCD01 corresponds to 010FX</li> <li>• CD720 corresponds to 71020</li> <li>• FCD02 corresponds to 020FX</li> </ul>			