Every Woman Counts

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This section includes information about Every Woman Counts (EWC). EWC is a comprehensive, public health program that assists uninsured and underinsured individuals whose household income is at or below 200 percent of the Department of Health and Human Services (HHS) poverty guidelines in obtaining high quality cancer screening and follow-up services. In addition to offering screening and diagnostic services, the program is designed to facilitate regular rescreening of women with normal or benign breast and/or cervical conditions to provide diagnostic services for individuals presented with symptoms and/or abnormal screening results, and to refer for treatment when necessary. The goal of the program is to affect the devastating effect of breast and cervical cancer by reducing morbidity and mortality rates of Californians.

Every Woman Counts (EWC)

Every Woman Counts (EWC) is the multi-faceted program managed by the Department of Health Care Services (DHCS), Benefits Division.

Components of EWC include the following:

- Health education and outreach activities
- Breast and cervical cancer screening and diagnostic services
- Quality assurance and improvement through professional education and evaluation of clinical and claims data
- Recipient care coordination to ensure women are screened regularly and at recommended intervals
- Provision of diagnostic services for individuals presenting with symptoms and/or abnormal screening results
- Referral to treatment when necessary

The program is funded by both federal and state dollars. Federal funds are received from the Centers for Disease Control and Prevention. State funds are received from two tobacco taxes and general funds.

Breast and cervical cancer early detection and screening services are provided in all counties of the state.

EWC and Medi-Cal Work Together

EWC and Medi-Cal are separate programs; however, EWC relies on Medi-Cal billing procedures to process both hard copy and electronic claims.

Regional Contractors

The Regional Contractors are local representatives of EWC. The Regional Contractors are public and private agencies that ensure low-income individuals receive breast and cervical cancer screening services. The Regional Contractors are responsible for recruitment, training, and maintenance of the EWC provider network and providing tailored health education for eligible recipients.

Clinical Standards

EWC services are performed in accordance with EWC clinical standards, which are available through 10 Regional Contractors statewide and online at *www.medi-cal.ca.gov*.

Activities

Regional Contractors conduct the following activities:

- Recruit and train EWC primary care providers (PCPs)
- Support EWC providers to participate in breast and/or cervical health service delivery networks
- Conduct local targeted outreach and public education
- Address gaps in the delivery of these services
- Coordinate professional education about breast and/or cervical cancer screening and related subjects
- Provide technical assistance for development of recipient tracking and follow-up systems that facilitate annual rescreening and timely referrals for individuals with abnormal findings
- Provide technical assistance and training in entering recipient information, eligibility, and data into the EWC data entry application known as DETEC (DETecting Early Cancer)
- Provide technical assistance and training with data entry to meet the Core Program Performance Indicators (CPPI) measuring quality outcomes

Provider Participation Requirements

All PCPs must contact the Regional Contractor in their area for information and orientation before rendering EWC services. Prior to providing services, all new PCPs must receive training about program standards and requirements, submission of hard copy or electronic claims, and submission of outcome data via DETEC. New PCPs are eligible to render services only after the effective date of enrollment, as stated in the EWC welcome letter. PCPs must adhere to all requirements contained in the Primary Care Provider Enrollment Agreement (PCPEA), EWC clinical standards and data submission requirements.

A Primary Care Provider must:

- Be a Medi-Cal provider in good standing and licensed in the state of California.
- Enroll in the program through a Regional Contractor.
- Complete and sign a *Primary Care Provider Enrollment Agreement*.
- Have Internet access.

Internet Access Required

PCPs must have Internet access to obtain the 14-character recipient identification number that is required for hard copy or electronic claim submission, and for completing DETEC online enrollment and data forms. See “Online Recipient Information Form” in this section for further instructions.

Regional Contractors Enroll PCPs

Regional Contractors determine who may be enrolled as a PCP based on the need to complete service networks in a geographic area or improve access to care for targeted populations.

NPI Billing Requirement

PCPs are required to use only a National Provider Identification (NPI) number to bill for services covered by EWC.

When a PCP acquires an NPI, the Medi-Cal Provider ID number (legacy number) is end-dated and all client records associated with that Provider ID are transferred to the new NPI. Therefore, any claims submitted under the legacy number will be denied.

Referral Providers

Referral providers are those who receive referrals from PCPs to render any screening or diagnostic services. Referral providers must be Medi-Cal providers in good standing and licensed in the state of California. Referral providers do not enroll in EWC or sign a provider agreement. Examples of referral providers include the following:

- Anesthesiologists
- Laboratories
- Mammography facilities
- Pathologists
- Radiologists
- Surgeons

Claimable Procedures for Referral Providers

Referral providers may bill EWC for all procedure codes marked with a section symbol (§) in the list under the “Approved Procedures” heading located in this section.

Referral Providers Rely on PCPs

In order to bill, EWC referral providers must have the recipient’s 14-character ID number provided by the PCP. Claims submitted without the recipient’s ID number will be denied.

After the PCP verifies the recipient’s eligibility for and enrolls them in EWC, the PCP must communicate the recipient ID number to the referral provider. The referral provider may then submit a claim for payment, according to EWC guidelines.

Referral providers must report their screening and diagnostic findings to the PCP, who is responsible for submitting data and outcomes to EWC and for coordinating further care or follow-up.

Payments from Recipient Disallowed

Referral and Primary Care providers must not attempt to obtain payment from recipients for co-payments or the balance of costs of breast and/or cervical cancer screening or diagnostic services. Payment received by providers from EWC in accordance with the Medi-Cal fee structure, constitutes payment in full.

LA County Waiver Program, RHC, FQHC and IHS Guidelines

Providers who render services for the following special programs may bill only as an EWC Primary Care Provider using an NPI number that is actively enrolled, and must submit claims according to EWC guidelines. These special programs cannot submit claims as a referring provider:

- LA County Waiver Program
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Indian Health Centers (IHS)

All other requirements in this section apply to these special program providers. Questions may be directed to the Telephone Service Center (TSC) at 1-800-541-5555.

Assessment of Tobacco Use and Referral for Smoking Cessation

PCPs are required to assess every individual enrolled into EWC and refer those who do use tobacco to a cessation program. Screening for tobacco use is to be completed by the PCP at the time of enrollment or recertification and recorded on the *Recipient Application* (DHCS 8699). The provider must keep a copy of the recipient-signed form on file.

Assessment is encouraged to be performed at every office visit and is not a separately reimbursable procedure. Tobacco assessments and cessation referrals must be documented and maintained in the recipient's medical record.

Tobacco Cessation Referral Resource Suggestions

The California Smoker's Helpline provides many valuable resources for users of tobacco products and health care providers. The helpline can be accessed online at *www.californiasmokershelpline.org* or by calling 1-800-NO-BUTTS (1-800-662-8887).

The California Tobacco Control Program provides information about a variety of topics, including help with quitting and local tobacco control efforts. Information can be found on the California Department of Public Health website (*www.cdph.ca.gov*) in the "Programs" section.

The Center for Tobacco Cessation provides training and technical assistance to organizations statewide to increase their capacity in tobacco cessation. Information is available at the website *www.centerforcessation.org*.

Breast and Cervical Cancer Treatment Program (BCCTP)

PCPs working in connection with EWC are authorized to enroll eligible individuals in the Breast and Cervical Cancer Treatment Program (BCCTP). The BCCTP has two programs for which individuals may be eligible. The federal BCCTP provides full-scope Medi-Cal to eligible individuals who meet all the federal criteria. The state-funded BCCTP only provides cancer treatment and related services to any individual, including men, who does not meet the federal criteria. BCCTP enrollment information is available from BCCTP eligibility specialists at 1-800-824-0088. BCCTP guidelines also are available on the Medi-Cal website at *www.medi-cal.ca.gov*.

Note: All BCCTP applicants must be determined ineligible for full-scope county Medi-Cal in order for BCCTP to complete its eligibility determination. If the applicant qualifies for full-scope county Medi-Cal, they cannot be approved for BCCTP.

Referral to BCCTP

BCCTP offers treatment through the Medi-Cal program for individuals with breast and/or cervical cancer who meet eligibility criteria. Family PACT (Planning, Access, Care and Treatment) Program providers may also enroll recipients into BCCTP.

Diagnoses Obtained Through EWC

Individuals who are already in EWC and are diagnosed with breast cancer (including in situ) and/or cervical cancer, cervical intraepithelial neoplasia II (CIN II) or CIN III can be referred into BCCTP. Providers should fill in the box on the *DETEC Screening Cycle Data* form that states, "Patient enrolled in BCCTP. Check only if you have completed the BCCTP enrollment process." Providers should go to the BCCTP page on the Medi-Cal website and follow the program enrollment procedures. If the recipient has a breast or cervical cancer that is not on the drop down menu of qualifying diagnoses for BCCTP enrollment, the provider should call BCCTP and request to speak with a manager for further instructions.

Diagnoses Obtained Outside EWC

Individuals who meet the EWC program income and insurance eligibility criteria can be referred to BCCTP through EWC PCPs. The provider must confirm that the recipient meets income and insurance EWC eligibility criteria, and that the recipient has presented documented proof of breast cancer (including in situ) and/or cervical cancer, CIN II or CIN III. The provider must be able to present this documentation upon request. In addition, the recipient completes the *Recipient Application* (DHCS 8699) on paper, and the provider completes the application verifying current financial and demographic information.

For individuals who meet all EWC eligibility criteria, the PCP must complete the DETEC *Enroll Recipient* form online and select the field labeled, "The purpose of this enrollment is to only refer the recipient to BCCTP for Breast [or Cervical] Cancer treatment," indicating the recipient is being referred to BCCTP. PCPs must enter the qualifying diagnosis and submit the EWC enrollment data. If the recipient has a breast or cervical cancer that is not on the drop-down menu of qualifying diagnoses for BCCTP enrollment, the provider should call BCCTP and request to speak with a manager for further instructions. No other data is required. The provider must keep recipient-signed documentation of the *Recipient Application* (DHCS 8699) on file. Providers then are to follow BCCTP enrollment procedures.

For information about billing an office visit for the verification of a cancer diagnosis, or for more BCCTP information, contact the Eligibility Specialist at 1-800-824-0088. Additional information can be found at *www.medi-cal.ca.gov*.

EWC Additional Testing to Confirm Diagnosis

If a provider determines more testing is needed for an individual from outside EWC before confirming a cancer diagnosis, the provider may perform testing under EWC as long as the testing is a program covered service. The provider must understand that once billing occurs in EWC, the same data requirements apply as if the individual were screened within EWC. This means complete screening cycle data must be submitted using the online DETEC Screening Cycle Data forms.

Provider Data-Reporting Requirements

Funding for the EWC Program is dependent on data reported by providers. Providers must maintain complete, accurate and timely recipient data using the appropriate DETEC online forms. Several guidelines for data maintenance include:

- Each recipient has a 365-day certification period when they are eligible to receive services
- DETEC will guide PCPs in how to submit screening procedures and dates
- DETEC will allow changes to data already submitted
- PCPs may update screening and follow-up forms for an additional 365 days after the recipient's eligibility has expired
- PCPs must ensure that all recipient screening, diagnostic, and treatment data have been entered through DETEC

Recipient Eligibility Criteria

The following information describes recipient eligibility criteria.

Age: Cervical Cancer Screening

Women must be 21 years of age or older to be eligible for cervical cancer screening. EWC follows the U.S. Preventive Services Task Force (USPSTF) recommendations. The USPSTF recommends that clinicians screen for cervical cancer in women 21 to 29 years of age every three years with the Pap test alone. For women 30 to 65 years of age, the USPSTF recommends screening either with the Pap test alone every three years, screening with the high-risk human papillomavirus (HPV) test alone (primary HPV testing) every five years, or screening with both tests together (co-testing) every five years. Women should talk to their clinician to choose which strategy is right for them. The USPSTF continues to recommend against screening in women younger than 21 years of age and in women older than 65 years of age who have had adequate prior screening.

Age: Breast Cancer Screening

Women 40 years of age or older are eligible for breast cancer screenings consisting of patient individual risk assessment, counseling and mammogram, as well as necessary follow-up breast diagnostic services. Therefore, screening mammography CPT® code 77067 is restricted to individuals 40 years of age or older.

Symptomatic Individuals

Any individual (women and men) of any age presented with breast cancer symptoms are eligible for breast diagnostic services.

Breast Cancer Symptoms

Warning signs and/or symptoms of breast cancer include, but are not limited to, the following:

- Palpable mass or lumps in the breast
- Changes in size or shape of the breast
- Changes in skin texture or color (dimpling, puckering, redness, scaliness or thickening) of the breast or nipple skin
- Nipple retraction or inversion
- Axillary lymphadenopathy or swelling
- Nipple discharge
- Breast pain

Warning signs and/or symptoms may occur with conditions other than breast cancer.

Note: Only certain providers are eligible to render cervical cancer screening and diagnostic services. See “Provider Participation Requirements” on a preceding page of this section.

Transgender Services

In all EWC sections, regardless of the gender stated, EWC benefits and policies apply to individuals of any gender identity as long as the procedure is medically necessary. The patient’s medical record must support medical necessity for the procedure.

For instructions on overriding gender limitations for procedures, refer to the *Transgender Services* section in the appropriate Part 2 provider manual.

Income Eligibility Guidelines

The federal Health and Human Services (HHS) poverty guidelines are used to determine financial eligibility for EWC. To qualify for breast and cervical cancer screening services, recipients must have a household income at or below 200 percent of the HHS poverty guidelines.

The HHS poverty guidelines are adjusted annually, and the EWC income criteria are likewise updated accordingly.

‹‹The following table lists the EWC income criteria based on the 2021 HHS poverty guidelines.››

EWC Income Eligibility Guidelines Table

‹‹200 Percent of the 2021 HHS Poverty Guidelines by Household Size
Effective April 1, 2021, through March 31, 2022

Number of Persons Living in Household	Monthly Gross Household Income (in dollars)	Annual Gross Household Income (in dollars)
1	2,147	25,760
2	2,903	34,840
3	3,660	43,920
4	4,417	53,000
5	5,173	62,080
6	5,930	71,160
7	6,687	80,240
8	7,443	89,320
For each additional person, add:	757	9,080››

“Gross household income” means the sum of incomes (before taxes and other deductions) of the individual(s) living in the household from sources identified by the U.S. Census Bureau. Monthly gross income for migrant farm workers and other seasonally employed persons may be computed by averaging total gross income received during the previous 12 months.

U.S. Census Bureau sources of income are:

- Money wages or salary
- Net income from non-farm self-employment
- Net income from farm self-employment
- Social Security
- Dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties
- Public assistance or welfare payments
- Pension and annuities
- Unemployment compensation/disability insurance
- Workers' compensation
- Child support
- Veterans' pension
- Alimony

Health Insurance

For an individual to be eligible for EWC, their PCP must certify that they are uninsured or underinsured, based on the individual's self-report.

Recipients may be certified as underinsured for EWC if all three of the following conditions are met:

- No Medicare Part B coverage
- Either no Medi-Cal coverage or limited scope Medi-Cal such as:
  - Medi-Cal for pregnancy or emergency service only, or
  - Medi-Cal with unmet Share of Cost (SOC) obligations
- Either no other public or private insurance coverage or other limited health insurance, such as:
  - Other health insurance co-payments or deductible obligations that cannot be met
  - Other health insurance benefit restrictions, public or private, which exclude services available through EWC

Residency

Eligible individuals must have a California address.

Eligibility Period

A recipient is eligible for EWC for one year, starting on the date when the DETEC *Recipient Information* form is completed and submitted. This eligibility period does not change if the recipient transfers to another PCP. The eligibility period is for the recipient, not the provider. Re-enrollment or recertification can only occur annually, when a recipient's one-year recipient eligibility period ends.

Example:

A recipient sees PCP provider A on February 1. Provider A establishes the patient's eligibility on this date by entering information into the DETEC form. The recipient's eligibility period spans from this date, February 1, to the following January 31 (one year).

Then, the recipient visits provider B in June, four months after seeing provider A. Provider B finds the recipient in the EWC application using the recipient's last name and date of birth. Provider B creates a new recipient record by updating the Recipient Information in DETEC. The recipient remains eligible only until January 31, as previously established. Each provider maintains separate records, but the recipient's dates of eligibility are not affected.

30-day Retroactive Eligibility Period

Claims for services provided prior to but within 30 days of the recipient certification date on the EWC recipient's recipient identification (ID) card are eligible for reimbursement. The recipient certification date is the first date in the date range that is listed in the data field labeled "Valid:" on the recipient ID card.

Payer of Last Resort

EWC is the payer of last resort, and pays providers only for breast and/or cervical screening and diagnostic services not covered by other programs.

Types of Forms and Worksheets

EWC uses two types of forms:

- Paper forms and worksheets that may be downloaded from the EWC program page on the Medi-Cal website. These worksheets and forms can be photocopied and are completed by hand.
- Online forms that are completed and submitted via DETEC.

Required Forms

The *Recipient Application* (DHCS 8699) is required and the original must be kept in the recipient's medical record.

The following online forms are required, and are completed and submitted via DETEC.

- DETEC – *Enroll Recipient and Recipient Information* forms
- DETEC – *Breast and Cervical Cancer Screening Cycle Data* forms

PCPs must print, sign and date the print copies of these DETEC forms and place the original copy in the patient medical record. This is evidence that data was entered in support of case management claims.

Optional Worksheets

EWC also uses paper worksheets that can be printed from the EWC program page on the Medi-Cal website and completed manually. Worksheets are intended to assist providers in gathering relevant information that will later be entered online via the DETEC forms. It is recommended that the worksheet be completed and kept in the recipient's medical record as evidence for case management claims.

Notice of Privacy Practices

The *Notice of Privacy Practices* (NPP) describes how medical information about recipients may be used and disclosed and how recipients can gain access to this information. The provider is responsible for distributing the NPP to each recipient at the time of enrollment and at annual recertification. The NPP form can be downloaded from the Medi-Cal website at *www.medi-cal.ca.gov*. NPP versions are available in English, Arabic, Chinese (Cantonese and Mandarin), Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog and Vietnamese.

Recipient Application

The paper *Recipient Application* (DHCS 8699) is required. This form enables provider staff or the recipient to complete their income and eligibility data. The form and detailed instructions for completing it may be downloaded on the Medi-Cal website at *www.medi-cal.ca.gov*. The *Recipient Application* (DHCS 8699) should be signed by the recipient and by the provider who determines that the recipient meets eligibility criteria for the program. The signed copy must be kept in the recipient's medical record. Providers should not send a copy of the *Recipient Application* (DHCS 8699) to DHCS.

Online Recipient Information Form

Once the provider has collected recipient demographic information, established recipient eligibility for EWC and obtained a signed recipient application, the PCP may enroll the recipient in the program using the online DETEC *Enroll Recipient* form. To access DETEC data entry forms:

1. Access www.medi-cal.ca.gov
2. ‹‹Click the "Providers" tab.››
3. Click "Transactions."
4. Enter User ID (National Provider Identifier [NPI]) and Personal Identification Number (PIN) (password)
5. Select the Prgms (Programs) tab
6. Click the "Every Woman Counts (EWC)" link

The PCP starts the enrollment process by entering demographic information in the online *Recipient Search* form. The first two letters of the recipient's last name and date of birth are required. The provider clicks the "Go" button to reach the online *Enroll Recipient* form. If the recipient is new to the program, the provider inputs information obtained directly from the *Recipient Application* (DHCS 8699). Entered information includes the recipient's name, mother's maiden name (if the recipient provides it), date of birth, address, telephone number and ethnicity. After the DETEC *Enroll Recipient* form is completed and submitted online, the recipient is assigned a 14-character recipient identification number.

Recipient ID Number

EWC recipients are identified by a 14-character recipient identification number (ID) that is computer generated when the online *Enroll Recipient* form is completed and submitted.

Note: All claims from enrolled PCPs and/or Medi-Cal referral providers must be submitted with this 14-character recipient ID number. Medi-Cal referral providers must obtain this ID number from the PCP or the recipient.

Viewing Breast and Cervical Cancer Screening Cycles Online

PCPs are allowed to view current and previous screening cycles online. DETEC can show up to three cycles at a time. The oldest cycle is locked and not accessible. The two most recent cycles are accessible. A cycle that includes errors in case management data entry will be identified by ‹‹an exclamation point›› (!).

DETEC Breast/Cervical Cancer Screening Cycle Forms

The recipient's PCP is required to input their clinical information using the DETEC *Breast/Cervical Cancer Screening Cycle Data* forms as part of the service and before the case management fees for HCPCS code T1017 (targeted case management) can be paid. Data must be submitted within 30 days after the practice receives all required information. Clinical information is used to evaluate effectiveness and quality of EWC.

DETEC "Lost to Follow-Up Status"

Recipients are considered to have a "lost to follow-up" status if they require immediate diagnostic work but cannot be reached because 1) they do not reside at the stated address and 2) their phone is disconnected or they can no longer be reached via the stated phone number.

Providers should document three or more attempts to contact the recipient in the recipient's medical record, including documenting that a sent, certified letter was undeliverable and returned. Documentation that a certified letter was sent is not sufficient. Recipients are not considered "lost to follow-up" if they can be located.

DETEC "Refused Care" Status

Recipients are considered to have a "refused care" status if they require immediate diagnostic work but the recipient does one of the following:

- Refuses the procedure
- Changes their PCP for any reason
- Fails to respond to the certified letter or telephone messages
- Fails to schedule or keep appointments

Providers should document three or more attempts to contact the recipient in the recipient's medical record, including documenting a reason for refused care and that a certified letter was sent.

Case Management: HCPCS Code T1017 Restrictions

HCPCS code T1017 is payable only to providers enrolled as PCPs in EWC and only for recipients enrolled in the EWC program. T1017 is not a benefit of Medi-Cal programs. Although the T1017 description is in units of 15 minutes, for EWC the quantity of units allowed for reimbursement is only one unit per recipient per provider per calendar year regardless of the time required to complete case management services. The amount reimbursed is $50.

Only complete and compliant "immediate work-up cycles" are eligible for reimbursement. An "immediate work-up" is the screening cycle which requires coordination of referral services and additional data reporting via the DETEC data reporting system. When a recipient does not require immediate follow-up (e.g. the findings are normal, or the findings require re-screening earlier than is routinely recommended) no additional payment shall be made and code T1017 may not be billed.

Case Management: Payment Policy

In DETEC, breast and cervical cancer each have their own one-page form that includes both screening cycle and follow-up data. It is anticipated this will facilitate accurate and complete data entry.

- Payment for case management will be based on submission of complete, accurate data.
- For abnormal results or findings, immediate work-up is advised and additional data will need to be submitted to qualify for case management.
- If immediate work-up is selected, whether based on clinical findings, results, provider's discretion or patient request, additional data will need to be submitted to qualify for case management.
- PCPs who provide both breast and cervical cancer screening are not required to submit both screening forms at the same time as a requirement for case management.
- Despite providing a recipient with both breast and cervical cancer screening services in the year, the PCP is only eligible for one case management payment per recipient per year.

Approved Procedures

The following CPT and HCPCS codes are benefits of EWC. The key at the bottom of each listing shows the providers who may be paid for each procedure code. Providers should review the key carefully to see if they qualify to bill the listed service. Providers must have an appropriate ICD-10-CM code(s) specified as the first or second diagnosis code on the claim to be eligible for reimbursement.

Cervical cancer screening ICD-10-CM codes are shown in tables 1a, 1b and 1c. Breast cancer screening ICD-10-CM codes are shown in tables 2a and 2b.

Table 1a

Cervical Cancer Screening ICD-10-CM Codes
Z01.411, Z01.419, Z01.42, Z11.51, Z12.4, ‹‹Z12.72››, Z15.01, Z15.02, Z21, Z40.01, Z40.02, Z78.0, Z80.41, Z80.49, Z85.3, Z85.40 thru Z85.44, Z87.410 thru Z87.412, Z87.891, Z90.710 thru Z90.712, Z90.721, Z90.722, Z90.79, Z92.0, Z92.25

Table 1b

Cervical Cancer Screening and Diagnosis ICD-10-CM Codes
‹‹A63.0, B20, B97.35, B97.7, C51.8, C53.0, C53.1, C53.8, C53.9, C55, C57.7 thru C57.9, C76.3, C80.1, D06.0, D06.1, D06.7, D06.9, D07.0, D07.2, D07.30, D25.0, D26.0, D49.511 thru D49.59, N72, N84.0, N84.1, N84.8, N84.9, N85.9, N86, N87.0, N87.1, N87.9, N88.0 thru N88.2, N88.4, N88.8, N88.9, N89.0, N89.1, N89.3, N89.4, N89.8, N89.9, N93.0, N93.9, N94.10 thru N94.12, N94.19, N94.89, N95.0, R10.2, R87.610 thru R87.616, R87.619 thru R87.625, R87.628, R87.810, R87.811, R87.820, R87.821››

Table 1c

Colposcopy and Cervical Biopsy ICD-10-CM Codes
C53.0, C53.1, C53.8, C53.9, D06.0, D06.1, D06.7, D06.9, D07.2, D26.0, N87.0, N87.1, N88.0, N89.0, N89.1, N89.3, N89.4, R87.610 thru R87.616, R87.619, thru R87.625, R87.628, R87.810, R87.811, R87.820, R87.821

Table 2a

Breast Cancer Screening Related ICD-10-CM Codes
Z12.31, Z12.39, Z15.01, Z15.02, Z15.09, Z17.0, Z17.1, Z77.123, Z77.128, Z77.22, Z77.9, Z78.0, Z78.9, Z79.810, Z79.818, Z79.890, Z80.0, Z80.3, Z80.41, Z80.8, Z80.9, Z85.038, Z85.3, Z85.40, Z85.43, Z85.71, Z85.72, Z85.79, Z85.9, Z90.10 thru Z90.13, Z91.89, Z92.3, Z92.89, Z98.82, Z98.86

Table 2b

Breast Cancer Diagnosis ICD-10-CM Codes
C43.52, C44.501, C44.511, C44.521, C44.591, C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C77.0, C77.3, C79.2, C79.81, D03.52, D04.5, D05.00 thru D05.02, D05.10 thru D05.12, D05.80 thru D05.82, D05.90 thru D05.92, D17.1, D17.20 thru D17.24, D17.30, D17.39, D17.72, D17.79, D18.01, D22.5, D23.5, D24.1, D24.2, D24.9, D48.5, D48.60 thru D48.62, D49.2, D49.3, I80.8, N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.21, N60.22, N60.29, N60.31, N60.32, N60.39, N60.41, N60.42, N60.49, N60.81, N60.82, N60.89, N60.91, N60.92, N60.99, N61.0, N61.1, N62, N63.0 thru N63.42, N64.0 thru N64.4, N64.51 thru N64.53, N64.59, N64.81, N64.82, N64.89, N64.9, N65.0, Q83.0 thru Q83.3, Q83.8, Q83.9, Q85.8, Q85.9, R23.4, R59.0, R59.1, R59.9, R92.0 thru R92.2, R92.8

Approved Procedures, CPT Codes Key

CPT Code	Description	ICD-10-CM Code	Additional Information
00400 §‡	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	see table 2b	N/A
10004 §‡	Fine needle aspiration biopsy, without imaging guidance; each additional lesion	see table 2b	N/A
10005 §‡	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	see table 2b	N/A
10006 §‡	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	see table 2b	N/A
10007 §‡	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	see table 2b	N/A
10008 §‡	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion	see table 2b	N/A
10011 §‡	Fine needle aspiration biopsy, including MR guidance; first lesion	see table 2b	N/A
10012 §‡	Fine needle aspiration biopsy, including MR guidance; each additional lesion	see table 2b	N/A
10021 §‡	Fine needle aspiration; biopsy, without imaging guidance; first lesion	see table 2b	N/A
19000 §‡	Puncture aspiration of cyst of breast	see table 2b	N/A
19001 §‡	Puncture aspiration of cyst of breast; each additional cyst	see table 2b	Use in conjunction with code 19000. If imaging guidance is performed, see code 76942

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19081 §‡	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including stereotactic guidance	see table 2b	Codes 19081 thru 19086 should not be used in conjunction with 19281 thru 19288 codes for image guidance placement of a localization device without image guided biopsy
19082 §‡	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous, each additional lesion, including stereotactic guidance	see table 2b	Same as for 19081
19083 §‡	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including ultrasound guidance	see table 2b	Same as for 19081
19084 §‡	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; each additional lesion, including ultrasound guidance	see table 2b	Same as for 19081 Use in conjunction with 19083
19085 §‡	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	see table 2b	Same as for 19081
19086 §‡	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; additional lesion	see table 2b	Same as for 19081

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19100 §‡	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	see table 2b	For fine needle aspiration, use codes 10004 thru 10008 or 10021
19101 §‡	Biopsy of breast; open, incisional	see table 2b	N/A
19120 §‡	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions	see table 2b	N/A
19125 §‡	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	see table 2b	N/A
19126 §‡	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	see table 2b	Use in conjunction with code 19125
19281 §‡	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance	see table 2b	Codes 19281 thru 19288 should not be used in conjunction with 19081 thru 19086 codes for breast biopsies that include image guidance, placement of localization device, and imaging of specimen
19282 §‡	Placement of breast localization device(s), percutaneous; each additional lesion, including mammographic guidance	see table 2b	Same as for 19281 Use in conjunction with 19281

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19283 §‡	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance	see table 2b	Same as for 19281
19284 §‡	Placement of breast localization device(s), percutaneous; each additional lesion, including stereotactic guidance	see table 2b	Same as for 19281 Use in conjunction with 19283
19285 §‡	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance	see table 2b	Same as for 19281
19286 §‡	Placement of breast localization device(s), percutaneous; each additional lesion, including ultrasound guidance	see table 2b	Same as for 19281 Use in conjunction with 19285
19287 §‡	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion, including magnetic resonance guidance	see table 2b	Codes 19281 thru 19288 should not be used in conjunction with 19081 thru 19086 codes for breast biopsies that include image guidance, placement of localization device, and imaging of specimen
19288 §‡	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	see table 2b	Same as for 19287

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
57452 §‡	Colposcopy of the cervix including upper/adjacent vagina	see table 1c	Cannot be billed in conjunction with any office visits or consults or with codes 57454 thru 57456
57454 §‡	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults
57455 §‡	Colposcopy of the cervix, with biopsy	see table 1c	Cannot be billed in conjunction with any office visits or consults
57456 §‡	Colposcopy of the cervix, with endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults
57500 §‡	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	see table 1c	Reimbursable only if used for evaluation of leukoplakia or other suspicious visible cervical lesion or abnormal Pap when colposcopy is not readily available. Cannot be billed in conjunction with 57452, 57454 thru 57456
57505 §‡	Endocervical curettage (not done as part of dilation and curettage)	R87.619	Reimbursable only if billed in conjunction with 58100, as the initial workup of AGC/atypical endometrial cells. Cannot be billed in conjunction with 57452, 57454 thru 57456

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
58100 §‡	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	R87.619	Reimbursable only if billed in conjunction with 57505. Cannot be billed in conjunction with 57452, 57454 thru 57456
58110 §‡	Endometrial sampling (biopsy) performed in conjunction with colposcopy	D06.0 thru D06.9 and R87.619	Reimbursable only for evaluation of adenocarcinoma in situ (AIS) and AGC subcategories except AGC/atypical endometrial cells in all women over age 35 and younger women with risk factors for endometrial neoplasia, such as, but not limited to, obesity or unexplained or anovulatory bleeding. Must be performed with colposcopy and used in conjunction with 57452 thru 57456
76098 §‡	Radiological examination, surgical specimen	see table 2b	N/A
76641 §‡	Ultrasound, complete examination of breast including axilla, unilateral	see tables 2a and 2b	N/A
76642 §‡	Ultrasound, limited examination of breast including axilla, unilateral	see tables 2a and 2b	N/A
76942 §‡	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	see table 2b	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77046 §‡	Magnetic resonance imaging (MRI), breast, without contrast; unilateral	see tables 2a and 2b	1. Breast MRI is recommended in conjunction with a mammogram when a client has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20 percent or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history 2. Breast MRI can be used to assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment 3. Breast MRI should never be done alone as a breast cancer screening tool 4. Breast MRI is <u>not</u> covered to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment
77047 §‡	Magnetic resonance imaging (MRI), breast, without contrast; bilateral	see tables 2a and 2b	Same as for 77046

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77048 §‡	Magnetic resonance imaging (MRI), breast, including computer-aided detection (CAD), without and with contrast material(s), when performed; unilateral	See tables 2a and 2b	Same as for 77046
77049 §‡	Magnetic resonance imaging (MRI), breast, including computer-aided detection (CAD), without and with contrast material(s), when performed; bilateral	See tables 2a and 2b	Same as for 77046
77065 §‡	Diagnostic mammography, including computer-aided detection (CAD); unilateral	see tables 2a and 2b	Reimbursable if the recipient either: • Has distinct signs and symptoms for which a diagnostic mammogram is indicated, or • Has a history of breast cancer, or • Is asymptomatic, but on the basis of history and other significant factors diagnostic mammogram is indicated and appropriate Codes 77065 and 77066 are not reimbursable when billed for the same day for the same recipient
77066 §‡	Diagnostic mammography, including computer-aided detection (CAD); bilateral	see tables 2a and 2b	Same as 77065

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77067 §‡	Screening mammography, bilateral	see tables 2a and 2b	Limited to one screening per 365 days, any provider Reimbursable with modifier U7 and 99, as appropriate Restricted to individuals 40 years of age or older
81025 §‡	Urine pregnancy test	see table 1c	This code may only be billed with one or more of the following codes: 57452, 57454 thru 57456, 57500, 57505, 58100, 58110
87624 §‡	Human Papillomavirus (HPV), high-risk types	N87.0, R87.610, R87.612, R87.615, R87.616 and Z11.51	R87.612, R87.615, R87.616 and Z11.51 covered only for recipients age 30 and older Use of modifier 33 indicates the service was provided in accordance with USPSTF A or B recommendations
87625 §‡	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	R87.615, R87.810 and Z11.51	R87.810, R87.615 and Z11.51 covered only for recipients age 30 and older Use of modifier 33 indicates the service was provided in accordance with USPSTF A or B recommendations

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
88141 §‡	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician	see tables 1a and 1b	Use in conjunction with code 88142, 88164, 88174 or 88175
88142 §‡	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	see tables 1a and 1b	N/A
88143 §‡	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	see tables 1a and 1b	N/A
88164 §‡	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	see tables 1a and 1b	N/A
88172 §‡	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site;	see tables 2a and 2b	N/A
88173 §‡	Cytopathology, evaluation of fine needle aspirate; interpretation and report	no ICD-10 code restrictions	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
88174 §‡	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	see tables 1a and 1b	N/A
88175 §‡	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	see tables 1a and 1b	N/A
88305 §‡	Level IV – Surgical pathology, gross and microscopic examination	no ICD-10 code restrictions	N/A
88307 §‡	Level V, gross and microscopic examination, requiring microscopic evaluation of surgical margins	no ICD-10 code restrictions	N/A
88341 §‡	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure).	Refer to tables 1b, 1c, and 2b	N/A
88342 §‡	Immunohistochemistry (including tissue immunoperoxidase), each antibody	see tables 1b, 1c and 2b	N/A
88360 §‡	Morphometric analysis, tumor immunochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual	see table 2b	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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)	see tables 1a, 1b, 2a and 2b	N/A
99202 ‡	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A
99203 ‡	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A
99204 ‡	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.

Approved Procedures Key, CPT Codes (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
99211 §	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	see tables 1a, 1b, 2a and 2b	N/A
99212 ‡	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	‹‹N/A
99213 ‡	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A
99214 ‡	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.

‹‹Approved Procedures Key, CPT Codes (continued)››

CPT Code	Description	ICD-10-CM Code	Additional Information
99241 §	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 15 minutes, which includes all three of the following: a problem-focused history, a problem-focused exam, straightforward medical decision-making. Cannot be billed in conjunction with CPT codes 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 99242 or 99243
99242 §	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 30 minutes, which includes all three of the following: An expanded problem-focused history, an expanded problem-focused exam, straightforward medical decision-making. Cannot be billed in conjunction with CPT codes 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 77032, 99241 or 99243
99243 §	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 40 minutes, which includes all three of the following: A detailed focused history, a detailed focused exam, low-complexity medical decision-making. Cannot be billed in conjunction with CPT codes 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 99241 or 99242

Approved Procedures Key, HCPCS Codes

HCPCS Code	Description	ICD-10-CM Code
A4217 §‡	Sterile water/saline, 500 ml	‹‹see tables 1b and 2b››
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only	see tables 1a, 1b, 2a and 2b
G2010 §‡	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.	see tables 2a and 2b
G2012 §‡	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	see tables 1a, 1b, 2a and 2b
J7030 §‡	Infusion, normal saline solution, 1000 cc	see tables 1b and 2b
J7040 §‡	Infusion, normal saline solution, sterile (500 ml = 1 unit)	see tables 1b and 2b
J7050 §‡	Infusion, normal saline solution, 250 cc	see tables 1b and 2b
J7120 §‡	Ringers lactate infusion, up to 1000 cc	see tables 1b and 2b
‹‹Q3014 §‡	Telehealth originating site facility fee	see tables 1a, 1b, 2a and 2b››

Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code
T1013 §‡	Sign language or oral interpreter services, per 15 minutes	see tables 1a, 1b, 2a and 2b Once per day, per recipient, per provider Oral interpretive services not covered
‹‹T1014 §‡	Telehealth transmission, per minute, professional services bill separately	see tables 1a, 1b, 2a and 2b››
T1017 ‡	Targeted case management, each 15 minutes	see tables 1a, 1b, 2a and 2b. Once per recipient, per provider, per calendar year
Z7500 §‡	Examining or treatment room use	see tables 1a, 1b, 2a and 2b
Z7506 §‡	Operating room or cystoscopic room use; first hour	see tables 1b and 2b
Z7508 §‡	Operating room or cystoscopic room use; first subsequent half hour	see tables 1b and 2b
Z7510 §‡	Operating room or cystoscopic room use; second subsequent half hour	see tables 1b and 2b
Z7512 §‡	Recovery room use	see tables 1b and 2b
Z7514 §‡	Room and board, general nursing care for stays of less than 24 hours, including ordinary medication	see tables 1b and 2b
Z7610 §‡	Miscellaneous drugs and medical supplies	see tables 1a, 1b, 2a and 2b

Quick Reference Sheets

‹‹The following figures are quick reference sheets for covered procedures under the EWC program.

- *Figure 1: Breast and Cervical Primary Care Provider Covered Procedures.*
- *Figure 2: Referral Provider Covered Procedures.*››

BREAST & 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/pubsdoco/publications/masters-mtp/part2/evwoman_m00o03.doc.

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** – With 10011: 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, with localization device plcmnt and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion
- ☐ **19082** – With 19081; each additional lesion
- ☐ **19083** – Biopsy, with localization device plcmnt and imaging of biopsy specimen, percutaneous; US 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; first lesion
- ☐ **19086** – With 19085; each addtnl lesion
- ☐ **19100** – Needle Core biopsy; without imaging guidance
- ☐ **19101** – Biopsy of breast, open, incisional
- ☐ **19120** – Excisional Biopsy, open
- ☐ **19125** – Excision of lesion, identified by preop plcmt of radiomarker; single lesion
- ☐ **19126** – With 19125; each additional lesion
- ☐ **19281** – Localization device plcmnt, percutaneous; mammographic guidance; first lesion
- ☐ **19282** – With 19281; each additional lesion
- ☐ **19283** – Localization device plcmnt, percutaneous; stereotactic guidance; first lesion
- ☐ **19284** – With 19283; each additional lesion
- ☐ **19285** – Localization device plcmnt, percutaneous; US guidance; first lesion
- ☐ **19286** – With 19285; each addtnl lesion
- ☐ **19287** – Plcmnt of breast localization device, percutaneous; magnetic resonance guidance; first lesion
- ☐ **19288** – with 19287; each addtnl lesion

CPT codes

- ☐ **57452** – Colposcopy
- ☐ **57454** – Colposcopy w/bx of cervix and ECC
- ☐ **57455** – Colposcopy w/bx of cervix
- ☐ **57456** – Colposcopy w/ECC
- ☐ **57500** – Biopsy of cervix
- ☐ **57505** – Endocervical curettage, w/58100
- ☐ **58100** – Endometrial sampling, w/57505
- ☐ **58110** – Endometrial sampling with colposcopy
- ☐ **76098** – X-ray Exam, surg specimen
- ☐ **76641** – Ultrasound, unilateral, include axilla; complete
- ☐ **76642** – Ultrasound, unilateral, include axilla; limited
- ☐ **76942** – US guidance for needle plcmt; imaging, supervis & interpret
- ☐ **77046** – MRI, breast, without contrast unilateral
- ☐ **77047** – With 77046; bilateral
- ☐ **77048** – MRI, breast, including CAD, with and without contrast materials, unilateral
- ☐ **77049** – With 77048; bilateral imaging, supervis & interpret
- ☐ **77065** – Diagnostic mammography; unilateral includes CAD
- ☐ **77066** – Diagnostic mammography; bilateral includes CAD
- ☐ **77067** – Screening mammogram bilateral
- ☐ **81025** – Urine pregnancy test
- ☐ **87624** – Infect agent detect by DNA or RNA; HPV, high-risks types
- ☐ **87625** – Human Papillomavirus (HPV), type 16 and 18 only, includes type 45, if performed
- ☐ **88141** – Pap, physician interpretation
- ☐ **88142** – Pap, liquid, based (LBP); man scrng
- ☐ **88143** – Cytopathology-C/V, LBP, manual
- ☐ **88164** – Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- ☐ **88172** – Cytopathology of FNA; to determine adequacy of specimen
- ☐ **88173** – Interp/report for eval of FNA
- ☐ **88174** – LBP, auto screen
- ☐ **88175** – LBP, auto screen w/man rescrn.
- ☐ **88305** – Level IV Surg path exam
- ☐ **88307** – Level V Surg path exam
- ☐ **88341** – Immunohistochemistry, each additional single a/b stain
- ☐ **88342** – Immunohistochemistry
- ☐ **88360** – Morphometric analysis, tumor immunohistochemistry; manual
- ☐ **99070** – Supplies/material, not inc w/OV

HCPCS codes

- ☐ **99202** – OV; new pt 20 min
- ☐ **99203** – OV; new pt 30 min
- ☐ **99204** – OV; new pt 45min
- ☐ **99212** – OV; new pt 10 min
- ☐ **99213** – OV; est pt 15 min
- ☐ **99214** – OV; est pt 25 min
- ☐ **A4217** – Sterile water/saline, 500 ml
- ☐ **G0071** – Brief tech comm/remote eval by FQHC/RHC; est pt
- ☐ **G2010** – Remote eval; est pt
- ☐ **G2012** – Brief tech comm; est pt
- ☐ **J7030** – Infus, norm sal sol, 1000 cc
- ☐ **J7040** – Infus, norm sal sol, sterile 500 mL = 1 unit
- ☐ **J7050** – Infus, norm sal sol, 250 cc
- ☐ **J7120** – Ringers lact infus, up to 1000 cc
- ☐ **Q3014** – Telehealth originating site facility fee
- ☐ **T1013** – Sign lang interpretive serv/15 min
- ☐ **T1014** – Telehealth transmission, per minute, professional services bill separately
- ☐ **T1017** – Case Mgmt – Immediate follow-up (PCP only)
- ☐ **Z7500** – Exam or Tx Rm use
- ☐ **Z7506** – OR Cysto Rm use, first hour
- ☐ **Z7508** – OR Cysto Rm use, 1st sub halfhr
- ☐ **Z7510** – OR Cysto Rm use, 2nd sub halfhr
- ☐ **Z7512** – Recovery Rm use
- ☐ **Z7514** – Rm/Brd gen nurs care, less than 24hr
- ☐ **Z7610** – Misc. drugs and medical supply

***Commonly Used Modifiers◊**

26 – Professional Component
51 – Multiple surg procedure
99 – Multiple Mod (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 w/no anesthesia or other than general anesthesia, provided in conjunction with surgical procedure code.

◊For a complete list of approved Medi-Cal modifiers, refer to the relevant section of the Medi-Cal Provider Manual.

Figure 1: Breast and Cervical Primary Care Provider Covered Procedures

REFERRAL Provider Primary Care Provider
Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) Program for "Breast and Cervical Referral 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/pubsdoc/publications/masters-mtp/part2/evwoman_m00o03.doc.

Procedure Code Definitions (May Require Modifier*)

CPT codes

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- ☐ **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** – With 1007: 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, with localization device plcmnt and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion
- ☐ **19082** – With 19081; each additional lesion
- ☐ **19083** – Biopsy, with localization device plcmnt and imaging of biopsy specimen, percutaneous; US 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; first lesion
- ☐ **19086** – With 19085; each additional lesion
- ☐ **19100** – Needle Core biopsy; without imaging guidance
- ☐ **19101** – Biopsy of breast, open, incisional
- ☐ **19120** – Excisional Biopsy, open
- ☐ **19125** – Excision of lesion, identified by preop plcmt of radiomarker; single lesion
- ☐ **19126** – With 19125; each additional lesion
- ☐ **19281** – Localization device plcmnt, percutaneous; mammographic guidance; first lesion
- ☐ **19282** – With 19281; each additional lesion
- ☐ **19283** – Localization device plcmnt, percutaneous; stereotactic guidance; first lesion
- ☐ **19284** – With 19283; each additional lesion
- ☐ **19285** – Localization device plcmnt, percutaneous; US guidance; first lesion

CPT codes

- ☐ **19286** – With 19285; each additional lesion
- ☐ **19287** – Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion, including magnetic resonance guide
- ☐ **19288** – With 19287; each additional lesion
- ☐ **57452** – Colposcopy
- ☐ **57454** – Colposcopy w/bx of cervix and ECC
- ☐ **57455** – Colposcopy w/bx of cervix
- ☐ **57456** – Colposcopy with endocervical curettage
- ☐ **57500** – Biopsy of cervix
- ☐ **57505** – Endocervical curettage, w/58100
- ☐ **58100** – Endometrial sampling, w/57505
- ☐ **58110** – Endometrial sampling with colposcopy
- ☐ **76098** – X-ray Exam, surg specimen
- ☐ **76641** – Ultrasound, unilateral, include axilla; complete
- ☐ **76642** – Ultrasound, unilateral, include axilla; limited
- ☐ **76942** – US guidance for needle plcmt; imaging, supervis & interpret
- ☐ **77046** – MRI, breast, without contrast Unilateral
- ☐ **77047** – With 77046; bilateral
- ☐ **77048** – MRI, breast, including CAD, with And without contrast materials, Unilateral
- ☐ **77049** – With 77048; bilateral
- ☐ **77065** – Diagnostic mammography; unilateral includes CAD
- ☐ **77066** – Diagnostic mammography; bilateral includes CAD
- ☐ **77067** – Screening mammogram; bilateral
- ☐ **81025** – Urine pregnancy test
- ☐ **87624** – Infect agent detect by DNA or RNA; HPV, high-risks types
- ☐ **87625** – Human Papillomavirus (HPV), type 16 and 18 only, includes type 45, if performed
- ☐ **88141** – Pap, physician interpretation
- ☐ **88142** – Pap, liquid, based (LBP); man scrng
- ☐ **88143** – Cytopathology-C/V, LBP, manual
- ☐ **88164** – Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- ☐ **88172** – Cytopathology of FNA; to determine adequacy of specimen
- ☐ **88173** – Interp/report for eval of FNA

CPT codes

- ☐ **88174** – LBP, auto screen **88175** – LBP, auto screen w/man rescrn.
- ☐ **88175** – LBP, auto screen w/man recm
- ☐ **88305** – Level IV Surg path exam
- ☐ **88307** – Level V Surg path exam
- ☐ **88341** – Immunohistochemistry, each additional single a/b stain
- ☐ **88342** – Immunohistochemistry
- ☐ **88360** – Morphometric analysis, tumor immunohistochemistry; manual
- ☐ **99070** – Supplies/material, not inc w/OV
- ☐ **99211** – OV; est pt 5 min
- ☐ **99241** – Consult, new or est pt 15 min
- ☐ **99242** – Consult, new or est pt 30 min
- ☐ **99243** – Consult, new or est pt 40 min

HCPCS codes

- ☐ **A4217** – Sterile water/saline, 500 ml
- ☐ **G0071** – Brief tech comm/remote eval by FQHC/RHC; est pt
- ☐ **G2010** – Remote eval; est pt.
- ☐ **G2012** – Brief tech comm; est pt
- ☐ **J7030** – Infus, norm sal sol, 1000 cc
- ☐ **J7040** – Infus, norm sal sol, sterile 500 ml = 1 unit
- ☐ **J7050** – Infus, norm sal sol, 250 cc
- ☐ **J7120** – Ringers lact infus, up to 1000 cc
- ☐ **Q3014** – Telehealth originating site facility fee
- ☐ **T1013** – Sign lang interpretive serv/15 min
- ☐ **T1014** – Telehealth transmission, per minute, professional services bill separately
- ☐ **Z7500** – Exam or Tx Rm use
- ☐ **Z7506** – OR or Cysto Rm use, first hour
- ☐ **Z7508** – OR or Cysto Rm use, 1st sub halfhr
- ☐ **Z7510** – OR or Cysto Rm use, 2nd sub halfhr
- ☐ **Z7512** – Recovery Rm use
- ☐ **Z7514** – Rm/Brd gen nurs care, less than 24hr
- ☐ **Z7610** – Misc. drugs and medical supply

***Commonly Used Modifiers◊**

26 – Professional Component
51 – Multiple surg procedure
99 – Multiple Mod (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 w/no anesthesia or other than general anesthesia, provided in conjunction with surgical procedure code.

◊For a complete list of approved Medi-Cal modifiers, refer to the relevant section of the Medi-Cal Provider Manual.

EWC REMINDERS

- **Program covered cancer screening and diagnostic services are FREE.**
- **Payment for program-covered services is at Medi-Cal rates.**
- **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#.**
- **Claims must be submitted with the woman's EWC Recipient ID# (14- digit identification number).**
- **Only PCP's may claim for case management.**
- **EWC enrollment is valid for 12 months; then, if eligible, the woman can be recertified/re-enrolled.**
- **All providers must verify current eligibility before rendering services.**
- **All services and findings must be reported to the PCP.**

‹‹**Figure 2:** Referral Provider Covered Procedures››

Case Management Coverage

The only cycles eligible for reimbursement for case management services (T1017) are those with findings that require immediate work-up and an additional referral together with coordination of services. EWC does not pay separately for case management for recipients who require routine or short-term follow-up re-screening.

T1017 is payable only to PCPs enrolled in the EWC program. This code is payable only to PCPs after submission of complete outcome data via DETEC.

To report results, use DETEC *Recipient Information* and *Breast/Cervical Cancer Screening Cycle* forms. Recipient cycle records must be complete to be eligible for case management reimbursement.

Case Management Coding

HCPCS code T1017 should be used to bill for the case management covered services.

Case Management Reimbursement

The annual allowance is $50. Case management will be paid once per recipient, per provider, per calendar year.

Claim Completion

EWC services are billed using either the *CMS-1500* or *UB-04* claim. Providers submitting the UB-04 should follow the instructions in the *UB-04 Completion: Outpatient Services* section of the Part 2 provider manual. Providers submitting the *CMS-1500* should follow the instructions in the *CMS-1500 Completion* section of the Part 2 provider manual. Electronic billing is done as per Medi-Cal electronic billing instructions.

Modifiers

Modifiers are required for some program procedures. Medi-Cal rules for use of modifiers apply to EWC.

Recipient ID Number Required

The 14-character recipient ID number must be entered on each claim whether hard copy or electronic. Claims submitted without the 14-character ID number will be denied. The recipient application should not be attached to the claim but must be retained by the PCP in the recipient's medical record instead.

ICD-10-CM Code Requirements

ICD-10-CM diagnosis codes are required on claims for diagnostic mammograms provided through EWC and must be appropriate for the clinical situation. For other screening and diagnostic services, the provider may enter an appropriate code.

Where To Submit Claims

Claims can be submitted either hard copy or electronically using the *CMS-1500* or *UB-04.* Providers who choose to submit hard copy claims must send to the appropriate address for their claim type, as follows:

Medical Services (*CMS-1500*)

California MMIS Fiscal Intermediary
P. O. Box 15700
Sacramento, CA 95852-1700

Outpatient Services (*UB-04*)

California MMIS Fiscal Intermediary
P. O. Box 15600
Sacramento, CA 95852-1600

Claims submitted to the wrong address will be forwarded appropriately, but processing will be delayed. To order pre-addressed envelopes for claim submission (thereby ensuring that claims are sent to the correct address), refer to the appropriate *Forms Reorder Request* section of this manual or call the Telephone Service Center (TSC) at 1-800-541-5555. For more information about claim submission requirements, refer to the appropriate submission and timeliness instructions section in this manual.

Program Inquiries

For questions about EWC claims or claims procedures, providers may call the TSC at 1-800-541-5555.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
‡	May be billed to Every Woman Counts only by PCPs authorized to provide breast and cervical cancer services.
§	May be billed to Every Woman Counts by referral providers.