

Table C**2011 Reimbursement Rates****Cervical Screening & Diagnostic Procedures**

	CPT	Mod 26	Mod TC
Screening			
Pap smear screening	88150		\$14.87
Pap smear, reported in Bethesda System requiring physician interpretation	88141	\$27.27	
Screening by automated system with manual re-screening	88148		\$14.87
Manual screening under physician supervision	88164		\$14.87
Automated thin preparation	88142		\$21.25
Computerized thin preparation	88175		\$25.89
HPV DNA Testing (high-risk typing only)	87621		\$49.39
Slide Consult	88321	\$86.37	

These procedures are covered for eligible women according to program policy. After 3 consecutive negative Pap tests, the frequency must be reduced to every 3 years. Specimens must be submitted to participating laboratories.

Office Visits

New Patient Office Visit	CPT	Mod 26	Mod TC	Facility
New Patient office visit	99201	\$38.44		\$24.02
New Patient office visit	99203	\$96.46		\$70.43
New Patient office visit	99204	\$96.46		\$70.43
New Patient office visit	99205	\$96.46		\$70.43
Established Patient Office Visit				
Established Patient office visit	99213	\$65.06		\$46.87
Established Patient, follow-up office visit	99212	\$38.86		\$23.81
Established Patient office visit	99214	\$65.06		\$46.87
Established Patient office visit	99215	\$65.06		\$46.87
New Or Established Office Consultations				
New or Established office consultations	99203	\$96.46		\$70.43
Diagnostics	CPT	Mod 26	FACILITY	
Vaginal biopsy	57105	\$125.27	\$115.87	
Endoscopy with biopsy of vagina/cervix	57421	\$144.30	\$113.89	
Colposcopy without biopsy	57452	\$100.68	\$85.00	
Colposcopy with biopsy of cervix	57455	\$132.49	\$103.42	
Colposcopy with endocervical curettage	57456	\$125.24	\$96.38	
Colposcopy with biopsy and endocervical curettage	57454	\$142.60	\$126.61	
Endocervical curettage	57505	\$94.25	\$84.84	
◆Colposcopy with loop electrode biopsy of cervix	57460	\$269.60	\$152.00	
◆Colposcopy with loop electrode conization of cervix	57461	\$303.25	\$175.62	
*Biopsy or local excision of lesion	57500	\$120.62	\$70.13	
◆Conization of cervix	57520	\$283.81	\$252.76	
◆Loop electrode excision	57522	\$244.59	\$225.77	
*Endometrial biopsy	58100	\$101.69	\$81.62	
*Colposcopy for vagina and cervix if present	57420	\$107.21	\$83.69	
*Endoscopy w/ biopsy of vagina/cervix	57421	\$144.30	\$113.89	
*Endometrial sampling , performed in conjunction with colposcopy	58110	\$44.91	\$38.32	

◆ Requires prior authorization to obtain BreastCare reimbursement for diagnostic procedures.

Mod 26 = Professional Fee

Mod TC = Technical Fee

Total = Combined (Professional and Technical) Fee

Facility =These amounts apply when a physician performs the service in a facility setting

Effective December 1, 2001, Arkansas Department of Health implemented “The Breast and Cervical Cancer Prevention and Treatment Act”. This law allows eligible women diagnosed with breast and cervical cancer, CIN II/III, and carcinoma-in-situ to receive the full range of Medicaid category 07 benefits. Medicaid coverage ends when cancer treatment ends.

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

Refer all clients enrolled in BreastCare and diagnosed with breast or cervical cancer, CIN II/III, or Carcinoma-in-situ to the 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.

Hospital/Ambulatory Surgery Center	CPT	INPATIENT	OUTPATIENT	
◆Conization of cervix	57520	\$8506	\$742.89	
◆Loop electrode excision	57522	\$8506	\$742.89	
◆Colposcopy with loop electrode biopsy of cervix	57460	\$8506	\$125.91	
◆Colposcopy with loop electrode conization of cervix	57461	\$8506	\$134.89	
Biopsy or local excision of lesion	57500	\$8506	\$58.22	
◆Requires prior authorization to obtain BreastCare reimbursement for diagnostic procedures only. These are not covered for treatment purposes.				
Note: If a BreastCare enrollee is diagnosed with cervical cancer, CIN II/III, or CIS on biopsy and is also a Medicaid recipient, the above procedures on Table C are billed to Medicaid according to Medicaid's guidelines.				
Pathology	CPT	Mod 26	Mod TC	Total
Surgical Pathology Level IV	88305	\$35.35	\$64.13	\$99.48
Surgical Pathology Level III	88304	\$10.45	\$47.50	\$57.95
Surgical Pathology Level V	88307	\$76.89	\$135.31	\$212.21
Surgical Pathology Level VI	88309	\$134.29	\$187.67	\$321.96
Frozen Section	88331	\$57.83	\$29.39	\$87.15
Frozen Section, Additional	88332	\$28.35	\$10.19	\$38.54
OR Consult	88329	\$49.08		
Anesthesia	CPT	Mod 26		
* 57520, 57522, 57420, 57460, 57461	00940	\$138.53		
Note: Anesthesiologist/CRNA will bill for actual charges or up to the capitated limit for each procedure code.				
Lab	CPT	Mod 26	Mod TC	Total
Complete CBC, automated and automated differential WBC count	85025		\$10.94	
Hepatic Function Panel	80076		\$11.49	
CBC, automated	85027		\$ 9.11	
Basic Metabolic Panel	80048		\$11.91	
Comprehensive Metabolic Panel	80053		\$14.87	
Radiology	CPT	Mod 26	Mod TC	Total
Chest x-ray, single view	71010	\$8.46	\$13.64	\$22.10
Chest x-ray	71020	\$10.45	\$18.65	\$29.10

07/01/2011

*** Requires specific diagnoses codes. See BreastCare billing instructions.**

If a BreastCare enrollee is diagnosed with cervical cancer, CIN II/III, or CIS on biopsy and is also a Medicaid recipient, the above procedures are billed to Medicaid according to Medicaid's guidelines. Patients receive the full range of Medicaid benefits until cancer treatment ends.

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.