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Women's Cancer Control Program (WCCP)
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Office Visits

(CPT Billing Codes Related to all Services under Form Contract I.A.)

CPT Codes	Description	County Rates
99201*	New Patient: Single Exam Problem focused history, a problem focused examination, and straightforward medical decision making.	$51.99
99202*	New Patient: Single Exam Expanded focused history, expanded focused examination and straightforward medical decision making (e.g. either a Pap smear with a pelvic exam or a clinical breast exam.)	$86.77
99203*	New Patient: Exam Detailed history, a detailed examination; and medical decision making of low complexity (e. including Pap test, pelvic exam and clinical breast exam. Can also be billed in conjunction with a colposcopy, with or without biopsy.	$124.43
99204*	New Patient: Exam Comprehensive history, examination, and medical decision making of moderate complexity. Average visit 45 minutes.	$188.16
99211	Established Patients: Single or Repeat Exam Problem focused history, a problem focused examination, and straightforward medical decision making.	$25.44
99212	Established Patient: Single or Repeat Exam Focused history, focused examination and/or straightforward medical decision making (e.g. either a Pap smear with a pelvic or clinical breast exam.)	$51.11
99213	Established Patient: Exam Expanded history, expanded examination and/or medical decision making of low complexity. (e.g. Pap smear, pelvic exam, and clinical breast exam. Can also be billed in conjunction with a colposcopy [with or without biopsy] procedure.)	$83.92
99214	Established Patient: Exam Includes at least two of the following: A detailed history, a detailed, exam, moderate-complexity medical decision-making. Average visit 25 minutes	$123.44
99386	New Patient: Initial Preventive Medicine Visit Age 40 – 64 years (Pap smear, pelvic exam, and clinical breast exam. If CBE or Pap test only, reimburse at 99202 rates).	Reimburse at 99203 rate
99387	New Patient: Initial Preventive Medicine Visit Age 65 and older (Pap smear, pelvic exam, and clinical breast exam. If CBE or Pap test only, reimburse at 99202 rates).	Reimburse at 99203 rate
99396	Established Patient: Preventive Medicine visit 40-64 years Age 40-64 years (e.g. Pap smear, pelvic exam, and clinical breast exam. If CBE or Pap test only, reimburse 99212 rates.	Reimburse at 99213 rate
99397	Established Patient: Preventive Medicine visit 65 and older Age 65 and older (e.g. Pap smear, pelvic exam, and clinical breast exam. If CBE or Pap test only, reimburse 99212 rates.	Reimburse at 99213 rate

99070	Supplies and Materials (except spectacles) – Provider's Office Provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided).	$9.99 (MA Rate)

***All consultations should be billed through 'new patient' office visit CPT codes 99201-99205. Consultations billed as 99204 and 99205 must meet the criteria for these codes and are not appropriate for screening visits.**

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Procedures-Screening

(CPT Billing Codes Related to Services under Form Contract Sections I.A.3 & 4)

CPT Codes	Description	County Rates Screening Rate/Diagnostic MA Rate
57452	Colposcopy Provider's Office	$125.81
57454	Colposcopy Colposcopy, with biopsy of the cervix and/or endocervical curettage, Provider's Office	$174.09
57455	Colposcopy Colposcopy, with biopsy (ies) of the cervix, Provider's Office	$164.29
57456	Colposcopy Colposcopy, with endocervical curettage, Provider's Office	$155.08

Procedures-Diagnostic

(CPT Billing Codes Related to Services under Form Contract Sections 1.A.5 & 7)

CPT Codes	Description	County Rates Diagnostic MA Rate
57460	Endoscopy Endoscopy with loop electrode biopsy(s) of the cervix. Provider's Office	$294.64
57461	Endoscopy Endoscopy with loop electrode conization of the cervix. Provider's Office	$330.34
57500	Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	$130.08
57505	Endocervical curettage (not done as part of a dilation and curettage) Provider's Office	$99.67
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser.	$302.33
57522	Loop electrode excision procedure Provider's Office	$258.36
58100	Endometrial sampling (biopsy with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure).	$108.64
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy. (List separately in addition to code for primary procedure)	$48.40

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Pathology - Screening

(CPT Billing Codes Related to Services under Form Contract Sections I.A.3 & 4)

CPT Codes	Description	County Rates *
88164	Cytopathology, Slides, Cervical, or Vaginal The Bethesda System, up to 3 smears, manual screening by technician under physician supervision.	$14.65
88141	Cytopathology, Cervical or Vaginal 1 smear requiring interpretation by physician. It should not include a physician modifier.	$37.53
88142	Cytopathology, Cervical or Vaginal Collected in preservative fluid, automated thin layer preparation; manual screening under Physician supervision. Reported in Bethesda System.	$25.01
88305	Surgical Biopsy, Biopsy of Cervix Global Technical Component (TC) Interpretation (26)	 $80.33 $36.46 $43.87

***Rate is inclusive of average rates for lab fees.**

Laboratory - Screening

(CPT Billing Codes Related to Services under Form Contract Sections I.A.3 & 4)

CPT Codes	Description	County Rates *
87624	HPV Hybrid Capture II test (high-risk panel) Must be reported in the Bethesda System	$43.33
87625	HPV Hybrid Capture II test (types 16-18 only)	$43.33

***Please refer to MCEs for circumstances where HPV test can be reimbursed.**

Pathology - Diagnostic

(CPT Billing Codes Related to Services under Form Contract Sections I.A.4-7)

CPT Codes	Description	County Rates *
88172	Cytopathology Evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s) Global Technical Component (TC) Interpretation (26)	 $40.60 $14.44 $26.14

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CPT Codes	Description	County Rates Screening Rate/Diagnostic MA Rate
88173	Cytopathology, Evaluation of fine needle aspirate: Interpretation and Report Global Technical Component (TC) Interpretation (26)	 $104.85 $56.01 $48.84
88174	Cytopathology, Cervical or Vaginal Collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision. Reported in Bethesda system.	$29.31
88175	Cytopathology, Cervical or Vaginal Collected in preservative fluid, automated thin layer preparation; screening by automated system, and manual rescreening, under physician supervision. Reported in Bethesda system.	$36.34
88143	Cytopathology, Cervical or Vaginal Collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision. Reported in Bethesda system.	$25.01
88307	Surgical Biopsy, Biopsy of Cervix Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins. Global Technical Component (TC) Interpretation (26)	 $155.70 $106.42 $49.28
88331	Pathology Consult during Surgery First tissue block, with frozen section(s) single specimen Global Technical Component (TC) Interpretation (26)	 $66.39 $22.61 $43.78
88332	Pathology Consult during Surgery First tissue block, with frozen section(s), each additional specimen Global Technical Component (TC) Interpretation (26)	 $29.78 $11.91 $17.87

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Procedures – Radiology Facilities
(CPT Billing Codes Related to Services under Form Contract Sections I.A.1-3)

CPT Codes	Description	County Rates Screening Rate/Diagnostic MA Rate
77063	Breast Tomosynthesis (3-D), Bilateral **(add to 77067 only, if performed)** Global Technical Component (TC) Interpretation (26)	 $64.28 $30.80 $33.48
77065*	Unilateral Mammography/Diagnostic Global Technical Component (TC) Interpretation (26)	 $133.30 $90.73 $42.58
77066	Bilateral Mammography/Diagnostic Global Technical Component (TC) Interpretation (26)	 $169.75 $117.13 $52.62
77067	Screening Mammography Global Technical Component (TC) Interpretation (26)	 $130.42 $89.45 $40.97
G0202	Screening Mammogram, Digital Bilateral Global Technical Component (TC) Interpretation	 $129.14 $88.83 $40.31
G0204	Diagnostic Mammogram, Digital Bilateral Global Technical Component (TC) Interpretation	 $167.98 $116.48 $51.52
G0206	Diagnostic Mammogram, Digital Unilateral Global Technical Component (TC) Interpretation	 $131.59 $90.12 $41.48
G0279	Breast Tomosynthesis (3-D), Bilateral or Unilateral (add to G0204 or G0206 only, if performed) Global Technical Component (TC) Interpretation (26)	 $64.28 $30.80 $33.48

***New mammogram codes. The 'G' codes are no longer valid.**
BCCP mammogram reimbursement rates are the average of Medicare digital and prior film rates.

Ultrasound of the Breast

(CPT Billing Codes Related to Services under Form Contract Sections I.A.2 & 3)

CPT Codes	Description	County Rates Screening Rate/Diagnostic MA Rate
76641*	Ultrasound Complete exam of the breast, unilateral Global Technical Component (TC) Interpretation (26)	 $128.64 $86.65 $40.99
76642*	Ultrasound Limited exam of the breast, unilateral Global Technical Component (TC) Interpretation (26)	 $105.07 $66.82 $38.24

***Ultrasound CPT code 76645 no longer valid.**

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MRI of the Breast

(CPT Billing Codes Related to Services under Form Contract Sections I.A.6-c)

CPT Codes	Description	County Rates Screening Rate/Diagnostic MA Rate
77058	Magnetic Resonance Imaging, Unilateral with and/or without contrast Global Technical Component (TC) Interpretation (26)	 $656.30 $564.86 $91.43
77059	Magnetic Resonance Imaging, Bilateral with and/or without contrast Global Technical Component (TC) Interpretation (26)	 $653.26 $561.83 $91.43
82565*	Blood Creatinine	$6.33
A9579*	Gadolinium-based contrast agent	$1.934 per ml
A9575*	Gadoterate meglumi agent	0.222 per 0.1 ml

***Allowable adjunct procedures for MRI's with contrast (appropriate invoice required).**

Diagnostic – Radiology Facilities (non-hospital)

(CPT Billing Codes Related to Services under Form Contract Sections 1.A.5 & 6)

CPT Codes	Description	County Rates Diagnostic MA Rate
19081*	Breast Biopsy, Stereotactic, 1st Lesion Modifier Base Modifier Multiplier Base 50 1.5 51 0.5 80 0.2	 $560.46 $840.69 $280.23 $112.09
19082	Breast Biopsy, Stereotactic, Additional Lesions Modifier Base Modifier Multiplier Base 50 2.0 51 1.0 80 0.2	 $459.58 $919.16 $459.58 $91.92
19281	Placement of Breast Location Device for Biopsy 1st Lesion, Mammographic Guidance Modifier Base Modifier Multiplier Base 50 1.5 51 0.5 80 0.2	 $200.15 $300.23 $100.08 $40.03
19282	Placement of Breast Location Device for Biopsy Additional Lesions, Mammographic Guidance	

	Modifier Base Modifier Multiplier Base 50 2.0 51 1.0 80 0.2	 $139.37 $278.74 $139.37 $27.87
76098	Radiological Examination, Surgical Specimen Global Technical Component (TC) Interpretation (26)	 $16.40 (MA Rate) $8.57 $7.83
76942	Ultrasonic Guidance for Needle Placement Imaging Supervision and Interpretation Global Technical Component (TC) Interpretation (26)	 $59.14 (MA Rate) $28.02 $31.32

***Modifier Codes:**

50 Bilateral
51 Multiple Procedures
80 Assistant Surgeon

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General Surgical Consultation and/or Clinical Breast Examination

(CPT Billing Codes Related to Services under Form Contract Sections 1.A.5, 6 & 7)

CPT Codes	Description	County Rates *
99202	New Patient: Single Exam Expanded focused history, expanded focused examination and straightforward medical decision making. (e.g. either a Pap test with a pelvic exam or a clinical breast exam; can also be both Pap test and CBE)	$86.20
99203	New Patient: Exam Detailed history, detailed examination and medical decision making of low complexity. (e.g. Pap test, pelvic exam and clinical breast exam. Can also be billed in conjunction with a colposcopy [with or without biopsy] procedure).	$124.25

Breast Incision, Repair and Reconstruction Codes

(CPT Billing Codes Related to Services under Form Contract Sections 1.A.5 & 6)

CPT Codes	Description	County Rates Diagnostic MA Rate
10021	Fine needle aspiration without imaging guidance	$103.10
10022	Fine needle aspiration with imaging guidance	$112.07
19000	Puncture aspiration of cyst of breast.	$90.02
19001	Puncture aspiration of cyst of breast, each additional cyst, used with 19000.	$21.33
19081	Breast biopsy, Stereotactic, 1st Lesion Modifier — Base Modifier Multiplier Base 50 — 1.5 51 — 0.5 80 — 0.2	 $560.46 $840.69 $280.23 $112.09
19082	Breast biopsy, Stereotactic, Additional Lesions Modifier — Base Modifier Multiplier Base 50 — 2.0 51 — 1.0 80 — 0.2	 $459.58 $919.16 $459.58 $91.92
19083	Breast biopsy, 1st Lesion, US Guided Imaging Modifier — Base Modifier Multiplier Base 50 — 1.5 51 — 0.5 80 — 0.2	 $556.79 $835.19 $278.40 $111.36
19084	Breast biopsy, Additional Lesions, US Guided Imaging Modifier — Base Modifier Multiplier Base 50 — 2.0	 $447.68 $895.36

	51	1.0	$447.68
	80	0.2	$89.54
19085	Breast biopsy, 1st Lesion, MRI Guided Imaging		
	Modifier	Base Modifier Multiplier	
	Base		$844.09
	50	1.5	$1,266.14
	51	0.5	$422.05
	80	0.2	$168.82
19086	Breast biopsy, Additional Lesions, MRI Guided Imaging		
	Modifier	Base Modifier Multiplier	
	Base		$673.43
	50	2.0	$1,346.86
	51	1.0	$673.43
	80	0.2	$134.69
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance.		$120.65
19101	Breast biopsy, open incisional		$273.03
19120	Excision of cyst, fibro-adenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions.		$395.48
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion.		$438.40
19126	Excision of breast lesion identified by preoperative placement of radiological marker; open; each additional lesion separately.		$130.77
19281	Placement of Breast Location Device for Biopsy, 1st Lesion, Mammographic Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$200.15
	50	1.5	$300.23
	51	0.5	$100.08
	80	0.2	$40.03
19282	Placement of Breast Location Device for Biopsy, Additional Lesion, Mammographic Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$139.37
	50	2.0	$278.74
	51	1.0	$139.37
	80	0.2	$27.87
19283	Placement of Breast Location Device for Biopsy, 1st Lesion, Stereotactic Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$227.75
	50	1.5	$341.63
	51	0.5	$113.88
	80	0.2	$45.55
19284	Placement of Breast Location Device for Biopsy, Additional Lesion, Stereotactic Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$167.56
	50	2.0	$335.12
	51	1.0	$167.56
	80	0.2	$33.51
19285	Placement of Breast Location Device for Biopsy, 1st Lesion, US Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$415.51
	50	1.5	$623.27
	51	0.5	$207.76

	80	0.2	$83.10
19286	Placement of Breast Location Device for Biopsy, Additional Lesion, US Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$363.25
	50	2.0	$726.50
	51	1.0	$363.25
	80	0.2	$72.56
19287	Placement of Breast Location Device for Biopsy, 1st Lesion, MRI Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$721.07
	50	1.5	$1,081.61
	51	0.5	$360.54
	80	0.2	$144.21
19288	Placement of Breast Location Device for Biopsy, Additional Lesion, MRI Guidance		
	Modifier	Base Modifier Multiplier	
	Base		$574.44
	50	2.0	$1,148.88
	51	1.0	$574.44
	80	0.2	$114.89

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Anesthesia

(CPT Billing Codes Related to Services under Form Contract Sections 1.A.5, 6 & 7)

CPT Codes	Description	County Rates *
00400	Anesthesia For procedures on the integumentary system, anterior trunk, not otherwise specified. (Provider's Office).	Conversion factor: 1.1486 Base Unites = 3 (RVU = 45)
	Anesthesia fees are the sum of the total time in minutes plus the base units converted to time units multiplied by the listed fee per unit and by the modifier rate (50% or 100%). Payment will be the lower of the provider' charge or the calculated fee amount. Base unit for 00400=3; base unit converted to time units for 00400=45 (3 base units x 15 minutes=Relative Value Unit).	

Example: CPT Code: 00400, Time = 100 minutes, Modifier = QX
Total Units = (number of minutes + RVU) x Conversion Factor
Total Reimbursement = (100 minutes + 45 RVU) x 1.1486 Conversion Factor = 166.55 x .50 QX modifier = $83.27

Modifiers:

Acceptable Modifiers:

-AA Anesthesia services performed personally by anesthesiologist (100%)
-QK Medically directed by a physician: two, three or four concurrent procedures (50%)
-QX Certified Registered Nurse Anesthetist (CRNA) with medical direction by a physician (50%)
-QY Medical direction of CRNA by an anesthesiologist (50%)
-QZ CCRNA without medical direction by a physician (100%)

Other Modifiers:
G8; G9; QS – informational purposes only, does not affect payment

AD; 47; 55; 66; 81 – Unacceptable modifiers