WISCONSIN WELL WOMAN PROGRAM (WWWP)
REIMBURSEMENT RATES
EFFECTIVE 07/01/2018 – 06/30/2019

WWWP services include **only** the breast and cervical cancer screening and diagnostic services listed here. The listed services are reimbursable per WWWP guidelines for covered **screenings and diagnostics.** The **type and duration of allowed office visits** used by the provider should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the WWWP, and reimbursement is not to exceed those rates published by Medicare. While the use of **Preventive Medicine Evaluation** visits themselves **are not appropriate** for the WWWP, these services, if used, shall be reimbursed at or below the 99203 or 99213 Evaluation and Management Code rate of reimbursements. (WWWP allowed Staged Assessment for Multiple Sclerosis procedure codes for high-risk women are listed in a separate Multiple Sclerosis guidance.)

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
EVALUATION AND MANAGEMENT – *Use these codes as primary coding for WWWP office visits*						
99201*	Initial – 10 minutes	$42.76	No	No		
99202	Initial – 20 minutes	$72.15	No	No		
99203	Initial – 30 minutes	$103.11	No	No		
99211*	Established – 5 minutes	$20.96	No	No		
99212	Established – 10 minutes	$42.29	No	No		
99213	Established – 15 minutes	$70.34	No	No		
99214	Established – 25 minutes	$103.94	No	No		
OFFICE VISIT						
G0101	Office visit – cervical cancer screening; pelvic and clinical breast examination	$36.53	No	No		
CONSULTATION OFFICE VISIT – Consultations should be billed through the standard "new patient" office visit CPT codes: 99201-99205. Consultations billed as 99204 or 99205 must meet the criteria for these codes. **These codes (99204-99205) are not appropriate for NBCCEDP screening visits.**						
99204	Initial – 45 minutes	$157.64	No	No		
99205	Initial – 60 minutes	$198.14	No	No		
PREVENTIVE MEDICINE OV – **Use only if necessary** for health and evaluation of risk profile for breast and/or cervical exams including Pap and annual CBE. **One** visit per **client per year**. (*See message in top paragraph*)						
99385	Initial Ages 35-39	$103.11	No	No		
99386	Initial Ages 40-64	$103.11	No	No		
99387	Initial Ages 65 and Over	$103.11	No	No		
99395	Established Ages 35-39	$70.34	No	No		
99396	Established Ages 40-64	$70.34	No	No		
99397	Established Ages 65 and Over	$70.34	No	No		
WWWP funds cannot be used for services that are unrelated to the breast and/or cervical cancer screening, including the time and materials needed to assess and manage problems unrelated to breast and cervical cancer. Grantees should have a protocol to appropriately educate, manage, and pay for the additional provider time and materials required to conduct unrelated services with non-WWWP funds.						
*** 99201 and 99211 – Use for normal annual Clinical Breast Exam (CBE) with no cervical screening component**						

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
ANESTHESIA						
00400 + modifier 3 Base Units + Time	Use CPT code + modifier **Modifier** **Reimbursed at % of Same Service if Provided by One Physician** AA 100% QZ 100% QK 50% QY 50% QX 50%	$21.25 per unit	Yes	Yes		
00942 + modifier **** limited to procedure code 57520**** 4 Base Units + Time	Use CPT code + modifier **Modifier** **Reimbursed at % of Same Service if Provided by One Physician** AA 100% QZ 100% QK 50% QY 50% QX 50%	$21.25 per unit	Yes	Yes		
ALLOWABLE BREAST SCREENING AND DIAGNOSTICS						
Radiology, use **TC** or **26** modifier as appropriate.						
77067	Screening mammography, bilateral (two-view study of each breast), including CAD when performed	$133.97	No	Yes	$37.04	$96.93
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed unilateral	$131.39	Yes *	Yes	$39.62	$91.77
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed bilateral	$166.14	Yes *	Yes	$48.88	$117.26
77063	Screening digital breast tomosynthesis, bilateral	$53.65	No	Yes	$29.19	$24.46
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	$53.65	Yes *	Yes	$29.19	$24.46
77053	Mammary ductogram or galactogram, single duct	$56.52	Yes *	Yes	$17.47	$39.06
77058[1]	Magnetic resonance imaging, breast, with and/or without contrast, unilateral	$527.38	No	Yes	$79.48	$447.90
77059[1]	Magnetic resonance imaging, breast, with and/or without contrast, bilateral	$524.97	No	Yes	$79.48	$445.49

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
[1] Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25 percent or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history. Breast MRI can also be used to better assess areas of concern on a mammogram for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed by the NBCCEDP to assess the extent of disease in a woman who is already diagnosed with breast cancer. WWWP will be conducting retrospective reviews on all MRI-performed procedures. See the "WWWP Reporting Instructions for Ductograms, Galactograms, and MRIs, P-01173" for information on how to report procedure results.						
76098	Radiological examination, surgical specimen	$16.25	Yes	Yes	$7.85	$8.39
76641	Ultrasound, complete exam of breast including axilla, unilateral	$105.01	Yes *	Yes	$35.63	$69.37
76642	Ultrasound, limited exam of breast including axilla, unilateral	$86.01	Yes *	Yes	$33.18	$52.84
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	$58.32	Yes	Yes	$31.66	$26.65
19000	Puncture aspiration of cyst of breast	$108.62	No	No		
19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*	$25.82	Yes	No		
19081[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	$671.46	No	No		
19082[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	$555.83	Yes	No		
19083[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	$653.34	No	No		
19084[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	$534.00	Yes	No		
19085[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	$979.16	No	No		
19086[2]	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	$794.37	Yes	No		
[2] Codes 19081 – 19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281 – 19288						
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	$142.62	Yes	No		
19101	Breast biopsy, open, incisional	$322.55	Yes	No		

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	$462.85	No	No		
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	$511.55	Yes	No		
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; *each additional lesion separately identified by a preoperative radiological marker*	$148.26	Yes	No		
19281[3]	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	$233.22	No	No		
19282[3]	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	$162.26	Yes	No		
19283[3]	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	$263.23	No	No		
19284[3]	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	$198.25	Yes	No		
19285[3]	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	$505.33	No	No		
19286[3]	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	$442.90	Yes	No		
19287[3]	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	$838.99	No	No		
19288[3]	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	$678.86	Yes	No		
[3] Codes 19281 – 19288 are for image guidance placement of localization device without image-guided biopsy. These codes are not to be used in conjunction with 19081 – 19086.						
10021	Fine needle aspiration (FNA) without imaging guidance	$117.00	Yes	No		
10022	Fine needle aspiration (FNA) with imaging guidance	$136.14	Yes	No		
99070	Supplies and materials (except spectacles), provided by physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	$16.04	Yes	No		
BREAST LAB						
Use **TC** or **26** modifier as appropriate.						
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	$56.49	Yes	Yes	$36.73	$19.76
88173	Cytopathology, evaluation of fine needle aspirate; *interpretation and report*	$151.45	Yes	Yes	$72.30	$79.14

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
88305	Surgical pathology, gross and microscopic examination	$67.22	Yes	Yes	$38.50	$28.72
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	$258.56	Yes	Yes	$84.67	$173.89
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	$130.71	Yes	Yes	$45.14	$85.56
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	$142.17	Yes	Yes	$47.99	$94.18
ALLOWABLE CERVICAL SCREENING AND DIAGNOSTICS						
88164, p3000	Pap Test (Routine Screening) Bethesda System	$14.39	No	No		
88165	Cytopathology (conventional Pap Test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	$14.39	No	No		
88174**	Cytopathology, cervical or vaginal collected I preservative fluid, automated thin layer prep; screening by automated system, under physician supervision	$29.11	No	No		
88175	Pap Test (Routine Screening) Bethesda System	$35.91	No	No		
G0123	Pap Test (Routine Screening) Bethesda System	$27.60	No	No		
G0124	Pap Test/Diagnostic (Interpretation by Physician)	$31.65	No	No		
88141, p3001**	Pap Test/Diagnostic (Interpretation by Physician)	$31.65	No	No		
88142**	Thin Prep	$27.60	No	No		
88143**	Thin Prep automated	$27.60	No	No		
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	$95.67	No	Yes	$64.19	$31.48
88332	Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen	$52.13	Yes	Yes	$31.68	$20.45
87624***	HPV HR test – HPV test High Risk Only	$47.80	No	No		
87625***	HPV test – types 16 and 18 only	$47.80	No	No		
	***HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. It is not reimbursable as a primary screening test for women of all ages. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.					
57452	Colposcopy w/o Biopsy	$103.47	No	No		
57454	Colposcopy with Biopsy and/or Endocervical Curettage	$144.74	No	No		
57455	Colposcopy with Biopsy(s) of Cervix	$135.56	No	No		
57456	Colposcopy with Endocervical Curettage	$127.94	No	No		
57505	Endocervical Curettage (not done as d & c)	$97.85	No	No		
88305	Surgical pathology, gross and microscopic examination	$67.22	Yes	Yes	$38.50	$28.72
88342	Immunohistochemistry or immunocytochemistry, per specimen; first strain	$106.80	No	Yes	$36.05	$70.75

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional strain	$90.91	Yes	Yes	$28.90	$62.01
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	$130.71	Yes	Yes	$45.14	$85.56
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	$142.17	Yes	Yes	$47.99	$94.18
99070	Supplies and materials (except spectacles), provided by physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	$16.04	Yes	No		
81025	Urine pregnancy test (if needed, to be done in conjunction with a WWWP allowed cervical diagnostic test)	$8.61	No	No		
ALLOWABLE CERVICAL DIAGNOSTICS - The following procedures are allowed by WWWP **ONLY** when performed for diagnostic procedures in accordance with ACS, ASCCP, ASCP Consensus Guidelines for the Prevention and Early Detection of Cervical Cancer 2012.						
57460	Endoscopy w/ loop electrode biopsy(s) of the cervix	$269.76	No	No		
57461	Endoscopy w/ loop electrode conization of the cervix	$304.52	No	No		
57500	Biopsy, single or multiple, or local excision of lesion, with or w/o fulguration (separate procedure)	$122.20	No	No		
57520	Conization of cervix, with or w/o fulguration, with or w/o dilation and curettage, with or w/o repair; cold knife or laser	$292.34	No	No		
57522	Loop electrode excision procedure	$250.47	No	No		
58100	Endometrial sampling (biopsy) with or w/o endocervical sampling (biopsy), w/o cervical dilation, any method (separate procedure)	$103.37	No	No		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure)	$45.72	No	No		
Procedures not listed are not covered by WWWP. Providers need to discuss any non-covered services with clients before providing them.						
*** These few radiology CPT codes are eligible for multiple units on an exception basis only (e.g., after breast surgery, implants).**						
**** All Pap test results, regardless of method performed, must be reported using Bethesda System.**						
PROCEDURES SPECIFICALLY NOT ALLOWED						
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer					

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