Alaska Breast and Cervical Screening Assistance Program List of APPROVED CPT CODES – 2025

Alaska Breast and Cervical Screening Assistance Program is a statewide program focused on providing breast and cervical cancer screening and diagnostic services to women who meet certain age, income and insurance coverage guidelines. Alaska Breast and Cervical Screening Assistance Program does not require preauthorization.

OFFICE VISITS		
DESCRIPTION OF SERVICE	**CPT CODE**	**AK RATE**
New Patient - Office Visit (20 minutes face to face)	99202	89.75
New Patient - Office Visit (30 minutes face to face)	99203	140.26
New Patient - Office Visit (45 minutes face to face) ***[see note 1]***	99204	213
New Patient - Office Visit (60 minutes face to face) ***[see note 1]***	99205	281.66
Established Patient - Office Visit (5 minutes face to face)	99211	27.54
Established Patient - Office Visit (10 minutes face to face)	99212	69.96
Established Patient - Office Visit (15 minutes face to face)	99213	114.74
Established Patient - Office Visit (25 minutes face to face)	99214	163.04
New Patient – Initial Preventive. Medicine Visit, 18-39 Years ***[see note 2]***	99385	140.26
New Patient – Initial Preventive Medicine Visit, 40-64 Years **[see note 2]**	99386	140.26
New Patient – Initial Preventive Medicine Visit, 65 Years and older ***[see note 2]***	99387	140.26
Established Patient–Periodic Prev. Medicine Visit, 18-39 Years ***[see note 2]***	99395	114.74
Established Patient – Periodic Prev. Medicine Visit, 40-64 Years ***[see note 2]***	99396	114.74
Established Patient – Periodic Prev. Medicine Visit, 65 Years and older ***[see note 2]***	99397	114.74
Pelvic examination (List separately, in addition to primary procedure) ***[see note 3]***	99459	22.38

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BREAST SCREENING & DIAGNOSTIC PROCEDURES

DESCRIPTION OF SERVICE	CPT CODE	AK RATE	PROFESSIONAL	TECHNICAL
Magnetic resonance imaging (MRI), breast, without contrast, unilateral ***[see note 8]***	77046	254.81	92.13	162.68
Magnetic resonance imaging (MRI), breast, without contrast, bilateral ***[see note 8]***	77047	263.58	101.62	161.96
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral ***[see note 8]***	77048	399.8	133.65	266.15
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral ***[see note 8]***	77049	409.99	146.35	263.63
Screening mammography, bilateral	77067	147.96	48.45	99.51
Diagnostic mammography, bilateral, includes CAD	77066	184.09	63.51	120.58
Diagnostic mammography, unilateral, includes CAD	77065	145.78	51.67	94.11
Screening digital breast tomosynthesis; bilateral ***[see note 9]***	77063	64.01	38.11	25.91
Diagnostic digital breast tomosynthesis; unilateral or bilateral ***[see note 4]***	G0279	58.98	38.11	20.87
Mammary ductogram or galactogram, single duct	77053	62.83	23.05	39.78
Radiological Exam, surgical specimen	76098	49.89	20.19	29.7
Ultrasound, complete examination of breast including axilla, unilateral	76641	120.2	46.59	73.6
Ultrasound, limited examination of breast including axilla, unilateral	76642	100.43	43.38	57.05
Ultrasonic guidance for needle placement, imaging supervision and interpretation	76942	71.31	40.88	30.42
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation only	88172	69.39	46.16	23.23
Cytopathology, evaluation of fine needle aspirate; *interpretation and report*	88173	199.21	91.75	107.46
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	88177	37.36	28.36	9
Surgical pathology, gross and microscopic examination	88305	87.5	49.16	38.34
Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	88307	331.94	106.97	224.97
Morphometric analysis, tumor immunohistochemistry, per specimen; manual	88360	141.43	54.87	86.56
Morphometric analysis, tumor immunohistochemistry, per specimen; using computer assisted technology	88361	141.75	58.43	83.32

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BREAST SCREENING & DIAGNOSTIC PROCEDURES

DESCRIPTION OF SERVICE	CPT CODE	OFFICE	FACILITY
Fine needle aspiration without imaging guidance, each additional lesion	10004	65.54	55.46
Fine needle aspiration biopsy including ultrasound guidance, first lesion	10005	162.77	95.48
Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	10006	77.09	65.58
Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	10007	349.49	117.02
Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	10008	166.23	68.71
Fine needle aspiration biopsy including CT guidance, first lesion	10009	488.17	143.09
Fine needle aspiration biopsy including CT guidance, each additional lesion	10010	273.28	96.24
Fine needle aspiration biopsy including MRI guidance, first lesion ***[see note 5]***	10011	488.17	143.09
Fine needle aspiration biopsy including MRI guidance, each additional lesion ***[see note 5]***	10012	273.28	96.24
Fine needle aspiration without imaging guidance, first lesion only	10021	121.48	70.74
Puncture aspiration of cyst of breast	19000	118.24	54.91
Puncture aspiration of cyst of breast, each additional cyst, used with 19000	19001	33.47	27.35
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion ***[see note 6]***	19081	574.87	212.88
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion ***[see note 6]***	19081	574.87	212.88
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion **[see note 6]**	19083	570.43	200.87
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion **[see note 6]**	19084	423.11	100.34
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion **[see note 6]**	19085	861.15	234.67
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion **[see note 6]**	19086	653.22	117.06
Breast biopsy, percutaneous, needle core, not using imaging guidance	19100	173.87	86.79
Breast biopsy, open, incisional	19101	387.71	274.72
Excision of cyst, fibro adenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	19120	624.67	514.2

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Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	19125	689.4	569.57
Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	19126	200.46	200.46
Placement of breast localization device, percutaneous; mammographic guidance; first lesion **[see note 7]**	19281	284.41	128.96
Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion **[see note 7]**	19282	196	64.66
Placement of breast localization device, percutaneous; stereotactic guidance; first lesion **[see note 7]**	19283	302.63	129.55
Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion **[see note 7]**	19284	215.47	64.69
Placement of breast localization device, percutaneous; ultrasound guidance; first lesion **[see note 7]**	19285	413.53	109.82
Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion **[see note 7]**	19286	331.01	55.01
Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion **[see note 7]**	19287	709.04	164.6
Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion **[see note 7]**	19288	537.47	82.27
Needle biopsy of an axillary lymph node	38505	207.65	110.61
Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Reimbursement Amount= $30.89 x (Time Units + Base Units) Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units= 3 **[see note 10, 12]**	00400		128.7
Pre-operative testing; complete blood count, urinalysis, pregnancy test, other procedures medically necessary for the planned surgical procedure.	Various		

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CERVICAL SCREENING & DIAGNOSTIC PROCEDURES

DESCRIPTION OF SERVICE	CPT CODE	AK RATE	PROFESSIONAL	TECHNICAL
Pelvic Examination, pelvic exam packs and in-room chaperones for cervical cancer screening (Pap or HPV tests) during an office visit	99459	22.38		
Cytopathology, cervical or vaginal, any reporting system, requiring interpretation by physician	88141	29.37		
Cytopathology (Liquid-based Pap test), cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	88142	29.37		
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	88143	29.37		263.63
Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	88164	29.37		99.51
Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision	88165	42.22		120.58
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	88174	26.38		94.11
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening	88175	32.71		25.91
Surgical pathology, gross and microscopic examination	88305	87.5	49.16	38.34
Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	88307	331.94	106.97	224.97
Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	88331	125.14	80.68	44.46
Pathology consultation during surgery, each additional tissue block, with frozen section(s)	88332	66.56	39.73	26.83
Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	88341	103.22	37.99	65.23
Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	88342	123.87	45.94	77.92
Human Papillomavirus, high-risk types ***[see note 10]***	87624	43.33		
Human Papillomavirus, types 16 and 18 only ***[see note 10]***	87625	43.33		
Human Papillomavirus, reported high-risk types separate and pooled ***[see note 10]***	87626	43.33		
Colposcopy of the cervix	57452	154.83		
Colposcopy of the cervix, with biopsy and endocervical curettage	57454	209.67		

Colposcopy of the cervix, with biopsy	57455	198.34		
Colposcopy of the cervix, with endocervical curettage	57456	186.64		
Colposcopy with loop electrode biopsy(s) of the cervix	57460	371.87		
Colposcopy with loop electrode conization of the cervix	57461	417.47		
Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	57500	180.09		
Endocervical curettage (not done as part of a dilation and curettage)	57505	182.11		
Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	57520	431.68		
Loop electrode excision procedure	57522	371.95		
Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	58100	123.73		
Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	58110	62.96		
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)	99070	12.95		
Pre-operative testing; complete blood count, urinalysis, pregnancy test, or other procedures medically necessary for the planned surgical procedure.	Various			

PATHOLOGY/OTHER

DESCRIPTION OF SERVICE	CPT CODE	AK RATE	PROFESSIONAL	TECHNICAL
COVID-19 Infectious agent detection by nuclei acid DNA or RNA; amplified probe technique	87426	35.33		
COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative	87635	51.31		
In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure ***outpatient ER procedure follow-up***	88365	203.22	56.73	146.49
In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure	88364	153.37	44.86	108.51
In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	88366	309.91	81.02	228.89
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure	88367	130.4	44.56	85.84
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each	88373	80.97	34.36	46.62

additional probe stain procedure				
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure	88374	323.19	56.71	266.48
Infectious agent detection by nucleic acid (dna or rna); severe acute	U0003	75.00		
Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure	88368	171.55	56.01	115.54
Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure	88369	147.98	44.5	103.47
Morphometric analysis, in situ hybridization, manual, per specimen, each additional multiplex stain procedure	88377	445.64	85.93	359.7

OTHER

DESCRIPTION OF SERVICE	CPT CODE	AK RATE
Outpatient ER services procedure follow-up	93010	10.84
ER visit procedure	96360	37.11
ER visit procedure follow-up	96361	14.41
Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months	G0136	
Community Health integration services performed by certified or trained AUX personnel, Including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month	G0019	
Community Health integration services, each additional 30 minutes per calendar month	G0022	

ANESTHESIA

DESCRIPTION OF SERVICE	CPT CODE	FACILITY FEE
Moderate anesthesia, 10–22 minutes for individuals 5 years or older	99156	$100.13
Moderate anesthesia for each additional 15 minutes ***[see note 12]***	99157	$78.98
Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified **[see note 11]**	00400	$128.70
Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified ***[see note 11]***	00940	$128.70

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PROCEDURES SPECIFICALLY NOT ALLOWED

DESCRIPTION OF SERVICE	CPT CODE
Treatment of breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia and cervical cancer.	Any
Breast Tomosynthesis, unilateral ***[see note 13]***	77061
Breast Tomosynthesis, bilateral ***[see note 13]***	77062
Human papillomavirus, low-risk types	87623

DESCRIPTION

END NOTE	DESCRIPTION
1	All consultations should be billed through the standard “new patient” office visit CPT codes 99201–99205. Consultations billed as 99204 or 99205 must meet the criteria for these codes. These codes (99204-99205) are typically not appropriate for NBCCEDP screening visits. However, they may be used when provider spends extra time to do a detailed risk assessment.
2	The 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rates. 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 NBCCEDP. Reimbursement rates should not exceed those published by Medicare. While some programs may need to use 993XX-series codes, Preventive Medicine Evaluation visits are not appropriate for the NBCCEDP. 9938X codes may be used to cover combined NBCCEDP and WISEWOMAN office visits. These codes may be reimbursed at their normal rates.
3	This provides fees for the cost of pelvic examination packs and in-room chaperones. This is only allowed when pelvic exam is done in order to do a Pap or HPV test.
4	List separately in addition to 77065 or 77066.
5	For CPT 10011 use the reimbursement rate for CPT code 10009. For CPT 10012 use the reimbursement rate for CPT code 10010.
6	Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.
7	Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.
8	Breast MRI can be reimbursed by the NBCCEDP in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history. Breast MRI can also 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. Breast MRI cannot be reimbursed for by the NBCCEDP to assess the extent of disease in women who has just been newly diagnosed with breast cancer in order to determine treatment plan.
9	List separately in addition to code for primary procedure 77067.
10	HPV DNA testing is not a reimbursable procedure if used as an adjunctive screening test to the Pap for women under 30 years of age. 87626 cannot be reimbursed along with 87624 or 87625.

11	Medicare's methodology for the payment of anesthesia services are outlined in chapter 12 of the Medicare Claims Processing Manual at www.cms.hhs.gov/manuals/downloads/clm104c12.pdf. The carrier-specific Medicare anesthesia conversion rates are available at www.cms.hhs.gov/center/anesth.asp. Fee is calculated using (Base Units + Time [in units]) x Conversion Factor = Anesthesia Fee Amount. No separate charge is allowed if procedure <10 minutes.
12	Example: If procedure is 50 minutes, code 99156+ (99157 x 2). No separate charge allowed if procedure is <10 minutes.
13	The current Physician Fee Schedule for 2025 (on the CMS website), does not price the requested code. These procedures have not been approved for coverage by Medicare.