Nebraska Women's & Men's Health Programs
Fee for Service Schedule
Effective July 1, 2024, through June 30, 2025

OFFICE VISITS			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
New Patient; *expanded* history, exam, straightforward decision-making (20 min. face-to-face)	99202	$66.08	
	99202 *	$43.26	
New Patient; *detailed* history, exam, straightforward decision-making (30 min. face-to-face)	99203	$101.73	
	99203 *	$74.40	
New Patient; *comprehensive* history, exam, decision-making of moderate complexity (45 min. face-to-face)	99204	$152.98	1
	99204 *	$121.45	
New Patient; *comprehensive* history, exam, decision-making of moderate complexity (60 min. face-to-face)	99205	$201.66	1
	99205 *	$165.03	
Established Patient, history, exam, straightforward decision-making. (5 min. face-to-face)	99211	$21.31	
	99211 *	$8.10	
Established Patient *expanded* history, exam, straightforward decision-making. (10 min. face-to-face)	99212	$51.74	
	99212 *	$32.23	
Established Patient *detailed* history, exam, straightforward decision-making. (15 min. face-to-face)	99213	$83.50	
	99213 *	$60.38	
Established Patient *detailed* history, exam, decision-making of moderate complexity (25 min. face-to-face)	99214	$118.01	
	99214 *	$89.18	
Established Patient *comprehensive* history, exam, decision-making of high complexity (40 min. face-to-face) ***Program allowed limit same as 99213***	99215	$83.50	3
	99215 *	$60.38	
Consultation; history, exam, straightforward decision-making; (15 min. face-to-face) ***Program allowed limit same as 99213***	99241	$83.50	3
	99241 *	$60.38	
Consultation; Patient *expanded* history, exam, straightforward decision-making; (30 min. face-to-face) ***Program allowed limit same as 99203***	99242	$101.73	2
	99242 *	$74.40	
Consultation; *detailed* history, exam, decision-making of low complexity; (40 min. face-to-face) ***Program allowed limit same as 99203***	99243	$101.73	2
	99243 *	$74.40	
Consultation; *comprehensive* history, exam, decision-making of moderate complexity; (60 min. face-to-face) ***Program allowed limit same as 99203***	99244	$101.73	2
	99244 *	$74.40	
New Patient Office Visit ***Program allowed limit same as 99203*** Only payable when client has eligible Pap according to program guidelines	99385	$101.73	2
	99385*	$74.40	
Initial comp. prev. med. evaluation & management; history, exam, counseling/guidance, risk factor reduction, ordering of appropriate lab procedures, etc. (Age 40-64) (Age 45 for NCP due to Age Guidelines) ***Program allowed limit same as 99203***	99386	$101.73	2
	99386 *	$74.40	
New Patient Comprehensive (Age 65 & Older – without Medicare B) ***Program allowed limit same as 99203***	99387	$101.73	2
	99387 *	$74.40	
Established Comprehensive Preventive Medicine (Age 18-39) ***Program allowed limit same as 99213***	99395	$83.50	3
	99395 *	$60.38	
Established Patient - ***Program allowed limit same as 99213*** Only payable when client has eligible Pap according to program guidelines	99395	$83.50	3
		$60.38	
Established Comprehensive Preventive Medicine (Age 40-64) (Age 50 for NCP due to Age Guidelines) ***Program allowed limit same as 99213***	99396	$83.50	3
	99396 *	$60.38	
Established Comprehensive Preventive Medicine; (Age 65 and Older–without Medicare B) (Age 50 for NCP due to Age Guidelines) ***Program allowed limit same as 99213***	99397	$83.50	3
	99397 *	$60.38	

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BREAST SCREENING & DIAGNOSTIC PROCEDURES			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Fine needle aspiration biopsy without imaging guidance, each additional lesion	10004	$46.71	
	10004*	$38.30	
Fine needle aspiration biopsy including ultrasound guidance, first lesion	10005	$121.76	
	10005*	$65.61	
Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	10006	$54.76	
	10006*	$45.15	
Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	10007	$274.04	
	10007*	$80.07	
Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	10008	$127.21	
	10008*	$45.84	
Fine needle aspiration biopsy including CT guidance, first lesion	10009	$385.76	
	10009*	$97.81	
Fine needle aspiration biopsy including CT guidance each additional lesion	10010	$211.96	
	10010*	$64.22	
Fine needle aspiration biopsy including MRI guidance, first lesion ***Program allowed limit same as 10009***	10011	$385.76	
	10011*	$97.81	
Fine needle aspiration biopsy including MRI guidance, each additional lesion ***Program allowed limit same as 10010***	10012	$211.96	
	10012*	$64.22	
Fine needle aspiration; without imaging guidance	10021	$91.27	
	10021 *	$48.93	
Puncture Aspiration of cyst of Breast	19000	$90.46	
	19000 *	$37.61	
Puncture Aspiration of cyst of Breast; each additional cyst (use in conjunction with 19000)	19001	$23.86	
	19001 *	$18.75	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; stereotactic guidance; first lesion	19081	$448.21	5
	19081 *	$146.14	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	19082	$343.67	5
	19082 *	$73.14	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; ultrasound guidance; first lesion	19083	$446.19	5
	19083 *	$137.82	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	19084	$338.20	5
	19084 *	$68.86	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	19085	$686.97	5
	19085 *	$161.21	
Biopsy, breast, with placement of breast localization device and imaging of the biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	19086	$527.80	5
	19086 *	$80.40	
Biopsy of breast; percutaneous, needle core, not using imaging guidance (ASC Group 1)	19100	$131.75	
	19100 *	$59.08	
Biopsy of breast; open, incisional (ASC Group 3)	19101	$289.58	
	19101 *	$195.30	
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areola lesion; open; one or more lesions (ASC Group 3)	19120	$458.90	
	19120 *	$366.72	
Excision of breast lesion identified by preoperative placement of radiological marker; single lesion (ASC Group 3)	19125	$504.62	
	19125 *	$404.63	
Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (ASC Group 1)	19126	$136.34	

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BREAST SCEENING & DIAGNOSTIC PROCEDURES - CONTINUED			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Placement of breast localization device, percutaneous; mammographic guidance; first lesion	19281	$218.31	6
	19281 *	$88.60	
Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	19282	$154.05	6
	19282 *	$44.45	
Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	19283	$233.33	6
	19283 *	$88.90	
Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	19284	$170.16	6
	19284 *	$44.35	
Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	19285	$328.80	6
	19285 *	$75.37	
Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	19286	$268.04	6
	19286 *	$37.74	
Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	19287	$567.41	6
	19287 *	$113.11	
Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	19288	$436.35	6
	19288 *	$56.52	
Diagnostic mammography, unilateral, includes CAD	77065	$114.10	7
	77065-TC	$78.47	
	77065-26	$35.63	
Diagnostic mammography, bilateral, includes CAD	77066	$144.24	7
	77066-TC	$100.49	
	77066-26	$43.75	
Screening mammography, bilateral, includes CAD	77067	$116.36	7
	77067-TC	$82.97	
	77067-26	$33.39	
Screening digital breast tomosynthesis, bilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	77063	$47.87	7
	77063-TC	$21.62	
	77063-26	$26.25	
Diagnostic digital breast tomosynthesis, unilateral or bilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	G0279	$43.67	7
	G0279-TC	$17.42	
	G0279-26	$26.25	
Radiological examination, surgical specimen	76098	$38.67	
	76098-TC	$24.72	
	76098-26	$13.95	
Magnetic resonance imaging (MRI), breast, without contrast, unilateral ***Requires PRIOR Approval***	77046	$199.11	
	77046-TC	$135.62	
	77046-26	$63.49	
Magnetic resonance imaging (MRI), breast, without contrast, bilateral ***Requires PRIOR Approval***	77047	$205.02	
	77047-TC	$135.02	
	77047-26	$70.00	
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral ***Requires PRIOR Approval***	77048	$313.97	
	77048-TC	$221.89	
	77048-26	$92.08	
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral ***Requires PRIOR Approval***	77049	$320.62	
	77049-TC	$219.79	
	77049-26	$100.83	
Ultrasound, complete examination of breast including axilla, unilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	76641	$93.46	7
	76641-TC	$61.35	
	76641-26	$32.11	

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BREAST SCREENING & DIAGNOSTIC PROCEDURES – CONTINUED

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Ultrasound, limited examination of breast including axilla, unilateral ***Age requirements must comply with Breast Diagnostic Enrollment Form***	76642	$77.41	7
	76642-TC	$47.54	
	76642-26	$29.87	
Ultrasonic guidance for needle placement; Breast; imaging supervision and interpretation	76942	$53.26	
	76942-TC	$25.32	
	76942-26	$27.94	
Mammary ductogram or galactogram, single duct ***Requires PRIOR Approval***	77053	$49.02	9
	77053-TC	$33.13	
	77053-26	$15.89	

CERVICAL DIAGNOSTIC PROCEDURES

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Colposcopy of the cervix	57452	$114.26	
	57452 *	$81.23	
Colposcopy of the cervix, with biopsy and endocervical curettage	57454	$151.64	
	57454 *	$118.91	
Colposcopy of the cervix, with biopsy	57455	$145.61	
	57455 *	$96.37	
Colposcopy of the cervix, with endocervical curettage	57456	$137.23	
	57456 *	$89.79	
Endoscopy with loop electrode biopsy(s) of the cervix; ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	57460	$282.01	10
	57460 *	$141.78	
Endoscopy with Loop electrode conization of the cervix; ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	57461	$314.06	10
	57461 *	$162.13	
Cervical biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	57500	$138.27	
	57500 *	$67.11	
Endocervical Curettage (not done as part of a dilation and curettage)	57505	$140.04	
	57505 *	$98.91	
Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser; ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	57520	$319.00	10
	57520 *	$267.36	
Loop electrode excision procedure ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	57522	$273.67	10
	57522 *	$230.14	
Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	58100	$91.16	
	58100 *	$56.02	
Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure) ***(allowable when in accordance with program guidelines-refer to Cervical Diagnostic Enrollment Form)***	58110	$44.82	
	58110 *	$35.52	

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COLORECTAL CANCER SCREENING & DIAGNOSTIC PROCEDURES

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) (ASC Group 1)	45378	$311.48	
	45378 *	$166.80	
	45378-53	$155.59	
	45378-53 *	$83.55	
Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple (ASC Group 1)	45380	$397.37	
	45380 *	$181.56	
Colonoscopy, with removal of tumor(s), polyp(s), or other lesion(s), by hot biopsy forceps or bipolar cautery (ASC Group 1)	45384	$444.86	
	45384 *	$204.33	
Colonoscopy, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique (ASC Group 1)	45385	$416.33	
	45385 *	$229.83	

LABORATORY AND PATHOLOGY

DESCRIPTION OF SERVICES	CPT Codes	Program Rates	END NOTES
Venipuncture ***Only allowable when samples collected during/for covered procedures***	36415	$8.83	13
Basic metabolic profile	80048	$8.46	
	80048QW	$8.46	
Comprehensive metabolic panel	80053	$10.56	
	80053QW	$10.56	
Lipid Panel	80061	$13.39	
	80061QW	$13.39	
Total Cholesterol	82465	$4.35	
	82465QW	$4.35	
Glucose quantitative	82947	$3.93	
	82947QW	$3.93	
Blood, regent strip	82948	$5.04	
Hemoglobin, glycosylated (A1c)	83036	$9.71	
	83036QW	$9.71	
HDL Cholesterol	83718	$8.19	
	83718QW	$8.19	
Human Papillomavirus (HPV), high risk types	87624	$35.09	14
Human Papillomavirus (PHV), types 16 and 18 only	87625	$40.55	14
Cytopathology, Smears, Smears with interpretation ***breast discharge or cervical smear only***	88104	$70.23	
	88104-TC	$44.46	
	88104-26	$25.76	
Cytopathology, Smears, (breast discharge or cervical smear only) filter method only with interpretation	88106	$65.73	
	88106-TC	$48.13	
	88106-26	$17.61	
Cytopathology, concentration technique, smears and interpretation (breast discharge or cervical smear only) (eg, Saccomanno technique)	88108	$63.69	
	88108-TC	$42.84	
	88108-26	$20.85	
Cytopathology (conventional Pap test), cervical or vaginal, any reporting system *requiring interpretation by physician.*	88141	$22.13	
Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	88142	$20.26	

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LABORATORY AND PATHOLOGY- CONTINUED			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	88143	$23.04	
Cytopathology (conventional Pap test), slides, cervical or vaginal in the Bethesda System; manual screening under physician supervision	88164	$17.76	
Cytopathology (conventional Pap test), slides, cervical or vaginal reported in Bethesda system; manual screening and rescreening under physician supervision	88165	$42.22	
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode	88172	$51.62	
	88172-TC	$19.32	
	88172-26	$32.30	
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	88177	$27.36	
	88177-TC	$7.51	
	88177-26	$19.86	
Cytopathology, evaluation of fine needle aspirate; Breast, interpretation and report	88173	$153.51	
	88173-TC	$89.48	
	88173-26	$64.03	
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	88174	$25.37	
Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	88175	$26.61	
Surgical Pathology, gross examination only (surgical specimen) ***Only allowable when samples collected during/for covered procedures***	88300	$14.77	13
	88300-TC	$10.79	
	88300-26	$3.99	
Surgical Pathology, gross and microscopic examination (review level II) ***Only allowable when samples collected during/for covered procedures***	88302	$30.48	13
	88302-TC	$24.22	
	88302-26	$6.26	
Surgical Pathology, gross and microscopic examination (review level III) ***Only allowable when samples collected during/for covered procedures***	88304	$39.58	13
	88304-TC	$29.10	
	88304-26	$10.48	
Surgical Pathology, gross and microscopic examination (review level IV) ***Only allowable when samples collected during/for covered procedures***	88305	$66.19	13
	88305-TC	$31.93	
	88305-26	$34.27	
Surgical Pathology, gross and microscopic examination (review level V) ***Only allowable when samples collected during/for covered procedures***	88307	$262.35	13
	88307-TC	$187.46	
	88307-26	$74.88	
Morphometric analysis, tumor immunohistochemistry, per specimen; manual ***Only allowable when samples collected during/for covered procedures***	88360	$110.30	13
	88360-TC	$72.16	
	88360-26	$38.14	
Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology ***Only allowable when samples collected during/for covered procedures***	88361	$109.68	13
	88361-TC	$69.46	
	88361-26	$40.21	
Surgical Pathology, gross and microscopic examination (review level VI) ***Only allowable when samples collected during/for covered procedures***	88309	$402.11	13
	88309-TC	$267.80	
	88309-26	$134.31	
Pathology consultation during surgery ***Only allowable when samples collected during/for covered procedures***	88329	$51.40	13
Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen ***Only allowable when samples collected during/for covered procedures***	88331	$95.17	13
	88331-TC	$37.65	
	88331-26	$57.52	
Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen ***Only allowable when samples collected during/for covered procedures***	88332	$50.98	13
	88332-TC	$22.69	
	88332-26	$28.29	

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LABORATORY AND PATHOLOGY- CONTINUED			
Immunohistochemistry or immunocytochemistry, each additional single antibody stain procedure (List separately in addition to code for primary procedure) (use 88341 in conjunction with 88342) ***Only allowable when samples collected during/for covered procedures***	88341	$84.37	13 15
	88341-TC	$58.30	
	88341-26	$26.07	
Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure ***Only allowable when samples collected during/for covered procedures***	88342	$98.59	13 15
	88342-TC	$66.03	
	88342-26	$32.56	
Immunohistochemistry or immunocytochemistry, each multiplex antibody stain procedure.	88344	$160.14	13 15
	88344-TC	$124.34	
	88344-26	$35.81	

HOSPITAL - ANESTHESIA – AMBULATORY SURGERY CENTERS			
DESCRIPTION OF SERVICES	**CPT Codes**	**Program Rates**	**END NOTES**
Bundled hospital fees ***Hospital responsible to provide EWM with updated Medicaid Rate Notification Letter***	00300	Medicaid % Rate	16
Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified. Medicare Base Units = 3	00400	Attachment 1	
Anesthesia during approved Colon Procedures	00800	Attachment 1	
Anesthesia during approved Colon Procedures	00811	Attachment 1	
Anesthesia during approved Colon Procedures	00812	Attachment 1	
Anesthesia during approved Cervical Procedures	00940	Attachment 1	
Ambulatory Surgery Centers related to approved Breast or Colon Procedures (NOTE: Refer to Procedure Code for ASC Group Assignment)	Group 1	$413.00	17
	Group 2	$552.00	
	Group 3	$637.00	

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END NOTES	
1	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 but may be used when provider spends extra time to do a detailed risk assessment.
2	Program allowed limit same as CPT 99203
3	Program allowed limit same as CPT 99213
4	Program allowed limit same as CPT 99395
5	CPT 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.
6	CPT 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.
7	Age requirements must comply with Breast Diagnostic Enrollment Form
8	Breast MRI is allowed under certain circumstances; pre-approval for these procedures must be obtained.
9	Prior approval by Program
10	A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations; must comply with Cervical Diagnostic Enrollment Form.
11	G0105 may be used for screening colonoscopy on clients considered to be at increased risk for CRC due to a family history of CRC or adenomatous polyps. The Medicare definition of high risk includes both those considered to be an increased risk (personal or family history of CRC or adenomatous polyps) or high risk (family history of FAP or Lynch Syndrome or personal history of inflammatory bowel disease) as defined by CRCCP policies and procedures.
12	G0106 (colorectal cancer screening; barium enema; as an alternative to G0104; screening sigmoidoscopy), G0120 (colorectal cancer screening; barium enema; as an alternative to G0105; screening colonoscopy), and G0122 (colorectal cancer screening; barium enema) are not included as barium enema is no longer recommended by USPSTF as a colorectal cancer screening test. Double contract barium enema may still be used as a diagnostic test to evaluate an abnormal FIT or FOBT (NOTE: Colonoscopy is the preferred test in this circumstance)
13	Only allowable when samples collected during/for covered procedures
14	HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. Cervista HPV HR is reimbursable at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. Genotyping (e.g., Cervista HPV 16/18) is not allowed.
15	Use 88342 for first slide; use 88341 in conjunction with 88342; for multiplex antibody stain procedure use 88344. ◆Do not use more than one unit of 88341, 88342, 88344 for each separately identifiable antibody per specimen. ◆When multiple separately identifiable antibodies are applied to the same specimen [ie, multiplex antibody stain procedure], use one unit of 88344 ◆When multiple antibodies are applied to the same slide that are not separately identifiable, [eg, antibody cocktails], use 88342, unless an additional separately identifiable antibody is also used, then use 88344
16	Allowable costs related to a breast, cervical or colon procedure, not shown on the fee schedule as a "Technical Fee" will be bundled together and shown on the billing authorization using CPT 00300. This code will be paid at the Hospital's approved Medicaid % rate. Hospitals are required to provide a copy of their approved Nebraska Medicaid Rate Letter each time the rate is modified.
17	ASC bills for the facility fee using the same procedure code as the professional service and attaching a modifier –SG. The modifier indicates that the claim is for the facility fee ONLY. Clients receiving more than one approved service at an ASC facility on the same date; the full rate will be applied to the first service and additional services will be reimbursed at 50%.

ADDITIONAL PROGRAM NOTES/THIRD PARTY BILLING

76499 Unlisted diagnostic radiography procedure (3D Mammography) is not allowed under the National Breast and Cervical Cancer Early Detection Program. Providers should discuss these charges with program participants and give them the option to waive the additional 3D services or write-off these charges.

The Program is the payer of last resort. Participating healthcare providers agree to file other third-party claims first and agree to accept the rates listed on the Fee Schedule as payment in full.

If the third-party payment is greater than or equal to the maximum allowable cost described in the Fee Schedule, that amount must be considered payment in full. Do not bill the Program or the client for services.

If the third-part payment is less than the maximum allowable costs described in the Fee Schedule, the claim should be sent to the Program, along with a copy of the explanation of benefits from the third-party payer. Do not bill the client for these services.

* THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

TC = Technical Component 26 = Professional Component CF = Conversion Factor QW = CLIA Certificate of Waiver

Nebraska Women's & Men's Health Programs
Fee for Service Schedule
Effective July 1, 2024, through June 30, 2025

Attachment 1: Anesthesia Rates

Fee Schedule for Anesthesia is based on Medicaid Reimbursement system with unit values rounded to nearest cent. Rates are adjusted annually with the Program's Fiscal Year which runs July 1 through June 30.

Anesthesia Claims Modifiers:

Healthcare providers report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. All claims for anesthesia services must include:

- CPT Code with Modifier (see list below)
- Start & Stop Times
- Explanation of Benefits from Primary Insurance (where applicable)

When a physician bills for anesthesia services, the correct procedure code AND modifiers indicate:

- The Physician personally provided services to the individual patient
- The physician provided medical direction for CRNA services, and the number of concurrent services directed.

The following modifiers MUST be used by when submitting claims for anesthesia services:

AA – Anesthesia Services performed personally by the anesthesiologist
AD – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX – RNA service; with medical direction by a physician
QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ – CRNA service; without medical direction by a physician

Fee Schedule:

To determine the allowable rate for anesthesia services, add the unit value for the procedure to the number of minutes for the procedure and multiple by the appropriate conversion factor.

(Unit Value + Minutes) x Conversion Factor = Allowable Rate

Unit Value:

CPT Code	AA/QY	QK	QX	QZ
00400*	$44.88	$67.87	$44.58	$44.79
00800*	$44.88	$67.87	$44.58	$44.79
00811*	$59.84	$90.49	$59.44	$59.72
00812*	$44.88	$67.87	$44.58	$44.79
00940*	$44.88	$67.87	$44.58	$44.79

*Anesthesia only covered when the surgical procedure performed is determined to be payable.

Minutes:
Anesthesia claims must include Start and Stop Times of the Procedure.

Conversion Factors: AA = $2.11 QX = $1.00
QY = $2.11 QZ = $1.72
QK = $1.05

(EXAMPLE: CPT 00400-QZ – 68minutes … ($44.79 + 68) x $1.72 = $194.00

* THESE AMOUNTS APPLY WHEN SERVICE IS PERFORMED IN A FACILITY SETTING – for the purpose of this program, "Facility" includes hospitals and ambulatory surgical centers (ASCs). Rates listed for services include all incidental charges related to the procedure; additional amounts may not be billed to the client.

TC = Technical Component 26 = Professional Component CF = Conversion Factor QW = CLIA Certificate of Waiver