

WISCONSIN WELL WOMAN PROGRAM (WWWP)
REIMBURSEMENT RATES
EFFECTIVE July 1, 2026 – June 30, 2027

WWWP services include **only** the breast and cervical cancer screening and diagnostic services listed here. The listed services are reimbursable per WWWP guidelines for covered **screenings and diagnostics**. The **type and duration of allowed office visits** used by the provider should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the WWWP, and reimbursement is not to exceed those rates published by Medicare. While the use of **Preventive Medicine Office Visits** themselves **are not appropriate** for the WWWP, these services, if used, shall be reimbursed at or below the 99203 or 99213 Evaluation and Management Code rate of reimbursements. WWWP allowed Staged Assessment for Multiple Sclerosis procedure codes for high-risk women are listed in a separate Multiple Sclerosis guidance.

Procedure Code	Current Procedural Terminology (CPT) Description	Reimbursement Rate	Multiple Units Yes/No	Modifier Yes/No	Professional (26)	Technical (TC)
EVALUATION AND MANAGEMENT – <i>Use these codes as primary coding for WWWP office visits</i>						
99202	New Patient – 15-29 minutes	\$71.78	No	No		
99203	New Patient – 30-34 minutes	\$111.40	No	No		
99211*	Established – Time Not Specified	\$23.39	No	No		
99212	Established – 10-19 minutes	\$56.64	No	No		
99213	Established – 20-29 minutes	\$91.06	No	No		
99214	Established – 30-39 minutes	\$129.57	No	No		
OFFICE VISIT						
G0101	Office visit – cervical cancer screening; pelvic and clinical breast examination (CBE)	\$37.18	No	No		
99459	Pelvic examination – fees for the cost of pelvic exam packs and in-room chaperones. This is only allowed in conjunction with a Pap or HPV test. List separately, in addition to primary procedure.	\$16.64	No	No		
CONSULTATION OFFICE VISIT – 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 WWWP screening visits. However, they may be used when provider spends extra time to do a detailed risk assessment.						
99204	New Patient – 45-59 minutes	\$168.35	No	No		
99205	New Patient – 60-74 minutes	\$223.96	No	No		
PREVENTIVE MEDICINE OFFICE VISIT – Use only if necessary for health and evaluation of risk profile for breast and/or cervical exams including annual CBE and Pap test. One visit per client per year. (See message in top paragraph.)						
99385	Initial Ages 35-39	\$111.40	No	No		
99386	Initial Ages 40-64	\$111.40	No	No		
99387	Initial Ages 65 and Over	\$111.40	No	No		
99395	Periodic Established Ages 35-39	\$91.06	No	No		
99396	Periodic Established Ages 40-64	\$91.06	No	No		
99397	Periodic Established Ages 65 and Over	\$91.06	No	No		
WWWP funds cannot be used for services that are unrelated to breast and/or cervical cancer screening, including the time and materials needed to assess and manage problems unrelated to breast and cervical cancer. Grantees should have a protocol to appropriately educate, manage, and pay for the additional provider time and materials required to conduct unrelated services with non-WWWP funds.						
* 99211 – Use for normal annual Clinical Breast Exam (CBE) with no cervical screening component						

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ANESTHESIA						
00400	Anesthesia for procedures on the integumentary system, anterior trunk and perineum; not otherwise specified	\$21.25 per unit	Yes	No		
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	\$21.25 per unit	Yes	No		
99156	Moderate sedation, 10-22 minutes for individuals 5 years or older	\$66.35	No	No		
99157	Moderate sedation for each additional 15 minutes	\$50.55	Yes	No		
ALLOWABLE BREAST SCREENING AND DIAGNOSTICS						
Radiology, use TC or 26 modifier as appropriate.						
77067	Screening mammography, bilateral (two-view study of each breast), including computer-aided detection (CAD) when performed	\$120.91	No	Yes	\$33.77	\$87.14
77065	Diagnostic mammography, including CAD when performed, unilateral	\$118.52	Yes	Yes	\$36.18	\$82.34
77066	Diagnostic mammography, including CAD when performed, bilateral	\$150.03	Yes	Yes	\$44.55	\$105.48
77063	Screening digital breast tomosynthesis, bilateral	\$49.13	No	Yes	\$26.73	\$22.40
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	\$38.89	Yes	Yes	\$26.73	\$12.16
77053	Mammary ductogram or galactogram, single duct	\$50.72	Yes	Yes	\$16.06	\$34.66
77046 ¹	Magnetic resonance imaging (MRI), breast, without contrast, unilateral	\$204.17	No	Yes	\$63.81	\$140.36
77047 ¹	MRI, breast, without contrast, bilateral	\$207.36	No	Yes	\$70.53	\$136.84
77048 ¹	MRI, breast, including CAD, with and without contrast, unilateral	\$319.60	No	Yes	\$93.06	\$226.53
77049 ¹	MRI, breast, including CAD, with and without contrast, bilateral	\$325.09	No	Yes	\$101.75	\$223.34
¹ Breast MRI must be preauthorized and can be reimbursed by the WWWP when performed in conjunction with a mammogram when a client has been determined to be high risk (for example, has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models). Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed by the WWWP to assess the extent of disease for staging in a client recently diagnosed with breast cancer and preparing for treatment. WWWP will be conducting retrospective reviews on all MRI performed procedures.						
76098	Radiological examination, surgical specimen	\$41.05	Yes	Yes	\$14.07	\$26.98
76641	Ultrasound, complete exam of breast, including axilla, unilateral	\$95.90	Yes	Yes	\$32.45	\$63.46
76642	Ultrasound, limited exam of breast, including axilla, unilateral	\$79.84	Yes	Yes	\$30.14	\$49.70
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	\$61.48	Yes	Yes	\$30.34	\$31.14
19000	Puncture aspiration of cyst of breast	\$90.92	No	No		
19001	Puncture aspiration of cyst of breast, each additional cyst, <i>used with 19000</i>	\$24.77	Yes	No		
19081 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	\$455.12	No	No		
19082 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	\$346.71	Yes	No		
19083 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	\$452.51	No	No		

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19084 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	\$341.02	Yes	No		
19085 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	\$685.98	No	No		
19086 ²	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	\$528.68	Yes	No		
² 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.						
19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	\$151.70	Yes	No		
19101	Breast biopsy, open, incisional	\$322.93	Yes	No		
19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	\$525.70	No	No		
19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	\$580.96	Yes	No		
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; <i>each additional lesion separately identified by a preoperative radiological marker</i>	\$126.08	Yes	No		
38505	Needle biopsy of axillary lymph node; must be done in conjunction with a breast biopsy	\$161.67	Yes	No		
10035	Placement of soft tissue localization device (e.g., clip)	\$329.50	No	No		
10036	Placement of soft tissue localization device (e.g., clip), each additional lesion	\$277.16	Yes	No		
19281 ³	Placement of breast localization device, percutaneous; mammographic guidance; first lesion	\$223.56	No	No		
19282 ³	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	\$157.39	Yes	No		
19283 ³	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	\$237.84	No	No		
19284 ³	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	\$173.06	Yes	No		
19285 ³	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	\$334.08	No	No		
19286 ³	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	\$273.75	Yes	No		
19287 ³	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	\$572.54	No	No		
19288 ³	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	\$436.88	Yes	No		
³ Codes 19281–19288 are for image guidance placement of localization device without image-guided biopsy. These codes are not to be used in conjunction with 19081–19086.						

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10004	Fine needle aspiration (FNA) without imaging guidance, each additional lesion	\$49.15	Yes	No		
10005	FNA including ultrasound guidance, first lesion	\$125.01	No	No		
10006	FNA including ultrasound guidance, each additional lesion	\$56.58	Yes	No		
10007	FNA including fluoroscopic guidance, first lesion	\$326.51	No	No		
10008	FNA including fluoroscopic guidance, each additional lesion	\$133.71	Yes	No		
10009	FNA including CT guidance, first lesion	\$393.27	No	No		
10010	FNA including CT guidance, each additional lesion	\$222.97	Yes	No		
10011	FNA including MRI guidance, first lesion	\$393.27	No	No		
10012	FNA including MRI guidance, each additional lesion	\$222.97	Yes	No		
10021	FNA without imaging guidance, first lesion	\$95.00	Yes	No		
ALLOWABLE CERVICAL SCREENING AND DIAGNOSTICS						
88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in The Bethesda System, manual screening under physician supervision	\$18.54	No	No		
88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in The Bethesda System, manual screening and rescreening under physician supervision	\$42.22	No	No		
88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	\$25.37	No	No		
88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	\$26.61	No	No		
G0123	Pap Test, thin prep	\$20.26	No	No		
G0124	Pap Test, thin prep, physician interpretation	\$22.72	No	No		
88141	Cytopathology, cervical or vaginal, any reporting system, <i>requiring interpretation by physician</i>	\$23.38	No	No		
88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	\$20.26	No	No		
88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	\$23.04	No	No		
87624***	HPV HR test – HPV test High Risk Only Types	\$35.09	No	No		
87625***	HPV genotyping test – types 16 and 18 only, includes type 45, if performed	\$40.55	No	No		
87626***	HPV test – separately reported high-risk types and high-risk pooled results	\$70.20	No	No		
	***HPV DNA testing is reimbursable when used for screening or follow-up of abnormal Pap results. HPV genotyping is reimbursable when used for follow-up of abnormal cervical cancer screening results as per ASCCP algorithms. Providers should specify the high-risk HPV DNA panel only. Low-risk HPV DNA panel is not reimbursable. Code 87626 cannot be reimbursed along with codes 87624 or 87625. Self-collected vaginal HPV testing is reimbursable in a healthcare setting only using code 87626.					

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57452	Colposcopy w/o Biopsy	\$116.72	No	No		
57454	Colposcopy with Biopsy and/or Endocervical Curettage	\$153.53	No	No		
57455	Colposcopy with Biopsy(ies) of Cervix	\$149.14	No	No		
57456	Colposcopy with Endocervical Curettage	\$139.67	No	No		
57505	Endocervical Curettage (not done as d & c)	\$139.78	No	No		
57460	Colposcopy w/ loop electrode biopsy(ies) of the cervix	\$289.43	No	No		
57461	Colposcopy w/ loop electrode conization of the cervix	\$326.36	No	No		
57500	Cervical biopsy, single or multiple, or local excision of lesion, with or w/o fulguration (separate procedure)	\$142.03	No	No		
57520	Conization of cervix, with or w/o fulguration, with or w/o dilation and curettage, with or w/o repair; cold knife or laser	\$333.73	No	No		
57522	Loop electrode excision procedure	\$279.11	No	No		
58100	Endometrial sampling (biopsy) with or w/o endocervical sampling (biopsy), w/o cervical dilation, any method (separate procedure)	\$91.17	No	No		
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure)	\$46.97	No	No		
PATHOLOGY						
88305	Surgical pathology, gross and microscopic examination	\$67.79	Yes	Yes	\$34.40	\$33.38
88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	\$266.88	Yes	Yes	\$74.80	\$192.08
88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	\$94.09	No	Yes	\$56.55	\$37.54
88332	Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen	\$51.58	Yes	Yes	\$28.43	\$23.14
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain	\$106.11	No	Yes	\$32.09	\$74.02
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain	\$90.79	Yes	Yes	\$26.15	\$64.64
88360	Morphometric analysis, tumor immunohistochemistry, per specimen; manual	\$115.92	Yes	Yes	\$38.38	\$77.54
88361	Morphometric analysis, tumor immunohistochemistry, per specimen; using computer-assisted technology	\$110.62	Yes	Yes	\$39.81	\$70.82
88365	In situ hybridization (e.g., FISH), per specimen; initial single probe stain procedure	\$162.47	No	Yes	\$39.71	\$122.76
88364	In situ hybridization (e.g., FISH), per specimen; each additional single probe stain procedure	\$121.79	Yes	Yes	\$31.13	\$90.66
88366	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain procedure	\$254.89	Yes	Yes	\$56.62	\$198.27
88367	Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure	\$101.04	No	Yes	\$30.54	\$70.50

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88368	Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure	\$140.39	No	Yes	\$39.39	\$101.00
88369	Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure	\$124.03	Yes	Yes	\$31.45	\$92.58
88373	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each additional probe stain procedure	\$61.38	Yes	Yes	\$23.52	\$37.86
88374	Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure	\$255.87	Yes	Yes	\$38.82	\$217.05
88377	Morphometric analysis, in situ hybridization, manual, per specimen, each multiplex stain procedure	\$369.03	Yes	Yes	\$59.94	\$309.09
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), first evaluation episode	\$52.34	No	Yes	\$32.40	\$19.94
88173	Cytopathology, evaluation of fine needle aspirate; <i>interpretation and report</i>	\$160.49	Yes	Yes	\$64.19	\$96.30
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	\$28.20	Yes	Yes	\$19.88	\$8.32
81025	Urine pregnancy test (if needed, to be done in conjunction with a WWWP allowed cervical diagnostic test)	\$8.61	No	No		
87426	COVID-19 infectious agent detection by nuclei acid DNA or RNA; amplified probe technique	\$35.33	No	No		
87635	COVID-19 infectious agent antigen detection by immunoassay technique; qualitative or semiquantitative	\$51.31	No	No		

Procedures not listed are not covered by WWWP. Providers need to discuss any non-covered services with clients before providing them.

All Pap test results, regardless of method performed, must be reported using The Bethesda System.

PROCEDURES SPECIFICALLY NOT ALLOWED

Any	Treatment of breast carcinoma in situ, breast cancer, cervical intraepithelial neoplasia and cervical cancer
77061	Breast tomosynthesis, unilateral
77062	Breast tomosynthesis, bilateral
87623	Human Papillomavirus, low-risk types



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