BCCS Billing Guideline

Effective September 2023

TEXAS
Health and Human Services

BCCS Billing Guideline

Breast and Cervical Cancer Services

Table of Contents

Using This Guide

To find specific information in this guide, you can use the table of contents or search the guide.

The rates associated with Breast and Cervical Cancer Services (BCCS) reimbursable codes may be found in Med-IT®. Click on the Reports/Utilities tab, then Billing and CPT codes. Please ensure you are looking at the correct contract year, located on the top right of the CPT® Code list in Med-IT®.

Conventions

Radiology Payment Types

* Indicates Radiology. A payment type is required when billing.

Professional (P): The **Professional** component is provided by the physician, and may include supervision, interpretation, and a written report. The **Professional** component is appropriate when the physician supervises and interprets a diagnostic test, even if he or she does not perform the test personally.

Technical (T): The **Technical** component of a service includes the provision of all equipment, supplies, personnel, and costs related to the performance of the exam. Fees for the **Technical** component are reimbursed to the facility or practice for these costs.

Full Procedure (F): The **Full Procedure** is both the **Technical** and **Professional** components combined.

Anesthesia Payment Types

** Indicates Anesthesia. A payment type is required when billing.

AA: Anesthesiologist only

QX: Supervised CRNA or AA

QZ: CRNA directed by a physician

AD: Anesthesiologist supervising 5 or more CRNA/AAs

QK: Anesthesiologist supervising 2 to 4 CRNA/AAs

QY: Anesthesiologist supervising one CRNA/AA

More Support

Policies and more information regarding the BCCS Program can be found online:

- BCCS Provider Portal

Questions

Please direct any questions, comments, or concerns regarding billing guidelines to:

Med-ITHelpdesk@hhs.texas.gov

BCCS Reimbursable Codes and Billing Guidelines

Office Visits

CPT ®Code	Code Description	Rate	End Note
99202	Office Visit - New Patient • Medically appropriate history/exam, straightforward decision-making • 15-29 minutes	$76.59	1
99203	Office Visit - New Patient • Medically appropriate history/exam, low level decision-making • 30-44 minutes	$110.67	1
99204	Office Visit - New Patient • Medically appropriate history/exam, moderate level decision-making • 45-59 minutes	$168.12	1
99205	Office Visit - New Patient • Medically appropriate history/exam, high level decision-making • 60-74 minutes	$211.71	1
99211	Office Visit - Established Patient • Evaluation and management, may not require presence of physician • Presenting problems are minimal	$20.71	1
99212	Office Visit - Established Patient • Medically appropriate history/exam, straightforward decision-making • 10-19 minutes	$44.65	1

CPT ®Code	Code Description	Rate	End Note
99213	Office Visit - Established Patient • Medically appropriate history/exam, low level decision-making • 20-29 minutes	$74.82	1
99214	Office Visit - Established Patient • Medically appropriate history/exam, moderate level decision-making • 30-39 minutes	$110.09	1

Breast Screening & Diagnostic Services

CPT ®Code	Code Description	Rate	End Note
77053*	Mammary ductogram or galactogram • Single duct	P $18.36 T $41.04 F $59.40	2
77046*	Magnetic resonance imaging, breast (MRI), **without contrast** • Unilateral	P $74.00 T $179.00 F $253.00	3
77047*	Magnetic resonance imaging (MRI), breast, **without contrast** • Bilateral	P $82.00 T $178.00 F $260.00	3
77048*	Magnetic resonance imaging (MRI), breast, **including CAD, with and without contrast** • Unilateral	P $107.00 T $294.00 F $402.00	3
77049*	Magnetic resonance imaging (MRI), breast, **including CAD, with and without contrast** • Bilateral	P $117.00 T $293.00 F $410.00	3
B7046*	Magnetic resonance imaging (MRI), breast, **without contrast** • Ages 40-49 • Unilateral	P $74.00 T $179.00 F $253.00	4
B7047*	Magnetic resonance imaging (MRI), breast, **without contrast** • Ages 40-49 • Bilateral	P $82.00 T $178.00 F $260.00	4

CPT ®Code	Code Description	Rate	End Note
B7048*	Magnetic resonance imaging (MRI), breast, **including CAD**, **with and without contrast** • Ages 40-49 • Unilateral	P $107.00 T $294.00 F $402.00	4
B7049*	Magnetic resonance imaging (MRI), breast, **including CAD**, **with and without contrast** • Ages 40-49 • Bilateral	P $117.00 T $293.00 F $410.00	4
77063*	Screening digital breast tomosynthesis (3-D mammography) • Bilateral	P $30.60 T $25.56 F $56.16	5
G0279	Diagnostic digital breast tomosynthesis (3-D mammography) • Unilateral or bilateral	$57.07	5
77065*	Diagnostic mammography • Includes computer-aided detection (CAD) • Unilateral	P $41.76 T $96.12 F $137.88	5
77066*	Diagnostic mammography • Includes computer-aided detection (CAD) • Bilateral	P $51.48 T $122.76 F $174.24	5
77067*	Screening mammography • Includes computer-aided detection (CAD) • Bilateral	P $38.88 T $101.52 F $140.40	5

CPT ®Code	Code Description	Rate	End Note
B7067*	Screening mammography • Includes computer-aided detection (CAD) • Ages 40-49 • Bilateral	P $38.88 T $101.52 F $140.40	6
19000	Puncture aspiration of cyst of breast	$116.01	7
19100	Breast biopsy, percutaneous, needle core • Not using imaging guidance • One or more lesions • Physician in Office	$154.83	8
F9100	Breast biopsy, percutaneous, needle core • Not using imaging guidance • One or more lesions • Physician in Facility	$72.99	8
100FX	Facility fee for needle core biopsy • Facility Fee	$521.64	8
19101	Breast biopsy, open, incisional • One or more lesions • Physician in Office	$350.88	9
F9101	Breast biopsy, open, incisional • One or more lesions • Physician in Facility	$229.93	9
101FX	Breast biopsy, open, incisional • Facility Fee	$1,007.50	9

CPT ®Code	Code Description	Rate	End Note
19120	Breast excision, open • Cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue • Duct, nipple, or areolar lesion • One or more lesions • Physician in Office	$509.42	10
F9120	Breast excision, open • Cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue • Duct, nipple, or areolar lesion • One or more lesions • Physician in Facility	$429.39	10
120FX	Excisional breast biopsy • Facility Fee	$1,007.05	10
19125	Excision of breast lesion, open • Identified by preoperative placement of radiological marker • Single lesion • Physician in Facility	$476.66	11
125FX	Excision of breast lesion, open • Identified by preoperative placement of radiological marker • Single lesion • Facility fee	$1,007.05	11
19126	Excision of breast lesion,open • Separately identified by preoperative placement of radiological marker • Each additional lesion • Physician in Facility	$168.92	11

CPT ®Code	Code Description	Rate	End Note
19081	Breast biopsy - stereotactic guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • First lesion • Physician in Office	$713.10	12
19082	Breast biopsy - stereotactic guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • Each additional lesion • Physician in Office	$590.41	12
F9081	Breast biopsy - stereotactic guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • First lesion • Physician in Facility	$177.54	12
F9082	Breast biopsy - stereotactic guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • Each additional lesion • Physician in Facility	$89.30	12
812FX	Percutaneous breast biopsy using stereotactic guidance • One or more lesions • Facility fee	$521.64	12
19083	Breast biopsy - ultrasound guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • First lesion • Physician in Office	$691.92	13

CPT ®Code	Code Description	Rate	End Note
19084	Breast biopsy - ultrasound guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • Each additional lesion • Physician in Facility	$567.71	13
F9083	Breast biopsy - ultrasound guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • First lesion • Physician in Facility	$167.03	13
F9084	Breast biopsy - ultrasound guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • Each additional lesion • Physician in Facility	$83.17	13

CPT ®Code	Code Description	Rate	End Note
834FX	Percutaneous breast biopsy using ultrasound guidance • One or more lesions • Facility fee	$521.64	13
F9085	Breast biopsy- magnetic resonance imaging (MRI) guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • First lesion • Physician in Facility	$195.06	14

CPT ®Code	Code Description	Rate	End Note
F9086	Breast biopsy- magnetic resonance imaging (MRI) guidance • With placement of localization device and imaging of biopsy specimen, percutaneous • Each additional lesion • Physician in Facility	$97.02	14
856FX	Percutaneous breast biopsy using magnetic resonance imaging (MRI) guidance • One or more lesions • Facility fee	$521.64	14
19281	Mammographic guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Office	$247.53	15
19282	Mammographic guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Office	$171.71	15
F9281	Mammographic guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Facility	$106.48	15
F9282	Mammographic guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Facility	$53.42	15

CPT ®Code	Code Description	Rate	End Note
19283	Stereotactic guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Office	$279.37	16
19284	Stereotactic guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Office	$210.10	16
F9283	Stereotactic guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Facility	$107.50	16
F9284	Stereotactic guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Facility	$54.08	16
19285	Ultrasound guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Office	$534.19	17
19286	Ultrasound guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Office	$466.74	17

CPT ®Code	Code Description	Rate	End Note
F9285	Ultrasound guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Facility	$91.18	17
F9286	Ultrasound guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Facility	$45.76	17
F9287	Magnetic resonance imaging (MRI) guidance • Placement of breast localization device, percutaneous • First lesion • Physician in Facility	$136.26	18
F9288	Magnetic resonance imaging (MRI) guidance • Placement of breast localization device, percutaneous • Each additional lesion • Physician in Facility	$67.97	18
00400**	Anesthesia • Procedures on the integumentary system, anterior trunk, not otherwise specified • [RVUs + (Minutes / 15] x Conversion Factor = Anesthesia Reimbursement	See Formula	19
76098*	Radiological examination- surgical specimen	P $8.28 T $9.00 F $17.28	20
76641*	Ultrasound - complete examination of breast including axilla • Unilateral	P $37.44 T $72.72 F $110.16	21

CPT ®Code	Code Description	Rate	End Note
76642*	Ultrasound - limited examination of breast including axilla • Unilateral	P $34.92 T $55.44 F $90.36	21
76942*	Ultrasonic guidance for needle placement • Imaging supervision and interpretation	P $33.12 T $28.08 F $61.20	22
10021	Fine needle aspiration biopsy without imaging guidance • First lesion	$100.00	23
10004	Fine needle aspiration biopsy without imaging guidance • Each additional lesion	$54.00	23
10005	Fine needle aspiration biopsy including ultrasound guidance • First lesion	$129.00	23
10006	Fine needle aspiration biopsy including ultrasound guidance • Each additional lesion	$62.00	23
10007	Fine needle aspiration biopsy including fluoroscopic guidance • First lesion	$292.00	23
10008	Fine needle aspiration biopsy including fluoroscopic guidance • Each additional lesion	$164.00	23
10009	Fine needle aspiration biopsy including CT guidance • First lesion	$477.00	23
10010	Fine needle aspiration biopsy including CT guidance • Each additional lesion	$288.00	23

CPT ®Code	Code Description	Rate	End Note
88173	Cytopathology • Evaluation of fine needle aspirate • Interpretation and report	$157.82	24
88305	Surgical pathology • Gross and microscopic examination	$70.55	25
88307	Surgical pathology • Gross and microscopic examination • Requiring microscopic evaluation of surgical margins	$273.57	26

Cervical Screening & Diagnostic Services

CPT ®Code	Code Description	Rate	End Note
87624	Human Papillomavirus • High-risk types	$48.14	27
88141	Cytopathology • Cervical or vaginal • Any reporting system • Requiring interpretation by physician	$33.45	28
88142	Cytopathology (liquid-based Pap Test) • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Manual screening under physician supervision	$27.79	29

CPT ®Code	Code Description	Rate	End Note
88143	Cytopathology • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Manual screening and rescreening under physician supervision	$27.79	30
88164	Cytopathology (conventional Pap test) • Slides cervical or vaginal reported in Bethesda System • Manual screening under physician supervision	$14.49	31
88174	Cytopathology • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Screening by automated system under physician supervision	$29.31	32
88175	Cytopathology • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Screening by automated system and manual rescreening under physician supervision	$36.34	33
88305	Surgical pathology • Gross and microscopic examination	$70.55	34
88307	Surgical pathology • Gross and microscopic examination • Requiring microscopic evaluation of surgical margins	$273.57	35
57452	Colposcopy of the cervix	$112.40	36

CPT ®Code	Code Description	Rate	End Note
57454	Colposcopy of the cervix • With biopsy and endocervical curettage • Physician in Office	$157.45	37
F7454	Colposcopy of the cervix • With biopsy and endocervical curettage • Physician in Facility	$140.79	37
454FX	Colposcopy of the cervix • With biopsy and endocervical curettage • Facility fee	$62.09	37
57455	Colposcopy of the cervix • With biopsy • Physician in Office	$146.88	38
F7455	Colposcopy of the cervix • With biopsy • Physician in Facility	$114.16	38
455FX	Colposcopy of the cervix • With biopsy • Facility fee	$64.96	38
57456	Colposcopy of the cervix • With endocervical curettage • Physician in Office	$138.54	39
F7456	Colposcopy of the cervix • With endocervical curettage • Physician in Facility	$106.19	39

CPT ®Code	Code Description	Rate	End Note
456FX	Colposcopy of the cervix • With endocervical curettage • Facility fee	$62.45	39
57460	Colposcopy • With loop electrode biopsy(s) of the cervix • Physician in Office	$290.04	40
F7460	Colposcopy • With loop electrode biopsy(s) of the cervix • Physician in Facility	$167.81	40
460FX	Colposcopy • With loop electrode biopsy(s) of the cervix • Facility fee	$173.34	40
57461	Colposcopy • With loop electrode conization of the cervix • Physician in Office	$328.46	41
F7461	Colposcopy • With loop electrode conization of the cervix • Physician in Facility	$193.52	41
461FX	Colposcopy • With loop electrode conization of the cervix • Facility fee	$186.62	41
57500	Cervical biopsy • Single or multiple, or local excision of lesion • With or without fulguration • Physician in Office	$131.22	42

CPT ®Code	Code Description	Rate	End Note
57505	Endocervical curettage • Not done as part of a dilation and curettage • Physician in Office	$105.12	43
57520	Conization of cervix • Cold knife or laser • With or without fulguration • With or without dilation and curettage • With or without repair • Physician in Facility	$285.25	44
520FX	Conization of the cervix • Cold knife or laser • With or without fulguration • With or without dilation and curettage • With or without repair • Facility fee	$1,066.87	44
57522	Loop Electrode Excision Procedure (LEEP) • Physician in office	$271.25	45
F7522	Loop Electrode Excision Procedure (LEEP) • Physician in Facility	$250.44	45
522FX	Loop Electrode Excision Procedure (LEEP) • Facility fee	$1,066.87	45
00940**	Anesthesia for vaginal procedures (including biopsy of cervix) • Not otherwise specified • [RVUs + (Minutes / 15] x Conversion Factor = Anesthesia Reimbursement	See Formula	46

CPT ®Code	Code Description	Rate	End Note
58110	Endometrial sampling (biopsy) • Performed in conjunction with colposcopy (list separately in addition to code for colposcopy) • Physician in Office	$49.35	47
F8110	Endometrial sampling (biopsy) • Performed in conjunction with colposcopy (list separately in addition to code for colposcopy) • Physician in Facility	$42.47	47

Pre-Operative Laboratory Procedures for Diagnostic Services

CPT ®Code	Code Description	Rate	End Note
93000	ECG	$17.40	48
80048	Basic Metabolic Panel (Chem 6)	$11.60	49
80053	Comprehensive Metabolic Panel (Chem 12)	$14.49	49
81025	Urine Pregnancy Test	$8.67	50
85025	CBC, automated with differential	$10.66	51
85027	CBC, automated	$8.87	51
85610	Prothrombin Time (PT)	$5.39	52
85730	Partial Thromboplastin Time (PTT)	$8.24	52
85384	Fibrinogen	$11.65	52
71045	Radiological examination, chest; • Single view	P $6.95 T $8.02 F $14.97	53
045FX	Radiological examination, chest; • Single view • Facility Fee	P $6.95 T $8.02 F $14.97	53
71046	Radiological examination, chest; • 2 views	P $8.29 T $14.70 F $22.99	53

CPT ®Code	Code Description	Rate	End Note
046FX	Radiological examination, chest; • 2 views • Facility Fee	P $8.29 T $14.70 F $22.99	53

Patient Navigation Services

CPT ®Code	Code Description	Rate	End Note
44410	Medicaid for Breast and Cervical Cancer (MBCC) • Comprehensive visit	$122.31	54
44413	Medicaid for Breast and Cervical Cancer (MBCC) • Follow-up visit	$29.36	55
99910	Patient Navigation for abnormal breast cancer screening • Comprehensive visit • Diagnostic test required	$122.31	56
99913	Patient Navigation for abnormal breast cancer screening • Follow-up visit	$29.36	57
SC100	Service Coordination	$0.00	58
88810	Patient Navigation for abnormal cervical cancer screening • Comprehensive visit • Diagnostic test required	$122.31	59
88813	Patient Navigation for abnormal cervical cancer screening • Follow-up visit	$29.36	60

Cervical Dysplasia Management and Treatment Services (CD)

CPT® Code	Code Description	Rate	End Note
CD202	Office Visit - New Patient • Medically appropriate history/exam, straightforward decision-making • 15-29 minutes	$76.59	61
CD203	Office Visit - New Patient • Medically appropriate history/exam, low level decision-making • 30-44 minutes	$110.67	61
CD204	Office Visit - New Patient • Medically appropriate history/exam, moderate level decision-making • 45-59 minutes	$168.12	61
CD211	Office Visit - Established Patient • Evaluation and management, may not require presence of physician • Presenting problems are minimal	$44.65	61
CD212	Office Visit - Established Patient • Medically appropriate history/exam, straightforward decision-making • 10-19 minutes	$44.65	61
CD213	Office Visit - Established Patient • Medically appropriate history/exam, low level decision-making • 20-29 minutes	$74.82	61

CPT® Code	Code Description	Rate	End Note
CD214	Office Visit - Established Patient • Medically appropriate history/exam, moderate level decision-making • 30-39 minutes	$110.09	61
CD810	Patient Navigation • "Referred-In" to Dysplasia Treatment Services • Comprehensive visit	$122.31	62
CD624	Human Papillomavirus • High-risk types	$48.14	63
CD141	Cytopathology • Cervical or vaginal • Any reporting system • Requiring interpretation by physician	$33.45	64
CD142	Cytopathology (liquid-based Pap Test) • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Manual screening under physician supervision	$27.79	65
CD143	Cytopathology • Cervical or vaginal • Collected in preservative fluid • Automated thin layer preparation • Manual screening and rescreening under physician supervision	$27.79	65
CD164	Cytopathology (conventional Pap test) • Slides cervical or vaginal reported in Bethesda System • Manual screening under physician supervision	$14.49	65

CPT® Code	Code Description	Rate	End Note
CD452	Colposcopy of the cervix	$112.40	66
CD455	Colposcopy of the cervix • With biopsy • Physician in Office	$146.88	67
FCX55	Colposcopy of the cervix • With biopsy • Physician in Facility	$115.01	67
FCD55	Colposcopy of the cervix • With biopsy • Facility fee	$64.96	67
CD456	Colposcopy of the cervix • With endocervical curettage • Physician in Office	$138.54	67
FCX56	Colposcopy of the cervix • With endocervical curettage • Physician in Facility	$107.03	67
FCD56	Colposcopy of the cervix • With endocervical curettage • Facility fee	$62.45	67
CD460	Colposcopy • With loop electrode biopsy(s) of the cervix • Physician in Office	$290.04	68

CPT® Code	Code Description	Rate	End Note
FCX60	Colposcopy • With loop electrode biopsy(s) of the cervix • Physician in Facility	$168.37	68
FCD60	Colposcopy • With loop electrode biopsy(s) of the cervix • Facility fee	$173.34	68
CD461	Colposcopy • With loop electrode conization of the cervix • Physician in Office	$328.46	69
FCX61	Colposcopy • With loop electrode conization of the cervix • Physician in Facility	$194.48	69
FCD61	Colposcopy • With loop electrode conization of the cervix • Facility fee	$186.62	69
CD454	• Colposcopy of the cervix With biopsy and endocervical curettage • Physician in Office	$157.45	70
FCX54	• Colposcopy of the cervix With biopsy and endocervical curettage • Physician in Facility	$140.79	70
FCD54	• Colposcopy of the cervix With biopsy and endocervical curettage • Facility fee	$62.09	70

CPT® Code	Code Description	Rate	End Note
CD505	Endocervical curettage • Not done as part of a dilation and curettage • Physician in Office	$105.12	71
CD511	Cryotherapy • Cryocautery • Initial or repeat	$149.08	72
CD513	Cervical cautery with laser ablation	$149.33	73
FCX20	Conization of cervix • Cold knife or laser • With or without fulguration With or without dilation and curettage With or without repair • Physician in Facility	$285.25	74
FCD20	• Conization of cervix Cold knife or laser • With or without fulguration With or without dilation and curettage With or without repair • Facility fee	$1,066.87	74
CD522	Loop Electrode Excision Procedure (LEEP) • Physician in Office	$271.25	74
FCX22	Loop Electrode Excision Procedure (LEEP) • Physician in Facility	$251.33	75

CPT® Code	Code Description	Rate	End Note
FCD22	Loop Electrode Excision Procedure (LEEP) • Facility fee	$1,066.87	75
CD811	Endometrial sampling (biopsy) • performed in conjunction with colposcopy (list separately in addition to code for colposcopy) • Physician in Office	$49.35	76
FCX81	• Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for colposcopy) • Physician in Facility	$42.47	76
CD940**	Anesthesia for vaginal procedures (including biopsy of cervix); • not otherwise specified • [RVUs + (Minutes / 15] x Conversion Factor = Anesthesia Reimbursement		77
CD305	Surgical Pathology • Gross and microscopic examination	$70.55	78
CD307	Surgical Pathology • Gross and microscopic examination • Requiring microscopic evaluation of surgical margins	$273.57	79
CD930	Electrocardiogram (ECG)	$17.40	80
CD048	Basic Metabolic Panel (Chem 6)	$11.60	81
CD053	Comprehensive Metabolic Panel (Chem 12)	$14.49	81

CPT® Code	Code Description	Rate	End Note
CD125	Urine Pregnancy Test	$8.67	82
CD025	CBC, automated with differential	$10.66	83
CD027	CBC, automated	$8.87	83
CD610	Prothrombin Time (PT)	$5.39	84
CD730	Partial Prothrombin Time (PTT)	$8.24	84
CD384	Fibrinogen	$11.65	84
CD745*	Radiological examination, chest • Single view	P $6.95 T $8.02 F $14.97	85
FCD45*	Radiological examination, chest • Single view • Facility Fee	P $6.95 T $8.02 F $14.97	85
FCD46	Radiological examination, chest • 2 views • Facility Fee	P $8.29 T $14.70 F $22.99	85
CD746*	Radiological examination, chest • 2 views	P $8.29 T $14.70 F $22.99	85

End Notes

Office Visits

1

- Office visits should only be billed for interactions with a licensed, qualified provider, i.e. MD, APN, PA or RN.
- The CPT® code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making.
- A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty and subspecialty who belongs to the same group practice, within the past three years.
- An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- All consultations should be billed through the standard "new patient" office visit CPT® codes 99202–99205. 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.

- No more than one BCCS office visit is billable on the same day.
- 99211 does not require physician presence, although client evaluation and/or management are required; 99211 cannot be billed for client phone calls or patient navigation.
- Consultation visits are billed using office visit codes and may be billed on the same day as the BCCS office visit.
- Global fee periods apply to certain diagnostic surgical procedures. Office visits are not allowed to be billed separately during the global fee periods.
- Global fee periods do not apply to consultations with a breast or cervical specialist.
- See specific diagnostic CPT® codes for any global fee periods that may apply.
- Neither the program, nor the patient, can be billed for "no show" visits.

Breast Screening & Diagnostic Services

2

- May be billed with 77065, 77066, 76641, 76642.
- Billable for clients with spontaneous nipple discharge and BI-RADS 1-3 after diagnostic mammogram.
- May not be billed with screening mammograms (77067, B7067) or MRI (77046, B7046, 77047, B7047, 77048, B7048, 77049, B7049).

3

- May only be reimbursed in conjunction with a mammogram when a client has a:
    - BRCA gene mutation;
    - A first-degree relative who is a BRCA carrier;
    - A lifetime risk of 20 percent or greater, as defined by risk assessment models such as BRCAPRO that depend largely on family history;
- May not be used alone as a breast cancer screening tool.
- May not be billed with B7046, B7047, B7048, B7049.
- May be billed with diagnostic mammograms used for additional views.
- Must be performed in a facility with dedicated breast MRI equipment that can perform MRI-guided breast biopsy.
- Breast MRI cannot be reimbursed to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.
- 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.
- **Preauthorization is required.**

4

- May only be reimbursed for clients with one or more of the following:
    - BRCA gene mutation;
    - A first-degree relative who is a BRCA carrier;
    - A lifetime risk of 20 percent or greater, as defined by risk assessment models such as BRCAPRO that depend largely on family history ;
- May not be used alone as a breast cancer screening tool.
- May not be reimbursed with 77046, 77047, 77048, 77049.
- May be billed with diagnostic mammograms used for additional views.

- Must be performed in a facility with dedicated breast MRI equipment that can perform MRI - guided breast biopsy.
- Breast MRI cannot be reimbursed to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.
- 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.
- **Preauthorization is required.**

5

- A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants and/or a history of breast cancer/lumpectomy.
- A screening mammogram may precede the clinical breast exam.
- An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided.
- List G0279 separately in addition to 77065 or 77066
- List 77063 separately in addition to 77067.

6

- Must be used to bill screening mammograms for women 40 to 49 years of age.
- Women in this age group may receive a screening mammogram every two (2) years or annually if high risk per risk assessment tool – see breast clinical guidelines.
- A screening mammogram may precede the clinical breast exam.
- An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided.
- List 77063 separately in addition to code B7067.

7

- 19000 may be billed once per breast regardless of the number of lesions.
- 19000 may be billed with 76942.
- Pathology (88305 or 88173) may not be reimbursed with 19000.
- Office visit codes on the day of the procedure are not payable (Global Fee Period 00).

8

- 19100 and F9100 may only be billed once per breast, regardless of the number of specimens.
- 19100 cannot be billed with 00400 or 100FX.

- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 100FX may be billed with F9100; but only once.
- 00400 may be billed with F9100 and 100FX for the total anesthesia units provided, up to the 8 unit maximum.
- 88305 may be billed for up to six biopsy specimens per breast.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).

9

- 19101 and F9101 may be billed only once (per breast) regardless of the number of lesions.
- 76098 (if indicated) may be billed for each lesion, up to the maximum of three per breast.
- 88305 may be billed for up to six biopsy specimens per breast.
- 101FX may be billed once with F9101.
- 19101 cannot be billed with 00400.
- 00400 may be billed with F9101 for the total anesthesia units provided, up to the eight-unit maximum.
- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammogram or MRI codes.
- May be billed with image guided preoperative placement of breast localization devices 19281-F9288 and their associated facility codes.
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 10).

10

- May be billed only once per breast regardless of the number of lesions.
- 120FX may be billed once with F9120. 76098 may be billed if indicated for each lesion up to the maximum of three per breast.
- 88305/88307 may be billed for up to six biopsy specimens per breast.
- 00400 cannot be billed with 19120.
- 00400 may be billed with F9120 for the total anesthesia units provided, up to the eight-unit maximum.
- May not be used with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- May be billed with imaging-guided preoperative wire placement (19281-F9288 and associated facility codes).
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).

11

- 19125 may be billed only once per breast, regardless of the number of lesions.
- 19126 may only be billed for up to two additional lesions.
- 125FX may be billed once with 19125.
- 76098 may be billed if indicated for each lesion, up to the maximum of three.
- 88305/88307 may be billed for up to six biopsy specimens per breast.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI.
- 19125 may be billed with image-guided preoperative wire placement (19281-F9288 and associated facility codes), if needed.
- For 19125-Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).
- For 19126-Codes related to another service are always included in the global period of the other service (Global fee period 90).

12

- 19081 and F9081 can only be billed once per breast, regardless of the number of lesions.
- 19082 and F9082 may be billed up to the maximum of two additional lesions per breast.
- May not be billed with 19281-19288 or F9281-F9288 or associated facility codes.
- 88305 may be billed for up to six biopsy specimens per breast.
- 76098 may be billed for each lesion up to the maximum of three, if indicated.
- 00400 cannot be billed with 19081 or 19082.
  - May be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 812FX may be billed with once with F9081 and F9082.
- Office visits not reimbursable on day of procedure (Global fee period 00).

13

- 19083 and F9083 may only be billed once per breast regardless of the number of lesions.
- 19084 and F9084 may be billed up to the maximum of two additional lesions per breast.
- May not be billed with 19281-19288 or F9281-F9288 or associated facility codes.
- 88305 may be billed for up to 6 biopsy specimens per breast.

- 76098 may be billed for each lesion up to the maximum of three, if indicated.
- 00400 cannot be billed with 19083 or 19084.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 834FX may be billed once with F9083 and F9084.
- Office visits not reimbursable on day of procedure.

14

- F9085 may only be billed once per breast regardless of the number of lesions.
- May only be performed in a facility with dedicated breast MRI equipment.
- F9086 may be billed up to the maximum of two additional lesions per breast.
- May not be billed with 19281-19288 or F9281-F9288 or associated facility codes.
- 88305 may be billed for up to six biopsy specimens per breast.
- 76098 may be billed for each lesion up to the maximum of three, if indicated.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes.
- 856FX may be billed once with F9085.
- Office visits not reimbursable on day of procedure.
- **Preauthorization is required.**

15

- May only be billed with incisional/excisional biopsy and their associated facility codes.
- Facility fees are included with the primary procedure code.
- 19281 and F9281 may only be billed once per breast regardless of the number of lesions.
- Additional lesions may be billed up to a maximum of two per breast.
- Cannot be billed with 19081-19086 or F9081-F9086 or their associated facility codes.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 00400 cannot be billed with 19281 or 19282.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
    - Office visits not reimbursable on day of procedure (Global fee period 00).

16

- May only be billed with incisional/excisional biopsies and their associated facility codes.
- Facility fees are included with the primary procedure code.
- 19283 and F9283 may only be billed once per breast regardless of the number of lesions.
- Additional lesions may be billed up to a maximum of two per breast.
- Cannot be billed with 19081-19086 or F9081-F9086 or their associated facility codes.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 00400 cannot be billed with 19283 or 19284.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- Office visits not reimbursable on day of procedure (Global fee period 00).

17

- May only be billed with incisional/excisional biopsies and their associated facility codes.
- Facility fees are included with the primary procedure code.
- 19285 and F9285 may only be billed once per breast regardless of the number of lesions.
- Additional lesions may be billed up to a maximum of two per breast.
- Cannot be billed with 19081-19086 or F9081-F9086 or their associated facility codes.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes.
- 00400 cannot be billed with 19283 or 19284.
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the eight-unit maximum.
- Office visits not reimbursable on day of procedure (Global fee period 00).

18

- Codes using magnetic resonance imaging may only be performed in a facility with dedicated breast MRI equipment.
- Facility fees are included with the primary procedure code.
- May only be billed with incisional/excisional biopsies and their associated facility codes.
- F9287 may only be billed once per breast regardless of the number of lesions.
- Additional lesions may be billed up to a maximum of two per breast.
- Cannot be billed with 19081-19086 or F9081-F9086 or their associated facility codes.
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes.

- May be billed with 00400 to reflect anesthesia units provided, up to the eight-unit maximum.
- Office visits not reimbursable on day of procedure.
- **Preauthorization is required.**

19

- [RVUs + (Minutes / 15)] x Conversion Factor = Anesthesia reimbursement.
- One unit equals 15 minutes.
- 00400 may only be billed with allowable BCCS facility codes.

20

- May be billed to reflect each lesion present, up to the maximum of three per breast.

21

- May not be billed with 76942.
- 76641 used when four quadrants of the breast are examined.
- 76642 used when fewer than four quadrants of the breast are examined.
- May be billed to reflect each breast examined.

22

- May be billed to reflect each lesion present, up to the maximum of three per breast.
- May only be billed with 19000. May not be billed with 76641, 76642.

23

- FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer. May be reimbursed for evaluation of abnormal lymph nodes for breast cancer staging and may not be reimbursed to evaluate a breast mass.
- 10021, 10005, 10007, and 10009 may be billed with 88173.

24

- FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer.
- 88173 may be billed to evaluate the aspirate of each abnormal lymph node for the purpose of breast cancer staging.
- 88173 may only be billed with 10021, 10005, 10007, and 10009.

- 88173 requires cytologic expertise.

25

- 88305 may be billed for up to six biopsy specimens per breast.

26

- May be billed with 19120, 19125 and their associated facility codes.

Cervical Screening & Diagnostic Services

27

- Used for cytology and HPV co-testing every five years for women ages 30 and over and management of specific abnormal Pap tests.
- HPV DNA testing is not a reimbursable procedure if used as an adjunctive screening test to the Pap for women under 30 years of age.
- Must be ordered by a provider and not done as part of lab protocol.
- When a conventional Pap test result is ASC-US, a follow-up office visit may be billed to collect the reflex HPV test.
- When a liquid-based Pap test result is ASC-US, the HPV test can be done on the original specimen and a follow-up visit for HPV testing cannot be billed.
- Refer to cervical algorithms for indications for HPV testing.
- HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated.

28

- Each laboratory may develop their own policy for indications for the pathologist's review of Pap slides.
- 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 test service.

29

- Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines.

30

- Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines.

31

- As indicated. Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines.

32

- Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines.

33

- Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines.

34

- May be billed with 57454, 57455, 57456, 57460 and their associated facility codes.
- May be billed for up to 4 specimens.

35

- May be billed with 57461, 57520, 57522 and their associated facility codes.
- May be billed for up to 4 specimens per cervical conization procedure.

36

- May be billed only once regardless of the number of lesions.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).

37

- 57454 and F7454 may be billed only once regardless of the number of lesions.
- 88305 may be billed for up to four specimens.
- May not be billed with 88307.
- May not be billed with colposcopy: 57452, 57455, 57456, 57460, 57461 or their associated facility codes.
- 00940 cannot be billed with 57454.
- 00940 may be billed to reflect anesthesia provided, up to the eight-unit maximum.
- 454FX may be billed once with F7454.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- **F7454 and 454FX – preauthorization is required.**

38

- May be billed only once, regardless of the number of lesions.
- 88305 may be billed for up to four specimens to reflect multiple biopsy sites on cervix.
- May not billed with 88307.
- May not be billed with colposcopy: 57452, 57454, 57456, 57460, 57461 or their associated facility codes.
- F7455 may be billed once with 455FX.
- 00940 cannot be billed with 57455.
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- **F7455 and 455FX - preauthorization is required.**

39

- May be billed only once regardless of the number of lesions.
- 88305 may only be billed once.
- May not be billed with 88307.
- 00940 cannot be billed with 57456.
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum.
- May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- F7456 may be billed once with 456FX.
- **F7456 and 456FX- preauthorization is required.**

40

- May be billed only once, regardless of the number of lesions.
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes.
- 00940 cannot be billed for 57460.
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum.
- 88305 may be billed for up to four specimens to reflect multiple biopsy sites on the cervix.
- May not bill with 88307.
- F7460 may be billed once with 460FX.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- **F7460 and 460FX - preauthorization is required.**

41

- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460 and their associated facility codes.
- 57461 may be billed only once and may not be billed with F7461, 461FX or anesthesia.
- 88307 may be billed for up to four specimens.
- 88305 may not be billed with 57461 or F7461.
- F7461 may be billed once with 461FX.
- 00940 may not be billed with 57461.
- 00940 may be billed for the total units of anesthesia provided, up to the 8 unit maximum.
- No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility.
- **F7461 and 461FX- preauthorization is required.**

42

- 88305 may be billed with 57500 for up to four specimens to reflect multiple biopsy sites on cervix.
- May not be billed with 88307.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).

43

- May be billed only once.
- 88305 may be billed once with 57505.
- May not be billed with 88307.
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 10).

44

- 57520 may be billed only once.
- 88307 may be billed with 57520 for up to four specimens.
- May not be billed with 88305.
- 00940 may be billed for the units of anesthesia provided, up to the 8 unit maximum.
- 57520 must be performed in a certified ambulatory surgery center or day surgery facility.
- 520FX may be billed once with 57520.

- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).

45

- 57522 may be billed only once and may not be billed with F7522, 522FX or anesthesia.
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or associated facility codes.
- 88307 may be billed for up to 4 specimens.
- May not be billed with 88305.
- F7522 may be billed only once with 522FX.
- 00940 may be billed with F7522 for the total units of anesthesia provided, up to the 8 unit maximum.
- No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility.
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).
- **F7522 and 522FX- preauthorization is required.**

46

- One unit equals 15 minutes.
- 00400 may only be billed with allowable BCCS facility codes.

47

- Must be billed with a colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or their associated facility codes.
- 00940 may not be billed with 58110.
- 00940 may be billed to reflect anesthesia, up to the maximum of 8 units.
- Code related to another service and is always included in the global period of the other service (Global fee period 00).
- **F8110 – preauthorization is required.**

Pre-Operative Laboratory Procedures for Diagnostic Services

48

- Refer to the American Society of Anesthesiologists for (ASA) grades.
- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3).
- For BCCS diagnostic services only.

49

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions (ASA Grade 2 or 3).
- For BCCS diagnostic services only
- 88048 may not be billed with 88053.

50

- Performed only prior to diagnostic procedures utilizing general anesthetic for women of child-bearing age. **May not be used as routine pregnancy screening.**
- For BCCS diagnostic services only.
- Contractors may be required to reimburse BCCS for CD125 if not billed in accordance with billing guideline.

51

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions (ASA grade 2 or 3).
- For BCCS diagnostic services only.
- 85025 cannot be billed with 85027.

52

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions (ASA grades 2 or 3).
- For BCCS diagnostic services only.
- 85610, 85730 and 85384 may be billed together.

53

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions (ASA grades 2 or 3).
- For BCCS diagnostic services only.
- 71045 and 045FX cannot be billed with 71046 or 046FX.

Patient Navigation Services

54

- 44410 may only be billed for a client diagnosed with breast or cervical cancer without the use of BCCS screening or diagnostic fund, by a non-BCCS provider who is referred to your agency to complete the MBCC application.
- 44410 may only be billed by one BCCS contractor, one time only per cancer diagnosis, upon completion of the MBCC assessment, service plan and application.
- Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT®.
- 44410 reimbursement requires completion of the Med-IT® patient navigation module.
- 44410 may only be billed with 44413 and may not be billed with any other codes, including patient navigation codes: 99910, 99913, 88810, and 88813.
- May not be billed for a reinstatement, renewal, or client transferring from another state
- May not be billed with SC100.

55

- May be billed up to a maximum of three follow-up phone calls.
- Note: Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered into Med-IT®.
- May not be billed with SC100.

56

- 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan.
- 99910 reimbursement requires completion of Med-IT® patient navigation module.
- May not bill with 44410, 44413, 88810 or 88813.
- May not be billed for a reinstatement, renewal, or client transferring from another state.

57

- May be billed up to a maximum of three follow-up phone calls or in-person visits to conduct patient navigation activities.
- May not bill with 44410, 44413, 88810 or 88813.

58

- Insurance assessment with Marketplace referral and Med-IT® documentation in *Cycle Initiation -> Insurance Referral.*
- "Marketplace Referral" types are variable by contractor and may include handouts, on-site assistance, counselor referrals, etc.

59

- 88810 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan.
- 88810 reimbursement requires completion of Med-IT® patient navigation module.
- May not bill with 44410, 44413, 99910 or 99913.
- May not be billed for a reinstatement, renewal, or client transferring from another state.

60

- May be billed up to a maximum of three follow-up phone calls or in-person visits to conduct patient navigation activities.
- May not bill with 44410, 44413, 99910 or 99913

Cervical Dysplasia Management and Treatment Services (CD)

61

- Office visits may only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN.
- The "CD" code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making.
- CD204 & CD214 are uncommon office visits for typical services provided under Title V dysplasia.
- No more than 1 BCCS office visit is billable on the same day.
- CD211 does not require physician presence, although client evaluation and/or management are required.
- CD211 is not billable for client phone calls.
- Global fee periods apply to certain management and treatment procedures.
- Office visits are not allowed to be billed separately during some global fee periods.
- See specific CD, FCD and FCX management & treatment procedure codes for any global fee periods that may apply.
- Neither BCCS, nor the patient, can be billed for "no show" visits.
- NOTE:
    - CD202 corresponds to 99202.
    - CD203 corresponds to 99203.
    - CD204 corresponds to 99204.
    - CD212 corresponds to 99212.
    - CD213 corresponds to 99213.
    - CD214 corresponds to 99214.

62

- CD810 may be billed for patient navigation services for a client who was referred-in for cervical dysplasia management and treatment.
- CD810 may not be billed with 88810 or 88813
- CD810 may only be billed by one BCCS contractor, one time only, per problem, and upon completion of the assessment and service plan.
- NOTE: CD810 corresponds to 88810.

63

- Use for management of dysplasia per dysplasia algorithms.
- HPV DNA testing is not a reimbursable procedure if used as an adjunctive screening test to the Pap for women under 30 years of age.
- Must be ordered by a provider and not done as part of lab protocol
- HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated.
- NOTE: CD624 corresponds to 87624.

64

- May be billed as the professional component with CD142 and CD164 as applicable.
- Each laboratory may develop their own policy for pathologist review of cervical Pap slides.

65

- Use for management of dysplasia.
- NOTE: CD164 corresponds to 88164.
- NOTE: CD142 corresponds to 88142.
- NOTE: CD143 corresponds to 88143

66

- May be billed only once.
- CD305 may be billed with CD455 and FCX55 up to 4 times to reflect multiple biopsy sites on the cervix.
- Cannot be billed with colposcopy codes.
- FCD55 may be billed once with FCX55.
- CD940 cannot be billed with CD455.
- CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- FCX55 and FCD55 - preauthorization is required.
- NOTE:
    - CD455 corresponds to 57455.
    - FCX55 corresponds to F7455.
    - FCD55 corresponds to 455FX.

67

- May be billed only once.
- CD305 may be billed only once with CD456 and FCX56.
- Cannot be billed with colposcopy codes.
- CD940 cannot be billed with CD456.
- CD940 can be billed to reflect anesthesia provided, up to the maximum of 8.
- FCD56 may be billed once with FCX56.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- NOTE:
    - CD456 corresponds to 57456.
    - FCX56 corresponds to F7456.
    - FCD56 corresponds to 456FX.
- **FCX55, FCD55, FCX56 and FCD56 - preauthorization is required.**

68

- May be billed only once.
- CD305 may be billed with CD460 and FCX60 up to 4 times to reflect multiple biopsy sites on the cervix.
- May not be billed with colposcopy codes.
- FCD60 may be billed once with FCX60.
- CD940 cannot be billed with CD460.
- CD940 can be billed to reflect anesthesia, up to the maximum of 8 units.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- NOTE:
    - CD460 corresponds to 57460.
    - FCX60 corresponds to F7460.
    - FCD60 corresponds to 460FX.
- **FCX60 and FCD60 - preauthorization is required.**

69

- May be billed only once.
- CD307 may be billed up to 4 times to reflect multiple biopsy sites on the cervix.
- May not be billed with colposcopy codes.
- FCD61 may be billed once with FCX61.
- CD940 cannot be billed with CD461.
- CD940 can be billed to reflect anesthesia, up to the maximum of 8 units.

- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- NOTE:
    - CD461 corresponds to 57461.
    - FCX61 corresponds to F7461.
    - FCD61 corresponds to 461FX.
- **FCX61 and FCD61 - preauthorization is required.**

70

- May be billed only once.
- May not be billed with colposcopy codes.
- CD305 may be billed up to 5 times to reflect 4 biopsy sites on the cervix and one (1) ECC biopsy.
- CD940 cannot be billed with CD454.
- CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.
- FCD54 may be billed once with FCX54.
- Office visit codes on the day of the procedure are not payable (Global fee period 00).
- NOTE:
    - CD454 corresponds to 57454.
    - FCX54 corresponds to F7454.
    - FCD54 corresponds to 454FX.
- **FCX54 and FCD54 - preauthorization is required.**

71

- May be billed only once.
- CD305 may be billed once with CD505.
- May not be billed with CD307.
- NOTE: CD505 corresponds to 57505.
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 10).

72

- There is no pathology associated with CD511 because a biopsy is not performed with this procedure.
- Decision to repeat is based upon provider medical decision-making and adherence to algorithms.

- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 10).
- NOTE: CD511 corresponds to 57511.

73

- There is no pathology associated with CD513 because a biopsy is not performed with this procedure.
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 10).
- NOTE: CD513 corresponds to 57513.

74

- FCX20 must be performed in a certified ambulatory surgical center or a day surgery facility.
- FCX20 may be billed only once.
- FCD20 may be billed with FCX20 for the facility fee.
- CD307 may be billed with FCX20 for up to 4 specimens per cervical conization procedure.
- Cannot be billed with CD305.
- CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum.
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).
- NOTE:
    - FCX20 corresponds to 57520.
    - FCD20 corresponds to 520FX.

75

- CD522 may be billed only once and cannot be billed with FCX22, FCD22, or CD940.
- CD522 and FCX22 may not be billed with CD452, CD454, CD455, CD456, CD460, CD461 or their associated facility codes.
- CD307 may be billed with CD522 or FCX22for up to 4 specimens.
- May not be billed with CD305.
- FCD22 may be billed once with FCX22.
- CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum.
- No greater than 20% of conization LEEPs should be done in a certified, ambulatory surgical center or a day surgery facility.

- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 90).
- NOTE:
  - CD522 corresponds to 57522.
  - FCX22 corresponds to F7522.
  - FCD22 corresponds to 522FX.
- **FCX22 and FCD22- preauthorization is required.**

76

- May be billed only once.
- D811 must be billed with a colposcopy.
- Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater if:
  - Client 35 or more years of age, or
  - At risk for endometrial neoplasia (see ASCCP algorithms).
- CD940 cannot be billed with CD811.
- CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.
- NOTE: CD811 corresponds to 58110.
- Code related to another service and is always included in the global period of the other service (Global fee period 00).
- **FCX81- preauthorization is required.**

77

- RVUs + (Minutes / 15] x Conversion Factor = Anesthesia reimbursement.
- One unit equals 15 minutes.
- CD940 may only be billed with allowable facility codes FCD20 or FCD22.
- NOTE: CD940 corresponds to 00940.

78

- May be billed for up to 4 specimens.
- May only be billed once with CD505.
- NOTE: CD305 corresponds to 88305.

79

- May be billed for up to 4 specimens per cervical conization procedure.
- NOTE: CD307 corresponds to 88307.

80

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grade 2 or 3).
- For CD treatment services only.
- NOTE: CD930 corresponds to 93000.

81

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grades 2 or 3).
- CD048 cannot be billed with CD053.
- For CD treatment services only.
- NOTE:
    - CD048 corresponds to 80048.
    - CD053 corresponds to 88053.

82

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grades 2 or 3).
- For CD treatment services only.
- Contractors may be required to reimburse BCCS for CD125 if billing is not in accordance with billing guidelines.
- NOTE: CD125 corresponds to 81025 (Urine Pregnancy Test).

83

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grades 2 or 3).
- For CD treatment services only.
- NOTE:
    - CD025 corresponds to 85025.
    - CD025 cannot be billed with CD027.
    - CD027 corresponds to 85027.

84

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grades 2 or 3).
- For CD treatment services only.
- CD610, CD730 and CD384 may be billed together.
- NOTE:
    - CD610 corresponds to 85610.
    - CD384 corresponds to 85384.

85

- Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions (ASA grades 2 or 3).
- For CD treatment services only.
- CD745 and FCD45 cannot be billed with CD746 or FCD46.
- NOTE:
    - CD745 corresponds to 71045.
    - FCD45 corresponds to 045FX.
    - CD746 corresponds to 71046.
    - FCD46 corresponds to 046FX.