Medicare Rates and CPT Codes - Updated November 2017

Women's Wellness Connection Clinical Services

Reimbursable Services and Procedures for June 30, 2017-June 29, 2018

Listed below are allowable procedures and the corresponding CPT codes for use in the Women's Wellness Connection Clinical Services program. These rates are based on information found on the Centers for Medicare and Medicaid website, https://www.cms.gov/apps/physician-fee-schedule/. Rates are incorporated into the program's Bundled Payment System (BPS) at the beginning of each fiscal year. Codes are provided to show what services are covered through WWC Clinical Services and to aid in negotiating subcontracts. Reimbursement for treatment services is not allowed.

CPT CODES	OFFICE VISITS	End Notes	2017 CO Rates	2017 Prof (26)	2017 Tech (TC)	2016 CO Rates
99203	New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes		$110.61			$109.91
99204	New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	1	$167.75			$167.62
99214	Established Patient; *detailed* history, exam, moderately complex decision-making; 25 minutes		$109.75			$109.01
99213	Established Patient; *expanded* history, exam, straightforward decision-making; 15 minutes		$74.65			$74.02
CPT CODES	**BREAST SCREENING AND DIAGNOSTIC SERVICES**	**End Notes**	**2017 CO Rates**	**2017 Prof (26)**	**2017 Tech (TC)**	**2016 CO Rates**
76098	Radiological examination, surgical specimen		$17.07	$8.31	$8.76	$17.01
76641	Ultrasound, complete examination of breast including axilla, unilateral	11	$110.80	$37.56	$73.24	$109.90
76642	Ultrasound, limited examination of breast including axilla, unilateral	11	$91.16	$35.04	$56.12	$90.73
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation		$62.00	$33.21	$28.80	$62.14
19000	Puncture aspiration of cyst of breast		$116.32			$116.18
19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*		$27.91			$27.85
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance		$155.75			$155.25
19101			$352.94			$352.31
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		$512.61			$512.38
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion		$568.32			$568.42
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; *each additional lesion separately identified by a preoperative radiological marker*		$170.16			$170.23
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	8	$714.33			$712.91
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	8	$589.94			$589.19
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	8	$692.89			$689.32
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	8	$566.99			$566.73
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	8	$1,052.92			$1,058.86
19086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	8	$842.62			$838.84
19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	9	$247.69			$245.87
19282	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	9	$171.93			$172.19
19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	9	$279.80			$276.72
19284	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	9	$210.59			$208.81
19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	9	$533.78			$529.03
19286	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	9	$465.61			$464.70

19287	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	9	$893.35			$884.39
19288	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	9	$718.98			$713.27
10021	Fine needle aspiration without imaging guidance		$126.03			$126.31
10022	Fine needle aspiration with imaging guidance		$145.26			$144.66
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)		$58.70	$38.28	$20.42	$58.45
88173	Cytopathology, evaluation of fine needle aspirate; *interpretation and report*		$157.44	$74.71	$82.73	$156.69
88305	Surgical pathology, gross and microscopic examination		$70.32	$40.07	$30.25	$74.72
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins		$273.19	$88.46	$184.72	$315.19
G0202	Screening Mammogram, Digital, Bilateral		$139.33	$37.91	$102.01	$136.33
G0204	Diagnostic Mammogram, Digital, Bilateral		$173.35	$49.84	$123.51	$166.70
G0206	Diagnostic Mammogram, Digital, Unilateral		$136.64	$40.09	$96.55	$130.90
400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3	3	(see end note)			
77053	Mammary ductogram or galactogram, single duct		$60.33	$18.78	$41.55	$59.31
77058	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral REQUIRES WWC PREAPPROVAL.	7	$556.31	$84.16	$472.15	$547.74
77059	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral REQUIRES WWC PREAPPROVAL.	7	$552.67	$84.16	$468.51	$544.84
77065	Diagnostic Mammography, unilateral, includes CAD	12	Use G0206			N/A
77066	Diagnostic Mammography, bilateral, includes CAD	12	Use G0204			N/A
77067	Screening Mammography, bilateral	12	Use G0202			N/A
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.					

CPT CODES	CERVICAL SCREENING AND DIAGNOSTIC SERVICES	End Notes	2017 CO Rates	2017 Prof (26)	2017 Tech (TC)	2016 CO Rates
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision		$14.49			$14.39
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision		$14.49			$14.39
88141	Cytopathology (conventional Pap test), cervical or vaginal, any reporting system, *requiring interpretation by physician*		$33.32			$33.19
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision		$27.79			$27.60
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	10	$27.79			$27.60
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	10	$39.31			$29.11
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	10	$36.34			$36.09
87624	Human Papillomavirus (HPV) high-risk types	4	$48.14			$47.80
87625	Human Papillomavirus, types 16 and 18 only	4	$48.14			$47.80
57452	Colposcopy of the cervix		$112.48			$111.83
57454	Colposcopy of the cervix, with biopsy and endocervical curettage		$157.35			$156.61
57455	Colposcopy of the cervix, with biopsy		$146.92			$146.16
57456	Colposcopy of the cervix, with endocervical curettage		$138.58			$137.84
57460	Colposcopy with loop electrode biopsy(s) of the cervix Requires WWC Preapproval Unless Done After HSIL or AIS Pap test.	5	$290.52			$289.10

57461	Colposcopy with loop electrode conization of the cervix Requires WWC Preapproval unless done after HSIL or AIS Pap test.	5	$328.97			$326.73
57500	Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure) Use this code for cervical polyp removal		$131.49			$130.63
57505	Endocervical curettage (not done as part of a dilation and curettage)		$105.29			$104.60
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	5	$317.62			$315.34
57522	Loop electrode excision procedure	5	$271.36			$269.56
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure). Only for diagnostic purposes following AGC Pap.		$112.45			$111.79
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure). Only for diagnostic purposes following AGC Pap.		$49.29			$49.18
88305	Surgical pathology, gross and microscopic examination		$70.32	$40.07	$30.25	$74.72
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen		$99.61	$66.44	$33.17	$97.74
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)		$54.00	$32.85	$21.15	$51.59
88341	Immunohistochemistry antibody slide		$93.33	$29.95	$63.38	$91.04
88342	Immunohistochemistry antibody slide		$109.69	$37.54	$72.14	$108.40
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	6				
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.					
CLINICAL SERVICES AND PROCEDURES SPECIFICALLY NOT ALLOWED						
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.					
77061, 77062, 77063, and G0279	Breast tomosynthesis, unilateral/bilateral. These procedures have not been approved for coverage by WWC.					
87623	Human Papillomavirus, low-risk types					

END NOTES FOR WWC CLINICAL SERVICES

1	All consultations should be billed through the standard "new patient" office visit CPT codes 99203 or 99204. Consultations billed as 99204 must meet the CPT coding guidelines for this code. CPT code 99204 is not appropriate for WWC screening visits.
2	The type and duration of office visits should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up. Reimbursement rates should not exceed those published by Medicare. While the use of 993XX-series codes may be necessary in some programs, the 993XX Preventive Medicine Evaluation visits themselves are not appropriate for WWC programs. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.
3	Medicare's methodology for the payment of anesthesia services are outlined in the Medicare Claims Processing Manual, Chapter 12, pages 99-107, available here: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf
	The carrier-specific Medicare anesthesia 2017 conversion rates are available here: http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html?redirect=/center/anesth.asp. The current rate is $22.19 (Medicare Base Units = 3).
4	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. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. Cervista HPV HR is reimbursed at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. HPV genotyping is allowed.
5	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Pre-approval of this procedure for reimbursement is required.
6	This charge should be used with caution to ensure programs do not reimburse for supplies, the cost of which, has already been accounted for in another clinical charge.
7	Breast MRI can be reimbursed 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 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history. Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should never be performed alone as a breast cancer screening tool. Breast MRI cannot be reimbursed to assess the extent of disease in a women who has just been diagnosed with breast cancer.
8	Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.

9	Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.
10	These procedures may be reimbursed at their own Medicare rates. They no longer have to be reimbursed at the 88142 rate.
11	For a bilateral breast ultrasound, a modifier 50 should be added to either 76641 or 76642 to indicate a bilateral procedure. The Medicare Physician Fee Schedule assigns a "1" bilateral indicator to both CPT codes 76641 and 76642 which means that Medicare will allow 150 percent of the standard reimbursement rate. There should not be two CPT codes billed if a bilateral ultrasound exam is needed.
12	Due to Medicare claims processing issues, CMS will not be able to process the new mammography codes. Therefore no reimbursement fees have been assigned to these codes. Use only G0202, G0204 and G0206 until this has been resolved.