Fee for Service Schedule
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OFFICE VISITS			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
New patient; history, exam, straightforward decision-making; 10 minutes	99201	$41.25	
	99201*	$24.87	
New patient; *expanded* history, exam, straightforward decision-making; 20 minutes	99202	$69.75	
	99202*	$47.15	
New patient; *detailed* history, exam, straightforward decision-making; 30 minutes	99203	$99.79	
	99203*	$70.96	
New patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	99204	$152.89	1
	99204*	$120.46	
New patient; comprehensive history, exam, high complexity decision-making; 60 minutes	99205	$192.31	1
	99205*	$157.26	
Established patient; evaluation and management, may not require presence of physician; 5 minutes	99211	$20.16	
	99211*	$8.69	
Established patient; history, exam, straightforward decision-making; 10 minutes	99212	$40.81	
	99212*	$23.77	
Established patient; *expanded* history, exam, straightforward decision-making; 15 minutes	99213	$68.09	
	99213*	$48.10	
Established patient; *detailed* history, exam, moderately complex decision-making; 25 minutes	99214	$100.70	
	99214*	$73.84	
Initial comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; 18 to 39 years of age. (limited to 99203 rate)	99385	$99.79	2
	99385*	$70.96	
Same as 99385, but 40 to 64 years of age (limited to 99203 rate)	99386	$99.79	2
	99386*	$70.96	
Same as 99385, but 65 years of age or older (limited to 99203 rate)	99387	$99.79	2
	99387*	$70.96	
Periodic comprehensive preventive medicine evaluation and management; history, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; 18 6o 39 years of age (limited to 99213 rate)	99395	$68.09	2
	99395*	$48.10	
Same as 99395, but 40 to 64 years of age (limited to 99213 rate)	99396	$68.09	2
	99395*	$48.10	
Same as 99395, but 65 years of age or older (limited to 99213 rate)	99397	$68.09	2
	99397*	$48.10	

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Breast Cancer Screening and Diagnostic Procedures			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
Diagnostic mammography, unilateral, includes CAD (Rate equivalent to G0206)	77065	$125.94	
	77065-TC	$87.26	
	77065-26	$38.69	
Diagnostic mammography, bilateral, includes CAD (Rate equivalent to G0204)	77066	$159.22	
	77066-TC	$111.50	
	77066-26	$47.73	
Screening mammography, bilateral (Rate equivalent to G0202)	77067	$128.34	
	77067-TC	$92.17	
	77067-26	$36.17	
Screening digital breast tomosynthesis, bilateral	77063	$51.76	
	77063-TC	$23.26	11
	77063-26	$28.50	
Diagnostic digital breast tomosynthesis, unilateral or bilateral	G0279	$51.76	
	G0279-TC	$23.26	12
	G0279-26	$28.50	
Radiological examination, surgical specimen	76098	$15.64	
	76098-TC	$7.98	
	76098-26	$7.67	
Mammary ductogram or galactogram, single duct	77053	$54.19	
	77053-TC	$37.13	
	77083-26	$17.06	
Magnetic resonance imaging (MRI), breast, with and/or without contract, unilateral	77058	$492.36	
	77058-TC	$414.75	8
	77058-26	$77.61	
Magnetic resonance imaging (MRI), breast, with and/or without contract, bilateral	77059	$492.36	
	77059-TC	$414.75	8
	77059-26	$77.61	
Ultrasound, complete examination of breast including axilla, unilateral	76641	$100.76	
	76641-TC	$65.96	
	76641-26	$34.79	
Ultrasound, limited examination of breast including axilla, unilateral	76642	$82.63	
	76642-TC	$50.24	
	76642-26	$32.39	
Ultrasonic guidance for needle placement, imaging supervision and interpretation	76942	$56.29	
	76942-TC	$25.34	
	76942-26	$30.95	
Puncture aspiration of cyst of breast	19000	$104.30	
	19000*	$40.75	

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Breast Cancer Screening and Diagnostic Procedures			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*	19001	$25.07	
	19001*	$20.15	
Breast biopsy, percutaneous, needle core, not using imaging guidance	19100	$137.10	
	19100*	$62.74	
Breast biopsy, open, incisional	19101	$310.50	
	19101*	$200.10	
Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	19120	$447.04	
	19120*	$373.00	
Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	19125	$494.24	
	19125*	$412.99	
Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	19126	$144.40	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	19081	$642.51	9
	19081*	$158.32	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	19082	$530.55	9
	19082*	$79.78	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	19083	$625.04	9
	19083*	$149.05	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	19084	$509.68	9
	19084*	$74.63	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	19085	$935.56	9
	19085*	$174.55	
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	19086	$757.60	9
	19086*	$87.66	
Placement of breast localization device, percutaneous; mammographic guidance; first lesion	19281	$224.23	10
	19281*	$95.81	
Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	19282	$155.52	10
	19282*	$48.07	
Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	19283	$252.75	10
	19283*	$95.83	
Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	19284	$189.72	10
	19284*	$48.20	
Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	19285	$482.60	10
	19285*	$81.95	
Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	19286	$422.19	10
	19286*	$40.87	
Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	19287	$800.92	10
	19287*	$122.14	
Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	19288	$647.10	10
	19288*	$61.68	
Fine needle aspiration without imaging guidance	10021	$112.80	
	10021*	$64.31	
Fine needle aspiration with imaging guidance	10022	$131.01	
	10022*	$61.56	
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	88172	$54.58	
	88172-TC	$18.79	
	88172-26	$35.79	

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Breast Cancer Screening and Diagnostic Procedures			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
Cytopathology, evaluation of fine needle aspirate; *interpretation and report*	88173	$145.75	
	88173-TC	$75.25	
	88173-26	$70.50	
Surgical pathology, gross and microscopic examination	88305	$64.86	
	88305-TC	$27.30	
	88305-26	$37.56	
Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	88307	$247.85	
	88307-TC	$165.34	
	88307-26	$82.52	
Morphometric analysis, tumor immunohistochemistry, per specimen; manual	88360	$125.36	
	88360-TC	$81.36	
	88360-26	$44.00	
Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	88361	$136.38	
	88361-TC	$89.55	
	88361-26	$46.83	
Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3	00400	See Attachment 1	3
Pre-operative testing; complete blood count, urinalysis, pregnancy test, or other procedures medically necessary for the planned surgical procedure.	Various		

Cervical Cancer Screening and Diagnostic Procedures			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	88164	$14.65	
Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	88165	$42.22	
Cytopathology, cervical or vaginal, any reporting system, *requiring interpretation by physician*	88141	$30.62	
Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	88142	$25.01	
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	88143	$25.01	4
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	88174	$26.38	4
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	88175	$32.71	4
Human Papillomavirus, high-risk types	87624	$43.33	5
Human Papillomavirus, types 16 and 18 only	87625	$43.33	5
Colposcopy of the cervix	57452	100.20	
	57452*	$85.14	
Colposcopy of the cervix, with biopsy and endocervical curettage	57454	$140.47	
	57454*	$125.08	
Colposcopy of the cervix, with biopsy	57455	$131.32	
	57455*	$101.84	

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Cervical Cancer Screening and Diagnostic Procedures			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**End Notes**
Colposcopy of the cervix, with endocervical curettage	57456	$123.91	
	57456*	$94.75	
Colposcopy with loop electrode biopsy(s) of the cervix	57460	$259.96	6
	57460*	$149.56	
Colposcopy with loop electrode conization of the cervix	57461	$293.74	6
	57461*	$172.53	
Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	57500	$117.66	
	57500*	$69.83	
Endocervical curettage (not done as part of a dilation and curettage)	57505	$94.49	
	57505*	$84.99	
Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	57520	$282.95	6
	57520*	$253.14	
Loop electrode excision procedure	57522	$242.63	6
	57522*	$223.95	
Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	58100	$100.16	
	58100*	$80.50	
Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	58110	$44.41	
	58110*	$37.86	
Surgical pathology, gross and microscopic examination	88305	$64.86	
	88305-TC	$27.30	
	88305-26	$37.56	
Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	88307	$247.85	
	88307-TC	$165.34	
	88307-26	$82.52	
Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	88331	$92.46	
	88331-TC	$29.93	
	88331-26	$62.54	
Pathology consultation during surgery, each additional tissue block, with frozen section(s)	88332	$50.32	
	88332-TC	$19.44	
	88332-26	$30.87	
Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	88342	$102.43	
	88342-TC	$67.27	
	88342-26	$35.16	
Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure	88341	$87.15	
	88341-TC	$58.97	
	88341-26	$28.19	
Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies or materials provided)	99070		7
Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.	Various		

Procedures Specifically Not Allowed	**CPT Codes**	**End Notes**
Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer	Any	
Breast tomosynthesis, unilateral	77061	13
Breast tomosynthesis, bilateral	77062	13
Human papillomavirus, low-risk types	87623	

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ATTACHMENT 1

Fee Schedule for Anesthesia is based on NE Medicaid Reimbursement system with unit values rounded to nearest cent. Rates are adjusted annually with the Program's Fiscal Year which runs July 1 through June 30.

Anesthesia Claims Modifiers:

Healthcare providers report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. All claims for anesthesia services must include:

- CPT Code **with Modifier** (see list below)
- Start & Stop Times
- Explanation of Benefits from Primary Insurance (where applicable)

When a physician bills for anesthesia services, the correct procedure code AND modifiers indicate:

- The Physician personally provided services to the individual patient
- The physician provided medical direction for CRNA services and the number of concurrent services directed.

The following modifiers MUST be used by when submitting claims for anesthesia services:

AA – Anesthesia Services performed personally by the anesthesiologist
AD – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX – RNA service; with medical direction by a physician
QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ – CRNA service; without medical direction by a physician

Fee Schedule:

To determine the allowable rate for anesthesia services, add the unit value for the procedure to the number of minutes for the procedure and multiple by the appropriate conversion factor.

(Unit Value + Minutes) x Conversion Factor = Allowable Rate

Unit Value:

CPT Code	AA/QY	QK	QX	QZ
00400*	$44.88	$67.87	$44.58	$44.79
00940*	$44.88	$67.87	$44.58	$44.79

*Anesthesia only covered when the surgical procedure performed is determined to be payable by EWM.

Minutes:
Anesthesia claims must include Start and Stop Times of the Procedure.

Conversion Factors:

AA = $1.89	QX = $0.89
QY = $1.89	QZ = $1.55
QK = $0.94	

(EXAMPLE: CPT 00400-QZ – 68minutes … ($44.79 + 68) x $1.52 = $171.44)

NOTE: ANESTHESIA RATES based on Nebraska Medicaid Rates effective 7/1/15; rates will be adjusted based on approved rates as of 7/1/16.

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End Notes	Description
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 (99024-99205) are typically not appropriate for NBCCEDP 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 the NBCCEDP. Reimbursement rates should not exceed those published by Medicare. NE fee schedule includes series 993XX codes; 9938X codes are limited to 99203 rate; 9939X codes are limited to 99213 rate.
3	NE reimbursement process for Anesthesia mirrors the rates for NE Medicaid; payment process described in Attachment 1 of Fee Schedule
4	These procedures may be reimbursed at their own Medicare rates
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 for screening for low-risk HPV types is not permitted. Cervista HPV HR reimbursed at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.
6	LEEP or conization of the cervix, as a diagnostic procedure reimbursed based on ASCCP recommendations; A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations; must comply with Cervical Diagnostic Enrollment Form.
7	Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies or materials provided) NE has not typically covered these charges but would require approval on a case-by-case basis
8	Breast MRI is allowed under certain circumstances; pre-approval for these procedures must be obtained.
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 G0202
12	List separately in addition to G0204 or G0206
13	These procedures have not been approved for coverage by Medicare; The treatment codes are not listed on the EWM Fee Schedule that is distributed to providers.

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