



Every Woman Counts Program  
**BREAST and CERVICAL** Primary Care Provider  
Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) program for “Breast and Cervical Primary Care Providers.” Providers must have an appropriate ICD-10-CM code(s) listed as the first and/or second diagnosis code on the claim to be eligible for payment. For the list of appropriate CPT® specific ICD-10-CM codes please refer to ev woman, the EWC section of the Medi-Cal Provider Manual:

[http://files.medi-cal.ca.gov/pubdoco/publications/masters-mtp/part2/evwoman\\_m00o03.doc](http://files.medi-cal.ca.gov/pubdoco/publications/masters-mtp/part2/evwoman_m00o03.doc).

See important EWC reminders below.

**Procedure Code Definitions** (May Require Modifier\*)

**CPT Codes**

- 00400** – Anesthesia, integumentary system anterior trunk
- 10004** – Fine needle aspiration biopsy, without imaging; each additional lesion
- 10005** – Fine needle aspiration biopsy, including ultrasound guidance; first lesion
- 10006** – With 10005; each additional lesion
- 10007** – Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
- 10008** – With 10007; each additional lesion
- 10011** – Fine needle aspiration biopsy including MRI guidance, first lesion
- 10012** – Fine needle aspiration biopsy including MRI guidance, each additional lesion
- 10021** – Fine needle aspiration; without imaging guidance
- 19000** – Puncture aspiration of cyst of breast
- 19001** – With 19000; each additional cyst
- 19081** – Biopsy of breast, with localization device placement and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion
- 19082** – With 19081; each additional lesion
- 19083** – Biopsy of breast, with localization device placement and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion
- 19084** – With 19083; each additional lesion
- 19085** – Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion
- 19086** – Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion
- 19100** – Needle Core biopsy of breast; without imaging guidance
- 19101** – Biopsy of breast, open, incisional
- 19120** – Excisional Biopsy, open
- 19125** – Excision of breast lesion, identified by preoperative placement of radiological marker; single lesion
- 19126** – With 19125; each additional lesion
- 19281** – Localization device placement, percutaneous; mammographic guidance; first lesion
- 19282** – With 19281; each additional lesion

- 19283** – Localization device placement, percutaneous; stereotactic guidance; first lesion
- 19284** – With 19283; each additional lesion
- 19285** – Localization device placement, percutaneous; ultrasound guidance; first lesion
- 19286** – With 19285; each additional lesion
- 19287** – Placement of breast localization device, percutaneous magnetic resonance guidance, first lesion
- 19288** – Placement of breast localization device, percutaneous magnetic resonance guidance, each additional lesion
- 57452** – Colposcopy
- 57454** – Colposcopy with biopsy of the cervix and endocervical curettage
- 57455** – Colposcopy with biopsy of the cervix
- 57456** – Colposcopy with endocervical curettage
- 57500** – Biopsy of cervix
- 57505** – Endocervical curettage, with 58100
- 58100** – Endometrial sampling, with 57505
- 58110** – Endometrial sampling with colposcopy
- 76098** – Radiological examination, surgical specimen
- 76641** – Ultrasound, complete examination of breast including axilla, unilateral
- 76642** – Ultrasound, limited examination of breast including axilla, unilateral
- 76942** – Ultrasonic guidance for needle placement; imaging supervision & interpretation
- 77046** – Magnetic resonance imaging (MRI), breast, without contrast, unilateral
- 77047** – Magnetic resonance imaging (MRI), breast, without contrast, bilateral
- 77048** – Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral
- 77049** – Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral
- 77065** – Diagnostic mammography; unilateral, includes CAD
- 77066** – Diagnostic mammography; bilateral, includes CAD
- 77067** – Screening mammogram, bilateral
- 81025** – Urine pregnancy test; only if billed with one or more code
- 87624** – Infectious agent detect by DNA or RNA; Human Papillomavirus (HPV), high-risk types
- 87625** – Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
- 88141** – Pap, physician interpretation
- 88142** – Pap, liquid based; manual screening
- 88143** – Cytopathology-C/V, liquid based, manual screening and rescreening
- 88164** – Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- 88172** – Cytopathology evaluation of fine needle aspirate; to determine adequacy of specimen
- 88173** – Interpretation and report for evaluation of fine needle aspirate
- 88174** – Liquid based, automated screening
- 88175** – Liquid based, automated screening with manual rescreening
- 88305** – Level IV Surgical pathology examination
- 88307** – Level V Surgical pathology examination
- 88341** – Immunohistochemistry, each additional single a/b stain
- 88342** – Immunohistochemistry
- 88360** – Morphometric analysis, tumor immunohistochemistry; manual
- 99070** – Supplies and material, not included with office visit

- 99202** – Office visit; new patient 20 minutes
- 99203** – Office visit; new patient 30 minutes
- 99204** – Office visit; new patient 45 minutes
- 99212** – Office visit; established patient 10 minutes
- 99213** – Office visit; established patient 15 minutes
- 99214** – Office visit; established patient 25 minutes

**HCPCS codes**

- A4217** – Sterile water/saline, 500 ml
- G2010** – Remote evaluation of recorded video and/or images; established patient
- G2012** – Brief communication technology-based; established patient
- J7030** – Infusion, normal saline solution, 1000 cc
- J7040** – Infusion, normal saline solution, sterile (500 ml = 1 unit)
- J7050** – Infusion, normal saline solution, 250 cc
- J7120** – Ringers lactate infusion, up to 1000 cc
- T1013** – Sign language or oral interpretive service/15 min
- T1017** – Case Management – Immediate follow-up (PCP only)
- Z7500** – Examination or Treatment Room use
- Z7506** – Operating Room or Cystoscopic Room use, first hour
- Z7508** – Operating Room or Cystoscopic Room use, first subsequent half hour
- Z7510** – Operating Room or Cystoscopic Room use, second subsequent half hour
- Z7512** – Recovery Room use
- Z7514** – Room and board general nursing care, less than 24 hours
- Z7610** – Miscellaneous drugs and medical supplies

**\*Commonly Used Modifiers** - For a complete list of approved Medi-Cal modifiers, refer to the relevant section of the Medi-Cal Provider Manual.

- 26** – Professional Component
- 51** – Multiple Surgeon Procedure
- 99** – Multiple Modifiers (e.g. AG+51)
- AG** – Primary Surgeon/Procedure
- KX** – Facilitates claim processing in instances where the patient’s gender conflicts with the billed procedure code
- TC** – Technical Component
- UA** – Surgical supplies with no anesthesia or other than general anesthesia, provided in conjunction with surgical procedure code.

## **EWC REMINDERS**

Program covered cancer screening and diagnostic services are FREE.

Balance billing is prohibited!

If non-covered services are recommended, written acknowledgment of cost and payment agreement must be obtained from the EWC recipient.

Only Primary Care Providers (PCP) can enroll women and obtain the Recipient ID#.

EWC enrollment is valid for 12 months; then, if eligible, the woman can be recertified or re-enrolled.

All providers must verify current eligibility before rendering services.

Only PCP's may claim for case management.

Only immediate work-up cycles are eligible for case management payment.

Claims must be submitted with the woman's EWC Recipient ID# (14 digit identification number).

Payment for program-covered services is at Medi-Cal rates.

All services and findings must be reported to the PCP.