2019 Ohio BCCP Allowable Procedure and Relevant CPT® Codes – State and Federal Funds
June 30, 2019 – June 29, 2020 Rates

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

The CPT codes listed are not all-inclusive, ODH BCCP Program may add on other, including temporary, CPT codes for an approved procedure.

F = Facility Rate, G = Global Rate, H = Hospital/ACS Rate, P = Professional (26) Rate, T = Technical (TC) Rate (see last page for more information)

CPT Code	Office Visit Description*	Rates	Funds	End Note
99201	New patient; history, exam, straightforward decision-making; 10 minutes	F $26.71 G $44.23 H $17.52	Federal State	
99202	New patient; *expanded* history, exam, straightforward decision-making; 20 minutes	F $50.29 G $74.09 H $23.80	Federal State	
99203	New patient; *detailed* history, exam, straightforward decision-making; 30 minutes	F $75.74 G $105.49 H $29.75	Federal State	
99204	New patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes (Used for Risk Assessment)	F $128.23 G $160.95 H $32.72	Federal State	1
99205	New patient; comprehensive history, exam, high complexity decision-making; 60 minutes (Used for Risk Assessment)	F $167.32 G $202.68 H $35.36	Federal State	1
99211	Established patient; evaluation and management, may not require presence of physician; 5 minutes	F $9.16 G $21.72 H $12.56	Federal State	
99212	Established patient; history, exam, straightforward decision-making; 10 minutes	F $25.36 G $43.53 H $18.17	Federal State	
99213	Established patient; *expanded* history, exam, straightforward decision-making; 15 minutes	F $50.71 G $72.19 H $21.48	Federal State	
99214	Established patient; *detailed* history, exam, moderately complex decision-making; 25 minutes	F $78.17 G $105.93 H $27.76	Federal State	
99385	*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	F $75.74 G $105.49 H $29.75	Federal State	2
99386	Same as 99385, but 40 to 64 years of age	F $75.74 G $105.49 H $29.75	Federal State	2
99395	*Periodic* 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	F $50.71 G $72.19 H $21.48	Federal State	2
99396	Same as 99395, but 40 to 64 years of age	F $50.71 G $72.19 H $21.48	Federal State	2

*Ohio BCCP does not pay for Well Women Visits without a screening or mammogram order. Women entering the program with symptoms can have a covered office visit without a screening service to determine if the symptoms are breast or cervical cancer related.

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CPT Code	Breast Cancer Screening and Diagnostic Procedures	Rates	Funds	End Notes
77065	Diagnostic mammography, unilateral, includes CAD	G $127.20 P $40.92 T $86.29	Federal State	
77066	Diagnostic mammography, bilateral, includes CAD	G $160.85 P $50.44 T $110.41	Federal State	
77067	Screening mammography, bilateral, includes CAD	G $129.34 P $38.09 T $91.24	Federal State	
77063	Screening digital breast tomosynthesis, bilateral	G $53.11 P $29.98 T $23.13	Federal State	3
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	G $53.11 P $29.98 T $23.13	Federal State	4
76098	Radiological examination, surgical specimen	G $16.07 P $8.11 T $7.96	Federal State	
77053	Mammary ductogram or galactogram, single duct	G $54.71 P $17.99 T $36.71	Federal State	
77046	Magnetic resonance imaging (MRI), breast, without contrast, unilateral	G $236.62 P $72.67 T $163.95	Federal State	
77047	Magnetic resonance imaging (MRI), breast, without contrast, bilateral	G $243.38 P $80.42 T $162.96	Federal State	
77048	Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral	G $375.21 P $105.14 T $270.06	Federal State	5
77049	Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral	G $383.77 P $115.03 T $268.74	Federal State	5
76641	Ultrasound, complete examination of breast including axilla, unilateral	G $102.15 P $36.68 T $65.47	Federal State	
76642	Ultrasound, limited examination of breast including axilla, unilateral	G $83.82 P $34.22 T $49.60	Federal State	
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	G $55.34 P $32.17 T $23.17	Federal State	
19000	Puncture aspiration of cyst of breast	F $44.50 G $105.97 H $61.47	Federal State	
19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*	F $21.90 G $26.86 H $4.96	Federal State	
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	F $71.84 G $147.52 H $75.68	Federal State	
19101	Breast biopsy, open, incisional	F $223.15 G $330.56 H $107.41	Federal State	

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19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	F $416.02 G $494.67 H $78.65	Federal State	
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	F $462.31 G $548.56 H $86.25	Federal State	
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	F $165.65 G $165.65	Federal State	
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	F $171.27 G $619.72 H $448.45	Federal State	6
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	F $86.14 G $502.22 H $416.08	Federal State	6
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	F $161.38 G $606.53 H $445.15	Federal State	6
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	F $80.49 G $484.01 H $403.52	Federal State	6
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	F $187.06 G $917.08 H $730.02	Federal State	6
19086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	F $93.53 G $732.01 H $638.48	Federal State	6
19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	F $102.72 G $234.58 H $131.86	Federal State	7
19282	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	F $51.53 G $162.57 H $111.04	Federal State	7
19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	F $103.48 G $262.11 H $158.63	Federal State	7
19284	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	F $52.98 G $197.39 H $144.41	Federal State	7
19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	F $88.24 G $461.35 H $373.11	Federal State	7
19286	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	F $44.14 G $396.43 H $352.29	Federal State	7
19287	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	F $131.3 G $778.37 H $647.07	Federal State	7
19288	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	F $65.98 G $620.85 H $554.87	Federal State	7
10021	Fine needle aspiration biopsy without imaging guidance, first lesion	F $56.73 G $95.40 H $38.67	Federal State	
10004	Fine needle aspiration biopsy without imaging guidance, each additional lesion	F $44.05 G $51.98 H $7.93	Federal State	

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10005	Fine needle aspiration biopsy including ultrasound guidance, first lesion	F $74.24 G $123.48 H $49.24	Federal State	
10006	Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	F $50.57 G $59.82 H $9.25	Federal State	
10007	Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	F $95.25 G $273.37 H $178.12	Federal State	
10008	Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	F $62.07 G $154.61 H $92.54	Federal State	
10009	Fine needle aspiration biopsy including CT guidance, first lesion	F $115.52 G $445.01 H $329.49	Federal State	
10010	Fine needle aspiration biopsy including CT guidance, each additional lesion	F $84.43 G $269.16 H $184.73	Federal State	
10011	Fine needle aspiration biopsy including MRI guidance, first lesion	F $115.52 G $445.01 H $329.49	Federal State	8
10012	Fine needle aspiration biopsy including MRI guidance, each additional lesion	F $84.43 G $269.16 H $184.73	Federal State	8
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode	G $55.04 P $36.83 T $18.21	Federal State	
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	G $29.05 P $22.44 T $6.61	Federal State	
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	G $147.08 P $72.00 T $75.08	Federal State	
88305	Surgical pathology, gross and microscopic examination	G $66.78 P $38.66 T $28.12	Federal State	
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	G $255.78 P $84.53 T $171.25	Federal State	
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	G $121.61 P $43.25 T $78.36	Federal State	
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	G $125.87 P $46.53 T $79.35	Federal State	
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. (See rates in Anesthesiology section below)	See Section	Federal State	
Various*	To include any pre-operative testing procedures medically necessary for the planned surgical procedure (e.g., complete blood count, urinalysis, pregnancy test, pre-operative CXR, etc.)	Various	Federal State	

*Ohio BCCP pays for pre-operative testing that is conducted within one week of a planned procedure. Codes will be paid per Medicare Part B rates. If the code is not approved by Medicare, it is not payable by Ohio BCCP.

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CPT Code	Cervical Cancer Screening and Diagnostic Procedures	Rates	Funds	End Notes
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	$14.99	Federal State	
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	$42.22	Federal State	
88141	Cytopathology, cervical or vaginal, any reporting system, *requiring interpretation by physician*	$31.06	Federal State	
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	$22.51	Federal State	
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	$23.04	Federal State	
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	$25.37	Federal State	
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	$29.44	Federal State	
87624	Human Papillomavirus, high-risk types	$38.99	Federal State	9
87625	Human Papillomavirus, types 16 and 18 only	$40.55	Federal State	9
57452	Colposcopy of the cervix	F $91.74 G $112.56 H $20.82	Federal State	
57454	Colposcopy of the cervix, with biopsy and endocervical curettage	F $133.74 G $154.89 H $21.15	Federal State	
57455	Colposcopy of the cervix, with biopsy	F $109.85 G $145.55 H $35.70	Federal State	
57456	Colposcopy of the cervix, with endocervical curettage	F $102.10 G $136.80 H $34.70	Federal State	
57460	Colposcopy with loop electrode biopsy(s) of the cervix	F $160.93 G $283.87 H $122.94	Federal State	14
57461	Colposcopy with loop electrode conization of the cervix	F $186.08 G $320.26 H $134.18	Federal State	14
57500	Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	F $74.46 G $129.65 H $55.19	Federal State	
57505	Endocervical curettage (not done as part of a dilation and curettage)	F $94.95 G $109.49 H $14.54	Federal State	
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	F $279.24 G $316.92 H $37.68	Federal State	14
57522	Loop electrode excision procedure	F $243.11 G $269.88 H $26.77	Federal State	14
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	F $70.52 G $91.34 H $20.82	Federal State	
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	F $41.29 G $50.21 H $8.92	Federal State	

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CPT Code	Cervical Cancer Screening and Diagnostic Procedures	Rates	Funds	End Notes
88305	Surgical pathology, gross and microscopic examination	G $66.78 P $38.66 T $28.12	Federal State	
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	G $255.78 P $84.53 T $171.25	Federal State	
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	G $94.57 P $63.80 T $30.77	Federal State	
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)	G $51.73 P $31.54 T $20.19	Federal State	
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	G $101.66 P $36.20 T $65.47	Federal State	
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	G $88.29 P $29.14 T $59.16	Federal State	
99070	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)	$100	Federal State	
00940	Anesthesia for vaginal procedures. (See rates in Anesthesiology section below)	See section	State	
Various	Pre-operative testing; CBC, urinalysis, pregnancy test, etc. These procedures should be medically necessary for the planned surgical procedure.	Various	Federal State	

CPT Code	HPV Vaccine	Rates	Funds	End Notes
90651	HPV vaccine 9 valent IM	$173.70	State	15
90471	Vaccine Administration for the HPV vaccine only	$16.07	State	15

CPT Code	Conscious Sedation Anesthesia	Rate	Fund	End Note
99156	10-22 minutes	$79.44	Federal State	
99157	For each additional 15 minutes	$64.20	Federal State	11

CPT Code	ANESTHESIOLOGY	Rates	Modifiers AA, QZ	Modifiers QK, QY, AD, QX	End Notes
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3. Calculated at (Time units + Base units) x Rate.	$21.99	$21.99	$11.00	13
00940	Anesthesia for vaginal procedures. Medicare Base Units = 3 Calculated at (Time units + Base units) x Rate.	$21.99	$21.99	$11.00	13

MISCELLANEOUS		
Code	Description of Service	Rate
99070/ A4649 Surgical Supplies	This code is used to reimburse when procedures are performed in an outpatient setting. Allowable charges include surgical supplies and pharmacy supplies. A separate line item indicating surgical supplies, operating room supplies, or similar language should be noted on the bill received along with the CPT Code.	$100 for CPT codes: 10021, 19000, 19100, 19101, 19081-19086, 19120, 19125, 57460, 57461, 57520, 57522, 58100, 58110 and 58558. $50.00 for CPT Codes: 57452, 57454, 57455, 57456, 57500 and 57505.

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CPT Code	Procedures Specifically Not Allowed with Federal Funds	Rate	Fund	End Note
Any	Treatment of breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia and cervical cancer.	Not allowed		
77061	Breast tomosynthesis, unilateral		State	10, 12
77062	Breast tomosynthesis, bilateral		State	10, 12
87623	Human papillomavirus, low-risk types		State	12

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

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End Note	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 (99204–99205) are typically not appropriate for NBCCEDP screening visits but may be used when provider spends extra time to do a detailed risk assessment.
2	The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the NBCCEDP. While some programs may need to use 993XX- series codes, Preventive Medicine Evaluation visits are not appropriate for the NBCCEDP. The 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or belowthe 99213 rates.
3	List separately in addition to code for primary procedure 77067.
4	List separately in addition to 77065 or 77066.
5	Breast MRI can be reimbursed by the NBCCEDP 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 the NBCCEDP to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.
6	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.
7	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.
8	For CPT 10011 use the reimbursement rate for CPT code 10009. For CPT 10012 use the reimbursement rate for CPT code 10010.
9	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.
10	These procedures have not been approved for coverage by Medicare.
11	Example: If procedure is 50 minutes, code 99156 + (99157 x 2). No separate charge allowed if procedure <10 minutes.
12	Rates have been applied with State Funds only usage. Providers should limit the usage of these CPT Codes and use those approved by the NBCCEDP. These codes may be removed in future listings and not payable.
13	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 . Modifiers: Split billing between Physician and Nurse allowed with modifiers QK, QY or AD for physician and modifier QX for nurse.
14	A LEEP or conization of the cervix should only be reimbursed as a diagnostic procedure. These should not be covered for treatment purposes for clients with a biopsy confirmed diagnosis. Pre-authorization by the Ohio Department of Health program staff is required for diagnostic LEEPs or conizations.
15	HPV vaccine is approved for payment from state funds. This is to be on age appropriate clients for the vaccine based on guidelines. Currently this is approved for women age 21 – 26. BCCP will cover the three vaccines and the administration CPT codes. An office visit can be covered for the first vaccine, but not for the additional two vaccines.

F = Facility Rate – This is the rate the provider receives if the service is provided in a facility
G = Global Rate – This is the rate the provider receives if the service is provided in an office
H = Hospital/ACS Rate – This is the rate the hospital or ASC will receive if the provider was also paid for the service
P = Professional (26) Rate – For claims marked with Modifier 26
T = Technical (TC) Rate – For claims marked with Modifier TC, or hospital claims that have not made arrangements to receive Global Rates