

The Ohio Department of Health  
Bureau of Healthy Ohio  
Ohio Breast and Cervical Cancer Project  
**Rates Subject to change without notice**

**OFFICE VISITS**

Code	Description of Service	Rate	CNP PA CNS	CNM	Notes
<b>New Patient</b>					
99201	History, exam, straight forward decision-making (~10 minutes)	\$41.97	\$35.67	\$27.28	
	99201 when performed at a facility (Physician Rate)	\$26.19	\$22.26	\$17.02	
	Amount Paid to Facility	\$15.78	\$13.41	\$10.26	
99202	Expanded history, straight forward decision-making (~20 minutes)	\$71.97	\$61.17	\$46.78	
	99202 when performed at a facility (Physician Rate)	\$49.62	\$42.18	\$32.25	
	Amount Paid to Facility	\$22.35	\$19.00	\$14.53	
99203	Detailed history, straight forward decision-making (~30 minutes)	\$104.49	\$88.82	\$67.92	
	99203 when performed at a facility (Physician Rate)	\$75.90	\$64.52	\$49.34	
	Amount Paid to Facility	\$28.59	\$24.30	\$18.58	
99204	Comprehensive history, moderate complexity decision-making (45 minutes)	\$160.23	\$136.20	\$104.15	1
	99204 when performed at a facility (Physician Rate)	\$128.35	\$109.10	\$83.43	
	Amount Paid to Facility	\$31.88	\$27.10	\$20.72	
99205	Comprehensive history, high complexity decision-making making (60 minutes)	\$201.38	\$171.17	\$130.90	1
	99205 when performed at a facility (Physician Rate)	\$166.87	\$141.84	\$108.47	
	Amount Paid to Facility	\$34.51	\$29.33	\$22.43	
<b>Established Patient</b>					
99211	Evaluation and management (~5 minutes)	\$18.96	\$16.12	\$12.32	
	99211 when performed at a facility (Physician Rate)	\$9.10	\$7.74	\$5.92	
	Amount Paid to Facility	\$9.86	\$8.38	\$6.41	
99212	Exam; Straight forward decision-making (~10 minutes)	\$41.62	\$35.38	\$27.05	
	99212 when performed at a facility (Physician Rate)	\$24.85	\$21.12	\$16.15	
	Amount Paid to Facility	\$16.77	\$14.25	\$10.90	
99213	Expanded history and exam straight forward decision-making (15 minutes)	\$70.42	\$59.86	\$45.77	
	99213 when performed at a facility (Physician Rate)	\$50.37	\$42.81	\$32.74	
	Amount Paid to Facility	\$20.05	\$17.04	\$13.03	
99214	Detailed history, exam, moderately complex decision making (25 minutes)	\$103.93	\$88.34	\$67.55	
	99214 when performed at a facility (Physician Rate)	\$77.31	\$65.71	\$50.25	
	Amount Paid to Facility	\$26.62	\$22.63	\$17.30	
99386	Initial Evaluation and Risk Factor Reduction, 40 – 64 years	\$104.49	\$88.82	\$67.92	2
	99386 when performed at a facility (Physician Rate)	\$75.90	\$64.52	\$49.34	
	Amount Paid to Facility	\$28.59	\$24.30	\$18.58	
99387	Same as 99386, 65 years and older	\$104.49	\$88.82	\$67.92	2
	99387 when performed at a facility (Physician Rate)	\$75.90	\$64.52	\$49.34	
	Amount Paid to Facility	\$28.59	\$24.30	\$18.58	
99396	Periodic Evaluation and Risk Factor Reduction, 40 – 64 years	\$70.42	\$59.86	\$45.77	2
	99396 when performed at a facility (Physician Rate)	\$50.37	\$42.81	\$32.74	
	Amount Paid to Facility	\$20.05	\$17.04	\$13.03	
99397	Same as 99396, 65 years and older	\$70.42	\$59.86	\$45.77	2
	99397 when performed at a facility (Physician Rate)	\$50.37	\$42.81	\$32.74	
	Amount Paid to Facility	\$20.05	\$17.04	\$13.03	
<b>99420</b>	<b>Administration &amp; interpretation of health risk assessment instrument</b>	\$10.22			14

CNS = Clinical Nurse Specialist    PA = Physician Assistant    CNP= Certified nurse practitioner    CNM = Certified Nurse Midwife

<b>BREAST SCREENING &amp; DIAGNOSTIC PROCEDURES</b>					
<b>Code</b>	<b>Description of Service</b>	<b>Rate</b>	<b>26</b>	<b>TC</b>	<b>Notes</b>
77053	Mammary ductogram or galactogram, single duct	\$55.04	\$17.87	\$37.17	
77055	Mammography, Diagnostic Follow-up, Unilateral	\$85.02	\$35.03	\$49.99	
77056	Mammography, Diagnostic Follow-up, Bilateral	\$109.21	\$43.45	\$65.76	
77057	Screening Mammogram, bilateral (screening) [4 views - 2 of each breast]	\$78.12	\$35.03	\$43.08	
77058	Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral	\$502.73	\$81.28	\$421.45	
77059	Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral	\$500.11	\$81.28	\$418.82	
76098	Radiological examination, surgical specimen	\$15.97	\$8.06	\$7.92	
76641	Ultrasound, complete examination of breast including axilla, unilateral	\$102.20	\$36.43	\$65.76	
76642	Ultrasound, limited examination of breast including axilla, unilateral	\$84.30	\$33.99	\$50.32	
76942	Ultrasonic guidance for needle placement, supervision and interpretation	\$58.63	\$33.30	\$25.34	
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s).	\$55.35	\$36.92	\$18.43	
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	\$146.86	\$72.20	\$74.66	
88305	Surgical pathology, gross and microscopic examination	\$70.32	\$38.74	\$31.58	
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	\$291.44	\$84.97	\$206.47	
G0202	Screening Mammogram, Digital, Bilateral	\$126.10	\$34.70	\$91.40	
G0204	Diagnostic Mammogram, Digital, Bilateral	\$154.24	\$43.45	\$110.79	
G0206	Diagnostic Mammogram, Digital, Unilateral	\$121.17	\$34.70	\$86.47	
<b>Code</b>	<b>Description of Service</b>	<b>Non-Facility Price</b>	<b>Facility Price</b>	<b>Hospital &amp; ASC Rate</b>	<b>Notes</b>
10021	Fine needle aspiration without imaging guidance	\$118.90	\$69.92	\$48.98	11
10022	Fine needle aspiration with imaging guidance	\$135.55	\$65.87	\$69.68	11
19000	Puncture aspiration of cyst of breast	\$108.27	\$44.18	\$64.09	11
19001	Code 19000 plus each additional cyst	\$26.68	\$22.07	\$4.61	11
19081	Breast biopsy, with placement of localization devise and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	\$658.21	\$171.76	\$486.45	9, 11
19082	Code 19081 plus each additional lesion	\$540.45	\$85.88	\$454.57	9, 11
19083	Breast biopsy, with placement of localization devise and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	\$636.16	\$160.88	\$475.28	9, 11
19084	Code 19083 plus each additional lesion	\$519.73	\$80.60	\$439.13	9, 11
19085	Breast biopsy, with placement of localization devise and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	\$973.49	\$188.92	\$784.57	9, 11
19086	Code 19085 plus each additional lesion.	\$767.69	\$93.56	\$674.13	9, 11
19100	Breast biopsy, percutaneous, needle core, not using imaging	\$145.18	\$70.90	\$74.28	11
19101	Breast biopsy, open, incisional	\$330.62	\$220.84	\$109.78	11
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	\$484.91	\$411.94	\$72.97	11
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	\$538.35	\$458.48	\$79.87	11
19126	Code 19125 plus each additional lesion separately identified by a preoperative radiological marker	\$164.31	\$164.31	\$0.00	11
19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	\$229.86	\$102.66	\$127.20	10, 11
19282	Code 19281 plus each additional lesion	\$159.66	\$51.52	\$108.14	10, 11
19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	\$257.88	\$103.40	\$154.48	10, 11
19284	Code 19283 plus each additional lesion	\$192.91	\$52.23	\$140.68	10, 11
19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	\$485.98	\$87.62	\$398.36	10, 11
19286	Code 19285 plus each additional lesion	\$424.77	\$44.15	\$380.62	10, 11
19287	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	\$811.46	\$131.41	\$680.05	10, 11
19288	Code 19288 plus each additional lesion	\$651.89	\$65.52	\$586.37	10, 11

CERVICAL SCREENING & DIAGNOSTIC PROCEDURES					
Code	Description of Service	Rate	Notes		
88141	Cytopathology (conventional Pap test), slides cervical or vaginal, any reporting system requiring interpretation by physician	\$31.53			
88142	Cytopathology (liquid-based Pap test), slides cervical or vaginal, collected in preservation fluid, automated thin layer prep, manual screening and rescreening under physician supervision	\$26.95			
88143	Cytopathology cervical or vaginal, collected in preservation fluid, automated thin layer prep, manual screening under physician supervision	\$26.95	4		
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	\$14.39			
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	\$14.39			
88174	Cytopathology cervical or vaginal, collected in preservation fluid, automated thin layer prep, screening by automated system, under physician supervision	\$27.69	4		
88175	Cytopathology cervical or vaginal, collected in preservation fluid, automated thin layer prep, screening by automated system and manual rescreening, under physician supervision	\$30.92	4		
87624	Human Papillomavirus, high risk types	\$47.80	5		
<b>87625</b>	<b>Human Papillomavirus, types 16 and 18 only</b>	<b>\$47.80</b>	<b>5</b>		
Code	Description of Service	Non-Facility Price	Facility Price	Hospital & ASC Rate	Notes
57452	Colposcopy of the cervix	\$106.50	\$91.38	\$15.12	11
57454	Colposcopy with biopsy and endocervical curettage	\$149.91	\$134.46	\$15.45	11
57455	Colposcopy with cervical biopsy	\$139.30	\$110.05	\$29.25	11
57456	Colposcopy with endocervical curettage	\$131.28	\$102.35	\$28.93	11
57460	Colposcopy with loop electrode biopsy(s) of the cervix	\$271.87	\$161.43	\$110.44	6, 11
57461	Colposcopy with loop electrode conization of the cervix	\$308.03	\$186.74	\$121.29	6, 11
57500	Cervical biopsy, single or multiple, or local excision of lesion with or without fulguration (separate procedure).	\$122.58	\$74.92	\$47.66	11
57505	Endocervical curettage (not done as part of a dilation and curettage)	\$98.91	\$90.04	\$8.87	11
57520	Conization of the cervix, with or without fulguration, with our without dilation and curettage, with or without repair; cold knife or laser	\$299.93	\$271.01	\$28.92	6, 11
57522	Loop electrode excision procedure	\$256.91	\$239.16	\$17.75	6, 11
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy) without cervical dilation, any method (separate procedure)	\$106.57	\$86.84	\$19.73	11
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (separate from primary function)	\$47.20	\$40.63	\$6.57	11

PATHOLOGY					
Code	Description of Service	Rate	26	TC	Notes
88305	Surgical pathology, gross and microscopic examination	\$70.32	\$38.74	\$31.58	
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	\$92.67	\$63.72	\$28.95	
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s).	\$48.79	\$31.34	\$17.45	
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	\$100.74	\$36.29	\$64.45	
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure	\$84.41	\$27.22	\$57.19	

**ANESTHESIOLOGY**

Code	Description of Service	Rate	Modifiers	Modifiers	Notes
			AA, QZ	QK, QY, AD, QX	
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3  Calculated at (Time units + Base units) x Rate.	\$21.71	\$21.71	\$10.86	3
00940	Anesthesia for vaginal procedures. Medicare Base Units = 3  Calculated at (Time units + Base units) x Rate	\$21.71	\$21.71	\$10.86	3

**PRE-OPERATIVE LAB CHARGES**

Pre-Operative Testing must be medically necessary for a planned surgical procedure (CPT CODE) covered by BCCP.  
Listing is not exhaustive and may include additional codes.

Code	Description of Service	Rate	26	TC	Notes
71010	Radiologic examination, chest; single view, frontal	\$21.29	\$9.10	\$12.19	12
71020	Radiologic examination, chest, 2 views, frontal and lateral	\$26.34	\$10.86	\$15.47	12
36415	Venous Puncture	\$3.00			12
80048	Basic Metabolic Panel	\$9.99			12
80053	Complex Metabolic Panel	\$14.39			12
81001	Urinalysis	\$4.32			12
81025	Pregnancy Test	\$8.61			12
82565	Assay of creatinine	\$6.98			12
84520	Assay of urea nitrogen	\$5.38			12
84703	Pregnancy Test	\$10.24			12
85014	Hematocrit	\$3.23			12
85018	Hemoglobin	\$3.23			12
85025	CBC with differential WBC Count	\$10.59			12
85027	CBC without differential	\$8.81			12
85610	Prothrombin time	\$5.36			12
85730	Thromboplastine time, partial (PTT); plasma or whole blood	\$8.18			12
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	\$16.33			12
93005	Electrocardiogram tracing, no interpretation or report	\$7.92			12, 13
93010	ECG interpretation and report	\$8.41			12, 13

**MISCELLANEOUS**

Code	Description of Service	Rate	Notes
99070/A 4649 Surgical Supplies	This code is used to reimburse when procedures are performed in an outpatient setting. Allowable charges include surgical supplies and pharmacy supplies. A separate line item indicating surgical supplies, operating room supplies or similar language should be noted on the bill received along with the CPT Code.	\$100 for CPT codes: 10021, 10022, 19000, 19100, 19101, 19081-19086, 19120, 19125, 57460, 57461, 57520, 57522, 58100, 58110 and 58558.  \$50.00 for CPT Codes: 57452, 57454, 57455, 57456, 57500 and 57505.	7

## PROCEDURES SPECIFICALLY NOT ALLOWED

Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics (77051). CAD is not reimbursed with federal funds.

## State Funded Codes

Code	Description of Service	Rate	26	TC	Notes
J-Codes	Various J Codes may be covered for a planned surgical procedure (CPT Code) covered by BCCP.	Medicare Rate			
88313	Special stains group 1	\$64.19	\$12.24	\$51.96	
88312	Special stains group 2	\$92.36	\$27.58	\$64.78	
77051	Computer dx mammogram add-on	\$7.74	\$2.81	\$4.93	
77052	Computer dx mammogram add-on	\$7.74	\$2.81	\$4.93	
0159T	Computer dx mammogram add-on	\$7.74	\$2.81	\$4.93	
77061	Breast tomosynthesis uni	\$53.12	\$29.78	\$23.34	
77062	Breast tomosynthesis bi	\$53.12	\$29.78	\$23.34	
77063	Breast tomosynthesis bi	\$53.12	\$29.78	\$23.34	
G0279	Breast tomosynthesis	\$53.12	\$29.78	\$23.34	
A9579	MRI Contrast Agent (Per Unit)	\$1.89			
G0123	Screen Cerv/Vag thin layer (not preferred Pap Code)	\$26.95			
87210	Smear wet mount saline/ink	\$5.82			
A9578	Inj multihance multipack	\$2.03			

Ohio BCCP may approve additional codes with "Pre-approval". Codes will be paid at the current Medicare Part B rates.

## END NOTES

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 <u>not</u> appropriate for NBCCEDP 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 within the NBCCEDP. 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 the NBCCEDP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.
3	Medicare’s methodology for the payment of anesthesia services are outlined in the Medicare Claims Processing Manual, Chapter 12, pages 99-107, available here: <a href="http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf">http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf</a> The carrier-specific Medicare anesthesia conversion rates are available here: <a href="http://www.cms.hhs.gov/center/anesth.asp">http://www.cms.hhs.gov/center/anesth.asp</a> Modifiers: Split billing between Physician and Nurse allowed with modifiers QK, QY or AD for physician and modifier QX for nurse.
4	These procedures may be reimbursed at their own Medicare rates. They no longer have to be reimbursed at the 88142 rate.
5	HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per 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.  The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.  <b>CDC Funds may be used for reimbursement of HPV genotyping.</b>
6	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Grantees are strongly encouraged to develop policies to closely monitor these procedures and should pre-authorize this service for reimbursement by having it medical advisory board or designated clinical representative(s) review these cases in advance, and on an individual basis.
7	This charge should be used with caution to ensure that programs do not reimburse for supplies, the cost of which, has already been accounted for in another clinical charge.
8	Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA 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 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 is already diagnosed with breast cancer.
9	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.
10	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.
11	Facility price is the rate paid to the physician when a procedure is performed in a facility (includes hospitals and ambulatory surgical centers – ASC). The Non-facility price is the amount paid to the physician when the procedure is performed in the office. Hospitals and ASC’s rate is the difference between the Facility price and non-facility price and can be paid to the facility.
12	Pre-Operative Testing must be medically necessary for a planned surgical procedure (CPT CODE) covered by BCCP.
13	Electrocardiogram (ECG) Codes: 93000 cannot be billed along with 93005 or 93010.
14	<b>Appropriate for use of breast risk assessment tools during an office visit. The modifier -25 should be added to the appropriate office visit CPT to indicate a separate service done on same day.</b>

For more information regarding the Ohio Breast and Cervical Cancer Project, please visit [www.healthy.ohio.gov](http://www.healthy.ohio.gov)

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