FY
2024

Women's Health Connection
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Women's Health Connection Manual

WOMEN'S HEALTH CONNECTION IN PARTNERSHIP
WITH ACCESS TO HEALTHCARE NETWORK

GRANT #1 NU58DP007102 | FY 2024

access to HEALTHCARE NETWORK

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Program Overview

The Nevada Division of Public and Behavioral Health Women's Health Connection Program (WHC) partners with Access to Healthcare Network (AHN) to administer the WHC program. This partnership increases access to primary and specialty healthcare services in Nevada.
Women's Health Connection is a breast and cervical cancer early detection program dedicated to serving low-income, high-risk, uninsured, and underinsured Nevadans.

Women's Health Connection has been federally funded through the Center for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) since 1997. The passage of Assembly Bill 388 during the 79th Nevada Legislative Session allocated state funding to the program. The program's goal is to reduce the burden of breast and cervical cancer through education, early screening and diagnostics, care coordination/case management, and improved access to treatment.

Program Successes

Since its implementation in 1997, WHC has provided breast and/or cervical cancer screening and diagnostic services to over 79,615 individuals. The program has diagnosed 1,373 breast cancers and 2,100 invasive cervical cancers or premalignant cervical lesions.

Case Management

Care Coordination Services

Care Coordination

Care coordination services ensure patients receive timely and appropriate services. Care Coordinators play a critical role in navigating clients through the cancer care continuum including appointment scheduling, assisting with barriers, providing follow-up, and expanding services through recruitment of providers. Their training and experience enable them to demonstrate core competencies and knowledge to improve health outcomes using interpersonal communication, service coordination, advocacy, organizational and teaching skills. Care Coordinators are cultural and linguistic partners to their communities; they help facilitate improved access to needed services.

Patient Navigation

Patient navigation is defined as individualized assistance provided to patients to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer. Patients often face significant barriers to accessing and completing cancer screening and diagnostic services. All patients with abnormal screening results **must** be assessed for need of patient navigation services; they must be provided with such services accordingly.

Quality Assurance

Clinical Quality Indicators

The NBCCEDP evaluates the Nevada WHC program performance through Clinical Quality Indicators, which are quality assurance measures. The NBCCEDP assesses Clinical Quality Indicators through the analysis of Minimum Data Element (MDE) records, which contain screening and diagnostic data submitted to the CDC in April and October annually. NBCCEDP has developed 9 Clinical Quality Indicators which are used to measure clinical performance by assessing reach to priority populations and timeliness of follow-up services and treatment referral.
Program Performance Indicators may change at the direction of the CDC.

Indicator Type	Clinical Quality Indicators	Target
Screening the Priority Population	**Priority population for cervical cancer screening:** Percentage of women aged 30 and older receiving their first cervical cancer screening through the program who have never been screened or not screened within the last 10 years	≥ 35%
Complete and Timely Diagnostic Follow-up of Abnormal Screening Results	**Complete Cervical Diagnostic Follow-up:** Percentage of cervical cancer screening records with planned and completed diagnostic follow-up	≥ 90%
	Timely Cervical Diagnostic Follow-up: Percentage of cervical cancer screening follow-up with time between screening results and final diagnosis less than or equal to 60 days	≥ 75%
	Complete Breast Diagnostic Follow-up: Percentage of mammogram screening records with abnormal results and completed diagnostic follow-up	≥ 90%
	Timely Breast Diagnostic Follow-up: Percentage of mammogram screening records with completed follow-up and time between abnormal mammogram screening and final diagnosis is less than or equal to 60 days	≥ 75%
Complete and Timely Initiation of Treatment for Cancers Diagnosed	**Treatment Started for Cervical Cancer:** Percentage of cervical cancer records with final diagnosis of HSIL, CIN2, CIN3/CIS, or invasive cervical cancer that have treatment started	≥ 90%
	Timely Treatment for Premalignant Cervical Lesions: Percentage of cervical cancer records with a final diagnosis of HSIL, CIN2, CIN3/CIS, or invasive cervical cancer and the time between final diagnosis and treatment is less than or equal to 60 days	≥ 80%
	Treatment Started for Breast Cancer: Percentage of breast cancer records with a final diagnosis of "CIS, other", DCIS, or invasive breast cancer that have treatment started	≥ 90%
	Timely Treatment for Breast Cancer: Percentage of breast cancer records with a final diagnosis of "CIS, other", DCIS, or invasive breast cancer and the time between final diagnosis and treatment is less than or equal to 60 days	≥ 80%

Administrative Roles and Responsibilities

Nevada WHC

Nevada WHC located within the Chronic Disease Prevention and Health Promotion Section, Bureau of Child, Family, and Community Wellness, allocates state and federal funds for breast and cervical cancer screening and diagnostic services. Nevada WHC ensures services adhere to all state and federal guidelines, reports on program efforts and progress, collects and analyzes data to conduct required evaluation, informs stakeholders, community partners, and the public of program progress, ensures quality services are performed, and facilitates provider reimbursement for services. In addition to administering direct screening and diagnostic services, Nevada WHC partners with clinics, coalitions, and providers statewide to improve access to screening, diagnostic services, and cancer treatment for all Nevadans.

Access to Healthcare Network

AHN helps administer the WHC program by collaborating with providers and providing case management services. AHN conducts mandatory trainings to inform and update providers on the rules and responsibilities of the WHC program. Additionally, case management services are provided to help patients overcome barriers. Case management staff explain the importance of follow-up services, assist with scheduling appointments, and refer patients to services to reduce barriers. Services through the WHC program conclude when a patient is determined to have a final diagnosis not requiring treatment, is found in need of treatment, and is successfully referred to a treatment source, or when a patient formally refuses necessary treatment. If a patient is diagnosed with cancer and is not eligible for Medicaid, AHN will refer the patient to other treatment resources.

Program Responsibilities

State WHC Responsibilities

- Ensure provider contracts are established
- Provide training, technical assistance, and professional education
- Provide WHC enrollment forms, reporting forms, and promotional materials
- Develop eligibility screening protocol, screening guidelines and reporting requirements
- Reimburse providers for screening and diagnostic services
- Ensure all providers meet quality standards, i.e. MQSA [acronym] CLIA

AHN Responsibilities

- Ensure provider contracts are established
- Provide training, technical assistance, and professional education
- Ensure Care Coordination services are provided to eligible patients
- Refer eligible patients to treatment services
- Maintain ongoing provider communication regarding policies and procedures
- Maintain a central patient tracking system

Care Coordinators Responsibilities

- Work closely with patients to ensure appropriate services are provided in a timely manner
- Coordinate access to health care and preventive services
- Review clinical records for appropriateness of recommended care
- Ensure recommended diagnostic procedures are completed within time frames
- Maintain timely contact with patients and documenting all contacts using a tracking system
- Assess patients for barriers (transportation, work schedule, etc.) and link patients to resources to reduce barriers
- If diagnosed with cancer, assist patient with referral to treatment resources
- Ensure WHC final diagnosis and treatment time frames are met

Provider Responsibilities

All providers enrolled with WHC are defined according to the services they agree to provide. These categories guide services offered, billing, and data collection. Providers are often enrolled in multiple categories. The standard provider types include:

Mamm Provider

Performs services associated with routine breast screening such as clinical breast exams, mammograms, and routine screening ultrasounds. This includes primary care providers, ob-gyn/ gyn providers, and imaging providers

Pap Provider

Performs services associated with routine cervical cancer screening such as Pap exams and Co-test (Pap plus HPV screening). This includes primary care providers and ob-gyn/ gyn providers.

Clinical Provider

Performs services beyond routine screening, often for diagnosis following an abnormal screening. This includes anesthesiologist, surgeons, breast specialist, and surgery centers. These providers do not typically provide clinical breast exams.

Pathology Provider

Determines the results of screening and diagnostic procedures. This category includes all lab providers.

Provider Responsibilities

- Per grant requirement the State WHC staff will conduct an in-person site visit annually (with exceptions)
- Providers must attend WHC orientation and training, conducted by Access to Healthcare Network (AHN) or the State WHC, once a year
- Providers are responsible for following WHC eligibility protocols
- Patients must undergo eligibility verification **before** receiving screening/diagnostic services paid for by WHC. Providers are responsible to verify patient eligibility with AHN for WHC services
- Enrollment forms must be completed, signed by patient, and submitted to AHN with the initial screening visit form within **90 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
- Additional screening results must be submitted within **90 days** of procedure date
- Ensure patients with abnormal or inadequate screening results receive timely follow up services as per screening guidelines
- All abnormal results must be faxed within **48 hours** to ensure timely follow-up and to initiate case management services
- Diagnostic results must be submitted within **90 days** of procedure date
- All billing claims must be submitted within **90 days** of service date
- Per NRS 457, providers **must report** all cancer diagnoses to the Cancer Registry
- Provide patients with educational and recommendations for breast and cervical cancer screening intervals, per screening guidelines, and educate patients about the importance of timely follow-up for diagnostic procedures.
- Maintain patient confidentiality
- If a woman refuses diagnostic procedures/treatment, the *Patient Refusal Form* must be completed and faxed to AHN within 48 hours.
- Ensure patients are not billed for reimbursable program services
- Ensure patients are recalled and screened at appropriate screening intervals
- Assemble documents as requested for WHC provider site audits
- HCFA 1500 form, UB 04 form or other forms of billings must be submitted within **90 days** of the date of service
- WHC will not reimburse for unnecessary "over-screening"

Nevada Revised Statutes (NRS)

All Women's Health Connection Providers are required to adhere to regulations as outlined in NRS. During the 81st Session, Senate 251 updated NRS 457 to include:

1. A primary care provider shall:

(a) Attempt to determine whether each adult woman to whom he or she provides care has a personal or family history of breast, ovarian, tubal or peritoneal cancer or an ancestry associated with a harmful mutation in the BRCA gene or meets any other criteria under which the United States Preventive Services Task Force has recommended screening for a risk of such a mutation; and (b) If the primary care provider determines that an adult woman to whom he or she provides care meets the criteria described in paragraph (a) and has not previously undergone genetic testing for a harmful mutation in the BRCA gene, use an appropriate brief familial risk assessment tool to screen for a risk of such a mutation.

2. If such a screening indicates that a woman is at risk of a harmful mutation in the BRCA gene, the primary care provider must: (a) Provide the woman with written notice of the need to discuss genetic counseling and testing with the provider; (b) Provide genetic counseling to the woman or ensure that the woman is referred for genetic counseling; and (c) If a genetic test for harmful mutations in the BRCA gene is clinically indicated as a result of the genetic counseling, administer such a test to the woman or ensure that the woman is referred for such testing.

Additionally, SB 251 added to Sec. 8. NRS 630.253 (d) that the Board of Medical Examiners *"Must allow the holder of a license to receive credit toward the total amount of continuing education required by the Board for the completion of a course of instruction relating to genetic counseling and genetic testing"*

All providers with WHC agree to abide by the following roles and responsibilities

ENROLLMENT SCREENING

Enrollment Methods

Enrollment with a Primary Care Provider

This is determined by the Care Coordinator and Navigators during the intake process.
Patients will be deemed eligible per statement using eligibility guidelines on page 12.
The primary care provider (PCP) will submit the Enrollment Form to AHN addressed to WHC within 90 day of initial screening date. *(A patient is considered enrolled in the WHC on the date screening services are performed. WHC will not pay for services performed before the date of service at the provider's office.)*
For eligible services please contact AHN: (844) 469-4930.

Enrollment through the AHN Helpline Call Center

A patient who establishes eligibility through the AHN helpline (877) 385-2345 will receive a welcome letter in the mail, a list of participating providers, and a WHC enrollment form.
At the patient's next scheduled visit, she will present the partially completed enrollment form to the PCP**.** The provider will submit the Enrollment form to AHN addressed to WHC within 90 days of initial screening date. *(A patient is considered enrolled in WHC on the date screening services are performed. WHC will not pay for services performed before the date of service at the provider's office.)*
For eligible services please contact AHN: (844) 469-4930.

(Re)-Enrollment after completing cancer treatment

A cancer survivor can be (re)-enrolled in the program for surveillance testing as needed should she continue to meet program eligibility guidelines. A reassessment for eligibility must be done. WHC will only reimburse for follow-up tests recommended for surveillance. Testing must be specifically related to assessing for recurrence of breast or cervical cancer.

Women's Health Connection Member ID Card

At each office visit please have WHC patients present assigned cards to verify patient enrollment.

Age 40+ | Age 21-39 | Copay Assistance Program (CAP)

ENROLLMENT SCREENING

Underinsured Policy

People with no health insurance and those with inadequate health insurance (commonly referred to as underinsured) or having health insurance not fully covering screening and diagnostic services will be eligible for the program. WHC will reimburse at Medicare's allowable rate. If a provider accepts payment from WHC there should be no outstanding balance to the patient. However, there is still the possibility of a remaining balance that may need to be written off by the provider. WHC patients should not be billed for services.

Copay Assistance Program (CAP)

A patient covered under a health insurance plan not fully covering breast and cervical cancer screenings and/or diagnostics may qualify. A patient with an insurance deductible of $100.00 or more is considered underinsured under WHC policy.

Rules

Before receiving services paid for by the WHC program, underinsured patients must be determined eligible for WHC services through the same process as patients enrolled into WHC.

- Underinsured patients must be deemed eligible for WHC services by AHN prior to deductible or co-pay reimbursement
- Patients who have insurance deductibles greater than or equal to $100.00 are considered underinsured
- 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
- Providers will be required to check insurance status prior to patient receiving services at each appointment

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 AHN for eligibility verification and enrollment into the CAP
3. Patient will submit bill(s) to WHC at AHN for reimbursement

MEDICAID ASSISTANCE FOR TREATMENT

Breast/Cervical Cancer Medicaid

If a patient is diagnosed with cancer through WHC and needs treatment, she may qualify for Medical Assistance under the Breast and Cervical Cancer Act through the Medicaid program. A Care Coordinator will assist the patient with the application process and will complete and submit the referral Form 2591- EM to the Division of Welfare Supportive Services (DWSS) for approval. Care Coordinators can be reached at (844) 469-4930.

Medical assistance is provided to patients:

- Under the age 65
- Are Nevada Residents
- Are Uninsured or underinsured
- Screened through WHC **and** found to need treatment for either breast or cervical cancer or.
    - Screened through a non-WHC provider but a WHC provider has verified positive screening and diagnostics indicating the patient needs treatment for either breast or cervical cancer
- With U.S. citizen or legal immigration status

Eligibility begins on the date the Care Coordinator determines the patient meets the above eligibility requirements. Once approved, the DWSS case manager sends an application for assistance to the individual. If the individual does not return the application for assistance by the last day of the month following the month during which presumptive eligibility was determined, medical assistance may be terminated. 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

ELIGIBILITY SCREENING

Determining Eligibility

Eligibility

This program does not reimburse for treatment services. Federal law mandates this 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, or prepaid health services, WHC funding may not be used. Coverage through Indian Health Services is the only exception to this rule. WHC funding may be used over Indian Health Services funding.

WHC eligibility components		
	Federal Funding*	**State Funding**
Program Eligibility	**At or below 250% Federal Poverty Level; uninsured or underinsured**	**Nevada Resident**
Breast Services	Patients 40-64 years¥	Patients 40-64 years (until funds are depleted)
Cervical Services	Patients 21-64 years¥ Priority: Never been screened and not screened within the last 10 years	
***Underinsured*:** A patient eligible for WHC, covered under health insurance plan that does not fully cover breast and cervical cancer screening and/or diagnostics, and has an insurance deductible of $100.00 or more considered underinsured under WHC policy. Underinsured status also includes co-pays for covered breast and cervical cancer screenings.		
**Must adhere to USPSTF screening guidelines* *¥ At age 64, a woman should be re-assessed for eligibility with other payor sources, such as Medicare. If the patient is not eligible for another payor source, they remain eligible for WHC services. See page 12 for further details.*		

2023 Monthly and Annual Poverty Guidelines		
Number of People in Household	**Household Income Before Taxes**	
	Monthly	**Annual**
1	$3,038	$36,450
2	$4,108	$49,300
3	$5,179	$62,150
4	$6,250	$75,000
5	$7,321	$87,850
6	$8,392	$100,700
7	$9,463	$113,550
8	$10,533	$126,400
For families/ households with more than 8 persons, add $5,140 (annual) for each additional person. Source: Poverty Guidelines | ASPE (hhs.gov)		

REIMBURSABLE SCREENING SERVICES

Reimbursement Policies for Breast Cancer Assessment

Breast Cancer Screening Services

Funds can be used to provide breast cancer screening services to patients ages 40 and older or who are considered high-risk. All patients should undergo a risk assessment to determine if they are at a high-risk for developing breast cancer.

Patients who are determined to be high-risk include those who have a known genetic mutation such as BRCA 1 or 2, first-degree relatives with premenopausal breast cancer or known genetic mutations, a history of radiation treatment to the chest area before the age of 30 (typically for Hodgkin's lymphoma), and a lifetime risk of 20% of more for the development of breast cancer based on risk assessment models largely dependent on family history. When determining if a patient is at high risk for breast cancer, providers can choose whichever method or assessment they prefer so long as the method chosen addresses the criteria listed above. *Patients at high-risk for breast cancer should be screened with both an annual mammogram and an annual breast magnetic resonance imaging (MRI).*

Funds can be used to evaluate patients under the age of 40 who are symptomatic. A woman who is symptomatic due to breast mass, nipple discharge, breast pain, etc. can be provided a clinical breast examination, diagnostic testing, and/or a surgical consultation. Funds can be used to evaluate asymptomatic patients under the age of 40 who have been determined to be high-risk (see criteria for high-risk above).

A patient aged 40 and older is eligible to receive CBE and screening mammogram services every 1 to 2 years based on the patient's history and clinical presentation.
(State Funds will be used for breast Screening Mammograms and/or diagnostic services for patients 40-64 based on funding availability; funding is disbursed on a first come, first served basis.)

A patient aged 65 and older is potentially eligible to receive Medicare benefits and should be encouraged to enroll. Patients enrolled in Medicare Part B are not eligible. Patients who are not eligible to receive Medicare Part B and Medicare-eligible patients who cannot pay the premium to enroll in Medicare Part B are eligible to receive mammograms. Please contact AHN or the State WHC unit for more information.

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services. While CDC does not make any recommendation about routine screening among this population, recipients and providers should counsel all eligible women, including transgender women, about the benefits and harms of screening and discuss individual risk factors to determine if screening is medically indicated. The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Those recommendations include "for transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use for 5-10 years, positive family history, BMI > 35)." Those preventive care recommendations can be found at http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-women.

Transgender men (female-to-male), who have not undergone a bilateral mastectomy and meet all program eligibility requirements, are also eligible to receive breast cancer screening and diagnostic services. Guidance on breast cancer screening for transgender men from the Center of Excellence for Transgender Health can be found at http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-men.

Persons who are **biologically male** are not eligible to receive breast cancer screening and/or diagnostic services through the program.

REIMBURSABLE SCREENING SERVICES

Breast Cancer Screening Services Continued

Those with a known History of Breast Cancer may be evaluated for screening or surveillance. Follow-up should be based on providers assessment and depending on their stage of disease and treatment course. Funds cannot be used to reimburse for any form of treatment.

The Women's Health Connection program goal is to increase screening in -populations disproportionately affected by Breast and Cervical cancer. Health Equity should be a priority for all WHC providers.

Clinical Breast Exam

- Patients transferring into WHC from another payor source will not need to have a CBE repeated for a screening mammogram or diagnostic procedures; however, the initial positive CBE will need to be verified.

Screening Mammograms

- Must be ordered for all eligible patients
- Mammography and Ultrasound Form must be used for all patients eligible for routine/diagnostic screening services. The form must include the results of the CBE and be signed and dated by the ordering clinician. *The form is valid for 60 days from date of issue by the ordering clinician.* If a patient does not complete screening within 60 days, and has not contacted AHN for Care Coordination, they will need to wait until their next annual appointment to get rescreened. Please ensure patients work with State WHC/AHN staff for timely follow-up 1(844)469-4930.

WHC WILL PAY for a PCP visit under the following circumstances:

- To initiate annual screening services (for eligibility, the new screening cycle may not begin less than one year from the previous screening)
- If a patient presents new breast symptoms before annual screening date
- Following an unsatisfactory office visit, WHC may offer a second office visit to another PCP
- To discuss diagnostic follow-up after an abnormal screening
- To verify results from another payor source in order to enroll the patient into WHC to receive necessary continued care

All office visits should be billed through the standard office visit CPT codes 99201-99203 for "new patients" and 99211-99213 for "established patients."

New Patient *is defined as*- Patients who are new to the PCP or the practice and/or have not been seen within three years by the PCP or at the practice.
Established Patient *is defined as* – Patients who have been seen at the practice, or/and by a different provider, at any time in the last three years. *CPT codes 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 their existing provider and is not eligible for a screening test, and the provider performs a screening test anyway. WHC will NOT PAY for office visit or lab fee for the screening (Applies to Breast and Cervical).

REIMBURSABLE SCREENING SERVICES

***Breast Cancer* Screening Services Continued**
Magnetic Resonance Imaging (MRI) for breast cancer screening

Screening breast MRI (PRIOR APPROVAL REQUIRED) performed in conjunction with a mammogram are reimbursable when a patient has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models. Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a patient 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 to assess the extent of disease for staging in patients who were recently diagnosed with breast cancer and preparing for treatment. Providers should discuss risk factors with all patients to determine if they are at high-risk for breast cancer. It is critical breast MRI is done at facilities with dedicated breast MRI equipment and can perform MRI-guided breast biopsies.

Reimbursement Policies for Cervical Cancer Assessment

***Cervical Cancer* Screening Services**

Funds cannot be used to reimburse for cervical cancer screening in patients under the age 21. Funds cannot be used to reimburse for standalone pelvic exams - only for services considered to screen for cervical cancer.

The priority population includes patients who have never been screened or have not been screened in the last 10 years. Recruitment efforts should be concentrated on the priority population. (*A minimum of 35% of screening Pap tests should be provided to patients who have never been screened or have not been screened in the last 10 years for cervical cancer*).

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

Transgender men (female-to-male) who have not undergone a total hysterectomy (i.e., still have a cervix) and meet all other eligibility requirements are eligible to receive cervical cancer screening and diagnostic services.

Funds can be used for *annual* cervical cancer screening among patients who are considered high-risk (e.g., in-utero DES exposure, organ transplantation, immunocompromised from another health condition, HIV infection, or history of cervical cancer).

REIMBURSABLE SCREENING SERVICES

Cervical Cancer Screening Services Continued

Patients 21 to 64 years of age may qualify for the following services:
Patients aged 21-29 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

Patients aged 30-64 years old:

- Pap test with Pelvic exam every 3 years, unless there is an abnormal result **OR**
- Co-testing (Pap and HPV) with pelvic exam every 5 years, unless there is an abnormal result **OR**
- Primary HPV testing every 5 years
- Diagnostic services after an abnormal result
- Referral for treatment

WHC WILL PAY for a PCP visit under the following circumstances:

- A pap test or co-testing on patients who had a total (i.e. those without cervix) hysterectomy because of cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer.
- Cervical cancer surveillance for patients whom the reason for the hysterectomy or final diagnosis of no neoplasia or invasive cancer cannot be documented.
- If it is unknown if the cervix was removed at the time of the hysterectomy, a physical examination (i.e. office visit for a pelvic examination) can be done to determine if the cervix is present.
- If a Pap test or co-test is unsatisfactory or false-positive the patient should have a repeat test within 2-4 months. 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.

WHC will NOT PAY for a PCP visit under the following circumstances:

- To discuss normal results. This service is included in the fee paid for the initial PCP visit and providers are expected to perform this service
- Low-risk HPV DNA panel

REIMBURSABLE SCREENING SERVICES

Annual Breast and Cervical Cancer Screening Visit Form

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 signed, dated, and submitted to the appropriate AHN office within **90 days** of date of service. Incomplete claims will be returned to providers with a request for additional information. Any corrected claims must be re-submitted within **30 days** from denial date.

Steps

Review patient history from page 1 (WHC Enrollment Form)
Complete the Clinical Breast Exam Findings section

- Patients 40 and older are eligible for an annual 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*

Complete the Reason for Imaging section

- A patient who is eligible for routine screening mammogram, complete Mammography and Ultrasound Referral Form
- A patient who is eligible for routine 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*
- Breast specialist referrals, complete *Breast Specialist Referral Form*

Review patient history from page 1 (WHC Enrollment Form)
Complete 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 and the patient 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
- Cervical specialist referrals, complete *Cervical Referral Form*

Complete the Reason for Pap/HPV test section

- Pap testing is the recommended method for cervical screening for patients aged 21-29.
- Co-testing (Pap and HPV test) is the recommended method for cervical screening for patients aged 30-64 after normal Pap results, patients who have an intact cervix, or for patients 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. Patients aged 21-29 are not eligible for co-testing and should receive a Pap test.

All WHC Enrollment Forms for patients with abnormal results must be faxed to WHC staff at AHN within 48 hours upon receipt (775) 284-1918

REIMBURSABLE DIAGNOSTIC SERVICES

Reimbursement Policies for Diagnostic Services

Reimbursable Breast Diagnostic Services

Final diagnosis should occur within 60 days of abnormal breast cancer screening result. Initiation of breast cancer treatment should occur within 60 days of final diagnosis.

Patients may receive diagnostic services for the following screening results:

Normal CBE and Abnormal Screening Mammography Test		
BI-RADS Category 0	(Need evaluation or film comparison)	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
Abnormal CBE results include Discrete palpable mass suspicious for cancer, bloody/serous nipple discharge, nipple/areolar scaliness, focal pain/tenderness, and skin dimpling/retraction	**Specialist Referrals** The patient will choose which specialist they want to see within the WHC provider network. AHN Care Coordinators will process the referral on behalf of the patient. Once the referral has been processed AHN Care Coordinators will notify the PCP.	
Abnormal CBE and Diagnostic Evaluation (Mammogram and Ultrasound) Test Results		
BI-RADS Category 0	(Need evaluation or film comparison)	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

Patients will be assigned a Care Coordinator to assist with the **diagnostic workup** process for Breast/Cervical, ensuring a final diagnosis is reached and treatment is initiated.

"An abnormal CBE, suspicious for cancer, regardless of the initial mammogram findings, requires additional work-up."

REIMBURSABLE DIAGNOSTIC SERVICES

Breast Diagnostic Services (Prior Approval Required)

- Consult-Repeat CBE
- Surgical consultation
- Breast MRI
- Mammary ductogram or galactogram single duct
- 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.

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
- If billing for more than one surgical consultation; the provider will need to provide an explanation as to why additional office visit is necessary (If request is not provided 30 days from AHN requested date, the claim will be denied.)
- All consultations should be billed through the standard "new patient" office visit CPT codes 99201–99205 and 99211-99214 for "established patients". Please refer to page 10 for "new patient" and "established patient" definition.
- 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
- Post-op office visit **unless positive for cancer** (This is included in the procedure reimbursement)
- If the purpose of office visit is for treatment

Follow-up Visits:

WHC's ability to pay for follow-up care is largely dependent on the *appropriate* inclusion of a global period corresponding to anticipated recovery and post-op evaluation required for each procedure. Typically:

- WHC will not cover a follow-up visit for a non-invasive biopsy with a normal result
- WHC will pay for follow-up visits for all abnormal results
- WHC will pay for follow-up visits associated with open or invasive biopsies regardless of result
- WHC will usually pay for follow-up visits for necessary care that is unanticipated but directly related to a procedure. Providers should submit these cases to AHN for special consideration.

REIMBURSABLE DIAGNOSTIC SERVICES

- 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.

Schedule for follow-up/return visits with breast specialist

- Once a diagnostic workup has been completed, WHC will pay the specialist for one short term (6 month from the date of the last specialist visit) follow-up 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 who have had a prior mammogram by a non-program payment source which yielded an abnormal result and meet program eligibility requirements may be referred into WHC for a *diagnostic follow-up* by a PCP. 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.

Reimbursable Cervical Diagnostic Services

Final diagnosis should occur within **60 days of abnormal cervical cancer screening result**. Initiation of cervical cancer treatment should occur within **60 days of final diagnosis**.

Patients 21 and older may receive diagnostic services for the following screening results at intervals appropriate to ASCCP guidelines: https://www.asccp.org/screening-guidelines

Cervical Diagnostic Services (Prior Approval Required)

- Cold Knife Conization (CKC)
- LEEP
- Endometrial biopsy
- Some pre-operative testing is allowed with prior approval

Other Cervical Diagnostic Services

- Repeat pelvic exam
- Repeat unsatisfactory Pap test
- Colposcopy (with or without biopsy)
- Local excision of lesion (polyp)
- Curettage (ECC)Endocervical

Cervical Specialist Services

WHC WILL PAY for a **consultation** with a specialist under the following circumstances:

- To discuss diagnostic follow-up after an abnormal Co-Test or abnormal Pap test
- If billing for more than one surgical consultation; the provider will need to provide an explanation as to why additional office visit is necessary. (If request is NOT provided 30 days from AHN requested date, then claim will be denied.)
- All consultations should be billed through the standard "new patient" office visit CPT codes 99201–99205 and 99211-9
- 9214 for "established patients". Please refer to page 10 for "new patient" and "established patient" definitions.
- 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 screening results an office visit that is billed concurrently with a procedure will not be reimbursed through the AHN
- Purpose of office visit is for treatment
- Post-op office visit *unless positive for cancer* (This is included in the procedure reimbursement)
- To discuss screening results which are paid through another payment source other than the WHC program
- To discuss diagnostic or treatment plans for non-WHC covered health conditions
- WHC does not pay for cervical cancer treatment services. AHN Care Coordinators will assist with referral to Medicaid (eligible under the Medicaid Treatment Act) or other treatment resources

REIMBURSABLE DIAGNOSTIC SERVICES

Schedule for follow-up/return visits with Cervical Specialist

- Surveillance after one year following a positive HPV test and negative Pap test
- 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. An 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 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 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**90 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.

Follow-up Visits:

WHC ability to pay for follow-up care is largely dependent on the *appropriate* inclusion of a global period corresponding to anticipated recovery and post-op evaluation required for each procedure. Typically:

- WHC will not cover a follow-up visit for a non-invasive biopsy with a normal result
- WHC will pay for follow-up visits for all abnormal results
- WHC will pay for follow-up visits associated with open or invasive biopsies regardless of result
- WHC will usually pay for follow-up visits for necessary care that is unanticipated but directly related to a procedure. Providers should submit these cases to AHN for special consideration.

For the management of 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/asccp-guidelines)

REIMBURSEMENT AND BILLING

Billing/Claims Guidelines for Reimbursement

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

Billing and claims for services

All billing claim forms for services provided to eligible patients must be received at the appropriate WHC office within **90 days** of the date of service. Incomplete claims will be returned to providers with a request for additional information. Any corrected claims must be re-submitted within **30 days** from denial date.

Reno Office
Access to Healthcare Network
Atten: WHC
4001 South Virginia Street, Suite F
Reno, NV 89502
Phone 844-469-4930
Fax 775-284-1918

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.

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

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 enrollment forms, medical reports and/or exam forms are submitted to AHN.

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. Please see the Denial Code Attachment for a comprehensive list of denial reasons.

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 2024 runs from 06/30/2023 to 06/29/2024
All Fee for Service CPT Codes run from 06/30/2023 to 06/29/2024
New CMS CPT Codes that go into effect 1/1/2023 will not be honored until 6/29/2023
WHC will update new CMS CPT Codes following the start of Fiscal Year 2024 (06/30/2023) upon release of the new CMS CPT Codes on the CMS website. Unfortunately, CMS does not always release the new CPT codes on a set date and time and some delay may occur.

REIMBURSEMENT AND BILLING

Reimbursements

Submit the original paperwork to the appropriate AHN office for <u>ALL</u> services listed below:

Breast and Cervical Screening

Original *AHN Enrollment Form* – completed and signed

- *Annual Screening Visit Form* – completed and signed
- Billing Claim Form with WHC program covered CPT codes

Breast Specialists

Before billing for services, you must ensure 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

Cervical Specialists

Before billing for services, you must ensure 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

Laboratory Facilities (Pap tests, HPV test, Pathology reports<u>)</u>

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

Anesthesia

- Original Billing Claim Form with WHC covered CPT codes

Ambulatory Surgery Centers

- Original Billing Claim with WHC covered CPT codes

Provider Packet Checklist

PCP - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	Original Enrollment Form	(Completed and signed)
☐	Annual Screening Visit Form	(Completed and signed)
☐	Billing Claim Form with WHC approved CPT codes	

IMAGING FACILITIES - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	*(Must Receive)* Mammography & Ultrasound Referral form	This form must be signed and dated by the contracted PCP.
☐	Imaging Report	
☐	Billing Claim Form with WHC approved CPT codes	

BREAST SPECIALIST - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	*(Must Receive)* Breast Specialist Referral Form	This form must have the ***top portion completed***, signed and dated by the contracted PCP.
☐	Breast Specialist Referral Form	This form must be completed, signed and dated by the specialist.
☐	Pathology Results / Documentation pertaining to the diagnostic procedure performed	
☐	Billing Claim Form with WHC approved CPT codes	

CERVICAL SPECIALIST - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	*(Must Receive)* Cervical Specialist Referral Form	This form must have the ***top portion completed***, signed and dated by the contracted PCP.
☐	Cervical Specialist Referral Form	This form must be completed, signed and dated by the specialist.
☐	Pathology Results / Documentation pertaining to the diagnostic procedure performed	
☐	Billing Claim Form with WHC approved CPT codes	

LABORATORY FACILITIES – PROVIDER INFORMATION AND CHECKLIST **(PAP TEST, HPV, PATHOLOGY REPORTS)**		
Provider name:		
☐	Pap test or Pathology result	
☐	Billing Claim Form with WHC approved CPT codes	

ANESTHESIA - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	Billing Claim Form with WHC approved CPT codes	

AMBULATORY SURGERY CENTERS - PROVIDER INFORMATION AND CHECKLIST		
Provider name:		
☐	Billing Claim Form with WHC approved CPT codes	

DIRECTORY/PROVIDER RESOURCES

Access to Healthcare Network Program staff

If you have questions or concerns about how WHC is working with your organization, please do not hesitate to call Access to Healthcare Network WHC Program staff. Our goal is to make sure WHC works using maximum efficiency and effectiveness for providers and patients. As part of our Quality Management Program, both providers and patients may be asked to participate in a satisfaction survey.

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

Las Vegas Office
1090 E. Desert Inn., Suite
100 Las Vegas, NV 89109
Phone (844) 469-4930 Fax
(775) 284-1918

AHN Helpline: 1(844)-469-4934
Care Coordinator: 1(844) 469-4930
Fax: (775) 284-1918
www.accesstohealthcare.org

Trevor Rice
Chief Executive Officer Phone:
775-284-1885
Email: trevor@ahnnv.org

Heather Potts
Chief Financial Officer
Phone: 775-284-1891
Email: hpotts@ahnnv.org

Erla Orozco
Preventive Care Director
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Email: eorozco@ahnnv.org

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Assistant Director
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Email: jrodriguez@ahnnv.org

Ivy Azamar
AHN Claims Processor
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Email: Iazmar@ahnnv.org

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Email: mchacon@ahnnv.org

Denise Savage
AHN Claims Processor
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Email: DSavage@ahnnv.org

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AHN Quality Improvement
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Email: mmanon@ahnnv.org

Angelica Ramirez
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Email: aramirez@ahnnv.org

Mayra Ramirez
AHN Care Coordinator
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Email: Mramirez@ahnnv.org

Victoria Gall
AHN Care Coordinator
Phone: 844-469-4930 ext. 375
Email: vgall@ahnnv.org

Elena Hernandez
AHN Care Coordinator
Phone: 844-469-4930, ext. 331
Email: elena@ahnnv.org

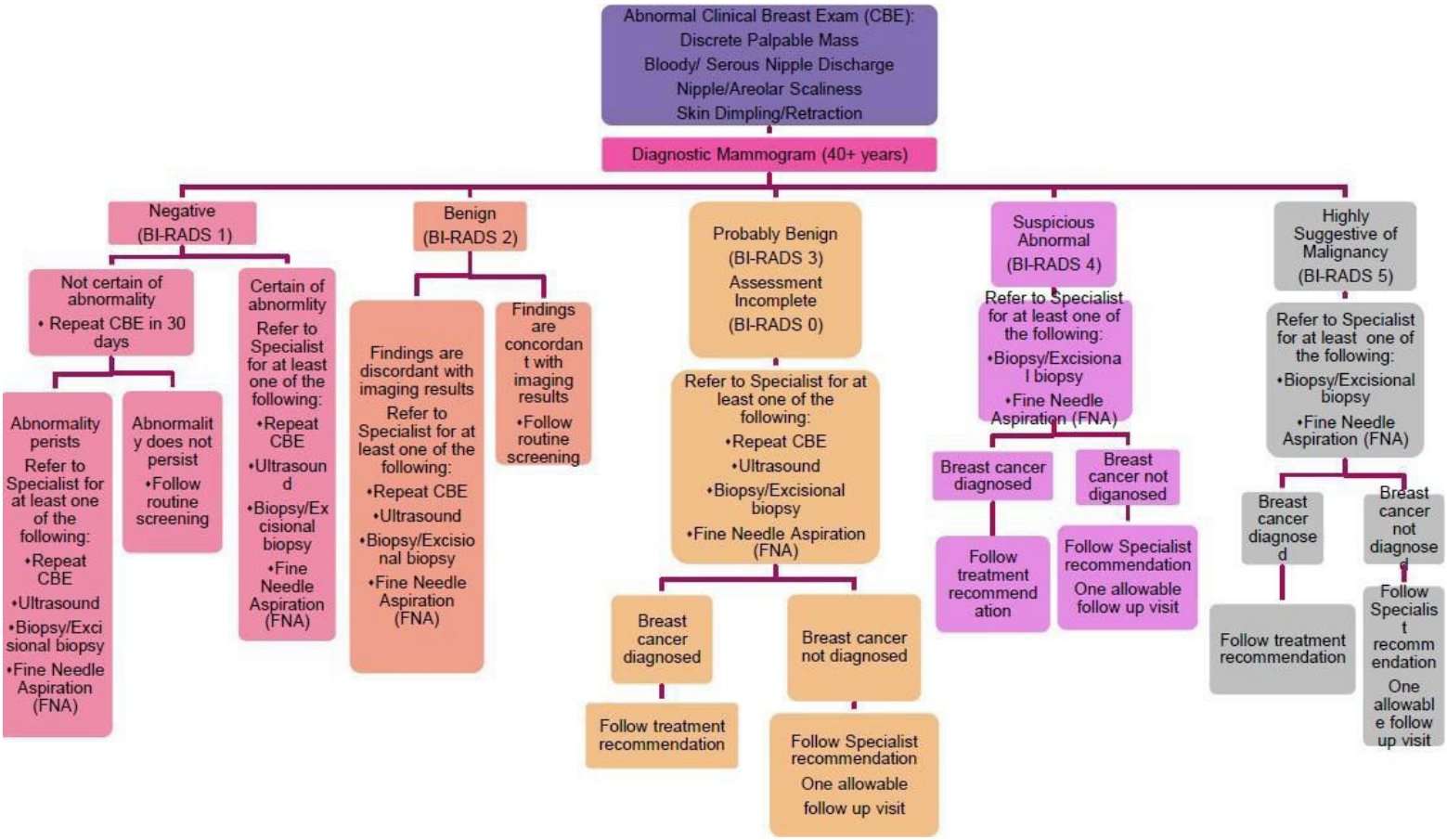
Leslie Vega
AHN billing/Clerical Support
Specialist
Phone: 844-469-4930 ext. 258 Email:
lvega@ahnnv.org

State of Nevada Women's Health Connection contact information

State of Nevada
Women's Health Connection Program
4150 Technology Way. Suite 210
Carson City, NV 8970
Email: DPBHCDPHPCancerUnit@health.nv.gov

State of Nevada – Women's Health Connection Program in Partnership with Access to Healthcare Network

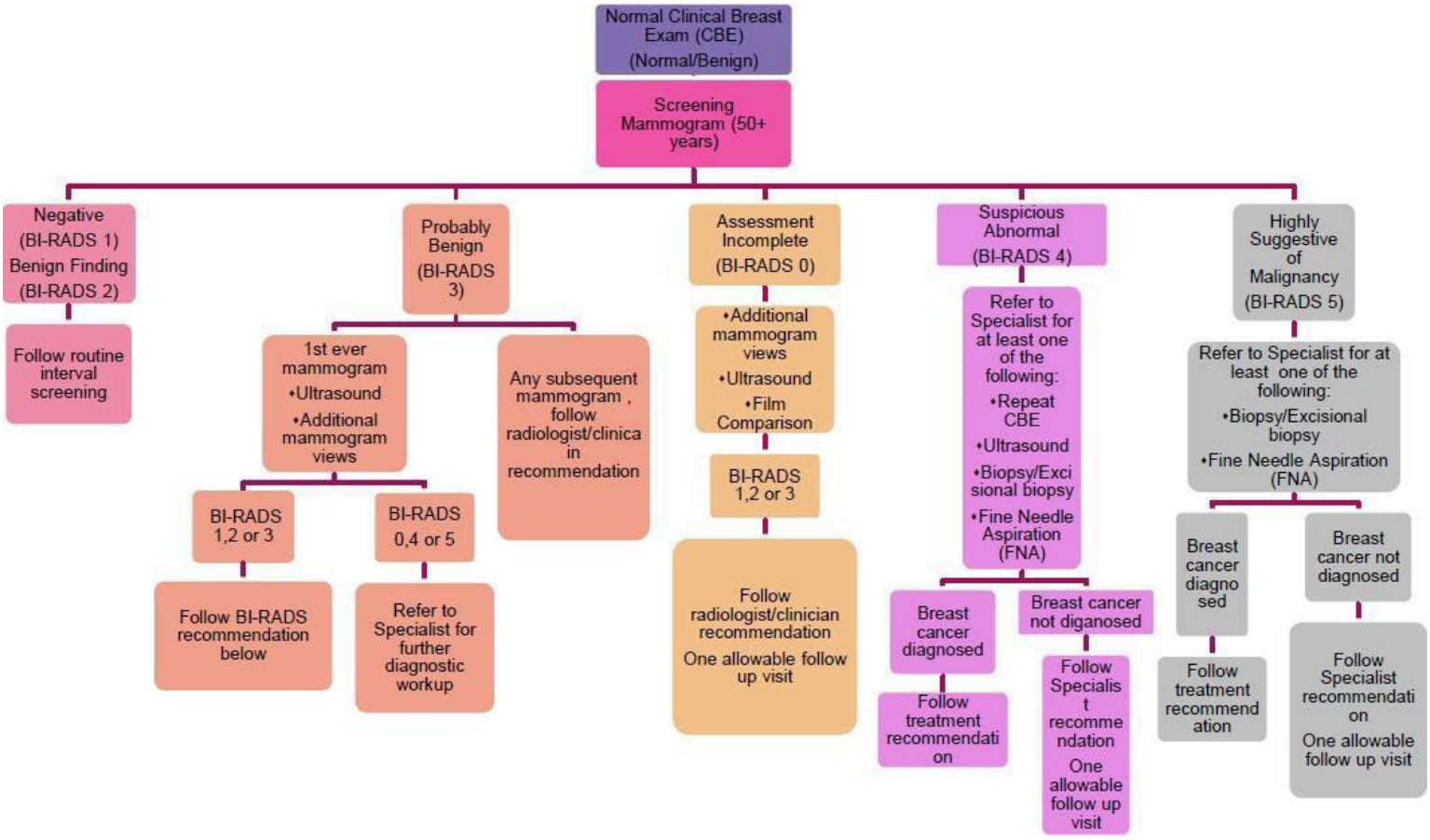
Abnormal Clinical Breast Exam (CBE) Algorithm



Breast Imaging Report and Data System (BI-RADS) were developed by the American College of Radiology (ACR) to standardize mammography reports. It is also used for breast ultrasound and MRI.

BI-RADS Category 0 (Assessment is Incomplete) — Used for indicating that further tests and/or records are needed before a final assessment category can be assigned.
BI-RADS Category 1 (Negative) — Continue routine interval screening
BI-RADS Category 2 (Benign Findings) — Continue routine interval screening
BI-RADS Category 3 (Probably Benign) — Initial short-interval follow-up examination, usually in 6 months, followed by another examination in 6 months, then annually until stability is demonstrated for a minimum of 2 to 3 years. Women at increased risk should be referred to a breast specialist. Category 3 is not recommended for screening mammograms: it is intended for use with diagnostic mammograms only
BI-RADS Category 4 (Suspicious Abnormality) — Requires intervention, usually biopsyBI-RADS Category 5 (Highly Suggestive of Malignancy) — Requires biopsy

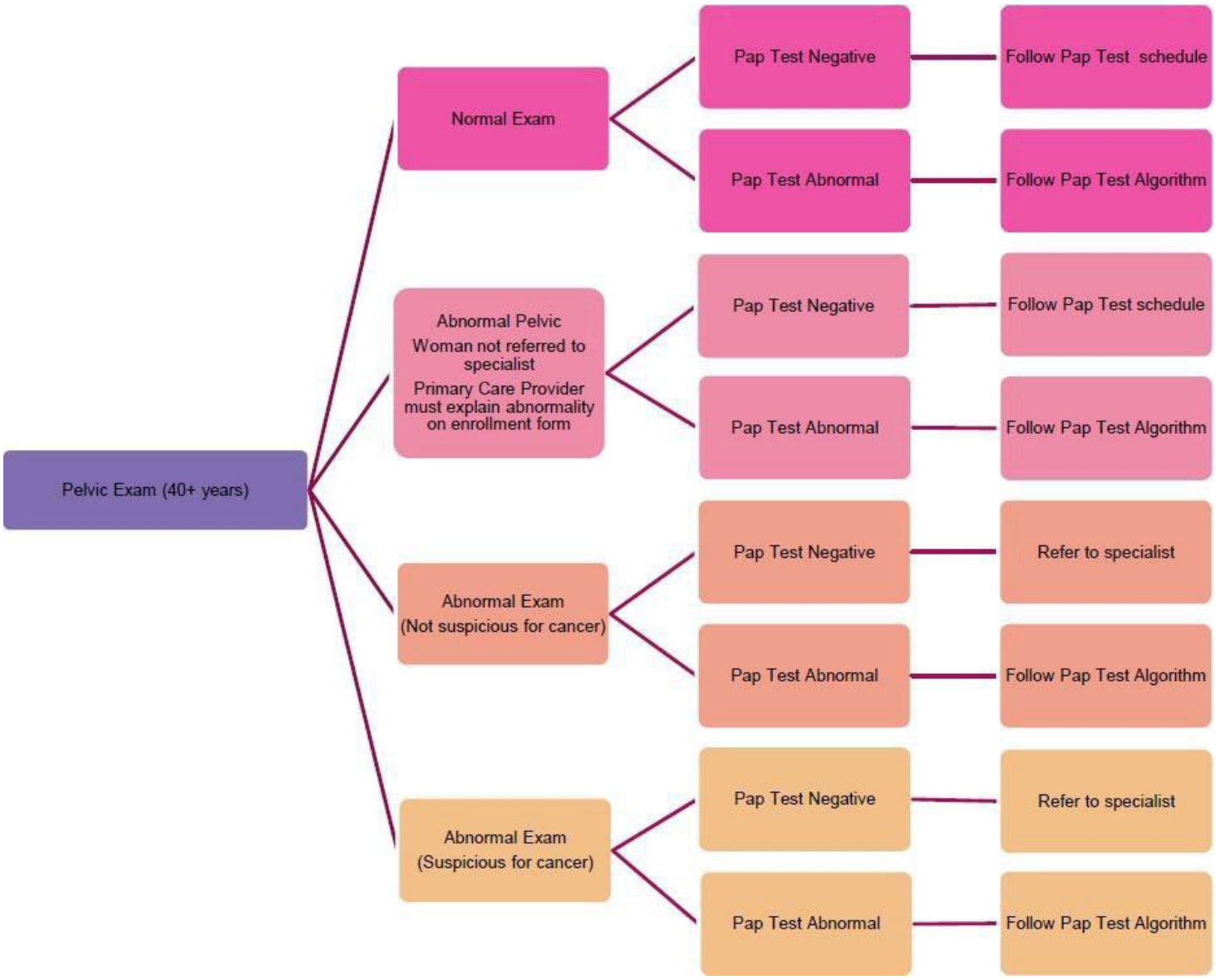
State of Nevada-Women's Health Connection Program in Partnership with Access to Healthcare Network
Normal Clinical Breast Exam (CBE) Algorithm



Breast Imaging Report and Data System (BI-RADS) was developed by the American College of Radiology (ACR) to standardize mammography reports. It is also used for breast ultrasound and MRI.

BI-RADS Category 0 (Assessment is Incomplete) — Used for indicating that further tests and/or records are needed before a final assessment category can be assigned.
BI-RADS Category 1 (Negative) — Continue routine interval screening.
BI-RADS Category 2 (Benign Findings) — Continue routine interval screening.
BI-RADS Category 3 (Probably Benign) — Initial short-interval follow-up examination, usually in 6 months, followed by another examination in 6 months, then annually until stability is demonstrated for a minimum of 2 to 3 years. Women at increased risk should be referred to a breast specialist. Category 3 is not recommended for screening mammograms; it is intended for u se with diagnostic mammograms only.
BI-RADS Category 4 (Suspicious Abnormality) — Requires an intervention, usually biopsy. BI-RADS Category 5 (Highly Suggestive of Malignancy) — Requires biopsy.

State of Nevada- Women's Health Connection Program in Partnership with Access to Healthcare Network
Pelvic Exam Algorithm



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

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY24

- 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 less than the approved rate for a service, the provider will be reimbursed at the billed amount.
- The 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 any additional charges that are not covered under the program prior to the procedure.
- Providers are encouraged to write off charges not reimbursed by WHC.
- A surgical center (modifier SG) is a distinct entity that operates exclusively to furnish surgical services to patients who do not require hospitalization, in which the expected duration of services does not exceed 24 hours following admission.
- A surgical center 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, the provider would be entitled to the professional rate (modifier 26), and the surgical center would be entitled to the facility fee (modifier SG).
- If a provider performs a service or procedure in their office, the provider would be entitled to the Global rate.
- Global fees and SG fees cannot be billed together.
- All billing claims must indicate an associated ICD-10 code for reimbursement.

A **new patient** is a patient new to WHC, or a patient who has NOT been seen by a WHC provider or practice within the last 3 years.
An **Established Patient** is a patient who has been seen by the provider or practice within the last three (3) years.
All **consultation visits** should be billed through the standard "new patient" office visit CPT codes, 99201-99205.

CPT CODE	OFFICE VISITS	RATE	END NOTE
99202	**New patient; medically appropriate history/exam; straightforward decision making**; 15-29 minutes	$73.12	
99203	**New patient; medically appropriate history/exam; low level decision making;** 30-44 minutes	$113.41	
99204	**New patient; medically appropriate history/exam; moderate level decision making;** 45-59 Minutes	$168.17	1
99205	**New patient; medically appropriate history/exam; high level decision making;** 60-74 minutes	$221.97	1
99211	**Established patient**; evaluation and management, may not require presence of physician; presenting problems are minimal	$23.42	
99212	**Established patient;** medically appropriate history/exam; straightforward decision making; 10-19 minutes	$57.13	
99213	**Established patient;** medically appropriate history/exam; low level decision making; 20-29 minutes	$91.15	
99214	**Established patient;** medically appropriate history/exam; moderate level decision making; 30-39 minutes	$128.90	
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**	$91.42	2

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

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**	$110.80	2
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**	$119.05	2
99395	*Periodic* 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**	$82.84	2
99396	*Periodic* 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** Approval Required	$90.07	2
99397	*Periodic* 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** Approval Required	$95.02	2

RADIOLOGY		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
77067	**Screening mammography, bilateral, includes CAD**	$130.63	$36.73	$93.90	
77063	**Screening digital breast tomosynthesis, bilateral** Do not report in conjunction with 77065,77066 List separately in addition to code for primary procedure 77067	$53.68	$29.28	$24.40	3
G0279	**Diagnostic digital breast tomosynthesis, unilateral or bilateral** List separately in addition to 77065 or 77066	$53.68	$29.28	$24.40	4
77065	**Diagnostic mammography, unilateral, includes CAD** A diagnostic mammogram can be performed as the initial screening mammogram for a woman with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results	$127.58	$38.76	$88.82	
77066	**Diagnostic mammography, bilateral, includes CAD** A diagnostic mammogram can be performed as the initial screening mammogram for a woman with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results	$160.79	$47.58	$113.22	
76098	**Radiological examination, surgical specimen**	$42.80	$15.32	$27.48	
76641	**Ultrasound, complete examination of breast including axilla, unilateral**	$105.56	$35.38	$70.18	
76642	**Ultrasound, limited examination of breast including axilla, unilateral**	$86.92	$33.00	$53.91	

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

CPT CODE	RADIOLOGY CODE DESCRIPTION	NON- FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
76942	**Ultrasonic guidance for needle placement, imaging supervision and interpretation**	$59.13	$30.63	$28.50	
77046	**Magnetic resonance imaging (MRI), breast, without contrast, unilateral**	$224.97	$69.36	$155.61	5
77047	**Magnetic resonance imaging (MRI), breast, without contrast, bilateral**	$233.14	$76.85	$156.29	5
77048	**Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral**	$357.67	$101.01	$256.66	5
77049	**Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral**	$365.16	$110.53	$254.63	5
77053	**Mammary ductogram or galactogram, single duct**	$54.32	$17.35	$36.97	
BREAST DIAGNOSTIC PROCEDURES		RATE			
CPT CODE	CODE DESCRIPTION	NON- FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
10004	**Fine needle aspiration biopsy without imaging guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$51.87	$43.06	$47.05	
10005	**Fine needle aspiration biopsy including ultrasound guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$138.49	$74.44	$81.32	
10006	**Fine needle aspiration biopsy including ultrasound guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$60.99	$50.49	$55.16	
10007	**Fine needle aspiration biopsy including fluoroscopic guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$302.23	$89.42	$97.69	
10008	**Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$146.62	$53.09	$58.00	

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

CPT CODE	BREAST DIAGNOSTIC PROCEDURES	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
10009	**Fine needle aspiration biopsy including CT guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$443.64	$109.85	$120.01	
10010	**Fine needle aspiration biopsy including CT guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$243.26	$72.47	$79.18	
10011	**Fine needle aspiration biopsy including MRI guidance, first lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$472.67	$115.53	$126.22	8
10012	**Fine needle aspiration biopsy including MRI guidance, each additional lesion** • May be billed with 76942 • 88172, 88173 may be billed by the lab/pathology	$277.45	$82.62	$90.26	8
10021	**Fine needle aspiration biopsy without imaging guidance, first lesion** • 88172, 88173 may be billed by the lab/pathology	$103.82	$55.70	$60.85	
19000	**Puncture aspiration of cyst of breast**	$104.06	$43.06	$47.05	
19001	**Puncture aspiration of cyst of breast, each additional cyst, *used with 19000***	$26.57	$20.80	$22.73	
19081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 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 • ASC codes may only be billed once ** No Global Period Office visit codes on the day of the procedure are not payable	$515.54	$164.47	$179.68	6

		NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
19082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 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 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	$399.45	$82.94	$90.62	6
19083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 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 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	$515.44	$154.54	$168.83	6
19084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19083 may only be billed once per breast regardless of the number of biopsies • 19084 may be billed for one additional lesion **(Next Page)**	$393.66	$78.17	$85.40	6

	• 76098 may be billed for each specimen • 88305 may be billed for up to 3 biopsy specimens per breast • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable **No Global Period				
19085	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 19085 may only be billed once per breast regardless of the number of biopsies • 19086 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 • For surgical specimen radiography, use 76098 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable **No Global Period	NON-FACILITY $790.94	26: PROFESSIONAL $179.62	SG: FACILITY $196.23	END NOTE 6
19086	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunctioiun with 19281–19288,76098,76942,77002,77021 for same lesion • 19085 may only be billed once per breast regardless of the number of biopsies • 19086 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 • For surgical specimen radiography, use 76098 • ASC codes may only be billed once **No Global Period Office visit codes on the day of the procedure are not payable	$614.94	$90.37	$98.72	6

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19100	**Biopsy of breast, percutaneous, needle core without imaging guidance** • 19100 may only be billed once per breast • 19100 may not be billed with imaging guidance (10022, 19290, 19291, 19295, 77031, 77032) or mammograms • 88305 may be billed for up to 3 biopsy specimens per breast • Office visit codes on the day of the procedure are not payable • SG codes may only be billed once • An SG 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 SG 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 SG, the provider would be entitled to the professional fee, the SG would be entitled to the SG 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 SG fees cannot be billed together **No global period	NON-FACILITY $154.84	26: PROFESSIONAL $70.47	SG: FACILITY $76.98	END NOTE
19101	**Breast biopsy, open, incisional** • 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 • 19101 may not be billed with imaging guidance (10011, 19290, 19291, 19295, 77031, 77032) and mammograms • SG 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	$339.06	$229.94	$251.21	

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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** • 19120 may only be billed once per breast regardless of the number of biopsies • 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 Office visit codes on the day of the procedure and during the 10-day post-operative period are not payable **10-day global period	NON-FACILITY $533.76	26: PROFESSIONAL $429.73	SG: FACILITY $469.48	END NOTE
19125	**Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion** • 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	$588.37	$475.53	$519.52	

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19126	**Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker** • 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	NON-FACILITY $163.35	26: PROFESSIONAL $163.35	SG: FACILITY $178.47	END NOTE
19281	**Placement of breast localization device, percutaneous; mammographic guidance; first lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 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 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	$246.62	$99.21	$108.39	7

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19282	**Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion** • Breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. • Do not report in conjunction with 19281–19288,76098,76942,77002,77021 for same lesion • 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 • ASC codes may only be billed once Office visit codes on the day of the procedure are not payable ** No Global Period	NON-FACILITY $175.19	26: PROFESSIONAL $50.15	SG: FACILITY $54.79	END NOTE 7
19283	**Placement of breast localization device, percutaneous; stereotactic guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19284\ • Office visit codes on the day of the procedure are not payable ** No Global Period	$266.34	$99.95	$109.20	7
19284	**Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19283 Office visit codes on the day of the procedure are not payable ** No Global Period	$196.23	$50.18	$54.82	7

		NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
19285	**Placement of breast localization device, percutaneous; ultrasound guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19286 Office visit codes on the day of the procedure are not payable ** No Global Period	$381.15	$85.32	$93.21	7
19286	**Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • May be billed in conjunction with 19285 • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion Office visit codes on the day of the procedure are not payable ** No Global Period	$312.77	$43.03	$47.01	7
19287	**Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19288 Office visit codes on the day of the procedure are not payable ** No Global Period Approval Required	$656.79	$126.11	$137.78	7
19288	**Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion** • Image guidance placement of a localization device without image-guided biopsy • Do not report 19281-19288 in conjunction with 19081-19086,76942,77002,77021 for same lesion • May be billed in conjunction with 19288 Office visit codes on the day of the procedure are not payable ** No Global Period Approval Required	$508.33	$63.40	$69.26	7

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	BREAST CYTOLOGY	RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88172	**Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode** • To be used with 10021,10022	$55.98	$34.94	$21.04	
88173	**Cytopathology, evaluation of fine needle aspirate; interpretation and report** • To be used with 10021,10022	$163.20	$68.86	$94.34	
88177	**Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode**	$29.52	$21.38	$8.13	
88360	**Morphometric analysis, tumor immunohistochemistry, per specimen; manual**	$119.35	$41.04	$78.31	
88361	**Morphometric analysis, tumor immunohistochemistry, per specimen; using computer assisted technology**	$119.35	$43.07	$76.28	
38505	**Needle biopsy lymph nodes**	$180.17	$86.64	$94.65	
	CERVICAL CYTOLOGY/SCREENING	RATE			
CPT CODE		NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88164	**Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision** • 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	$7.21			
88165	**Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision** • 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	$7.21			

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88141	**Cytopathology, cervical or vaginal, any reporting system, requiring interpretation by physician** • 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	NON-FACILITY $23.08	26: PROFESSIONAL $23.08	TC: FACILITY $25.21	END NOTE
88142	**Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision** • Pap tests are subject to frequency guidelines. See Provider Manual and Cervical Clinical Guidelines	$16.44			
88143	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening and rescreening under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$13.82			
88174	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system, under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$14.58			
88175	**Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system and manual rescreening, under physician supervision** • 88143,88174 and 88175 No longer will be reimbursed at the 88142 rates	$18.07			
87624	**Human Papillomavirus, high-risk types** • 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	$23.88			9

87625	**Human Papillomavirus, types 16 and 18 only** • 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 are 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.	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
		$23.88			9
CERVICAL CYTOLOGY/SCREENING					
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	SG: FACILITY	END NOTE
57452	**Colposcopy of the cervix, without biopsy** • May be billed only once Office visit codes on the day of the procedure are not payable **No global period	$130.28	$92.67	$101.24	
57454	**Colposcopy with biopsy of the cervix and endocervical curettage** • 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	$173.38	$135.42	$147.95	
57455	**Colposcopy of the cervix with biopsy** • 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	$165.38	$110.49	$120.71	

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57456	**Colposcopy of the cervix with endocervical curettage** • 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	NON-FACILITY $156.20	26: PROFESSIONAL $103.00	SG: FACILITY $112.52	END NOTE
57460	**Colposcopy with loop electrode biopsy(s) of the cervix.** • 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 Authorization is required **No global period	$324.13	$162.49	$177.52	
57461	**Colposcopy with loop electrode conization of the cervix.** • 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 Authorization is required **No global period day surgery facility	$361.40	$186.88	$204.17	
57500	**Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)** • 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	$158.21	$76.20	$83.25	
57505	**Endocervical curettage (not done as part of a dilation and curettage)** • 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	$159.56	$112.12	$122.49	

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57520	**Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser** • 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 Authorization is required **90-day Global period	NON-FACILITY $363.46	26: PROFESSIONAL $304.50	SG: FACILITY $332.67	END NOTE
57522	**Loop electrode excision procedure (LEEP)** • 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 • 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 Authorization is required **90-day Global fee period	$312.03	$261.87	$286.10	
58100	**Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation, any method (separate procedure)** • May be billed only once • Must be billed with a colposcopy • Office visit codes on the day of the procedure are not payable Authorization is required **No global period	$104.33	$64.34	$70.29	

58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)** • List separately in addition to code for primary procedure	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
	• 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 forendometrial neoplasia • Code related to another service and is always included in the global period of the other service	$50.89	$40.72	$44.49	
PATHOLOGY		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
VARIOUS	**Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.**				
87426	**COVID-19 infectious agent detection by nuclei acid DNA or RNA; amplified probe technique**	$35.33			
87635	**COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative**	$51.31			
88305	**Surgical pathology, gross and microscopic examination; breast or cervical specimens**	$71.91	$36.63	$35.28	
88307	**Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins; breast or cervical specimens**	$293.05	$81.12	$211.93	
88331	**Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen**	$102.78	$61.06	$41.71	
88332	**Pathology consultation during surgery, each additional tissue block, with frozen section(s)**	$55.30	$30.19	$25.11	
88341	**Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**	$87.12	$27.82	$59.30	
88342	**Immunohistochemistry or immunocytochemistry, per specimen. each additional single antibody stain procedure (List separately in addition to code for primary procedure)**	$101.05	$34.26	$66.79	

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CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
88365	**In situ hybridization (eg,FISH), per specimen; initial single probe stain procedure**	$182.41	$42.39	$140.02	
88364	**In situ hybridization (eg,FISH), per specimen; each additional single probe stain procedure**	$137.99	$33.58	$104.41	
88366	**In situ hybridization (eg,FISH), per specimen; each multiplex probe stain procedure**	$281.74	$61.06	$220.67	
88367	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure**	$114.94	$32.90	$82.04	
88373	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each additional probe stain procedure**	$69.13	$24.74	$44.39	
88374	**Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure**	$306.41	$42.05	$264.35	
88368	**Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure**	$143.78	$41.04	$102.75	
88369	**Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure**	$123.42	$32.57	$90.85	
88377	**Morphometric analysis, in situ hybridization, manual, per specimen, each multiplex stain procedure**	$400.31	$62.73	$337.58	
99070	**Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins**	$15.50			
PREOPERATIVE TESTING		RATE			
CPT CODE	CODE DESCRIPTION	NON-FACILITY	26: PROFESSIONAL	TC: FACILITY	END NOTE
71046	**Chest x-ray, 2 view**	$34.29	$10.54	$23.75	
80048	**Basic Metabolic Panel**	$5.77			
80053	**Comprehensive Metabolic Panel** Cannot be billed with 80048	$7.21			
81001	**Urinalysis** Should only be performed when there is concern the client may be pregnant. This should not be routinely performed.	$2.16			
81025	**Pregnancy Test** Should only be performed when there is concern the client may be pregnant. This should routinely perform.	$4.32			

85014	**Hematocrit** • 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. Approval Required	NON-FACILITY $1.62	26: PROFESSIONAL	TC: FACILITY	END NOTE
85018	**Hemoglobin** • 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. Approval Required	$1.62			
85025	**CBC with differential** • 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. Approval Required	$5.31			
85027	**CBC without differential** • 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. Approval Required	$4.42			

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93000	**EKG, 12 leads, with interpretation and report** • 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. Approval Required	NON-FACILITY $14.64	26: PROFESSIONAL	TC: FACILITY	END NOTE

CPT CODE	ANESTHESIA	END NOTE
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified • Rates for time based codes are calculated using base units plus time spent (15 minutes = 1 unit) • Base unit is 3 x $22.11 = $66.33 + time unit spent - 1 unit (15 minutes) = $22.11	
00940	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified • Rates for time-based codes are calculated using base units plus time spent (15 minutes = 1 unit) • Base unit is 3 x $22.11 = $66.33 + time unit spent - 1 unit (15 minutes) = $22.11	
99156	Moderate anesthesia, 10-22 minutes for individuals 5 years or older $76.51	
99157	Moderate anesthesia for each additional 15 minutes $62.38	**10**
CPT CODE	**PROCEDURES SPECIFICALLY NOT ALLOWED**	**END NOTE**
Any	Treatment of breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia and cervical cancer.	
77061	Breast tomosynthesis, unilateral	**11**
77062	Breast tomosynthesis, bilateral	**11**
87623	Human papillomavirus, low-risk types	

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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. However, they may be used when provider spends extra time to do a detailed risk assessment.
2	The 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate. 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. While some programs may need to use 993XX-series codes, Preventive Medicine Evaluation visits are not covered by Medicare and not appropriate for the NBCCEDP.
3	List separately in addition to code for primary procedure 77067.
4	List separately in addition to 77065 or 77066.
5	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 newly diagnosed with breast cancer in order to determine treatment plan.
6	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.
7	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.
8	For CPT 10011 use the reimbursement rate for CPT code 10009. For CPT 10012 use the reimbursement rate for CPT code 10010.
9	HPV DNA testing is not a reimbursable test for women under 30 years of age.
10	Example: If procedure is 50 minutes, code 99156 + (99157 x 2). No separate charge allowed if procedure <10 minutes.
11	These procedures have not been approved for coverage by Medicare.

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 website at

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 providing screening, diagnostic or therapeutic services to patients with respect to cancer or other neoplasm.

Thanks to the generosity of WHC providers, eligible Nevada residents may receive free cervical and breast cancer screenings at no charge.

Thanks for making a difference