Wisconsin Well Woman Program Policy and Procedures Manual
Appendix 5: WWWP Covered Breast and Cervical Cancer Screening Services

This appendix identifies breast and cervical cancer screening procedures that are covered by the Wisconsin Well Woman Program (WWWP). Services not listed are not covered.

Procedures specifically **not covered** by WWWP include, but are not limited to:

- Any service or procedure code not listed in this appendix.
- Any cytology or Human Papillomavirus (HPV) test not included in the parameters of the American Society for Colposcopy and Cervical Pathology (ASCCP) Guidelines.
- Treatment services for breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia, and cervical cancer.

Please note that the WWWP Enrollment form (F-44818, F-44818s) and the following WWWP report forms, per services received, must be completed and submitted to the ForwardHealth Portal in order for claims to be paid:

- WWWP Breast and Cervical Cancer Screening Activity Report Form (ARF) (F-44723) (F-44723i instructions)
    - ❖ Documentation on this form must include the service date, service result, and follow-up recommendation.

- WWWP Breast Cancer Diagnostic and Follow-up Report Form (DRF) (F-44724) (F-44724i instructions)
- WWWP Cervical Cancer Diagnostic and Follow-up Report Form (DRF) (F-44729) (F-44729i instructions)
    - ❖ Documentation on these forms must include the service date, service result, recommendation, status of the final diagnosis, and the final diagnosis.
    - ❖ When indicated, documentation must also include tumor stage, tumor size, treatment status, and treatment date.

WWWP BREAST CANCER SCREENING AND DIAGNOSTIC TESTING CRITERIA

The Center for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) grantees should focus on populations with high rates of late-stage breast cancer diagnosis and high rates of breast cancer mortality as determined by available data in effort to reduce breast cancer disparities. This is not an eligibility requirement.

Women 40–64 years

- Clinical Breast Exam (CBE) and screening mammogram every 1–2 years
- Covered diagnostic services per clinical guidelines

Exceptions to age criteria (See WWWP Policy and Procedure Manual, Chapter 3, for details on age exception eligibility.)

Women 35–39 years are eligible for a CBE and further covered services as clinically necessary when they are**:**

- Self-reporting breast symptoms. Breast symptoms are defined as:
  - ❖ Breast lump or palpable mass
  - ❖ Bloody or serous nipple discharge
  - ❖ Breast skin changes (dimpling, retraction, redness, thickening)
  - ❖ Nipple or areolar scaliness
  - ❖ Breast pain unrelated to menstrual cycle
  - ❖ Abnormal mammogram that is suspicious for cancer
- Eligible and enrolled in Family Planning Only Services (FPOS) and referred directly to WWWP after an abnormal breast exam or abnormal mammogram that is suspicious for cancer.

Women ≥ 65 years who are not eligible to receive Medicare Part B and Medicare-eligible women who cannot pay the premium to enroll in Medicare Part B may be eligible for breast cancer screening services. A woman who is eligible but not enrolled in Medicare Part B should be encouraged to enroll in Medicare Part B.

Women at high risk for breast cancer should ask their health care provider for guidance about screening. Annual screening is available for women who are considered at high risk for breast cancer. Women at high risk for breast cancer should be screened with both an annual mammogram and an annual breast MRI.

Breast Cancer High-Risk Criteria Includes Women:

- Who have a history of breast cancer.
- Who have a lifetime risk of breast cancer of 20% or greater, according to risk assessment models that are largely dependent on family history.
- Who have a known BRCA1 or BRCA2 gene mutation.
- Who have a first-degree relative with premenopausal breast cancer or with a BRCA1 or BRCA2 gene mutation.
- Who have a history of radiation treatment to the chest area before the age of 30.

Providers should follow professionally-accepted clinical practice guidelines for details on diagnosing breast cancer.

WWWP Covered Office Visit Codes for Breast and Cervical Cancer Screening Services

The type and duration of allowable 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. Reimbursement is not to exceed those rates published by Medicare.

Office Visit Procedure Codes	Description	Reimbursement Notes
New 99202 – 15-29 min. 99203 – 30-44 min. **Established** 99211 – Time Not Specified 99212 – 10-19 min. 99213 – 20-29 min. 99214 – 30-39 min.	**Evaluation and Management Office Visit (EMOV)** Per CDC, EMOV are adequate and appropriate for breast and cervical cancer screening and follow-up services. EMOV should not be used to discuss test results or treatment. A CBE and Pap test should be done at the same visit when appropriate to maximize resources. Telehealth visits may be used in place of the standard EMOV as appropriate. EMOV may be used as a WWWP related office visit without a breast or cervical exam.	Use these codes as primary coding for WWWP office visits, including visits for required follow up. Use 99211 for normal, annual CBE with no cervical screening component. May use G0101 when necessary. The provider must complete the Office Visit Without CBE section on the F-44723 form for reimbursement of an WWWP office visit without a breast or cervical exam or for a WWWP telehealth visit.
G0101	**Office Visit (OV)** Cervical cancer screening; pelvic and clinical breast examination. Should not be used to discuss test results or treatment.	May use when necessary.
99459	Pelvic examination; fees for the cost of pelvic exam packs and in-room chaperones.	Only allowed in conjunction with a Pap or HPV test. List separately, in addition to primary procedure.
Initial 99385 35-39 yrs. 99386 40-64 yrs. 99387 ≥ 65 yrs. **Periodic** 99395 35-39 yrs. 99396 40-64 yrs. 99397 ≥ 65 yrs.	**Preventive Medicine Office Visit (PMOV)** Per CDC, the PMOV is **not** appropriate for WWWP screening visits. Use only if necessary for health and evaluation of risk profile for breast and/or cervical exams including annual CBE and Pap test. PMOV should not be used to discuss test results or treatment. ^PMOV may be used as a WWWP realted office visit without a breast or cervical exam.	The PMOV is not covered by Medicare. Limited to one PMOV per client per year. If used, these codes will be reimbursed using comparable Medicare rates for the EMOV. The 9938X codes shall be reimbursed at or below the 99203 rate. The 9939X codes shall be reimbursed at or below the 99213 rate.
New 99204 – 45-59 minutes 99205 – 60-74 minutes	**Consultation Office Visit (COV)** The COV (99204 & 99205) is typically not appropriate for WWWP screening visits, but may be used when a provider spends extra time to do a detailed risk assessment. COV can be used to determine further breast diagnostic studies only after abnormal breast findings and to discuss additional testing needs. COV should not be used to discuss test results or treatment.	All COV should be billed through the standard “new patient” office visit CPT codes 99202-99205. The COV billed at 99204 and 99205 must meet the criteria for these codes. No other consultations are covered.
Follow-Up Notes	**Any abnormal breast or cervical cancer screening requires follow up.**	

WWWP Covered Breast Cancer Screening and Diagnostic Services

Current Procedural Terminology (CPT) Codes - Breast	Description	Reimbursement Notes Radiology, use TC or 26 modifier as indicated
77067	Screening mammography, bilateral, includes CAD	
77065	Diagnostic mammography, unilateral, includes CAD	Additional views can be reimbursed for women with implants or after chest surgery.
77066	Diagnostic mammography, bilateral, includes CAD	Additional views can be reimbursed for women with implants or after chest surgery.
77063	Screening digital breast tomosynthesis, bilateral	List separately in addition to code for primary procedure 77067
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	List separately in addition to 77065 or 77066
76641	Ultrasound, complete examination of breast including axilla, unilateral	Reimbursable as follow up for abnormal breast findings. Not reimbursed for screening.
76642	Ultrasound, limited examination of breast including axilla, unilateral	Reimbursable as follow up for abnormal breast findings. Not reimbursed for screening.
77053	Mammary ductogram or galactogram, single duct	
76098	Radiological examination, surgical specimen	
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	
77046[1]	Magnetic resonance imaging (MRI), breast, without contrast, unilateral	[1] **Breast MRI must be preauthorized** and can be reimbursed by the WWWP when performed in conjunction with a mammogram when a client has been determined to be high risk (for example, has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models). Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed by the WWWP to assess the extent of disease for staging in a client recently diagnosed with breast cancer and preparing for treatment. WWWP will be conducting retrospective reviews on all MRI performed procedures.
77047[1]	Magnetic resonance imaging (MRI), breast, without contrast, bilateral	
77048[1]	Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral	
77049[1]	Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral	
Follow-up Notes	**Any abnormal mammogram or breast finding requires follow up.**	

WWWP Covered Breast Cancer Screening and Diagnostic Services

Biopsy	Reimbursement Notes
Biopsy, Incision, Excision	Physician, facility, imaging, anesthesia, and pathology can be reimbursed for listed outpatient biopsy procedures.
Room charges, in-patient services, drugs, and non-listed testing are not covered. WWWP clients need to be apprised of any additional costs to them prior to the services being provided. Clients will need to agree to personal costs based on non-covered WWWP procedures and services.	

Current Procedural Terminology (CPT) Codes - Breast	Description
10021	Fine needle aspiration biopsy without imaging guidance, first lesion
10004	Fine needle aspiration biopsy without imaging guidance, each additional lesion
10005	Fine needle aspiration biopsy including ultrasound guidance, first lesion
10006	Fine needle aspiration biopsy including ultrasound guidance, each additional lesion
10007	Fine needle aspiration biopsy including fluoroscopic guidance, first lesion
10008	Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion
10009	Fine needle aspiration biopsy including CT guidance, first lesion
10010	Fine needle aspiration biopsy including CT guidance, each additional lesion
10011	Fine needle aspiration biopsy including MRI guidance, first lesion, **for code 10011, use reimbursement rate for code 10009**
10012	Fine needle aspiration biopsy including MRI guidance, each additional lesion, **for code 10012, use reimbursement rate for code 10010**
19000	Puncture aspiration of breast cyst
19001	Puncture aspiration of breast cyst, each additional cyst, used with 19000
19081[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; stereotactic guidance, first lesion
19082[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; stereotactic guidance, each additional lesion
19083[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; ultrasound guidance, first lesion
19084[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; ultrasound guidance, each additional lesion
19085[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; magnetic resonance guidance, first lesion
19086[2]	Breast biopsy, placement of localization device & imaging of biopsy specimen, percutaneous; magnetic resonance guidance, each additional lesion
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance
19101	Breast biopsy, open incisional
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
19125	Excision of breast lesion identified by pre-op placement of radiological marker; open; single lesion
19126	Excision of breast lesion identified by pre-op placement of radiological marker; open; each additional lesion separately identified by a preoperative radiological marker
38505	Needle biopsy of axillary lymph node; superficial; **must be done in conjunction with a breast biopsy**
	[2]Codes 19081–19086 are to be used for breast biopsies that include image guidance, placement of a localization device, and imaging of specimen. They should not be used in conjunction with 19281–19288.
Follow-Up Notes	**Any abnormal breast findings require follow up and referral for treatment per clinical program time frames and guidelines.**

WWWP COVERED BREAST CANCER SCREENING AND DIAGNOSTIC SERVICES

Current Procedural Terminology (CPT) Codes - Breast	Description
19281[3]	Placement of breast localization device, percutaneous; mammographic guidance; first lesion
19282[3]	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion
19283[3]	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion
19284[3]	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion
19285[3]	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion
19286[3]	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion
19287[3]	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion
19288[3]	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion
	[3]Codes 19281–19288 are for image guidance placement of a localization device without image-guided biopsy. These codes should not be used in conjunction with 19081–19086.
Follow-Up Notes	**Any abnormal breast findings require follow up and referral for treatment per clinical program time frames and guidelines.**

WWWP Cervical Cancer Screening and Diagnostic Testing Criteria

A CDC NBCCEDP grant requirement specifies that a minimum of 35% of cervical cancer screenings should be provided to program-eligible women who have never been screened for cervical cancer or have not been screened within the past 10 years. This is not an eligibility requirement.

Women 40–64 years

- Pelvic Exam (PE) **with** routine cervical cancer screening per clinical guidelines
  Routine cervical cancer screening per CDC guidelines for WWWP are based on a prior negative cytology or a prior negative co-test (cytology & HPV test)
  - ❖ Negative results = Routine screening for 40-64 years old with cytology alone every 3 years
  - ❖ Negative results = Routine screening for 40-64 years old with co-testing (cytology & HPV test) every 5 years
  - ❖ Negative results = Routine screening for 40-64 years old with Primary HPV testing every 5 years.
  - ❖ Abnormal results = Additional screening and care per ASCCP guidelines
- Covered diagnostic services per ASCCP clinical guidelines

Exceptions to above age criteria (See WWWP Policy and Procedure Manual, Chapter 3, for details on age exception eligibility.)

Women 35–39 years are eligible for a PE with routine cervical cancer screening and further covered services as clinically necessary when they are:

- Not eligible for Family Planning Only Services (FPOS) and have never been screened for cervical cancer **or** have not been screened for cervical cancer in the past 10 years.

Women ≥ 65 years who are not eligible to receive Medicare Part B and Medicare-eligible women who cannot pay the premium to enroll in Medicare Part B may be eligible for cervical cancer screening services. A woman who is eligible but not enrolled in Medicare Part B should be encouraged to enroll in Medicare Part B.

Women with a history of CIN2, CIN3, adenocarcinoma in situ (AIS) or cervical cancer should continue screening for at least 20 years after spontaneous regression or appropriate management, even when screening exceeds the age of 65.

Women with high-risk factors for cervical cancer should ask their health care provider for guidance about screening. Women at high risk for cervical cancer are screened more frequently than women at average risk. Annual Pap testing or co-testing every 3 years is available for women who are considered at high risk for cervical cancer.

Cervical Cancer High-Risk Criteria Includes Women:

- With a prior history of CIN2, CIN3 or cervical cancer.
- With HIV infection.
- Who have had an organ transplantation.
- Who may be immunocompromised from another heath condition.
- Who had DES exposure in utero.

Providers should follow professionally-accepted clinical practice guidelines for details on diagnosing cervical cancer.

WWWP funds **cannot** be used to pay for cervical cancer screening in women with total hysterectomies (those without a cervix), unless the hysterectomy was performed because of cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer.

When to stop Pap test screening

Cervical cancer screening is not recommended for women older than 65 years of age who have had adequate screening and are not at high risk.

WWWP COVERED CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES

Current Procedural Terminology (CPT) Codes - Cervical	Description	Reimbursement Notes
Pap Test	**All Pap test results, regardless of method performed, must be reported using Bethesda System.**	
88141	Cytopathology, cervical or vaginal, (any reporting system), requiring interpretation by physician	
88142	Cytopathology cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	
88143	Cytopathology cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	
88174	Cytopathology cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	
88175	Cytopathology cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	
Human Papillomavirus (HPV) Tests	**HPV DNA testing is reimbursable when used for screening or follow-up of abnormal Pap results. HPV genotyping is reimbursable when used for follow-up of abnormal cervical cancer screening results as per ASCCP algorithms.**	
87624	Human Papillomavirus (HPV), high-risk types	Screening for low-risk HPV types will not be reimbursed. Providers should specify the high-risk HPV DNA panel only.
87625	Human Papillomavirus, types 16 and 18 only, includes type 45, if performed	Genotyping
87626	Human Papillomavirus, separately reported high-risk types and high-risk pooled results	Cannot be reimbursed along with 87624 or 87625.
Follow-up Notes	**Any abnormal cervical finding requires follow up according to the professionally accepted ASCCP Risk-Based Management Consensus Guidelines for abnormal cervical cancer screening tests and cancer precursors.**	

WWWP Covered Cervical Cancer Screening and Diagnostic Services

Current Procedural Terminology (CPT) Codes - Cervical	Description	Reimbursement Notes
57452	Colposcopy of the cervix	
57454	Colposcopy of the cervix, with biopsy and endocervical curettage	
57455	Colposcopy of the cervix, with biopsy	
57456	Colposcopy of the cervix, with endocervical curettage	
57505	Endocervical curettage (not done as part of a dilation and curettage)	
99212	Evaluation & Management Office Visit - Established patient; medically appropriate history/exam; strait forward decision making; 10-19 minutes	Can be billed for colposcopy and cervical biopsy procedures only.
Follow-Up Notes	**Any abnormal cervical findings require follow up and referral for treatment per clinical program time frames and guidelines. Follow up for uterine or other gynecological conditions are not covered. Treatment services are not covered.**	

The following procedures are allowed by WWWP only when performed as diagnostic procedures in accordance with the 2019 American Society for Colposcopy and Cervical Pathology (ASCCP) Risk-Based Management Consensus Guidelines.		
57460	Colposcopy with loop electrode biopsy(s) of the cervix	
57461	Colposcopy with loop electrode conization of the cervix	
57500	Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	For reimbursement of a LEEP or conization of the cervix, there must be a diagnostic component to the procedure. These services are not covered for treatment purposes only.
57522	Loop electrode excision procedure	
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	Endometrial biopsy can only be reimbursed as a follow-up to a recent abnormal Pap test with atypical glandular cells (AGC) or when a Pap test in postmenopausal women shows endometrial cells.
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	
Follow-Up Notes	**Any abnormal cervical findings require follow up and referral for treatment per clinical program time frames and guidelines. Follow up for uterine or other gynecological conditions are not covered. Treatment services are not covered.**	

WWWP COVERED PATHOLOGY CODES

Current Procedural Terminology (CPT) Codes - Pathology	Description	Reimbursement Notes
88305	Surgical pathology, gross and microscopic examination	Radiology, use TC or 26 modifier as indicated.
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)	
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode	
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	
88365	In situ hybridization (eg,FISH), per specimen; initial single probe stain procedure	
88364	In situ hybridization (eg,FISH), per specimen; each additional single probe stain procedure	
88366	In situ hybridization (eg,FISH), per specimen; each multiplex probe stain procedure	
88367	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure	
88373	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each additional probe stain procedure	
88374	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure	
88368	Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure	
88369	Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure	
88377	Morphometric analysis, in situ hybridization, manual, per specimen, each multiplex stain procedure	

WWWP COVERED CODES

Current Procedural Terminology (CPT) Codes - COVID-19 Testing	Description	Reimbursement Notes
87426	COVID-19 infectious agent detection by nuclei acid DNA or RNA; amplified probe technique	NBCCEDP reimburses for COVID antigen or PCR testing only when required prior to a breast or cervical cancer procedure and no other payment for testing is available. NBCCEDP does not reimburse for COVID antibody testing.
87635	COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semi quantitative	

Current Procedural Terminology (CPT) Codes – Anesthesia & Sedation	Description	Reimbursement Notes
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	Use modifiers AA, QZ, QK, QY, or QX Include base units
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	Use modifiers AA, QZ, QK, QY, or QX Include base units
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older.	For 10-22 minutes, use CPT code 99156 No separate charge if < 10 minutes.
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes of intraservice time, patient age 5 years or older.	For 23-37 minutes, use CPT code 99156 plus 99157 x 1 For 38-52 minutes, use CPT code 99156 plus 99157 x 2

Current Procedural Terminology (CPT) Codes - Miscellaneous	Description	Reimbursement Notes
81025	Urine pregnancy test (if needed, to be done in conjunction with a WWWP allowed cervical diagnostic test)	
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	