Arkansas BreastCare
Billing Instructions

Administered by the
Arkansas Department of Health

September 2014

BREASTCARE BILLING INSTRUCTIONS CONTENTS

100 GETTING STARTED
- 110 Contacts
- 120 Supplies
- 130 Claim Submission and Payment
- 140 Claim Reversals

200 CHECKING CLIENT ELIGIBILITY
- 210 Using PES to Check Eligibility
- 220 Eligibility Verification Response
- 230 HP PES Response Report

300 BILLING BREASTCARE CLAIMS
- 310 Completing the BreastCare Claim Form

400 BREASTCARE PROCEDURE CODES
- 410 Surgical Procedures
- 420 Cervical Diagnostic/Surgical Procedures
- 430 Radiology Procedures
- 440 Laboratory Procedures
- 450 Pathology Procedures
- 460 Office Visits
- 470 Anesthesia for Breast & Cervical Procedure
- 480 Procedure Codes to Provider Types/Specialties/Diagnosis Codes

500 ADDITIONAL BILLING INFORMATION
- 510 Modifiers
- 520 Place of Service (POS) Codes
- 530 Result and Recommendation Reporting Procedures

600 REMITTANCE ADVICE/WEBRA
- 610 Report Heading
- 620 Paid Claims
- 630 Denied Claims
- 640 Claims in Process
- 650 Financial Items
- 660 AEVCS Transactions
- 670 Claims Payment Summary

700 ADJUSTMENT REQUEST FORM
- 710 Completing the Adjustment Request Form

800 CHECK REFUND FORM
- 810 Completing the Check Refund Form

900 TEAR-OUT FORMS AND CONTACT INFORMATION

100 GETTING STARTED

This manual describes the BreastCare program billing and payment process, explains the methods for submitting claims electronically or on paper, and lists the procedure codes and other elements required for submitting an accurate claim and ensuring timely payment. The manual also serves as a reference for the forms and documentation used by providers in the BreastCare program.

110 Contacts

For provider enrollment, please call Provider Enrollment at 1-800-462-0599, ext. 8236.

For questions regarding billing, please call HP at 1-855-661-7830 between 8:00 a.m. and 4:30 p.m. Do not call the Arkansas Department of Health with billing questions.

Mailing addresses:

Claims, Adjustments, and Refunds
HP Enterprise Services—BreastCare
P.O. Box 709
Little Rock, AR 72203

120 Supplies

For all supplies, including software and claim forms, please call 1-855-661-7830. Providers are encouraged to make copies of the forms in this manual to use in the billing process. See Section 900 of this manual.

Provider Electronic Solutions (PES) software is available at no cost for any provider who wants to submit BreastCare claims electronically. The software requires, at a minimum, a Pentium II processor with 64 MB RAM, a 28.8 kb/s (or greater) modem, 100 MB free space, a CD-ROM drive, a monitor with 800 x 600 resolution, and Windows 98/2000/XP. Claims can be transmitted for processing by almost any modem, with the exception of "Win voice" modems. Eligibility verifications are also part of the base software system. Instructions for using the PES software are available by using the application's Help feature.

130 Claim Submission and Payment

Providers submit BreastCare claims using the following methods:

1. Provider Electronic Solutions (PES) software
2. Internet-based claim submission
3. A paper claim form

The BreastCare program makes all payments for claims by electronic funds transfer (EFT). BreastCare mails a weekly Remittance Advice describing payment and the status of any claims not paid.

140 Claim Adjustments and Reversals

If you discover an error in a claim submitted using Provider Electronic Solutions (PES) software or the Internet, select a claim frequency code of 8 to cancel the claim. The reversal can be submitted up to one year from the date of service on the claim. After submitting the reversal, you will be given an accepted message indicating that the claim was reversed or rejected. The rejection will be described as: *matching data couldn't be found (keying error), the claim has already been reversed*, or *the reversal wasn't submitted in a timely manner*. To adjust a claim using the PES software or Internet, use the Claim Frequency code of 7 (replacement of claim).

200 CHECKING CLIENT ELIGIBILITY

Providers are encouraged to check the eligibility status of a client before providing services. A provider rendering services without verifying eligibility for BreastCare does so at the risk of not

being reimbursed for the services. An accepted eligibility verification ensures that claims will not deny due to client ineligibility. Each client has an ID card with initial dates of eligibility listed, but these may change over time.

Providers have three options to check eligibility:

1. Use the Provider Electronic Solutions (PES) software
2. Use the Internet billing application
3. Contact BreastCare Billing at 1-855-661-7830

210 Using PES to Check Eligibility

Complete the following fields for eligibility verification. Once the request is submitted, the system will respond with a verification report that can be printed.

Field Name	Field Completion
Transaction Type	Select Eligibility Verification for this type of transaction.
Date of Eligibility Request	Enter today's date.
Provider Number	Enter the Provider Number.
Patient ID #	Enter the client's BreastCare ID number (begins with 7777). If you don't know the ID number, enter the client's social security number, date of birth, or name (first, last, and middle initial).
From Date of Service	Enter the beginning date of service.
To Date of Service	Enter the ending date of service.

220 Eligibility Verification Response

A verification transaction is completed with a response from PES. The following information is listed in the top three sections of this report. The bottom four sections do not apply to the BreastCare program. Please print the report for your records.

Field Name	Field Description
Name	Client's first name, middle initial, and last name.
Date of Birth	Client's date of birth.
Sex	Client's gender.
Authorization Code	HP assigns a transaction code for each successful eligibility verification. This is not a Prior Authorization number and is not used on the claim.
Eligible From	The beginning and ending dates of eligibility for the client.
County of Residence	The county code where the client resides.
Aid Category	Client's aid category code: 53 or 55.

Field Name	Field Description
Description	Description of aid categories: 53 – BC State (Plan A) 55 – BC State/Federal (Plan C)
Patient ID	Client's BreastCare ID number (always begins with 7777).

230 HP PES Response Report

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                        270 Eligibility Request Response File

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P R O V I D E R   I N F O R M A T I O N

PROVIDER LAST NAME:      BREASTCARE PROVIDER
PROVIDER NPI:            770000000
- - - - - - - - - - - - - - - - - - - - - - - - -
R E C I P I E N T   I N F O R M A T I O N

ELIGIBILITY
AUTHORIZATION #:         113

TRACE:                   561265488630559684843205
RECIPIENT LAST NAME:     SMITH
RECIPIENT FIRST NAME:    SUE
RECIPIENT MI:            I
RECIPIENT ID:            777700000
RECIPIENT ACCOUNT #:     SMITH001
RECIPIENT DOB:           08/22/1945
RECIPIENT GENDER:        F FEMALE

- - - - - - - - - - - - - - - - - - - - - - - - -
E L I G I B I L I T Y    I N F O R M A T I O N

ELIGIBILITY/BENEFIT:     1 ACTIVE COVERAGE
PLAN DESCRIPTION:        53NONMED BCS
ELIGIBILITY PERIOD:      11/20/2002 - 9/08/2003
COUNTY                   79CALHOUN

ELIGIBILITY/BENEFIT:     L PRIMARY CARE PROVIDER
MESSAGE                  PCP REQUIRED / NONE
                         ASSIGNED
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300 BILLING BREASTCARE CLAIMS

While providers have options for submitting claims, the information needed on claims is the same. Refer to this section for required fields, field descriptions, and references to codes.

If you choose to submit paper claims instead of billing electronically, please forward the completed and signed form to:

HP Enterprise Services—BreastCare
P.O. Box 709
Little Rock, AR 72203

310 Completing the BreastCare Claim Form

Please follow these instructions for completing the BreastCare claim.

Field Name	Field # (on paper)	Field Completion
NPI	1.	Enter the 10-digit pay-to National Provider Identifier
Taxonomy code	1a.	Enter the pay-to 13-digit taxonomy code
Provider Name, Address and Zip code	1b.	Enter your first and last names, and your billing address including zip code.
Client Number	2.	Enter the 10-digit client ID number.
Client SSN	2a.	Enter client's Social Security number.
Client's Last Name	2b.	Enter the client's last name.
Client's First Name	2c.	Enter the client's first name.
Client's Street Address	2d.	Enter the client's home address.
Client's City, State, Zip Code	2e.	Enter the client's city, state, and Zip code.
Patient Account Number	3.	Enter a patient account number assigned by your office for client identification. There is space for 20 numerals or letters.
Primary Diagnosis	4.	Enter the primary diagnosis code from the ICD-9-CM.
Referring Provider	5.	Enter the referring provider's NPI.
Place of Service	6.	Enter the appropriate place of service code. See Section 520 for list.
Prior Authorization Number	7.	Enter the prior authorization number assigned by the AR Department of Health and Human Services, if applicable. Required for specific procedures.
TPL Indicator	8.	Enter Y for other insurance or N for no insurance.
TPL Paid Amount	8a.	Enter the amount paid by insurance company.
TPL Denial Date	8b.	Enter the denial date from the insurance EOB.
Hospital Admit Date	9.	Enter the date of the client's hospital admission, if applicable.
Facility Name and Address	10.	Name and address at which services were rendered.

Performing Provider	11A.	Enter the NPI of the person who performed this procedure. Enter the taxonomy code of the person who performed this procedure.
Dates of Service From and To	11B.	Enter the date the procedure was performed.
Place of Service	11C.	Enter the appropriate place of service code. See Section 520 for list.
Procedure Code	11D.	Enter the appropriate procedure code. See Section 400 for list.
Modifier	11E.	Enter the appropriate modifier. See Section 510 for list.
Diagnosis Code	11F.	Enter the appropriate diagnosis code. See the ICD-9-CM for codes.
Units	11G.	Enter the number of units of service provided for the procedure.
Charges	11H.	Enter the amount charged for the procedure. If billing more than one unit, enter the total amount for all units.
Result Code	11I.	Enter the appropriate result code for either breast or cervical procedures.
Recommendation Code	11J.	Enter the appropriate recommendation code for either breast or cervical procedures
Months for short-term follow-up	11K.	If the recommendation code is 2, enter 1 to 12 months.
Pap Smear Adequacy Code	11L.	1 = Satisfactory 2 = Unsatisfactory
Provider Signature and Date	12.	The provider or authorized representative must sign and date the claim certifying that all information given is true, accurate, and complete.

1. Billing Provider NPI	1a. Taxonomy Code	2. Client ID Number	2a. Client's SSN

1b. Provider' s Name, Address, Zip code	2b. Client's Last Name	2c. Client's First Name
	2d. Client's Street Address	
	2e. Client's City, State, Zip Code	

3. Patient Account Number	4. Primary Diagnosis	5. Referring Provider NPI	6. Place of Service	7. Prior Authorization Number	8. TPL Indicator (Y or N)	8a. Paid Amount	8b. Denial Date (MM DD YY)

9. Hospital Admit Date	10. Facility Name and Address

11. DETAIL 1	A. Performing Provider	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 2	A. Performing Provider	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 3	A. Performing Provider ID	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 4	A. Performing Provider ID	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11–L and sign.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

12. Provider Signature _____ Date _____

I certify that the information on both sides of this claim is true, accurate, and complete.

BREAST RESULT CODES

Screening & Diagnostic Mammography	Surgical/Treatment Consultation
0=Assessment is incomplete - Need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign - Short interval follow-up indicated 4=Suspicious Abnormality - Biopsy should be considered 5=Highly suggestive of malignancy - Appropriate action should be taken	19=No intervention at this time - routine follow-up 20=Short-term follow-up 21=Biopsy/FNA required

Ultrasound	Biopsy	Cyst Aspirate
15=Normal/no abnormality noted 16=Cystic mass 17=Suspicious for malignancy 18=Other benign abnormality	25=Hyperplasia 26=Other benign changes 28=Invasive breast cancer 29=Normal breast tissue 38=Ductal carcinoma in situ 39=Lobular carcinoma in situ	22=No fluid or tissue obtained 23=Non-suspicious 24=Suspicious for neoplasm

ADH RESULT/RECOMMENDATION CODE COMBINATIONS

For billing procedure codes 88141, 88142, 88148, 88150, 88175 and 88164, use the following combinations of result/recommendation codes:
Result Code 1 or 2=Recommendation Code 1
Result Code 3=Recommendation Code 2
Result Code 8=Recommendation Code 3
Result Code 4, 5, 6, 30, or 31=Recommendation Code 4

CERVICAL RESULT CODES

Colposcopy with Biopsy
1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3/CIS 18=Invasive squamous cell carcinoma 19=Other non-malignant abnormality - HPV, condyloma 31=Adenocarcinoma, NOS 32=Other malignant neoplasms

Colposcopy without Biopsy
1=Negative (WNL) 2=Inflammation/infection/HPV changes 8=Unsatisfactory 23=Other abnormality

Pap Smear Screenings
For ADH contracted cervical cytology lab, see the ADH table for result/ recommendation code combinations. 1=Negative (WNL) 2=Inflammation/infection/reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (include. HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 11=Atrophic atypia 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms

RECOMMENDATION CODES

Breast Recommendation Codes	Cervical Recommendation Codes
1=Follow routine screening 2=Short-term follow-up mammogram 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated	1=Follow routine screening 2=Short-term follow-up 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultation 8=Cryotherapy/Laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

PAP SMEAR ADEQUACY CODES

1=Satisfactory
2=Unsatisfactory

PLACE OF SERVICE (POS) CODES

POS Code=Description
11=Office
15=Mobile Unit
21=Inpatient Hospital
22=Outpatient Hospital
24=Ambulatory Surgical Center
50=Federally Qualified Health Center
72=Rural Health Clinic
81=Independent Laboratory
99=Other Place of Service

MODIFIERS

TC=Technical Component
26=Professional Component
Blank=Complete Component, Facility Setting, Inpatient and Outpatient Services

HP–BreastCare
PO Box 709
Little Rock, AR 72203

Refer to Section 520 for further descriptions

400 BREASTCARE PROCEDURE CODES

This section lists the procedure codes used for billing in the BreastCare program.

410 Surgical Procedures

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
10060	Incision and drainage of abcess, simple	A, C	4 per lifetime, 1 per DOS, 2 per year
10061	Incision and drainage of abcess, complicated	A, C	4 per lifetime, 1 per DOS, 2 per year
11400	Excision, benign, lesion, axilla, diameter 0.5cm or less	A, C	4 per year, 2 per DOS, 8 per lifetime
11401	Excision, benign, lesion, axilla, diameter 0.6cm – 1.0cm	A, C	4 per year, 2 per DOS, 8 per lifetime
11402	Excision, benign, lesion, axilla, diameter 1.1cm – 2.0cm	A, C	4 per year, 2 per DOS, 8 per lifetime
11403	Excision, benign, lesion, axilla, diameter 2.1cm – 3.0cm	A, C	4 per year, 2 per DOS, 8 per lifetime
11404	Excision, benign, lesion, axilla, diameter 3.1cm – 4.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
11406	Excision, benign, lesion, axilla, diameter over 4.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
11600	Excision, malignant, lesion, axilla, diameter 0.5 cm or less	A, C	4 per year, 2 per DOS, 4 per lifetime
11601	Excision, malignant lesion, axilla, diameter 0.6cm – 1.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
11602	Excision, malignant lesion, axilla, diameter 1.1cm – 2.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
11603	Excision, malignant lesion, axilla, diameter 2.1cm – 3.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
11604	Excision, malignant lesion, axilla, diameter 3.1cm – 4.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
11606	Excision, malignant lesion, axilla, diameter over 4.0cm	A, C	4 per year, 2 per DOS, 4 per lifetime
19000	Aspiration of cyst of breast	A, C	2 per year, 1 per DOS
19001	Aspiration of cyst of breast, each additional	A, C	2 per year, 1 per DOS
19081	Breast biopsy with placement of localization, device, stereotactic guidance; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19082	Breast biopsy with placement of localization device; stereotactic guidance, each addition lesion lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19083	Breast biopsy with placement of localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19084	Breast biopsy with placement of localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19085	Breast biopsy with placement of localization device; magnetic resonance guidance, first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
19086	Breast biopsy with placement of localization device; magnetic resonance guidance; each additional lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19100	Biopsy of breast; needle core (surgical procedure only)	A, C	4 per year, 2 per DOS
19101	Incisional biopsy of breast	A, C	Professional – 4 per year, 2 per DOS; Hospital – 2 per year, 1 per DOS
19102	Percutaneous, needle core with image guidance **(no longer payable as of 09/15/14)**	A, C	2 per year, 2 per DOS
19103	Percutaneous, automated vacuum assisted or rotating biopsy device using imaging guidance **(no longer payable as of 09/15/14)**	A, C	2 per year, 2 per DOS
19110	Nipple Excision (effective 01/01/09)	A, C	4 per year, 2 per DOS
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	A, C	Professional – 4 per year, 2 per DOS; Hospital – 2 per year, 1 per DOS
19125	Excision of breast lesion identified by preoperative placement of radiological marker	A, C	4 per year, 2 per DOS

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
19126	Excision of breast lesion identified by preoperative placement of radiological marker; each additional marker	A, C	4 per year, 2 per DOS
19281	Placement of breast localization device; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19282	Placement of breast localization device; each additional lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19283	Placement of breast localization device; stereotactic guidance; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19284	Placement of breast localization device; stereotactic guidance; each addition lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19285	Placement of breast localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19286	Placement of breast localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19287	Placement of breast localization device; magnetic resonance guidance; first lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19288	Placement of breast localization device; magnetic resonance guidance; each additional lesion **(effective 04/01/14)**	A,C	4 per year, 2 per DOS
19290	Preoperative placement of needle localization wire, breast **(no longer payable as of 09/15/14)**	A, C	4 per year, 2 per DOS

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
19291	Preoperative placement of needle localization wire, breast, each additional **(no longer payable as of 09/15/14)**	A, C	4 per year, 2 per DOS
19295	Image guided placement, metallic localization clip, percutaneous during breast biopsy (**(no longer payable as of 09/15/14)**	A, C	4 per year, 2 per DOS, 8 per lifetime
38500	Biopsy or excision of lymph node(s); open, superficial	A, C	4 per year, 2 per DOS, 8 per lifetime
38525	Biopsy or excision of lymph node(s); open, deep axillary nodes	A, C	4 per year, 2 per DOS, 8 per lifetime

420 Cervical Diagnostic/Surgical Procedures

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
57105	Vaginal Biopsy (effective 01/01/08)	A, C	2 per year, 1 per DOS, 5 per lifetime
57420	Colposcopy for entire vagina & cervix, if present	A, C	2 per year, 1 per DOS, 5 per lifetime
57421	Colposcopy with biopsy of vagina/cervix	A, C	2 per year, 1 per DOS, 5 per lifetime
57452	Colposcopy without biopsy	A, C	4 per year, 1 per DOS
57454	Colposcopy with biopsy and endocervical curettage	A, C	4 per year, 1 per DOS
57455	Colposcopy with biopsy of cervix	A, C	2 per year, 1 per DOS, 5 per lifetime

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
57456	Colposcopy with endocervical curettage	A, C	2 per year, 1 per DOS, 5 per lifetime
57460	Colposcopy with loop electrode biopsy of cervix (PA required for physician services)	A, C	2 per year, 1 per DOS, 2 per lifetime
57461	Colposcopy with loop electrode conization of cervix (PA required for physician services)	A, C	2 per year, 1 per DOS, 2 per lifetime
57500	Biopsy or local excision of lesion	A, C	2 per year, 1 per DOS, 2 per lifetime
57505	Endocervical curettage	A, C	2 per year, 1 per DOS, 5 per lifetime
57520	Conization of cervix (PA required for physician services)	A, C	2 per year, 1 per DOS, 2 per lifetime
57522	Loop electrode excision (PA required for physician services)	A, C	2 per year, 1 per DOS, 2 per lifetime
58100	Endometrial biopsy	A, C	2 per year, 1 per DOS, 5 per lifetime
58110	Endometrial sampling, biopsy	A, C	2 per year, 1 per DOS, 5 per lifetime

430 Radiology Procedures

71010	Single view chest x-ray **– (no longer payable as of 01/01/14)**	A, C	2 per year, 1 per DOS, 4 per lifetime
71020	Chest X-ray – **(no longer payable as of 01/01/14)**	A, C	2 per year, 1 per DOS, 4 per lifetime
G0202	Digital Screening Mammogram	A, C	1 per year, 1 per DOS
G0204	Digital Diagnostic Mammogram,	A, C	3 per year, 1 per

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
	bilateral		DOS
G0206	Digital Diagnostic Mammogram, unilateral	A, C	3 per year, 1 per DOS
G0461	Immunohistochemistry or immunocytochemistry, per specimen, first stain **(replaces 88342 effective 04/01/14)**	A,C	6 per year, 3 per DOS, 12 per lifetime
G0462	Immunohistochemistry or immunocytochemistry, per specimen, each additional stain **(replaces 88342 effective 04/01/14)**	A,C	6 per year, 3 per DOS, 12 per lifetime
77051	Computer-aided detection for diagnostic mammography (replaced 76082 01/01/07)	A, C (state funds)	3 per year, 1 per DOS
77052	Computer-aided detection for screening mammography (replaced 76083 01/01/07)	A, C (state funds)	1 per year, 1 per DOS
77053	Mammary ductogram or galactogram, single duct **(effective 04/01/14)**	A,C	1 per year, 1 per DOS
77055	Diagnostic/Follow-up mammogram; unilateral (replaced 76090 01/01/07)	A, C	3 per year, 1 per DOS
77056	Diagnostic/Follow-up mammogram; bilateral (replaced 76091 01/01/07)	A, C	3 per year, 1 per DOS
77057	Screening mammogram (replaced 76092 01/01/07)	A, C	1 per year, 1 per DOS
77058	Magnetic Resonance Imaging (MRI), breast, with or without contrast, unilateral **(effective 04/01/14)**	A,C	1 per year, 1 per DOS
77059	Magnetic Resonance Imaging (MRI), breast, with or without contrast,	A,C	1 per year, 1 per

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
	bilateral **(effective 04/01/14)**		DOS
77031	Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation **(no longer payable as of 09/15/14)**	A, C	2 per year, 2 per DOS
77032	Preoperative placement of needle localization wire, breast, radiological supervision and interpretation **(no longer payable as of 09/15/14)**	A, C	4 per year, 2 per DOS
76098	Radiological examination, surgical specimen	A, C	4 per year, 2 per DOS
76645	Ultrasound – Echography, breast (unilateral or bilateral), real time with image documentation	A, C	4 per year, 2 per DOS
76942	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	A, C	4 per year, 2 per DOS
76998	Ultrasound guided localization, intraoperative guidance **(effective 04/01/13)**	A, C	4 per year, 2 per DOS

440 Laboratory Procedures

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
80048	Basic Metabolic Panel **(effective 08/01/14)**	A, C	3 per year, 1 per DOS
80053	Comprehensive Metabolic Panel	A, C	2 per year, 1 per DOS, 4 per lifetime
80076	Hepatic Function Panel	A, C	2 per year, 1 per DOS, 4 per lifetime

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
81025	Urine Pregnancy test **(effective 01/01/13)**	A, C	2 per year, 1 per DOS
85025	Blood Count, Complete CBC	A, C	16 per year, 1 per DOS, 32 per lifetime
85027	Hemogram and platelet count, automated	A, C	16 per year, 1 per DOS, 32 per lifetime

450 Pathology Procedures

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
87070	Culture, aerobic	A, C	4 per lifetime, 1 per DOS, 2 per year
87075	Culture, anaerobic	A, C	4 per lifetime, 1 per DOS, 2 per year
87205	Smear, primary source with interpretation gram or griemsa stain for bacteria fungi or cell types	A, C	4 per lifetime, 1 per DOS, 2 per year
87621	High Risk HPV DNA Test (effective 07/01/07)	A, C	1 per year, 1 per DOS
88112	Cytopathology, enhancement technique with interpretation	A, C	6 per year, 3 per DOS
88108	Cytopathology, concentration technique, smears and interpretation	A, C	2 per year, 1 per DOS, 4 per lifetime
88141	Pap smear, reported in Bethesda system	A, C	3 per year, 1 per DOS

88142	Automated thin preparation	A, C	3 per year, 1 per DOS
88148	Screening by automated system with manual re-screening	A, C	3 per year, 1 per DOS
88150	Pap smear screening	A, C	3 per year, 1 per DOS
88160	Cytopathology, smears, any other source, screening and interpretation	A, C	2 per year, 1 per DOS, 4 per lifetime
88164	Manual screening under physician supervision	A, C	3 per year, 1 per DOS
88165	Manual screening and rescreening under physician supervision **(effective 04/01/14)**	A,C	3 per year, 1 per DOS
88173	Interpretation of Fine Needle Aspirate	A, C	2 per year, 1 per DOS
88175	Computerized Thin Prep	A, C	3 per year, 1 per DOS
88304	Surgical Pathology Level III	A, C	8 per year, 4 per DOS
88305	Surgical Pathology Level IV	A, C	8 per year, 4 per DOS
88307	Surgical Pathology Level V (cervical only)	A, C	2 per year, 1 per DOS, 2 per lifetime
88309	Surgical Pathology Level VI (cervical only)	A, C	2 per year, 1 per DOS, 2 per lifetime
88321	Slide Consult	A, C	3 per year, 1 per DOS
88329	OR Consult	A, C	2 per year, 1 per DOS, 4 per lifetime
88331	Frozen Section Pathology	A, C	4 per year, 2 per DOS, 8 per lifetime

88332	Frozen Section Pathology, Additional	A, C	4 per year, 2 per DOS, 8 per lifetime
88342	Immunohistochemistry (including tissue immunoperoxidase) each antibody (breast or cervical only) **(no longer payable as of 04/01/14- new code G0461 or G0462)**	A, C	6 per year, 3 per DOS, 12 per lifetime

460 Office Visits/Consultation Visits

Please note that an combination of the NEW codes apply to the benefit limit and a combination of the Established codes apply to the benefit limit. The benefit limit does not apply to each code.

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
99203, 99204, 99205	New office consultations	A, C	2 per year, 2 per DOS
99212	Established Patient, follow-up office visit	A, C	3 per year, 1 per DOS
99213, 99214, 99215	Established patient office visit	A, C	3 per year, 1 per DOS

470 Anesthesia for Breast Procedure

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits
00400	Breast biopsy/excision of axillary lesion/Node biopsy	A, C	2 per year, 1 per DOS, 2 per lifetime
00940	Anesthesia for vaginal procedures (57420, 57460, 57461, 57520, 57522)	A, C	2 per year, 1 per DOS, 2 per lifetime
01610	Excision of lymph nodes, anesthesia	A, C	2 per year, 1 per DOS, 2 per lifetime

Procedure Code	Procedure Code Description	Plan Code	Benefit Limits

480 Procedure Codes to Provider Types/Specialties/Diagnosis Codes

If a BreastCare enrollee has a biopsy diagnosis of breast or cervical cancer, CIN II, CIN III, or carcinoma-in-situ and is also a Medicaid recipient, all treatment procedures must be billed to Medicaid according to Medicaid's guidelines.

Effective January 21, 2010, BreastCare no longer covers treatment with state funds.

Refer all clients enrolled in BreastCare and are diagnosed with breast or cervical cancer to your Regional BreastCare Care Coordinator.

The diagnosing or treatment provider must call the Medicaid Case Manager at 501-661-2513 to refer patients who are not enrolled in the BreastCare program and are diagnosed with breast or cervical cancer or CIN II/III. Calls will not be accepted from the patient. After the provider calls confirming a diagnosis, the Medicaid Case Manager will contact the patient and complete the Medicaid application.

Procedure Code	Old Type of Service Code	New MOD	Procedure Code Description	Provider Types	Provider Specialties	Diagnosis Codes	Plan Code
SURGICAL PROCEDURES							
*10060	P	26	Incision and drainage of abcess, simple (effective 01/01/07)	01, 02, 49, 68	02, 30, 08, F2, 11, 16	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10060	9		Incision and drainage of abcess, simple (effective 01/01/07)	01, 02, 49, 68	02, 30, 08, F2, 11, 16	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10060	G		Incision and drainage of abcess, simple (effective 01/01/07)	28, 05	A4, W6, W7	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10060	2		Incision and drainage of abcess, simple (effective 01/01/07)	28, 05	A4, W6, W7	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10061	P	26	Incision and drainage of abcess, complicated (effective 01/01/07)	01, 02, 49, 68	02, 30, 08, F2, 11, 16	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81,	A, C

						793.89	
*10061	9		Incision and drainage of abcess, complicated (effective 01/01/07)	01, 02, 49, 68	02, 30, 08, F2, 11, 16	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10061	G		Incision and drainage of abcess, complicated (effective 01/01/07)	28, 05	A4, W6, W7	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*10061	2		Incision and drainage of abcess, complicated (effective 01/01/07)	28, 05	A4, W6, W7	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
11400	P	26	Excision, benign, lesion, axilla, diameter 0.5cm or less	01, 03	02, 08, 16		A, C
11400	9		Excision, benign, lesion, axilla, diameter 0.5cm or less	01, 03	02, 08, 16		A, C
11401	P	26	Excision, benign, lesion, axilla, diameter 0.6cm - 1.0cm	01, 03	02, 08, 16		A, C
11401	9		Excision, benign, lesion, axilla, diameter 0.6cm - 1.0cm	01, 03	02, 08, 16		A, C
11402	P	26	Excision, benign, lesion, axilla, diameter 1.1cm - 2.0cm	01, 03	02, 08, 16		A, C
11402	9		Excision, benign, lesion, axilla, diameter 1.1cm - 2.0cm	01, 03	02, 08, 16		A, C
11403	P	26	Excision, benign, lesion, axilla, diameter 2.1cm - 3.0cm	01, 03	02, 08, 16		A, C
11403	9		Excision, benign, lesion, axilla, diameter 2.1cm - 3.0cm	01, 03	02, 08, 16		A, C
11404	P	26	Excision, benign, lesion, axilla, diameter 3.1cm - 4.0cm	01, 03	02, 08, 16		A, C
11404	9		Excision, benign, lesion, axilla, diameter 3.1cm - 4.0cm	01, 03	02, 08, 16		A, C
11404	G		Excision, benign, lesion, axilla, diameter 3.1cm - 4.0cm	05, 28	W7, A4		A, C
11406	P	26	Excision, benign, lesion, axilla, diameter over 4.0cm	01, 03	02, 08, 16		A, C
11406	9		Excision, benign, lesion, axilla, diameter over 4.0cm	01, 03	02, 08, 16		A, C
11406	G		Excision, benign, lesion, axilla, diameter over 4.0cm	05, 28	W7, A4		A, C

*19000	P	26	Aspiration of cyst of breast	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19000	9		Aspiration of cyst of breast	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19001	P	26	Aspiration of cyst of breast, each additional	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19001	9		Aspiration of cyst of breast, each additional	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19081	P	26	Breast biopsy with placement of localization, device, stereotactic guidance; first lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19081	9		Breast biopsy with placement of localization, device, stereotactic guidance; first lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19082	P	26	Breast biopsy with placement of localization device; stereotactic guidance, each addition lesion lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19082	9		Breast biopsy with placement of localization device; stereotactic guidance, each addition lesion lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19083	P	26	Breast biopsy with placement of localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19083	9		Breast biopsy with placement of localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19084	P	26	Breast biopsy with placement of localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19084	9		Breast biopsy with placement of localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19085	P	26	Breast biopsy with placement of localization device; magnetic resonance guidance, first lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19085	9		Breast biopsy with placement of localization device; magnetic resonance guidance, first	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6,	A,C

			lesion **(effective 04/01/14)**			793.80, 793.81, 793.89,	
*19086	P	26	Breast biopsy with placement of localization device; magnetic resonance guidance, each additional lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19086	9		Breast biopsy with placement of localization device; magnetic resonance guidance, each additional lesion **(effective 04/01/14)**	01, 03, 49, 68	F2, 02, 08, 11, 16, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89,	A,C
*19100	P	26	Biopsy of breast; needle core (surgical procedure only)	01, 03	02, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19100	9		Biopsy of breast; needle core (surgical procedure only)	01, 03	02, 30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19101	G		Incisional biopsy of breast	05, 28	A4, W7	217, 610.0, 610.1, 610.4, 610.8, 6101, 610.2, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19101	P	26	Incisional biopsy of breast	01, 03	02, 30	217, 610.0, 610.1, 610.4, 610.8, 6101, 610.2, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19101	9		Incisional biopsy of breast	01, 03	02, 30	217, 610.0, 610.1, 610.4, 610.8, 6101, 610.2, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19102	P	26	Percutaneous, needle core with image guidance **(no longer payable as of 09/15/14)**	01,03	02,30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19102	9		Percutaneous, needle core with image guidance **(no longer payable as of 09/15/14)**	01,03	02,30	217, 610.0, 610.1, 610.4, 610.8, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19102	G		Percutaneous, needle core with image guidance **(no longer payable as of 09/15/14)**	05, 28	A4, W7	217, 610.0, 610.1, 610.4, 610.89, 611.72, 611.79, 611.0, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
*19103	P	26	Percutaneous, automated vacuum assisted or rotating biopsy device using imaging guidance **(no longer payable as of 09/15/14)**	01,03	02,30	217, 610.0, 610.1, 610.4, 610.89, 611.72, 611.79, 611.0, 611.8, 785.6, 793.80, 793.81, 793.89	A, C

*19103	9		Percutaneous, automated vacuum assisted or rotating biopsy device using imaging guidance **(no longer payable as of 09/15/14)**	01,03	02,30	217, 610.0, 610.1, 610.4, 610.89, 611.72, 611.79, 611.0, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
*19103	G		Percutaneous, automated vacuum assisted or rotating biopsy device using imaging guidance **(no longer payable as of 09/15/14)**	05, 28	A4, W7	217, 610.0, 610.1, 610.4, 610.89, 611.72, 611.79, 611.0, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
19110	G		Nipple Excision (effective 01/01/09)	05, 28	W6, W7, A4		A, C
19110	P	26	Nipple Excision (effective 01/01/09)	01, 03	02		A, C
19110	9		Nipple Excision (effective 01/01/09)	01, 03	02		A, C
*19120	G		Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	05, 28	A4, W7	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19120	P	26	Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19120	9		Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19125	G		Excision of breast lesion identified by preoperative placement of radiological marker	05, 28	A4, W7	214.1, 214.8, 217, 610.0, 610.1, 610.4, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19125	P	26	Excision of breast lesion identified by preoperative placement of radiological marker	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.4, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19125	9		Excision of breast lesion identified by preoperative placement of radiological marker	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.4, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C

*19126	P	26	Excision of breast lesion identified by preoperative placement of radiological marker; each additional marker	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.4, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*19281	P	26	Placement of breast localization device; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19281	9		Placement of breast localization device; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19282	P	26	Placement of breast localization device; each additional lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19282	9		Placement of breast localization device; each additional lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19283	P	26	Placement of breast localization device; stereotactic guidance; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19283	9		Placement of breast localization device; stereotactic guidance; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19284	P	26	Placement of breast localization device; stereotactic guidance; each addition lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19284	9		Placement of breast localization device; stereotactic guidance; each addition lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19285	P	26	Placement of breast localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19285	9		Placement of breast localization device; ultrasound guidance; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19286	P	26	Placement of breast localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19286	9		Placement of breast localization device; ultrasound guidance; each addition lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19287	P	26	Placement of breast localization device; magnetic resonance guidance; first lesion	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80,	A,C

			(effective 04/01/14)			793.81, 793.89	
*19287	9		Placement of breast localization device; magnetic resonance guidance; first lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19288	P	26	Placement of breast localization device; magnetic resonance guidance; each additional lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19288	9		Placement of breast localization device; magnetic resonance guidance; each additional lesion **(effective 04/01/14)**	01, 03	02, 30	610.1, 610.1, 610.4, 611.72, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A,C
*19290	P	26	Preoperative placement of needle localization wire, breast **(no longer payable as of 09/15/14)**	01, 03	30, 02	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19290	9		Preoperative placement of needle localization wire, breast **(no longer payable as of 09/15/14)**	01, 03	30, 02	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19291	P	26	Preoperative placement of needle localization wire, breast, each additional **(no longer payable as of 09/15/14)**	01, 03	30, 02	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19291	9		Preoperative placement of needle localization wire, breast, each additional **(no longer payable as of 09/15/14)**	01, 03	30, 02	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19295	P	26	Image guided placement, metallic localization clip, percutaneous during breast biopsy **(no longer payable as of 09/15/14)**	01, 03	02, 30	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*19295	9		Image guided placement, metallic localization clip, percutaneous during breast biopsy **(no longer payable as of 09/15/14)**	01, 03	02, 30	610.0, 610.1, 611.72, 610.4, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*38500	P	26	Biopsy or excision of lymph node(s); open, superficial (effective 03/05/12)	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*38500	G		Biopsy or excision of lymph node(s); open, superficial (effective 03/05/12)	05, 28	W7, A4	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
*38525	P	26	Biopsy or excision of lymph node(s); open, deep axillary nodes (effective 03/05/12)	01, 03	02	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C

*38525	G		Biopsy or excision of lymph node(s); open, deep axillary nodes (effective 03/05/12)	05, 28	W7, A4	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
CERVICAL DIAGNOSTIC/SURGICAL							
*57105	P	26	Vaginal Biopsy (effective 01/01/08)	01, 03, 49, 58, 68	F2, 08, 16, N3, 02	219.0, 622.10, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57105	9		Vaginal Biopsy (effective 01/01/08)	01, 03, 49, 58, 68	F2, 08, 16, N3, 02	219.0, 622.10, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57420	P	26	Colposcopy for entire vagina & cervix, if present (effective 01/01/09)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57420	9		Colposcopy for entire vagina & cervix, if present (effective 01/01/09)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57421	P	26	Colposcopy with biopsy of vagina/cervix (effective 01/01/07)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57421	9		Colposcopy with biopsy of vagina/cervix (effective 01/01/07)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57452	P	26	Colposcopy without biopsy	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57452	9		Colposcopy without biopsy	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57454	P	26	Colposcopy with biopsy and endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57454	9		Colposcopy with biopsy and endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57455	P	26	Colposcopy with biopsy of cervix	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C

*57455	9		Colposcopy with biopsy of cervix	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57456	P	26	Colposcopy with endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57456	9		Colposcopy with endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57460	P	26	Colposcopy with loop electrode biopsy of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03. 795.04. 795.05, 795.06	A, C
*57460	9		Colposcopy with loop electrode biopsy of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03. 795.04. 795.05, 795.06	A, C
*57460	G		Colposcopy with loop electrode biopsy of cervix	05,28	W7,A4	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03. 795.04. 795.05, 795.06	A, C
*57460	2		Colposcopy with loop electrode biopsy of cervix	05	W6	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03. 795.04. 795.05, 795.06	A, C
*57461	P	26	Colposcopy with loop electrode conization of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57461	9		Colposcopy with loop electrode conization of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57461	G		Colposcopy with loop electrode conization of cervix	05,28	W7,A4	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57461	2		Colposcopy with loop electrode conization of cervix	05	W6	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57500	P	26	Biopsy or local excision of lesion	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 622.7, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57500	9		Biopsy or local excision of lesion	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 622.7, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C

*57500	G		Biopsy or local excision of lesion	05, 28	W7, A4	219.0, 622.10, 622.11, 622.7, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57500	2		Biopsy or local excision of lesion	05	W6	219.0, 622.10, 622.11, 622.7, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57505	P	26	Endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3, 02	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57505	9		Endocervical curretage	01, 03, 49, 58, 68	F2, 08, 16, N3, 02	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57520	P	26	Conization of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57520	9		Conization of cervix (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57520	G		Conization of cervix	05, 28	W7, A4	219.0, 622.10, 622.11, 622.12, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57520	2		Conization of cervix	05	W6	219.0, 622.10, 622.11, 622.12, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57522	P	26	Loop electrode excision (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57522	9		Loop electrode excision (PA required)	01, 03, 49, 68	16, 02, 08, F2	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57522	G		Loop electrode excision	05, 28	W7, A4	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*57522	2		Loop electrode excision	05	W6	219.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*58100	P	26	Endometrial Biopsy	01, 03, 49, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.2, 627.1, 626.8, 626.9, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C

*58100	9		Endometrial Biopsy	01, 03, 49, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.2, 627.1, 626.8, 626.9, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*58110	P	26	Endometrial sampling, biopsy, performed in conjunction with colposcopy (effective 01/01/07)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.2, 627.1, 626.8, 626.9, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
*58110	9		Endometrial sampling, biopsy, performed in conjunction with colposcopy (effective 01/01/07)	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 625.8, 626.2, 627.1, 626.8, 626.9, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
RADIOLOGY PROCEDURES							
*71010	T	TC	Single view chest X-ray – **(No longer payable as of 01/01/14)**	05, 49, 68, 10, 01, 03	W7, F2, 08, 02, X1, R9	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C
*71010	P	26	Single view chest X-ray- **(No longer payable as of 01/01/14)**	01, 02, 03, 49, 68	08, 30, 02, X1, 31	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C
*71010	C		Single view chest X-ray - **(No longer payable as of 01/01/14)**	01, 03, 68, 05, 49, 10	08, 02, X1, W7, F2, 63	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C
*71020	T	TC	Chest X-Ray - **(No longer payable as of 01/01/14)**	05, 49, 68, 10, 01, 03	W7, F2, 08, 02, X1, R9, 11, 16	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C
*71020	P	26	Chest X-Ray - **(No longer payable as of 01/01/14)**	01, 03, 49, 68	08, 30, 02, X1, 31, 11, 16	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C

*71020	C		Chest X-Ray - **(No longer payable as of 01/01/14)**	01, 03, 68, 05, 49, 10	08, 02, X1, W7, F2, 63, 11, 16	219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 795.00, 795.02, 795.05, 785.6, 793.80, 793.81, 793.89	A, C
G0202	C		Digital Screening Mammogram	01, 03, 05, 68	W7, 08, 30, 63		A, C
G0202	P	26	Digital Screening Mammogram	01, 03	30		A, C
G0202	T	TC	Digital Screening Mammogram	01, 03, 05, 10, 68	08, W7, 63		A, C
G0204	C		Digital Diagnostic Mammogram bilateral	01, 03, 05, 68	W7, 08, 30, 63		A, C
G0204	P	26	Digital Diagnostic Mammogram bilateral	01, 03	30		A, C
G0204	T	TC	Digital Diagnostic Mammogram bilateral	01, 03, 05, 10, 68	08, W7, 63		A, C
G0206	C		Digital Diagnostic Mammogram unilateral	01, 03 05, 68	W7, 08, 30, 63		A, C
G0206	P	26	Digital Diagnostic Mammogram unilateral	01, 03	30		A, C
G0206	T	TC	Digital Diagnostic Mammogram unilateral	01, 03, 05, 10, 68	08, W7, 63		A, C
77051	C		Computer-aided detection for diagnostic mammography (replaces 76082 01/01/07)	01, 03, 05, 68	W7, 08, 30, 63		A, C
77051	P	26	Computer-aided detection for diagnostic mammography (replaces 76082 01/01/07)	01, 03	30		A, C
77051	T	TC	Computer-aided detection for diagnostic mammography (replaces 76082 01/01/07)	01, 03, 05, 10, 68	08, W7, 63		A, C
77053	C		Mammary ductogram or galactogram, single duct **(effective 04/01/14)**	01, 03, 05, 10	30, W6, W7, 63		A, C
77053	P	26	Mammary ductogram or galactogram, single duct **(effective 04/01/14)**	01, 03, 05, 10	30, W6, W7, 63		A, C
77053	T	TC	Mammary ductogram or galactogram, single duct **(effective 04/01/14)**	05, 10	W6, W7, 63		A, C
77058	C		Magnetic Resonance Imaging (MRI), breast, with or without contrast, unilateral **(effective**	01, 03, 05, 10	30, W6, W7, 63		A, C

			04/01/14)				
77058	P	26	Magnetic Resonance Imaging (MRI), breast, with or without contrast, unilateral **(effective 04/01/14)**	01, 03	30		A, C
77058	T	TC	Magnetic Resonance Imaging (MRI), breast, with or without contrast, unilateral **(effective 04/01/14)**	05, 10	W6, W7, 63		A, C
77059	C		Magnetic Resonance Imaging (MRI), breast, with or without contrast, bilateral **(effective 04/01/14)**	01, 03, 05, 10	30, W6, W7, 63		A, C
77059	P	26	Magnetic Resonance Imaging (MRI), breast, with or without contrast, bilateral **(effective 04/01/14)**	01, 03	30		A, C
77059	T	TC	Magnetic Resonance Imaging (MRI), breast, with or without contrast, bilateral **(effective 04/01/14)**	05, 10	W6, W7, 63		A, C
77055	C		Diagnostic/Follow-up mammogram; unilateral (replaces 76090 01/01/07)	01, 03, 05, 68	W7, 08, 30, 63		A, C
77055	P	26	Diagnostic/Follow-up mammogram; unilateral (replaces 76090 01/01/07)	01, 03	30, 02		A, C
77055	T	TC	Diagnostic/Follow-up mammogram; unilateral (replaces 76090 01/01/07)	01, 03, 05, 10, 68	08, W7, 63		A, C
77056	C		Diagnostic/Follow-up mammogram; bilateral (replaces 76091 01/01/07)	01, 03, 05, 68	W7, 08, 30, 63		A, C
77056	P	26	Diagnostic/Follow-up mammogram; bilateral (replaces 76091 01/01/07)	01, 03	30, 02		A, C
77056	T	TC	Diagnostic/Follow-up mammogram; bilateral (replaces 76091 01/01/07)	01, 03, 05, 10, 68	08, W7, 63		A, C
77057	C		Screening mammogram (replaces 76092 01/01/07)	01, 03, 05, 68	W7, 08, 30, 63		A, C
77057	P	26	Screening mammogram (replaces 76092 01/01/07)	01, 03	30		A, C
77057	T	TC	Screening mammogram (replaces 76092 01/01/07)	01, 03, 05, 10, 68	08, W7, 63		A, C
77052	C		Computer-aided detection for screening mammography (replaces 76083 01/01/07)	01, 03, 05, 68	W7, 08, 30, 63		A, C

77052	P	26	Computer-aided detection for screening mammography (replaces 76083 01/01/07)	01, 03	30		A, C
77052	T	TC	Computer-aided detection for screening mammography (replaces 76083 01/01/07)	01, 03, 05, 10, 68	08, W7, 63		A, C
77031	C		Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation (replaces 76095 01/01/07)	01, 03, 05	W7, 08, 30, 63, 02		A, C
77031	P	26	Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation (replaces 76095 01/01/07)	01, 03	02, 30		A, C
77031	T	TC	Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation (replaces 76095 01/01/07)	05, 10, 28	A4, W7, 63		A, C
77032	C		Preoperative placement of needle localization wire, breast, radiological supervision and interpretation (replaces 76096 01/01/07)	01, 03, 05	30, W7, 63, 02		A, C
77032	P	26	Preoperative placement of needle localization wire, breast, radiological supervision and interpretation (replaces 76096 01/01/07)	01, 03	30, 02		A, C
77032	T	TC	Preoperative placement of needle localization wire, breast, radiological supervision and interpretation (replaces 76096 01/01/07)	05, 10, 28	A4, W7, 63		A, C
76098	C		Radiological examination, surgical specimen	01, 03, 05	W7, 08, 30, 63		A, C
76098	P	26	Radiological examination, surgical specimen	01, 03	02, 30		A, C
76098	T	TC	Radiological examination, surgical specimen	05, 10, 28	A4, W7, 63		A, C
76645	C		Ultrasound – Echography, breast (unilateral or bilateral), real time with image documentation	01, 03, 05, 68	W7, 08, 30, 02, 63		A, C
76645	P	26	Ultrasound – Echography, breast (unilateral or bilateral), real time with image documentation	01, 03	02, 30		A, C
76645	T	TC	Ultrasound – Echography, breast (unilateral or bilateral), real time with image documentation	01, 03, 05, 10, 28	08, W7, 63, A4, 02		A, C
76942	C		Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	01, 03, 05	02, 30, W7, 63		A, C
76942	P	26	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	01, 03	02, 30		A, C

76942	T	TC	Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	05, 10, 28	A4, W7, 63		A, C
76998	P	26	Ultrasound guided localization, intraoperative guidance **(added effective 04/01/13)**	01, 03,05, 10	02, 30, W7, 63		A, C
LABORATORY PROCEDURES							
*80048	T	TC	Basic Metabolic Panel	01, 03, 05, 09, 28, 49, 68,	01, 11, 16, 02, X1, 31, F2, W6, W7, 69, A4	214.1, 214.8, 217, 219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.05	A, C
*80053	T	TC	Comprehensive Metabolic Panel	01, 03, 05, 10, 49, 68	08, 02, X1, W7, F2, 11, 16	214.1, 214.8, 217, 219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.05	A, C
*80076	T	TC	Hepatic Function Panel	01, 03, 05, 10, 49, 68	08, 02, X1, W7, F2, 11, 16	214.1, 214.8, 217, 219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.05	A, C
*81025	T	TC	Urine pregnancy test **(effective 01/01/03)**	01, 03, 49, 58, 68	F2, 08, 16, N3	219.0, 622.10, 622.11, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06, 795.09	A, C

*85025	T	TC	Blood Count, Complete CBC	01, 03, 05, 10, 49, 68	08, 02, X1, W7, F2, 11, 16	214.1, 214.8, 217, 219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.05	A, C
*85027	T	TC	Hemogram and platelet count, automated	01, 03, 05, 10, 49, 68	08, 02, X1, W7, F2, 11, 16	214.1, 214.8, 217, 219.0, 610.0, 611.72, 611.0, 622.10, 622.11, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.05	A, C
PATHOLOGY							
*87070	T	TC	Culture, aerobic (effective 01/01/07)	05, 09	W7, 69	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*87075	T	TC	Culture, anaerobic (effective 01/01/07)	05, 09	W7, 69	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*87205	T	TC	Smear, primary source with interpretation gram or griemsa stain for bacteria fungi or cell types (effective 01/01/07)	05, 09	W7, 69	217, 610.0, 611.72, 611.79, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
87621	T	TC	High Risk HPV DNA Test (effective 07/01/07)	05, 09	W6, W7, 69		A, C
*88108	P	26	Cytopathology, concentration technique, smears and interpretation	01, 03	22	214.1, 214.8, 217, 610.0, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*88108	T	TC	Cytopathology, concentration technique, smears and interpretation	05, 09	W6, W7, 69	214.1, 214.8, 217, 610.0, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*88108	C		Cytopathology, concentration technique, smears and interpretation	01, 03, 05, 09	22, W6, W7, 69	214.1, 214.8, 217, 610.0, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*88112	P	26	Cytopathology, enhancement technique with interpretation	01, 03	22	214.1, 214.8, 217, 610.0, 610.1, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
*88112	T	TC	Cytopathology, enhancement technique with interpretation	05, 09	69, W6, W7	214.1, 214.8, 217, 610.0, 610.1, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C

*88112	C		Cytopathology, enhancement technique with interpretation	01, 03, 05, 09	22, 69, W6, W7	214.1, 214.8, 217, 610.0, 610.1, 611.72, 611.0, 785.6, 793.80, 793.81, 793.89	A, C
88141	P	26	Pap smear, reported in Bethesda system	01, 03, 05	22, W6, W7		A, C
88142	T	TC	Automated thin preparation	09, 05	69, W6, W7		A, C
88148	T	TC	Screening by automated system with manual re-screening	09, 05	69, W6, W7		A, C
88150	T	TC	Pap smear screening	09, 05	69, W6, W7		A, C
88160	P	26	Cytopathology, smears, any other source, screening and interpretation	01, 03	22		A, C
88160	T	TC	Cytopathology, smears, any other source, screening and interpretation	05, 09	W6, W7, 69		A, C
88160	C		Cytopathology, smears, any other source, screening and interpretation	01, 03, 05, 09	22, W6, W7, 69		A, C
88164	T	TC	Manual screening under physician supervision	09, 05	69, W6, W7		A, C
88165	T	TC	Manual screening and rescreening under physician supervision	09, 05	69, W6, W7		A, C
88173	P	26	Interpretation of Fine Needle Aspirate	01, 03	22		A, C
88173	C		Interpretation of Fine Needle Aspirate	01, 03, 05, 09	22, W6, W7, 69		A, C
88173	T	TC	Interpretation of Fine Needle Aspirate	05, 09	W6, W7, 69		A, C
88175	T	TC	Computerized Thin Prep (effective 01/01/06)	09, 05	69, W6, W7		A, C
*88304	P	26	Surgical Pathology Level III	01, 03	22	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89, 219.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C

*88304	T	TC	Surgical Pathology Level III	05, 09	W7, 69	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89, 219.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88304	C		Surgical Pathology Level III	01, 03, 05, 09	W7, 69, 22	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89, 219.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88305 (Breast)	C		Biopsy interpretation, Surgical Pathology Level IV	01, 03, 05, 09	W7, 69, 22	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
*88305 (Breast)	P	26	Biopsy interpretation, Surgical Pathology Level IV	01, 03	22	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
*88305 (Breast)	T	TC	Biopsy interpretation, Surgical Pathology Level IV	05, 09	W7, 69	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 785.6, 793.80, 793.81, 793.89	A, C
*88305 (Cervical)	C		Biopsy interpretation, Surgical Pathology Level IV	01, 03, 05, 09	W7, 69, 22	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C

*88305 (Cervical)	P	26	Biopsy interpretation, Surgical Pathology Level IV	01, 03	22	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88305 (Cervical)	T	TC	Biopsy interpretation, Surgical Pathology Level IV	05, 09	W7, 69	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88307 (Breast)	C		Surgical Pathology Level V (Effective 07/01/12)	01, 03, 05, 09	22, W7, 69	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89	A, C
*88307 (Breast)	P	26	Surgical Pathology Level V (Effective 07/01/12)	01, 03	22	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89	A, C
*88307 (Breast)	T	TC	Surgical Pathology Level V (Effective 07/01/12)	05, 09	W7, 69	214.1, 214.8, 217, 610.0, 610.1, 610.2, 610.3, 610.4, 611.0, 611.1, 611.3, 611.72, 611.79, 611.8, 627.0, 785.6, 793.80, 793.81, 793.89	A, C
*88307 (Cervical)	C		Surgical Pathology Level V	01, 03, 05, 09	22, W6, W7, 69	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C

*88307 (Cervical)	P	26	Surgical Pathology Level V	01, 03	22	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88307 (Cervical)	T	TC	Surgical Pathology Level V (	05, 09	W6, W7, 69	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88309 (Cervical only)	C		Surgical Pathology Level VI	01, 03, 05, 09	22, W6, W7, 69	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88309 (Cervical only)	P		Surgical Pathology Level VI	01, 03	22	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88309 (Cervical only)	T		Surgical Pathology Level VI	05, 09	W6, W7, 69	219.0, 616.0, 622.10, 622.11, 623.0, 625.8, 626.8, 626.2, 626.9, 627.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05	A, C
*88321	P	26	Slide Consult	01, 03, 05	22, W6, W7		A, C

*88329	P	26	OR Consult	01, 03	22	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C
*88331	P	26	Frozen Section Pathology	01, 03	22	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C
*88331	C		Frozen Section Pathology	01, 03, 05, 09	22, W6, W7, 69	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C
*88331	T	TC	Frozen Section Pathology	05, 09	W6, W7, 69	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C
*88332	C		Frozen Section Pathology, Additional	01, 03, 05, 09	22, W6, W7, 69	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C
*88332	T	TC	Frozen Section Pathology, Additional	05, 09	W6, W7, 69	217, 219.0, 610.0, 610.1, 610.2, 611.72, 611.79, 622.10, 625.8, 626.9, 627.1, 785.6, 793.80, 793.81, 793.89, 795.00, 795.02, 795.03, 795.04, 795.05	A, C

88342	P	26	Immunohistochemistry (including tissue immunoperoxidase) each antibody (breast or cervical only) **(no longer payable as of 04/01/14 - new code G0461 or G0462)**	01, 03	22		A, C
88342	C		Immunohistochemistry (including tissue immunoperoxidase) each antibody (breast or cervical only) **(no longer payable as of 04/01/14 - new code G0461 or G0462)**	01, 03, 05, 09	22, W6, W7, 69		A, C
88342	T	TC	Immunohistochemistry (including tissue immunoperoxidase) each antibody (breast or cervical only) **(no longer payable as of 04/01/14 - new code G0461 or G0462)**	05, 09	W6, W7, 69		A, C
G0461	P	26	Immunohistochemistry or immunocytochemistry, per specimen, first stain **(replaces 88342 effective 04/01/14)**				A, C
G0461	T	TC	Immunohistochemistry or immunocytochemistry, per specimen, first stain **(replaces 88342 effective 04/01/14)**				A, C
G0461	C		Immunohistochemistry or immunocytochemistry, per specimen, first stain **(replaces 88342 effective 04/01/14)**				A, C
G0462	P	26	Immunohistochemistry or immunocytochemistry, per specimen, each additional stain **(replaces 88342 effective 04/01/14)**				A, C
G0462	T	TC	Immunohistochemistry or immunocytochemistry, per specimen, each additional stain **(replaces 88342 effective 04/01/14)**				A, C
G0462	C		Immunohistochemistry or immunocytochemistry, per specimen, each additional stain **(replaces 88342 effective 04/01/14)**				A, C
OFFICE VISIT CODES							
99203	P	26	New or Established office consultations	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C

99203	9		New or Established office consultations	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C
99204	P	26	New or Established office consultations (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99204	9		New or Established office consultations (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99205	P	26	New or Established office consultations (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99205	9		New or Established office consultations (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99212	P	26	Established Patient, follow-up office visit	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C
99212	9		Established Patient, follow-up office visit	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C
99213	P	26	Established Patient office visit	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C
99213	9		Established Patient office visit	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 30, 02, H2, X1, 31		A, C

99214	P	26	Established Patient office visit (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99214	9		Established Patient office visit (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99215	P	26	Established Patient office visit (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
99215	9		Established Patient office visit (effective 07/09/11)	01, 03, 49, 58, 68	F2, N3, 08, 16, 11, 02		A, C
ANESTHESIA FOR BREAST PROCEDURES							
*00400	P	26	Breast biopsy/excision of axillary lesion/Node biopsy	01, 03, 05	05, C3, W6, W7	217, 610.0, 610.1, 610.4, 611.72, 611.0, 611.79, 785.6, 793.80, 793.81, 793.89	A, C
*01610	P	26	Excision of lymph nodes, anesthesia (effective 03/05/12)	01, 03, 05	05, C3, W7	214.1, 214.8, 217, 610.0, 610.1, 610.3, 610.4, 611.71, 611.72, 611.79, 611.0, 611.89, 785.6, 793.80, 793.81, 793.89	A, C
ANESTHESIA FOR CERVICAL PROCEDURES							
*00940	P	26	Anesthesia for vaginal procedures (57460, 57461, 57520,57522)	01, 03, 05	05, C3, W6, W7	219.0, 622.10, 622.11, 622.7, 625.8, 795.00, 795.02, 795.03, 795.04, 795.05, 795.06	A, C
			*** When billing BreastCare, these codes require specific diagnosis codes**				
			Effective January 21, 2010, BreastCare no longer covers treatment with state funds.				

500 ADDITIONAL BILLING INFORMATION

510 Modifiers

Modifiers are to be used in place of type of service codes “P” and “T” when billing for the Professional and Technical components of BreastCare procedures. If you do not bill a modifier for these procedures, the system will assume you are billing for the complete component (both Professional and Technical).

Modifiers Used by BreastCare	
TC	Technical Component
26	Professional Component

A modifier is not required if billing the complete component, facility setting, inpatient or outpatient services.

520 Place of Service (POS) Codes

The following places of service (POS) codes are used in the BreastCare program. Place of service is the location where the billed procedure was performed.

POS Code	Place of Service	Description
11	Office	Location other than a hospital, skilled nursing facility, military treatment facility, CHC, or intermediate care facility where the health professional routinely provides health exams, diagnosis, and treatment of illness or injury on an ambulatory basis.
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.
21	Inpatient Hospital	A facility other than psychiatric that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
24	Ambulatory Surgical Center	A freestanding facility other than a physician's office where surgical and diagnostic services are provided on an ambulatory basis.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries with preventive primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other POS	Other place of service not identified above.

530 Result and Recommendation Reporting Procedures

This section outlines the process for submitting result and recommendation codes and lists the values associated with these codes. Some providers are required to submit result and recommendation codes when billing certain procedures.

Result and recommendation code reporting is part of the claim transaction as of January 1, 2005. You no longer need to complete the paper form if you use the PES software. However, if you currently bill on paper, please use the new BreastCare claim form. Please mail your claims to HP Enterprise Services, BreastCare, P. O. Box 709, Little Rock, AR 72203. We cannot accept claims by fax.

Use the following chart to determine which result and recommendation codes are required with the procedure code being billed.

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
G0202	Digital Screening Mammogram	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated
G0204	Digital Diagnostic Mammogram, bilateral	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
G0206	Digital Diagnostic Mammogram, unilateral	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated
19000	Aspiration of cyst of breast	Physician office If billing the Professional component or Facility Setting	22=No fluid or tissue obtained 23=Non-suspicious 24=Suspicious for neoplasm	1=Follow routine screening 2=Short-term follow-up mammogram (number of months required if using this value) 3=Diagnostic mammogram 4=Repeat Mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
19001	Aspiration of cyst of breast, each additional	Physician office If billing the Professional component or Facility Setting	22=No fluid or tissue obtained 23=Non-suspicious 24=Suspicious for neoplasm	1=Follow routine screening 2=Short-term follow-up mammogram (number of months required if using this value) 3=Diagnostic mammogram 4=Repeat Mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated
57420	Colposcopy for entire vagina & cervix, if present	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
57421	Colposcopy with biopsy of cervix	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
57452	Colposcopy without Biopsy	Physician office If billing the Professional component or Facility Setting	1=Negative(WNL) 2=Inflammation/infection/ HPV changes 8=Unsatisfactory 23=Other abnormality	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
57454	Colposcopy with Biopsy and endocervical curettage	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
57455	Colposcopy with biopsy of cervix	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
57456	Colposcopy with endocervical curettage	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
57460	Colposcopy with loop electrode biopsy of cervix PA Required	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
57461	Colposcopy with loop electrode conization of cervix PA Required	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
57505	Endocervical curettage	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
57520	Conization of cervix PA Required	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
57522	Loop electrode excision PA Required	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
58110	Endometrial sampling, biopsy, performed in conjunction w/colposcopy	Physician office If billing the Professional component or Facility Setting	1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3 18=Invasive squamous cell carcinoma 19=Other nonmalignant abnormality-HPV, condylom 31=Adenocarcinoma, NOS 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultant 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone
77055	Diagnostic/ Follow-up mammogram; unilateral	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
77056	Diagnostic/ Follow-up mammogram; bilateral	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
77057	Screening Mammogram	Mammography Facility If billing the Technical component or Complete component	0=Assessment is incomplete–need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign–short interval follow-up indicated 4=Suspicious abnormality–biopsy should be considered 5=Highly suggestive of malignancy–appropriate action should be taken	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated
76645	Ultrasound-Echography, breast (unilateral or bilateral) B-scan and/or real time with image documentation	Mammography Facility If billing the Technical component or Complete component	15=Normal–no abnormality noted 16=Cystic mass 17=Suspicious for malignancy 18=Other benign abnormality	1=Follow routine screening 2=Short-term follow-up mammogram (number of months consultation required if using this value) 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88141	Pap smear, reported in Bethesda system (For use by ADH contracted cervical cytology lab only)	Pathology Facility If billing the Professional component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 9=Atypical squamous cells—favors high grade (ASC-H) 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88141, you must use the following combinations of Result/ Recommendation codes: Result Code 1 or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88142	Automated thin preparation	Pathology Facility If billing the Technical component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88142, you must use the following combinations of Result/ Recommendation codes: Result Code 1 or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88148	Screening by automated system with manual re-screening	Pathology Facility If billing the Technical component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88148, you must use the following combinations of Result/ Recommendation codes: Result Code 1or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88150	Pap smear screening (For use by ADH contracted cervical cytology lab only)	Laboratory Facility If billing the Technical component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88150, you must use the following combinations of Result/ Recommendation codes: Result Code 1 or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88175	Computerized Thin prep	Pathology Facility If billing the Technical component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88142, you must use the following combinations of Result/ Recommendation codes: Result Code 1 or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88164	Manual Screening under physician supervision	Laboratory Facility If billing the Technical component	1=Negative (WNL) 2=Infection/inflammation/ reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (including HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 30=Atypical glandular cells of undetermined significance (AGUS) 31=Adenocarcinoma 32=Other malignant neoplasms	1=Follow routine screening 2=Short-term follow-up (number of months required if using this value) 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consult 8=Cryotherapy/laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone **Note**: For the ADHHS contracted cervical cytology lab, when billing procedure code 88150, you must use the following combinations of Result/ Recommendation codes: Result Code 1 or 2 = Rec Code 1, Result Code 3 = Rec Code 2, Result Code 8 = Rec Code 3, Result Code 4,5,6,30,or 31 = Rec Code 4. Adequacy Code: 1 = Satisfactory 2 = Unsatisfactory

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
88305 (breast)	Biopsy interpretation	Laboratory Facility If billing the Technical component or Complete component	25=Hyperplasia 26=Other benign changes 28=Invasive breast cancer 29=Normal breast tissue 38=Ductal carcinoma in situ 39= Lobular carcinoma in situ	No code is needed.
99203 99204 99205	New or Established office visits/consultations	Physician office If billing the Professional component or the Facility Setting	No code is needed.	1=Follow-up routine screening 2= Short-term follow-up mammogram (number of months required if using this value) 3= Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

Proc. Code	Procedure Code Description	Required to Report	Result Codes	Recommendation Codes
99212	Established Patient, follow-up office visit	Physician office If billing the Professional component or the Facility Setting	No code is needed.	1=Follow-up routine screening 2= Short-term follow-up mammogram (number of months required if using this value) 3= Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated
99213 99214 99215	Established patient office visit	Physician office If billing the Professional component or the Facility Setting	No code is needed.	1=Follow-up routine screening 2= Short-term follow-up mammogram (number of months required if using this value) 3= Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated

600 REMITTANCE ADVICE

Remittance Advices (RAs) are now available in a PDF format, referred to as WebRAs.

Providers will have to register in order to have access to their WebRAs. A link to the registration site is available through the Provider Portal @ www.medicaid.state.ar.us_ Click on Providers, once logged in, the WebRA link will be accessible. For logon or password issues, please contact the EDI support center: In-state toll-free: (800) 457-4454 or local and out-of-state: (501) 376-2211.

Providers cannot receive both paper and WebRAs. WebRAs are only available on the website for 35 days. There is a charge if a paper RA is requested. The charge is .25 cents per page and a check must be received by BreastCare before the RA can be mailed out. Checks need to be sent to BreastCare at P.O. Box 709, Little Rock, AR 72203.

The Remittance Advice (RA) is an weekly status report for submitted claims that have been paid, denied, or are still in process. The RA is the first source of reference for questions regarding a particular claim. If you have a question that isn't answered by the RA and need to contact BreastCare billing assistance, please have the RA and claim control number available.

Please keep all RAs so your claim and payment records remain current. The RA is the only record of paid and denied claims that the BreastCare program sends you.

There are seven main segments of an RA:

Report Heading

Paid Claims

Denied Claims

Claims In Process

Financial Items

AEVCS Transactions

Claims Payment Summary

610 Report Heading

This section describes the heading information on each page of the RA. Brief messages regarding policy or billing are often included on the first page of the RA.

Report Heading	Description
1. Provider Name and Address	The name and address of the BreastCare provider to whom payment will be made.
2. RA Number	A unique identification number assigned to each RA.
3. Provider ID & NPI Number	BreastCare Provider number & NPI Number
4. Report Sequence	Assigned sequentially for the provider's convenience in identifying the RA. The first RA for the calendar year is numbered "1," the second "2," etc. Filing your RAs in chronological order by this number should ensure that none are missing.
5. Date	The date the RA was produced.
6. Page	Page number assigned to each page of the RA.
7. Cover Page	Messages written for provider information.

620 Paid Claims

This section of the RA lists all claims that have been paid in full, or partially paid, since the previous cycle.

Column Heading	Description
1. Patient Name	The client's last name, first name, and middle initial.
2. Client ID	The client's 10-digit BreastCare identification number.
3. County Code	This field not applicable.
4. RCC	This field not applicable.
5. Claim Control Number	The 13-digit control number assigned to each claim by HP for internal control purposes. Please use this internal control number (ICN) when inquiring about a claim.
6. Patient Control Number	A patient control number assigned by the provider for identification of the client. There is space for 16 numerals or letters.
7. Diagnosis	The primary diagnosis code that appeared on the claim form.
8. Servicing Physician	The servicing physician's provider NPI number will appear only when included on the claim for groups or clinics.
9. Service Dates	Format MM/DD/YY (Month, Day, Year) in "From" and "To" dates of service. For each detail, "From" indicates the beginning date of service and "To" indicates the ending date of service.
10. Days or Units	The number of times a particular service is billed within the given service dates.
11. Procedure/Accommodation	Procedure code corresponding to the service.

Summary totals for this section are as follows:

12. Total Billed	The amount the provider bills per detail.
13. Total Non-Allowed	The amount of the billed charge that is non-allowed per detail.
14. Total Allowed	The total amount BreastCare allows for that detail. (Total Allowed = Total Billed - Non-Allowed)
15. Spend Down	This field not applicable.
16. Patient Liability	This field not applicable.
17. Other Deducted Charges	The total amount paid by other insurance.
18. Paid Amount	The amount BreastCare pays (Paid Amount = Total Allowed - Other Deducted Charges).
19. Explanation of Benefit Code(s)	A number corresponding to a message that explains the action taken on claims. The messages are on the final page of the RA.
20. TPL	Third Party Liability will show the amount paid by other insurance coverage.

630 Denied Claims

This section of the RA identifies claims that have been denied for such reasons as ineligibility or non-covered services. Recoupments resulting from an adjustment request are also displayed in this section. Denied claims are listed alphabetically by the client's last name. Up to three codes specifying why the claim was denied are listed in the EOB (Explanation of Benefit) field. Definitions for the codes are on the last page of the RA.

Denied claims are finalized, and no additional action will be taken on the claims unless the provider has additional information that would allow payment and refiles the claim accordingly.

Denied claims are listed on the RA in the same format as paid claims.

640 Claims in Process

This section of the RA lists claims that have been entered into the system but have not reached final disposition. Please do not rebill a claim shown in this section, as it is already in our system and will result in a denial as a duplicate claim. As long as you have claims in process, you will receive a weekly RA listing claims in this section until they are paid or denied.

Column Heading	Description
1. Client ID	The client's identification number.
2. Patient Name	The client's last name, first name, and middle initial.
3. Service Dates: From	The beginning date of service for the claim.
4. Service Dates: To	The ending date of service for the claim.
5. Claim Number	The unique 13-digit number assigned to each claim for control purposes.
6. Total Billed	The total amount billed by the provider (the sum of the detail lines).
7. Patient Control	The client's patient control number as listed on the claim form.
8. Explanation of Benefit Code(s)	A number corresponding to a message that explains the action taken on claims. The messages are on the final page of the RA.

650 Financial Items

This section of the RA contains a listing of the payments refunded by the provider, amounts recouped since the previous check write, payouts, and other transactions. It also includes any other recoupment activities being applied that will reflect negatively to the provider's total earnings for the year. The Explanation of Benefit codes beside each item indicate the action taken.

The "Credit To" entries from the Adjusted Claims Section that are being recouped are listed in the Financial Items Section. The "Credit To" portion of all adjusted claims appears in the Adjusted Claims Section as information only and is actually applied in the Financial Items Section.

Column Heading	Description
1. Client ID	The client's BreastCare identification number.
2. From DOS	The from date of service.
3. Transaction Dates	The date on which this transaction was entered into the system.
4. Claim Control Number	The unique number assigned to this transaction by HP.
5. Reference	Information that may be of help in identifying the transaction (example, client's name).
6. Original Amount	The original amount of the transaction. This amount will be the same on each RA for a particular transaction until it has been completed.
7. Beginning Balance	The amount remaining for this transaction prior to this RA. (For example, if a recoupment had been initiated for $1,000.00, but the provider had only $200.90 deducted, then the provider's next RA would show a beginning balance of $799.10 to be recouped.)
8. Applied Amount	The amount applied on this RA to the beginning balance. (If monies were recouped from two different clients, then the amounts applicable to each client would be displayed in the applied amount column individually.)
9. New Balance	The amount left for this transaction after this RA.
10. Explanation of Benefit Code(s)	A number corresponding to a message that explains the action taken on claims. The messages are on the final page of the RA.

660 AEVCS Transactions

This section of the RA lists all AEVCS transactions by the transaction category and transaction type. It also contains separate totals for claim transactions, reversal transactions, and total transactions for this provider.

Column Heading	Description
1. Transaction Category	The type of transaction, such as a claim or eligibility verification.
2. Transaction Types	The type of claim transmitted by the provider.
3. Transaction Count	The total number of transactions for the transaction type.
4. Transaction Amount	The total charges for transactions transmitted for the transaction type. $0.17 is charged per accepted claim transaction. $0.10 is charged per eligibility transaction. The claim fee also applies to paper claims since they are entered into AEVCS for processing.

5. Total Claim Transaction	The total number of claims transmitted and the total charges for the transaction category.
6. Total Reversal Transaction	The total number of reversals submitted by the provider. This is informational only as there are no transaction fees for reversals.
7. Total Eligibility Transaction	The total number of eligibility verifications transmitted and total charges for the transactions.
8. Total Transactions For This Provider	The total number of AEVCS transactions, including claims transmitted, reversals, eligibility verifications, and total charges.

670 Claims Payment Summary

This section of the RA summarizes all BreastCare payments and credits made for the specific RA pay period entitled “Current Processed” as well as for the year entitled “Year to Date Total.”

Column Heading	Description
1. Days or Units	The total days or units paid, denied, and adjusted.
2. Claims Paid	Total number of claims paid, denied, and adjusted by the BreastCare Program.
3. Claims Amount	Total paid amount from Paid Claims Section plus any supplemental payouts (e.g., resulting from a “Debit To” adjustment listed in the Adjusted Claims Section).
4. Withheld Amount	Total amount withheld from RA (e.g., resulting from recoupments). This amount is obtained from each “Applied Amount” field of the Financial Items Section.
5. Net Pay Amount	Claim amount less withheld amount. This is the amount of the provider’s payment.
6. Credit Amount	Total amount refunded to the BreastCare Program by the provider. HP posts check refunds here.
7. Net 1099 Amount	The provider’s income reported to Federal and State governments for tax purposes. This amount is derived from the Net Pay Amount less the Credit Amount.
8. Tax Payment	The amount of tax withheld on this RA. Not currently used.
9. Quarterly Tax Amount	The cumulative amount of tax withheld for this financial quarter. Not currently used.
10. AEVCS Transaction Fees	Total amount of AEVCS transaction fees charged to the provider. $0.17 is charged per accepted claim transaction. $0.10 is charged per eligibility transaction. The claim fee also applies to paper claims since they are entered into AEVCS for processing.

Column Heading	Description
11. AEVCS Transaction Recoupment Amount	Total amount of AEVCS transaction fees withheld from the RA. This amount is obtained from the "Total Transactions For This Provider" field of the AEVCS Transactions section.
12. Explanation of Benefit Code(s)	The definitions of explanation codes used throughout the RA.
13. Federal Tax ID	The provider's social security number or federal Employer Identification Number (EIN). All monies paid to the provider will be reported to the IRS under this number. If the number listed is incorrect, contact the BreastCare program to update the file.

BREASTCARE
REMITTANCE AND STATUS REPORT

1 PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

2 R/A NUMBER 12345

STATE OF ARKANSAS

PROVIDER NUMBER 123456126 3 4 REPORT SEQ. NUMBER 10 5 DATE XX/XX/XX PAGE 1 6

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES

7

TO ALL PROVIDERS

THE PURPOSE OF THE "RA MESSAGE" IS TO KEEP YOU INFORMED. PLEASE READ EACH ONE, AND CONTACT HP IF YOU HAVE ANY QUESTIONS CONCERNING THE RA MESSAGE.

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

REMITTANCE ADVICES CANNOT BE FORWARDED. THEREFORE, THE BREASTCARE PROGRAM MUST BE NOTIFIED OF AN ADDRESS CHANGE WITH THE PROVIDER'S ORIGINAL SIGNATURE (NO FACSIMILE). PLEASE INDICATE ALL PROVIDER NUMBERS AFFECTED BY THE CHANGE.

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 2

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
PAID CLAIMS												
1	3	4		5	6	7		8				
SMITH, JOHN 2 0123456789	CO = 40 xx xx xx 9	RCC = xx xx xx	2 1 10	CLAIM NUMBER = 9898113230530 Procedure Code/Description 11	MRN = 47398721 XXX XX 12	DIAG = XXX XXX XX 13	XXX XX 14	SERV PHYS = 123456789 XXX XX 15	XXX XX 16	XXX XX 17	XXX XX 18	XX 19
			PA/LEA =	20 TPL =	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	TAX =
1 CLAIMS			1 MEDICAL	*********	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX TAX =	
**** TOTAL PAID CLAIMS				1 CLAIMS	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX TAX =	

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 3

NAME / CLIENT ID	SERVICE DATES FROM MM DD YY	SERVICE DATES TO MM DD YY	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
DENIED CLAIMS												
SMITH, JOHN 0123456789	xx xx xx	xx xx xx	2 1	CLAIM NUMBER = 9898113230530 Procedure Code/Description	MRN = 47398721 XXX XX	DIAG = XXX XXX XX	XXX XX	SERV PHYS = 123456789 XXX XX	XXX XX	XXX XX	XXX XX	XX
			PA/LEA =	TPL =	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	TAX =
1 CLAIMS		1	MEDICAL	*********	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX TAX =	
**** TOTAL DENIED CLAIMS				1 CLAIMS	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX	XXX XX TAX =	

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 5

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS IN PROCESS	THESE CLAIMS ARE BEING PROCESSED AS LISTED											
PROFESSIONAL												
1	2		3	4	5	6	7					8
3253669001 SMITH EMERY			XXXXXX	XXXXXX	ICN 9892131067390	XXX XX	MEDICAL RECORD =					XX
1 CLAIMS					PROFESSIONAL							
*** TOTAL PENDING CLAIMS					1 CLAIMS							

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 6

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
FINANCIAL ITEMS												
1	2	3	4	5			6	7	8		9	10
RECIP ID	FROM DOS	TXN DATES	CONTROL NUMBER	REFERENCE			ORIGINAL AMOUNT	BEGINNING BALANCE	APPLIED AMOUNT		NEW BALANCE	EOB
0123456790	xx xx xx	xx xx xx	2166750144	000111000011110			xxx xx	xxx xx	xxx xx		xxx xx	XX
			2359925009	AEVCS TRANSACTION FEES			xxx xx	xxx xx	xxx xx		xxx xx	
				TOTAL FINANCIAL ITEMS 2								

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 7

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
AEVCS TRANSACTIONS												
1				2	3			4				
TRANSACTION CATEGORY					TRANSACTION COUNT				TRANSACTION AMOUNT			
CLAIM				BREASTCARE		11			xxx xx			
				5 TOTAL CLAIM TRANSACTIONS:		11			xxx xx			
REVERSAL				BREASTCARE		6			xxx xx			
				6 TOTAL REVERSAL TRANSACTIONS		6			xxx xx			
ELIGIBILITY VERIFICATION				BREASTCARE		4			xxx xx			
				7 TOTAL ELIGIBILITY TRANSACTIONS		11			xxx xx			
				8 TOTAL TRANSACTIONS FOR THIS PROVIDER:		32			xxx xx			

BREASTCARE
REMITTANCE AND STATUS REPORT

PROVIDER NAME
100 MAIN ST.
ANYWHERE, AR 12345

STATE OF ARKANSAS

R/A NUMBER 12345

PROVIDER NUMBER 123456126 REPORT SEQ. NUMBER 10 DATE XX/XX/XX PAGE 8

NAME / CLIENT ID	SERVICE DATES FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	DAYS OR UNITS	PROCEDURE/REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	SPENDDOWN	PATIENT LIABILITY	OTHER DEDUCTED CHARGES	PAID AMOUNT	EOB CODES
CLAIMS PAYMENT SUMMARY												
			1	2 / 3	4	5	6	7	8	9		
			DAYS OR UNITS	CLAIMS PAID / CLAIMS AMOUNT	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT	TAX AMOUNT	QTR TAX AMOUNT		
CURRENT PROCESSED			4	2 / XXXX.XX	XXX.XX	XXXX.XX	XXX.XX	XXXX.XX	XXX.XX	XXXX.XX		
YEAR-TO-DATE TOTAL			12	13 / XXXX.XX	XXXX.XX	XXXX.XX	XXX.XX	XXXX.XX	XXXX.XX	XXXX.XX		
			10	11								
			AEVCS TXN FEES	AEVCS TXN RECOUP AMT								
CURRENT PROCESSED			XX.XX	XX.XX								
YEAR-TO-DATE TOTAL			XX.XX	XX.XX								

12

IF AN * APPEARS TO THE LEFT OF A DETAIL, PAID DETAIL HAS BEEN ADDED SYSTEMATICALLY.
IF ** APPEAR TO THE LEFT OF A DETAIL, A DENIED DETAIL WAS ADDED SYSTEMATICALLY. RECOMMENDED BILLING INDICATED ON DETAIL.

THE FOLLOWING IS A DESCRIPTION OF THE EOB CODES UTILIZED THROUGHOUT THE REPORT
XX CLAIM STILL IN PROCESS. PLEASE DO NOT REBILL.
XX PAID IN FULL BY BREASTCARE.

13

**** FEDERAL TAX ID EIN 012345678

700 ADJUSTMENT REQUEST FORM

The Adjustment Request Form is to be submitted when a claim has been incorrectly **paid** due to incomplete or inaccurate claim information, processing errors, or pricing errors. The Adjustment Request Form cannot be used for denied claims. All necessary information for processing the adjustment must be included on the request form. A copy of the page of the RA it was paid on may be attached to give further clarification. When the adjustment request is processed, the original claim will be recouped and re-paid under an adjustment ICN beginning with 50. These claims will appear under your Adjustment Section on your RA.

Adjustment Request Forms should be filed as soon as the incorrect payment has been identified. The following instructions explain how to complete the form. Please read the instructions carefully and complete all Adjustment Request Forms thoroughly and accurately so they may be handled efficiently.

710 Completing the Adjustment Request Form

Field Name	Instructions for Completion
1. Provider NPI Number	Enter the provider NPI number under which payment was made.
2. Provider Name and Address	Complete this field with the same information with which you billed the claim.
3. Claim Number (ICN – Internal Control Number)	Enter the 13-digit claim number exactly as it is printed on the Remittance Advice.
4. Patient Name	Enter the patient's last name, first name, and middle initial.
5. Client ID Number	Enter the entire 10-digit BreastCare identification number assigned to the client as it appears on the Remittance Advice.
6. Remittance Advice Date	Enter the date of the RA found in the top right corner.
7. Date(s) of Service	Enter the beginning and ending month, day, and year of services rendered.
8. Billed Amount	Enter the amount the BreastCare program was actually billed for the service(s).
9. Paid Amount	Enter the amount actually paid by BreastCare for the service(s) in question.
10. Description of the Problem	Indicate a specific reason for the adjustment request and the nature of the incorrect payment.
11. Signature and Date	Enter the signature of the requester and the date the adjustment request was prepared.

ADJUSTMENT REQUEST FORM – BREASTCARE

MAIL TO: HP Enterprise Services; Adjustments; P.O. Box 709; Little Rock, Arkansas 72203
IMPORTANT: If all required information is not complete, the form will be returned to the provider.

Provider NPI Number:_____ Provider Name:_____

Address:_____

_____

Phone Number:_____

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

Claim Number: _____Patient Name:_____

Client I.D. Number:_____Remittance Advice Date:_____

Date(s) of Service:_____

Billed Amount:_____Paid Amount:_____

Description of the Problem:

_____

_____

_____

_____

_____

Signature:_____Date:_____

HP USE ONLY

_____Date of Adjustment Reviewer:_____

Adjustment Action:

_____Recoup

800 CHECK REFUND FORM

810 Completing the Check Refund Form

If an overpayment or a payment error has occurred, it is the responsibility of the provider to refund the BreastCare Program. Refunds to the BreastCare program may be done by sending a check in the amount of the overpayment made payable to the Arkansas Dept. of Health and Human Services, BreastCare Program. The Arkansas BreastCare Explanation of Check Refund Form must be completed and mailed with the refund to HP Enterprise Services.

Please provide the following information in the appropriate fields on an Arkansas BreastCare Explanation of Check Refund Form, for each refund:

1. Provider Name and Provider NPI Number
2. Check Number, Check Date and Check Amount
3. 13-digit Claim Number (from RA)
4. Client ID Number and Name
5. Dates of Service
6. Date of RA
7. Date of Service Being Refunded
8. Procedure Codes Being Refunded
9. Amount of Refund
10. Amount of Insurance Received
11. Insurance Name, Address and Policy Number
12. Reason for Return (from codes listed on form)
13. Signature, Date and Telephone

This information will ensure the refund is processed accurately and efficiently.

Arkansas BreastCare Explanation of Check Refund Form

Mail To: HP Enterprise Services
Attention: BreastCare Refunds
P.O. Box 709
Little Rock, AR 72203

Provider Name: _____ Provider NPI: _____

Refund Check Number: _____ Refund Check Date: _____ Refund Check Amount: _____

Information needed on each claim being refunded	**Claim 1**	**Claim 2**	**Claim 3**
13-digit Claim Number (from RA)			
Client's ID Number (from RA)			
Client's Name (Last, First)			
Date(s) of service on claim			
Date of RA			
Date(s) of service being refunded			
Procedure being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made.
2. DUP: A payment was made more than once for the same service(s).
3. INS: A payment was received by a third party source.
4. PNO: A payment was made on a client who is not a client in your office.
5. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

HP-CRBC-002 (Revised 7/04)

900 TEAR-OUT FORMS AND CONTACT INFORMATION

The contact information sheet may be torn out of this manual and posted.

The following forms may be torn out of this manual and photo-copied for use.

- BreastCare Claim Form
- Adjustment Request Form
- Explanation of Check Refund Form

Mailing Addresses

Claims, Adjustments, and Refunds

HP Enterprise Services - BreastCare

P.O. Box 709

Little Rock, AR 72203

Arkansas BreastCare Contacts

For billing questions:

1-855-661-7830 or

501-372-0225

(8:00 a.m. to 4:30 p.m.)

BreastCare
Say Yes to a Mammogram!

administered by the Arkansas Department of Health

1. Billing Provider NPI	1a. Taxonomy Code	2. Client ID Number	2a. Client's SSN

1b. Provider' s Name, Address, Zip code	2b. Client's Last Name	2c. Client's First Name
	2d. Client's Street Address	
	2e. Client's City, State, Zip Code	

3. Patient Account Number	4. Primary Diagnosis	5. Referring Provider NPI	6. Place of Service	7. Prior Authorization Number	8. TPL Indicator (Y or N)	8a. Paid Amount	8b. Denial Date (MM DD YY)

9. Hospital Admit Date	10. Facility Name and Address

11. DETAIL 1	A. Performing Provider	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 2	A. Performing Provider	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 3	A. Performing Provider ID	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields11-I through 11-L and sign below.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

11. DETAIL 4	A. Performing Provider ID	B. Dates of Service		C. Place of Service	D. Procedure Code	E. Modifier	F. Diagnosis Code	G. Units	H. Charges
	NPI	From MM DD YY	To MM DD YY						
		/ /	/ /						
	Taxonomy Code	Please complete appropriate fields 11-I through 11–L and sign.							
		I. Result code		J. Recommendation code					
		K. Months for short-term follow-up		L. Pap Smear Adequacy Code					

12. Provider Signature _____ Date _____

I certify that the information on both sides of this claim is true, accurate, and complete.

BREAST RESULT CODES

Screening & Diagnostic Mammography	Surgical/Treatment Consultation
0=Assessment is incomplete - Need additional imaging evaluation 1=Negative 2=Benign 3=Probably benign - Short interval follow-up indicated 4=Suspicious Abnormality - Biopsy should be considered 5=Highly suggestive of malignancy - Appropriate action should be taken	19=No intervention at this time - routine follow-up 20=Short-term follow-up 21=Biopsy/FNA required

Ultrasound	Biopsy	Cyst Aspirate
15=Normal/no abnormality noted 16=Cystic mass 17=Suspicious for malignancy 18=Other benign abnormality	25=Hyperplasia 26=Other benign changes 28=Invasive breast cancer 29=Normal breast tissue 38=Ductal carcinoma in situ 39=Lobular carcinoma in situ	22=No fluid or tissue obtained 23=Non-suspicious 24=Suspicious for neoplasm

ADH RESULT/RECOMMENDATION CODE COMBINATIONS

For billing procedure codes 88141, 88142, 88148, 88150, 88175 and 88164, use the following combinations of result/recommendation codes:
Result Code 1 or 2=Recommendation Code 1
Result Code 3=Recommendation Code 2
Result Code 8=Recommendation Code 3
Result Code 4, 5, 6, 30, or 31=Recommendation Code 4

CERVICAL RESULT CODES

Colposcopy with Biopsy
1=Negative (WNL) 14=CIN-1 15=CIN-2 17=CIN-3/CIS 18=Invasive squamous cell carcinoma 19=Other non-malignant abnormality - HPV, condyloma 31=Adenocarcinoma, NOS 32=Other malignant neoplasms

Colposcopy without Biopsy
1=Negative (WNL) 2=Inflammation/infection/HPV changes 8=Unsatisfactory 23=Other abnormality

Pap Smear Screenings
For ADH contracted cervical cytology lab, see the ADH table for result/ recommendation code combinations. 1=Negative (WNL) 2=Inflammation/infection/reactive changes (benign cellular changes) 3=Atypical squamous cells of undetermined significance (ASCUS) 4=Low grade SIL (include. HPV changes) 5=High grade SIL 6=Squamous cell cancer 7=Other 8=Unsatisfactory 11=Atrophic atypia 30=Atypical glandular cells (AGU) 31=Adenocarcinoma 32=Other malignant neoplasms

RECOMMENDATION CODES

Breast Recommendation Codes	Cervical Recommendation Codes
1=Follow routine screening 2=Short-term follow-up mammogram 3=Diagnostic mammogram 4=Repeat mammogram 5=Repeat breast exam 6=Ultrasound 7=Surgical consultation 8=Cyst aspirate 9=Biopsy 10=Treatment indicated	1=Follow routine screening 2=Short-term follow-up 3=Repeat Pap smear immediately 4=Colposcopy 5=Pelvic Ultrasound 6=Endometrial biopsy 7=Gynecologic consultation 8=Cryotherapy/Laser 9=Hysterectomy 10=LEEP/LLETZ 11=Cone

PAP SMEAR ADEQUACY CODES

1=Satisfactory
2=Unsatisfactory

PLACE OF SERVICE (POS) CODES

POS Code=Description
11=Office
15=Mobile Unit
21=Inpatient Hospital
22=Outpatient Hospital
24=Ambulatory Surgical Center
50=Federally Qualified Health Center
72=Rural Health Clinic
81=Independent Laboratory
99=Other Place of Service

MODIFIERS

TC=Technical Component
26=Professional Component
Blank=Complete Component, Facility Setting, Inpatient and Outpatient Services

HP–BreastCare
PO Box 709
Little Rock, AR 72203

Refer to Section 520 for further descriptions

Reserved

ADJUSTMENT REQUEST FORM – BREASTCARE

MAIL TO: HP Enterprise Services; Adjustments; P.O. Box 709; Little Rock, Arkansas 72203
IMPORTANT: If all required information is not complete, the form will be returned to the provider.

Provider NPI Number:_____ Provider Name:_____

Address:_____

_____

Phone Number:_____

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

Claim Number: _____Patient Name:_____

Client I.D. Number:_____Remittance Advice Date:_____

Date(s) of Service:_____

Billed Amount:_____Paid Amount:_____

Description of the Problem:

_____

_____

_____

_____

_____

Signature:_____Date:_____

HP USE ONLY

_____Date of Adjustment Reviewer:_____

Adjustment Action:

_____Recoup

Arkansas BreastCare Explanation of Check Refund Form

Mail To: HP Enterprise Services
Attention: BreastCare Refunds
P.O. Box 709
Little Rock, AR 72203

Provider Name: _____ Provider Number: _____

Refund Check Number: _____ Refund Check Date: _____ Refund Check Amount: _____

Information needed on each claim being refunded	**Claim 1**	**Claim 2**	**Claim 3**
13-digit Claim Number (from RA)			
Client's ID Number (from RA)			
Client's Name (Last, First)			
Date(s) of service on claim			
Date of RA			
Date(s) of service being refunded			
Procedure being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made.
2. DUP: A payment was made more than once for the same service(s).
3. INS: A payment was received by a third party source.
4. PNO: A payment was made on a client who is not a client in your office.
5. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

HP-CRBC-002 (Revised 7/04)