Locale 1/2

Approved Procedures Medicare "B" Maximum Allowable Fees
Current Procedural Terminology (CPT) Description

2019 Florida Rates

CPT Code	Office Visits	Fee Schedule	Professional (26)	Technical (TC)
99201	New patient; history, exam, straightforward decision-making - office visit (10 minutes face-to-face) **(Initial CBE only)**	$45.82		
99201*	The provider's reduced fee if they provide service in a facility outside their own office	$27.64		
99202	New patient; expanded history, exam, straightforward decision-making - office visit (20 minutes face-to-face)	$76.54		
99202*	The provider's reduced fee if they provide service in a facility outside their own office	$51.84		
99203	New patient - office visit (30 minutes face-to-face) **Usual charge for initial CBE with Pap smear and pelvic exam, or for Pap and pelvic exam**	$109.15		
99203*	The provider's reduced fee if they provide service in a facility outside their own office	$78.27		
99204	New patient, comprehensive history, exam, moderate complexity decisionmaking; 45 minutes (only for diagnostic services)[1]	$166.13		
99204*	The provider's reduced fee if they provide service in a facility outside their own office[1]	$132.16		
	Established, Rescreening or Clients needing Short Term Follow-Up - Office Visits			
99211	Established patient - office visit (5 minutes face-to-face)	$22.42		
99211*	The provider's reduced fee if they provide service in a facility outside their own office	$9.38		
99212	Established patient - office visit (10 minutes face-to-face) **Usual charge for repeat Pap/pelvic only or Repeat CBE only**	$44.99		
99212*	The provider's reduced fee if they provide service in a facility outside their own office	$26.12		
99213	Established patient - office visit (15 minutes face-to-face) **Usual charge for repeat CBE with Pap smear and pelvic exam**	$74.41		
99213*	The provider's reduced fee if they provide service in a facility outside their own office	$52.11		
99214	Established patient; detailed history, exam, moderatly complex decision-making, 25 minutes.	$109.04		
99214*	The provider's reduced fee if they provide service in a facility outside their own office[1]	$80.22		
	Procedure Codes - Cervical			
	Screening	**Fee Schedule**	**Professional (26)**	**Technical (TC)**
87624**	Human Papillomavirus, high-risk types[5]	$38.99		
87624**	Human Papillomavirus, high-risk types, **County Health Departments state contract with Quest**	$18.00		
87625	Human Papillomavirus, types 16 and 18 only	$40.55		
88141	Pap smear (conventional Pap Test) any reporting system requiring interpretation by physician	$31.90		
88141	Pap smear (conventional Pap Test) any reporting system requiring interpretation by physician **County Health Departments state contract with Quest**	$5.00		
88142	Cytopathology, Liquid Based Pap Test, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision. See color coded notes at bottom of document.	$22.51		
88142	Cytopathology, Liquid Based Pap Test, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision. See color coded notes at bottom of document. **County Health Departments state contract with Quest**	$12.60		
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision.[4]	$23.04		
88164	Pap smear reported in Bethesda System (manual screening under physician supervision) **Pap Smear Cytology (lab fee)**	$14.99		
88164	Pap smear reported in Bethesda System (manual screening under physician supervision) **Pap Smear Cytology (lab fee) County Health Departments state contract with Quest**	$12.60		
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision.	$42.22		
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision. **County Health Departments state contract with Quest**	$12.60		
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	$56.53	$ 37.51	$ 19.02
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	$151.35	$ 73.18	$ 78.17
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.[4]	$25.37		
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual screening, under physician supervision.[4]	$29.44		
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; *screening by automated system and manual screening* , under physician supervision **County Health Departments state contract with Quest**	$12.60		
	Procedure Codes - Cervical			
CPT Code	**Diagnostic**	**Fee Schedule**	**Professional (26)**	**Technical (TC)**
57452	Colposcopy of the cervix (vaginoscopy) without biopsy (surgical procedure only)	$117.17		
57452*	The provider's reduced fee if they provide service in a facility outside their own office	$95.56		
57454	Colposcopy of the cervix with biopsy and endocervical curettage (surgical procedure only)	$160.66		
57454*	The provider's reduced fee if they provide service in a facility outside their own office	$138.70		
57455	Colposcopy of the cervix with biopsy(s)	$151.20		
57455*	The provider's reduced fee if they provide service in a facility outside their own office	$114.15		
57456	Colposcopy of the cervix with endocervical curettage	$142.09		
57456*	The provider's reduced fee if they provide service in a facility outside their own office	$106.06		
57500	Biopsy, single or multiple, w/wo fulguration (separate procedure) Female genital system - Cervix uteri	$134.65		
57500*	The provider's reduced fee if they provide the service in a facility outside their own office	$77.35		
57505	Endocervical curettage (not done as part of a dilation and curettage)	$113.85		
57505	The provider's reduced fee if they provide the service in a facility outside their own office	$98.75		
58100	Endometrial Sampling w/wo endocervical Sampling (biopsy), w/o cervical dilation, any method (seperate procedure)	$94.86		
58100*	The provider's reduced fee if they provide the service in a facility outside their own office.	$73.25		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (list seperately in addition to code for primary procedure).	$52.20		
58110*	The provider's reduced fee if they provide service in a facility outside their own office	$42.94		
00400***	Anesthesia fee - associated only with diagnostic procedures (listed in this workbook) which were performed on an outpatient basis.[3] 3 base units plus 7 time units maximum ($22.59 per unit)	$225.90		
88305	Colposcopy biopsy - surgical pathology, gross and microscopic examination (2013)	$68.64	$39.33	$29.31
88305	Colposcopy biopsy - surgical pathology, gross and microscopic examination **County Health Departments state contract with Quest**	$18.00	$7.00	$11.00
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	$96.99	$64.94	$32.05
88332	Pathology consultation during surgery,each additional tissue block, with frozen section(s)	$53.12	$32.05	$21.07
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional stain	$91.01	$29.59	$61.41
88342	Immunohistochemistry or immunocytochemistry, per specimen; first stain	$104.92	$36.84	$68.08
	Procedures Codes - Breast			
CPT Code	**Screening**	**Fee Schedule**	**Professional (26)**	**Technical (TC)**
77067	Mammogram - Screening, bilateral (4 view film total - 2 view film of each breast)	$133.79	$38.95	$94.84
77063	Breast tomosynthesis bilateral[11] (3D mammogram)	$54.66	$30.64	$24.02

Procedures Codes - Breast				
	Diagnostic	Fee Schedule	Professional (26)	Technical (TC)
77065	Mammogram - Diagnostic Follow Up, unilateral (2 views of 1 breast)	$131.62	$41.93	$89.69
77066	Mammogram - Diagnostic Follow Up, bilateral (4 views - 2 of each breast)	$166.41	$51.67	$114.74
G0279	Tomosynthesis, mammography[11]	$54.66	$30.64	$24.02
76098	Radiological examination, surgical specimen	$16.69	$8.31	$8.38
76641	Ultrasound, complete examination of breast including axilla, unilateral *replaces 76645	$105.61	$37.53	$68.08
76642	Ultrasound, limited examination of breast including axilla, unilateral *replaces 76645	$86.65	$35.04	$51.61
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	$56.98	$32.82	$24.16
77053	Mammary ductogram or galactogram, single duct	$56.64	$18.41	$38.23
19000	Puncture aspiration of breast cyst	$110.11		
19000*	The provider's reduced fee if they provide service in a facility outside their own office	$46.29		
19001	Puncture aspiration of breast cyst, each additional cyst	$27.88		
19001*	The provider's reduced fee if they provide service in a facility outside their own office	$22.73		
19100	Breast biopsy, percutaneous, **needle core**, not using imaging guidance (surgical procedure only)	$154.80		
19100*	The provider's reduced fee if they provide service in a facility outside their own office	$76.23		
19101	Breast biopsy; open, **incisional**	$347.01		
19101*	The provider's reduced fee if they provide service in a facility outside their own office	$235.50		
19081	**Breast Biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance, first lesion[9]**	**$642.93**		
19081*	**The provider's reduced fee if they provide service in a facility outside their own office[9]**	**$177.36**		
19082	**Breast Biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance, each additional lesion[9]**	**$521.16**		
19082*	**The provider's reduced fee if they provide service in a facility outside their own office[9]**	**$89.20**		
19083	**Breast Biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance, first lesion[9]**	**$629.28**		
19083*	**The provider's reduced fee if they provide service in a facility outside their own office[9]**	**$167.13**		
19084	**Breast Biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance, each additional lesion[9]**	**$502.16**		
19084*	**The provider's reduced fee if they provide service in a facility outside their own office[9]**	**$83.25**		
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, one or more lesions	$521.05		
19120*	The provider's reduced fee if they provide service in a facility outside their own office	$439.40		
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	$578.44		
19125*	The provider's reduced fee if they provide service in a facility outside their own office	$488.89		
19126	**Excision** of breast lesion identified by preoperative placement of radiological marker; open; each additional lesion separately identified by a preoperative radiological marker.	$175.88		
19281	**Placement of breast localization device, percutaneous; mammographic guidance; first lesion[10]**	**$242.83**		
19281*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$105.93**		
19282	**Placement of breast localization device, percutaneous; mammographic guidance; each additional leasion[10]**	**$168.42**		
19282*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$53.14**		
19283	**Placement of breast localization device, percutaneous; stereotactic guidance; first lesion[10]**	**$271.74**		
19283*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$107.06**		
19284	**Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion[10]**	**$205.03**		
19284*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$55.10**		
19285	**Placement of breast localization device, percutaneous; ultrasound guidance; first lesion[10]**	**$478.55**		
19285*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$91.20**		
19286	**Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion[10]**	**$411.41**		
19286*	**The provider's reduced fee if they provide service in a facility outside their own office[10]**	**$45.67**		

	Procedures Codes - Breast			
	Diagnostic	Fee Schedule	Professional (26)	Technical (TC)
10004	Fine needle aspiration without imaging guidance, each additional lesion	$54.11		
10004*	The provider's reduced fee if they provide service in a facility outside their own office	$45.88		
10005	Fine needle aspiration biopsy including ultrasound guidance, first lesion	$127.89		
10005*	The provider's reduced fee if they provide service in a facility outside their own office	$76.77		
10006	Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	$61.86		
10006*	The provider's reduced fee if they provide service in a facility outside their own office	$52.26		
10007	Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	$283.47		
10007*	The provider's reduced fee if they provide service in a facility outside their own office	$98.55		
10008	Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	$160.25		
10008*	The provider's reduced fee if they provide service in a facility outside their own office	$64.18		
10009	Fine needle aspiration biopsy including CT guidance, first lesion	$461.38		
10009*	The provider's reduced fee if they provide service in a facility outside their own office	$119.32		
10010	Fine needle aspiration biopsy including CT guidance, each additional lesion	$278.98		
10010*	The provider's reduced fee if they provide service in a facility outside their own office	$87.19		
10011	Fine needle aspiration biopsy including MRI guidance, first lesion[8]	$461.38		
10011*	The provider's reduced fee if they provide service in a facility outside their own office.[8]	$438.31		
10012	Fine needle aspiration biopsy including MRI guidance, each additional lesion[8]	$278.98		
10012*	The provider's reduced fee if they provide service in a facility outside their own office.[8]	$265.03		
10021	Fine needle aspiration without imaging guidance	$99.21		
10021*	The provider's reduced fee if they provide service in a facility outside their own office	$59.07		
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	$56.53	$37.51	$19.02
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	$29.69	$22.83	$6.86
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	$151.35	$73.18	$78.17
00400***	Anesthesia fee - associated only with diagnostic procedures (listed in this workbook) which were performed on an outpatient basis (effective July 1, 2006)[3] **$22.59 per unit x 10 units maximum**	$225.90		
88305	Breast **biopsy** - surgical pathology, gross and microscopic examination, **not requiring** microscopic evaluation of surgical margins	$68.64	$39.33	$29.31
88305	Breast **biopsy** - surgical pathology, gross and microscopic examination, **not requiring** microscopic evaluation of surgical margins **County Health Departments state contract with Quest**	$18.00	$7.00	$11.00
88307	Breast, **excision of lesion** - surgical pathology, gross and microscopic examination **requiring** microscopic evaluation of surgical margins	$264.04	$86.02	$178.01
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	$125.42	$43.96	$81.46
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	$129.71	$47.22	$82.49

PROCEDURES THAT MUST HAVE CENTRAL OFFICE AUTHORIZATION PRIOR TO REIMBURSING FOR THE SERVICE

NOTE: CARE COORDINATOR - must have discussion with Nursing Consultant prior to authorizing reimbursement for service

	Current Procedural Terminology (CPT) Description	Fee Schedule	Professional (26)	Technical (TC)
57460	Colposcopy of the cervix with loop electrode biopsy(s) of the cervix. [6]	$294.78		
57460*	The provider's reduced fee if they provide the service in a facility outside their own office.[6]	$167.15		
57461	Colposcopy with loop electrode conization of the cervix.[6]	$332.53		
57461*	The provider's reduced fee if they provide the service in a facility outside their own office.[6]	$193.23		
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser.[6]	$330.16		
57520*	The provider's reduced fee if they provide the service in a facility outside their own office.[6]	$291.05		
57522	Loop electrode excision.[6]	$280.35		
57522*	The provider's reduced fee if they provide the service in a facility outside their own office.[6]	$252.56		

CPT Code	MRI Procedure Description	Fee Schedule	Professional (26)	Technical (TC)
10011	Fine needle aspiration biopsy including MRI guidance, first lesion[8]	$461.38		
10011*	The provider's reduced fee if they provide service in a facility outside their own office.[8]	$438.31		
10012	Fine needle aspiration biopsy including MRI guidance, each additional lesion[8]	$278.98		
10012*	The provider's reduced fee if they provide service in a facility outside their own office.[8]	$265.03		
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance* ; first lesion	$950.71		
19085*	The provider's reduced fee if they provide service in a facility outside their own office.	$192.82		
19086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance;* each additional lesion	$759.26		
19086*	The provider's reduced fee if they provide service in a facility outside their own office.	$96.41		
19287	Placement of breast localization device, percutaneous; *magnetic resonance guidance* ; first lesion	$807.18		
19287*	The provider's reduced fee if they provide service in a facility outside their own office.	$135.41		
19288	Placement of breast localization device, percutaneous; *magnetic resonance guidance* ; each additional lesion	$644.03		
19288*	The provider's reduced fee if they provide service in a facility outside their own office.	$67.98		
77046	Magnetic resonance imaging (MRI), breast, contrast, unilateral[8]	$244.68	$74.36	$170.32
77047	Magnetic resonance imaging (MRI), breast, contrast, bilateral[8]	$251.60	$82.31	$169.29
77048	Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral[8]	$388.23	$107.63	$280.60
77049	Magnetic resonance imaging (MRI), breast, with and/or without contrast, bilateral[8]	$396.96	$117.73	$279.23

CPT Code	Procedures Specifically Not Allowed
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**

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 typically not appropriate for NBCCEDP screening visits, but may be used when provider spends extra time to do a detailed risk assessment.

2 The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP. While some programs may need to use 993XX- series codes, Preventive Medicine Evaluation visits are not appropriate for the NBCCEDP. The 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 conversion rates are available here: http://www.cms.hhs.gov/center/anesth.asp

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 pes is not permitted. The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. **CDC funds may be used for reimbursement of HPV genotyping**.

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.

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 women 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.

11The NBCCEDP will allow 3D mammography as a reimbursable procedure. The appopriate CPT codes are 77063 and G0279. As per instructions from the CMS guidance for Medicare reimbursement:
• 77063 should be listed as a separate code in addition to the code for the primary mammogram code, 77067. Do not report with this code with 77065 or 77066.
• The codes 77061 and 77062 not allowed as they are not approved by Medicare.

ADDITIONAL NOTE:

Other codes for pre-operative testing such as CBC, urinalysis, pregnanacy test, etc. are allowable however, these procedures should be medically necessary for the planned surgical procedure.

For those ambulatory surgical centers or hospitals that wish to invoice for the remaining portion of the full fee, they must cite the CPT code and place an "SG" behind it, e.g. 19120SG. "SG" will signify to UGP authorization to pay the surgery center or hospital. Under no circumstance may the payment exceed the difference between full fee minus the health providers portion designated in italics on these pages.

NOTE: CARE COORDINATOR must have discussion with Nursing Consultant prior to authorizing reimbursement for service.