Breast, Cervical and Colon Health Program Fee Schedule - January 2019 Update
Maximum Allowable Reimbursement July 1, 2018 - June 30, 2019

Billing Code*	Billing Code Description*	Professional Non Facility Setting	Professional Facility Setting	Hospital Outpatient	Ambulatory Surgery Center	Lab	TC (Tech Fee)	26 (Prof Fee)	Notes
Evaluation and Management Services									
99201	New patient-problem focused, straightforward, 10 min	$ 49.54	$ 28.91	$ 124.92	n/a	n/a	n/a	n/a	
99202	New patient - expanded focused, straightforward, 20 min	$ 82.86	$ 54.39	$ 124.92	n/a	n/a	n/a	n/a	
99203	New patient - detailed, low complexity, 30 min	$ 118.59	$ 82.28	$ 124.92	n/a	n/a	n/a	n/a	
99204	New patient - comprehensive, moderate complexity, 45 min	$ 179.73	$ 138.88	$ 124.92	n/a	n/a	n/a	n/a	1
99205	New patient - comprehensive, high complexity, 60 min	$ 225.52	$ 181.38	$ 124.92	n/a	n/a	n/a	n/a	1
99211	Established patient-minimal problem, 5 min	$ 24.32	$ 9.88	$ 124.92	n/a	n/a	n/a	n/a	
99212	Established patient- problem focused, straightforward 10 min	$ 48.79	$ 27.34	$ 124.92	n/a	n/a	n/a	n/a	
99213	Established patient-expanded focused, low complexity 15 min	$ 80.29	$ 55.12	$ 124.92	n/a	n/a	n/a	n/a	
99214	Established patient - detailed, moderate complexity, 25 min	$ 118.22	$ 84.39	$ 124.92	n/a	n/a	n/a	n/a	
99385	Initial comprehensive preventive eval/mgmt, new pt: 18-39 yrs	$ 118.59	$ 82.28	$ 124.92	n/a	n/a	n/a	n/a	2
99386	Initial comprehensive preventive eval/mgmt, new pt: 40-64 yrs	$ 118.59	$ 82.28	$ 124.92	n/a	n/a	n/a	n/a	2
99387	Initial comprehensive preventive eval/mgmt, new pt: 65+ yrs	$ 118.59	$ 82.28	$ 124.92	n/a	n/a	n/a	n/a	2
99395	Periodic comprehensive preventive eval/mgmt, estab pt: 18-39 yrs	$ 80.29	$ 55.12	$ 124.92	n/a	n/a	n/a	n/a	2
99396	Periodic comprehensive preventive eval/mgmt, estab pt: 40-64 yrs	$ 80.29	$ 55.12	$ 124.92	n/a	n/a	n/a	n/a	2
99397	Periodic comprehensive preventive eval/mgmt, estab pt: 65+ yrs	$ 80.29	$ 55.12	$ 124.92	n/a	n/a	n/a	n/a	2
G0463	Hospital Outpt visit-Facility reimb- UB-04 only (same as hospital column)	$ -	$ -	$ 124.92	n/a	n/a	n/a	n/a	
Anesthesia Services									
00400	Anesthesia, anterior trunk and perineum procedure [(Base Unit (3) + Time Unit) x $23.07 = Fee	Base + Time	Base + Time	$ -	$ -	n/a	n/a	n/a	Max $250 3,18,19
00811	Anesthesia lower intestinal procedures [(Base Unit (4) + Time Unit) x $23.07 = Fee	Base + Time	Base + Time	$ -	$ -	n/a	n/a	n/a	Max $250 3,18,19
00812	Anesthesia lower intestinal endoscopy procedures, screening colonoscopy [(Base Unit (3) + Time Unit) x $23.07 = Fee	Base + Time	Base + Time		$ -				Max $250 3,18,19
00840	Anesthesia intraperitoneal procedure lower abdomen, including laparoscopy [(Base Unit (6) + Time Unit) x $23.07 = Fee	Base + Time	Base + Time	$ -	$ -	n/a	n/a	n/a	Max $250 3,18,19
99070	Supplies and materials (except spectacles), provided by the physician over/above those usuallyincl w/ office visit (list supplies/materials)	Max $100.00	Max $100.00	$ -	Max $100.00	n/a	n/a	n/a	7
Breast Surgical Procedures									
10021	Fine needle aspiration without imaging, initial	$ 109.31	$ 60.99	$ 347.42	$ 64.18	n/a	$ -	$ -	
10022	Fine needle aspiration w/ imaging (valid 7/1/18 to 12/31/18 only)	$ 158.58	$ 71.11	$ 629.46	$ 101.31	n/a	$ -	$ -	
10004	Fine needle aspir w/o imaging, ea add lesion (1/1/19 to 06/30/19)	$ 57.25	$ 47.34	$ -	$ -	n/a	$ -	$ -	

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10005	Fine needle aspir ultrasound guide, first lesion (1/1/19 to 06/30/19)	$ 140.85	$ 79.31	$ 640.83	$ 77.66	n/a	$ -	$ -	
10006	Fine needle aspir ultrasound, ea add lesion (1/1/19 to 06/30/19)	$ 65.56	$ 54.00	$ -	$ -	n/a	$ -	$ -	
10007	Fine needle aspir fluoroscop guide, first lesion (1/1/19 to 06/30/19)	$ 324.89	$ 102.28	$ 640.83	$ 242.75	n/a	$ -	$ -	
10008	Fine needle aspir fluoroscop, ea add lesion (1/1/19 to 06/30/19)	$ 182.34	$ 66.70	$ -	$ -	n/a	$ -	$ -	
10009	Fine needle aspir CT guide, first lesion (1/1/19 to 06/30/19)	$ 535.43	$ 123.66	$ 640.83	$ 330.12	n/a	$ -	$ -	
10010	Fine needle aspir CT , ea add lesion (1/1/19 to 06/30/19)	$ 321.26	$ 90.39	$ -	$ -	n/a	$ -	$ -	
10011**	Fine needle aspir MRI guide, first lesion (**Not covered by BCCHP)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
10012**	Fine needle aspir MRI, ea add lesion (**Not covered by BCCHP)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
19000	Puncture aspiration breast cyst without imaging	$ 127.57	$ 47.53	$ 629.46	$ 87.67	n/a	$ -	$ -	
19001	Puncture aspiration breast cyst, each additional use with 19000	$ 29.58	$ 23.39	$ -	$ -	n/a	$ -	$ -	
19081	Biopsy breast 1st lesion strtctc	$ 792.97	$ 183.21	$ 1,481.24	$ 587.59	n/a	$ -	$ -	9
19082	Biopsy breast add lesion strtctc	$ 660.21	$ 92.54	$ -	$ -	n/a	$ -	$ -	9
19083	Biopsy breast 1st lesion us imag	$ 771.73	$ 172.29	$ 1,481.24	$ 587.59	n/a	$ -	$ -	9
19084	Biopsy breast add lesion us imag	$ 634.06	$ 86.18	$ -	$ -	n/a	$ -	$ -	9
19085	Biopsy breast 1st lesion mr imag	$ 1,158.62	$ 200.25	$ 1,481.24	$ 587.59	n/a	$ -	$ -	9
19086	Biopsy breast add lesion mr imag	$ 944.38	$ 100.70	$ -	$ -	n/a	$ -	$ -	9
19100	Breast biopsy percutaneous without imaging	$ 169.30	$ 75.65	$ 1,481.24	$ 587.59	n/a	$ -	$ -	
19101	Breast biopsy open-incisional	$ 382.34	$ 243.31	$ 2,997.40	$ 1,114.79	n/a	$ -	$ -	
19120	Breast excision(s)-open	$ 548.06	$ 454.82	$ 2,997.40	$ 1,114.79	n/a	$ -	$ -	
19125	Breast excision- open radiological marker, single	$ 605.92	$ 503.61	$ 2,997.40	$ 1,114.79	n/a	$ -	$ -	
19126	Breast excision-radiological marker (add-on)	$ 174.69	$ 174.69	$ -	$ -	n/a	$ -	$ -	
19281	Placement breast localization device, mamm, 1st	$ 271.81	$ 110.09	$ 629.46	$ -	n/a	$ -	$ -	10
19282	Placement breast localization device, mamm, add lesion	$ 190.57	$ 55.25	$ -	$ -	n/a	$ -	$ -	10
19283	Placement breast localization device, strtctc, 1st	$ 308.30	$ 110.69	$ 629.46	$ -	n/a	$ -	$ -	10
19284	Placement breast localization device, strtctc, add lesion	$ 234.40	$ 56.18	$ -	$ -	n/a	$ -	$ -	10
19285	Placement breast localization device, us, 1st	$ 599.10	$ 94.54	$ 629.46	$ -	n/a	$ -	$ -	10
19286	Placement breast localization device, us, add lesion	$ 527.45	$ 47.23	$ -	$ -	n/a	$ -	$ -	10
19287	Placement breast localization device, mr guide, 1st	$ 995.17	$ 140.35	$ 629.46	$ -	n/a	$ -	$ -	10
19288	Placement breast localization device, mr guide, add lesion	$ 808.05	$ 70.81	$ -	$ -	n/a	$ -	$ -	10
	Colon Surgical Procedures								
45330	Diagnostic Sigmoidoscopy (Base)	$ 193.91	$ 63.13	$ 780.14	$ 150.01	n/a	$ -	$ -	20
45331	Sigmoidoscopy-biopsy, single or multiple	$ 297.60	$ 80.59	$ 780.14	$ 400.30	n/a	$ -	$ -	20

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45333	Sigmoidoscopy-removal tumors, polyps, lesions, hot biopsy forceps	$ 338.05	$ 104.96	$ 780.14	$ 400.30	n/a	$ -	$ -	20
45334	Sigmoidoscopy-control of bleeding	$ 638.78	$ 131.75	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45335	Sigmoidoscopy-submucosal injection(s)	$ 270.38	$ 74.42	$ 780.14	$ 400.30	n/a	$ -	$ -	20
45338	Sigmoidoscopy-removal of tumors, polyps, lesions, snare technique	$ 305.82	$ 135.02	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45346	Sigmoidoscopy-ablation of tumors, polyps, lesions, w or w/o dilation and guide wire passage	$ 3,593.64	$ 179.75	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45378	Diagnostic Colonoscopy (Base)	$ 354.52	$ 206.83	$ 780.14	$ 400.30	n/a	$ -	$ -	20
45380	Colonoscopy-biopsy, single or multiple	$ 457.54	$ 224.85	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45381	Colonoscopy-submucosal injection(s)	$ 436.91	$ 224.85	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45382	Colonoscopy-control of bleeding	$ 824.02	$ 289.76	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45384	Colonoscopy- removal tumors, polyps or lesions, hot biopsy forceps	$ 507.07	$ 254.59	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45385	Colonoscopy- removal of tumors, polyps, lesions, snare technique	$ 476.13	$ 284.29	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45388	Colonoscopy, flexible; w/ ablation of tumors, polyps, other lesions (incl pre-/post-dilation & guide wire passage, when performed)	$ 3,759.36	$ 302.15	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
45390	Colonoscopy, flexible; with endoscopic muscosal resection	$ 372.06	$ 372.06	$ 1,028.92	$ 527.95	n/a	$ -	$ -	20
G0104	Screening Sigmoidoscopy	$ 193.91	$ 63.13	$ 780.14	$ 150.01	n/a	$ -	$ -	20
G0105	Screening Colonoscopy-increased risk individual	$ 354.19	$ 206.49	$ 780.14	$ 400.30	n/a	$ -	$ -	16, 20
G0121	Screening Colonoscopy-average risk individual	$ 354.52	$ 206.83	$ 780.14	$ 400.30	n/a	$ -	$ -	20
Cervical Surgical Procedures (LEEP and Conization procedures require Prior Authorization)									
57452	Colposcopy- cervical	$ 119.51	$ 100.53	$ 176.58	$ 54.16	n/a	$ -	$ -	
57454	Colposcopy-cervical with biopsy and Endocervical Curettage (ECC)	$ 165.74	$ 146.35	$ 294.87	$ 66.63	n/a	$ -	$ -	
57455	Colposcopy-cervical with biopsy	$ 156.21	$ 119.08	$ 294.87	$ 70.14	n/a	$ -	$ -	
57456	Colposcopy-cervical with Endocervical Curettage (ECC)	$ 147.48	$ 110.76	$ 294.87	$ 67.41	n/a	$ -	$ -	
57460	Colposcopy-cervical biopsy with LEEP (requires Prior Auth)	$ 314.05	$ 175.02	$2,497.36	$ 187.03	n/a	$ -	$ -	4, 6
57461	Colposcopy cervical conization with LEEP (requires Prior Auth)	$ 354.10	$ 201.46	$2,497.36	$ 201.06	n/a	$ -	$ -	4, 6
57500	Cervical biopsy(ies) or excision, single or multiple, w or w/o fulguration	$ 142.63	$ 82.40	$ 632.48	$ 87.78	n/a	$ -	$ -	
57505	Endocervical curettage (ECC)	$ 113.72	$ 101.75	$ 632.48	$ 59.94	n/a	$ -	$ -	
57520	Conization of cervix, w or w/o fulguration, w or w/o repair, cold knife or laser (requires Prior Auth)	$ 338.81	$ 301.27	$ 2,279.29	$ 1,214.36	n/a	$ -	$ -	4, 6
57522	Conization of cervix LEEP (requires Prior Auth)	$ 288.82	$ 265.30	$ 2,279.29	$ 1,214.36	n/a	$ -	$ -	4, 6
58100	Endometrial Biopsy (EMB), w or w/o ECC, separate proc	$ 119.04	$ 94.29	$ 176.58	$ 52.99	n/a	$ -	$ -	

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58110	Endometrial Biopsy (EMB) with colposcopy (add-on)	$ 52.45	$ 44.20	$ -	$ -	n/a	$ -	$ -	
Imaging Services and Procedures (Radiology)									
74261	Computed tomographic (CT) colongraphy, diagnostic, inlcuding image post-processing: without contrast material(s)	$ 556.16	$ 556.16	$ 125.77	$ 64.54	n/a	$ 426.43	$ 129.73	17
74262	Computed tomographic (CT) colongraphy, diagnostic, inlcuding image post-processing: w/ contrast materials, incl non-contrast images if used	$ 623.80	$ 623.80	$ 277.72	$ 142.49	n/a	$ 488.72	$ 135.08	17
74270	X-ray exam, colon-contrast (e.g. Barium) w or w/o KUB	$ 171.58	$ 171.58	$ 277.72	$ -	n/a	$ 134.42	$ 37.16	17
74280	X-ray exam, colon-air contrast, high-density barium, w or w/o glucagon	$ 243.58	$ 243.58	$ 277.72	$ 142.49	n/a	$ 190.11	$ 53.46	17
76098	X-ray exam, breast specimen	$ 18.96	$ 18.96	$ 534.78	$ -	n/a	$ 10.24	$ 8.73	
76641	Ultrasound, breast, unilateral, complete, real time w/image doc	$ 122.73	$ 122.73	$ 125.77	$ -	n/a	$ 83.26	$ 39.47	
76642	Ultrasound, breast, unilateral, limited, real time w/image doc	$ 100.25	$ 100.25	$ 68.26	$ -	n/a	$ 63.46	$ 36.80	
76942	Ultrasound guide, needle placement (biopsy, aspiration, localization device) imaging supervision & interpretation	$ 66.95	$ 66.95	$ -	$ -	n/a	$ 34.85	$ 32.10	
77053	Mammary ducto/galactogram, single duct, rad superv & interpret	$ 66.30	$ 66.30	$ 255.27	$ -	n/a	$ 46.95	$ 19.34	
77046	MRI breast, unilateral, without contrast (requires Prior Auth)	$ 283.02	$ 283.02	$ 255.03	$ 131.38	n/a	$ 204.77	$ 78.24	4, 8
77047	MRI breast, bilateral, without contrast (requires Prior Auth)	$ 290.14	$ 290.14	$ 255.03	$ 131.38	n/a	$ 203.54	$ 86.61	4, 8
77048	MRI breast, unilateral, inc CAD, w/ or w/o contrast (requires Prior Auth)	$ 450.41	$ 450.41	$ 255.03	$ 131.38	n/a	$ 337.27	$ 113.14	4, 8
77049	MRI breast, bilateral, inc CAD, w/ or w/o contrast (requires Prior Auth)	$ 459.39	$ 459.39	$ 255.03	$ 131.38	n/a	$ 335.62	$ 123.77	4, 8
77058	MRI, breast, unilateral, w or w/o contrast (**valid 7/1/18 to 12/31/18)	$ 624.95	$ 624.95	$ -	$ -	n/a	$ 536.91	$ 88.03	4, 8
77059	MRI, breast, bilateral, w or w/o contrast (**valid 7/1/18 to 12/31/18)	$ 622.06	$ 622.06	$ -	$ -	n/a	$ 534.03	$ 88.03	4, 8
77063	Screening digital breast tomosynthesis, bilateral	$ 61.56	$ 61.56	$ 29.29	$ -	n/a	$ 29.29	$ 32.26	11
77065	Diagnostic mammography, unilateral, includes CAD	$ 154.07	$154.07	$ 110.07	$ -	n/a	$ 110.07	$ 44.00	
77066	Diagnostic mammography, bilateral, includes CAD	$ 194.85	$ 194.85	$ 140.60	$ -	n/a	$ 140.60	$ 54.25	
77067	Screening mammography, bilateral	$ 157.25	$ 157.25	$ 116.26	$ -	n/a	$ 116.26	$ 40.99	
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	$ 61.56	$ 61.56	$ 29.29	$ -	n/a	$ 29.29	$ 32.26	12
Pathology and Laboratory Services									
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous	$ -	$ -	$ -	$ -	$ 19.64	$ -	$ -	
81528	Oncology (colorectal) screening (FIT-DNA) - Prior Approval required	$ -	$ -	$ -	$ -	$ -	$ -	$ -	15
82270	FOBT, Fecal Occult Blood Test	$ -	$ -	$ -	$ -	$ 4.38	$ -	$ -	14
82274	FIT, Immunochemical Fecal Hemoglobin Test	$ -	$ -	$ -	$ -	$ 19.64	$ -	$ -	14

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83520	Immunoassay, quantitative, FIT only	$ -	$ -	$ -	$ -	$ 17.27	$ -	$ -	
87624	HPV, Human Papillomavirus, high risk types	$ -	$ -	$ -	$ -	$ 43.33	$ -	$ -	5
87625	Human Papilloma virus, types 16 and 18 only	$ -	$ -	$ -	$ -	$ 43.33	$ -	$ -	5
88141	Cytopathology, Pap, cervical or vaginal, any reporting system, physician interpretation	$ 36.00	$ 36.00	$ -	$ -		$ -	$ -	
88142	Cytopathology, Liquid Based Pap, cervical or vaginal, any reporting system, automated thin layer preparation, manual screening, physician supervision	$ -	$ -	$ -	$ -	$ 25.01	$ -	$ -	
88143	Cytopathology, Liquid Based Pap, cervical or vaginal, automated thin layer preparation, manual screening & rescreening, physician supervision	$ -	$ -	$ -	$ -	$ 25.01	$ -	$ -	
88164	Cytopathology, Conventional Pap, cervical or vaginal, Bethesda System, manual screening, physician supervision	$ -	$ -	$ -	$ -	$ 14.65	$ -	$ -	
88165	Cytopathology, Conventional Pap, cervical or vaginal, Bethesda System, manual screening & rescreening, physician supervision	$ -	$ -	$ -	$ -	$ 42.22	$ -	$ -	
88172	Cytopathology, evaluation of Fine Needle Aspirate (FNA), immediate, first eval episode, each site	$ 64.47	$ 64.47	$ 141.95	$ -		$ 23.85	$ 40.62	
88173	Cytopathology, evaluation of FNA, interpretation and report	$ 174.77	$ 174.77	$ 49.12	$ -		$ 95.15	$ 79.62	
88174	Cytopathology, Liquid Based Pap, cervical or vaginal, any reporting system, automated thin layer, screening automated system, physician supervision	$ -	$ -	$ -	$ -	$ 26.38	$ -	$ -	
88175	Cytopathology, Liquid Based Pap, cervical or vaginal, any reporting system, automated thin layer, screening automated system & manual rescreening or review, physician supervision	$ -	$ -	$ -	$ -	$ 32.71	$ -	$ -	
88300	Surgical Pathology, gross examination only (surgical specimen)	$ 18.89	$18.89	$ 19.20	$ -	$ -	$ 13.95	$ 4.94	
88302	Surgical Pathology, gross and microscsopic examination (review level II)	$ 35.59	$35.59	$ 34.94	$ -	$ -	$ 27.56	$ 8.03	
88304	Surgical Pathology, gross and microscsopic examination (review level III)	$ 46.76	$ 46.76	$ 49.12	$ -	$ -	$ 33.75	$ 13.01	
88305	Tissue pathology, gross and microscopic (Level IV)	$ 77.00	$ 77.00	$ 49.12	$ -	$ -	$ 34.58	$ 42.43	
88307	Tissue pathology, gross and microscopic (Level V)	$ 302.14	$ 302.14	$ 236.72	$ -	$ -	$ 208.60	$ 93.54	
88309	Surgical Pathology, gross and microscsopic examination, colon, segmental resection for tumor or total resection (review level VI)	$ 457.13	$457.13	$ 594.42	$ -	$ -	$ 291.03	$ 166.10	

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88331	Path consultation, first tissue block, frozen section (s), single spec	$ 108.87	$ 108.87	$ 141.95	$ -	$ -	$ 37.88	$ 70.99	
88332	Path consultation, addtnl tissue block, frozen section(s), Add on	$ 59.61	$ 59.61	$ -	$ -	$ -	$ 24.68	$ 34.94	
88341	Immunohisto/ immunocyto chemistry, single antibody, Add on	$ 106.03	$ 106.03	$ -	$ -	$ -	$ 74.26	$ 31.77	
88342	Immunohisto/immunocyto chem, Per Spec, Inl single antibody	$ 124.66	$ 124.66	$ 236.72	$ -	$ -	$ 84.91	$ 39.75	
88344	Immunohisto/immunocyto chemistry, Multiplex antibody stain	$ 201.10	$ 201.10	$ 236.72	$ -	$ -	$ 157.52	$ 43.58	
88360	Tumor immunohistochem/manual - quantitative result	$ 152.48	$ 152.48	$ 236.72	$ -	$ -	$ 102.65	$ 49.84	
88361	Tumor immunohistochem/computer assist - quantitative result	$ 165.67	$ 165.67	$ 236.72	$ -	$ -	$ 112.96	$ 52.71	
88363	Examination - retrieved archival tissue molec analysis	$ 26.31	$ 22.19	$ 19.20	$ -	$ -	$ -	$ -	
88374	Morphometric analysis in situ quant/semiq - Computer-assisted	$ 398.52	$ 398.52	$ 141.95	$ -	$ -	$ 349.77	$ 48.75	
88377	Morphometric analysis in situ quant/semiq - manual	$ 472.26	$ 472.26	$ 141.95	$ -	$ -	$ 401.67	$ 70.58	
	Moderate Sedation								
G0500	Moderate sedation services by *the same* qualified health care prof performing *GI endoscopic service* that sedation supports, requiring presence of independent trained observer to assist i*nitial 15 mins* ; patient age 5 yrs or older (add time may be reported with 99153).	$ 67.90	$ 6.02	$ -	$ -	$ -	$ -	$ -	
99152	Moderate sedation services by *the same* qualified health care prof performing the *diagnostic or therapeutic service* that sedation supports, requiring presence of independent trained observer to assist *initial 15 mins* ; patient age 5 yrs or older.	$ 58.93	$ 13.55	$ -	$ -	$ -	$ -	$ -	
99153	Moderate sedation services by *the same* qualified health care prof performing the diagnostic or therapeutic service that sedation supports, requiring presence of independent trained observer to assist; *each add 15 mins* (List separately from primary code).	$ 12.71	$ 12.71	$ -	$ -	$ -	$ -	$ -	21
99156	Moderate sedation services provided by physician/other qualified health care prof other than the physician/other qualified health care prof performing the diagnostic or therapeutic service that sedation supports; *initial 15 mins* , patient age 5 years or older.	$ 80.47	$ 80.47	$ -	$ -	$ -	$ -	$ -	
99157	Moderate sedation services provided by qualified health care prof other than the physician or other qualified health care prof performing the diagnostic or therapeutic service that sedation supports; *each add 15 mins* (List separately from primary code).	$ 61.45	$ 61.45	$ -	$ -	$ -	$ -	$ -	21

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Electrocardiogram - Prior-Authorization Needed (Covered only when required to complete screening or diagnostics)									
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	$ 18.92	$ 18.92	$ -	$ -	$ -	$ -	$ -	4
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	$ 9.82	$ 9.82	$ 61.49	$ -	$ -	$ -	$ -	4
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	$ 9.10	$ 9.10	$ -	$ -	$ -	$ -	$ -	4
93040	Rhythm ECG, one to three leads; with interpretation and report	$ 14.05	$ 14.05	$ -	$ -	$ -	$ -	$ -	4
93041	Rhythm ECG, one to three leads; tracing only, without interpretation and report	$ 6.52	$ 6.52	$ 61.49	$ -	$ -	$ -	$ -	4
93042	Rhythm ECG, one to three leads; interpretation and report only	$ 7.53	$ 7.53	$ -	$ -	$ -	$ -	$ -	4
Lab Work - Prior-Authorization Needed (Covered only when required to complete screening or diagnostics)									
80048	Basic metabolic panel (calcium, total). This panel must include the following: calcium, total (82310), carbon dioxide (82374), creatinine (82565), glucose (82947), potassium (84132), sodium (84295)	$ -	$ -	$ -	$ -	$ 10.44	$ -	$ -	4
80053	Comprehensive metabolic panel. Must include: albumin (82040); bili, tot (82247); Ca (82310); CO2 (bicarbonate) (82374); chloride (82435); creat (82565); gluc (82947); phosphatase, alk (84075); K (84132); prot, tot (84155); Na (84295); transferase, alan amino (84460); transferase, aspart amino (84450); urea nitro (84520)	$ -	$ -	$ -	$ -	$ 13.04	$ -	$ -	4
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	$ -	$ -	$ -	$ -	$ 9.59	$ -	$ -	4
85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	$ -	$ -	$ -	$ -	$ 7.98	$ -	$ -	4
85610	Prothrombin time	$ -	$ -	$ -	$ -	$ 4.85	$ -	$ -	4
85730	Thromboplastin time, partial (PTT); plasma or whole blood	$ -	$ -	$ -	$ -	$ 7.42	$ -	$ -	4
BCCHP Special Codes									
CPREP	Colon Preparation Kit-maximum (pay lower of billed or allowable)	$ 100.00	$ 100.00	$ 100.00	$ 100.00	$ 100.00	n/a	n/a	Max $100
STAMP	Stamped envelope (for mailing FOBT/FIT only)	$ 2.50	$ 2.50	$ 2.50	$ 2.50	$ 2.50	n/a	n/a	Max $2.50
EVGCM	Estrogen vaginal cream (pay lower of billed or allowable)	$ 150.00	$ 150.00	$ 150.00	$ 150.00	$ 150.00	n/a	n/a	Max $150

Billing Code*	Billing Code Description*	Professional Non Facility Setting	Professional Facility Setting	Hospital Outpatient	Ambulatory Surgery Center	Lab	TC (Tech Fee)	26 (Prof Fee)	Notes

Notes

*	CPT® codes and descriptions only are copyright 2018 & 2019 American Medical Association. All rights reserved. The BCCHP Fee Schedule uses a limited set of the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT®) codes for identifying procedures and services performed by providers. The BCCHP Fee Schedule does not contain full text descriptions of HCPCS or CPT® codes and modifiers. Providers must bill according to the full text descriptions published by the American Medical Association and the Centers for Medicare & Medicaid Services (CMS). Reimbursement is based on Medicare rules and may not exceed Medicare rates. The BCCHP uses locality code 2 and CBSA code 42644 for the King County area to calculate reimbursement rates for the whole state. Reimbursement rates for the CPT codes in the January 2019 version of the current fee schedule are based on calculations using the 2017/2018 Wage Index and 2018 information from CMS, with the exception of the codes updated and added in January (10004-10010, 10021 and 77046-77049). Procedures will not be reimbursed for more than BCCHP allows.
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 BCCHP screening visits.
2	The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within BCCHP. Reimbursement rates should not exceed those published by Medicare. While some programs may need to use 993XX-series codes, 993XX Preventive Medicine Evaluation visits are not appropriate for BCCHP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.
3	Medicare’s methodology for the payment of anesthesia services are outlined in chapter 12 of the Medicare Claims Processing Manual at www.cms.hhs.gov/manuals/downloads/clm104c12.pdf. The carrier-specific Medicare anesthesia conversion rates are available at www.cms.hhs.gov/center/anesth.asp.
4	**Prior Authorization** needed from Regional Prime Contractors in collaboration with BCCHP Nurse Consultant.
5	HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. CDC allows reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. CDC funds may be used for reimbursement of HPV genotyping.
6	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. **Prior authorization** for LEEP or conization procedures must be obtained in accordance with Washington State BCCHP policies.
7	This charge should be used with caution to ensure that programs do not reimburse for supplies which have been accounted for in another clinical charge.

Billing Code*	Billing Code Description*	Professional Non Facility Setting	Professional Facility Setting	Hospital Outpatient	Ambulatory Surgery Center	Lab	TC (Tech Fee)	26 (Prof Fee)	Notes
8	Breast MRI can be reimbursed by BCCHP 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 BCCHP to assess the extent of disease in a women who has just been diagnosed with breast cancer. **Prior authorization** for MRI procedures must be obtained in accordance with Washington State BCCHP policies.								
9	Codes 19081–19086 are to be used for breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. They should not be used in conjunction with 19281–19288.								
10	Codes 19281–19288 are for image guidance placement of a localization device without image-guided biopsy. These codes should not be used in conjunction with 19081–19086.								
11	List separately in addition to code for primary procedure 77067.								
12	List separately in addition to 77066 or 77065.								
13	These procedures have not been approved for coverage by Medicare.								
14	Codes 82271 and 82272 (performed for other than colorectal neoplasm screening) are not included as they do not adhere to guideline-recommended screening.								
15	Use of FIT-DNA requires prior approval from BCCHP in collaboration with CDC.								
16	G0105 may be used for screening colonoscopy on clients considered to be at increased risk for CRC due to a family history of CRC or adenomatous polyps. The Medicare definition of high risk includes both those considered to be a increased risk (personal or family history of CRC or adenomatous polyps) or high risk (family history of FAP or Lynch Syndrome or personal history of inflammatory bowel disease) as defined by CRCCP policies and procedures.								
17	G0106 (colorectal cancer screening; barium enema; as an alternative to G0104; screening sigmoidoscopy), G0120 (colorectal cancer screening; barium enema; as an alternative to G0105; screening colonoscopy), and G0122 (colorectal cancer screening; barium enema) are not included as barium enema is no longer recommended by USPSTF as a colorectal cancer screening test. Colonoscopy should be performed as a diagnostic test to evaluate an abnormal FIT or gFOBT. Barium enema or CT colonography can be used as alternatives if a colonoscopy cannot be completed.								
18	If the client fails standard moderate sedation, anesthesia may be used to complete the endoscopic procedure. Documentation should be provided.								
19	Surgery or surgical staging may be required to provide a histological diagnosis of cancer. **Prior Authorization** must be obtained for all surgery for diagnostic purposes by the BCCHP Nurse Consultant in conjunction with the BCCHP Medical Advisory Committee.								
20	**Endoscopies:** BCCHP follows the Medicare endoscopy payment methodology for professional services based on "family" codes. When two endoscopies (colonoscopy or sigmoidoscopy) in the same family are performed on the same day reimbursement will be at 100% for the code with the highest reimbursement rate. Additional related endoscopies will be reimbursed by subtracting the base endoscopy rate from the actual endoscopy done. BCCHP follows Medicare multiple procedure rules for facility payments to hospitals and ASCs for endoscopies. The endoscopy with the highest reimbursement rate is paid at 100%. Each additional endoscopy is paid at 50%, this applies to provider fees as well.								
21	Example: If procedure is 50 minutes, code 99156 + (99157 x 2). No separate charge allowed if procedure <10 minutes								

For clinical coverage guidelines refer to BCCHP clinical algorithms and policies. Contact your BCCHP regional Prime Contractor for additional questions.