Allowable CPT Codes for the Illinois Breast and Cervical Cancer Program
FOR INTERNAL USE ONLY
Effective February - 2016

- 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	$47.07	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	$80.08	
99203	XXX	Office Visit, New Patient - Breast and Pelvic Exam	F S	$117.08	
99212	XXX	Office Visit, Established Patient - Breast **or** Pelvic Exam **Repeat CBE** (Considered a Dx Procedure) – 10 minutes	F S	$46.34	
99213	XXX	Office Visit, Established Patient - Breast **and** Pelvic Exam	F S	$77.85	

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	$80.08	Usually, the presenting problem(s) are of low complexity.
99203	XXX	Office Consultation Visit (Considered a Dx Procedure) – 30 minutes	F S	$117.08	Usually, the presenting problem(s) are of low complexity.
99204	XXX	Office Consultation Visit – (Considered a Dx Procedure) - 45 minutes	F S	$178.19	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 S	$56.79	$38.01	$94.80	**State funding -** Asymptomatic women 40-49 years old (to include **initial** mammograms for this age group – initial is defined as the first mammogram (screening or diagnostic) of the screening cycle). **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 S	$74.61	$47.14	$121.75	
77057	XXX	Screening Mammogram, Bilateral (2 view study each breast)	F S	$48.99	$38.01	$87.00	
G0202	XXX	Screening Mammogram, Digital, Bilateral	F S	$103.57	$37.64	$141.21	
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	$125.48	$47.14	$172.62	
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	$98.00	$37.64	$135.64	

CPT Code	Global Billing Info	Additional BREAST - Radiology Codes 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	F	$42.31	$19.37	$61.68	
77058	XXX	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral	F	$477.05	$88.08	$565.13	Reimbursed in conjunction with mammogram when a client has a BRCA mutation, is a first-degree relative who is a BRCA carrier or has a lifetime risk of 20-25% or greater as defined by risk assessment models that are largely dependent on family history. Breast MRI can be used to better assess areas of concern on mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should **never** be done alone as a breast cancer screening tool. Breast MRI **cannot** be reimbursed to assess the extent of disease in a woman who is already diagnosed with breast cancer.
77059	XXX	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral	F	$474.08	$88.08	$562.16	

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	$9.26	$8.77	$18.03	
76641	XXX	Ultrasound breast, **complete** examination of breast including axilla, unilateral	F	$74.61	$39.47	$114.08	For bilateral ultrasound use 2 units
76642	XXX	Ultrasound breast, **limited** examination of breast including axilla, unilateral	F	$57.16	$36.91	$94.07	For bilateral ultrasound use 2 units.
76942	XXX	Ultrasonic guidance for needle placement (e.g., biopsy aspiration or localization device); imaging supervision and interpretation	F	$28.94	$36.18	$65.12	Can be used with CPT Codes 10022, 19000, 19081-19086, 19281-19288.

For radiological lesion codes 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	
77054	XXX	Mammary ductogram or galactogram, multiple duct, radiological supervision and interpretation **(Not paid by IBCCP or State funds)**	∅	$56.42	$24.85	$81.27	Not reimbursed through IBCCP. These codes are used to document diagnostic workup only.

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	$134.60	Surgical supplies are allowed. May be paid to physician and outpatient facility.
10022	XXX	Fine Needle Aspiration (FNA) **with** imaging guidance	F	$152.13	Surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Code 76942. Surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Codes 19281, 19282, 19081, 19082, 19283, 19284, 76942.
19000	000	Puncture aspiration of breast cyst	F	$122.42	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility. Can be used with CPT Code 19281, 19282, 19081, 19082, 19283, 19284, 76942.
19001	ZZZ	Puncture aspiration of breast cysts, each additional cyst	F	$30.03	Must be used with 19000.
19100	000	Breast biopsy, percutaneous, needle core, not using imaging guidance	F	$168.15	Preoperative testing and surgical supplies are allowed. May be paid to physician and outpatient facility.
19101	010	Breast biopsy, open incisional	F	$384.11	Preoperative testing, anesthesia, and surgical supplies are allowed. May be paid to physician and outpatient facility.
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	$568.66	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	$632.65	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	$196.17	Must be used with CPT Code 19125. Limit 2 additional lesions.

For surgical biopsy codes, IBCCP will pay for no more than 3 lesions per breast.

CPT Code	Global Billing Info	BREAST - Surgical Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
19081	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	F	$742.68	Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging specimen. These codes should not be used in conjunction with 19281-19288. Can be used with 76942, 10022, 19000 and 19101. May be paid to physician and outpatient facility.
19082	XXX	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	F	$609.90	
19083	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	F	$716.93	
19084	XXX	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	F	$586.25	
19085	000	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	F	$1097.72	
19086	XXX	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	F	$865.26	
19281	000	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	F	$257.30	Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086. May be paid to physician and outpatient facility.
19282	XXX	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	F	$179.50	
19283	000	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	F	$289.92	
19284	XXX	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	F	$217.70	
19285	000	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	F	$547.53	
19286	XXX	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	F	$479.26	

CPT Code	Global Billing Info	BREAST - Surgical Codes Description and Payers (F = Federal/BCCP, S = State)		Fee	Instructions for Use
19287	000	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	F	$914.31	Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.
19288	XXX	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	F	$734.72	May be paid to physician and outpatient facility.
For surgical biopsy codes, IBCCP will pay for no more than 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	$34.55	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 must be used with 88142 and 88164.
88142	XXX	Pap Test, cervical or vaginal, Liquid Based, thin prep, manual screening under physician supervision	F S	$27.60	**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	$14.39	Allowed every 3 or 5 years. **See exceptions in Section 5.6.**
87624	XXX	HPV (Human Papillomavirus), high risk types	F	$47.80	• HPV high risk testing is allowed in conjunction with PAP testing or for follow-up of an abnormal Pap result or surveillance .and reimbursed by IBCCP per ASCCP guidelines • Not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 yrs. • Providers should specify the high-risk HPV DNA panel only. • Reimbursement of screening for low-risk HPV types is **not permitted.** • IBCCP **does not** reimburse for HPV DNA Typing as

					referenced in the ASCCP algorithm for Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive. **Note**: HPV DNA typing is different from HPV high risk testing. • CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.
87625	XXX	Human Papillomavirus, **types 16 and 18 only**	F	47.80	CDC funds may be used for reimbursement of HPV genotyping.

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	$120.63	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	$168.86	
57455	000	Colposcopy of the cervix **with** biopsy	F	$157.30	
57456	000	Colposcopy of the cervix **with** endocervical curettage	F	$148.16	
57460	000	Endoscopy with Loop Electrode biopsy(s) of the cervix	F	$306.84	
57461	000	Endoscopy with Loop Electrode Conization biopsy of the cervix	F	$347.82	
57500	000	Biopsies or Local Excision of Cervical Lesion, single or multiple	F	$138.41	Polypectomies are covered.
57505	010	Endocervical Curettage (ECC)	F	$112.03	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	$341.05	**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	$290.38	

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	$120.26	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, and 57461.
58110	000	Endometrial Sampling (Biopsy) performed in conjunction with colposcopy	F	$53.08	
58558	000	Hysteroscopy with Endometrial Biopsy	S	$441.94	

87624	XXX	HPV (Human Papillomavirus), high risk types		F		$47.80	• HPV high risk testing is allowed in conjunction with PAP testing or for follow-up of an abnormal Pap result or surveillance .and reimbursed by IBCCP per ASCCP guidelines • Not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 yrs. • Providers should specify the high-risk HPV DNA panel only. • Reimbursement of screening for low-risk HPV types is **not permitted.** • IBCCP **does not** reimburse for HPV DNA Typing as referenced in the ASCCP algorithm for Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive. **Note**: HPV DNA typing is different from HPV high risk testing. • CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay • CDC funds cannot be used for reimbursement of genotyping (e.g., Cervista HPV 16/18). • When the HPV high risk testing results are positive, a colposcopy is required per ASCCP guidelines and should be coded as a CCD in Cornerstone.

				Fees			
				TC	**26**	**Total**	
76856	XXX	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	S	$79.44	$37.27	$116.71	Only allowable after diagnosis of cervical cancer to determine metastasis in the pelvic region.

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	$306.84	Follow the ASCCP guidelines. May be paid to physician and outpatient facility. Preoperative testing and surgical supplies are allowed.
57461	000	Endoscopy with Loop Electrode Conization biopsy of the cervix	S	$347.82	
57511	010	Cryocautery of the cervix	S	$158.85	

57520	090	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser	S	$341.05	**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.
57522	090	Loop Electrode Excision Procedure (LEEP)	S	$290.38	

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	$21.14	$39.54	$60.69	
88173	XXX	Interpretation and report of FNA of Breast(s)	F	$84.99	$76.87	$161.85	
88305	XXX	Surgical pathology, breast **(does not evaluate surgical margins)** or cervical biopsy specimens	F	$36.00	$41.35	$77.35	IBCCP will pay up to 3 specimens from each breast or 3 cervical specimens.

88307	XXX	Surgical pathology, breast **(evaluates surgical margins)**	F S	$233.87	$90.81	$324.68	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 (cervical)	F S	$33.03	$68.11	$101.13	**State Funding:** Breast **Federal Funding (IBCCP):** Cervical
88332	XXX	Frozen section, <u>each additional</u> specimen **(Limit 2)** (cervical)	F S	$20.03	$33.32	$53.35	
88342	XXX	Immunohistochemistry or immunocytochemistry, per specimen; 1st stain **(cervical only)**	F	$73.12	$38.79	$111.92	Only allowable after a diagnosis of CIN2. Other special requests require prior approval.
88341	XXX	Immunohistochemistry or immunocytochemistry, per specimen; each additional stain **(cervical only)**	F	$64.60	$28.91	$93.52	Only allowable after a diagnosis of CIN2. Other special requests require prior approval.

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	F S	$14.09	$9.87	$23.96	These codes may be used <u>only</u> in conjunction with the following procedures: 19000, 19100, 19101, 19081-19086, 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	F S	$17.80	$11.70	$29.50	
80048	Basic metabolic panel	F S			$11.52	
80053	Comprehensive metabolic panel	F S			$14.39	
81001	Urinalysis	F S			$4.32	
81025	Pregnancy test	F S			$8.61	
85014	Hematocrit	F S			$3.23	
85018	Hemoglobin	F S			$3.23	
85025	CBC with differential WBC count	F S			$10.59	
85027	CBC without differential	F S			$8.81	
93000	EKG	F S			$18.40	

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, 19081-19086, 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, 19081-19086, 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

CORNERSTONE PROGRAM CODES FOR CLINICAL NAVIGATED INSURED - CNI		
CNI	Clinical Navigated Insured	**Fee** $75.00

PROCEDURES SPECIFICALLY NOT ALLOWED	
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics