FY 2019

Women's Health Connection Policy and Procedure Manual

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH WOMEN'S HEALTH CONNECTION IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK

FUNDED THROUGH THE NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (NBCCEDP)

GRANT # 1U58DP003929 | FY 2019

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Program Overview

In 1990, Congress passed The Breast and Cervical Cancer Mortality Prevention Act due to an increase in the number of low-income and uninsured women being diagnosed with breast cancer. This bill authorized the Centers for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide high-quality and timely breast and cervical cancer screening and diagnostic services to low-income, and uninsured women. The bill created the first national cancer screening program in the United States. NBCCEDP funds 67 programs, including all 50 states, the District of Columbia, five US territories, and eleven tribes or tribal organizations.

In 1997, The Nevada Division of Public and Behavioral Health received funding from the NBCCEDP to establish the Women's Health Connection (WHC) Program. The purpose of WHC is to reduce breast and cervical cancer morbidity and mortality rates among medically underserved women in Nevada. This is accomplished through education, screening, and early diagnosis. Since its implementation, WHC has provided breast and cervical cancer screening services to over **60,491** women.

Further, as a result of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354), women who are enrolled and active in WHC for breast and cervical cancer screenings, and are diagnosed with breast or cervical cancer, have access to treatment services through Medicaid.

The Division of Public and Behavioral Health entered into a multi-year contract in 2011 with Access to Healthcare Network (AHN) to administer the WHC Program. This partnership increases access to primary and specialty healthcare services for breast and cervical cancer screenings for Nevada women.

The priority population for WHC are women aged 21 to 64 years old. The target population for cervical cancer screenings are women aged 21 to 64 years old and women aged 40 to 64 years old for breast cancer screening services.

"The mission of Chronic Disease Prevention and Health Promotion is to maximize the health of Nevadans by improving policy, systems and environment that influence quality of life"

Case Management

Case Management Services

WHC at DPBH partners with Access to Healthcare Network to provide care coordination and case management services, including collaborating with providers, to meet the health needs of women. The NBCCEDP evaluates the WHC program performance through Minimum Data Elements (MDEs), which are quality assurance measures. MDEs contain screening and diagnostic data which is submitted to the CDC in April and October every year. NBCCEDP has eleven core performance indicators with benchmarks to ensure timely, complete, and accurate data is collected.

Core Program Performance Indicators			
Indicator Type	DQIG Item	Program Performance Indicator	CDC Standard
Screening	**6a.**	Initial Program Pap Tests; Never Screened	≥ 20%
	19e.	Mammograms Provided to Women	≥ 75%
Cervical Cancer Diagnostic Indicators	**11a.**	Abnormal Screening Results with Complete Follow-Up	≥ 90%
	16d.	Abnormal Screening Results; Time from Screening to Diagnosis >90 Days	≤ 25%
	17.	Treatment Started for Diagnosis of HSIL, CIN2, CIN3, CIS, Invasive	≥ 90%
	18d.	HSIL, CIN2, CIN3, CIS; Time from Diagnosis to Treatment >90 Days	≤ 20%
	18g.	Invasive Carcinoma; Time from Diagnosis to Treatment >60 Days	≤ 20%
Breast Cancer Diagnostic Indicators	**20a.**	Abnormal Screening Results with Complete Follow-Up	≥ 90%
	25d.	Abnormal Screening Results; Time from Screening to Diagnosis >60 Days	≤ 25%
	26.	Treatment Started for Breast Cancer	≥ 90%
	27d.	Breast Cancer; Time from Diagnosis to Treatment > 60 Days	≤ 20%

AHN provides case management services to ensure patients receive timely and appropriate screening and diagnostic services. The WHC program does not reimburse for treatment services. If a woman is diagnosed with cancer and is not eligible for Medicaid services, AHN will refer her to other treatment resources. Staff will explain the importance of follow-up services, and assist with scheduling appointments. Case management services will also help women identify and resolve barriers, to ensure women receive follow-up services. Case management services conclude when a patient is determined to have a final diagnosis not requiring treatment, or when a patient initiates or refuses treatment.

Care Coordinators:

- Work closely with patients to ensure the patient receives the appropriate services in a timely manner,
- Coordinate the patient's care with provider(s),
- Review clinical records to ensure providers are complying with USPSTF Guidelines,
- Ensure recommended diagnostic procedures are completed within recommended time frames,
- Maintain timely contact with patients and document all contact using a tracking system,
- Assess patients for barriers and provide assistance (transportation, work schedule, etc.)

- If diagnosed with cancer, assist patients with Medicaid application and track Medicaid approval, and/or refer to other treatment resources.

Responsibilities: *WHC and Providers*

WHC Responsibility to Providers:

- Ensure provider contracts are established
- Provide training, technical assistance, and professional education resources to enrolled providers
- Provide WHC enrollment forms, reporting forms, and promotional materials
- Ensure all providers meet quality standards. i.e. MQSA CLIA
- WHC will remit payment to providers within 30 days of receiving HCFA 1500 form, UB 04 form or other forms of billing
- Ensure case management services are provided to eligible women
- Refer eligible women to treatment services
- Maintain ongoing provider communication in regards to policies and procedures
- Maintain a central patient tracking system
- Ensure providers adhere to USPSTF Guidelines

Provider Responsibility to WHC:

- Providers must attend mandatory WHC orientation and training, conducted by AHN, once a year
- Providers are responsible for following WHC eligibility screening protocols
- Enrollment form must be completed, signed by patient and submitted to WHC at AHN with the initial screening visit form within **30 days** of initial screening date
- Ensure patients receive eligible screening and diagnostic services covered under the WHC Program
- Notify patients verbally, or in writing, of results within **10 days** of receiving results, and explain abnormal results and processes to obtain diagnostic services
- Per NRS 457, providers **MUST** report all cancer diagnoses to the Cancer Registry http://www.leg.state.nv.us/NRS/NRS-457.html
- Provide patients with educational materials and recommendations for breast and cervical cancer screening intervals, per USPSTF screening guidelines, and educate patients about the importance of timely follow-up for diagnostic procedures.
- All diagnostic and abnormal screening results must be faxed to WHC staff at AHN within **48 hours of the procedure** to initiate case management services and ensure timely follow-up for the patient.
- If a woman refuses diagnostic procedures/treatment, the *Patient Refusal Form* must be completed and faxed to WHC staff at AHN within **48 hours.**
- Ensure patients are not be billed for reimbursable program services
- Ensure women are recalled and screened at appropriate screening intervals (WHC will not reimburse for unnecessary "over-screening")
- Maintain patient confidentiality
- Assemble documents as requested for WHC provider site audits from either AHN or DPBH
- HCFA 1500 form, UB 04 form or other forms of billings must be submitted within **30 days** of the date of service

Eligibility Screening & Enrollment

Determining Eligibility

WHC expects providers to encourage eligible women to pursue health insurance coverage. Federal law mandates that the WHC program is the "payor of last resort." If breast and cervical cancer services are available through any other state compensation program, under an insurance policy or federal or state health benefits program, prepaid health services, AHN funding may not be used.

AHN eligibility components:

- Must be at least 21 years of age
- Must be at or below 250% of federal poverty level **(see chart)**
- Nevada Resident
- Uninsured or underinsured
- Transgender women (male to female) 40 years and above who have taken or are taking hormones can receive breast cancer screening services
- Transgender women (female to male) 21 years and above who have not undergone bilateral breast mastectomy and hysterectomy can receive breast and/or cervical cancer screening services

Fiscal Year 2019 Income Guidelines		
Number of People in Household	**Household Income Before Taxes**	
	Yearly 250% FPL	**Monthly 250% FPL**
1	$30,350	$2,529
2	$41,150	$3,429
3	$51,950	$4,329
4	$62,750	$5,229
5	$73,550	$6,129
6	$84,350	$7,029
7	$95,150	$7,929
8	$105,950	$8,829
For each additional person, add $4,320 per year		

Underinsured Policy

The intent of the underinsured policy is to relieve financial burdens which may prevent the patient from receiving cancer screening or diagnostic testing. WHC will reimburses at Medicare's allowable rate. If the provider accepts payment from WHC there should be no outstanding balance to the patient.

Copay Assistance Program (CAP):

A patient covered under a health insurance plan that does not fully cover breast and cervical cancer screenings and/or diagnostics, and has an insurance deductible of $100.00 or more is considered underinsured under WHC policy. Underinsured status also includes co-pays for covered breast and cervical cancer screenings.

Guidelines:

- Underinsured women must be deemed eligible for WHC services by Access to Healthcare Network (AHN) prior to deductible or co-pay reimbursement
- WHC will reimburse providers for deductibles and co-pays for WHC covered services
- WHC will reimburse providers at the Medicare allowable rates
- Reimbursable providers must be part of WHC provider network

Steps to Reimbursement:

1. Providers will bill patient's insurance company first
2. If the patient has an outstanding balance following insurance processing, the patient will contact Access to Healthcare Network for eligibility verification and enrollment into CAP
3. Patient will submit bill(s) to WHC at AHN for reimbursement

Methods of Enrollment into WHC Program

1. Enrollment at the PCP's Office

A woman enrolls into WHC by completing the *Enrollment Form* at the providers office. The provider then submits the Enrollment Form to WHC at AHN on the woman's behalf. The provider shall determine eligibility based on a woman's age, income and insurance status. A woman is considered enrolled in WHC on the date screening services are performed, not before.
WHC will not pay for services prior to the enrollment date.

2. Enrollment through the AHN Helpline Call Center

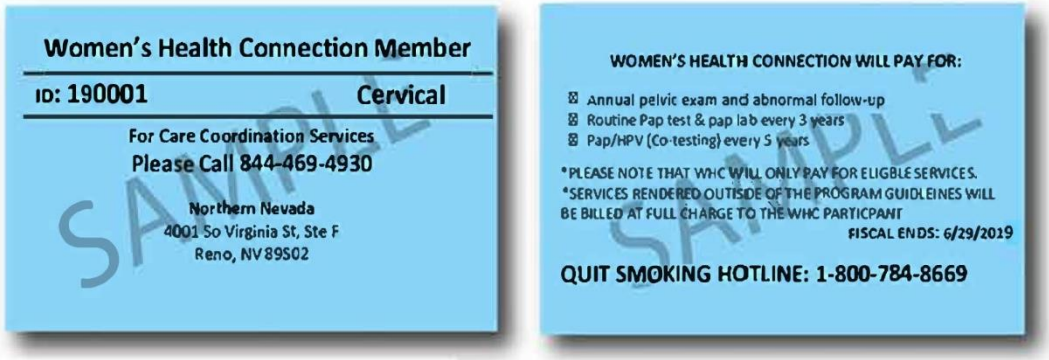
A woman who establishes eligibility for WHC through the AHN Helpline will receive a welcome letter in the mail, list of participating providers, and a *WHC Enrollment Form*. When the patient arrives at the PCP's office for her scheduled appointment, she should present the partially completed WHC Enrollment Form (page 1 of the form). A woman is considered enrolled in WHC on the date that eligible screening services were performed and not before.
WHC will not pay for services performed before the date of service at the provider's office.

Women's Health Connection Member ID Card

Every woman screened must be assigned a card. To verify a patient's enrollment in WHC, please advise every woman to present this card to the provider at the time of each appointment.

Card for women ages 40-64:

Card for women ages 21-39:



Card for the CAP program

Reimbursable Screening Services

Breast Screening Services reimbursed by WHC:

A woman, 40 - 64 years of age, enrolled in WHC, is eligible to receive the following services annually:

- Clinical breast exam (CBE)
- Screening Mammogram
  - Screening mammograms for women aged 40-49 are based on funding availability; funding is disbursed on a first come, first served basis. Please contact WHC staff at AHN for more information.
  - Screening mammograms must be ordered for all patients 50 years and older.
  - Screening mammograms must be ordered for all patients using the WHC *Mammography and Ultrasound Referral Form*. The form must include the results of the clinical breast exam and be signed and dated by the ordering clinician.
  - The *Mammography and Ultrasound Referral Form* is valid for 60 days from date of issue by the ordering clinician. If the patient does not complete screening within 60 days, and has not contacted WHC staff at AHN for case management, she will need to wait until her next annual appointment to get rescreened. Please ensure all patients work with AHN WHC staff to ensure timely follow-up.

PLEASE NOTE:
Mammography and Ultrasound Referral Form are valid for **60 days** after date of issue by PCP.

Cervical Screening Services reimbursed by WHC:

A woman, 21-64 years of age, enrolled in WHC shall receive the following services:

- 21 to 29 years old:
  - Pap Test with pelvic exam every 3 years, unless there is an abnormal result
  - Diagnostic services after an abnormal result
  - Referral for treatment
- 30 to 64 years old:
  - Pelvic exam and Pap Test with pelvic exam every 3 years, unless there is an abnormal result, **OR**
  - Co-test (Pap and HPV) with pelvic exam every 5 years, unless there is an abnormal result
  - Diagnostic services after an abnormal result
  - Referral for treatment

Cervical cancer screening is not recommended for women older than age 65 who have had adequate screening and are not at high risk. If a woman over the age of 64 needs to be screened and is eligible to receive Medicare benefits but is not enrolled, she should be encouraged to enroll in Medicare. Women enrolled in Medicare Part B are not eligible for WHC.

WHC **will pay** for a PCP visit under the following circumstances:

- A Pap test or co-testing on women who have had a hysterectomy with or without removal of the cervix if the hysterectomy was due to cervical cancer.

- If a Pap test or co-test is unsatisfactory or false-positive the patient should have a repeat test immediately. The unsatisfactory result is not to be considered in the Pap (3 year) and co-testing (5 year) period of the cervical cancer screening schedule.
- If patient presents new breast symptoms before annual screening date.
- To offer a second office visit to another PCP if the first visit was unsatisfactory.
- **All office visits should be billed through the standard office visit CPT codes: 99201-99203 for "new patients" and 99211-99213 for "established patients". A "new patient" is defined as a woman who is new to the PCP or the practice and/or hasn't been seen within three years by the PCP or at the practice, they are considered a new patient. If the patient has been seen at the practice, but by a different provider, at any time in the last three years, then they are considered an established patient. CPT codes 99204, 99205 and 99214 are not appropriate for WHC screening visits.**

WHC **will not** pay for a PCP visit under the following circumstances:

- To discuss normal screening results (including mammogram with BIRADS 0-3). This service is included in the fee paid for the initial PCP visit and providers are expected to perform this service.
- If a patient returns to her existing provider and is not eligible for a screening test, and the provider performs a screening test anyway, WHC will **NOT** pay for the office visit or the lab fee for the screening.
- WHC will not pay for an initial screening mammogram screening without a corresponding CBE unless authorized by WHC staff.

Annual Breast and Cervical Cancer Screening Visit Form

- Review patient history from page 1 (*WHC Enrollment Form*)
- Fill out the *Clinical Breast Exam Findings* section
  - Clients ages 40 and above are eligible to receive an annual clinical breast exam
  - If there is an abnormal finding, refer patient for diagnostic services. Imaging results must be reviewed by clinician before referral to breast specialist.
- Fill out the *Reason for Imaging* section
  - If the patient is eligible for a routine screening mammogram, complete *Mammography and Ultrasound Referral Form*
  - If the patient is eligible for diagnostic services due to abnormal clinical breast exam findings, complete *Mammography and Ultrasound Referral Form.* Results must be reviewed by clinician before referral to breast specialist.
  - For breast specialist referral, complete *Breast Specialist Referral Form*
- Fill out the *Pelvic Exam Findings* section
  - All patients are eligible to receive a pelvic exam, unless the woman had a total hysterectomy not due to cervical cancer.
  - If an abnormal pelvic is noted that is referred to the cervical specialist, describe the abnormality in the notes field of the form.
  - If an abnormal pelvic is noted that is not referred to the cervical specialist, describe the abnormality in the notes field of the form.

    - For cervical specialist referral, complete *Cervical Specialist Referral Form*
- Fill out the *Reason for Pap/HPV Test* section
    - Pap Testing is the recommended method for cervical cancer screening for women aged 21-29 years old.
    - Co-testing (Pap and HPV test) is the recommended method for cervical cancer screening for women aged 30-64 years old after normal Pap results for women who have an intact cervix, or for women who have had a hysterectomy due to cervical neoplasia.
    - WHC will reimburse Pap tests every 3 years
    - WHC will reimburse co-testing (Pap and HPV test) every 5 years. Women aged 21-29 are not eligible for co-testing and should receive a Pap test.
- The clinician should discuss exam results with the patient and indicate any concerns in the notes field.
- Test results must be delivered verbally or in writing to patients within **10 days** of receipt
- All *WHC Enrollment* and *Annual Screening Visit Forms* must be submitted signed and dated to the appropriate AHN office within **30 days** of date of service.
- **All *WHC Enrollment Forms* for patients with abnormal results must be faxed to WHC staff at AHN within 48 hours upon receipt - Fax 775-284-1918**

Reimbursable Diagnostic Services

If a woman receives an abnormal screening test at any time, the appropriate diagnostic workup must be completed within **60 days** from the date of the abnormal test. The woman will be assigned a Care Coordinator to assist with the diagnostic workup process, ensuring a final diagnosis is reached and treatment is initiated. AHN Care Coordinators can be reached at **844-469-4930.**

Breast Diagnostic Services reimbursed by AHN

Women **40 years** of age and older, enrolled in WHC shall receive diagnostic services for the following screening results:

Normal CBE and Abnormal Screening Mammography Test Results

- ***BI-RADS Category 0*** (Assessment Incomplete) – Additional imaging is required
- ***BI-RADS Category 3*** (Probably Benign) – If this is the first ever mammogram, additional imaging is required. (Please refer to breast algorithm for further follow up, located as an attachment)
- ***BI-RADS Category 4*** (Suspicious Abnormality) – Refer to specialist.
- ***BI-RADS Category 5*** (Highly Suggestive of Malignancy) – Refer to specialist.

Women 40 years and older enrolled in AHN shall receive diagnostic services with the following screening results:

Abnormal CBE and Diagnostic Evaluation (Mammogram and Ultrasound) Test Results

- ***BI-RADS Category 0*** (Assessment Incomplete) – Additional imaging is required
- ***BI-RADS Category 1*** (Negative) – If certain of abnormality or mass is persistent refer to specialist. If not certain of abnormality, repeat CBE in 30 days by PCP, if mass is not persistent follow routine screening, if mass is persistent refer to specialist
- ***BI-RADS Category 2*** (Benign) – Correlate physical findings with diagnostic imaging evaluation and assure finding is concordant, if finding is concordant follow routine screening, if finding is discordant, refer to specialist
- ***BI-RADS Category 3*** (Probably Benign) – Refer to specialist
- ***BI-RADS Category 4*** (Suspicious Abnormality) – Refer to specialist
- ***BI-RADS Category 5*** (Highly Suggestive of Malignancy) – Refer to specialist

Abnormal CBE results include:
Discrete palpable mass suspicious for cancer, Bloody/serous nipple discharge, Nipple/areolar scaliness, and Skin dimpling/retraction

Important! Specialist Referrals
WHC Care Coordinator will select a specialist to process the referral. Once the referral has been processed, WHC will notify the PCP.

Other Breast Diagnostic Services (Prior Approval Required)

- Consult-Repeat CBE
- Surgical consultation
- Mammary ductogram or galactogram single duct
- MRI with or without contrast. Breast MRI can be reimbursed in conjunction with a mammogram when a patient has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history. Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a patient 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 by the program to assess the extent of disease in a woman who is already diagnosed with breast cancer - **Prior approval required**
- Biopsy (Fine Needle Aspiration (FNA), core needle biopsy, and excisional biopsy)
- Some pre-operative testing is allowed with prior approval from WHC. These procedures should be medically necessary for the planned surgical procedure.

Breast Specialist Services

WHC **will pay** for a consultation with a specialist under the following circumstances:

- To discuss follow-up if CBE is normal and screening imaging results are BI-RADS 4 or BI-RADS 5
- To discuss follow-up if CBE is abnormal and diagnostic imaging results are BI-RADS Category 0, 3, 4, & 5
- **All consultation visits should be billed through the standard office visit CPT codes: 99201-99205 for "new patients" and 99211-99214 for "established patients". A "new patient" is defined as a woman who is new to the AHN and/or is at their first annual appointment with the AHN. If the patient hasn't been seen in three years they are considered a new patient. If less than three years they are considered an established patient. Consultations billed as 99204 or 99205 must meet the criteria for these codes of moderate complexity for 45 minutes or high complexity for 60 minutes, respectively, during a new patient visit. A summary report of this visit must be attached to the reimbursement request.**

WHC **will not** pay for a consultation with a specialist under the following circumstances:

- To discuss normal/benign screening results depending on global period
- If diagnostic imaging is not performed before initial specialist visit. All imaging results must be presented at time of initial visit
- An office visit that is billed concurrently with a procedure will not be reimbursed through AHN
- Post-op office visit (This is included in the procedure reimbursement)
- If the purpose of office visit is for treatment
- For patients who have a **BI-RAD Category 0 – Assessment Incomplete** mammogram result and additional imaging is recommended, WHC will not pay for an office visit to give the patient another referral form for the additional imaging. The PCP shall fax the Mammography and Ultrasound Referral Form ordering the additional imaging to the imaging facility following verbal notification to the patient.

- To discuss mammogram results which are paid through another payment source other than WHC.
- To discuss diagnostic or treatment plans for non-WHC covered health conditions; WHC does not pay for breast cancer treatment services. AHN will assist with referral to Medicaid (eligible under the Medicaid Treatment Act) or other treatment resources.

Schedule for follow-up/return visits:

- Once a diagnostic workup has been completed, WHC will pay the specialist for one short term follow-up visit. Short-term is defined as 6 months from the date of last specialist visit. The patient must have imaging performed prior to the short term follow up with the specialist if their initial mammogram was a BI-RAD 3. If the results from that visit are negative, normal, or benign and not suspicious for cancer, the patient must resume normal screening with a PCP.
- Patients may be referred into WHC for a diagnostic follow-up by a PCP if they have had a prior mammogram by a non-program payment source which yielded an abnormal result, and they meet program eligibility requirements. A clinical breast exam must be performed and a copy of the abnormal mammogram results must be included in the medical records before referral to specialist.

Breast Specialist Referral Form

- Review PCP section of the form for CBE findings and imaging results
- Only the initial visit requires a referral from the PCP. For each additional visit, a new *Breast Specialist Referral Form* must be completed
- Indicate if the office visit is a repeat CBE exam or a surgical consultation
- Indicate the diagnostic procedure performed
- Indicate the final diagnosis
- Indicate date of service date(s)
- Complete treatment status information
- Specialist should discuss exam results with patient and indicate any concerns in the notes field
- Specialist must sign and date the bottom of the page
- All completed *Breast Specialist Referral Forms* must be faxed to AHN within **48 hours** of office visit at **775-284-1918** to ensure timely and adequate follow-up
- Any test results must be delivered verbally or in writing to patients within **10 days** of test result receipt

Cervical Diagnostic Services reimbursed by AHN

Women age **21 years** and older, who are enrolled in WHC shall receive diagnostic services for the following screening results:

Abnormal Pelvic Exam Results

- Abnormal cervix (Suspicious for cervical cancer) – Refer to specialist
- Abnormal cervix (Not suspicious for cancer) – Refer to specialist

Abnormal Co-Test (Pap and HPV) Screening Results

- ***ASC-US*** -Atypical squamous cells of undetermined significance Pap test with **positive HPV** test - Refer to specialist for colposcopy
- ***ASC-H*** - Atypical squamous cells cannot exclude HSIL Pap test with negative or **positive HPV** test– Refer to specialist for colposcopy
- ***LSIL*** - Low grade squamous intraepithelial lesion Pap test with **negative or positive HPV** test - Refer to specialist for colposcopy
- ***HSIL*** -High grade squamous intraepithelial lesion Pap test with **negative or positive HPV** test - Refer to specialist
- ***Squamous cell carcinoma Pap test with negative or positive HPV test*** – Refer to specialist for biopsy and further evaluation
- ***AGC*** - Atypical glandular cells Pap test with **negative or positive HPV** test – Refer to specialist for colposcopy with endometrial sampling
- ***AIS*** - Endocervical adenocarcinoma in situ Pap test with **negative or positive HPV** test – Refer to specialist for colposcopy
- ***Adenocarcinoma Pap test with negative or positive HPV test*** – Refer to specialist for biopsy and further evaluation
- ***Positive HPV and Negative Pap*** - Repeat co-test in 1 year

Abnormal Pap Test Screening Results

- ***ASC-US*** – Atypical squamous cells of undetermined significance – Repeat test in 1 year
- ***ASC-H*** – Atypical squamous cells cannot exclude HSIL – Refer to specialist for colposcopy
- ***LSIL*** – Low grade squamous intraepithelial lesion - Refer to specialist for colposcopy
- ***HSIL*** - High grade squamous intraepithelial lesion – Refer to specialist for colposcopy
- ***Squamous cell carcinoma*** – Refer to specialist for biopsy and further evaluation
- ***AGC*** – Atypical glandular cells – Refer to specialist for colposcopy with endometrial sampling
- ***AIS*** – Endocervical adenocarcinoma in situ – Refer to specialist for colposcopy
- ***Adenocarcinoma*** – Refer to specialist for biopsy and further evaluation

Other Cervical Diagnostic Services

- Repeat pelvic exam
- Repeat unsatisfactory Pap test
- Colposcopy (with or without biopsy)
- Local excision of lesion (polyp)
- Endocervical Curettage (ECC)
- Cold Knife Conization (CKC) - **Prior approval required**
- LEEP - **Prior approval required**
- Endometrial biopsy - **Prior approval required**

Some pre-operative testing is allowed with prior approval.

Cervical Specialist Services

WHC **will pay** for a consultation with a specialist under the following circumstances:

- To discuss diagnostic follow-up after an abnormal pelvic exam
- To discuss diagnostic follow-up after an abnormal Co-Test or abnormal Pap test
- **All consultation visits should be billed through the standard office visit CPT codes: 99201-99205 for "new patients" and 99211-99213 for "established patients". A "new patient" is defined as a woman who is new to the AHN and/or is at their first annual appointment with the AHN. If the patient hasn't been seen in three years they are considered a new patient. If less than three years they are considered an established patient. Consultations billed as 99204 or 99205 must meet the criteria for these codes of moderate complexity for 45 minutes or high complexity for 60 minutes, respectively, during a new patient visit. A summary report of this visit must be attached to the claim.**

WHC **will not** pay for a consultation with a specialist under the following circumstances:

- To discuss normal screening results
- An office visit that is billed concurrently with a procedure will not be reimbursed through the AHN
- Post-op office visit (This is included in the procedure reimbursement)
- Purpose of office visit is for treatment
- To discuss screening results which are paid through another payment sources other than AHN
- To discuss diagnostic or treatment plans for non-AHN covered health conditions
- AHN does not pay for cervical cancer treatment services. AHN will assist with referral to Medicaid (eligible under the Medicaid Treatment Act) or other treatment resources

Schedule for follow-up/return visits:

- Surveillance after one year following a positive HPV test and negative Pap test
- **For the management of women with abnormal screening results the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:** http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.aspx
- Patients may be referred into WHC for a diagnostic follow-up up if they had a prior Pap or co-test performed by a non-program payment source which yielded an abnormal result, and they meet program eligibility requirements. A clinical pelvic exam must be performed, and a copy of the abnormal test results must be included in the medical records before referral to a specialist.

Cervical Specialist Referral Form

- Review the Primary Care Physician (PCP) section of the form for pelvic exam findings and Pap test results.
- The initial visit requires a referral from the PCP. For each additional visit, a new *Cervical Specialist Referral Form* must be completed
- Indicate if the office visit is a repeat pelvic exam or a gynecologic consultation.
- Indicate the type of recommended/performed diagnostic procedure(s)
- Indicate the final diagnosis with recommended treatment information and date(s) of service.

- The specialist should discuss exam results with the patient and indicate any concerns in the notes field.
- The specialist must sign and date the bottom of the page.
- All original *Cervical Specialist Referral Forms* must be submitted to the appropriate AHN office within **30 days** of the date of service.
- All completed *Cervical Specialist Referral Forms* must be faxed to AHN within **48 hours** of office visit at **775-284-1918** to ensure timely and adequate follow-up.
- Any test results must be delivered verbally or in writing to patients within **10 days** of test result receipt.

For the management of a woman with abnormal screening results, the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:
http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.aspx

Medicaid Assistance for the Treatment of Breast and Cervical Cancer

If a patient is diagnosed with cancer through WHC and needs treatment, she may qualify for Medicaid under the Medicaid Assistance for the Treatment of Breast and Cervical Cancer Act. A WHC Care Coordinator will assist the patient with the application process. WHC Care Coordinators can be reached at 844-469-4930.

WHC care coordinators complete and submit Referral Form 2591-EM to the Division of Welfare and Supportive Services for approval. The following documentation must also be submitted:

- Proof of age, income, Nevada residency
- Proof of U.S. Citizenship or U.S. National or Alien Status

Eligibility begins the date on which the Care Coordinator determines the woman meets the above eligibility requirements and ends if the woman does not file an application for assistance by the last day of the month following the month during which eligibility was determined. Regular eligibility begins the first day of the first eligible month.

For more information regarding Women's Health Connection & Medicaid Treatment for Breast & Cervical Cancer, please refer to the resource section

Reimbursement and Billing

WHC reimburses providers at the published Nevada Medicare allowable rates. A list of allowable CPT codes and reimbursement rates may be found in attachment.

Billing and claims for services

- All billing claim forms for services provided to eligible patients must be received at the appropriate AHN office within **30 days** of the date of service

ALL ENROLLMENTS, SPECIALIST BILLING, PATHOLOGY & IMAGING

Reno Office
4001 South Virginia Street, Suite F
Reno, NV 89502
Phone 844-469-4930
Fax 775-284-1918

- **Do not mail your claim to the Division of Public and Behavioral Health WHC state office in Carson City.**
- Claims will only be paid if the appropriate medical reports and/or exam forms are submitted with the billing claim. Appropriate medical reports and/or exam forms are described below
- If a woman is diagnosed with cancer through WHC and is eligible for Medicaid, the services rendered through WHC that lead to diagnosis will need to be billed to Medicaid. Claims will be denied by WHC.

Incomplete claims **will be returned** to providers with a request for additional information. All corrected claims must be re-submitted within **30 days** from denial date.

Providers agree to accept the payable amount as payment in full. If the provider disagrees with the payable amount the provider has **30 days** from the date the check was issued to dispute any payable amounts.

Fiscal Year 2019 runs from 06/30/2018 to 06/29/2019

All Fee for Service CPT Codes run from 06/30/2018 to 06/29/2019

*New CMS CPT Codes that go into effect 1/1/19 will not be honored until 6/29/19

PLEASE NOTE: WHC must have the original completed enrollment documents for the client, or payment for any screening/diagnostic services will be denied.

Reimbursement for Breast and Cervical Screening Services by PCP

Submit the following original paperwork to the appropriate AHN office:

- Original *AHN Enrollment Form* – completed and signed
- *Annual Screening Visit Form* – completed and signed
- Billing Claim Form with AHN covered CPT codes

Reimbursement for Imaging Facilities

Before billing for services, you must ensure that the patient has a proper referral form (*Mammography and Ultrasound Referral Form*) from a contracted PCP. This form must be signed and dated by the clinician.

Submit the following original paperwork to the appropriate AHN office:

- Imaging report
- Billing Claim Form with AHN covered CPT codes

Reimbursement for Breast Specialists

Before billing for services, you must ensure that the patient has a *Breast Specialist Referral Form* from a contracted PCP and the top portion of the form is completed. The form must be completed, signed and dated by specialist.

Submit the following original paperwork to the appropriate AHN office:

- *Breast Specialist Referral Form*
- Any documentation pertaining to the diagnostic procedure performed
- Pathology results
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Cervical Specialists

Before billing for services, you must ensure that the patient has a *Cervical Specialist Referral Form* from a contracted PCP and the top portion of the form is completed. The form must be completed, signed and dated by specialist

Submit the following original paperwork to the appropriate AHN office:

- *Cervical Specialist Referral Form*
- Any documentation pertaining to the diagnostic procedure performed
- Pathology results

Billing Claim Form with WHC covered CPT codes

Reimbursement for Laboratory Facilities (Pap tests, HPV test, Pathology reports)

Submit the following original paperwork to the appropriate AHN office:

- Pap test or pathology result
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Anesthesia

Submit the following original paperwork to the appropriate AHN office:

- Billing Claim Form with WHC covered CPT codes

Reimbursement for Ambulatory Surgery Centers

Submit the following original paperwork to the appropriate AHN office:

- Billing Claim Form with WHC covered CPT codes

WHC Directory

If you have questions or concerns about how WHC is working with your organization, please do not hesitate to call WHC program staff. Our goal is to make sure that WHC works the best it possibly can for providers and patients. And as a part of our Quality Management Program, both providers and patients may be asked to participate in a satisfaction survey.

Access to Healthcare Women's Health Connection Staff

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Chronic Disease Prevention and Health Promotion Section
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Provider Resources

The NBCCEDP follows screening recommendations from the United States Prevention Services Task Force (USPSTF). For more information on USPSTF recommendations, please refer to their web-site at:

Breast Cancer Screening
http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm

Cervical Cancer Screening
http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm

Nevada Cancer Coalition, Women's Health Connection & Medicaid Treatment for Breast and Cervical Cancer
http://www.nevadacancercoalition.org/AHN-medicaid

Cancer Registry
http://www.leg.state.nv.us/NRS/NRS-457.html

Who must report to the cancer registry?

- A health care provider that diagnoses or provides treatment for cancer or other neoplasm.
- Facilities, medical laboratory, or hospitals that provides screening, diagnostic or therapeutic services to patients with respect to cancer or other neoplasm.

For the management of women with abnormal screening results the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:
http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.asp

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNETION REIMBURSEMENT SCHEDULE FY19

- Reimbursement rates are based on Nevada's maximum allowable Medicare rates. The total payment is not to exceed the approved rates.
- If the provider bills for services that are less than the approved rates, the provider will be reimbursed at the billed amount.
- Provider must accept Medicare's reimbursement rates as payment in full for services rendered. Balances may not be billed to the patient.
- Providers are encouraged to give WHC patients a written estimate of additional charges that are not covered under the program prior to procedure.
- Providers are encouraged to write off charges not reimbursed by the program.
- An ASC is a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission.
- An ASC is not the same as a provider-based outpatient surgery center. Procedures and services performed in a provider-based outpatient surgery center should be billed using the non-facility fee.
- If a provider performs a service or procedure at an ASC, they provider would be entitled to the facility fee, the ASC would be entitled to the ASC fee.
- If a provider performs a service or procedure in their office the provider would be entitled to the non-facility fee.
- Non-facility fees and ASC fees cannot be billed together.
- All billing claims must indicate an associated ICD-10 code for reimbursement.

OFFICE VISITS

CPT Code	Code Description	Rate
99201	**New Patient** - history, exam, straightforward decision-making; **10 minutes**	$ 45.68
99202	**New Patient** - expanded history, exam, straightforward decision-making; **20 minutes**	$ 76.80
99203	**New Patient** - detailed history, exam, straightforward decision-making; **30 minutes**	$ 110.32
99204	**New Patient** - comprehensive history, exam, moderate complexity decision making; **45 minutes** - Consultations must meet the criteria of this code as outlined by the AMA. **This code is not appropriate for screening visits**	$ 168.08
99205	**New Patient** - comprehensive history, exam, moderate complexity decision making; **60 minutes** - Consultations must meet the criteria of this code as outlined by the AMA. **This code is not appropriate for screening visits**	$ 211.34
99211	**Established Patient -** evaluation and management, may not require presence of physician; **5 minutes**	$ 22.20
99212	**Established Patient** – history, exam, straightforward decision-making; **10 minutes**	$ 44.98
99213	**Established Patient** – expanded history, exam, low complexity decision-making; **15 minutes**	$ 74.62
99214	**Established Patient –** detailed history, exam, moderately complex decision-making; **25 minutes**	$ 110.10
99385	***Initial* - comprehensive preventive medicine evaluation and management –** history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **18 to 39 years of age**. **The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.**	$ 110.32
99386	***Initial* - comprehensive preventive medicine evaluation and management –** history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **40 to 64 years of age**. **The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.**	$ 110.32
99387	***Initial* - comprehensive preventive medicine evaluation and management –** history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **65 years of age or older**. **The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.**	$ 110.32
99395	***Periodic* - comprehensive preventative medicine evaluation and management -** history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **18 to 39 years of age. The type and duration of office visits**	$ 74.62

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	should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.	
99396	***Periodic* - comprehensive preventative medicine evaluation and management** - history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **40 to 64 years of age. The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.**	**$ 74.62**
99397	***Periodic* - comprehensive preventative medicine evaluation and management** - history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **65 years of age or older. The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP.**	**$ 74.62**

- Office visits are spent face-to-face with the patient focusing on 3 key components: history, exam, and decision-making.
- **"New Patient"** is a patient new to WHC or has **NOT** been seen by a WHC provider or practice within the last 3 years.
- **"Established Patient"** patient has been seen by the provider or the practice within the last 3 years.
- All consultation visits should be billed through the standard "new patient" office visit CPT codes (99201-99205).
- Consultations billed as 99204 or 99205 must meet the criteria for these codes of moderate complexity, 45 minutes (99204), or high complexity (99205), 60 minutes, based on the most recently published AMA guidance in the CPT Professional manual. A summary report must be attached to the reimbursement request to justify the use of 99204 or 99205 or the claim will be denied.
- **"No Show"** visits cannot be billed to the program or patient.
- **Approval is required for 993XX codes.**

RADIOLOGY

CPT Code	Code Description	Rate		
		Global	26: Professional	TC: Technical
77065	**Diagnostic mammography**, unilateral, includes CAD	**$ 139.55**	**$ 41.84**	**$ 97.71**
77066	**Diagnostic mammography,** bilateral, includes CAD	**$ 176.39**	**$ 51.58**	**$ 124.81**
• A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results				
77067	**Screening mammography,** bilateral	**$ 142.18**	**$ 38.97**	**$ 103.21**
77063	**Screening digital breast tomosynthesis,** bilateral	**$ 56.67**	**$ 30.68**	**$ 25.99**
• List separately in addition to code for primary procedure 77067				
G0279	**Diagnostic digital breast tomosynthesis,** unilateral or bilateral	**$ 56.67**	**$ 30.68**	**$ 25.99**
• List separately in addition to code for primary procedure 77065 or 77066				
76098	**Radiologic exam,** surgical specimen	**$ 17.41**	**$ 8.30**	**$ 9.11**
76641	**Ultrasound,** complete examination of breast including axilla, unilateral	**$ 111.44**	**$ 37.53**	**$ 73.92**
76642	**Ultrasound,** limited examination of breast including axilla, unilateral	**$ 91.33**	**$ 34.99**	**$ 56.34**
76942	**Ultrasonic guidance for needle placement,** imaging supervision and interpretation	**$ 61.72**	**$ 33.20**	**$ 28.52**
77053	**Mammary ductogram or galactogram,** single duct	**$ 60.10**	**$ 18.40**	**$ 41.70**
77058	**Magnetic Resonance Imaging (MRI),** breast, with and/or without contrast, unilateral	**$ 560.28**	**$ 83.71**	**$ 476.57**

- Approval required
- Breast MRI can be reimbursed in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history
- Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a client with a 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 for to assess the extent of disease in a woman who is already diagnosed with breast cancer.

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77059	**Magnetic Resonance Imaging (MRI)**, breast, with and/or without contrast, bilateral	**$ 557.71**	**$ 83.71**	**$ 474.00**

- Approval required
- Breast MRI can be reimbursed in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history
- Breast MRI should never be done alone as a breast cancer screening tool.

BREAST DIAGNOSTIC PROCEDURES

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
10021	**Fine needle aspiration w/o imaging guidance;** breast	**$ 125.70**	**$ 71.51**	**$ 81.37**

- 88172, 88173 may be billed by the lab/pathology

10022	**Fine needle aspiration w/imaging guidance;** breast	**$ 145.26**	**$ 67.64**	**$ 104.22**

- May be billed with 76942
- 88172, 88173 may be billed by the lab/pathology

19000	**Puncture aspiration of cyst of breast**	**$ 116.28**	**$ 45.25**	**$ 90.19**
19001	**Each additional cyst,** puncture aspiration of cyst of breast	**$ 27.77**	**$ 22.28**	**n/a**
19100	**Biopsy of breast,** percutaneous, needle core w/o imaging guidance	**$ 155.25**	**$ 72.14**	**$ 604.47**

- 19100 many only be billed once per breast
- Imaging guidance (10022, 19290, 19291, 19295, 77031, 77032) and mammograms cannot be billed with 19100
- 88305 may be billed for up to 3 biopsy specimens per breast
- Office visit codes on the day of the procedure are not payable
- ASC codes may only be billed once.
- An ASC is a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission.
- An ASC is not the same as a provider-based outpatient surgery center. Procedures and services performed in a provider-based outpatient surgery center should be billed using the non-facility fee.
- If a provider performs a service or procedure at an ASC, they provider would be entitled to the facility fee, the ASC would be entitled to the ASC fee.
- If a provider performs a service or procedure in their office the provider would be entitled to the non-facility fee.
- Non-facility fees and ASC fees cannot be billed together.

No global

19101	**Biopsy of breast,** open, incisional	**$ 352.01**	**$ 228.63**	**$ 1,146.82**

- 19101 may be billed only once per breast
- 76098 may be billed for each specimen
- 88305 may be billed for up to 3 biopsy specimens per breast
- 00400 may be billed for the total time anesthesia provided
- Imaging guidance (10022,19290, 19291, 19295, 77031, 77032) and mammograms **cannot** be billed with 19101
- ASC codes may only be billed once
- Office visit codes on the day of the procedure and during the 10 day post-operative period are not payable

10-day global period

19120	**Excision of cyst,** fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	**$ 509.82**	**$ 427.08**	**$ 1,146.82**
19125	**Excision of breast lesion, identified by preoperative placement of radiological marker,** open; single lesion	**$ 564.28**	**$ 473.48**	**$ 1,146.82**
19126	**Additional lesion, identified by preoperative placement of radiological marker**, open; one additional lesion separately identified by a preoperative radiological marker	**$ 166.67**	**$ 166.67**	**n/a**

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- 19125 may only be billed once per breast regardless of the number of biopsies
- 19126 may be billed for one additional lesion
- 76098 may be billed for each specimen
- 88305 may be billed for up to 3 biopsy specimens per breast
- 00400 may be billed for the total anesthesia provided
- ASC codes may only be billed once.
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day post-operative period are not payable

90-day global period

19081	**Breast biopsy**, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	**$ 715.51**	**$ 174.39**	**$ 604.47**
19082	**each additional lesion,** with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance	**$ 591.84**	**$ 88.07**	**n/a**

- 19081 may only be billed once per breast regardless of the number of biopsies
- 19082 may be billed for one additional lesion
- 76098 may be billed for each specimen
- 88305 may be billed for up to 3 biopsy specimens per breast
- Office visit codes on the day of the procedure are not payable
- ASC codes may only be billed once

No global

Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion

19083	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	**$ 695.96**	**$ 163.99**	**$ 604.47**
19084	**each additional lesion,** with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance	**$ 568.22**	**$ 82.02**	**n/a**

- 19083 may only be billed once per breast regardless of the number of biopsies
- 19084 may be billed for one additional lesion
- 76098 may be billed for each specimen
- 88305 may be billed for up to 3 biopsy specimens per breast
- Office visit codes on the day of the procedure are not payable
- ASC codes may only be billed once

No global

Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion

19085	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	**$ 1040.99**	**$ 190.50**	**$ 604.47**
19086	**each additional lesion,** with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance	**$ 844.49**	**$ 95.78**	**n/a**

Approval required

- 19085 may only be billed once per breast regardless of the number of biopsies
- 19086 may be billed for one
- 76098 may be billed for each specimen
- 88305 may be billed for up to 3 biopsy specimens per breast
- For surgical specimen radiography, use 76098
- Office visit codes on the day of the procedure are not payable
- ASC codes may only be billed once

No global

Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion

19281	**Placement of breast localization device,** percutaneous, mammographic guidance; first lesion	**$ 248.28**	**$ 104.76**	**n/a**
19282	**Each additional lesion,** percutaneous, mammographic guidance	**$ 172.65**	**$ 52.56**	**n/a**

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- 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.
- 19282 May billed for each additional lesion
- 19281 may not be billed with mammograms or 76645
- Office visit codes on the day of the procedure are not payable.
- No global
- Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion

19283	**Placement of breast localization device,** percutaneous; stereotactic guidance; first lesion	**$ 280.75**	**$ 105.38**	**n/a**
19284	**Each additional lesion,** percutaneous; stereotactic guidance	**$ 211.67**	**$ 53.51**	**n/a**

- 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.
- 19282 may billed for each additional lesion
- 19281 may not be billed with mammograms or 76645
- Office visit codes on the day of the procedure are not payable.
- No global
- Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion

19285	**Placement of breast localization device,** percutaneous; ultrasound guidance; first lesion	**$ 537.71**	**$ 89.95**	**n/a**
19286	**Each additional lesion,** percutaneous; ultrasound guidance	**$ 471.11**	**$ 44.96**	**n/a**

- 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.
- 19282 may billed for each additional lesion
- 19281 may not be billed with mammograms or 76645
- Office visit codes on the day of the procedure are not payable.
- No global fee allowed
- Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion

19287	**Placement of breast localization device,** percutaneous, magnetic resonance guidance; first lesion	**$ 892.15**	**$ 133.56**	**n/a**
19288	**Each additional lesion,** percutaneous, magnetic resonance guidance	**$ 721.59**	**$ 67.34**	**n/a**

- Approval Required
- May be billed with 19120, 19125
- May not be billed with mammograms or 76645
- Office visit codes on the day of the procedure are not payable
- No global fee allowed
- Do not report with 19281-19288 in conjunction with 19081-19086, 76942,77002, 77021, for same lesion

CYTOLOGY BREAST

CPT	Code Description	Rate		
		Global	26: Professional	TC: Technical
88172	**Evaluation of fine needle aspirate**	**$ 59.55**	**$ 38.36**	**$ 21.20**
88173	**Evaluation of fine needle aspirate,** interpretation	**$ 159.78**	**$ 75.28**	**$ 84.50**
• To be used with 10021, 10022				
88305	**Surgical pathology/biopsy lab, breast or cervical specimens**	**$ 70.87**	**$ 40.16**	**$ 30.71**
88307	**Surgical pathology, breast, excision of lesion**	**$ 273.50**	**$ 88.32**	**$ 185.18**
88360	**Morphometric analysis, tumor immunohistochemistry, per specimen, manual**	**$ 138.18**	**$ 47.06**	**$ 91.12**
88361	**Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology**	**$ 150.21**	**$ 49.93**	**$ 100.28**

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CERVICAL CANCER SCREENING AND CYTOLOGY PROCEDURES

CPT	Code Description	Rate
88164	**Cytopathology (conventional Pap test),** slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	$14.65
88165	**Cytopathology (conventional Pap test),** slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	$44.22
88141	**Cytopathology (conventional Pap test**), cervical or vaginal, any reporting system, *requiring* physician interpretation	$ 33.38
• Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review • Bill with 88142, 88143, 88164, 88174, 88175 as the technical pap service		
88142	**Cytopathology (liquid-based Pap test),** cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision	$25.01
• Pap tests are subject to frequency guidelines. See Provider Manual and Cervical Clinical Guidelines		
88143	**Cytopathology,** cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening and rescreening under physician supervision.	$25.01
88174	**Cytopathology,** cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system, under physician supervision.	$26.38
88175	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system and manual rescreening, under physician supervision.**	$32.71
• 88143, 88174 and 88175 No longer will be reimbursed at the 88142 rate		
87624	**Human Papillomavirus, high-risk types.**	$43.33
• Used for cytology and HPV co-testing every 5 years • When a conventional Pap tests results is ASC-US, a follow up office visit may be billed to complete the HPV test • When a liquid based pap test results is ASC-US, the HPV test can be done on the original specimen and follow up visit for HPV testing cannot be billed • Refer to cervical algorithms for indications for HPV testing		
87625	**Human Papillomavirus, types 16 and 18 only.**	$43.33
• HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. • HPV DNA testing is not reimbursable procedure if used as an adjunctive screening test to the Pap for women under 30 years of age. • Providers should specify the high-risk HPV DNA panel only. • Reimbursement of screening for low-risk HPV types is not permitted. • The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. • **CDC funds may be used for reimbursement of HPV genotyping.**		

CERVICAL DIAGNOSTIC PROCEDURES

CPT	Code Description	Rate		
		Non-Facility	Facility	ASC
57452	**Colposcopy of the cervix, without biopsy**	$ 111.54	$94.70	$55.72
• May be billed only once • Office visit codes on the day of the procedure are not payable No global period				
57454	**Colposcopy with biopsy of the cervix and endocervical curettage**	$ 155.49	$138.28	$68.54
• 57454 may be billed only once regardless of the number of biopsies performed • 88305 may be billed with 57454 for up to 4 specimens to reflect multiple biopsy sites on the cervix & one (1) ECC biopsy • Office visit codes on the day of the procedure are payable No global period				

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57455	**Colposcopy of the cervix with biopsy**	**$ 145.86**	**$112.91**	**$72.15**
• May be billed only once. • 88305 may be billed with 57455 for up to 3 specimens to reflect multiple biopsy sites on cervix • Office visit codes on the day of the procedure are payable No global period				
57456	**Colposcopy of the cervix with endocervical curettage**	**$ 137.60**	**$105.01**	**$69.35**
• May be billed only once • 88305 may be billed once with 57456 • Office visit codes on the day of the procedure are payable No global period				
57460	**Colposcopy with loop electrode biopsy(s) of the cervix.**	**$ 288.94**	**$165.56**	**$192.40**
Authorization is required • May be billed only once • 57460 may not be billed with colposcopy: 57452, 57454, 57455, or 57456 • 88307 may be billed for up to 4 specimens per cervical procedure • Office visit codes on the day of the procedure are not payable No global period				
57461	**Colposcopy with loop electrode conization of the cervix.**	**$ 326.71**	**$ 191.25**	**$206.83**
Authorization is required • May be billed only once • 57461 may not be billed with colposcopy: 57452, 57454, 57455, or 57456 • 88307 may be billed for up to 4 specimens per cervical conization procedure • 88305 may not be billed with 57461 • 00400 may be billed for the total anesthesia provided • Office visit codes on the day of the procedure are not payable No global period day surgery facility				
57500	**Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)**	**$ 130.94**	**$77.48**	**$90.59**
• 88305 may be billed with 57500 for up to 3 specimens to reflect multiple biopsy sites on cervix • Office visit codes on the day of the procedure are not payable No global period				
57505	**Endocervical Curettage (not done as part of a dilation and curettage)**	**$ 105.28**	**$ 94.66**	**$62.53**
• May be billed only once • 88305 may be billed once with 57505 • Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable 10 day Global period				
57520	**Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser.**	**$ 315.84**	**$282.52**	**$1,249.26**
Authorization is required • May be billed only once • 88307 may be billed with 57520 for up to 4 specimens per cervical conization procedure • 00400 may be billed for the units of anesthesia provided • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable 90-day Global period				
57522	**Loop electrode excision procedure (LEEP)**	**$ 269.68**	**$248.81**	**$1,249.26**
Authorization is required • May be billed only once • 57522 and 57522 Facility may not be billed with colposcopy (57452, 57454, 57455, or 57456) • 88307 may be billed with 57522 or 57522 Facility for up to 4 specimens per cervical conization procedure				

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- 00400 may be billed for the total units of anesthesia provided
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable

90-day Global fee period

58100	**Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation, any method (separate procedure)**	**$ 111.20**	**$89.23**	**$54.51**

Authorization is required

- May be billed only once
- Must be billed with a colposcopy
- Office visit codes on the day of the procedure are not payable

No global period

58110	**Endometrial sampling (biopsy), performed in conjunction with colposcopy**	**$ 49.35**	**$42.03**	**n/a**

- List separately in addition to code for primary procedure
- May be billed only once
- 58110 must be billed with a colposcopy: 57452, 57454, 57455, 57456, or 57461
- Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater, if client 35 or more years of age, or at risk for endometrial neoplasia
- Code related to another service and is always included in the global period of the other service

ANESTHESIA

CPT	Code Description	Rate
00400	**Rates for time based codes are calculated using base units plus time spent (15 minutes = 1 unit)**	**$66.48 + Time Units Spent**

- Rates for time based codes are calculated using base units plus time spent (15 minutes = 1 unit)
- Base unit is 3 x $22.16 = $66.48 + time unit spent
- 1 unit (15 minutes) = $22.16

PATHOLOGY

CPT	Code Description	Rate		
		Global	26: Professional	TC: Technical
88305	**Surgical pathology/biopsy lab, breast or cervical specimens**	**$ 70.87**	**$ 40.16**	**$ 30.71**
88307	**Surgical pathology, breast, excision of lesion**	**$ 273.50**	**$ 88.32**	**$ 185.18**
88331	**Pathology consultation during surgery, first tissue block, frozen section, single specimen**	**$ 100.62**	**$ 66.97**	**$ 33.64**
88332	**Each additional tissue block with frozen sections**	**$ 54.89**	**$ 32.96**	**$ 21.93**
88341	**Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**	**$ 95.95**	**$ 30.05**	**$ 65.90**
88342	**Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)**	**$ 113.00**	**$ 37.62**	**$ 75.38**

SUPPLIES

CPT	Code Description	Rate
99070	**Supplies and materials (except spectacles), 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).**	**$15.50**

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PREOPERATIVE TESTING				
CPT	Code Description	Rate		
		Global	26: Professional	TC: Technical
71010	**Chest x-ray, 1 view,** frontal	$23.49	$9.42	$14.07
71020	**Chest x-ray, 2 views,** frontal and lateral	$29.02	$11.24	$17.78
80048	**Basic Metabolic Panel**			$10.48
80053	**Comprehensive Metabolic Panel**			$13.04
• Cannot be billed with 80048				
81001	**Urinalysis**			$3.92
81025	**Pregnancy test**			$8.61
• Should only be performed when there is concern the client may be pregnant. This should not be routinely performed.				
85014	**Hematocrit**			$2.93
85018	**Hemoglobin**			$2.93
85025	**CBC with differential**			$8.59
85027	**CBC without differential**			$7.98
93000	**EKG, 12 leads, with interpretation and report**			$17.57

- Approval Required
- Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests.
- Office visits may not be charged in conjunction with pre-operative tests unless the patient is seeing a provider who is providing medically necessary evaluation and management services.

CPT Code	Procedures Specifically Not Allowed	End Note
Any	**Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer**	
77061	**Breast tomosynthesis, unilateral**	13
77062	**Breast tomosynthesis, bilateral**	13
87623	**Human papillomavirus, low-risk types**	

End Note	Description
1	**All consultations should be billed through the standard "new patient" office visit CPT codes 99201-99205. Consultations billed as 99204 or 99205 must meet the criteria for these codes. These codes (99204-99205) are typically not appropriate for NBCCEDP screening visits.**
2	**The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP. Reimbursement rates should not exceed those published by Medicare. While some programs may need to use 993XX-series codes, 993XX Preventive Medicine Evaluation visits are not appropriate for the NBCCEDP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.**
3	**Medicare's methodology for the payment of anesthesia services are outlined in chapter 12 of the Medicare Claims Processing Manual at** www.cms.hhs.gov/manuals/downloads/clm104c12.pdf**. The carrier-specific Medicare anesthesia conversion rates are available at** www.cms.hhs.gov/center/anesth.asp**.**
4	**These procedures may be reimbursed at their own Medicare rates.**
5	**HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines. It is 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 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted.** **CDC allows reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. CDC funds may be used for reimbursement of HPV genotyping.**

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6	**A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Grantees are strongly encouraged to develop policies to monitor these procedures closely, and should pre-authorize this service for reimbursement by having its medical consultants review these cases in advance, and on an individual basis.**
7	**This charge should be used with caution to ensure that programs do not reimburse for supplies, the cost of which has been accounted for in another clinical charge.**
8	**Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history. Breast MRI also can be used to assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed for by the NBCCEDP to assess the extent of disease in a woman who has just been diagnosed with breast cancer.**
9	**Codes 19081–19086 are to be used for breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. They should not be used in conjunction with 19281–19288.**
10	**Codes 19281–19288 are for image guidance placement of a localization device without image-guided biopsy. These codes should not be used in conjunction with 19081–19086.**
11	**List separately in addition to code for primary procedure G0202.**
12	**List separately in addition to G0204 or G0206.**
13	**These procedures have not been approved for coverage by Medicare.**
14	**Due to Medicare claims processing issues, CMS will not be able to process the new CPT codes. Therefore, no reimbursement fees have been assigned to these codes. Grantees should use only G0202, G0204 and G0206 until this has been resolved. It is expected that these codes will be operationalized in 2018.**