

# Chapter 6 - Reimbursement

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CSP Operations Manual 04/14

New York State Department of Health

**Cancer Services Program**

Your partner for cancer screening, support and information





## Chapter 6: Reimbursement

### A. Guidelines

Clinical services are paid for by the CSP contractor (Component A grantees) or the State, Health Research Inc. (HRI) and/or its Fiscal Agent (Component B grantees) to the CSP-credentialed provider after the contractor has submitted all required data to the NYSDOH CSP. Monthly billing reports generated from the data system are used to create vouchers, which are then used to bill the State and HRI for reimbursable clinical services provided to eligible clients.

Component A contractors receive payment from the State and HRI and subsequently reimburse the providers with whom they have agreements for provision of services to eligible CSP clients and invoices for services in accordance with the CSP maximum allowable reimbursement rates.

All contractors must have written agreements with participating providers that include consent to provide services as outlined by the CSP Operations Manual and provisions of the contract described in Participating Provider Requirements (see CSP Operations Manual, Chapter 2: Required Activities and Standards, [Section D](#)). For reimbursement of clinical services, contractors and providers must:

1. request reimbursement for clinical services only for clients who meet the eligibility criteria as defined in the CSP Operations Manual, [Chapter 3: Eligibility](#)
2. treat the CSP as the Payor of last resort. All providers agree to first bill client's other insurance and/or third party payor(s) for services provided through the CSP. Providers further agree that they may not submit claims for reimbursement directly to New York State (NYS) but will provide information to the CSP contractors for submission on the CSP Data system for reimbursement.
3. accept reimbursement rates established by the CSP as payment in full for all services that are covered by the CSP. Maximum Allowable Reimbursement Schedule (MARS) rates are issued annually by the CSP and are included in the *New York State Department of Health Cancer Services Program Reimbursement Schedule* ([Attachment 6-1](#)). *The New York State Department of Health Cancer Services Program Reimbursement Schedule* represents reimbursement in full for specific services.

The CSP does not reimburse for services billed by Current Procedural Terminology (CPT) code or on Health Care Financing Administration (HCFA) billing forms. Providers agree not to charge clients for the difference between the CSP reimbursement rate and the provider's usual fees or the amount allowed by the clients' insurance plan. The CSP reimbursement rate is based on Medicare regional global rates, which include the technical and professional component of the service to be reimbursed. Under no circumstance shall providers bill CSP clients for the services that are reimbursed by the CSP.

4. submit reimbursable services in a timely manner on a completed Screening Intake Form (SIF) and, where applicable, a Follow-up Form (FF)
5. submit accurate demographic, screening, diagnostic, treatment and any other data required by NYS in a timely manner and in the format required by NYS
6. the provider agrees that the reimbursement for clinical services will not be provided by NYS for reimbursement to the provider until appropriate data have been submitted and accepted in the CSP data system

## **B. Maximum Allowable Reimbursement for Clinical Services**

The CSP is the Payor of last resort. The CSP will pay for services according to the *New York State Department of Health Cancer Services Program Reimbursement Schedule* ([Attachment 6-I](#)) ONLY if the client meets all eligibility criteria and no other sources of payment are available for the services. Other sources include private insurance, managed care plans, Medicare, Medicaid, and Title X Family Planning Services.

Payor of last resort as it applies to Indian Health Service (IHS) Clinics and Tribally Operated Clinics: IHS is designated as the Payor of last resort, meaning that all other available alternative resources, including IHS facilities, must first be used before payment is expected. According to 42 CFR 136.61 (2002), IHS is the Payor of last resort for persons who have an alternate resource, notwithstanding any State or local law or regulation to the contrary. Accordingly, IHS will not be responsible for or authorize payment for medical services to the extent that an alternate resource is available (Reference: CDC, NBCCEDP Program Guidance Manual, Policies and Procedures, Attachment C-1, April 2007). Therefore, the CSP may be billed for eligible services rendered outside of the IHS provider or facility to persons qualifying under the IHS who have no additional health insurance coverage or source of payment.

Refer to the *New York State Department of Health Cancer Services Program Reimbursement Schedule* ([Attachment 6-I](#)).

The reimbursement criteria are not clinical guidelines. These criteria address reimbursement of services through the CSP only. Alternate funds must be identified to reimburse for services that are recommended by providers, but are not reimbursed by the CSP.

NOTE: For reimbursement policies related to Family Planning Programs, refer to [Attachment 6-II](#) *Guidance for Cancer Services Program Contractors and Title X Family Planning Providers, July 2009*.

### 1. Breast Cancer Screening Services

#### *a. Clinical Breast Exam (CBE)*

The CSP will reimburse for:

- a screening CBE annually for women aged 40 years and older

- a screening CBE for a women under age 40 who has been determined to be high-risk for breast cancer in accordance with CSP high-risk criteria and has a signed attestation. See CSP Operations Manual, Chapter 4: Cancer Screening Guidance, [Section H](#)
- a short-term CBE (i.e.: performed sooner than one year) for women aged 40 years and older, if ordered by a clinician at least 30 days after an initial CBE to assess a probably benign CBE finding. This should be submitted on a new SIF.
- a repeat CBE performed as follow-up to a CBE finding initially reported as suspicious for breast cancer. This should be submitted on the FF.
- more than one CBE in a year if a woman aged 40 years or older presents with an interval finding within the year (e.g., a woman finds a lump in her breast after having a negative CBE within the past year)

The CSP does not reimburse for screening CBE in women under age 40 who have clinically significant findings for breast cancer or for men at any age. The CSP will, however, reimburse for a repeat CBE reported on the FF as part of diagnostic evaluation for a woman under age 40 and for men 18 years of age and older for clinical correlation of diagnostic testing and when it is performed within 30 days of the diagnostic testing.

#### *b. Screening Mammogram*

The CSP will reimburse for:

- a screening mammogram annually for women ages 40 years and older
- a short-term repeat mammogram (i.e., a mammogram performed sooner than one year) following a reported BI-RAD 3 probably benign short-term mammogram recommended. This should be submitted on a new SIF.

The CSP does not reimburse for screening mammography in average-risk women under age 40. Women ages 18-39 who are determined to be at high risk for breast cancer or who have clinically significant findings for breast cancer may be eligible for some CSP-reimbursed services (see CSP Operations Manual, Chapter 3: Eligibility, [Section C-3](#)).

The CSP reimburses for film-screen and digital mammography at the same rate. The CSP will not reimburse for computer-assisted detection (CAD). *The CSP will not reimburse for a screening mammogram for men.*

## 2. Cervical Cancer Screening Services

#### *a. Pelvic Exam*

The CSP will reimburse for:

- a pelvic exam for women ages 40 years and older, when performed at the same time as an appropriate cervical cancer screening test

- a short-term repeat pelvic exam (i.e., a pelvic exam performed sooner than one year) in women ages 40 years and older based on abnormal findings of a previous cervical cancer screening or a cervical cancer screening performed for surveillance purposes following recommended treatment when performed at the same time as an appropriate cervical cancer screening test. This should be submitted on a new SIF.
- a short-term pelvic exam (i.e., pelvic exam performed sooner than one year) in women ages 40 years and older who present with an interval finding that may be suspicious for cervical cancer. This should be documented in the medical record and submitted on a new SIF.
- an initial pelvic exam for women ages 40 and older who have had a hysterectomy and who are not sure if their cervix is intact for the purpose of determining if the client still has a cervix. For further explanation, see CSP Operations Manual, Chapter 3: Eligibility, [Section C-8](#).

The CSP will not reimburse for pelvic exams performed during the years in between cervical cancer screenings for women who are receiving cervical cancer screening according to an appropriately lengthened interval.

*b. Cervical Cytology (Pap Test)*

The CSP will reimburse for:

- a liquid-based Pap test every three years for women ages 40 years and older with an intact cervix and a prior negative test. Once there are three consecutive negative Pap tests in a 60-month period, the CSP will reimburse for Pap test and pelvic exam once every three years for cervical cancer screening, except in those for whom there is medical exemption from the every three year screening interval (see below)
- a conventional Pap test every three years for women ages 40 years and older with an intact cervix and a prior negative test; a liquid based Pap test every five years when performed in combination with a high risk HPV test and when both tests are negative
- a short-term repeat Pap test (i.e.: a Pap test performed sooner than one year) in women ages 40 years and older based on the prior Pap test was unsatisfactory. This should be submitted on a new SIF.
- a conventional or liquid-based Pap test every three years (after initial surveillance at the appropriate prescribed intervals with negative results) for women ages 40 years and older who have had a hysterectomy due to cervical cancer or pre-cancerous cervical dysplasia. See CSP Operations Manual, Chapter 3: Eligibility, [Section C-8](#) for more information.
- a conventional or liquid-based Pap test annually for women 40 years and older who have a documented medical exception of being immunocompromised, are infected with HIV, or were exposed in utero (as a fetus) to diethylstilbestrol (DES).

The CSP provides reimbursement for conventional and liquid-based cytology at different reimbursement rates. The CSP reimburses one reimbursement rate for conventional and another rate for liquid-based cytology, regardless of the methodology, level of interpretation, or the CPT code billed for reimbursement.

The CSP will reimburse for cervical cancer screening at intervals prescribed by the updated Cervical Cancer Screening CSP Reimbursement Guidelines ([Attachment 6-IV](#)).

The CSP will not reimburse for a Pap test for a client who has had a total hysterectomy and whose cervix was removed for reasons other than those listed above (see CSP Operations Manual, Chapter 3:Eligibility, [Section C-8](#)).

*c. Human Papillomavirus (HPV) DNA Testing (High-Risk Only)*

The CSP will reimburse for High-Risk (HR) HPV DNA (Hybrid Capture II), Cervista HR HPV or cobas<sup>®</sup> HPV test for women ages 40 and older for screening:

- in conjunction with cytology for cervical cancer screening performed at the appropriate interval
- when performed as surveillance 12 months after biopsy has confirmed CIN 1 or less with index Pap test for colposcopy of ASC-US, ASC-H, or LGSIL
- when performed in 12 months, as follow-up to a prior negative Pap test and a positive HR HPV DNA test
- when performed as surveillance co-testing 12 months and 24 months after treatment of CIN 2 or greater.

3. Colorectal Cancer Screening Services

*a. Fecal Tests*

i. Fecal Occult Blood Test (FOBT) Kit

The CSP will reimburse for an annual multi-slide, take-home FOBT kit:

- only for men and women ages 50 years and older at average risk for colorectal cancer who have not completed an FOBT or FIT kit in the past ten months

The CSP will not reimburse for an in-office, single-slide fecal test.

*Please note: diagnostic services based on a positive in-office, single-slide fecal test will not be reimbursed.*

ii. Fecal Immunochemical Test (FIT) Kit

The CSP will reimburse for an annual multi-slide, take-home FIT kit:

- only for men and women ages 50 years and older at average risk for colorectal cancer who have not completed a FIT or FOBT kit in the past ten months

*b. Screening Colonoscopy*

The CSP will reimburse for:

- screening colonoscopy for clients who are at increased or high risk for colorectal cancer (see CSP Operations Manual, Chapter 3: Eligibility, [Section C-9](#))

The CSP will not reimburse for screening colonoscopy in clients who are at average risk for colorectal cancer. An exception is those clients who have undergone screening in the selected CSP pilot programs.

4. Breast Cancer Diagnostic Services

The reimbursement policies below apply to women ages 40 and older, women under the age of 40 who are deemed high-risk for or with clinically significant findings for breast cancer, and men deemed at high risk for or with clinically significant findings for breast cancer who are otherwise eligible for the CSP. The following diagnostic procedures can be reimbursed only following an abnormal CBE or a screening mammogram with a finding of BI-RAD 4, 5, or 6/0. The CSP will reimburse for the following services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS Medicaid Cancer Treatment Program (MCTP) (see CSP Operations Manual, [Chapter 7](#): NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below represent the codes for each procedure on the Follow-up Form and Indus.

**(01) Unilateral Diagnostic Mammogram, (90) Bilateral Diagnostic Mammogram (Special Views ONLY)**

The CSP will reimburse for:

- a diagnostic mammogram, either bilateral or unilateral. In the CSP, a diagnostic mammogram is defined as one or more special views such as a cone view, magnification view, or compressed view which is performed in addition to the four standard views - medial, lateral, oblique [MLO] and craniocaudal [CC] of the left and right breasts
- a specimen radiograph (post-operative mammogram of the removed area of concern), if not included in an all-inclusive procedure fee.
- a post-procedure mammogram to examine the site of biopsy, if not included in an all-inclusive procedure fee.
- A 6 month short term follow up after the biopsy for a mammographic finding to ascertain stability.

Note: procedure (16) and (84) Stereotactic breast biopsy and procedure (25) and (86) are all inclusive codes and already include specimen radiograph and post-procedure film. The CSP does not reimburse for additional implant displaced views as a diagnostic mammogram. The CSP does not reimburse for tomography as special views.

## **(02) Repeat Clinical Breast Exam**

The CSP will reimburse for:

- a repeat CBE following a finding on a screening CBE
- a repeat CBE if done at the time of a surgical consult or second opinion for a clinically palpable finding.
- a repeat CBE for clinical correlation of imaging findings within 30 days of the original abnormal screening CBE

## **(03) Surgical Consult/Second Opinion**

The CSP will reimburse for:

- a surgical consult prior to a biopsy OR on the same day of the biopsy
- a second opinion when performed prior to the biopsy
- the CSP does not reimburse for a surgical consult or a second opinion once a diagnosis has been determined (i.e., post-diagnosis)
- a second opinion/surgical consult, (1): when performed by a different provider and (2) following a biopsy that is discordant with imaging findings, pathology findings or physical examination and (3) that requires a second biopsy for a definitive diagnosis to rule out breast cancer. Example: A client has stereotactic breast biopsy in which atypical micropapillomas are present in pathology specimen and the recommendation is a surgical consult for excisional biopsy. This second surgical consult, if performed by a different provider after the initial biopsy, would be reimbursed.

## **(04) Diagnostic Breast Ultrasound (Sonogram)**

The CSP will reimburse for:

- a breast ultrasound only after a clinically significant finding has been determined by a NYS-licensed health care provider on a CBE or mammogram
- bilateral ultrasounds (i.e., ultrasounds performed on both breasts) is reimbursed at the same rate as a unilateral ultrasound and should only be performed if there are bilateral findings that require diagnostic ultrasound
- one short-term, repeat ultrasound when clinically indicated based on the findings from a previous probable benign short-term study. In order to receive reimbursement for this procedure, the provider must submit the procedure on a Revision Form for inclusion on the follow up form that contains the initial Probable Benign short-term ultrasound .
- a diagnostic ultrasound when performed as image guidance to a biopsy

- a diagnostic ultrasound when performed as image guidance to a biopsy procedure that does not result in biopsy, because the lesion/area to be biopsied is not located

The CSP reimbursement for a diagnostic breast ultrasound is for a unilateral OR a bilateral ultrasound. The CSP will not reimburse for screening breast ultrasounds or survey ultrasounds for dense breast tissue alone. The CSP will not reimburse for ultrasounds when performed as follow-up on mammography findings of benign dense breast tissue alone or to follow benign breast conditions post-diagnosis; this includes routine 6 month US following a breast biopsy with a benign finding. The CSP will reimburse for only one ultrasound on the same day by the same provider.

### **(07) Fine Needle Aspiration Breast Biopsy (FNAB) with ultrasound guidance**

The CSP will reimburse for:

- FNAB with image guidance only when performed to rule out breast cancer, not when performed to drain a cyst or performed to reduce pain from simple cysts
- one FNAB with image guidance per lesion if there are multiple lesions
- only one FNAB with image guidance if there are multiple samples taken from a single lesion

Please note that the reimbursement rate includes reimbursement for ultrasound guidance used during the FNAB. If the ultrasound does not locate the lesion at the time of FNAB and the biopsy is not performed, then the ultrasound can be reimbursed as (04) Diagnostic Ultrasound, and the FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining or when performed to relieve mastalgia.

### **(08) Core Breast Biopsy**

The CSP will reimburse for:

- core biopsy taken from a lesion to rule out breast cancer

### **(09) Incisional Breast Biopsy**

The CSP will reimburse for:

- an incisional biopsy taken from a lesion to rule out breast cancer

### **(10) Excisional Breast Biopsy**

The CSP will reimburse for:

- an excisional breast biopsy that removes the entire lesion to rule out breast cancer
- one excisional biopsy per lesion if there are multiple lesions
- only one excisional biopsy if there are multiple samples taken from a single lesion

The CSP does not reimburse for an excisional breast biopsy (lumpectomy) if performed after a diagnosis of cancer has already been determined.

### **(11) Cytology, Breast Fluids**

The CSP will reimburse for:

- cytology of breast fluids, only when submitted to a lab for diagnosis following an FNAB
- one cytology per lesion if there are multiple samples

### **(12) Histology, Breast Tissue**

The CSP will reimburse for:

- histology, breast tissue following a core, incisional, excisional or stereotactic biopsy
- only one histology per lesion for all biopsies. Multiple samples from the same lesion will be reimbursed as one histology.

### **(82) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.**

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. It is not used for examination of benign specimens.

### **(14) Cytology, Nipple Smear**

The CSP will reimburse for:

- cytology, nipple smear when done to rule out breast cancer

The reimbursement fee includes both the collection and reading of the sample.

### **(15) Pre-operative Mammographic Needle Localization and Wire Placement all inclusive procedure reimbursement.**

The CSP will reimburse for:

- mammographic needle localization when performed pre-operatively to a biopsy to locate a lesion and place a wire to localize the lesion prior to biopsy

When a mammographic needle localization is attempted and the area of concern is not found and, therefore, no needle/wire is advanced and the biopsy is cancelled, a (01) Diagnostic Mammogram and (03) Surgical Consult can be reimbursed and the (15) Pre-operative Mammographic Needle Localization and wire placement is not reported on the FF.

### **(83) Additional pre-operative Mammographic Needle Localization and Wire Placement second lesion**

- when a second lesion requires mammographic needle localization and wire placement on the same day.

**(16) Stereotactic Biopsy Procedures (regardless of biopsy apparatus employed) all inclusive procedure; placement of breast localization device(s),(eg, clip, metallic pellet) imaging of the biopsy specimen, percutaneous biopsy; first lesion, including stereo guidance**

The CSP will reimburse for:

- a stereotactic biopsy when performed to rule out breast cancer

When a stereotactic procedure is performed utilizing standard core biopsy(s), the all-inclusive rate for stereotactic procedures includes payment for mammographic localization, core biopsy(s), image-guided clip placement and post procedure imaging of placement and the post-procedure specimen radiograph. Procedure code (16) Stereotactic Biopsy Procedures with standard core(s) must be reported.

**(84) Second lesion Stereotactic Procedure all inclusive (as above.)**

When a second stereotactic procedure is performed on a second lesion (same breast or opposite breast) on the same day, Procedure code **(84)** is reported for the second lesion and any additional lesions where Stereotactic biopsy procedure is employed

For pathology reimbursement associated with the stereotactic biopsy procedure, see (12) Histology, Breast Tissue, above.

If a stereotactic breast biopsy is attempted and the lesion cannot be identified and, subsequently, the biopsy cannot be performed, (01) Diagnostic Mammogram view(s) taken to locate the lesion and the (03) Surgical Consult can be reimbursed; the all-inclusive stereotactic procedure should not be reported on the FF.

**(18) Anesthesiologist Services**

The CSP will reimburse for:

- anesthesiologist services only when an anesthesiologist or nurse anesthetist administers IV-monitored anesthesia care

An anesthesiologist fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

**(19) Chest X-Ray**

The CSP will reimburse for:

- a pre-operative chest X-ray only prior to an incisional or excisional breast biopsy

### **(20) Electrocardiogram (ECG/EKG)**

The CSP will reimburse for:

- a pre-operative ECG/EKG only prior to an incisional or excisional breast biopsy

### **(21) Complete Blood Count (CBC)**

The CSP will reimburse for:

- a pre-operative CBC only prior to an incisional or excisional breast biopsy

### **(22) Pre-operative Ultrasonic Needle Localization and Wire Placement- all inclusive procedure reimbursement.**

The CSP will reimburse for:

- ultrasonic needle localization when performed pre-operatively to locate a lesion and place a wire to localize the lesion prior to excisional biopsy

When ultrasonic needle localization is attempted and the area of concern is not found and, subsequently, the needle/wire is not advanced and the biopsy is cancelled, a (04) Diagnostic Ultrasound and (03) Surgical Consult can be reimbursed and the (22) Pre-operative Ultrasonic Needle Localization and Wire Placement is not reported.

### **(85) Additional pre-operative Ultrasonic Needle Localization and Wire Placement second lesion**

- when a second lesion requires US needle localization and wire placement on the same day.

### **(23) Facility Fee – Core Biopsy**

The CSP will reimburse for:

- a facility fee for a core biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. Only one facility fee per day, regardless of the number of biopsies performed.

### **(24) Facility Fee – Excisional/Incisional Biopsy**

The CSP will reimburse for:

- a facility fee for an excisional or an incisional biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. Only one facility fee per day, regardless of the number of biopsies performed.

**(25) Ultrasound-Guided Core Needle Biopsy with Vacuum-Assisted Device all inclusive procedure; placement of breast localization device(s),(eg, clip, metallic pellet) imaging of the biopsy specimen, percutaneous biopsy (s); first lesion, including US guidance**

The CSP will reimburse for:

- ultrasound-guided core needle biopsy using a vacuum-assisted rotating biopsy device only when performed to rule out breast cancer

Please note that the reporting of this procedure code is all-inclusive

**(86) Second lesion US guided vacuum assisted breast biopsy procedure - all inclusive (as above.)**

When a second US guided vacuum assisted breast biopsy procedure is performed on a second lesion (same breast or opposite breast) on the same day, Procedure code **(86)** is reported for the second lesion and any additional lesions where Stereotactic biopsy procedure is employed

**(29) Fine Needle Aspiration Breast Biopsy (FNAB) without image guidance**

The CSP will reimburse for:

- FNAB without image guidance only when performed to rule out breast cancer, not when performed to drain a cyst or performed to reduce pain from simple cysts
- one FNAB without image guidance per lesion if there are multiple lesions
- only one FNAB without image guidance if there are multiple samples taken from a single lesion

Please note that if the lesion is not palpable at the time of the biopsy and the biopsy is not performed, then the FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining or when performed to relieve mastalgia.

**Cervical Cancer Diagnostic Services**

The reimbursement policies below apply to women ages 40 years and over who are otherwise eligible for the CSP.

The following procedures can be reimbursed only after one or more of the following conditions have been met:

- a screening pelvic exam with an exam finding that is reported as suspicious for cervical cancer
- a Pap test with a finding of:
  - 2<sup>nd</sup> Atypical Squamous Cells of Undetermined Significance (ASC-US) @12 months(03)
  - Low-grade Squamous Intraepithelial Lesion (LSIL) (04) no HPV performed , or + HR HPV Co-test

- High-grade Squamous Intraepithelial Lesion (HSIL) (05)
- Squamous Cell Cancer (06)
- Atypical Squamous Cells: Cannot Exclude HSIL (ASC-H) (08),
- Atypical Glandular Cells (AGC); all subtypes including adenocarcinoma in situ, but excluding atypical endometrial cells only (12).
- 2<sup>nd</sup> Negative Pap cytology with a +HR HPV @ 12 months

The CSP will reimburse for services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS Medicaid Cancer Treatment Program (MCTP) (see CSP Operations Manual, [Chapter 7](#): NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below are the codes that should be reported for each procedure on the CSP Follow-up Form and on Indus.

### **(52) Colposcopy without Biopsy**

The CSP will reimburse for:

- a colposcopy without biopsy when a colposcopy is performed and no lesion is visualized or biopsied

According to the American Society for Colposcopy and Cervical Pathology (ASCCP), colposcopy with endocervical sampling is preferred in women with no lesions observed and/or with unsatisfactory colposcopy (incomplete visualization of entire squamocolumnar junction and margin of any visible lesion).

The CSP will not reimburse for the colposcopy if a Pap test and a colposcopy are performed on the same day.

The CSP will reimburse for a short-term repeat colposcopy without biopsy only as active surveillance at 6-month intervals to a biopsy confirmed Cervical Intraepithelial Neoplasia - Grade 2 or 2,3 (CIN2 or 2,3) that is not being actively treated when the client is not eligible for MCTP Active Surveillance.

The CSP will not pay for surveillance or repeat colposcopy when a diagnosis of Cervical Intraepithelial Neoplasia- Grade 1 is obtained, unless the client has a new abnormal Pap test that initiates colposcopy follow-up.

### **(53) Colposcopy-Directed Biopsy**

The CSP will reimburse for:

- a colposcopy-directed biopsy when a colposcopy is performed, lesions are visualized, and a biopsy is taken from one or more lesions

Only one colposcopy fee will be reimbursed regardless of the number of tissue samples taken during biopsy.

### **(54) Gynecologic Consultation (Cervical)**

The CSP will reimburse for:

- a gynecologic consultation prior to a colposcopy in order to discuss the risks and benefits with the client and/or the procedure that is about to be performed
- a gynecologic consultation after a colposcopy but prior to a diagnostic excisional procedure in order to discuss the options available to the client and/or the procedure that is about to be performed

Only one gynecologic consult will be reimbursed, unless it is a second opinion by a participating provider prior to the colposcopy. The CSP will not reimburse for a surgical consult or a second opinion that is completed post-diagnosis. The gynecologic consultation is not intended to be the appointment to discuss results of a Pap test.

### **(56) Diagnostic Loop Electrosurgical Excision Procedure (LEEP) or Loop Electrical Excision of the Transformation Zone (LEETZ) Biopsy** (the process of obtaining a specimen from the transformation zone and endocervical canal for histological evaluation)

The CSP will reimburse for:

- a LEEP or LEETZ biopsy that is performed as a diagnostic procedure and meets the criteria below:
  - the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
  - the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

### **(57) Diagnostic Cold Knife Cone Biopsy**

The CSP will reimburse for:

- a diagnostic cold knife cone biopsy which is performed as a diagnostic procedure and meets the following criteria:
  - the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
  - the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

### **(58) Diagnostic Laser Cone Biopsy**

The CSP will reimburse for:

- a diagnostic laser cone biopsy which is performed as a diagnostic procedure and meets the following criteria:

- the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
- the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

### **(59) Cervical Pathology Tissue**

The CSP will reimburse for:

- one pathology charge when the tissue samples are submitted in one container (in toto)
- multiple pathology charges if the tissue samples are submitted in separate containers
- ECC pathology when the procedure is performed on the same day as the colposcopy

### **(88) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.**

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. (e.g. +LEEP, + cone) It is not used for examination benign specimens.

### **(61) Conventional Cytology**

The CSP will reimburse for:

- conventional cytology when required to be performed at the time of surveillance colposcopy or when the colposcopy for a HSIL or AGC Pap test occurs greater than 5 months after the initial (index) cytology. These are the only instance a Pap test is submitted on the Follow-up Form.

### **(62) Chest X-Ray**

The CSP will reimburse for:

- a pre-operative chest X-ray only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

### **(63) Electrocardiogram (ECG/EKG)**

The CSP will reimburse for:

- a pre-operative ECG/EKG only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

### **(64) Complete Blood Count (CBC)**

The CSP will reimburse for:

- a pre-operative CBC only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

### **(65) High-Risk Human Papillomavirus DNA Test (HR HPV)**

The CSP will reimburse for:

- HR HPV DNA Hybrid Capture 2 high-risk types only or Cervista HR HPV test immediately following a finding of ASCUS (03) on a screening Pap test (reflex testing)
  - when performed at the time as a colposcopy for evaluation of an AGC pap, when HPV testing was not done as part of screening with a Pap test

The CSP will not reimburse for HR HPV testing performed on a Pap test finding greater than ASC, as those clients will be referred to diagnostic evaluation with colposcopy/ECC.

The CSP will not reimburse for HR HPV DNA test performed on the same day as a colposcopy, except in the case of a woman aged 40 and older with a diagnosis of AGC as indicated above.

### **(66) Colposcopy with Cervical Biopsy and Endocervical Curettage (ECC)**

The CSP will reimburse for:

- a colposcopy with cervical biopsy and ECC when a colposcopy is performed, lesions are visualized, a biopsy is taken from one or more lesions and an ECC is performed

### **(67) Colposcopy with ECC**

The CSP will reimburse for:

- a colposcopy without cervical biopsy and an ECC is performed

### **(68) Endometrial Biopsy**

The CSP will reimburse for:

- endometrial biopsy after a Pap test result of AGC (all subcategories except endometrial only) AND the client is either aged 40 years or older with a clinical history of abnormal bleeding or a condition consistent with chronic anovulation (a condition whereby an egg is not released from a woman's ovary)

### **(69) Article 28 – Facility Fee for Diagnostic LEEP, LEETZ, Cold Knife or Laser Cone Biopsy**

The CSP will reimburse for:

- a facility fee for diagnostic LEEP, LEETZ, cold knife or laser cone biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms, personnel and medical-surgical supplies.

### **(70) Anesthesiologist Services**

The CSP will reimburse for:

- anesthesiologist services during diagnostic LEEP, LEETZ, cold knife or laser cone biopsy only when an anesthesiologist or nurse anesthetist administers IV-monitored anesthesia care

An anesthesiologist fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

### **(71) Liquid-based Cytology**

The CSP will reimburse for:

- liquid-based cytology when required to be performed at the time of surveillance colposcopy, or when the colposcopy for a HSIL or AGC Pap test occurs greater than 5 months after the index cytology. These are the only instance a Pap test is submitted on the Follow-up Form.

### **Colorectal Cancer Diagnostic Services**

The following diagnostic procedures will be reimbursed only after a positive multi-slide, take-home fecal test result or if the client is assessed to be at increased or high risk for colorectal cancer or symptomatic for colorectal cancer (see CSP Operations Manual, Chapter 3: Eligibility, [Section C-9](#)). The CSP will reimburse for services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS MCTP (see CSP Operations Manual, [Chapter 7](#): NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below are the codes for each procedure that should be indicated on the CSP Follow-up Form and on Indus.

### **(32) Flexible Sigmoidoscopy**

The CSP will reimburse for:

- a flexible sigmoidoscopy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

### **(33) Flexible Sigmoidoscopy with Polypectomy by Hot Biopsy Forceps or Cautery**

The CSP will reimburse for:

- a flexible sigmoidoscopy with polypectomy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy with polypectomy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

### **(34) Flexible Sigmoidoscopy with Biopsy (Single or Multiple)**

The CSP will reimburse for:

- a flexible sigmoidoscopy with biopsy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy with biopsy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

### **(35) Radiologic Exam; Colon, Barium Enema**

The CSP will reimburse for:

- a double contrast barium enema (DCBE) when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a DCBE when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

### **(36) Colonoscopy**

The CSP will reimburse for:

- a diagnostic colonoscopy following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer, according to CSP eligibility and guidance for prior approval. See CSP Operations Manual Chapter 3: Eligibility, Section C-9 and Chapter 4: Cancer Screening Guidance, Section E for more information.
- a repeat colonoscopy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

### **(37) Colonoscopy with Biopsy (Single or Multiple)**

The CSP will reimburse for:

- a diagnostic colonoscopy with biopsy following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy with biopsy for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (see CSP Operations Manual, Chapter 3: Eligibility, Section C-9)
- a repeat colonoscopy with biopsy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

### **(38) Colonoscopy with Removal of Tumor(s), Polyp(s), by Hot Biopsy Forceps or Bipolar Cautery**

The CSP will reimburse for:

- a diagnostic colonoscopy with hot biopsy or bipolar cautery following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy with hot biopsy or bipolar cautery for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (See Chapter 3: Eligibility, Section C-10)
- a repeat colonoscopy with biopsy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

### **(39) Colonoscopy with Removal of Tumor(s), Polyp(s) By Snare Technique**

The CSP will reimburse for:

- a diagnostic colonoscopy by snare technique following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy by snare technique for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (see CSP Operations Manual Chapter 3: Eligibility, Section C-9)
- a repeat colonoscopy by snare technique if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

### **(41) Anesthesiologist Services**

The CSP will reimburse for:

- monitored anesthesia care (MAC) only when medically indicated and administered by an anesthesiologist/anesthetist

The CSP will not reimburse for the administration of medication and monitoring of the patient performed by the endoscopy team. The presence of an anesthesiologist/anesthetist will not be

deemed medically necessary, except in those rare instances when a client has a pre-existing unstable medical condition. For more information, see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, [Section F](#).

Conscious sedation (such as with Versed and Demerol) is included in the reimbursement fee for colonoscopy.

### **(42) Surgical Pathology, Gross and Microscopic Examination**

The CSP will reimburse for:

- surgical pathology of tissue removed during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)
- multiple pathologies of tissue samples if removed and analyzed separately during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)

### **(87) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.**

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. It is not used for examination benign specimens.

### **(43) Medical or Surgical Consultation**

The CSP will reimburse for:

- a consultation following a positive multi-slide, take-home fecal test kit result and prior to a colonoscopy, sigmoidoscopy, or barium enema or following the identification of symptoms of colorectal cancer
- a medical consultation for a client who is determined at increased or high risk for colorectal cancer according to CSP guidance prior to a colonoscopy, sigmoidoscopy, or barium enema. For more information, see CSP Operations Manual, Chapters 3 and 4
- a medical consultation for a client age 50-64 who presents with symptoms as outlined in CSP Operation Manual, Chapter 3: Eligibility, Sections C-9 and C-10. If the GI consult does not result in a colonoscopy at this time, the CSP Data Unit must be contacted to provide an override for this service
- a second opinion by another program provider occurring prior to a colonoscopy, sigmoidoscopy, or barium enema
- a medical consultation provided for an increased- or high-risk client at an eligible interval determined by prior colonoscopy (see Attachment 6-III) where the GI consult does not result in a colonoscopy at this time. Contact the CSP Data Unit to provide an override to allow for this service

The CSP will not reimburse for a medical consultation that is completed post-diagnosis. The CSP will not reimburse for a medical or surgical consultation to determine if a client is increased or high-risk.

#### **(45) Chest X-Ray**

The CSP will reimburse for:

- a pre-operative chest x-ray provided only prior to a colonoscopy,

#### **(46) Electrocardiogram (EKG/ECG)**

The CSP will reimburse for:

- a pre-operative EKG provided only prior to a colonoscopy,

#### **(47) Complete Blood Count (CBC)**

The CSP will reimburse for:

- a pre-operative CBC provided only prior to a colonoscopy,

#### **(48) Facility Fee – Sigmoidoscopy**

The CSP will reimburse for:

- a facility fee for a sigmoidoscopy performed at an Article 28 facility
- a facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies

#### **(49) Facility Fee – Colonoscopy**

The CSP will reimburse for:

- a facility fee for a colonoscopy performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. The facility fee does not apply to non-Article 28 accredited office-based surgery practices.

#### **(50) Second Technique – Colonoscopy Biopsy Procedure**

The CSP will reimburse for:

- a second biopsy technique performed during a colonoscopy.

This reimbursement addresses the additional expense associated with performing a second biopsy technique. For example, one polypectomy may be performed using the snare technique (procedure code 39), while another polypectomy may be performed using hot biopsy forceps (procedure code 38) during the same colonoscopy procedure. In this example, the more expensive procedure (snare technique) should be entered on the Follow-up Form using

procedure code 39. The second technique by hot biopsy forceps should be entered on the Follow-up Form using procedure code 50.

A second technique will not be reimbursed if more than one polyp is removed using the same technique.

### **5. Re-screening after a CSP-funded Colonoscopy**

- Refer to [Attachment 6-III](#) for detailed reimbursement criteria about what colorectal cancer screening and diagnostic services can be reimbursed and when those services can be reimbursed after a CSP-funded colonoscopy has been completed

These reimbursement criteria are not eligibility guidelines for an initial screening through the CSP. For eligibility guidelines, refer to CSP Operations Manual Chapter 3: Eligibility, [Section C-9](#).

## Attachment 6-I NYSDOH CSP Reimbursement Schedule

New York State Department of Health Reimbursement Schedule 4/1/2014 - 3/31/2015							
	INDUS Proced ure Codes	Guiding CPT Code(s)***	<-----Medicare Regions ----->				
			Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
<b>Breast/Cervical Procedures</b>							
Screening mammogram - bilateral (film or digital) **	SIF	77057	\$87.58*	\$94.33	\$97.23	\$87.58*	\$96.69
Screening mammogram - bilateral diagnostic (film or digital) **	SIF	77056	\$110.54	\$132.61	\$136.80	\$122.81	\$135.94
Screening mammogram - unilateral diagnostic (film or digital) **	SIF	77055	\$87.20*	\$103.09	\$106.34	\$95.49	\$105.69
Assessment, education and CBE	SIF	99201	\$41.43	\$49.15	\$50.57	\$45.65	\$50.39
Assessment, education and pelvic exam with Pap test	SIF	99201	\$41.43	\$49.15	\$50.57	\$45.65	\$50.39
Repeat CBE	2	1/2 of 99201	\$20.72	\$24.58	\$25.29	\$22.88	\$25.20
Diagnostic mammogram - unilateral (film or digital) **	1	77055	\$87.20*	\$103.09	\$106.34	\$95.49	\$105.69
Diagnostic mammogram bilateral	90	77056	\$110.54	\$132.61	\$136.80	\$122.81	\$135.94
Diagnostic breast US ( <b>unilateral or bilateral</b> ) w/image documentation	4	76645	\$94.77	\$114.98	\$118.99	\$106.18	\$118.07
Fine needle aspiration biopsy without image guidance	29	10021	\$142.25	\$173.09	\$179.43	\$159.91	\$178.53
Fine needle aspiration biopsy with image guidance	7	10022	\$134.29	\$161.16	\$166.38	\$149.33	\$165.55
Core biopsy	8	19100	\$142.53	\$74.36	\$181.18	\$160.98	\$180.31
Incisional biopsy	9	19101	\$321.86	\$393.32	\$408.71	\$363.35	\$407.10
Pre-operative ultrasonic needle localization and wire placement	22	19285	\$446.68	\$545.49	\$565.38	\$502.82	\$560.29
Additional US needle loc and wire placement for second lesion	85	19286	\$374.35	\$458.25	\$475.06	\$421.98	\$470.25
Pre-operative mammographic needle localization and wire placement	15	19281	\$233.73	\$280.96	\$290.12	\$260.17	\$288.47
Additional mammographic needle loc and wire placement second lesion	83	19282	\$162.40	\$195.16	\$201.32	\$180.57	\$199.78

Excisional biopsy	10	19120	\$468.26	\$571.12	\$593.66	\$528.29	\$592.52
Stereotactic biopsy procedure-breast - <b>all inclusive</b> of placement of breast localization device(s), (e.g., clip, metallic pellet), imaging of the biopsy specimen, percutaneous bx; first lesion, including stereotactic guidance	16	19081	\$641.99	\$791.11	\$822.91	\$728.43	\$816.64
Each additional lesion, including stereotactic guidance	84	19082	\$520.01	\$638.51	\$662.88	\$587.87	\$656.71
US guided vacuum-assisted biopsy breast - <b>all inclusive</b> of placement of breast localization device(s) (e.g., clip, metallic pellet)imaging of the biopsy specimen, percutaneous bx; first lesion, including ultrasound guidance	25	19083	\$637.92	\$785.53	\$816.83	\$723.31	\$810.42
Each additional lesion, including US guidance	86	19084	\$512.92	\$629.88	\$653.91	\$579.87	\$647.75
Article 28 facility fee - Core Biopsy	23	APC 0005	\$702.08	\$702.08	\$702.08	\$702.08	\$702.08
Article 28 facility fee - incisional/excisional biopsy	24	APC 0028	\$1,974.26	\$1,974.26	\$1,974.26	\$1,974.26	\$1,974.26
<b>Cervical Diagnostics</b>							
Colposcopy without biopsy	52	57452	\$106.09	\$127.31	\$131.67	\$118.18	\$131.53
Colposcopy with cervical biopsy and ECC	66	57454	\$150.03	\$179.58	\$185.66	\$166.86	\$165.66
Colposcopy with one or more cervical biopsies	53	57455	\$139.27	\$167.46	\$173.32	\$155.39	\$173.15
Colposcopy with ECC	67	57456	\$131.75	\$158.56	\$164.15	\$147.10	\$163.96
Endometrial biopsy	68	58100	\$106.62	\$128.29	\$132.89	\$119.03	\$132.69
High-risk HPV DNA hybrid capture 2 or Cervista HR	65	87621	\$47.87	\$47.87	\$47.87	\$47.87	\$47.87
Pap smear cytology, conventional	SIF, 61	88164	\$14.42	\$14.42	\$14.42	\$14.42	\$14.42
Pap smear cytology, liquid based prep	SIF, 71	88142	\$27.64	\$27.64	\$27.64	\$27.64	\$27.64
Fluid cytology, breast and nipple, (not vaginal / cervical)	11,14	88173	\$140.74	\$166.36	\$170.85	\$154.60	\$169.88
Diagnostic LEEP/LEETZ	56	57461	\$309.58	\$374.84	\$388.42	\$346.98	\$387.11

Diagnostic cone biopsy- cold knife or laser	CKC 57, LC 58	57520	\$297.27	\$357.49	\$369.96	\$331.66	\$369.47
Article 28 facility fee - diagnostic LEEP/LEETZ, etc.	69	APC 0193	\$1,375.00	\$1,375.00	\$1,375.00	\$1,375.00	\$1,375.00
<b>Colorectal Procedures</b>							
FOBT kit processing	SIF	82270	\$4.44	\$4.44	\$4.44	\$4.44	\$4.44
FIT	SIF	82274	\$16.99	\$21.70	\$21.70	\$21.70	\$21.70
Colonoscopy	36	45378 or G0121 or G0105	\$374.24	\$453.13	\$469.33	\$419.26	\$467.28
Colonoscopy w/biopsy single or multiple	37	45380	\$445.83	\$538.92	\$ 557.88	\$498.80	\$555.45
Colonoscopy w/removal of tumor(s), polyp(s) by hot biopsy	38	45384	\$446.11	\$539.09	\$558.12	\$499.09	\$555.94
Colonoscopy w/removal of tumor(s), polyp(s) by snare technique	39	45385	\$503.36	\$607.72	\$628.98	\$562.73	\$626.53
Sigmoidoscopy	32	45330	\$130.94	\$159.02	\$164.72	\$146.92	\$163.68
Sigmoidoscopy with polypectomy	33	45333	\$284.70	\$347.59	\$360.57	\$320.71	\$358.05
Flexible sigmoidoscopy with biopsy	34	45331	\$156.58	\$190.51	\$197.46	\$175.95	\$196.23
Radiological exam; colon, barium enema	35	74270	\$153.12	\$186.18	\$192.73	\$171.79	\$191.07
2 <sup>nd</sup> Technique- colonoscopy dir bx	50	n/a	\$90.86	\$108.78	\$112.33	\$100.95	\$112.03
Article 28 facility fee - colonoscopy	49	APC 0158	\$ 645.73	\$646.73	\$646.73	\$646.73	\$646.73
Article 28 facility fee - sigmoidoscopy	48	APC 0146	\$461.00	\$461.00	\$461.00	\$461.00	\$461.00
<b>Other Procedures</b>							
Surgical consultation	3, 54, 43	99203	\$103.55	\$122.19	\$125.59	\$113.75	\$125.35
Anesthesiologist fee	18, 70, 41	n/a	\$150.00	\$150.00	\$150.00	\$150.00	\$150.00
Chest X-ray	19, 62, 45	71020	\$29.61	\$35.71	\$36.90	\$33.04	\$36.66
CBC - complete blood count pre-operative testing	21, 64, 47	85025	\$10.55	\$10.61	\$10.61	\$10.61	\$10.61
EKG	20, 63, 46	93000	\$16.01	\$19.21	\$19.84	\$17.81	\$19.76
Surgical pathology - level IV-gross and microscopic	12, 59, 42	88305	\$67.8	\$79.57	\$81.52	\$74.08	\$81.17

Surgical pathology - level IV- needing examination of surgical margins; some excisional, LEEP, cone, and some polyps	82, 87, 88	88307	\$274.45	\$330.44	\$341.04	\$305.58	\$338.35
*Reimbursement rates are the higher of either the NY regional Medicare rate or the NYS Medicaid fee.							
**NYS provides reimbursement for digital mammography and or mammography with CAD at the conventional film rate							
***These CPT codes are for reference only. Reimbursement is not limited to these CPT codes. Other CPT codes that fulfill the service/procedure as listed may also be reimbursed at these rates.							

## **Attachment 6-II Guidance for CSP Contractors & Title X Family Planning Providers**

### **Guidance for Cancer Services Program Contractors and Title X Family Planning Providers July 2009**

This information is being provided to assist CSPs and providers with understanding client eligibility for CSP reimbursable services when clients are referred to Title X family planning providers. As of April 1, 2009, the CSP eligibility for reimbursable services changed to serve women ages 40 years and older. There are a few exceptions to this, which are outlined in the CSP policy. See CSP Operations Manual Chapter 4: Cancer Screening Guidance, [Section H](#) (*CSP Policy for Breast Cancer Screening for Women below the Age of 40*).

However, clients 40 years of age and older who are referred to a Title X family planning provider should not automatically be assured that the visit will qualify for submission to the CSP for reimbursement.

The NYS Department of Health recommends that clients receive, as appropriate, the full range of services for which they are eligible. Therefore, if a woman 40 years of age or older presents to a Title X family planning provider for a visit (annual exam) for breast cancer screening (CBE) and cervical cancer screening (pelvic exam, Pap test and /or HR HPV DNA) and is also in need of contraceptive services, the full range of services are to be provided.

Therefore, when a client aged 40 years or older requires information and a service to regulate fertility, the visit becomes a Title X family planning visit; the breast and/or cervical cancer screening performed at this family planning visit are not eligible for CSP reimbursement. Clients who receive Title X eligible services will be assessed and assigned to a sliding fee scale for the Title X family planning visit.

A woman 40 years of age and older who has breast and/or cervical cancer screening at a family planning provider and who meets CSP eligibility will still qualify for a CSP-reimbursable mammogram at a CSP-participating provider, whether or not she is a Title X client. Title X does not cover breast imaging services.

It is recommended that clients referred by CSP contractors to Title X family planning providers be informed at the time of referral, that if, at the time of the visit for breast and/or cervical cancer screening, they need or require any services related to birth control or family planning, the visit will not be eligible for CSP reimbursement and that they will be responsible for the fee-scaled cost of the visit. CSP contractor staff members are not required to triage or ask women questions about their methods of contraception. However, CSP contractor staff must communicate to a woman referred to a Title X family planning provider that the cancer screening services at this visit may not be reimbursable by the CSP.

Some examples of this include:

- *A 40-year-old woman is referred by CSP contractor staff to a Title X family planning provider for breast and cervical cancer screening. During the visit, the woman indicates that she needs either a new prescription or renewal for birth control (oral contraceptives, NuvaRing, Evra, Depo-Provera, etc.). The visit becomes a Title X family planning visit and is not eligible to be billed to the CSP.*
- *A 40-year-old woman is referred by CSP contractor staff to a Title X family planning provider for breast and cervical cancer screening and she has an IUD. If at the visit there is a need to*

discuss a problem with her IUD or the need to change the method, then it is not a CSP-eligible visit: this constitutes a Title X family planning visit, which is not eligible for CSP reimbursement. If however, she has an IUD, but there is no required counseling or method change for this client, and all that is performed is her routine breast and cervical cancer screening, then it is a CSP eligible visit.

- *A 40-year-old woman had a tubal ligation at age 37 and is not in need of any services for birth control or regulation of her fertility; she requests breast and cervical cancer screening. This woman is CSP-eligible. If however, at the time of the visit, she requests counseling and information regarding reversal of her tubal ligation so that she might achieve another pregnancy, the visit would then be a Title X family planning visit and is not reimbursable by the CSP.*
- *A 40-year-old woman is relying on her male partner's vasectomy as her method of birth control. This woman is eligible for breast and cervical cancer screening. However, if this same woman indicates at the time of the visit that while one of her partners has a vasectomy, she has another partner, who does not and needs to discuss the use of other methods of birth control, including the use of condoms, that visit now becomes a Title X family planning visit and is not reimbursable by the CSP.*
- *A 40-year-old woman has a same sex partner and is not in need of contraception or a 40-year-old woman is not sexually active and requires no information or services related to birth control or the regulation of her fertility. This woman is eligible for a CSP-reimbursed visit for breast and cervical cancer screening. If, in either of these situations, the woman indicated at the visit that she needed information regarding planning a pregnancy, then the visit is not eligible for CSP reimbursement. This example would include the client with a same sex partner who is interested in information regarding her and her partner attempting a pregnancy with a donor. This is not a CSP eligible visit*

## Attachment 6-III Rescreening Reimbursement Criteria Following Program-Funded Colonoscopy

### New York State Department of Health Cancer Services Program Re-screening Reimbursement Criteria Following a Program-Funded Colonoscopy

This document outlines CSP criteria for the reimbursement of re-screening after a CSP-funded colonoscopy. These criteria are based on the updated recommendations of the American Cancer Society (ACS)<sup>1</sup>, the American College of Gastroenterology (ACG)<sup>2</sup>. These criteria are not eligibility guidelines for an initial screening through the CSP. Furthermore, these criteria are not clinical guidelines. These criteria pertain only to the reimbursement of services through the CSP. Alternate funds must be identified to reimburse for services that are recommended by providers, but are not covered through the CSP.

Information about the client's risk status and findings from the previously funded colonoscopy must be taken into account to determine what subsequent services will be reimbursed and when those services will be reimbursed after a CSP-funded colonoscopy. The following are three examples of situations that might occur:

1. A client enrolled in the CSP had a positive fecal test and a subsequent diagnostic colonoscopy. The final diagnosis was hemorrhoids. This client would now be eligible for reimbursement for a fecal test no sooner than five years after that previously funded colonoscopy. Please note: An annual fecal test is not recommended for five years after a colonoscopy has been performed.<sup>3</sup> The CSP will not reimburse for annual fecal tests for five years following a program-funded colonoscopy.
2. A client enrolled in the CSP is determined to be at increased risk due to a family history of colorectal cancer in a first-degree relative. During the colonoscopy, the client was found to have 2 small (<10mm) adenomatous polyps. This client would now be eligible for reimbursement for a colonoscopy no sooner than three years after that last colonoscopy. Please note: If the physician recommends that the next colonoscopy be scheduled five years later, then the client should be recalled for the next colonoscopy in five years. These reimbursement criteria represent the minimum time interval between reimbursable services.
3. A client enrolled in the CSP (regardless of risk status) was referred for a colonoscopy, which was unable to be completed. Reasons why a colonoscopy could not be completed include, but are not limited to, poor bowel preparation, client's inability to tolerate the procedure, or incomplete polypectomy or biopsy. In this case, the client would be eligible for another colonoscopy within one year of that incomplete colonoscopy. Ideally, the client should be scheduled for another colonoscopy as soon as possible.

The table below outlines the combination of scenarios when an enrolled client would be eligible for reimbursement for a subsequent colonoscopy or fecal test based on risk status and findings of the previously funded colonoscopy.

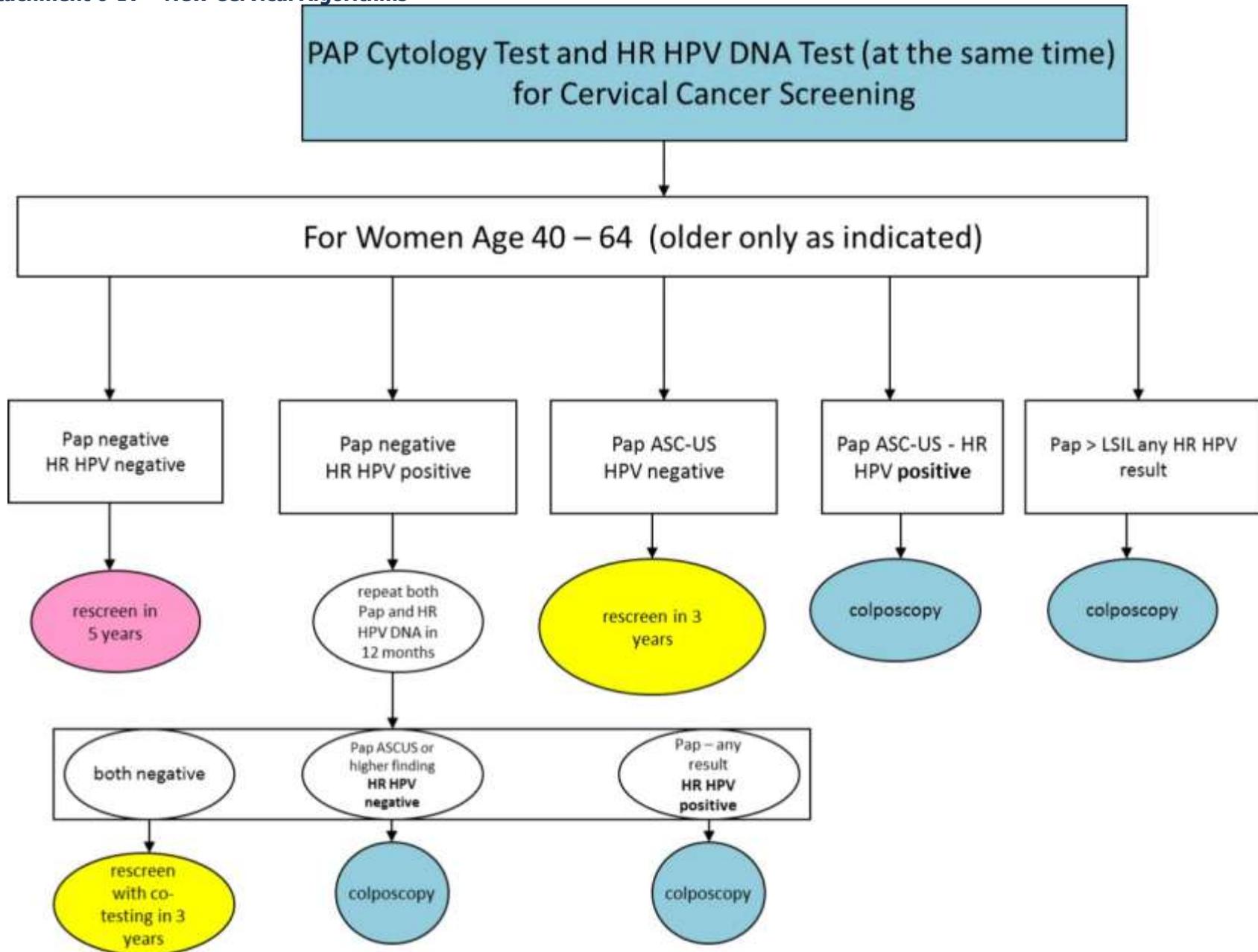
While these criteria address the majority of situations that may occur, individual cases may still warrant consultation with CSP staff. Should you have any questions, please feel free to contact your regional manager or NYSDOH CSP Clinical Care Unit staff at (518) 474-1222.

#### References:

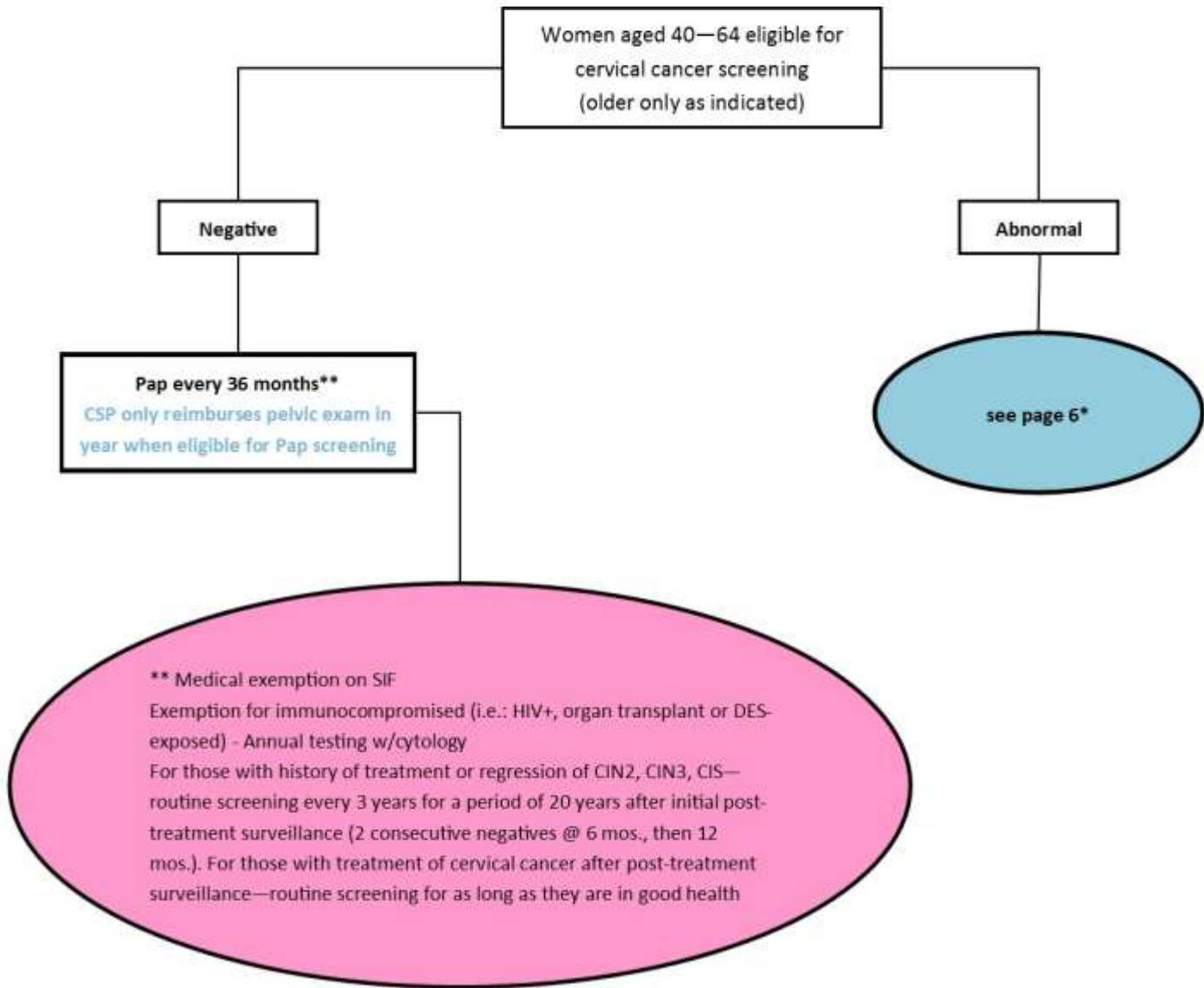
1. Lieberman D, Rex D, Winawer S, Giardiello F, Johnson D, Levin T, Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology* 2012; 143:844-857.
2. Winawer S, Zauber A, Fletcher R, Stillman J, et al. American Cancer Society Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *CA A Cancer Journal for Clinicians*. On line at <http://onlinelibrary.wiley.com/doi/10.3322/canjclin.56.3.143/abstract>

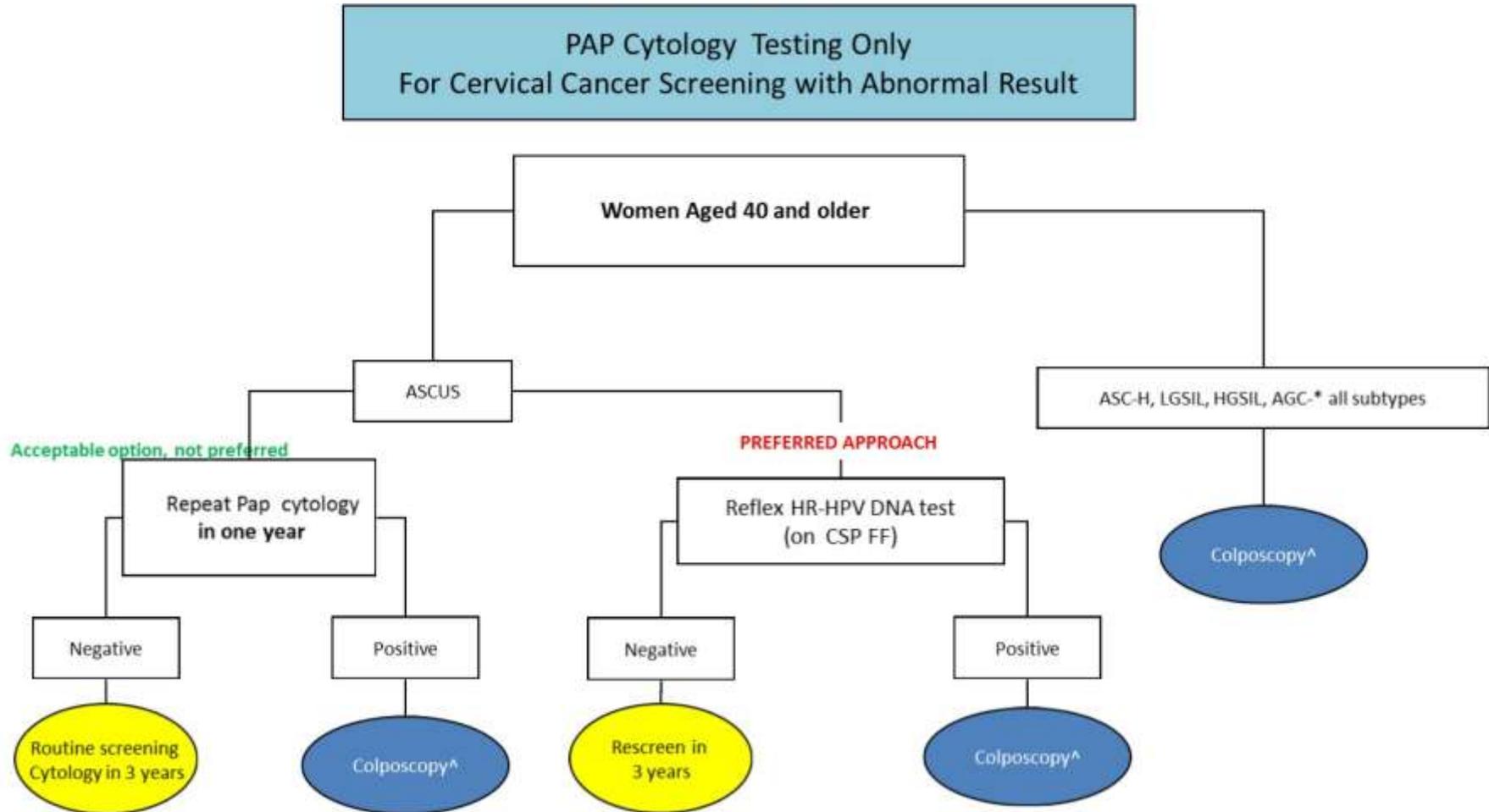
Finding on Most Recent Colonoscopy	Eligible for Reimbursement for:			
	Colonoscopy			Fecal Test
	< 1 Year	≥ 1 Year	≥ 3 Years	≥ 5 Years
<b>During the previous CSP screening visit, the client completed a program-funded diagnostic colonoscopy, because the client was either 1) average risk, asymptomatic, age 50 or older and had a positive fecal test or 2) average risk, symptomatic, age 50 to 64.<sup>2</sup></b>				
1 <sup>st</sup> Colonoscopy was unable to be completed with no final diagnosis determined (this is a repeat colonoscopy) or incomplete removal of sessile serrated polyp/removed piecemeal with retention	√			
Colorectal Cancer diagnosed and cancer treatment completed		√		
Adenomatous polyposis syndrome (>10 adenomas) or serrated polyposis syndrome		√		
Inflammatory Bowel Disease			√	
Crohn's Disease			√	
Chronic Ulcerative Colitis			√	
Adenomatous Polyp			√	
Other Polyps				√
Hemorrhoids				√
Diverticulitis				√
Other Diagnosis				√
No Abnormality At This Time				√
<b>During the previous CSP screening visit, the client completed a program-funded screening colonoscopy, because the client was at increased or high risk for colorectal cancer, regardless of whether symptoms were present.<sup>2</sup></b>				
1 <sup>st</sup> Colonoscopy was unable to be completed with no final diagnosis determined (this is a repeat colonoscopy) or incomplete removal of sessile serrated polyp/ removed piecemeal with retention	√			
Colorectal Cancer diagnosed and cancer treatment completed		√		
Adenomatous polyposis syndrome (>10 adenomas) or Serrated polyposis syndrome		√		
Inflammatory Bowel Disease			√	
Crohn's Disease			√	
Chronic Ulcerative Colitis			√	
Adenomatous Polyp			√	
Other Polyps			√	
Hemorrhoids			√	
Diverticulitis			√	
Other Diagnosis			√	
No Abnormality At This Time			√	

**Attachment 6-IV – New Cervical Algorithms**



**Pap Cytology Testing Only**  
(conventional or liquid-based for cervical cancer screening)



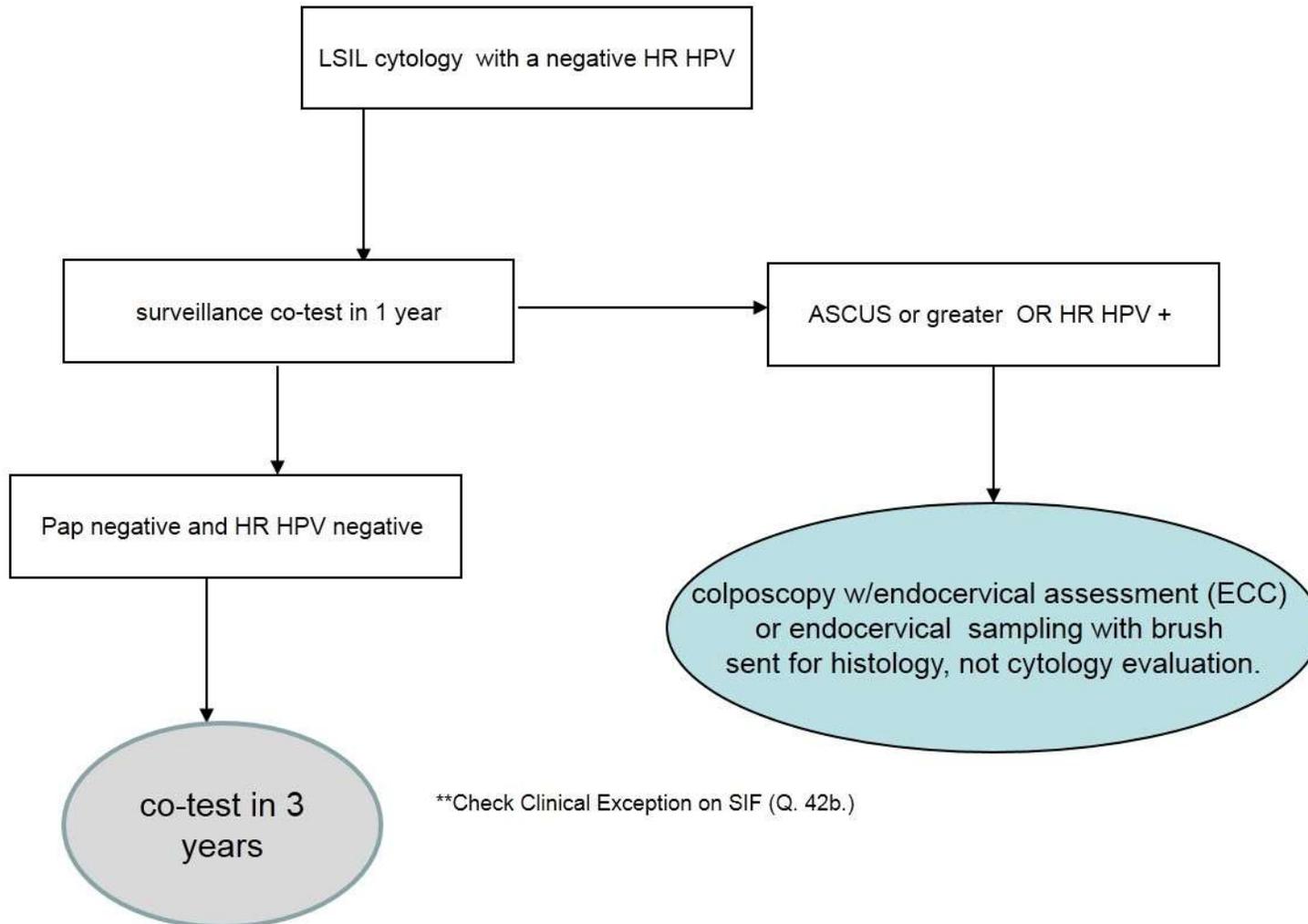


\*The CSP will reimburse for HR HPV DNA test at time of colposcopy for AGC- all subtypes if not part of screening (except when specified "atypical endometrial" only)

^See CSP Diagnostic Algorithms Reimbursement .

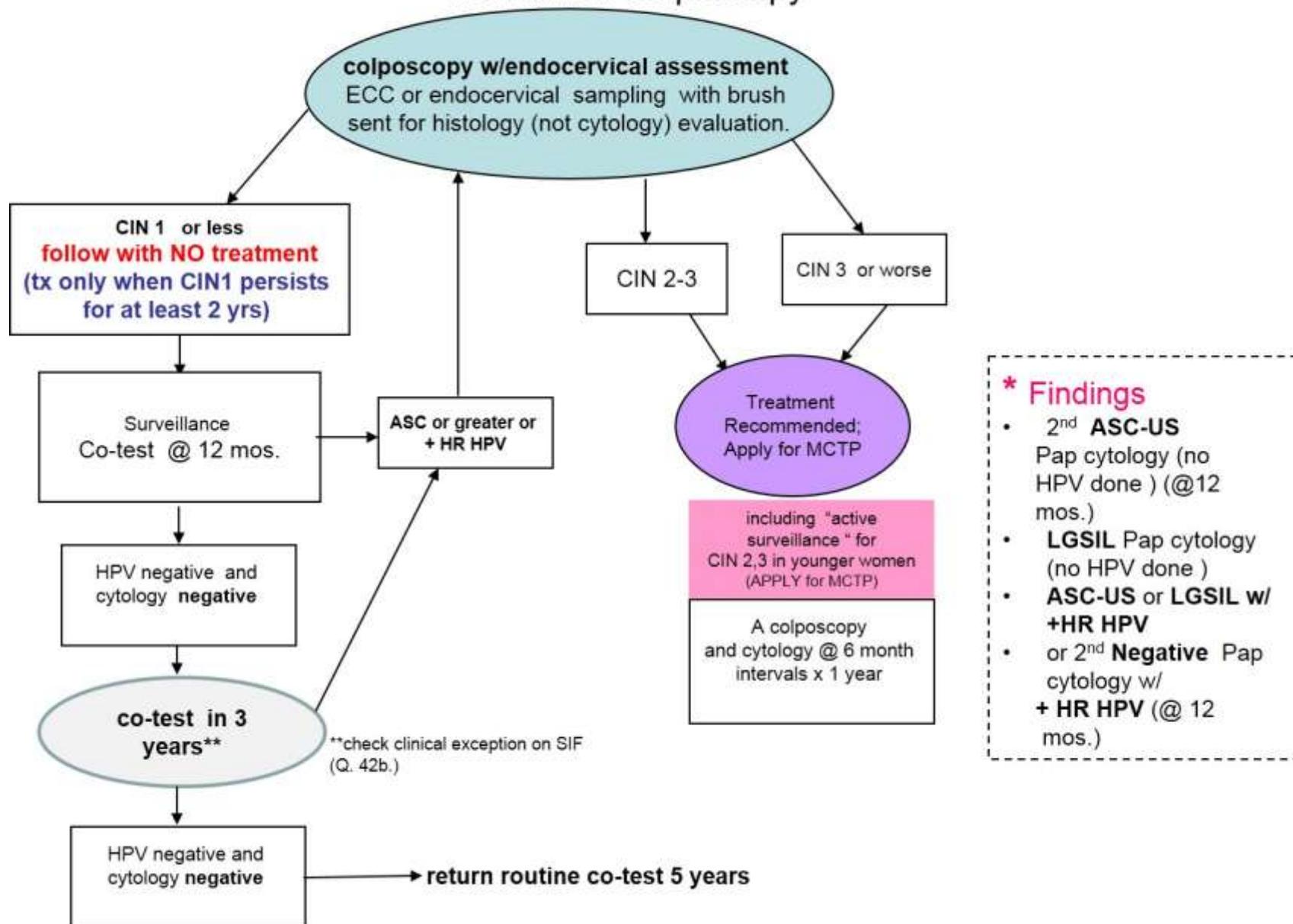
Attachment 6-V: Reimbursement Guidelines Algorithms for Cervical Cancer Diagnostic Follow-up Procedures

# LSIL Pap cytology with negative HR HPV as co-test

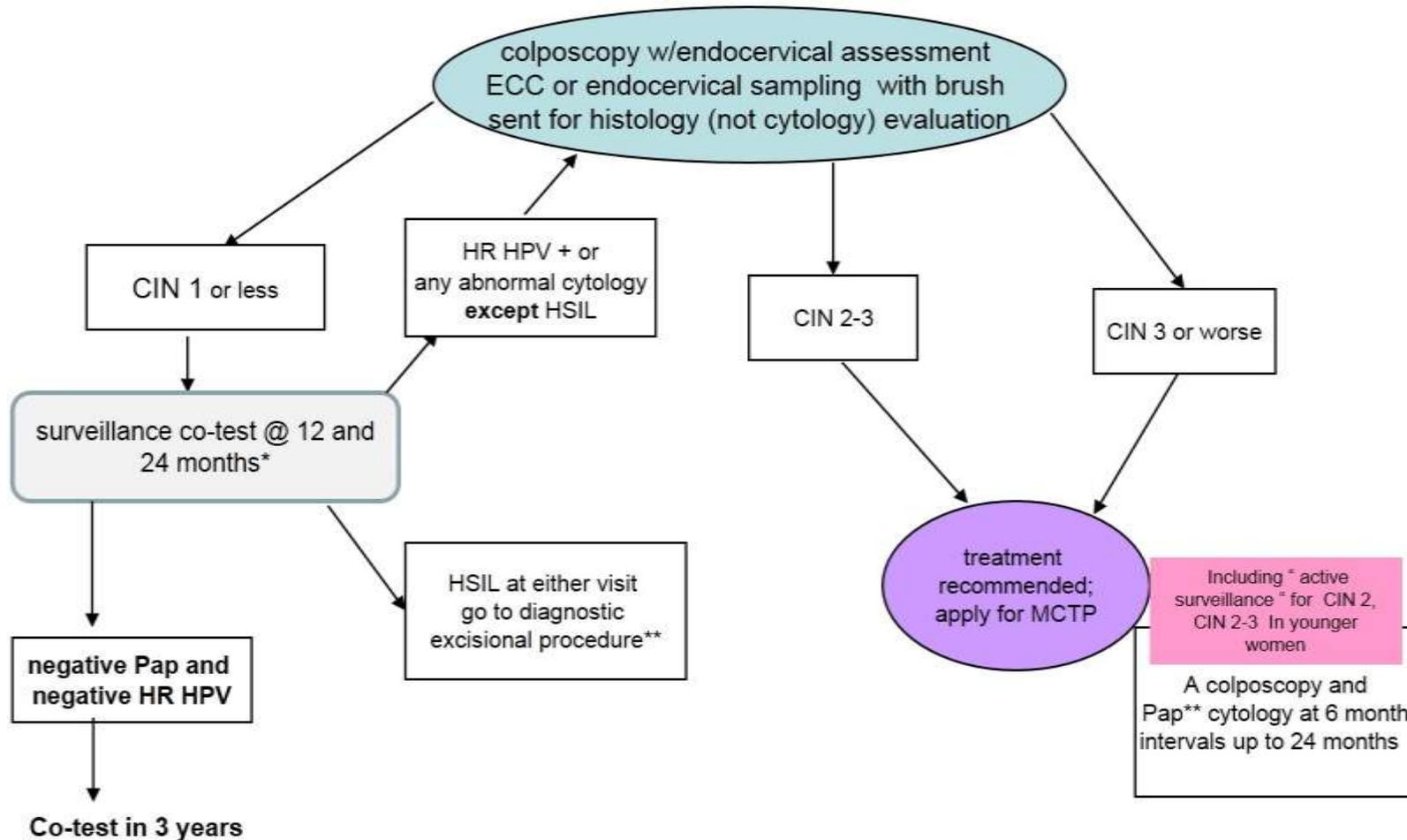


\*\*Check Clinical Exception on SIF (Q. 42b.)

## Minor Grade Cytology or HR HPV+ Findings\* That Refer a CSP-eligible Woman for Colposcopy



## ASC-H or HSIL Cytology That Refers a Woman Age 40 or Older for Colposcopy (regardless of HR HPV status)

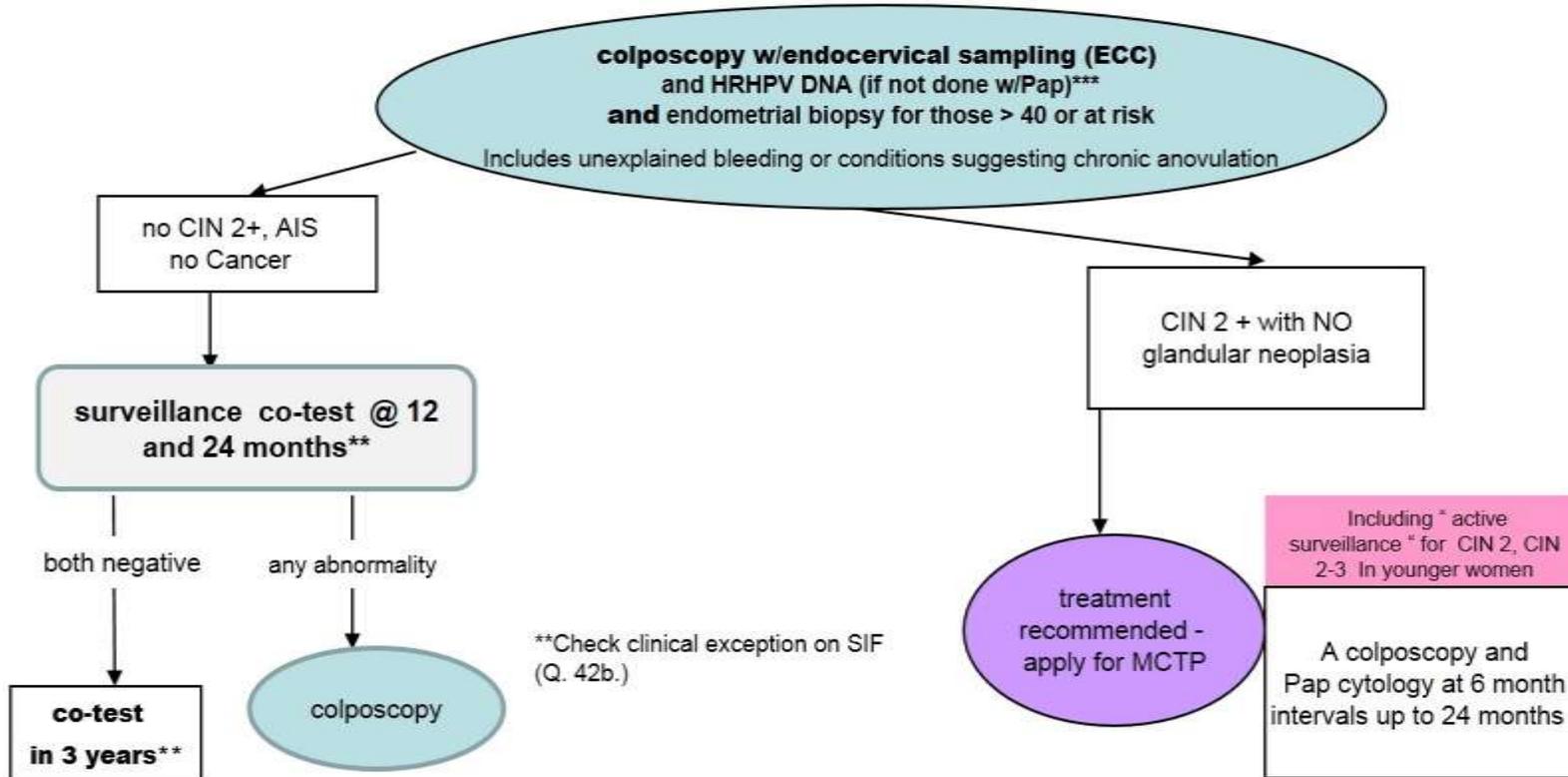


\* provided colposcopy is satisfactory (Check clinical exception for 24 mo. pap and co test in 3 years on SIF (Q. 42b.))

\*\*diagnostic excisional procedure (LEEP) (on CSP FF) is only reimbursed when the colposcopy is inadequate or if HSIL is found on surveillance testing. Should be an intact specimen with interpretable margins. ECC performed after excision /post procedure on same day is preferred.

## Cytology That Referred a Woman Age 40 or Older for Colposcopy Atypical Glandular Cells NOS (not otherwise specified)

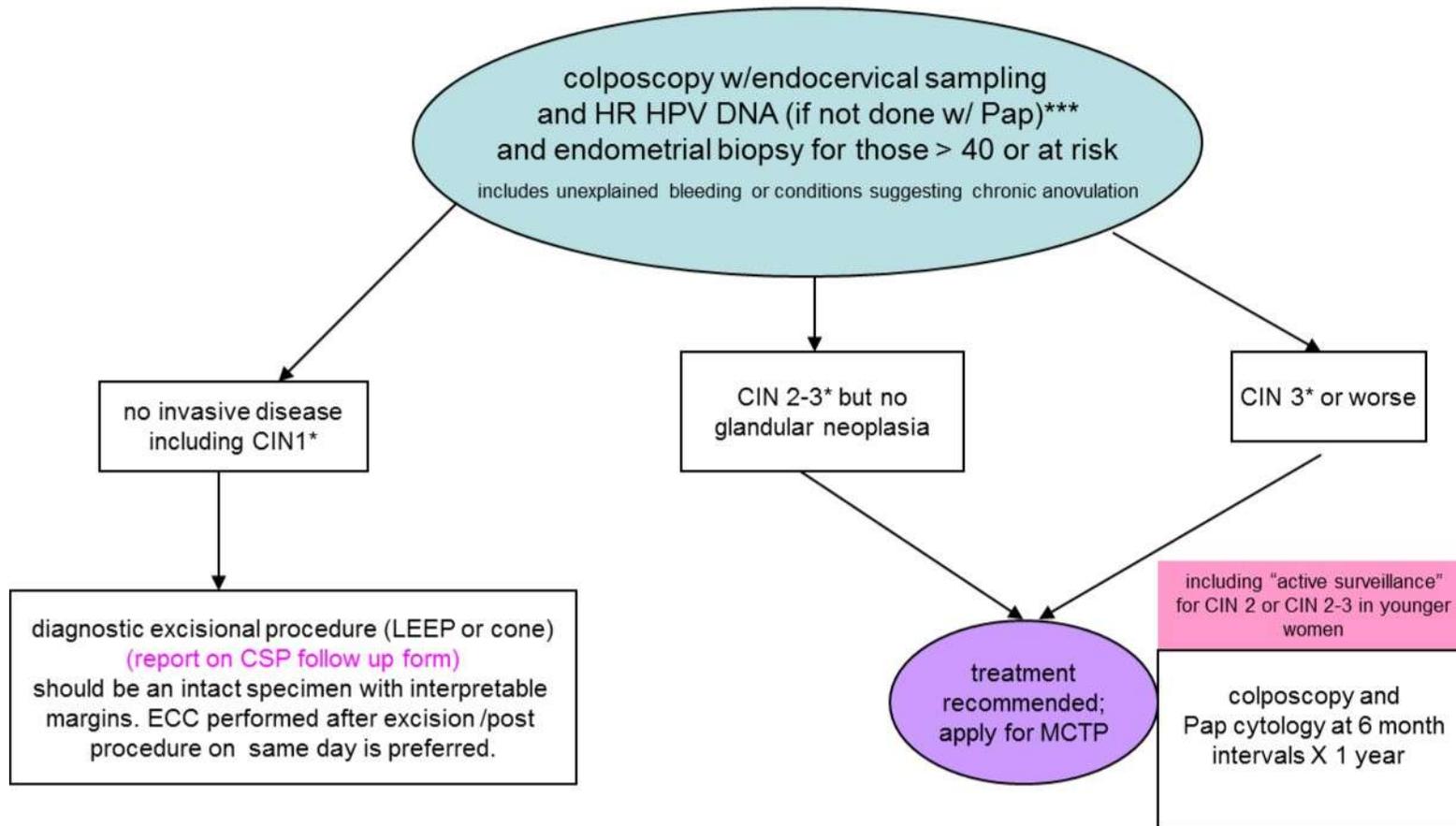
All sub-types-**except atypical endometrial** ∞



∞The CSP does not reimburse for services to evaluate a finding of atypical endometrial cells (only) in the cervical cancer screening program as the evaluation that is required is for endometrial conditions, not cervical. ( i.e., endometrial biopsy/ECC) . However, if there is no endometrial pathology and client continues to colposcopy, the endo biopsy gets reported as “other funds” and the CSP will reimburse for colposcopy evaluation of cervical abnormality.

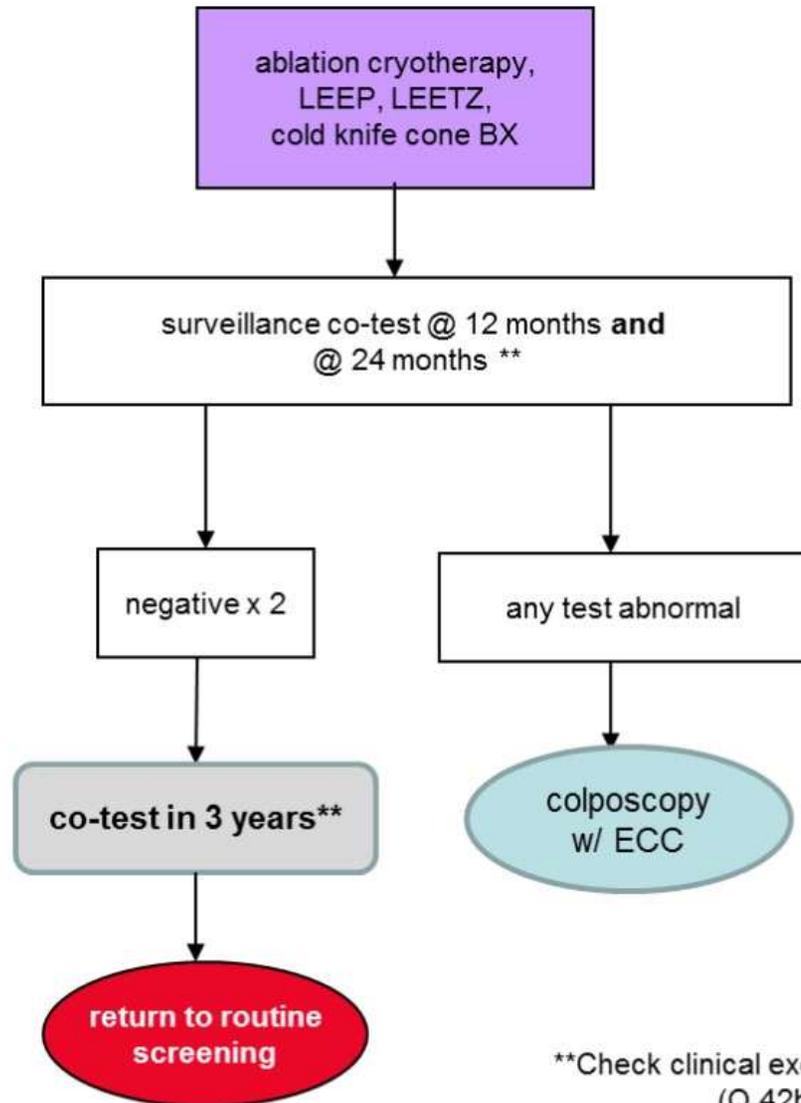
\*\*\* Repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap until colposcopy is performed. (Report on CSP Follow up form)

## Cytology That Referred a Woman Age 40 or Older to Colposcopy AGC favors neoplasia or adenocarcinoma in situ



\*\*\* A repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap, until colposcopy is performed (report on CSP Follow up form)

## CSP Reimbursement of Follow-up After Active Treatment of **CIN 2, CIN 3 or Greater** (diagnosis by histology)



**Attachment 6-VI: MCTP Enrollment for Cervical Dysplasia**

### Enrollment in MCTP for Cervical Dysplasia

The Medicaid Cancer Treatment Program (MCTP) is available for treatment of CIN 1, CIN2, CIN 3 for all eligible women in NYS. The CSP does not provide screening/diagnostic testing for women ages 18-39. However, for eligible women 18 years of age and older for whom treatment, including active surveillance for CIN 2,3 is recommended, an application to the MCTP should be made.

