Allowable CPT Codes for the Illinois Breast and Cervical Cancer Program
FOR INTERNAL USE ONLY
Effective February 1, 2013

- Screening services should include CBE, pelvic exam, mammogram and Pap test.
- Every screening cycle must include one procedure that is reimbursed using IBCCP funds with BCCP selected as the payor on SV01.
- Providers must accept the CPT rate as full payment for services. Balances may not be billed to the client.
- IBCCP clients are responsible for paying the bills for CPT codes not included on this list or not reimbursed by IBCCP. A written estimate of the additional charges must be provided to the client by the provider/hospital/clinic prior to being rendered. Providers are encouraged to write-off the charges not reimbursed by IBCCP.
- All services must be provided on an outpatient basis. CDC does not allow for payment of inpatient services.
- The reimbursement rates are based on the highest allowable Medicare rates for Illinois. Total payment is not to exceed these approved rates. If a provider bill is less than the approved rates only reimburse the amount of the bill.
- Payment amounts **CANNOT** be entered into Cornerstone until the bill is received.
- Reimbursement for these codes are according to the established technical and professional components described below:
    - **TC** = Technical Component or the cost of performing the test or procedure at the hospital or outpatient surgery center or clinic and reimbursed to those sites.
    - **26** = Professional Component or the cost of interpretation of the test or procedure by a physician including radiologists or pathologists when that person is not an employee of the hospital or free standing surgery center.

  Each fee component rate is established individually by Medicare; therefore the TC and 26 fees may not add up to equal the total fee.
- Refer to Current Procedural Terminology (CPT) Standard Edition, American Medical Association, for detailed explanation of codes.
- Remember, when entering "split" codes into Cornerstone, both results codes need to match.
- For women enrolled in Category XP (women with incomes above 250% of FPL), only "State" or "Other" may be entered as Payor Codes in Cornerstone, even for CPT Codes listed as "F."
- If the Medical Provider deviates from CDC approved standards, contact the Quality Assurance Nurse for prior approval.
- Refer to page 12 for Global Billing information.

CPT Code	Global Billing Info	Office Visits – Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
99201	XXX	Office Visit, New Patient - Breast Exam Only	F S	$47.18	Paying for an office visit with another procedure, such as a colposcopy, is not allowed. **Payment of CBEs** • **State Funding** – symptomatic women ages 19-34 State funding can be used to pay for the 6-month follow-up repeat CBE for established IBCCP **symptomatic women ages 19-34**, only if the woman does not have financial resources to pay for the 6-month repeat CBE. Remember, IBCCP is payor of last resort. • **Federal Funding (IBCCP)** – All women 35-64 (35-39 receiving a CBE **MUST** have cervical services) When a **repeat CBE** is performed during the same screening cycle it should be paid as a 99212 Office Visit and coded as a BCD even if the same physician is performing the repeat CBE. The PA30 should be completed as "F1" Diagnostic Work-up Complete. If a repeat CBE is performed as a 6 month follow up, it should also be paid as a 99212 and coded as a BCS. If the original CBE was done by an NP or PA, it is preferred that the repeat CBE is done by a physician. When a **CBE is performed following an ultrasound** in the same screening cycle, the CBE must be coded as a BCD. A **post- op visit** must be billed as 99212 and coded as a BCD to incur the least expensive of the office visit codes. IBCCP only pays for 1 post op visit for those CPT codes when a visit is not included. The visit must be completed within the 60 day screening cycle to avoid an MDE error. Post op visits due to surgical complications are the responsibility of the surgeon and should be written off.
99202	XXX	Office Visit, New Patient - Pelvic Exam Only	F S	$80.09	
99203	XXX	Office Visit, New Patient - Breast and Pelvic Exam	F S	$117.58	
99212	XXX	Office Visit, Established Patient - Breast **or** Pelvic Exam **Repeat CBE** (Considered a Dx Procedure) – 10 minutes	F S	$47.18	
99213	XXX	Office Visit, Established Patient - Breast **and** Pelvic Exam	F S	$78.27	

CPT Code	Global Billing Info	Consultation Visits – Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
99202	XXX	Office Consultation Visit (Considered a Dx Procedure) – 20 minutes	F S	$80.09	Usually, the presenting problem(s) are of low complexity.
99203	XXX	Office Consultation Visit (Considered a Dx Procedure) – 30 minutes	F S	$117.58	Usually, the presenting problem(s) are of low complexity.
99204	XXX	Office Consultation Visit – (Considered a Dx Procedure) - 45 minutes	F S	$179.36	If used for breast or cervical follow-up visits, the presenting problem(s) must be of moderate complexity.

CPT Code	Global Billing Info	BREAST - Radiology Codes – Mammography Description and Payers (F = Federal/BCCP, S = State)		Fees			Instructions for Use
				TC	26	Total	
77055	XXX	Diagnostic Mammogram, Unilateral	F	$58.63	$36.30	$94.93	**State funding -** Asymptomatic women 40-49 years old (to include **screening** mammograms for this age group). **Federal funding (IBCCP)** – All women 50-64 years old and all symptomatic women (to include **diagnostic** mammograms for all age groups). If a diagnostic mammogram is the ONLY mammogram done for short term follow-up, the SV01 screen must be completed as a BCS and the PA30 must be completed as "P2" diagnostic work-up not planned. If a diagnostic mammogram is the only mammogram done following an abnormal CBE, additional diagnostic must be completed. (Refer to the Breast algorithms).
77056	XXX	Diagnostic Mammogram, Bilateral	F	$76.51	$45.46	$121.98	
77057	XXX	Screening Mammogram, Bilateral	F S	$50.41	$36.65	$87.06	
G0202	XXX	Screening Mammogram, Digital, Bilateral	F S	$109.77	$37.37	$147.14	
G0204	XXX	Diagnostic Mammogram, Digital, Bilateral **REMEMBER** if a client has a discrete palpable mass (B3) further diagnostic work-up is required, either breast ultrasound or office consult visit or repeat CBE (99212).	F	$132.65	$46.54	$179.19	
G0206	XXX	Diagnostic Mammogram, Digital, Unilateral **REMEMBER** if a client has a discrete palpable mass (B3) further diagnostic work-up is required, either breast ultrasound or office consult visit or repeat CBE (99212).	F	$104.05	$37.37	$141.42	

CPT Code	Global Billing Info	BREAST - Radiology Codes - DIAGNOSTICS Description and Payers (F = Federal/BCCP, S = State)		Fees			Instructions for Use
				TC	26	Total	
76098	XXX	Radiological exam, surgical specimen	F	$12.15	$8.46	$20.61	
76645	XXX	Ultrasound breast(s), Bilateral or Unilateral	F	$68.29	$28.90	$97.19	
76942	XXX	Ultrasonic guidance for needle placement (e.g., biopsy aspiration or localization device); imaging supervision and interpretation	F	$185.22	$35.25	$220.46	Can be used with CPT Codes 10022, 19000, 19102, 19103, 19290, 19291.
77031	XXX	Stereotactic localization guidance for breast biopsy or needle placement (e.g. for wire localization), each lesion; radiological supervision and interpretation	F	$55.06	$84.94	$140.00	Can be used with CPT Codes 10022, 19000, 19101, 19102, 19103, 19290, 19291.
77032	XXX	Mammographic guidance for needle placement, breast, each lesion	F	$27.17	$28.91	$56.06	Can be used with CPT Codes 10022, 19000, 19102, 19103, 19290, 19291.

For radiological lesion codes 76098, 77031, 77032, IBCCP will pay for no more than 3 lesions per breast.

CPT Code	Global Billing Info	BREAST - Radiology Codes - DIAGNOSTICS NOT PAID BY IBCCP OR STATE FUNDS Description and Payers (F = Federal/BCCP, S = State)		Fees			Instructions for Use
				TC	26	Total	
77053	XXX	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation **(Not paid by IBCCP or State funds)**	∅	$45.40	$17.97	$63.38	Not reimbursed through IBCCP. These codes are used to document diagnostic workup only.
77054	XXX	Mammary ductogram or galactogram, multiple duct, radiological supervision and interpretation **(Not paid by IBCCP or State funds)**	∅	$62.21	$23.61	$85.82	
77058	XXX	Breast MRI, Unilateral **(Not paid by IBCCP or State funds)**	∅	$577.84	$84.93	$662.77	
77059	XXX	Breast MRI, Bilateral **(Not paid by IBCCP or State funds)**	∅	$575.70	$84.93	$660.63	

CPT Code	Global Billing Info	BREAST - Surgical Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
10021	XXX	Fine Needle Aspiration (FNA) **without** imaging guidance	F	$168.76	Surgical supplies are allowed. May be paid to physician and outpatient facility.
10022	XXX	Fine Needle Aspiration (FNA) **with** imaging guidance	F	$152.38	Surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Code 76942, 77031, 77032.
19000	000	Puncture aspiration of breast cyst	F	$123.03	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Codes 76942, 77031, 77032.
19001	000	Puncture aspiration of breast cysts, each additional cyst	F	$29.34	Must be used with 19000.
19100	000	Breast biopsy, percutaneous, needle core, not using imaging guidance	F	$171.58	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility.
19101	010	Breast biopsy, open incisional	F	$390.46	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility.
19102	000	Breast biopsy, percutaneous needle core, using imaging guidance	F	$234.75	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with 76942.
19103	000	Breast biopsy, percutaneous automated vacuum assisted or rotating biopsy device using imaging guidance (Mammatome)	F	$608.42	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Codes 19102, 76942, 77031, 77032.
19120	090	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	F	$566.48	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility. Cannot be billed with 19125 unless a **separate** lesion.
19125	090	Excision of breast lesion identified by preoperative placement of radiological marker, single; open; lesion	F	$629.79	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility. Cannot be billed with 19120 unless a **separate** lesion.
19126	ZZZ	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	F	$188.68	Must be used with CPT Code 19125. Limit 2 additional lesions.

For surgical biopsy codes 19100, 19101, 19102, 19120, 19295 IBCCP will pay for no more then 3 lesions per breast.

CPT Code	Global Billing Info	BREAST - Surgical Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
19290	000	Preoperative placement of needle localization wire, breast	F	$171.34	May be paid to physician and outpatient facility.
19291	ZZZ	Preoperative placement of needle localization wire, breast, <u>each additional lesion</u>	F	$73.17	Must be used with CPT Code 19290. Limit 2 additional lesions.
19295	ZZZ	Image guided placement of percutaneous metallic localization clip during breast biopsy	F	$100.83	May be paid to physician and outpatient facility. Can be used with CPT Codes 10022, 19102, 19103.
<u>For surgical biopsy codes</u> 19100, 19101, 19102, 19120, 19295, IBCCP will pay for no more then 3 lesions per breast.					

CPT Code	Global Billing Info	CERVICAL - Screening Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
88141	XXX	Pap Test, (Liquid Based or Conventional), cervical or vaginal, reported in the Bethesda System, requiring physician interpretation	F S	$34.00	This code cannot be used unless interpretation by a physician is actually performed and documented. This does not include routine quality assurance review by pathologist. This CPT Code <u>must</u> be used with 88142 and 88164.
88142	XXX	Pap Test, cervical or vaginal, Liquid Based, thin prep, manual screening under physician supervision	F S	$27.85	**ONLY allowed every 3 or 5 years.** If provider chooses to do annually, IBCCP will not reimburse. CPT codes 88143, 88174, 88175 must be reimbursed at the applicable 88142 Medicare reimbursement rate (or less based on bill received). **See exceptions in Section 5.6.**
88164	XXX	Pap Test, Conventional slides, cervical or vaginal, reported in the Bethesda System, manual screening under physician supervision	F S	$14.53	Allowed every 3 or 5 years. **See exceptions in Section 5.6.**

CPT Code	Global Billing Info	CERVICAL - Diagnostic Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
57452	000	Colposcopy of cervix including upper/adjacent vagina **without** biopsy or Endocervical Curettage (ECC)	F	$123.88	Follow the ASCCP guidelines for appropriate screening and follow-up to abnormals. May be paid to physician and outpatient facility. Paying for an office visit with another procedure, such as a colposcopy, is not allowed. Surgical supplies are allowed. DO NOT REPORT 57452 in addition to 57454-57456. DO NOT REPORT 57456 with 57461.
57454	000	Colposcopy of the cervix **with** biopsy **and** endocervical curettage	F	$175.73	
57455	000	Colposcopy of the cervix **with** biopsy	F	$163.50	
57456	000	Colposcopy of the cervix **with** endocervical curettage	F	$154.32	
57460	000	Endoscopy with Loop Electrode biopsy(s) of the cervix	F	$321.90	
57461	000	Endoscopy with Loop Electrode Conization biopsy of the cervix	F	$364.64	
57500	000	Biopsies or Local Excision of Cervical Lesion, single or multiple	F	$144.87	Polypectomies are not covered unless they block the cervical os and/or prevent obtaining an adequate Pap test.
57505	010	Endocervical Curettage (ECC)	F	$116.27	CPT code 57505 is not reimbursable if done as a part of a dilation and curettage.
57520	090	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser	F	$348.35	**Federal Funding (IBCCP):** When procedures **57460, 57461, 57520, 57522** are done as **Diagnostic** for the following: • HSIL Pap Test but negative CIN 1 on colposcopy or biopsy • AGC but negative colposcopy • Positive ECC – ungraded • Micro-invasive cancer on biopsy (LEEP to diagnose deeply invasive cancer, if present) • If LEEP or Cone done for CIN2 & CIN3 without colposcopy enter as a diagnostic on Cornerstone. **DO NOT** enter as treatment
57522	090	Loop Electrode Excision Procedure (LEEP)	F	$302.57	

CPT Code	Global Billing Info	CERVICAL - Diagnostic Codes Description and Payers (F = Federal/BCCP, S = State)		Fee		Instructions for Use
58100	000	Endometrial Sampling (Biopsy) **with** or **without** endocervical sampling (Biopsy), without cervical dilation		F	$125.27	May be paid to physician and outpatient facility. Preoperative testing and surgical supplies are allowed. Abnormal bleeding alone is not justification for endometrial biopsy per CDC. **Criteria for Endometrial Sampling:** **IBCCP will pay for the following:** • AGC Pap for women age 35 and over → endometrial biopsy covered • AGC Pap for women under 35 but abnormal bleeding/anovulation → endometrial biopsy covered • Post-menopausal women with a negative Pap, but endometrial cells are present (enter this result as AGC in Cornerstone). **IBCCP CANNOT pay for the following:** • Post-menopausal bleeding and a negative Pap (required to look for endometrial hyperplasia/cancer). • Abnormal Pap (Not AGC) with abnormal bleeding at any age. Use 58110 in conjunction with 57452, 57454, 57455, 57456, 57460, 57461.
58110	000	Endometrial Sampling (Biopsy) performed in conjunction with colposcopy		F	$54.77	
58558	000	Hysteroscopy with Endometrial Biopsy		S	$451.13	
				Fees		
				TC	**26**	**Total**
76856	XXX	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	S	$99.04	$35.24	$134.28	Only allowable after diagnosis of cervical cancer to determine metastasis in the pelvic region.

87621	XXX	HPV (Human Papillomavirus) testing
		(Considered a Diagnostic Procedure)
		• Hybrid Capture II from Digene (High Risk Typing, only)
		• Cervista HPV HR
			F		$48.24	If an HPV test is performed as follow-up to an ASCUS Pap test, and the HPV test is positive, further diagnostic work-up **must** be performed.
						Reimbursement for HPV testing is allowed:
						For the following (code as CCS.)
						• For HPV co-testing, the combination of cytology and HPV testing every 5 years for women 35-64.
						• For a **negative Pap test, with no prior abnormality**, lacking endocervical cells/borderline cellularity/obscuring factors. An HPV test can be done at 12-months or re-Papped at 12-months.
						
						For the following (code as CCD.)
						• The Pap result is negative, with a positive high risk HPV identified, the IBCCP will reimburse for a 12-month repeat Pap and HPV test, regardless of the testing modality. Colposcopy is indicated if after one year the woman still has a Pap test result of negative and a positive high risk HPV is identified.
						• As **reflex testing to an ASCUS Pap result**. "Reflex" testing refers to testing either the original LBC residual specimen or a separate sample co-collected at the time of the **initial screening visit** for HPV testing.
						• As **initial workup of women with AGC** (in combination with Colposcopy and Endometrial Sampling if >35 years or at risk for endometrial neoplasia, see ASCCP algorithms)
						• For **Post-Colposcopy management at 12-months** in the following:
						  • ASC-US HPV positive
						  • ASC-H, no CIN 2/3
						  • LSIL, no CIN 2/3
						  • Subsequent Management of AGC (not initial workup), refer to ASCCP algorithms for HPV +/- status.
						• For **Post-Treatment management at 6-12 months** following a Diagnostic Excisional Procedure for CIN 2/3.
						• For **Post-Treatment management** of Adenocarcinoma in situ **at 6 months** if re-excision was required due to positive margins (refer to Section 5.7)

CPT Code	Global Billing Info	CERVICAL - Treatment Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
57460	000	Endoscopy with Loop Electrode Biopsy(s) of the cervix	S	$321.90	Follow the ASCCP guidelines. May be paid to physician and outpatient facility. Preoperative testing and surgical supplies are allowed. **State Funding:** Treatment for CIN 2 **Federal Funding (IBCCP):** When procedures **57460, 57461, 57520, 57522** are done as **Diagnostic** for the following: • HSIL Pap Test but negative CIN 1 on colposcopy or biopsy • AGC but negative colposcopy • Positive ECC – ungraded • Micro-invasive cancer on biopsy (LEEP to diagnose deeply invasive cancer, if present • If LEEP or Cone done for CIN2 & CIN3 without colposcopy enter as diagnostic in Cornerstone. **DO NOT** enter as treatment. Precancerous cervical conditions eligible for **Treatment Act:** • CIN 3 • Severe dysplasia of the cervix • HSIL • AGC with a suspicion of AIS **Federal Funding (IBCCP)**: Pays for least expensive Service. **Medicaid:** Pays all other procedures. Data enter all diagnostic services into Cornerstone including those paid by Medicaid.
57461	000	Endoscopy with Loop Electrode Conization biopsy of the cervix	S	$364.64	
57511	010	Cryocautery of the cervix	S	$166.75	
57520	090	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser	S	$348.35	
57522	090	Loop Electrode Excision Procedure (LEEP)	S	$302.57	

CPT Code	Global Billing Info	Pathology Fees Description and Payers (F = Federal/BCCP, S = State)		Fees			Instructions for Use
				TC	26	Total	
88172	XXX	Evaluation of FNA of Breast(s) to determine specimen adequacy	F	$20.73	$37.04	$57.78	
88173	XXX	Interpretation and report of FNA of Breast(s)	F	$84.38	$74.07	$158.45	
88305	XXX	Surgical pathology, breast **(does not evaluate surgical margins)** or cervical biopsy specimens	F	$35.39	$38.43	$73.82	IBCCP will pay up to 3 specimens from each breast or 3 cervical specimens.
88307	XXX	Surgical pathology, breast **(evaluates surgical margins)** or cervical specimens	F S	$226.70	$86.44	$313.14	If 88307 entered for **cervical** services, bill to **State.** Only covered for conization of the cervix for treatment of **CIN 2.**
88331	XXX	Frozen section, first tissue block, single specimen (breast or cervical)	F S	$40.76	$63.86	$104.62	**State Funding:** Breast **Federal Funding (IBCCP):** Cervical
88332	XXX	Frozen section, each additional specimen **(Limit 2)** (breast or cervical)	F S	$14.29	$31.75	$46.05	

CPT Code	Preoperative Testing Description and Payers (F = Federal/BCCP, S = State)		Fees			Instructions for Use
			TC	26	Total	
71010	Chest x-ray, 1 view	S	$16.08	$9.52	$25.60	These codes may be used only in conjunction with the following procedures: 19000, 19100, 19101, 19102, 19103, 19120, 19125, 10021, 10022, 57460, 57461, 57520, 57522, 58100, 58110 and 58558. A pregnancy test may be reimbursed prior to colposcopy procedures, only when there is concern that the client may be pregnant. The test should not be routinely performed on every client scheduled for colposcopy.
71020	Chest x-ray, 2 views	S	$21.80	$11.28	$33.08	
80048	Basic metabolic panel	S			$11.63	
80053	Comprehensive metabolic panel	S			$14.53	
81001	Urinalysis	S			$4.35	
81025	Pregnancy test	S			$8.70	
85014	Hematocrit	S			$3.26	
85018	Hemoglobin	S			$3.26	
85025	CBC with differential WBC count	S			$10.69	
85027	CBC without differential	S			$8.89	
93000	EKG	S			$19.89	

CPT Code	Additional Procedures Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
99144	Conscious Sedation	S	Limited to $200.00	Conscious Sedation is a drug induced depression of consciousness. Patients will still respond to verbal and tactile stimulation. No artificial airway or ventilation is required. This code can be used with CPT codes 57454, 57455, 57456, 57460, 57461, 57500, 57505, 57520, 57522, 58100, 58110 and 58558. Conscious sedation should only be used for these procedures when absolutely necessary. When both a Certified Registered Nurse Anesthetist (CRNA) and an Anesthesiologist bill for the procedure, the amount must be split between the two. This amount is NOT reimbursed to the hospital unless the CRNA or anesthesiologist is a hospital employee and will not be submitting a separate bill.
00400	General Anesthesia	F	Limited to $300.00	General anesthesia is unconscious sedation rendered by administration of intravenous medication and/or gas inhalation. This code can be used with CPT codes 19101, 19120, or 19125. When both a Certified Registered Nurse Anesthetist (CRNA) and an Anesthesiologist bill for the procedure, the amount must be split between the two. This amount is NOT reimbursed to the hospital unless the CRNA or anesthesiologist is a hospital employee and will not be submitting a separate bill.
99070	Surgical Supplies	F S	Limited to $500.00	This code is used to reimburse facilities when procedures are performed in an outpatient setting. Allowable charges include surgical supplies and pharmacy supplies. This code may be used in conjunction with the following procedures: 10021, 10022, 19000, 19100, 19101, 19102, 19103, 19120, 19125, 57460, 57461, 57520, 57522, 58100, 58110 or 58558. Surgical supply fees should be reimbursed to the hospital or freestanding surgical clinic where the procedure was performed. A separate line item indicating surgical supplies, operating room supplies or similar language should be noted on the bill received. Reimbursement of $50.00 is allowed for minor procedures including CPT Codes 57454, 57455, 57456, 57500, 57505 and 57511. The charge must be listed on the bill received. It is not an automatic payment to the facility or provider. This charge should be used with caution to ensure that programs do not reimburse for supplies, the cost of which, has already been accounted for in another clinical charge. CDC funds can be used to pay for estrogen vaginal cream for **postmenopausal women prior to colposcopy** (limited to 6 weeks prior to colposcopy) in those instances when the cream is necessary to ensure adequate visualization for diagnostic purposes. **State Funding:** When the procedure can only be paid using state funds, reimbursement for surgical supplies **MUST** be paid with state funds as well.

GLOBAL BILLING INFORMATION CODE	
Code	**Explanation** The global period is the number of days following a procedure during which all services furnished by the physician are included in the reimbursement for that procedure. This includes postoperative visits and complications following a procedure including all additional medical and/or surgical services required of the physician (not resulting in a return trip to the operating room) during the designated global period.
XXX	The global period concept does not apply to the code.
ZZZ	These represent add-on codes. This code is related to another service and is always included in the global period of the primary service.
0 days	Endoscopic or minor procedure without an associated global period.
10 days	Minor procedure that has an associated 10 day global period, where any postoperative office visit is included in the procedure fee.
90 days	Major surgery with a 1-day preoperative period and a 90-day postoperative period included in the procedure fee.

CORNERSTONE PROGRAM CODES FOR REFERRAL TO TREATMENT ACT – RTTA		
		Fee
RTAA	Referral to Treatment Act – Approved	$50.00
RTAD	Referral to Treatment Act – Denied	$50.00

PROCEDURES SPECIFICALLY NOT ALLOWED	
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
Any	HPV testing for screening purposes
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics
Any	Magnetic Resonance Imaging (MRI) in breast cancer screening or diagnostics.