FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
FEDERAL POVERTY GUIDELINES FOR MARYLAND

Source: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

2024 Annual

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%	200%	225%	250%
1	$7,530	$11,295	$15,060	$18,825	$19,578	$20,030	$20,331	$20,783	$22,590	$26,355	$27,108	$27,861	$30,120	$33,885	$37,650
2	$10,220	$15,330	$20,440	$25,550	$26,572	$27,185	$27,594	$28,207	$30,660	$35,770	$36,792	$37,814	$40,880	$45,990	$51,100
3	$12,910	$19,365	$25,820	$32,275	$33,566	$34,341	$34,857	$35,632	$38,730	$45,185	$46,476	$47,767	$51,640	$58,095	$64,550
4	$15,600	$23,400	$31,200	$39,000	$40,560	$41,496	$42,120	$43,056	$46,800	$54,600	$56,160	$57,720	$62,400	$70,200	$78,000
5	$18,290	$27,435	$36,580	$45,725	$47,554	$48,651	$49,383	$50,480	$54,870	$64,015	$65,844	$67,673	$73,160	$82,305	$91,450
6	$20,980	$31,470	$41,960	$52,450	$54,548	$55,807	$56,646	$57,905	$62,940	$73,430	$75,528	$77,626	$83,920	$94,410	$104,900
7	$23,670	$35,505	$47,340	$59,175	$61,542	$62,962	$63,909	$65,329	$71,010	$82,845	$85,212	$87,579	$94,680	$106,515	$118,350
8	$26,360	$39,540	$52,720	$65,900	$68,536	$70,118	$71,172	$72,754	$79,080	$92,260	$94,896	$97,532	$105,440	$118,620	$131,800

2024 Monthly

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%	200%	225%	250%
1	$628	$941	$1,255	$1,569	$1,632	$1,669	$1,694	$1,732	$1,883	$2,196	$2,259	$2,322	$2,510	$2,824	$3,138
2	$852	$1,278	$1,703	$2,129	$2,214	$2,265	$2,300	$2,351	$2,555	$2,981	$3,066	$3,151	$3,407	$3,833	$4,258
3	$1,076	$1,614	$2,152	$2,690	$2,797	$2,862	$2,905	$2,969	$3,228	$3,765	$3,873	$3,981	$4,303	$4,841	$5,379
4	$1,300	$1,950	$2,600	$3,250	$3,380	$3,458	$3,510	$3,588	$3,900	$4,550	$4,680	$4,810	$5,200	$5,850	$6,500
5	$1,524	$2,286	$3,048	$3,810	$3,963	$4,054	$4,115	$4,207	$4,573	$5,335	$5,487	$5,639	$6,097	$6,859	$7,621
6	$1,748	$2,623	$3,497	$4,371	$4,546	$4,651	$4,721	$4,825	$5,245	$6,119	$6,294	$6,469	$6,993	$7,868	$8,742
7	$1,973	$2,959	$3,945	$4,931	$5,129	$5,247	$5,326	$5,444	$5,918	$6,904	$7,101	$7,298	$7,890	$8,876	$9,863
8	$2,197	$3,295	$4,393	$5,492	$5,711	$5,843	$5,931	$6,063	$6,590	$7,688	$7,908	$8,128	$8,787	$9,885	$10,983

MEDICARE *(Screening Services Requiring Anesthesia)*

Source: Medicare Claims Processing Manual, 50 - Payment for Anesthesiology Services (Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
Source: Medicare Anesthesia Conversion Factors for 2024 (JL)
https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00282909
Source: How anesthesia reimbursement is calculated (JL)
https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144512
Source: For a list of base units assigned to anesthesia CPT codes for 2024, please refer to the 2022 Anesthesia base units by CPT code on the CMS website. The anesthesia base units are unchanged for calendar year 2024. Prior years can be found in the CMS Anesthesiologists Center.
https://www.cms.gov/center/provider-type/anesthesiologists-center

1. General Payment Rule
The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base units and conversion factor are available below and on the CMS website at: https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html. The actual anesthesia time will be reported on the claim in minutes. For example, 30 minutes of anesthesia time is reported as '0030' in the units' field or item 24G of the CMS-1500 claim form or its electronic equivalent.

Medicare Formula: (Base Units + Time Units) x Anesthesia Conversion Factor = Reimbursement Allowance
- **Base Units** = Add assigned base units for Anesthesia CPT Code(s)
- **Time Units** = Total minutes divided by 15.
- **Conversion Factor** = Region's assigned conversion factor (01, 99, and 01- DC Metro)

Example: CPT Code=00812 (base unit is 3), Time=34 mins, Allegany=Region 99, therefore conversion factor is $21.97
(Base Units + Time Units) x Conversion Factor = Reimbursement Allowance
[3 base units + (34mins/15)] x 20.64= Reimbursement Allowance
(3 base units + 2.27 time units= 5.27) x 20.64= Reimbursement Allowance
5.27 x 20.64 = $108.77

CPT Codes ↓	Procedures ↓	MD CMS Regions →	MD Region 01	MD Region 99	DC Metro 01
			MD Region Conversion Factors ↓		
00811*	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum: not otherwise specified **(4 Base Units)**		**$21.41**	**$20.64**	**$22.19**
00812*	Medicare Screening Anesthesia for Screening Colonoscopy **(3 Base Units)**				
00813	Medicare Screening Anesthesia for combined colonoscopy and EGD **(5 Base Units)**				

***NOTE:** *Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and the coinsurance and deductible are waived. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.*

Other Notes:
- Append modifier –33 (Preventive Service) to anesthesia CPT code 00812 when you supply a separately payable anesthesia service with a screening colonoscopy (G0105 and G0121) to eliminate patient copayment, coinsurance, and deductible.
- When a screening colonoscopy becomes a diagnostic colonoscopy, report anesthesia services with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified) with only the –PT modifier; we don't charge the deductible. Report this with 00812.
- CMS waives coinsurance and deductible for moderate sedation services (reported with G0500 or 99153) when provided with and in support of a screening colonoscopy service and when reported with modifier –33. When a screening colonoscopy becomes a diagnostic colonoscopy, report moderate sedation services (G0500 or 99153) with only the –PT modifier; we don't charge the deductible.

2. Payment at Personally Performed Rate
The A/B MAC must determine the fee schedule payment, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:
- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident, the physician is a teaching physician as defined in §100;
- The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case that meets the requirements for payment at the medically directed rate. The physician meets the teaching physician criteria in §100.1.4;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- If the physician is involved with a single case with a qualified nonphysician anesthetist (a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant)), A/B MACs may pay the physician service and the qualified nonphysician anesthetist service in accordance with the requirements for payment at the medically directed rate;

Or
- The physician and the CRNA (or anesthesiologist's assistant) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the **AA** modifier and the CRNA reports the **QZ** modifier.

3. Payment at the Medically Directed Rate
Determine payment at the medically directed rate for the physician on the basis of 50% of the allowance for the service performed by the physician alone. Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases and the physician performs the following activities.

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care

The physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated postanesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated. provided indicated postanesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated.

4. Payment at Medically Supervised Rate
Allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

5. Anesthesia Time and Calculation of Anesthesia Time Units
Anesthesia time: the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished, compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place.
For purposes of this section, **anesthesia practitioner** means:
- A physician who performs the anesthesia service alone,
- A CRNA who is furnishing services that do not meet the requirements for payment at the medically directed rate,
- A qualified nonphysician anesthetist who is furnishing services that meet the requirements for payment at the medically directed rate.

The physician who medically directs the qualified nonphysician anesthetist would ordinarily report the same time as the qualified nonphysician anesthetist reports for the service.

6. Monitored Anesthesia Care

Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

Pay for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services.

- If the physician personally performs the monitored anesthesia care case, payment is made under the fee schedule using the payment rules for payment at the personally performed rate.
- If the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrentcases, payment is made under the fee schedule using the payment rules for payment at the medically directed rate. Anesthesiologists use the QS modifier to report monitored anesthesia care cases, in addition to reporting the actual anesthesia time and one of the payment modifiers on the claim.

7. Anesthesia Claims Modifiers

Physicians report the appropriate modifier to denote whether the service meets the requirements for payment at the personally performed rate, medically directed rate, or medically supervised rate. If using a CRNA supervised by an anesthesiologist, the anesthesiologist receives 50% (modifier QK or QY), and the CRNA receives 50% (modifier QX). If using a CRNA without medical direction by a physician the reimbursement is 100% of the calculated amount (modifier QZ).

AA - Anesthesia Services performed personally by the anesthesiologist (100%)
GC - These services have been performed by a resident under the direction of a teaching physician.
NOTE: The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100 of this chapter. One of the payment modifiers must be used in conjunction with the GC modifier.
G8 - Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures
G9 - Monitored anesthesia care for patient who has a history of severe cardio- pulmonary condition
QK - Medical direction of 2-4 concurrent anesthesia procedures (50%)
QS - Monitored anesthesia care service
NOTE: The QS modifier can be used by a physician or a qualified nonphysician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim.
QX - CRNA services with medical direction by a physician (50%)
QY - Medical direction of one CRNA/AA by an anesthesiologist (50%)
QZ - CRNA service without medical direction by a physician (100%)
33 - Preventive services
50 - Bilateral Procdures (50%)
51 - Multiple Procdures (50%)

Anesthesia Risk- Qualifying Circumstances Modifier:

Modifier codes sometimes are used to indicate unusual circumstances related to anesthesia services. The CPT 99100 modifier code is recognized for administration of anesthesia to a patient who is younger than age 1 or older than age 70 and it's unit value= 1. Programs will perform the following actions when a Qualifying Circumstance Modifier code, along with one of the anesthesia CPT codes is billed:

1. Identify whether the modifier code is appropriately billed by verifying that client is older than 70 years of age.
2. Add the billed CPT 99100's unit value (1) to the assigned base unit of the billed Anesthesia CPT code.

Formula with Example: CPT Code= 00812 and 99100, Time= 34 mins, Region= Allegany

[(3 base units + 1 unit value) + (34 mins/15)] x 20.64 = Reimbursement Allowance
(4 units + 2.27 time units= 6.27) x 20.64= Reimbursement Allowance
6.27 x 20.64 = $129.41

MARYLAND MEDICAID ASSISTANCE (MMA) (*Diagnostic and Treatment Service Requiring Anesthesia)*

The Program does not reimburse anesthesia in the same way as Medicare.The anesthesia procedure code, modifier, base units, total time in minutes, and procedure fee are utilized for calculating payments for anesthesia services.
The Program will not make additional payments for participant risk factors such as participant age, health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for monitored anesthesia care (MAC).
There is no separate payment for the medical supervision of a Certified Registered Nurse Anesthetist (CRNA) by a physician.

Source for information below: 2024 Maryland Medical Assistance Program: Professional Services Provider Manual, pages 48-52
2024 Professional Services Provider Manual, Effective 1/1/2024

Procedure code:

Use procedure codes 00100 – 01999 to report the administration of anesthesia. These codes describe anesthesia for procedures categorized by areas or systems of the body. Other codes describe anesthesia for radiological and miscellaneous procedures. Report only one primary anesthesia service for a surgical session using the anesthesia code related to the major surgery. Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.

Modifier:

If an appropriate modifier for anesthesia services is not reported, the service will be denied. A separate payment will not be made for any anesthesia services performed by the physician or nurse anesthetist who also performs the medical or surgical service for which the anesthesia is required.
The Program will not make additional payments for participant risk factors such as participant age, health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for monitored anesthesia care (MAC). There is no separate payment for the medical supervision of a Certified Registered Nurse Anesthetist (CRNA) by a physician.
If a physician personally provides the entire anesthesia service, payment will be 100% of the calculated amount. Medically directed anesthesia services will be paid at 50% of the calculated amount for both the CRNA and the physician. The Program will make separate payment to physicians and CRNAs for medically directed anesthesia services. Non-medically directed CRNA services are paid at 100% of the calculated fee. Physician supervision services are not paid separately.

AA - Anesthesia Services performed personally by the anesthesiologist (100%)
AD - is not payable by the Program
QK - Medical direction of 2-4 concurrent anesthesia procedures (50%)
QS - is for informational purposes only and will not change payment.
QX - CRNA services with medical direction by a physician (50%)
QY - Medical direction of one CRNA by an anesthesiologist (50%)
QZ - CRNA service without medical direction by a physician (100%)
50 - Bilateral Procdures (50%)
51 - Multiple Procdures (50%)

Time and Base Units:

Anesthesia time starts when the anesthesia provider begins to prepare the participant for induction of anesthesia and ends when the participant is placed under post-operative supervision, and the anesthesia provider is no longer in personal attendance. In the event of an interruption, only the actual anesthesia time is counted; all anesthesia start and stop times must be documented in the medical record.
Hours are coverted to minutes and entered into the total anesthesia minutes provided for the procedure. Medicaid does not determine time units on the basis of one time unit for each 15 minutes of anesthesia time. Instead, anesthesia base units (ABUs) are converted to time units by multiplying by 15. Payment for anesthesia services will be the sum of the total time in minutes and the base units converted to time units multiplied by the listed fee per unit and by the modifier rate (50% or 100%). Payment will be the lower of the provider's charge or the calculated fee amount. To bill for anesthesia administered for multiple surgeries, use the anesthesia code with the highest anesthesia base unit value and report the actual time in minutes that extends over all procedures. Base units have been assigned to each anesthesia procedure code (see table below) and reflect the difficulty of the anesthesia service, including the usual preoperative and post-operative care and evaluation. The current professional service fee for CPT codes 00400, 00940, 00811, 00540 and 00541 is 1.1486, as listed in the 2024 Professional Services Fee Schedule. Payment for anesthesia services is based on the following formula.

[Time Units (Total minutes) + (Base Units x 15)] x Fee x Modifier = Maryland Medicaid Reimbursement Allowance

Example: Time = 100 mins., **CPT Code =** 00811, **Listed Fee =** 1.1486, **Modifier =** QX (50% or 0.50)

[Time Units=(Total minutes) + (Base units x 15)] x Fee x Modifier rate= Maryland Medicaid Reimbursement Allowance
[45 mins + (4 base units x 15)] x 1.1486 x 0.50= Reimbursement Allowance
[45 mins + (4 base units x 15)] x 1.1486 x 0.50= Reimbursement Allowance
[45 + 60] x 1.1486 x 0.50= Reimbursement Allowance
(105 x 1.1486) x 0.50= $60.30

CPT Codes ↓	Procedures ↓	Base Units ↓
	BREAST AND CERVICAL	
00400	Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified	**3**
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	**3**
	COLORECTAL	
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum: not otherwise specified	**4**
	LUNG	
00540	Anesthesia for thoracotomy procedures (involving lungs, pleura, diaphragm, and mediastinum [including surgical thoracoscopy]; not otherwise specified); If the patient's carrier only accepts CPT codes, use 00540; this code makes no assumption about how the lungs are ventilated during the procedure.	**12**
00541	Anesthesia for intra-thoracic procedures, (excluding procedures on the heart, great vessels, trachea; utilizing one lung ventilation) and has 15 base units (BUs). If the patient's carrier only accepts CPT codes, use 00540.	**15**

CPT Codes ↓	Procedures ↓ BREAST AND CERVICAL	2024 Medicaid Physician Fee Schedule
99156	Moderate anesthesia, 10-22 minutes for individuals 5 years or older	**$64.40**
99157*	Moderate anesthesia for each additional 15 minutes	**$48.81**
***Note:** If procedure is 50 minutes, code 99156 + (99157 x 2). No separate charge allowed if procedure <10 minutes.		

The anesthesia base units are unchanged for calendar year 2024. For a list of base units assigned to anesthesia CPT codes for 2024, please refer to the 2022 Anesthesia base units by CPT code on the CMS website. Prior years can also be found in the CMS Anesthesiologists Center at https://www.cms.gov/center/provider-type/anesthesiologists-center

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
GUIDANCE FOR PAYMENT OF FACILITY FEE

1. Facility Fee Reimbursement:

The facility fee is payment for services performed in a facility other than the physician's office and is typically less than the nonfacility fee for services performed in the physician's office. Facility Fees are usually billed on the UB04 Form 1450. See Block #4, of the Form 1450 to verify the "Bill Type"; a 4-digit code that identifies the type of facility performing the procedure. For an **outpatient claim, the only allowed "Bill Type" is "0131"**; for an **Ambulatory Surgical Center (ASC) claim the "Bill Type" is 0831** and a **hospital claim the "Bill Type" will range between 0110 - 0319.** There are many other "Bill Types" that are not applicable to this program.

Hospital Services Facility Fee:

All Maryland Hospitals are regulated by the Maryland Health Services Cost Review Commission (HSCRC). July 1, 1977, a waiver of federal law was granted that required Medicare and Medicaid to begin reimbursing Maryland HSCRC regulated facilities and hospitals-on the basis of HSCRC-approved rates. Maryland Hospitals bill TOB 13X for outpatient colorectal cancer screenings.

As of December 14, 2022 public meeting, the HSCRC voted to increase the public-payer (Medicare, Medicare Advantage Plans, Medicaid Fee-for-Service, and Medicaid MCOs) differential by 1 percentage point from 7.7 percent to 8.7 percent, effective April 1, 2023 through June 30, 2024. This rate may have changed; therefore, **programs must check with their contracted hospital for their HSCRC reimbursement rate.**

The HSCRC-regulated facility must bill the full HSCRC-regulated rate. For procedures billed, any remaining balance between the HSCRC-regulated rate and the allowable reimbursement rate shall be treated pursuant to the facility's charity care policy or be considered a contractual allowance in accordance with HSCRC regulations and policies.

Ambulatory Surgical Center (ASC) Facility Fee:

Two primary costs are involved in the surgical procedures performed in an ASC- the physician's professional services for performing procedure and the cost of services furnished by facility where procedure was performed. The professional fee is paid to the physician and payment for facility costs are paid to the ASC.

ASCs must not report separate line items, HCPCS Level II codes, or any other charges for procedures, services, drugs, devices, or supplies that are packaged into the payment allowance for covered surgical procedures. The allowance for the surgical procedure itself includes these other services or items. Covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals and radiology procedures, should be billed on the same claim as the related ASC surgical procedure.

CMS uses **Core Based Statistical Area (CBSA)** delineations issued by the Office of Management and Budget (OMB) for CY24 Ambulatory Surgical Center (ASC) facillity fee reimbursement rates. Review the list below to determine your counties CBSA number to be used to determine the appropriate ASC facility fee reimbursement rate for applicable CPT codes listed in the BCCP/CPEST Reimbursement Rate Sheets. If a procedure is performed in an ambulatory surgical center (ASC) or non-MHSCRC regulated facility then the facility fee is reimbursed at the Medicare rate for one of the nine (9) Core-Based Statistical Areas (CBSA) listed below:

CBSA-21: Caroline, Dorchester, Garrett, Kent and Talbot Counties
CBSA-12580: Anne Arundel, Baltimore City, Baltimore Co, Carroll, Harford, Howard and Queen Anne's Counties
CBSA-15680: St. Mary's County
CBSA-19060: Allegany County
CBSA-23224: Frederick and Montgomery Counties
CBSA-25180: Washington County
CBSA-41540: Somerset, Wicomico and Worcester Counties
CBSA-47894: Calvert, Charles and Prince George's Counties
CBSA-48864: Cecil County

FY2025 Medicare Ambulatory Surgical Center (ASC) Facility Fee Reimbursement Rates

CPT ↓	CBSA # 21	CBSA # 12580	CBSA # 15680	CBSA # 19060	CBSA # 23224	CBSA # 25180	CBSA # 41540	CBSA # 47894	CBSA # 48864
G0104	$82.08	$83.23	$82.51	$82.30	$83.11	$82.35	$82.79	$83.57	$83.79
45330									
G0105	$256.68	$260.26	$258.01	$257.37	$259.88	$257.51	$258.88	$261.32	$262.01
G0121									
45331									
45333									
45335									
45378									
45332	$331.41	$336.03	$331.13	$332.30	$335.54	$332.48	$334.26	$337.41	$338.30
45334									
45379									
45380									
45381									
45382									
45384									
45385									
45388									
45390	$730.38	$740.57	$734.16	$732.34	$739.49	$732.74	$736.65	$743.60	$745.56

Source:
https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00092536 (JL)

2. Ambulatory Surgical Center (ASC) Facility Fees- Colonoscopy:

CPT code 45378, which is used to code a diagnostic colonoscopy, is on the list of procedures approved by Medicare for payment of an ambulatory surgical center facility under section 1833 of the Act. CPT code 45378 is currently assigned to ASC payment group 2. Code G0105, colorectal cancer; colonoscopy on individuals at high risk, was added to the ASC list effective for services furnished on or after January 1, 1998. Code G0121, colorectal cancer; colonoscopy on individual not meeting criteria for high risk, was added to the ASC list effective for services furnished on or after July 1, 2001. Codes G0105 and G0121 are assigned to ASC payment group 2. The ASC facility service is the same whether the procedure is a screening or a diagnostic colonoscopy. If during the course of the screening colonoscopy performed at an ASC, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than code G0105. Effective for services performed on or after January 1, 2007, a 25% coinsurance payment will apply for the colorectal cancer services (G0105 and G0121) by Medicare.

Sources:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf
https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1753-fc (2023 NFRM Addendum AA, BB, DD1, DD2, EE, and FF: view Addendum AA to determine if procedure is subject to 'Multiple Procedure Discounting.')

3. Ambulatory Surgical Center (ASC) Facility Fees- Multiple Procedures:

When more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the procedures have the same HCPCS code.
When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, pay **100** percent of the highest paying surgical procedure on the claim, plus **50** percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year. **Note**: All sigmoidoscopy and colonoscopy procedures listed on the Colorectal tab of this BCCP/CPEST Reimbursement Rate Sheet are subject to multiple procedure discounting for CY24.

The multiple procedure payment reduction is the last pricing routine applied to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier **-73** and **-52** shall not be subjected to further pricing reductions. (i.e., the multiple procedure price reduction rules do not apply). Payment for an ASC surgical procedure billed with modifier **-74** may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of **50** percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session, report 31020 on two separate lines or with "2" in the units field. Depending on whether the claim includes other services to which the multiple procedure discount applies, the contractor applies the multiple procedure reduction of **50** percent to the payment for at least one of the CPT code 31020 payment rates.

Sources:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf
https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1753-fc (2023 NFRM Addendum AA, BB, DD1, DD2, EE, and FF: view Addendum AA to determine if procedure is subject to 'Multiple Procedure Discounting.')

4. Ambulatory Surgical Center (ASC) Facility Fees- Terminated Procedures:

The following guidance determines the appropriate ambulatory surgical center (ASC) facility payment for a scheduled surgical procedure that is terminated due to medical complications, which increase the surgical risk to the patient.

Payment is denied when an ASC submits a claim for a procedure that is terminated before the patient is taken into the treatment or operating room. If the surgery is cancelled or postponed because the patient on intake complains of a cold or flu. Payment is made at the rate of **50** percent if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated.

Example: If the patient develops an allergic reaction to a drug administered by the ASC prior to surgery. Modifier **73** should be utilized to indicate that the procedure was terminated prior to induction of anesthesia or initiation of a procedure. Full payment of the surgical procedure is made if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated. **74** should be used to indicate that the procedure was terminated after administration of anesthesia or initiation of the procedure. An ASC claim for payment for terminated surgery must include an operative report kept on file by the ASC, and made available, if requested.

- **Modifier 73- Procedure terminated before administration of anesthesia:** Pay 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated (use modifier -73). For example, 50 percent is paid if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery or if, upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents continuation of the procedure. Although some supplies and resources are expended, they are not consumed to the same extent had anesthesia been fully induced and the surgery completed. Facilities use a 73 modifier to indicate that the procedure was terminated prior to induction of anesthesia or initiation of the procedure.
  Modifier 74- Procedure terminated after administration of anesthesia: Make full payment of the surgical procedure if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or
- the procedure initiated (use modifier -74). For example, A/B MACs (B) make full payment if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient. In this case, the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. Facilities use a 74 modifier to indicate that the procedure was terminated after administration of anesthesia or initiation of the procedure.

Sources:

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150922
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
GUIDANCE FOR PAYMENT OF LABORATORY/PATHOLOGY FEE

The Cancer Screening Programs Unit encourages programs to access Medicare rates and information on the Centers for Medicare & Medicaid Services (CMS) website for looking up CPT codes, reimbursement rates and information for laboratory services not listed in the reimbursement chart.

Medicare Laboratory Rate Look-up: Look up clinical labs by downloading the most current Clinical Laboratory Fee Schedule (CLABS) from the CMS website.

1. Go to: https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files
2. On the CLFS Files page, scroll downward to view to the table organized by "File Name, Description, Calendar Year." File Name uses the following naming convention: Year, Fee Schedule Type and Quarter. For example, "24CLABQ1" under File Name column means the year 2024, **C**linical **Lab**s, and first quarter. Based on the year and quarter, click on the most current file name.
3. Once you click on the most current file name, you will be advanced to its page. Scroll to the middle of the page to 'Related Links' and click on the file's link.
4. Once you click on the link, you will be advanced to a 'License for Use of Current Procedural Terminology, Fourth Edition ("CPT®") End User Point and Click Agreement'. On this page, scroll all the way to the bottom of the CMS Disclaimer and click the blue 'Accept' button.
5. Once you click on the 'Accept' button, the zipped file will automatically download to your computer, extract the files and open the top Excel file. Allow Excel to remove any leading zeros by clicking 'Convert'.
6. Notice that Clinical Laboratory CPT codes are listed in the B column and their rates are listed in the F column. You can do a search by using "ctrl + f" to find the exact CPT code.
7. If the CPT code is not found, please reach out to MDH.

The Cancer Screening Programs Unit encourages programs to access Medicare rates and information on the Novitas website for looking up CPT codes, reimbursement rates and information for pathology services not listed in the reimbursement chart.

Medicare Pathology Rate Look-up: look up pathology codes by downloading the most current fee schedule for your region or directly in the Novitas website.

To look up pathology codes by downloading the most current fee schedule:

1. Go to: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/FeeLookup
2. Look for the search box on the left titled "Search using a single code" and enter information in the following fields:
   -Enter Current Year
   -Select Maryland or District of Columbia
   -Select locality (01, 99, DC Metro & MD/VA suburbs)
   -Select file type (pdf, excel, or text)
   -Click Download
3. **Note:** Under the first column "FAC IND" the "#" in the cell indicates the Participating Provider (PAR FEE) amounts when the service is performed in a facility.
4. If the CPT code is not found, please reach out to MDH.

To look up pathology codes directly in the Novitas website:

1. Go to: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/FeeLookup
2. Look for the search box on the left titled "Search using a single code" and enter information in the following fields:
   -Enter Procedure Code and modifier if applicable
   -Enter Date of Service
   -Select Maryland or District of Columbia
   -Select locality (01, 99, DC Metro & MD/VA suburbs)
   -Click Search
3. For facility procedures, select the "Participating Provider" amount under "When performed in a facility setting". For office visits and non-facility procedures, select the "Participating Provider" amount under "Fee Schedule Amount".
4. If the CPT code is not found, please reach out to MDH

The Cancer Screening Programs Unit encourages programs to access Medicaid rates and information on the Maryland Medicaid Administration website for looking up CPT codes, reimbursement rates and information for laboratory/pathology services not listed in the reimbursement chart.

Medicaid Laboratory/Pathology Rate Look-up: look up laboratory/pathology codes by downloading the most current fee schedule

1. Go to: https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx
2. Scroll downward to the heading "Dental and Laboratory". Under this heading, click on the most current "Medical Laboratory Fee Schedule (Excel)". This will automatically download the file to your computer.
3. Look up the appropriate CPT code in column A.
4. Notice that the rates are the same irrespective of the place of service.
5. If the CPT code is not found, please reach out to MDH

CPT Code Look-Up on Labcorp Website:

Please follow the below guidance to locate the CPT code for the screening and diagnostic tests performed at Labcorp.

1. Go to: https://www.labcorp.com/test-menu/search
2. Scroll to the middle of this page until you see the search browser "Use a keyword, test name or number." In this browser, type in the test number or type the test's name provided by Labcorp.
3. To browse tests by name, you may click on the first letter of the test's name from the Alphabet below the browser.
4. Once the test or the Lab Corp code is located on the next page, click on the arrow located to the right of the test.
5. Notice that the CPT code is listed right under the test name and beside the Labcorp test number.
6. Now check the CPT code against the CPT code provided on this reimbursement sheet for payment.
7. If the CPT code is not found, please reach out to MDH.

Sources for information below: Medicare Claims Processing Manual, 60 - Payment for Pathology Services (Rev. 2714, Issued: 05-24-13, Effective: 07-01-12 Implementation: 06-25, 13)

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c16.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf

Definitions:

• **Global Service:** Represents the complete study, including both technical and professional components. It is represented by reporting the procedure code without the 26 or TC modifiers

• **Technical Component (TC):** Refers to the facility and equipment costs of performing a study, inclusive of supplies and a technologist or technician to conduct the exam. It is represented by appending the modifier**-TC** to the procedure code

• **Professional Component (26):** Refers to supervision and interpretation of results from the test, which requires a written narrative report of the service provided, including results and analysis by the provider. It is represented by appending the **-26** modifier to the procedure code

A. Global Billing

Billing globally for services that are split into separate PC and TC services is only possible when the PC and TC are furnished by the same physician or supplier entity. For example, where the PC and the TC of a diagnostic service are provided in the same service location, this is reflected as the address entered into Item 32 on CMS Form 1500, which provides the ZIP Code to pay the right locality/GPCI. In this case, the physician/entity may bill globally. However, if the PC and the TC are each provided in different service locations (enrolled practice locations), the PC and the TC must be separately billed.

Merely applying the same place of service (POS) code to the PC and the TC does not permit global billing for any diagnostic procedure.

B. Payment for Technical Component (TC) Services

1. General Rule: Payment ***is not*** made under the physician fee schedule for TC services furnished in institutional settings where the TC service is bundled into the facility payment, e.g., hospital inpatient and outpatient settings. Payment ***is*** made under the physician fee schedule for TC services furnished in institutional settings where the TC service is not bundled into the facility payment, e.g., an ambulatory surgery center (ASC). Payment may be made under the physician fee schedule for the TC of physician pathology services furnished by an independent laboratory, or a hospital if it is acting as an independent laboratory, to non-hospital patients. The physician fee schedule identifies physician laboratory or physician pathology services that have a TC service.

2. TC Services Furnished by Independent Laboratories to Hospital Inpatients and Outpatients

For services furnished on or after July 1, 2012, an independent laboratory may not bill the A/B MAC (B) (and the A/B MAC (B) may not pay) for the TC of a physician pathology service furnished to a hospital inpatient or outpatient.

C. Payment for Professional Component (PC) Services

Payment for Professional Component (PC) Services Payment may be made under the physician fee schedule for the professional component of physician laboratory or physician pathology services furnished to hospital inpatients or outpatients by hospital physicians or by independent laboratories, if they qualify as the reassignee for the physician service.

D. Physician Laboratory and Pathology Services

Physician laboratory and pathology services are limited to:

- Surgical pathology services;
- Specific cytopathology, hematology and blood banking services that have been identified to require performance by a physician and are listed below;
- Clinical consultation services that meet the requirements in subsection 3 below; and
- Clinical laboratory interpretation services that meet the requirements and which are specifically listed in subsection 4 below

1. Surgical Pathology Services

Surgical pathology services include the gross and microscopic examination of organ tissue performed by a physician, except for autopsies, which are not covered by Medicare. Depending upon circumstances and the billing entity, the A/B MACs (B) may pay professional component, technical component or both.

2. Specific Hematology and Cytopathology

Cytopathology services include the examination of cells from fluids, washings, brushings or smears, but generally excluding hematology. Examining cervical and vaginal smears are the most common service in cytopathology. Cervical and vaginal smears do not require interpretation by a physician unless the results are or appear to be abnormal. In such cases, a physician personally conducts a separate microscopic evaluation to determine the nature of an abnormality. This microscopic evaluation ordinarily does require performance by a physician. When medically necessary and when furnished by a physician, it is paid under the fee schedule.

For services furnished prior to January 1, 1999, A/B MACs (B) pay separately under the physician fee schedule for the interpretation of an abnormal pap smear furnished to a hospital inpatient by a physician. They must pay under the clinical laboratory fee schedule for pap smears furnished in all other situations. This policy also applies to screening pap smears requiring a physician interpretation. For services furnished on or after January 1, 1999, A/B MACs (B) allow separate payment for a physician's interpretation of a pap smear to any patient (i.e., hospital or non-hospital) as long as: (1) the laboratory's screening personnel suspect an abnormality; and (2) the physician reviews and interprets the pap smear.

This policy also applies to screening pap smears requiring a physician interpretation and described in the National Coverage Determination Manual and Chapter 18. These services are reported under codes P3000 or P3001.

3. Clinical Consultation Services

Clinical consultations are paid under the physician fee schedule only if they:

a. Are requested by the patient's attending physician;
b. Relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;
c. Result in a written narrative report included in the patient's medical record; and
d. Require the exercise of medical judgment by the consultant physician.

Clinical consultations are professional component services only, i.e., there is no TC service. The clinical consultation codes are 80500 and 80502. Routine conversations held between a laboratory director and an attending physician about test orders or results do not qualify as consultations unless all four requirements are met. Laboratory personnel, including the director, may from time to time contact attending physicians to report test results or to suggest additional testing or be contacted by attending physicians on similar matters. These contacts do not constitute clinical consultations. However, if in the course of such a contact, the attending physician requests a consultation from the pathologist, and if that consultation meets the other criteria and is properly documented, it is paid under the fee schedule.

EXAMPLE: A pathologist telephones a surgeon about a patient's suitability for surgery based on the results of clinical laboratory test results. During the course of their conversation, the surgeon asks the pathologist whether, based on test results, patient history and medical records, the patient is a candidate for surgery. The surgeon's request requires the pathologist to render a medical judgment and provide a consultation. The pathologist follows up his/her oral advice with a written report and the surgeon notes in the patient's medical record that he/she requested a consultation. This consultation is paid under the fee schedule.

In any case, if the information could ordinarily be furnished by a nonphysician laboratory specialist, the service of the physician is not a consultation payable under the fee schedule. See the Program Integrity Manual for guidelines for related data analysis to identify inappropriate patterns of billing for consultations.

4. Clinical Laboratory Interpretation Services

Only clinical laboratory interpretation services, which meet the criteria in subsections C.3.a, c, and d, are billable under the physician fee schedule. These codes have a PC/TC indicator of "6" on the Medicare Physician Fee Schedule database. These services are reported under the clinical laboratory code with modifier 26. These services can be paid under the physician fee schedule if they are furnished to a patient by a hospital pathologist or an independent laboratory. Note that a hospital's standing order policy can be used as a substitute for the individual request by the patient's attending physician. A/B MACs (B) are not allowed to revise CMS's list to accommodate local medical practice. The CMS periodically reviews this list and adds or deletes clinical laboratory codes as warranted.

Note: Reimbursement rates for laboratory and pathology CPT codes are located on their specific cancer tabs (e.g., Breast, Cervical, Colorectal, Lung, Skin)

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
GUIDANCE FOR PAYMENT OF PHYSICIAN SERVICE FEE

1. Physician Service Fee:

Maryland Medical Assistance rates: Refer to the current BCCP/CPEST Reimbursement Sheets for MMA rates or visit the Maryland Medical Assistance website at https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx for the current copy of the Professional Fee Schedule and Professional Services Provider Manual. The purpose of the MMA Professional Services Provider Manual is to provide policy and billing instructions for providers who bill on the paper CMS-1500 claim form or the electronic CMS 837P (professional) claim format and are reimbursed according to the Professional Services Provider Manual and Fee Schedule. This manual describes the Maryland Fee-For-Service Program and explains covered services, service limitations, billing practices, and fee schedules.

Medicare: Refer to the current BCCP/CPEST Reimbursement Sheet for the Medicare (Part B) rates OR visit the Maryland Medicare Contractor Novitas Inc at http://www.novitas-solutions.com (Jurisdiction L).

To look up the Medicare rate for a Physician Fee directly in the Novitas website:

1. Go to: https://www.novitas-solutions.com/webcenter/portal/MedicareJL/FeeLookup
2. Look for the search box on the left titled "Search using a single code" and enter information in the following fields:
   - -Enter Procedure Code (CPT code) and, if applicable, modifier
   - -Enter Date of Service
   - -Select Maryland or District of Columbia
   - -Select locality (01, 99, DC Metro & MD/VA suburbs). To determine your region, refer to the table below.
   - -Click Search
3. For procedures performed in a facility, select the "Participating Provider" amount under "When performed in a facility setting". For office visits and non-facility procedures, select the "Participating Provider" amount under "Fee Schedule Amount".
4. If the CPT code is not found, please reach out to MDH

Locality	Region	Region	Maryland Counties
Baltimore & Surrounding	Region 01	Region 02	Anne Arundel Co, Baltimore City, Baltimore Co, Carroll Co, Harford Co, and Howard
REST OF MARYLAND	Region 99	Region 100	Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset,Talbot, Washington, Wicomico and Worcester
DC + MD/VA SUBURBS	DC Metro 01	DC Metro 02	Montgomery and Prince George's

2. Physician Service Fee- Site of Service Payment Differential:

Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility (FAC) and nonfacility (NFAC) settings. The CMS furnishes both rates in the MPFSDB update. The rate, facility or nonfacility, that a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. For the professional component (PC) of diagnostic tests, the facility and nonfacility payment rates are the same – irrespective of the POS code on the claim. Physicians' services are paid at nonfacility rates for procedures furnished in the following settings: Office (POS code 11) and Federally Qualified Health Center (POS code 50). To access additional POS codes, please refer to section 20.4.2 located here: https://go.cms.gov/manual-physicians-nonphysician-practitionersUnder the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility (FAC) and nonfacility (NFAC) settings. The CMS furnishes both rates in the MPFSDB update.The rate, facility or nonfacility, that a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. For the professional component (PC) of diagnostic tests, the facility and nonfacility payment rates are the same – irrespective of the POS code on the claim. Physicians' services are paid at nonfacility rates for procedures furnished in the following settings: Office (POS code 11) and Federally Qualified Health Center (POS code 50). To access additional POS codes, please refer to section 20.4.2 located here: https://go.cms.gov/manual-physicians-nonphysician-practitioners

3. Physician Service Fee- Multiple Endoscopic Procedures (Modifier 51):

Medicare's payment rules are determined by classifying endoscopy procedures according to families. Each family has a base code and related codes that include the base procedure with additional components such as biopsy or polyp removal. If Field 21 of the Medicare fee schedule payment (MFSDB) contains an indicator of "3," and the procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure), the special rules for multiple endoscopic procedures apply. ***Note:*** *the multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).*

CPT 45378 is the **base code** for the following CPT family: 45379, 45380, 45381, 45382, 45384, 45385, 45388, 45390 and 45393

CPT 45330 is the **base code** for the following CPT family: 45331, 45332, 45333, 45334, 45335 and 45338

CPT 44388 does not belong to an endoscopy family, having an indicator of "2", and follow the rules listed above under Multiple Surgeries

If Field 21 contains an indicator of "3," and multiple endoscopies are billed, the following special rules for multiple endoscopic procedures apply:

Related Endoscopy Family

- When endoscopies are in the same family, rank endoscopies by fee schedule amount
- Pay the highest valued endoscopy at 100%
- Subsequent related endoscopies are reimbursed based on difference between base (or mother) code and subsequent codes.

NOTE: *If an endoscopic procedure is reported with only its base procedure, the base procedure is not paid seperately. Payment for the base procedure is included in the payment for the other endoscopy.*

Example:

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

CPT Code	Region 99	Approved Amount	Rationale
45385	$247.79	$247.79	Code has the highest fee schedule amount and is allowed at 100%
45380	$195.86	$15.57	Base code= 45378
			Fee schedule amount of 45378 = $180.29
			Difference between 45380 ($195.86) and Base 45378 ($180.29) = $15.5
45378	$180.29	$0	Payment for base amount is already included in the payment of its family CPT 45385

Programs in MD Region 99 would pay the full value of the highest endoscopic procedure 45385 ($247.79), plus the difference between CPT 45380 and CPT 45378 ($15.57), for a total of $263.36.

NOTE: the base colonoscopy is included in the highest endoscopic procedure's rate.

Source:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

4. Physician Service Fee- Bilateral Surgery (Modifier 50):

"Bilateral surgery" means surgical procedures that are performed on both sides of the body at the same operative session or on the same day. The descriptions for some procedure codes include the term "bilateral" or the phrase "unilateral or bilateral." The fee for these codes reflects the work involved if done bilaterally, as the description states. If a procedure is performed bilaterally, report the bilateral procedure code, if available. When there is no code describing bilateral services, report the bilateral service on one claim line, adding modifier -50, bilateral procedure. Payment for a bilateral procedure reported appropriately with modifier -50 is based on the lower of the amount billed or 150% of the listed fee for the procedure. If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.
Note: For bilateral procedures, do not bill the same code on two separate lines using the modifiers –RT (right side) and –LT (left side). Modifiers -RT and -LT are not acceptable substitutes for modifier -50 (bilateral), and will not process correctly.

Source:
https://health.maryland.gov/mmcp/Documents/2021%20Professional%20Services%20Provider%20Manual%20website.pdf

5. Physician Service Fee- Multiple Surgical Procedures (Modifier 51):

For multiple surgical procedures performed during the same surgical session, by the same provider, report the major or primary surgery on the first service line with no modifier. Report each additional procedure performed by the same provider during the same surgical session on subsequent service lines with the modifier -51. Including "Add-On codes", "51- exempt codes", any additional procedure or service codes. All services should be reported on one claim. The maximum units of service allowed for a surgery procedure without a modifier -51 is one.

Example: Excision of tendon

26180: Excision of tendon, finger, flexor or extensor, each tendon

26180-51: Excision of tendon, finger, flexor or extensor, each tendon (multiple procedures)

Note: Procedures identified as "Add-on" or "-51-exempt" should still be reported using the modifier -51. They are paid at 100% of the listed fee for the procedure and are not subject to the multiple surgery reduction of 50%.

Source:
https://health.maryland.gov/mmcp/Documents/2021%20Professional%20Services%20Provider%20Manual%20website.pdf

6. Physician Service Fee- Multiple and Bilateral Surgery (Modifiers 51 and 50):
The payment rate for each modifier is a percentage of the listed fee. Payment rates for multiple modifiers are multiplied together to determine the payment amount.

Example: Modifiers -50 (bilateral) and -51 (multiple) typically have rates at 150% of the base rate and 50% of the base rate, respectively.
If reported together on the same service line, the payment rate is 75% of the base rate (1.50 x .50 = 0.75).

Source:
https://health.maryland.gov/mmcp/Documents/2021%20Professional%20Services%20Provider%20Manual%20website.pdf

6. Physician Service Fee- Incomplete Colonoscopies (modifier 53) (Codes 44388, 45378, G0105 and G0121):
An incomplete colonoscopy, e.g., the inability to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, is billed and paid using colonoscopy through stoma code 44388, colonoscopy code 45378, and screening colonoscopy codes G0105 and G0121 with modifier "-53." (Code 44388 is valid with modifier 53 beginning January 1, 2016.) The Medicare physician fee schedule database has specific values for codes 44388-53, 45378-53, G0105-53 and G0121-53. Beginning January 1, 2016, Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Source:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - OFFICE VISITS

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

CPT Codes ↓	Procedures ↓ MD CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
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)				**$9.99**
CPT ↓	**New Patient: Exam/Office Visit ↓**				
99202	Medically appropriate history/exam, straightforward decision-making; **15-29 minutes**	**$76.69**	**$73.15**	**$81.86**	
99203	Medically appropriate history/exam, low level decision-making; **30-44 minutes**	**$118.35**	**$112.86**	**$125.61**	
99204	Medically appropriate history/exam, moderate level decision-making; **45-59 minutes**	**$176.96**	**$169.09**	**$187.31**	
99205	Medically appropriate history/exam, high level decision-making; **60-74 minutes**	**$233.33**	**$222.95**	**$246.68**	
NOTE: *For Breast/Cervical, all consultations should be billed through the standard "new patient" office visit CPT codes* ***99202–99205.*** *Consultations billed as* ***99204*** *or* ***99205*** *must meet the criteria for these codes. These codes (99204–99205) are typically not appropriate for NBCCEDP screening visits. However, they may be used when provider spends extra time to do a detailed risk assessment.*					
CPT ↓	**Established Patient: Exam/Office Visit ↓**				
99211	Evaluation and management, may not require presence of physician; presenting problems are minimal	**$24.85**	**$23.64**	**$26.96**	
99212	Medically appropriate history/exam, straightforward decision making; **10-19 minutes**	**$60.11**	**$57.32**	**$64.26**	
99213	Medically appropriate history/exam; low level decision making; **20-29 minutes**	**$96.22**	**$92.01**	**$102.40**	
99214	Medically appropriate history/exam; moderate level decision making; **30-39 minutes**	**$135.52**	**$129.75**	**$144.02**	
99215	Comprehensive history & examination requiring highly complex medical decision; **40 minutes (CPEST Program Only)**	**$190.78**	**$182.62**	**$202.30**	
CPT ↓	**Initial comprehensive preventive medicine evaluation and management ↓**				
99385	History, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations & lab procedures; **18 to 39 years of age**	**$118.35**	**$112.86**	**$125.61**	
99386	Same as 99385, but **40 to 64 years of age**	**$118.35**	**$112.86**	**$125.61**	
99387	Same as 99385; but **65 years of age or older**	**$118.35**	**$112.86**	**$125.61**	
NOTE: The 9938X codes shall be reimbursed at or below the 99203 rate. The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the BCCP. While some programs may need to use 993XX-series codes, Preventive Medicine Evaluation visits are not covered by Medicare and not appropriate for the BCCP.					
CPT ↓	**Periodic comprehensive preventive medicine evaluation and management ↓**				
99395	History, examination, counseling and guidance, risk factor reduction, ordering of appropriate immunizations and lab procedures; **18 to 39 years of age**	**$60.11**	**$57.32**	**$64.26**	
99396	Same as 99395, but **40 to 64 years of age**	**$60.11**	**$57.32**	**$64.26**	
99397	Same as 99395; but **65 years of age and older**	**$60.11**	**$57.32**	**$64.26**	
NOTE: The 9939X codes shall be reimbursed at or below the 99213 rate. *The type and duration of office visits should be appropriate to the level of care needed to accomplish screening and diagnostic follow-up within the BCCP. While some programs may need to use* ***993XX series codes,*** *Preventive Medicine Evaluation visits are not covered by Medicare and not appropriate for the BCCP.*					
CPT ↓	**Office Consult (with a Specialist) which requires 3 key components, listed below↓ (LUNG MODULE ONLY)**				
99242	**3 key components:** An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, **30 minutes are spent face-to-face with the patient and/or family.**				**$94.39**
99243	**3 key components:** A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, **40 minutes are spent face-to-face with the patient and/or family.**				**$129.98**
99244	**3 key components:** A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **60 minutes are spent face-to-face with the patient and/or family.**				**$193.14**
99245	**3 key components:** A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, **80 minutes are spent face-to-face with the patient and/or family.**				**$235.44**
NOTE: *CPT codes reserved for an office consultation with a specialist, typically at the request of another physician to either recommend care for a specific condition/problem or to determine whether to accept responsibility for ongoing management of the patient's care. (* ***For example:*** *An office consultation with a Pulmonologist (CPT 99242-99245) whom the client's Primary Care Physician has referred due to a LDCT finding of a Lung-RAD 4, requiring Pulmonologist's consultation with a tumor board.)*					

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - PRE-OPERATIVE LABS AND TESTS

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/
Note: In the BCCP and CPEST Programs, the pre-operative testings; CBC, urinalysis, pregnancy test, pre-operative CXR, etc are allowed if these procedures are medically necessary for the planned surgical procedure.

CPT Code ↓	Procedures ↓ CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
71045	**Radiologic examination, chest,** single view	Global - $27.44	Global - $25.99	Global - $28.73	Global - $17.29
		26 - $8.70	26 - $8.42	26 - $9.10	26 - $5.48
		TC - $18.74	TC - $17.57	TC - $20.62	TC - $11.81
71046	**Radiologic examination, chest,** two views, frontal and lateral;	Global - $35.97	Global - $34.10	Global - $39.07	Global - $26.61
		26 - $10.78	26 - $10.44	26 - $11.30	26 - $7.97
		TC - $25.20	TC - $23.66	TC - $27.77	TC - $11.81
80048	**Basic Metabolic Panel**	$8.46	$8.46	$8.46	$8.30
80053	**Comprehensive Metabolic Panel**	$10.56	$10.56	$10.56	$10.37
80069	**Renal Function Panel** - includes albumin, calcium, bicarbonate, chloride, creatinine, glucose, phosphate, potassium, sodium, urea nitrogen (BUN)	$8.68	$8.68	$8.68	$8.52
80076	**Hepatic Function Panel** - includes albumin, bilirubin (total), bilirubin (direct), alanine amino transferase (SGPT), aspartate amino transferase (SGOT) alkaline phosphatase, protein (total)	$8.17	$8.17	$8.17	$8.02
81001	**Manual urinalysis test with examination** using microscope, automated	$3.17	$3.17	$3.17	$3.12
81002	**Urinalysis,** manual test	$3.48	$3.48	$3.48	$2.77
81025	**Urine pregnancy test**	$8.61	$8.61	$8.61	$6.84
82565	**Blood Creatinine Level**	$5.12	$5.12	$5.12	$5.03
82948	**Blood Glucose,** reagent strip	$5.04	$5.04	$5.04	$4.01
85007	**Blood Count;** blood smear, micro exam with manual diff WBC count	$3.80	$3.80	$3.80	$3.37
85025	**Blood Count; complete (CBC)** automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count.	$7.77	$7.77	$7.77	$7.62
85027	**Complete Blood Count, automated**	$6.47	$6.47	$6.47	$6.34
85210	**Prothrombin (PT),** specific clotting factor II	$12.98	$12.98	$12.98	$12.74
85730	**Thromboplastin (PTT) time,** partial, plasma or whole blood	$6.01	$6.01	$6.01	$5.90
93000	**Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report**	15.26	$14.49	$16.28	$15.01
93005	**Electrocardiogram, routine ECG with at least 12 leads, tracing only, without interpretation and report**	$6.89	$6.41	$7.53	$6.78
93010	**Interpretation and report only**	$8.36	$8.08	$8.75	$6.56
93015	**Stress Test (Global)**	76.37	$72.89	$82.30	$75.12
CPT ↓	**COVID Tests ↓**				
87426	**COVID-19 infectious agent detection by nuclei acid DNA or RNA; amplified probe technique**		$35.33		
87635	**COVID-19 infectious agent antigen detection by immunoassay technique**; qualitative or semiquantitative		$51.31		
U0002	**2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19),** any technique, multiple types or subtypes (includes all targets), non-CDC		$51.31		

Sources:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - BREAST

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

1. Screening services are reimbursed at the Medicare rate based on the region in which the service was provided.
For reimbursement purposes, the term "screening services" is defined by the Cancer Screening Program Unit (CSPU) as a clinical breast exam through appropriate services (e.g., screening mammogram, diagnostic mammogram, ultrasound, screening MRI*, diagnostic MRI*, surgical consult) up to, but not including, a biopsy for breast cancer screening.
***Note:** A screening breast MRI can be reimbursed 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% or greater a defined by risk assessment models such as BRCAPRO that depend largely on family history. Breast MRI should never be done alone as a breast cancer screening tool. A diagnostic MRI also 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. A breast MRI cannot be reimbursed to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.*

2. Diagnostic services are reimbursed at the Maryland Medicaid rate as stated in the schedule below.
For reimbursement purposes, the term "diagnostic services" is defined by the Cancer Screening Program Unit (CSPU) as appropriate diagnostic tests and procedures including and following a breast biopsy for the diagnosis of breast cancer.
***Note:** The treatment of breast carcinoma in situ and breast cancer is not allowed in the BCCP program.*

3. Services that are regulated by the Maryland Health Services Cost Review Commission (MHSCRC) are reimbursed not to exceed the rate approved for the Contractor by the MHSCRC.

4. Below are the MBCCP program-approved procedures, rates, and diagnosis codes. If a program is unable to find a procedure or CPT code on the list, please reach out to your Technical Lead with questions prior to paying for the procedure.

CPT Code ↓	Procedures ↓ CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
CPT ↓	**Radiologic Procedures ↓**				
76098	**Radiologic Examination,** Surgical specimen				Global - $16.40 26 - $5.96 TC - $10.44
76641	**Ultrasound,** complete examination of the breast, including axilla, unilateral	Global - $109.50 26 - $35.86 TC - $73.64	Global - $104.00 26 - $34.68 TC - $69.32	Global - $118.89 26 - $37.56 TC - $81.33	
76642	**Ultrasound,** limited examination of the breast, including axilla, unilateral	Global - $90.58 26 - $33.44 TC - $57.13	Global - $86.08 26 - $32.32 TC- $53.76	Global - $98.08 26 - $35.00 TC - 63.08	
76942	**Ultrasonic guidance for needle placement,** imaging supervision and interpretation				Global - $59.14 26 - $29.71 TC - $29.43
77046*	**Magnetic Resonance Imaging (MRI),** breast, without contrast, unilateral	Global -$233.29 26 -$70.58 TC -$162.71	Global - $221.54 26 - $68.36 TC - $153.18	Global -$253.70 26 - $73.98 TC - $179.73	
77047*	**Magnetic Resonance Imaging (MRI),** breast, without contrast, bilateral	Global - $239.90 26 - $77.91 TC - $161.99	Global - $227.93 26 - $75.43 TC - $152.50	Global - $260.56 26 - $81.63 TC - $178.93	
77048*	**Magnetic Resonance Imaging (MRI),** breast, including CAD, with and without contrast, unilateral	Global - $368.78 26 -$102.65 TC - $266.13	Global - $349.90 26 - $99.33 TC - $250.56	Global - $401.52 26 - $107.53 TC - $294.00	
77049*	**Magnetic Resonance Imaging (MRI),** breast, including CAD, with and without contrast, bilateral	Global -$376.01 26 - $112.39 TC - $263.62	Global - $356.96 26 - $108.76 TC - $248.20	Global - $408.95 26 - $117.73 TC - $291.22	
NOTE:** Breast Magnetic Resonance Imaging (MRI) billed as **77046, 77047, 77048** and **77049 cannot be reimbursed to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.** Breast MRI can be reimbursed by the NBCCEDP 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% or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history. Breast MRI also 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. **Breast MRI should never be done alone as a breast cancer screening tool.					
77063	**Screening Digital Breast Tomosynthesis (3D),** bilateral (list separately in addition to code for primary procedure 77067)	Global - $55.05 26- $29.21 TC -$25.84	Global - $52.64 26 - $28.29 TC - $24.35	Global - $59.18 26 - $28.57 TC - $30.61	
G0279	**Diagnostic Digital Breast Tomosynthesis (3-D),** unilateral or bilateral (list separately in addition to 77065 or 77066)	Global - $50.03 26 - $29.21 TC - $20.81	Global - $47.12 26 - $27.82 TC - $19.30	Global - $53.62 26 - $30.61 TC - $23.01	
77065	**Diagnostic Mammography,** unilateral (includes CAD)	Global - $133.74 26 - $39.65 TC - $94.09	Global - $126.98 26 - $38.39 TC - $88.59	Global - $145.51 26 - $41.56 TC - $103.95	Global - $105.85 26 - $31.37 TC - $74.48
77066	**Diagnostic Mammography,** bilateral (includes CAD)	Global -$169.42 26 - $48.69 TC - $120.72	Global - $160.75 26 - $47.14 TC - $113.61	Global - $184.32 26 - $51.02 TC - $133.30	Global - $134.31 27 - $38.60 TC - $95.71
77067	**Screening Mammography,** bilateral (includes CAD)	Global - $136.71 26 -$37.24 TC - $99.48	Global - $129.70 26 - $36.03 TC - $93.67	Global - $148.91 26 - $39.01 TC - $109.90	
***Note:** CPT Code 77061 (Breast Tomosynthesis, unilateral) and CPT Code 77062 (Breast Tomosynthesis, bilateral) are not allowed in the BCCP program.*					
CPT ↓	**Other↓**				
77053	**Mammary ductogram or galactogram,** single duct	Global - $57.67 26 - $17.76 TC - $39.91	Global - $54.70 26 - $17.17 TC - $37.53	Global - $62.64 26 - $18.60 TC - $44.04	
A9575	**Gadoterate meglumi agent**	$0.13 per 0.1 ml	$0.13 per 0.1 ml	$0.13 per 0.1 ml	
A9577	**Gadobenate dimeglumine (multihance)**	$1.82 per 1 ml	$1.82 per 1 ml	$1.82 per 1 ml	
A9579	**Gadolunium-based contrast agent**	$1.51 per 1 ml	$1.51 per 1 ml	$1.51 per 1 ml	
***NOTE:** Other contrast agents may be allowable. Please contact MDH.*					
CPT ↓	**Laboratory and Pathology Tests↓**				
88172	**Cytopathology,** evaluation of fine needle aspirate- immediate cytohistological study to determine adequacy of specimen(s), first evaluation episode				Global - $48.95 26 - $31.64 TC - $17.31
88173	**Cytopathology,** evaluation of fine needle aspirate- interpretation and report				Global - $132.95 26 - $61.62 TC - $71.33
88177	**Cytopathology, evaluation of fine needle aspirate-** immediate cytohistological study to determine adequacy of specimen(s), each separate additional evaluation episode				Global - $25.54 26 - $19.27 TC - $6.27
88305	**Surgical pathology,** gross and microscopic examination				Global - $67.05 26 - $37.09 TC - $29.97
88307	**Surgical pathology,** gross and microscopic examination; requiring microscopic evaluation of surgical margins				Global - $235.18 26 - $72.55 TC - $162.63

88341	**Immunohistochemistry or immunocytochemistry,** per specimen; each additional single antibody stain procedure				Global - $81.10 26 - $24.94 TC - $56.16
88342	**Immunohistochemistry or immunocytochemistry,** per specimen; initial single antibody stain procedure				Global - $93.16 26 - $30.99 TC - $62.17
88360	**Morphomectric analysis,** tumor immunohistochemistry, per specimen; manual				Global - $111.36 26 - $36.95 TC - $74.41
88361	**Morphomectric analysis,** tumor immunohistochemistry, per specimen; using computer-assisted technology				Global - $124.71 26 - $42.94 TC - $81.78
88364	**In situ hybridization (e.g. FISH),** per specimen; each additional single probe stain procedure				Global - $116.06 26 - $30.36 TC - $85.71
88364	**In situ hybridization (e.g., FISH),** per specimen; initial single probe stain procedure				Global - $154.91 26 - $38.14 TC - $116.77
88366	**In situ hybridization (e.g. FISH),** per specimen; each multiplex probe stain procedure				Global - $231.08 26 - $54.07 TC - $177.01
88367	**Morphometric analysis,** in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure				Global - $104.22 26 - $32.75 TC - $71.46
88368	**Morphometric analysis,** in situ hybridization, manual, per specimen, initial single probe stain procedure				Global - $114.84 26 - $37.52 TC - $77.32
88369	**Morphometric analysis,** in situ hybridization, manual, per specimen, each additional probe stain procedure				Global - $97.18 26 - $28.10 TC - $69.08
88373	**Morphometric analysis,** in situ hybridization, computer-assisted, per specimen, each additional probe stain procedure				Global - $65.05 26 - $23.33 TC - $41.73
88374	**Morphometric analysis,** in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure				Global - $286.20 26 - $38.29 TC - $247.91
88377	**Morphometric analysis,** in situ hybridization, manual, per specimen, each multiplex stain procedure				Global - $340.24 26 - $55.56 TC - $284.68

CPT↓	Procedures↓	Location	2024 Medicaid Physician Fee Schedule Reimbursement Rates
19000	**Puncture aspiration of cyst of breast**	NFAC	$90.02
		FAC	$34.72
19001	**Puncture aspiration of cyst of breast,** each additional cyst, *used with 19000*	NFAC	$21.33
		FAC	$17.34
19100	**Breast biopsy,** percutaneous, needle core, not using imaging guidance	NFAC	$120.65
		FAC	$56.23
19101	**Breast biopsy,** open, incisional	NFAC	$273.03
		FAC	$177.82
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	NFAC	$395.48
		FAC	$332.48
19125	**Excision of breast lesion,** identified by preoperative placement of radiological marker; open; single lesion	NFAC	$438.40
		FAC	$369.13
19126	**Excision of breast lesion,** identified by preoperative placement of radiological marker; open; *each additional lesion separately identified by a preoperative radiological marker*	NFAC	$130.37
		FAC	$130.37
10004	**Fine needle aspiration biopsy without imaging guidance**, each additional lesion	NFAC	$45.73
		FAC	$38.20
10005	**Fine needle aspiration biopsy including ultrasound guidance**, first lesion	NFAC	$110.47
		FAC	$63.73
10006	**Fine needle aspiration biopsy including ultrasound guidance,** each additional lesion	NFAC	$52.16
		FAC	$43.38
10007	**Fine needle aspiration biopsy including fluoroscopic guidance**, first lesion	NFAC	$251.16
		FAC	$82.05
10008	**Fine needle aspiration including fluoroscopic guidance**, each additional lesion	NFAC	$141.31
		FAC	$52.55
10009	**Fine needle aspiration including CT guidance**, first lesion	NFAC	$411.98
		FAC	$99.16
10010	**Fine needle aspiration including CT guidance**, each additional lesion	NFAC	$247.31
		FAC	$72.51
10011	**Fine needle aspiration including MRI guidance**, first lesion (For CPT 10011 use the reimbursement rate for CPT code 10009)	NFAC	$411.98
		FAC	$99.16
10012	**Fine needle aspiration including MRI guidanc**e, each additional lesion (For CPT 10012 use the reimbursement rate for CPT code 10010).	NFAC	$247.87
		FAC	$72.50
10021	**Fine needle aspiration biopsy without imaging guidance**, first lesion	NFAC	$103.10
		FAC	$55.22
38505	**Needle biopsy of axillary lymph node**	NFAC	$100.56
		FAC	$56.95

NOTE: *To include any pre-operative testing procedures medically necessary for the planned surgical procedure (e.g., CBC; urinalysis, pregnancy test, pre-operative CXR, etc.)*

CPT↓	Breast Biopsy Procedures ↓				
19081	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; **stereotactic guidance;** first lesion	NFAC	Base Fee		$520.43
			(modifier)	(of base amount)	
			50	1.5	$780.65
			51	1.0	$520.43
			80 or 81 or 82	0.2	$104.09
		FAC	Base Fee		$151.34
			50	1.5	$227.01
			51	1.0	$151.34
			80 or 81 or 82	0.2	$30.27
19082	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	NFAC	Base Fee		$400.91
			(modifier)	(of base amount)	
			50	1.5	$601.37
			51	1.0	$400.91
			80 or 81 or 82	0.2	$80.18
		FAC	Base Fee		$72.60
			50	1.5	$108.90
			51	1.0	$72.60
			80 or 81 or 82	0.2	$14.52
19083	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; **ultrasound guidance;** first lesion	NFAC	Base Fee		$519.02
			(modifier)	(of base amount)	
			50	1.5	$778.53
			51	1.0	$519.02
			80 or 82	0.2	$103.80
		FAC	Base Fee		$139.20
			50	1.5	$208.80
			51	1.0	$139.20
			80 or 81 or 82	0.2	$27.84
19084	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; **ultrasound guidance;** each additional lesion	NFAC	Base Fee		$394.67
			(modifier)	(of base amount)	
			50	1.5	$592.01
			51	1.0	$394.67
			80 or 82	0.2	$78.93
		FAC	Base Fee		$67.13
			50	1.5	$100.70
			51	1.0	$67.13
			80 or 81 or 82	0.2	$13.43
19085	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; **MRI guidance;** first lesion	NFAC	Base Fee		$795.79
			(modifier)	(of base amount)	
			50	1.5	$1,193.69
			51	1.0	$795.79
			80 or 81 or 82	0.2	$159.16
		FAC	Base Fee		$168.79
			50	1.5	$253.19
			51	1.0	$168.79
			80 or 81 or 82	0.2	$33.76
19086	**Breast biopsy,** with placement of localization device and imaging of biopsy specimen, percutaneous; **MRI guidance;** each additional lesion	NFAC	Base Fee		$616.53
			(modifier)	(of base amount)	
			50	1.5	$924.80
			51	1.0	$616.53
			80 or 81 or 82	0.2	$123.31
		FAC	Base Fee		$74.11
			50	1.5	$111.17
			51	1.0	$74.11
			80 or 81 or 82	0.2	$14.82

NOTE: *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.***

CPT ↓	Placement of Breast Localization Devises ↓				
19281**	**Placement of breast localization devise,** percutaneous; **mammographic guidance;** first lesion	NFAC	Base Fee		$200.15
			(modifier)	(of base amount)	
			50	1.5	$300.23
			51	1.0	$200.15
			80 or 81 or 82	0.2	$40.03
		FAC	Base Fee		$84.06
			(modifier)	(of base amount)	
			50	1.5	$126.09
			51	1.0	$84.06
			80 or 81 or 82	0.2	$16.81
19282**	**Placement of breast localization devise,** percutaneous; **mammographic guidance;** each additional lesion	NFAC	Base Fee		$139.37
			(modifier)	(of base amount)	
			50	1.5	$209.06
			51	1.0	$139.37
			80 or 81 or 82	0.2	$27.87
		FAC	Base Fee		$40.33
			(modifier)	(of base amount)	
			50	1.5	$60.50
			51	1	$40.33
			80 or 81 or 82	0.2	$8.07
19283**	**Placement of breast localization devise, percutaneous; stereotactic guidance; first lesion**	NFAC	Base Fee		$227.75
			(modifier)	(of base amount)	
			50	1.5	$341.63
			51	1.0	$227.75
			80 or 81 or 82	0.2	$45.55
		FAC	Base Fee		$84.27
			(modifier)	(of base amount)	
			50	1.5	$126.41
			51	1.0	$84.27
			80 or 81 or 82	0.2	$16.85

19284**	**Placement of breast localization devise,** percutaneous; **stereotactic guidance;** each additional lesion	**NFAC**	**Base Fee**		**$167.56**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$251.34**
			51	**1.0**	**$167.56**
			80 or 81 or 82	**0.2**	**$33.51**
		FAC	**Base Fee**		**$41.00**
			50	**1.5**	**$61.50**
			51	**1.0**	**$41.00**
			80 or 81 or 82	**0.2**	**$8.20**
19285**	**Placement of breast localization devise,** percutaneous; **ultrasound guidance;** first lesion	**NFAC**	**Base Fee**		**$383.16**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$574.74**
			51	**1.0**	**$383.16**
			80 or 81 or 82	**0.2**	**$76.63**
		FAC	**Base Fee**		**$69.89**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$104.84**
			51	**1.0**	**$69.89**
			80 or 81 or 82	**0.2**	**$13.98**
19286**	**Placement of breast localization devise,** percutaneous; **ultrasound guidance;** each additional lesion	**NFAC**	**Base Fee**		**$313.57**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$470.36**
			51	**1.0**	**$313.57**
			80 or 81 or 82	**0.2**	**$62.71**
		FAC	**Base Fee**		**$35.90**
			50	**1.5**	**$53.85**
			51	**1.0**	**$35.90**
			80 or 81 or 82	**0.2**	**$7.18**
19287**	**Placement of breast localization devise,** percutaneous; **MRI guidance;** first lesion	**NFAC**	**Base Fee**		**$661.21**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$991.82**
			51	**1.0**	**$661.21**
			80 or 81 or 82	**0.2**	**$132.24**
		FAC	**Base Fee**		**$115.38**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$173.07**
			51	**1.0**	**$115.38**
			80 or 81 or 82	**0.2**	**$23.08**
19288**	**Placement of breast localization devise,** percutaneous; **MRI guidance;** each additional lesion	**NFAC**	**Base Fee**		**$509.87**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$764.81**
			51	**1.0**	**$509.87**
			80 or 81 or 82	**0.2**	**$101.97**
		FAC	**Base Fee**		**$51.70**
			(modifier)	**(of base amount)**	
			50	**1.5**	**$77.55**
			51	**1.0**	**$51.70**
			80 or 81 or 82	**0.2**	**$10.34**

****NOTE:** 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.***

Facility Fee (FAC): The FAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Outpatient Hospital (POS 19 or 22), Ambulatory Surgical Center (POS 24), or Inpatient Hospital (POS 21)-only if there is too much risk is involved to perform the procedure in the outpatient service area.

Non-Facility Fee (NFAC): The NFAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Office (POC 11), Independent Clinic (POS 49), Federally Qualified Health Center (POS 50), State or Local Health Clinic (POS 71), or Rural Health Clinic (POS code 72).

Note: For many procedures, the Non-Facility and Facility rates are identical. Certain procedures may have higher non-facility rates compared to facility rates to accommodate overhead and indirect expenses providers incur by operating their own facility. The CMS link to POS code: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - CERVICAL

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

1. Screening services are reimbursed at the Medicare rate based on the region in which the service was provided.
For reimbursement purposes, the term "screening services" is defined by the Cancer Screening Program Unit (CSPU) as appropriate screening services (Pap and/or hrHPV with or without genotyping) through and including a colposcopy, with or without biopsy and ECC, for cervical cancer screening.

2. Diagnostic services are reimbursed at the Maryland Medicaid rate as stated in the schedule below.
For reimbursement purposes, the term "diagnostic services" is defined by the Cancer Screening Program Unit (CSPU) as appropriate services beyond a colposcopy for the diagnosis of cervical cancer.
Note: *Treatment of cervical intraepithelial neoplasia and cervical cancer is not allowed in the BCCP program.*

3. For services that are regulated by the Maryland Health Services Cost Review Commission (MHSCRC) are reimbursed not to exceed the rate approved for the Contractor by the MHSCRC.

4. Below are the MBCCP program-approved procedures, rates, and diagnosis codes. If a program is unable to find a procedure or CPT code on the list, please reach out to your Technical Lead with questions prior to paying for the procedure.

CPT Codes ↓	Procedures ↓ MD CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
CPT ↓	**Laboratory and Pathology ↓**				
87624*	**Human Papillomavirus (HPV),** high-risk types	$35.09	$35.09	$35.09	
87625*	**Human Papillomavirus (HPV),** genotyping	$40.55	$40.55	$40.55	
*NOTE: *HPV DNA testing is not a reimbursable procedure for women under 30 years of age. CPT Code 87623 (Humna Papilloma, low-risk types) is not allowed under the BCCP program.*					
88141	**Cytopathology, cervical or vaginal,** any reporting system, requiring interpretation by physician	$25.41	$24.30	$27.39	
88142	**Cytopathology (liquid-based Pap test) cervical or vaginal - collected in preservative fluid,** automated thin layer preparation; manual screening under physician supervision	$20.26	$20.26	$20.26	
88143	**Cytopathology, Cervical or Vaginal - collected in preservative fluid,** automated thin layer preparation; manual screening and rescreening under physician supervision	$23.04	$23.04	$23.04	
88164	**Cytopathology (conventional Pap test), slides cervical or vaginal - reported in Bethesda System,** manual screening under physician supervision	$17.76	$17.76	$17.76	
88165	**Cytopathology (conventional Pap test), slides cervical or vaginal -** reported in Bethesda System, manual screening and rescreening under physician supervision	$42.22	$42.22	$42.22	
88174	**Cytopathology, cervical or vaginal - collected in preservative fluid,** automated thin layer preparation; screening by automated system, under physician supervision	$25.37	$25.37	$25.37	
88175	**Cytopathology, cervical or vaginal - collected in preservative fluid,** automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	$26.61	$26.61	$26.61	
88305	**Surgical pathology,** gross and microscopic examination				Global - $67.05 26 - $37.09 TC - $29.97
88307	**Surgical pathology,** gross and microscopic examination; requiring microscopic evaluation of surgical margins				Global - $235.18 26 - $72.55 TC - $162.63
88331	**Pathology consultation during Surgery -** First tissue block, with frozen section(s), single specimen				Global - $84.05 26 - $54.82 TC - $29.23
88332	**Pathology consultation during Surgery -** each additional tissue block, with frozen section(s)				Global - $46.27 26 - $27.08 TC - $19.19
88341	**Immunohistochemistry or immunocytochemistry,** per specimen; each additional single antibody stain procedure				Global - $81.10 26 - $24.94 TC - $56.16
88342	**Immunohistochemistry or immunocytochemistry,** per specimen; initial single antibody stain procedure				Global - $93.16 26 - $30.99 TC - $62.17
NOTE: *Pre-operative testing; CBC; urinalysis, pregnancy test, etc...These procedures should be medically necessary for the planned surgical procedure.*					
CPT ↓	**Procedures ↓**				
57452	**Colposcopy of the cervix**	NFAC - $136.38 FAC - $96.91	NFAC - 128.99 FAC - 91.79	NFAC - $145.04 FAC - $101.39	
57454	**Colposcopy of the cervix,** with biopsy and endocervical curettage (ECC)	NFAC - $181.51 FAC - $142.39	NFAC - 171.61 FAC - 134.75	NFAC - $191.58 FAC - $148.33	
57455	**Colposcopy of the cervix,** with biopsy	NFAC - $174.17 FAC - $115.32	NFAC - 164.64 FAC - 109.18	NFAC - $184.82 FAC - $119.75	
57456	**Colposcopy of the cervix,** with endocervical curettage	NFAC - $164.24 FAC - $107.54	NFAC - 155.22 FAC - 101.78	NFAC - $174.36 FAC - $111.67	

CPT Codes ↓	Procedures ↓		Location	2024 Medicaid Physician Fee Schedule Reimbursement Rates
57460	**Colposcopy with loop electrode biopsy(s) of the cervix in conjunction with 57461**	**Cannot bill	NFAC	$294.64
			FAC	$159.14
57461	**Colposcopy with loop electrode conization of the cervix in conjunction with 57460**	**Cannot bill	NFAC	$330.34
			FAC	$183.47
57500	**Cervical biopsy,** single or multiple, or local excision of lesion, with/without fulguration (separate procedure)		NFAC	$130.08
			FAC	$71.53
57505	**Endocervical curettage** (not done as part of a dilation and curettage)		NFAC	$99.67
			FAC	$88.67
57520	**Conization of cervix,** with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser **bill in conjunction with 57522**	**Cannot	NFAC	$302.33
			FAC	$266.35
57522	**Conization of cervix,** with or without fulguration, with or without dilation and curettage, with or without repair **conjunction with 57520**	**Cannot bill in	NFAC	$258.36
			FAC	$234.41
58100	**Endometrial sampling (biopsy) with or without endocervical sampling (biopsy),** without cervical dilation, any method (separate procedure) **bill in conjunction with 58110**	**Cannot	NFAC	$107.23
			FAC	$65.93
58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy** (list separately in addition to code for primary procedure) **bill in conjunction with 58100**	**Cannot	NFAC	$48.40
			FAC	$40.26

Facility Fee (FAC): The FAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Outpatient Hospital (POS 19 or 22), Ambulatory Surgical Center (POS 24), or Inpatient Hospital (POS 21)-only if there is too much risk is involved to perform the procedure in the outpatient service area.

Non-Facility Fee (NFAC): The NFAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Office (POC 11), Independent Clinic (POS 49), Federally Qualified Health Center (POS 50), State or Local Health Clinic (POS 71), or Rural Health Clinic (POS code 72).

Note: For many procedures, the Non-Facility and Facility rates are identical. Certain procedures may have higher non-facility rates compared to facility rates to accommodate overhead and indirect expenses providers incur by operating their own facility. The CMS link to POS code: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - COLORECTAL

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

1. Screening services are reimbursed at the Medicare rate based on the region in which the service was provided.
For reimbursement purposes, the term "screening services" is defined by the Cancer Screening Program Unit (CSPU) as a pre-screening exam through the full screening continuum—from an initial stool test, CT colonography or endoscopy test up to a follow-up colonoscopy performed to reach a definitive diagnosis within the same screening cycle. Colonoscopy screening CPT codes are G0105 (High Risk) and G0121 (Not High Risk). If during the course of the screening colonoscopy (G0105 or G0121), a lesion or growth is detected which results in a biopsy or removal of the growth, then the appropriate diagnostic CPT codes for a colonoscopy with biopsy (45380) or tissue removal/polyp (45384/45385/45390) along with modifier -PT or -33 should be billed instead of the CPT Codes G0105 or G0121.
For reimbursement purposes, CSPU defines the following colonoscopy CPT codes as a screening service: G0105, G0121, 45378, 45380, 45384, 45385 or 45390.

2. Diagnostic services are reimbursed at the Maryland Medical Assistance (MMA) rate as stated in the schedule below.
For reimbursement purposes, the term "diagnostic services" is defined by the Cancer Screening Programs Unit (CSPU) as appropriate services beyond the full screening continuum, as defined above, for the diagnosis of colorectal cancer.

3. Services that are regulated by the Maryland Health Services Cost Review Commission (MHSCRC) are reimbursed not to exceed the rate approved for the Contractor by the MHSCRC.
4. Below are the MBCCP program-approved procedures, rates, and diagnosis codes. If a program is unable to find a procedure or CPT code on the list, please reach out to your Technical Lead with questions prior to paying for the procedure.

CPT Codes ↓	Procedures ↓ MD CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
CPT ↓	**Laboratory and Pathology ↓**				
G0328	**Immunochemical [iFOBT, also referred to as fecal immunochemical test (FIT)],** 1-3 simultaneous determinations (Immunoassay-based fecal-occult blood tests)	$18.05	$18.05	$18.05	
81528	**Cologuard** (Multitarget Stool DNA Test): Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	$508.87	$508.87	$508.87	
88305	**Surgical Pathology (Level IV):** gross and microscopic examination	Global - $75.86	Global - $72.58	Global - $81.92	Global - $67.05
		26 - $37.38	26 - $36.41	26 - $ 39.47	26 - $37.09
		TC - $38.47	TC - $36.17	TC - $42.45	TC - $29.97
88341	**Surgical Pathology:** Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	Global - $96.60	Global - $91.90	Global - $105.40	Global - $81.10
		26 - $28.06	26 - $27.31	26 - $29.62	26 - $24.94
		TC - $68.54	TC - $64.60	TC - $75.79	TC - $56.16
88342	**Surgical Pathology:** Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	Global - $112.91	Global - $107.43	Global - $123.02	Global - $93.16
		26 - $34.97	26 - $34.05	26 - $36.92	26 - $30.99
		TC - $77.95	TC - $73.38	TC - $86.09	TC - $62.17
88344	**Surgical Pathology:** Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure	Global - $184.90	Global - $172.53	Global - $202.46	Global - $150.43
		26 - $38.42	26 - $36.81	26 - $40.58	26 - $33.67
		TC - $146.48	TC - $135.72	TC - $161.88	TC - $116.76
CPT ↓	**Sigmoidoscopy ↓**				
G0104	**Screening; flexible sigmoidoscopy**	$59.94	$56.87	$63.19	
45330	**Sigmoidoscopy,** diagnostic	$59.94	$56.87	$63.19	$45.59
45331	**Sigmoidoscopy with biopsy,** single or multiple	$76.10	$72.35	$80.07	$58.53
45332	**Sigmoidoscopy with removal of foreign body(s)**	$110.76	$105.28	$116.09	$85.69
45333	**Sigmoidoscopy with removal of tumors,** polyps or other lesions by hot biopsy	$99.33	$94.15	$103.94	$78.37
45334	**Sigmoidoscopy with control the bleeding**	$122.86	$117.08	$128.90	$117.89
45335	**Sigmoidoscopy with submucosal injection**	$70.48	$66.96	$74.18	$65.58
45338	**Sigmoidoscopy with removal of tumors,** polyps or other lesions by snare technique	$125.79	$119.75	$131.84	$101.39
CPT ↓	**Colonoscopy ↓**				
G0105	**Screening;** colonoscopy on individual at high risk	$192.50	$183.28	$201.26	
G0121	**Screening;** colonoscopy on individual not meeting criteria for high risk	$192.94	$183.61	$201.65	
44388	**Colonoscopy thru STOMA**	$163.68	$155.30	$170.76	$127.25
45378	**Base, flexible, diagnostic;** colonoscopy with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	$192.50	$183.28	$201.26	$155.38
45380	**Colonoscopy with biopsy, single or multiple**	$208.94	$199.11	$218.55	$186.45
45381	**Colonoscopy with submucosal injection**	$208.94	$198.77	$218.15	$176.04
45382	**Colonoscopy with control the bleeding**	$268.67	$256.30	$280.97	$237.58
45384	**Colonoscopy with removal of tumors,** polyps or other lesions by **hot biopsy**	$238.77	$226.52	$248.65	$194.70
45385	**Colonoscopy with removal of tumors,** polyps or other lesions by **snare technique**	$264.25	$251.90	$276.21	$221.04
45388	**Colonoscopy with ablation of tumor(s), polyp(s), or other lesion(s)** (includes pre- and postdilation and guide wire passage, when performed)	$281.42	$267.99	$293.81	$219.95
45390	**Colonoscopy with Endoscopic Mucosal Resection (EMR)**	$345.18	$329.26	$360.74	$269.95
CPT ↓	**Radiography CPT Codes ↓**				
74261	**CT Colonography, diagnostic, without dye** (Virtual CT)	Global - $454.40	Global - $431.01	Global - $495.40	Global - $227.98
		26 - $116.86	26 - $113.14	26 - $122.44	26 - $114.95
		TC - $337.54	TC - $317.87	TC - $372.96	TC - $113.03
74262	**CT Colonography, diagnostic, with dye** (Virtual CT)	Global - $511.70	Global - $485.09	Global - $558.42	Global - $309.05
		26 - $122.13	26 - $118.19	26 - $127.93	26 - $120.13
		TC - $389.57	TC - $366.91	TC - $430.49	TC - $188.92

Physician Service Fee- Multiple Endoscopic Procedures (Modifier 51):

Medicare's payment rules are determined by classifying endoscopy procedures according to families. Each family has a base code and related codes that include the base procedure with additional components such as biopsy or polyp removal. the Medicare fee schedule payment (MFSDB) contains an indicator of "3," and the procedure is billed with another endoscopy in the same family (that is, another endoscopy that has the same base procedure), the special rules for multiple endos procedures apply. ***Note:*** *the multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endos another family or on the same day as a non-endoscopic procedure).*

CPT 45378 is the **base code** for the following CPT family: 45379, 45380, 45381, 45382, 45384, 45385, 45388, 45390 and 45393

CPT 45330 is the **base code** for the following CPT family: 45331, 45332, 45333, 45334, 45335 and 45338

CPT 44388 does not belong to an endoscopy family, having an indicator of "2", and follow the rules listed above under Multiple Surgeries

If Field 21 contains an indicator of "3," and multiple endoscopies are billed, the following special rules for multiple endoscopic procedures apply:

Related Endoscopy Family

- When endoscopies are in the same family, rank endoscopies by fee schedule amount
- Pay the highest valued endoscopy at 100%
- Subsequent related endoscopies are reimbursed based on difference between base (or mother) code and subsequent codes.

NOTE: *If an endoscopic procedure is reported with only its base procedure, the base procedure is not paid seperately. Payment for the base procedure is included in the payment for the other endoscopy.*

Example:

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45 value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endosco

CPT Code	Region 99	Approved Amount	Rationale
45385	$247.79	$247.79	Code has the highest fee schedule amount and is allowed at 100%
45380	$195.86	$15.57	Base code= 45378
			Fee schedule amount of 45378 = $180.29
			Difference between 45380 ($195.86) and Base 45378 ($180.29) = $15.57
45378	$180.29	$0	Payment for base amount is already included in the payment of its family CPT 45385

Programs in MD Region 99 would pay the full value of the highest endoscopic procedure 45385 ($247.79), plus the difference between CPT 45380 ($195.86) and CPT 45378 ($180.29)=$15.57, for a total of $263.36 to be reimbursed

NOTE: the base colonoscopy is included in the highest endoscopic procedure's rate.

Source:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - LUNG

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

1. Screening services are reimbursed at the Medicare rate based on the region in which the service was provided.
For reimbursement purposes, the term "screening services" is defined by the Cancer Screening Programs Unit (CSPU) as a shared decision making/office visit and an annual screening Low Dose Computed Tomography (LDCT) for lung cancer screening.

2. Diagnostic services are reimbursed at the Maryland Medical Assistance (MMA) rate as stated in the schedule below.
For reimbursement purposes, the term "diagnostic services" is defined by the Cancer Screening Programs Unit (CSPU) as appropriate services for the diagnosis of lung cancer.

3. Services that are regulated by the Maryland Health Services Cost Review Commission (MHSCRC) are reimbursed not to exceed the rate approved for the Contractor by the MHSCRC.

4. Below are the CPEST program-approved procedures, rates, and diagnostic codes. If a program is unable to find a procedure or CPT code on the list, please reach out to your Technical Lead with questions prior to paying for the procedure.

CPT Codes ↓	Procedures ↓ MD CMS Regions →	2024 Medicare Physician Fee Schedule Reimbursement Rates			2024 Medicaid Physician Fee Schedule Reimbursement Rates
		MD Region 01	MD Region 99	DC Metro 01	
CPT ↓	**Shared Decision Making Offive Visit ↓**				
G0296	**Counseling Visit to discuss need for lung cancer screening using Low Dose Computed Tomography (LDCT) scan,** service is for eligibility determination and shared decision making	$29.01	$27.96	$30.57	
CPT ↓	**Radiology↓**				
71271	**Computed tomography (LDCT), thorax, low dose for lung cancer screening, without contrast material,** initial or subsequent annual lung cancer screening LDCT	Global-$150.32 26 - $52.92 TC - $97.40	Global-$142.80 26 - $51.18 TC - $91.62	Global-$162.92 26 - $55.41 TC - $107.51	
71250	**Computed tomography (CT), thorax, diagnostic;** without contrast, interim CT for Lung-RAD categories 3 and 4 with recommendations for 3-6 month follow-up				Global - $142.85 26 - $52.05 TC - $90.80
71260	**Computed tomography (CT), thorax, diagnostic;** with contrast, noncardiac				Global - $179.84 26 - $56.15 TC - $123.69
71270	**Computed tomography (CT), thorax, diagnostic;** without contrast, followed by contrast and further sections				Global - $211.43 26 - $59.86 TC - $151.57
78814	**Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging,** chest				Global - $1,133.51 26 - $70.39 TC - $1,063.12
CPT ↓	**Bronchoscopies ↓**				
31623 (51)	**Bronchoscopy;** Endoscopy Procedures on the Trachea and Bronchi; rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushing.				$108.45
31625	**Bronchoscopy;** Endoscopy Procedures on the Trachea and Bronchi; rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites.				$126.62
31652	**Endobronchial Ultrasound (EBUS);** guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures				$202.03
31653	**Endobronchial Ultrasound (EBUS);** guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures.				$222.94
31654	**Transendoscopic Endobronchial Ultrasound (EBUS);** Endoscopy Procedures on the Trachea and Bronchi; rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites.				$58.29
CPT ↓	**Core Needle Biopsy ↓**				
32408	**Core needle biopsy, lung or mediastinum, percutaneous,** including imaging guidance, when performed				$130.57
CPT ↓	**Laboratory and Pathology ↓**				
88305	**Surgical pathology,** gross and microscopic examination				Global - $67.05 26 - $37.09 TC - $29.97
88307	**Surgical pathology,** gross and microscopic examination; requiring microscopic evaluation of surgical margins				Global - $235.18 26 - $72.55 TC - $162.63
88331	**Pathology Consult during Surgery** - First tissue block, with frozen section(s), single specimen				Global - $84.05 26 - $54.82 TC - $29.23
88332	**Pathology Consult during Surgery** - First tissue block, with frozen section(s), each additional specimen				Global - $46.27 26 - $27.08 TC - $19.19
88341	**Immunohistochemistry or immunocytochemistry,** per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)				Global - $81.10 26 - $24.94 TC - $56.16
88342	**Immunohistochemistry or immunocytochemistry,** per specimen; initial single antibody stain procedure				Global - $93.16 26 - $30.99 TC - $62.17

FY2025 Maryland Cancer Screening Programs (BCCP & CPEST) Reimbursement Rate Sheets
Physician Fee Schedule - SKIN

Listed below are excerpts from the Centers for Medicare and Medicaid Services (CMS) professional fee schedule rates for the Maryland Jurisdiction Current Procedural Terminology (CPT) Codes for Calendar Year (CY) 2024. Maryland Medical Assistance (MMA) rates are used instead of the National Medicaid rates published on the Novitas-Solutions website at http://www.novitas-solutions.com/

1. Screening services are reimbursed at the Medicare rate based on the region in which the service was provided.

For reimbursement purposes, the term "screening services" is defined by the Cancer Screening Programs Unit (CSPU) as a visual skin exam during an Office Visit (refer to Office Visit tab) for the purpose of skin cancer screening.

2. Diagnostic services are reimbursed at the Maryland Medical Assistance (MMA) rate as stated in the schedule below.

For reimbursement purposes, the term "diagnostic services" is defined by the Cancer Screening Programs Unit (CSPU) as appropriate services beyond a visual skin exam for the diagnosis of skin cancer.

3. Services that are regulated by the Maryland Health Services Cost Review Commission (MHSCRC) are reimbursed not to exceed the rate approved for the Contractor by the MHSCRC.

4. Below are the CPEST program-approved procedures, rates, and diagnostic codes. If a program is unable to find a procedure or CPT code on the list, please reach out to your Technical Lead with questions prior to paying for the procedure.

CPT Codes ↓	Procedures ↓	Location	2024 Medicaid Physician Fee Schedule Reimbursement Rates
11102	**Tangential biopsy of skin** (e.g., shave, scoop, saucerize, curette) **single lesion**	NFAC	$87.00
		FAC	$34.92
11103	**Plus each separate/additional lesion (List separately in addition to code for primary procedure 11102)**	NFAC	$46.87
		FAC	$20.21
11104	**Punch biopsy of skin;** including simple closure, when performed; **single lesion**	NFAC	$109.35
		FAC	$43.78
11105	**Plus each separate/additional lesion** (List separately in addition to code for primary procedure **11104**)	NFAC	$53.69
		FAC	$23.89
11106	**Incisional biopsy of skin** (e.g. wedge); including simple closure, when performed; **single lesion**	NFAC	$132.37
		FAC	$53.31
11107	**Plus each separate/additional lesion** (List separately in addition to code for primary procedure **11106**)	NFAC	$63.29
		FAC	$28.46
11600	**Excision, malignant lesion including margins, of 0.5 cm or less in diameter from trunk, arms or legs**	NFAC	$153.38
		FAC	$95.53
11601	**Excision, malignant lesion including margins, of 0.6 to 1.0 cm or less in diameter from trunk, arms or legs**	NFAC	$182.48
		FAC	$119.49
11602	**Excision, malignant lesion including margins, of 1.1 to 2.0 cm in diameter from trunk, arms or legs**	NFAC	$197.88
		FAC	$131.19
11603	**Excision, malignant lesion including margins, of 2.1 to 3.0 cm in diameter from trunk, arms, or legs**	NFAC	$226.00
		FAC	$157.30
11604	**Excision, malignant lesion including margins, of 3.1 to 4.0 cm in diameter from trunk, arms, or legs**	NFAC	$251.28
		FAC	$173.18
11606	**Excision, malignant lesion including margins, over 4.0 cm in diameter from trunk, arms or legs**	NFAC	$359.18
		FAC	$257.14
11620	**Excision, malignant lesion including margins, of 0.5 cm or less in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$154.85
		FAC	$96.70
11621	**Excision, malignant lesion including margins, of 0.6 to 1.0 cm or less in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$183.64
		FAC	$120.36
11622	**Excision, malignant lesion including margins, of 1.1 to 2.0 cm in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$204.57
		FAC	$137.88
11623	**Excision, malignant lesion including margins, of 2.1 to 3.0 cm in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$239.60
		FAC	$170.33
11624	**Excision, malignant lesion including margins, of 3.1 to 4.0 cm in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$270.38
		FAC	$193.13
11626	**Excision, malignant lesion including margins, of over 4.0 cm in diameter from scalp, neck, hands, feet, or genitalia**	NFAC	$325.14
		FAC	$236.51
11640	**Excision, malignant lesion including margins, of 0.5 cm or less in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$159.93
		FAC	$100.07
11641	**Excision, malignant lesion including margins, of 0.6 to 1.0 cm in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$189.77
		FAC	$125.36
11642	**Excision, malignant lesion including margins, of 1.1 to 2.0 cm in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$216.57
		FAC	$147.87
11643	**Excision, malignant lesion, including margins, of 2.1 to 3.0 cm in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$254.86
		FAC	$185.03
11644	**Excision, malignant lesion including margins, of 3.1 to 4.0 cm in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$313.81
		FAC	$228.58
11646	**Excision, malignant lesion including margins, over 4.0 cm in diameter, from the skin of the face, ears, eyelids, nose, lips**	NFAC	$409.79
		FAC	$317.42
12031	**Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less**	NFAC	$189.45
		FAC	$123.05
12032	**Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm**	NFAC	$242.02
		FAC	$156.80
13102	**Complex repair of each additional 5 cm or less of a wound to the trunk.** This CPT code is listed separately to denote an additional procedure to the primary procedure.	NFAC	$96.75
		FAC	$59.70
13122	**Complex repair of a wound to the scalp, arms, and/or legs. This code is for each additional 5 cm or less, in addition to the primary wound.** This CPT code is listed separately to denote an additional procedure to the primary procedure.	NFAC	$106.18
		FAC	$68.84
17000*	**Destruction Procedures (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) on Premalignant Lesions (e.g., actinic keratoses) of the Integumentary System**	NFAC	$53.00
		FAC	$42.46
17003*	**Destruction Procedures (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) on Premalignant Lesions (e.g., actinic keratoses) of the Integumentary System**	NFAC	$5.47
		FAC	$2.04
17004*	**Destruction Procedures (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement on Benign or Premalignant Lesions (e.g., actinic keratoses) of the Integumentary System**	NFAC	$123.69
		FAC	$96.08

* **NOTE**: ***17000*** *should be reported with one unit of service for destruction of the first lesion.* ***17003*** *should be reported with the units equal to the number of additional lesions from 2 through 14.* ***17004*** *should be reported with one unit of service, representing 15 or more lesions and should* ***not be used with 17000 or 17003.***

96567	**Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa** with application and illumination/activation of photosensitive drug(s), per day. (Use 96567 for reporting photodynamic therapy when physician or other qualified health care professional is not directly involved in the delivery of the photodynamic therapy service)	**NFAC**	**$108.95**
		FAC	
96573	**Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa** with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	**NFAC**	**$167.47**
		FAC	
96574	**Debridement of premalignant hyperkeratotic lesion(s) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa** with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day	**NFAC**	**$215.07**
		FAC	
CPT ↓	**Topical Drug↓**		
J7308	**Aminolevulinic acid HCl for topical administration,** 20%, single unit dosage form (354 mg)		**$392.32**
J7309	**Methyl Aminolevulinate (MAL) for topical administration,** 16.8%, 1 gram		**Invoice**
J7345	**Aminolevulinic acid HCl for topical administration,** 10% gel, 10 mg (effective 01/01/2018)		**$1.65**
CPT ↓	**Pathology↓**		
88305	**Surgical pathology, gross and microscopic examination**		**Global - $67.05**
			26 - $37.09
			TC - $29.97
88307	**Surgical pathology,** gross and microscopic examination; requiring microscopic evaluation of surgical margins		**Global - $235.18**
			26 - $72.55
			TC - $162.63

Facility Fee (FAC): The FAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Outpatient Hospital (POS 19 or 22), Ambulatory Surgical Center (POS 24), or Inpatient Hospital (POS 21)-only if there is too much risk is involved to perform the procedure in the outpatient service area.

Non-Facility Fee (NFAC): The NFAC Fee is the Maryland Medicaid reimbursement amount used for the services rendered in an Office (POC 11), Independent Clinic (POS 49), Federally Qualified Health Center (POS 50), State or Local Health Clinic (POS 71), or Rural Health Clinic (POS code 72).

Note: For many procedures, the Non-Facility and Facility rates are identical. Certain procedures may have higher non-facility rates compared to facility rates to accommodate overhead and indirect expenses providers incur by operating their own facility.

BCCP/CPEST Reimbursement Calculator

ENTER APPROPRIATE DATA IN COLUMN 'D'

Enter Medicare or Medicaid Rate for Service (CPT Codes Billed):	$0.00	Enter Maximum amount Program can Pay
Enter Provider Charge:	$0.00	
Allowed Amount (from EOB/EOP):	$0.00	Enter amount in EITHER the "Allowed" or "Disallowed" Cell, depending on how listed in EOB/EOP (Disallowed preferred)
- OR -		
Disallowed/Discounted (non-covered) Amount (from EOB/EOP):	$0.00	
Maximum Contracted Amount Insurance Will Pay for Service:	$0.00	Calculated field - will show either the 'Allowed' amount (if 'Allowed' cell entered) or 'Provider Charge' minus 'Disallowed Amount' (if 'Disallowed 'cell entered)
Insurance Payment (from EOB/EOP):	$0.00	Enter Amount Insurance Company Paid (even if $0)
Other Non-Program Payments (if applicable):	$0.00	This cell will usually be left blank

PROGRAM CAN PAY:

$0.00

DATA AUTOMATICALLY CALCULATED AND ENTERED - DO NOT CHANGE OR ENTER DATA

Amount Billable to Client after Primary Insurance:	$0.00	Amount unpaid after Insurance and Other Non-Porgram Payments (gray cells) on the Maximum Contracted Amount (gold cell)
Amount Program Can Pay:	$0.00	Amount the Program can pay towards the unpaid amount listed in the green cell directly above
Disallowed Amount:	$0.00	Difference $0 or less, no remaining balance