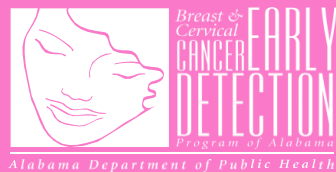


ABCCEDP Clinic Training Packet



May 2026

Program Contact Information

<https://www.alabamapublichealth.gov/bandc/index.html>

Call toll-free – 1-877-252-3324



THE ALABAMA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM

ABOUT THE PROGRAM: For the last 30 years, the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) has partnered with providers to offer cancer screening, diagnosis, and treatment referral at no cost to uninsured, low income women statewide.

FROM 1996-2025, ABCCEDP HAS...



Served more than

150,000

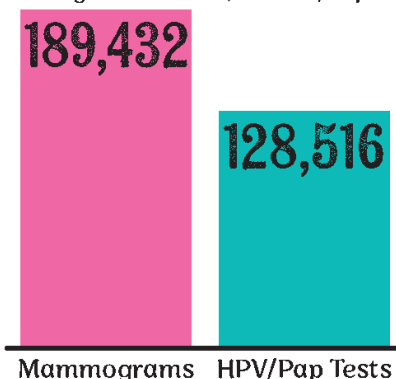
**UNDERSERVED
WOMEN**

in Alabama

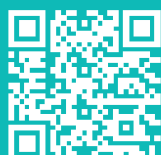
Diagnosed
more than
2,866
**BREAST
CANCERS**

Provided more than
317,000
**BREAST AND
CERVICAL CANCER
SCREENING
EXAMINATIONS**

317,000 breaks down to 189,432
mammograms and 128,516 HPV/Pap tests



Diagnosed
more than
5,858
**CERVICAL
CANCERS**
and pre-invasive
cervical cancers



Learn more about
ABCCEDP by visiting
alabamapublichealth.gov/bandc



Breast & Cervical
CANCER
Program of Alabama
Alabama Department of Public Health



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ABCCEDP Provider Training Videos can be found at:
<https://www.alabamapublichealth.gov/bandc/index.html>

Standard Operating Procedures

1. Become an Alabama Breast and Cervical Cancer Early Detection Program, ABCCEDP (ABC) provider, complete contract (1-877-252-3324)
2. Request training with ABCCEDP Regional Coordinator (see page 27)
3. Obtain Med-IT User ID from ABCCEDP Regional Coordinator
 - a. Every user must have their own User ID, it cannot be shared
 - b. User IDs are site-specific and cannot be used at multiple clinics
4. Review ABCCEDP Protocol (www.alabamapublichealth.gov/bandc)
5. Review ABCCEDP Training Packet (www.alabamapublichealth.gov/bandc)
6. Patient walks into clinic for ABCCEDP Program Services Only (Why are you here today?)

Scenario 1: Clerk Enrolls Patient in ABCCEDP

1. Clerk asks:
 - a. Are you a resident of Alabama? Yes (see page 4)
 - b. Do you have insurance? No
 1. Medicaid/BCBS/HealthCare.gov is insurance
 2. Plan First is not insurance
 - c. Is income below 250% federal poverty level? (see page 5)
 1. How many people are in your household?
 2. What is your income (annually, monthly, weekly, or bi-weekly)?
 3. Look at the Income Guidelines Form
 4. Proof of income is not required
 - d. Is patient age 40-64*? Yes
2. Enroll patient in Med-IT
 - a. Log in to Med-IT
 - b. Search Med-IT for patient by DOB/SSN/name – (see page 6)
 - i. If patient's name is found, double click on the patient's name to begin the enrollment and update the patient's demographics, select "Update" (see page 7, Screen 1)
 - ii. If patient's name is not found, click on "Client Info" in the top left corner and select "Add Client" from the drop-down menu (see page 6, ADD CLIENT) to enter the new patient's demographics, select "Set Appointment" (see page 7, Screen 1)
 - c. Screen 1: Client Information – Demographics (see page 7, Screen 1)
 - i. If no SSN, leave blank.
 - ii. If patient has two last names, enter both last names in the last name box, no hyphen.
 - d. Screen 2: BCC Screening – Eligibility Screen (see page 8)
 - i. Select BCC
 - ii. Enter age, income, and insurance verification, accept Pap smear criteria
 - e. Screen 3: Set Appointment (see page 9)
 - i. Answer Family Planning, Eligible to enroll (always yes), Smoker, Enter day of appt
 - ii. Select "Update/Set Appointment"
 - iii. Print/Save confirmation; (see page 9)

Standard Operating Procedures

Note: BCC tracking number is required on all forms

3. Ask patient to sign Consent Form; enter tracking number on Consent Form (see page 10)
4. No fee should be charged for breast or cervical screenings
5. Sign patient in for breast and cervical screening (office visit)
 - a. Office visit includes blood pressure (BP), height/weight, clinical breast exam (CBE), HPV/Pap test only
 - b. Does not include STD testing, urinalysis, blood work, or pregnancy test

Scenario 2: Clinical Staff Enrolls Patient

1. Clerk does not charge a fee for breast or cervical screenings
2. Clerk signs patient in for breast and cervical screening (office visit)
 - a. Office visit includes BP, height/weight, CBE, HPV/Pap test only
 - b. Does not include STD testing, urinalysis, blood work, or pregnancy test
3. Nurse/Medical Assistant/Clinic Aide sees patient
 - a. Confirm eligibility (residence, insurance status, income status, age) (see pages 4 and 5)
 - b. Enroll patient in Med-IT (see pages 6-9)
4. Ask patient to sign Consent Form; enter tracking number on Consent Form (see page 10)
5. Complete the office visit
6. Refer for mammogram/complete ABCCEDP Mammogram Voucher and send with order to mammogram facility (see page 13)
7. Initiate ABCCEDP Screening Form (see page 12)
 - a. Add tracking number
 - b. Add personal data
 - c. Add breast screening data
 - d. Add cervical screening data
(will not be able to complete until HPV/Pap test results are received)
8. Scan completed forms into EHR using a naming convention
(Recommended: ABC screening date, ABC mammogram date)
9. Claim form (HCFA/1500) and completed ABCCEDP Screening Form should be sent to ABCCEDP Regional Coordinator for payment (see page 19) Claims are reimbursed at the Medicare rate. The Rate Reimbursement Table is updated annually. (see pages 22-24)
10. If abnormal HPV/Pap test, schedule needed follow-up visit with ABCCEDP provider, if needed
 - a. Initiate Cervical Diagnostic Follow-up Form (see page 14)
 - b. Send to provider who provides follow-up service
11. If abnormal CBE; schedule diagnostic mammogram and ultrasound (see page 13)
Note: Surgeon referral if indicated
 - a. Initiate Breast Diagnostic Form (see page 15)
 - b. Send to ABCCEDP provider who provides follow-up service

Specific Situations: Breast

- Patients who are determined to be at high-risk for breast cancer (Breast Risk Assessment Score is greater than 20%) and have a normal screening mammogram may be eligible for screening MRI in alternation with a screening mammogram every 6 months. An ABCCEDP MRI Authorization Form must be completed and submitted to ABCCEDP Regional Coordinator for prior approval. ABCCEDP does not cover diagnostic MRIs. (see page 17)

Specific Situations: Cervical

***Women ages 21-39**

(See ABCCEDP Eligibility Guidelines for details)

- Women who have had a bilateral tubal ligation or partial hysterectomy with cervix remaining are eligible for cervical cancer screening. ABCCEDP will reimburse for cervical cancer screening after a hysterectomy if the hysterectomy is due to cervical cancer or other reasons, and the patient still has a cervix.
- Women at high-risk for cervical cancer due to personal history of CIN II, CIN III, or invasive cervical cancer, or conditions such as DES, immuno-compromised, organ transplantation, or HIV, may be eligible for cervical cancer screening.
- If a woman is unsure post hysterectomy if she still has a cervix, ABCCEDP will reimburse for one exam to determine if a cervix is present. Please note when an exam is performed and the cervix is **NOT** present on the ABCCEDP Screening Form.

Women ages 65 and Older:

- Women age 65 or older with no insurance or Medicare Part A only are eligible for breast and cervical cancer screening.

Pre-Cancer or Cancer Diagnosis:

- Women with a diagnosis of cancer will be referred to Kelli Hardy (1-877-252-3324) for treatment through Medicaid. (see page 18) Patients who are not citizens and not eligible for Medicaid may be eligible for charity care or sliding fee scales.

ABCCEDP ELIGIBILITY GUIDELINES—EFFECTIVE JULY 1, 2024

ABCCEDP Eligibility Criteria

- ❖ Be a resident of Alabama (have an Alabama address)
- ❖ Women with a household income at or below 250% of the Federal Poverty Level
- ❖ Women who have no insurance
- ❖ Women who meet the age and other eligibility requirements as described below

Breast Cancer Screening

- ❖ **Women age 40-64: every year**
CBE and Screening Mammogram
- ❖ **Women age 40-64 (High-Risk): every year**
Women in this category may be eligible for a CBE, Screening Mammogram, Diagnostic Mammogram, Ultrasound, MRI, Biopsy, or other Diagnostics. If MRI is indicated complete MRI prior-approval form which outlines MRI eligibility criteria.
 - ♦ Breast Mass
 - ♦ Bloody nipple discharge expressed by Provider during CBE
 - ♦ Dimpling noted by Provider during CBE
 - ♦ Personal history of breast cancer (***Must have documentation of breast cancer***)
 - ♦ Genetic Mutation such as BRCA 1 or 2 (***Must have documentation of genetic mutation***)
 - ♦ 1st degree relative with breast cancer (mother, sister, father)
 - ♦ Greater than 20% lifetime risk of breast cancer based on risk assessment models largely dependent of family history
 - ♦ History of radiation treatment to the chest area before age of 30 (***typically for Hodgkin's Lymphoma***)
- ❖ **Women age 65 or older with no insurance or Medicare Part A only: every year**
CBE and Screening Mammogram

Cervical Cancer Screening

Screening Guidelines:

- ❖ **Women (Average Risk) age 40-64 (for those NOT eligible for Family Planning)***
Ages 40-64: Co-test every 5 years, Pap smear every 3 years
- ❖ **Women (Average Risk) age 21-39 (who have had tubal ligation or partial hysterectomy with cervix remaining)**
 - ♦ Ages 21-39: Pap test only every 3 years
 - ♦ Ages 30-39: Co-test every 5 years or Pap test every 3 years
- ❖ **Women (High Risk) any age with a past personal history (biopsy) of CIN II, CIN III, or invasive cervical cancer**
Follow ASCCP recommended guidance for surveillance after treatment and follow-up, thereafter for at least 20 years post treatment (for those NOT eligible for Family Planning)*
- ❖ **Women (High Risk) ages 21-64 (for those NOT eligible for Family Planning)* with one of the following:**
 - ♦ Diethylstilbestrol (DES) exposure in utero
 - ♦ Immuno-compromised due to health condition
 - ♦ Organ transplantation
 - ♦ Human Immunodeficiency Virus (HIV)
 - Ages 21-29: Annual Pap test (for those NOT eligible for Family Planning)*
 - Ages 30-64: Co-test every 3 years or annual Pap test (for those NOT eligible for Family Planning)*
- ❖ **Women age 65 or older with no insurance or Medicare Part A only** if meets ASCCP guidelines for screening

Diagnostic Follow-Up Guidelines:

- ❖ **Women (High Risk) age 21-39 who need diagnostic follow-up for abnormal cervical cancer screening results**
Follow ASCCP guidelines regarding appropriate cervical cancer diagnostics and follow-up

****Women of any age who have had a bilateral tubal ligation or partial hysterectomy are not eligible for Family Planning.***

Revised July 2024



Alabama Breast and Cervical Cancer Early Detection Program

2026 Income Eligibility Guidelines

(Effective February 1, 2026, until revised)

At or below 250% of the Federal Poverty Level determines program eligibility.

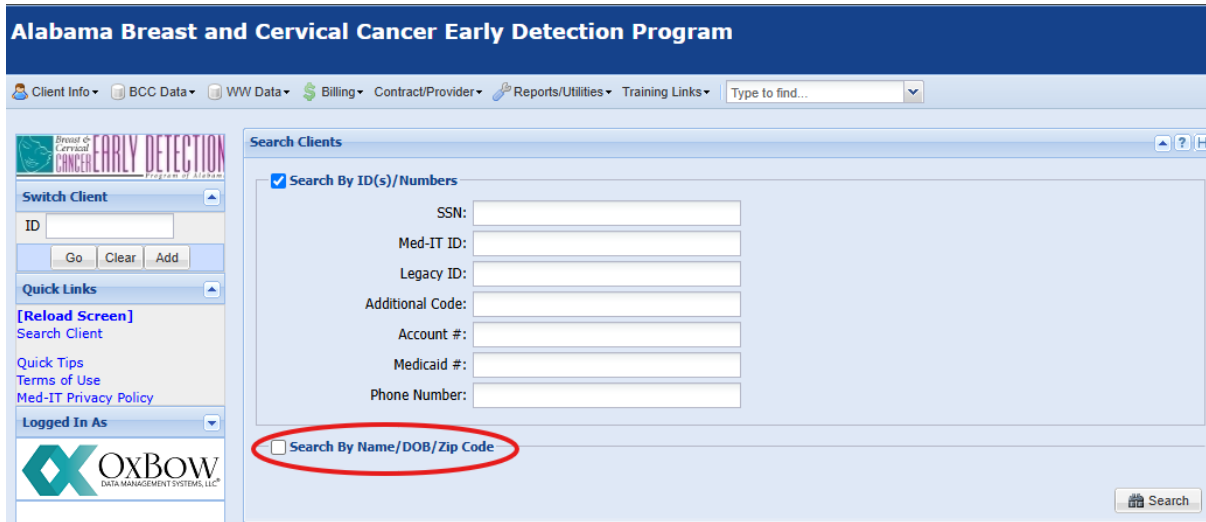
Household Size	Annual	Monthly *	Weekly	Bi-weekly
1	\$39,900	\$3,325	\$831	\$1,663
2	\$54,100	\$4,508	\$1,127	\$2,254
3	\$68,300	\$5,692	\$1,423	\$2,846
4	\$82,500	\$6,875	\$1,719	\$3,438
5	\$96,700	\$8,058	\$2,015	\$4,029
6	\$110,900	\$9,242	\$2,311	\$4,621
7	\$125,100	\$10,425	\$2,606	\$5,213
8	\$139,300	\$11,608	\$2,902	\$5,804

Each additional household member add \$14,200 annual or \$1,184 monthly, or \$296 weekly or \$592 bi-weekly.

*Based on DHHS Poverty Guidelines issued 1/2026.

Med-IT Enrollment Example

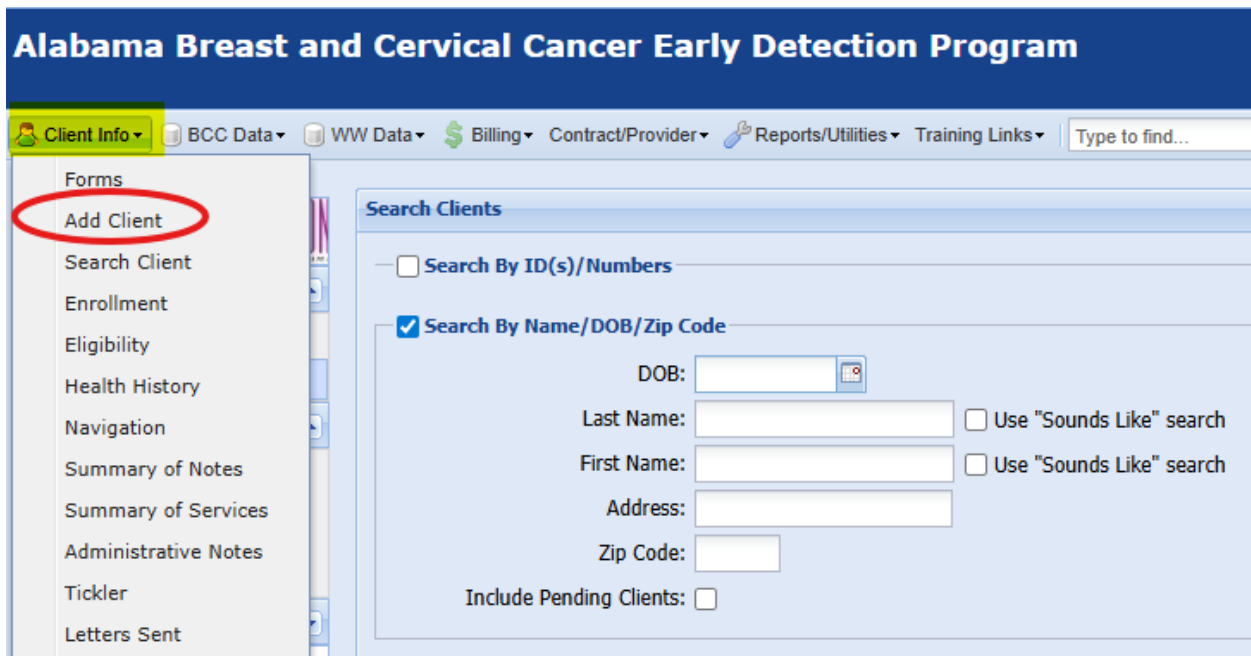
Patient Search



If the patient’s name is found, double click on the patient’s name to begin the enrollment and update the patient’s demographics, select “Update”.

If the patient’s name is not found, click on “Client Info” in the top left corner and select “Add Client” from the drop-down menu to begin the enrollment and enter the new patient’s demographics, select “Set Appointment”.

Add Client



Med-IT Enrollment Example (Cont'd)

Screen 1

EARLY DETECTION

Switch Client
ID: 241040
Go Clear Add

Client Information
Doe, Jane
Status: Active
Active
Poss Dup Name
Last T.#:
Cell #: 601-310-3338
SSN:
DOB: 08/10/1981 (44)
Language: English
Custom Id:
Address:
123 ABC
Mobile, AL 36604
Eligibility
FPL: 0%
Status: Ineligible
Enrolled: 04/10/2023
Additional Information
Quick Links
[Reload Screen]
Search Client
Summary of Services
Summary of Notes
Mark to Send Letter
Client Activity
FPL Calculator
Quick Tips
Terms of Use
Med-IT Privacy Policy
Logged In As
OXBOW
DATA MANAGEMENT SYSTEMS, LLC
This Page May Contain Protected

Client Information [?] [H]

Personal Information

Last Name: Doe
First Name: Jane
MI:
Maiden Name:
Alternate ID:
SSN:
Date of Birth: 08/10/1981 [mm/dd/yyyy]
Gender: Female
MED-IT ID: 0000000241040
Note:
B I S Ix [List Icons]

Contact Information

Address: 123 ABC
Address 2:
Zip Code: 36604
State: AL
County: Mobile
City: Mobile
Equivalent County: Mobile
Email:
Phone 1: Type: Cell Preferred
Phone 2: Type: Select one Preferred
Phone 3: Type: Select one Preferred
Best Time to Call:
 Alternate Contact

Residency, Race, Ethnicity, Language, and Education

Country of birth: USA
Hispanic: Yes No Unknown
Primary Language: English
Needs Translator:
Race (Check All that Apply):
 Asian/Pacific v4.1 only White
 African American Asian
 Native American Pacific Islander
 Unknown
Tribe/Other race: Select one
Last Grade Completed: Select one


Enrollment Information

Date Enrolled: 04/10/2023 [mm/dd/yyyy]
Send Correspondence: Yes No
Pending: Yes No
Status: Active
As of: [mm/dd/yyyy]
Medical Site: 11011
Learned of Program: Select one
Medical Record #

Update History Set Appointment Delete Client

Med-IT Enrollment Example (Cont'd)

Screen 2



Switch Client ▲

ID

Client Information ▲

Doe, Jane
Status: Active
Active

Screening Guidelines

Screen for...

BCC **CRC** **WW**

BCC Screening

Client must meet one of the following criteria in the areas of eligibility

Age criteria

- Women Age 21-64 who need diagnostic testing after abnormal cervical screening result
- Women Age 21-64 Cervical Screening Only having one of these conditions: 1. Not eligible for family planning due to having tubal ligation or partial hysterectomy; 2. Women with a previous diagnosis of CINII OR CINIII or Cervical Cancer
- Women 40-64 year old every year screening only
- Women Age 40-64 with breast complaints such as bloody nipple discharge, dimpling, discrete palpable mass (or) requiring an annual mammogram based on previous mammogram results (or) high risk for breast cancer
- Age 65 and above, with No Insurance, or Medicare Part A only
- Women Age 40-49 every other year screening only

Income criteria

Client's household income BEFORE TAXES: [Numbers only, do not use comma (,)]

Income frequency: Monthly ▼

Number of people living on this income: 1 ▼

Eligibility level: 0%

Program acceptable eligibility is up to 250%

Insurance criteria

Does the patient have insurance: Yes No

Pap Smear criteria

Under CDC guidelines, ABCCEDP may reimburse for Pap smear and HPV test (co-testing) for primary cervical cancer screening at no more than the maximum allowable Medicare rate. The screening interval when using Pap Smear and HPV test (co-testing) is every 5 years. If a woman is receiving Pap smear alone then the screening interval is once in every 3 years. Women who are at high-risk for cervical cancer are eligible to get annual cervical cancer screening with Pap smear only (no HPV is recommended). High-risk women are women diagnosed HIV positive, exposed to DES (diethylstilbestrol) in utero, immunocompromised, or previously treated for CIN II, CIN III or cervical cancer. If anytime the Pap smear or HPV test is abnormal, then policies for abnormal pap tests should be followed.

I agree to accept payment under these Pap frequency guidelines: Yes No

Med-IT Enrollment Example (Cont'd)

Screen 3

Set Appointment [?]

Provider:

Name: Jane Doe
SSN: 000-00-0000
DOB: 12/30/1975
Region: 0110011

CHD Family planning: Yes No

Eligible to enroll: Yes No

Is the Patient Smoker? Yes - Refer to quit line 1-800-784-8669
 No
 Unknown

BCC Appointment date: [mm/dd/yyyy]


Authorization date: 05/19/2026

Existing Cycles

No BCC cycles found No CRC cycles found No WW cycles found

Update/Set Appointment

Pop-Up confirming patient enrollment

 **Client's BCC information has been added successfully. Please note the following information.**

Appointment Information

Name: Jane Doe
DOB: 08/10/1981
SSN:
BCC Tracking number: 2026241040
BCC Appointment date: 03/27/2026
Family planning: Yes

Download PDF **Office Visit**

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Tracking Number (required)

ABCCEDP INFORMED CONSENT/RELEASE OF INFORMATION CONSENT

PROGRAM DESCRIPTION	
<p>The Alabama Breast and Cervical Cancer Early Detection Program, ABCCEDP, is a cooperative effort between clinics and doctors, the Alabama Department of Public Health and the U.S. Centers for Disease Control and Prevention to encourage screening for breast and cervical cancer. The purpose of screening is to detect cancer in the earliest stage so that it can be treated or cured. Screening for breast cancer involves a breast examination and a breast X-ray called a mammogram. Screening for cervical cancer involves a pelvic examination and a scraping from the cervix (opening of the uterus) called a Pap smear.</p> <ul style="list-style-type: none"> ▪ You will be able to receive your clinic/doctor visit, Pap smear and/or mammogram for FREE, if you meet the income eligibility requirements of the program and have no insurance or these services are not covered fully by your insurance. ▪ If you have an abnormal screening test result, the clinic/doctor will work with the program to help you obtain further diagnostic tests and treatment. The program can pay for limited diagnostic services but cannot pay for treatment. Your health care provider at the clinic or doctor can tell you which specific services can be paid for and which are not covered by the program. In the event that a biopsy is done and it is necessary to do further surgery (at that time) for treatment purposes, the ABCCEDP cannot pay for the treatment portion of the surgery. ▪ In order to assure that adequate diagnostic and treatment services are available, following abnormal screening results, the ABCCEDP program and/or service provider may need to do additional needs evaluation and assessment with the patient in the form of case management. ▪ The program will work with this clinic/doctor to let you know when you are due for your next Pap smear and/or mammogram. 	
CONSENT FOR SERVICES/RELEASE INFORMATION	
<p>I have read the above and understand the explanation about the Alabama Breast and Cervical Cancer Early Detection Program and hereby consent to receive the health services as indicated. By agreeing to take part in this program, I give permission to any and all of my doctors, clinics, mammography facilities and/or hospitals to provide all information concerning my Pap smears, breast exams and mammograms and any related diagnostic treatment procedures to the ABCCEDP, which may include referral to case managers employed by the Alabama Department of Public Health.</p> <p>Any information released to the program will remain confidential, which means that the information will be available only to me and the employees of the Alabama Department of Public Health working with this program. The information will be used only to meet the purposes of the program described above and any published reports which result from this program will not identify me by name.</p> <p>I understand that my participation in this program is voluntary and that I may drop out of the program and withdraw my consent to release information at any time.</p> <p>Privacy Notice: I have received notice of my privacy rights and I have been given or offered a copy of the "Notice of Privacy Practices" by the Alabama Department of Public Health or your health care provider.</p> <p>Signature _____ Clinic or MD Name _____</p> <p>Name _____ Date _____ (Please Print) Last First MI</p>	

NOTE: CLINICS/DOCTORS MAY SUGGEST OR OFFER SERVICES WHICH ARE NOT PART OF ABCCEDP. IF YOU DECIDE TO USE THESE SERVICES, THEY WILL NOT BE PAID FOR BY ABCCEDP.

Revised April 3, 2023

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Tracking Number (required)

CONSENTIMIENTO INFORMADO PARA ABCCEDP/CONSENTIMIENTO PARA DIVULGACIÓN DE INFORMACIÓN

DESCRIPCIÓN DEL PROGRAMA	
<p>Entiendo que el Programa de Detección Temprana de Cáncer de Mama y Cuello Uterino de Alabama (ABCCEDP, por sus siglas en inglés), es un esfuerzo cooperativo entre clínicas y médicos, el Departamento de Salud Pública de Alabama y los Centros para el Control y Prevención de Enfermedades de los EE.UU. para fomentar la detección del cáncer de mama y de cuello uterino. El propósito de la evaluación de detección es detectar el cáncer en la fase más temprana para que pueda tratarse y curarse. La evaluación de detección para el cáncer de mama involucra un examen y una radiografía de mamas llamada mamograma. La evaluación de detección para el cáncer de cuello uterino involucra una examen pélvico y un raspado del cérvix (apertura del útero) llamada Papanicolau.</p> <ul style="list-style-type: none"> ▪ Usted podrá obtener su visita a la clínica/el médico, Papanicolau y/o mamograma GRATIS si cumple con los requisitos de elegibilidad por ingresos del programa y no tiene seguro, o si su seguro no cubre estos servicios al ciento por ciento. ▪ Si su resultado de la evaluación de detección es anormal, la clínica/el médico trabajará con el programa para ayudarle a conseguir más pruebas de diagnóstico y tratamiento. El programa puede pagar algunos servicios de detección, pero no puede pagar el tratamiento. Su proveedor de atención médica en la clínica o médico puede indicarle qué servicios específicos pueden pagarse y cuáles no están cubiertos por el programa. En el caso de que se realice una biopsia y que se necesite más cirugía (en ese momento) con propósitos de tratamiento, el ABCCEDP no puede pagar por la porción de tratamiento correspondiente a la cirugía. ▪ Entiendo que para garantizar que los servicios de tratamiento y diagnóstico adecuados estén disponibles luego de los resultados de detección anormales, es posible que el programa ABCCEDP y/o el proveedor de servicios necesiten evaluaciones adicionales y análisis con el paciente en forma de gestión de casos. ▪ El programa trabajará con la clínica/el médico para comunicarle cuando ya sea hora de su próximo Papanicolau y/o mamograma. 	
CONSENTIMIENTO PARA SERVICIOS/DIVULGACIÓN DE INFORMACIÓN	
<p>He leído lo anterior y entiendo la explicación acerca del Programa de tratamiento del cáncer de mama y cervical y por medio del presente acepto recibir los servicios de salud indicados. Al aceptar formar parte de este programa, doy permiso a cualquier y a todos mis médicos, clínicas, centros de mamografías y/u hospitales a proporcionar toda la información respecto de mis Papanicolaus, exámenes de mamas y mamogramas y cualesquier procedimientos de tratamiento de diagnóstico al ABCCEDP, que puede incluir derivación a administradores de casos empelados por el Departamento de Salud Pública de Alabama.</p> <p>Cualquier información que se divulgue al programa permanecerá en confidencialidad, lo que significa que la información estará disponible únicamente para mí y para los empleados del Departamento de Salud Pública de Alabama que trabajan con este programa. La información se utilizará únicamente para cumplir con el propósito del programa descrito anteriormente y cualesquier informes publicados que resulten de este programa no me identificarán por mi nombre.</p> <p>Entiendo que mi participación en este programa es voluntaria y que puedo abandonar el programa y revocar mi consentimiento para divulgar información en cualquier momento.</p> <p>Aviso de privacidad: Me han notificado mis derechos de privacidad y me han brindado u ofrecido una copia del “Aviso de las Prácticas de Privacidad” del Departamento de Salud Pública de Alabama o su proveedor de atención médica.</p>	
<p>Firma _____</p> <p>Nombre _____ (En letra de molde) Apellido Nombre Inicial del segundo nombre</p>	<p>Clinica o nombre del MD _____</p> <p>Fecha _____</p>

NOTA: LAS CLÍNICAS/LOS MÉDICOS PUEDEN SUGERIR U OFRECER SERVICIOS QUE NO SON PARTE DEL ABCCEDP. SI DECIDE UTILIZAR ESTOS SERVICIOS, EL ABCCEDP NO PAGARÁ POR ELLOS.

Revised 4-3-2023



MAMMOGRAPHY VOUCHER
ALABAMA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM (ABCCEDP)

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Tracking Number (required)

PATIENT IDENTIFICATION

1. Name: _____
(Last) (First) (Middle)

2. Date of Birth: ____ / ____ / ____
(mm) (dd) (yyyy)

3. Address: _____
(Street)

(City) (State) (Zip)

4. Social Security Number: XXX-XX- _____

5. Ethnicity: Hispanic Non-Hispanic

6. Race (Check all that apply):
 White Black/African American
 Asian American Indian /Alaskan Native
 Native Hawaiian/Other Pacific Islander
 Asian/Pacific Islander Unknown

7. Prior mammogram?
 Yes (if Yes, date ____ / ____ / ____)
 No

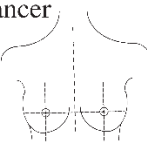
8. Breast symptoms?
 Yes Describe _____
 No

9. Date of clinical breast exam (CBE): ____ / ____ / ____

10. Date referred (if different from CBE date): ____ / ____ / ____

11. Results of CBE: Normal exam
 Benign findings, not suspicious for cancer
 Discrete palpable mass
 Bloody or serous nipple discharge
 Nipple or areolar scaliness
 Skin dimpling or retraction

12. (Risk Score _____%)



13. Type of mammogram requested:
 Screening* Diagnostic* Short term follow-up
 *with additional views or ultrasound as needed

14. Ultrasound requested Follow-up ultrasound

15. Comments _____

16. Referring M.D., CRNP, or PA _____

17. Provider name and address _____

MAMMOGRAPHY DATA

Mammography appointment information
 (Completed by primary screening provider.)
Mammography Facility _____
Appointment Date: ____ / ____ / ____ **Time:** _____

(Completed by mammography facility.)

1. Date mammogram performed: ____ / ____ / ____

2. Type of mammogram:
 Screening
 Diagnostic Unilateral
 Diagnostic Bilateral

3. Result of initial mammogram:
 BIRADS 0* Radiologic assessment incomplete (must complete #6 - Final Imaging Outcome)
 Need additional imaging
 Film comparison required

*No prior authorization by the referral provider is required. Mammography provider can perform additional mammographic views/ultrasound as needed.

BIRADS 1 Negative
 BIRADS 2 Benign Finding
 BIRADS 3 Probably benign, recommend short term follow-up
 BIRADS 4 Suspicious for abnormality, consider biopsy
 BIRADS 5 Highly suggestive of malignancy, take appropriate action

ADDITIONAL IMAGING PROCEDURES

4. Results of additional mammographic views:
 Date: ____ / ____ / ____
 BIRADS 0 BIRADS 1 BIRADS 2
 BIRADS 3 BIRADS 4 BIRADS 5

5. Result of ultrasound:
 Date: ____ / ____ / ____
 BIRADS 1 Normal/no abnormality
 BIRADS 2 Benign Finding (cystic mass or fibroadenoma)
 BIRADS 3 Probably benign, recommend short term follow-up (indeterminate)
 BIRADS 4 Suspicious for abnormality, consider biopsy
 BIRADS 5 Highly suggestive of malignancy, take appropriate action

6. Final imaging outcome:
 Date: ____ / ____ / ____
 BIRADS 1** BIRADS 2** BIRADS 3**
 BIRADS 4** BIRADS 5** Unsatisfactory**
 Additional imaging pending
 **Date of final imaging should be completed

RECOMMENDATION

7. Repeat CBE/ Consultation results: Date: ____ / ____ / ____
 Refused/Not Done No intervention/routine follow-up
 Short term follow-up Biopsy/FNA recommended

ADPH-1118-CF1-11-1-2011



**CERVICAL DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM (ABCCEDP)**

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Tracking Number (required)

Name: _____ Date of Birth: ____ / ____ / ____ <small>(Last) (First) (Middle) (mm) (dd) (yyyy)</small>	
Social Security Number: <u>XXX - XX -</u>	Referring Clinic / Provider: _____
Gynecologist: _____ Phone No: _____	Appointment Date: ____ / ____ / ____
Reason For Referral: _____ Pap Result: _____	Date Performed: ____ / ____ / ____
Insurance Status: <input type="checkbox"/> No Insurance <input type="checkbox"/> Underinsurance <input type="checkbox"/> Insured	Billed to Medicaid: <input type="checkbox"/> Yes
<input type="checkbox"/> Gynecologic Consultation	<input type="checkbox"/> Colposcopy no biopsy
<input type="checkbox"/> Diagnostic Col Knife Cone	<input type="checkbox"/> Colposcopy with biopsy and/or ECC
<input type="checkbox"/> Diagnostic ECC	<input type="checkbox"/> Diagnostic LEEP
<input type="checkbox"/> Other _____	Date Performed: ____ / ____ / ____
Final Diagnosis	Provider: _____
<input type="checkbox"/> Normal/Benign/Inflammation	Date Performed: ____ / ____ / ____
<input type="checkbox"/> HPV/Condylomata/Atypia	Other Abnormalities
<input type="checkbox"/> CIN I/Mild Dysplasia	<input type="checkbox"/> Cervical Polyps
<input type="checkbox"/> CIN II/Moderate Dysplasia*	<input type="checkbox"/> VAIN – Vaginal Intraepithelial Neoplasia
<input type="checkbox"/> CIN III/Severe Dysplasia/Carcinoma Insitu/Adenocarcinoma Insitu*	<input type="checkbox"/> VIN – Vulvar intraepithelial Neoplasia
<input type="checkbox"/> Invasive Cervical Carcinoma*	<input type="checkbox"/> Other _____
*Please contact your Area Screening Coordinator as soon as a cancer or pre-cancer diagnosis is known.	
Status of Diagnostic Work-Up	Date Performed: ____ / ____ / ____
<input type="checkbox"/> Work-up completed	<input type="checkbox"/> Work-up pending
<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> Irreconcilable*
<input type="checkbox"/> Work-up refused	
*If the provider refers for short-term follow-up instead of following guidelines for diagnostic work-up.	
Treatment Status	Date Performed: ____ / ____ / ____
<input type="checkbox"/> Initiated	<input type="checkbox"/> Refused
<input type="checkbox"/> Pending	<input type="checkbox"/> Not indicated
<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> Updated (follow-up information)
Treatment (not paid by Alabama Breast and Cervical Cancer Program)	Treatment Date: ____ / ____ / ____
<input type="checkbox"/> Cryotherapy	Treatment Provider: _____
<input type="checkbox"/> LEEP	
<input type="checkbox"/> Laser Therapy	
<input type="checkbox"/> Cone Biopsy	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Other _____	
Please Contact your Area Screening Coordinator to initiate Medicaid application if patient is eligible for the treatment Program.	
Case Management Needed	<input type="checkbox"/> Yes, Contact your Area Screening Coordinator
Further Treatment Required:	
Referred to: _____	Phone No: _____ Appt. Date: ____ / ____ / ____
ABCCEDP does not pay for treatment, but the patient may be eligible for Medicaid Treatment Program.	



BREAST DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM (ABCCEDP)

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Tracking Number (required)

Name: _____ <small>(Last) (First) (Middle)</small>		Date of Birth: ____ / ____ / ____ <small>(mm) (dd) (yyyy)</small>
Social Security Number: XXX - XX - _____		Referring Clinic Provider: _____
Physician/Surgeon: _____		Phone No: _____
		Appointment Date: ____ / ____ / ____
Reason for Referral: _____		Mammogram/US Result _____
		Date Performed: ____ / ____ / ____
Insurance Status: <input type="checkbox"/> No Insurance <input type="checkbox"/> Underinsurance <input type="checkbox"/> Insured		Billed to Medicaid: _____ Yes
<input type="checkbox"/> Repeat CBE/Surgical consultation: Result: <input type="checkbox"/> Refused/Not done Date Performed: ____ / ____ / ____ <input type="checkbox"/> No intervention/routine follow-up Provider: _____ <input type="checkbox"/> Short term follow-up: ____ mos. <input type="checkbox"/> Biopsy/FNA recommended		
<input type="checkbox"/> Fine Needle Aspiration/Cyst Aspiration Result: <input type="checkbox"/> Refused/Not done Date Performed: ____ / ____ / ____ <input type="checkbox"/> No fluid or tissue obtained Provider: _____ <input type="checkbox"/> Non-suspicious <input type="checkbox"/> Suspicious for neoplasm		
<input type="checkbox"/> Biopsy Result: <input type="checkbox"/> Refused/Not done <input type="checkbox"/> Surgical <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Stereotactic <input type="checkbox"/> Other benign changes <input type="checkbox"/> Core Needle <input type="checkbox"/> Lobular Carcinoma In Situ (LCIS)* <input type="checkbox"/> Carcinoma in situ* Date Performed: ____ / ____ / ____ <input type="checkbox"/> Invasive breast cancer* Provider: _____ <input type="checkbox"/> Normal breast tissue <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other Tests Performed Date Performed: ____ / ____ / ____ If yes, specify: _____ Provider: _____		
Final Diagnosis <input type="checkbox"/> Breast Cancer not diagnosed Date Performed: ____ / ____ / ____ <input type="checkbox"/> Ductal Carcinoma In Situ (DCIS) <input type="checkbox"/> Lobular Carcinoma In Situ (LCIS) <input type="checkbox"/> Invasive Breast Cancer		
Status of Diagnostic Work-up <input type="checkbox"/> Work-up completed <input type="checkbox"/> Work-up pending Date Performed: ____ / ____ / ____ <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Irreconcilable* <input type="checkbox"/> Work-up refused		
* If the provider refers for short-term follow-up instead of following guidelines.		
Treatment Status <input type="checkbox"/> Initiated <input type="checkbox"/> Refused <input type="checkbox"/> Pending <input type="checkbox"/> Not indicated <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Updated (follow-up information)		
Treatment (not paid by Alabama Breast and Cervical Cancer Program) <input type="checkbox"/> Mastectomy Treatment Date: ____ / ____ / ____ <input type="checkbox"/> Lumpectomy Treatment Provider: _____ <input type="checkbox"/> Re-excision of the biopsy site <input type="checkbox"/> Other		
Case Management Needed: <input type="checkbox"/> Yes Contact your area screening coordinator		
Further Treatment required: Referred to: _____ Phone No: _____ Appt. Date: ____ / ____ / ____		
ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.		



MRI FORM Instructions/Guidance

1. **ALL MRIs MUST HAVE PRIOR AUTHORIZATION AND BE SIGNED** by the Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) Regional Coordinator.
2. ABCCEDP will reimburse a screening breast MRI for high-risk women with one of the following:
 - Genetic mutation such as BRCA 1 or 2 (**Must have documentation of genetic mutation**)
 - First degree relative (mother, sister, daughter) with a genetic mutation such as BRCA 1 or 2 (**Must have documentation of breast cancer and/or genetic mutation**)
 - History of radiation treatment to the chest area before the age of 30 (**typically for Hodgkin's Lymphoma**)
 - Personal history of lobular carcinoma in situ (**Must have documentation of lobular carcinoma in situ**)
 - Patient has unusual circumstances that need to be approved by the Medical Advisory Board (**Must supply adequate reports for review by the Medical Advisory Committee**)

*Any of the above reasons constitutes a >20% lifetime breast risk assessment score which is considered high risk.
3. MRIs should **NEVER** be done alone as a breast cancer screening tool. A screening MRI will be reimbursed for high-risk women 6 months after a negative/benign mammogram. The ABCCEDP Program will only reimburse a screening MRI for high-risk women once a year.
4. The ABCCEDP only covers screening MRIs, not diagnostic MRIs.
5. Breast MRIs cannot be reimbursed to assess the extent of disease in clients who have already been diagnosed with breast cancer.
6. To be most effective, it is critical to complete MRIs at facilities equipped with breast MRI equipment and perform MRI guided biopsies.



BREAST MRI AUTHORIZATION & RESULTS FORM

TRACKING NUMBER REQUIRED

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PATIENT INFORMATION (to be completed by the primary provider or breast surgeon's office)

Patient Name (Last Name, First Name) _____
 Date of Birth (MM/DD/YYYY) _____ Social Security Number XXX-XX-____ Patient Telephone _____
 Provider Name (Breast Surgeon/Primary Care Provider) _____ Date of Referral _____
 Name of the Referral Hospital _____ Provider Phone _____

1. INDICATIONS FOR ORDERING MRI (to be completed by the primary provider/breast surgeon's office)

Please check all that apply:

- I. Patient has genetic mutation such as BRCA 1 or 2 (Must have documentation of genetic mutation)
- II. Patient has a 1st degree relative (mother, sister, daughter) with a known genetic mutation such as BRCA 1 or BRCA 2 (Must have documentation of genetic mutation)
- III. History of radiation treatment to the chest area before the age of 30
- IV. Personal history of lobular carcinoma in situ (Must have documentation of lobular carcinoma in situ)
- V. Patient has findings/risk factors that the provider deems necessary for further consideration from the Medical Advisory Committee (Must supply adequate reports for review by the Medical Advisory Committee)

*Any of the above reasons constitutes a >20% lifetime breast risk assessment score which is considered high risk.
 (e.g. www.cancer.gov/bcrisktool/ or <https://ibis-risk-calculator.magview.com/>)

2. MRI ORDER

Ordering Provider: _____

Facility/Provider Contact Number: _____

Facility Name or County Health Department Address:

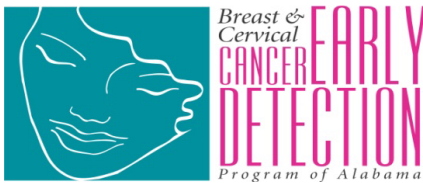
3. AUTHORIZATION FROM ABCCEDP REGIONAL COORDINATOR

Signature of Regional Coordinator: _____ Date: _____

Date of MRI: _____ Provider Signature: _____

4. MRI RESULTS (Attach a copy of the results, completed by MRI provider)

- 1. Negative (BI-RADS 1)
- 2. Benign Finding (BI-RADS 2)
- 3. Probably Benign (BI-RADS 3)
- 4. Suspicious (BI-RADS 4)
- 5. Highly Suggestive of Malignancy (BI-RADS 5)
- 6. Known Malignancy (BI-RADS 6)
- 7. Incomplete: Need Additional Imaging for Evaluation (BI-RADS 0)
- 8. Results Pending
- 9. Not Done



Alabama Breast & Cervical Cancer Program Medicaid Treatment Referral Form for Women Diagnosed with Breast/Cervical Cancer

Date: _____

Physician: _____

AL License #: _____

Person completing form: _____

Phone # of person completing form: _____

PATIENT INFORMATION

1. Last name: _____ 2. First name: _____ 3. MI: _____

4. Social security # _____ - _____ - _____ 5. Date of Birth: ____ / ____ / ____

6. Age: ____ 7. Phone #: (____) _____

8. Patient's address: _____

(City)

(State)

(Zip)

9a. Family monthly income: _____

10. Family Size: _____

9b. Family yearly income: _____

11. Insurance coverage? Yes No
(Circle one)

12. U.S. Citizen? Yes No
(Circle one)

MEDICAL INFORMATION

13. Type of Diagnosis:

- 13a. Breast 13b. Cervical
- CIN II
- CIN III
- Carcinoma

Pathology report
must be attached

14. Date of Diagnosis: ____ / ____ / ____

15. Has patient begun treatment? Yes No
(Circle one)

Eligibility Information

- 1) 64 years of age or under
- 2) No insurance
- 3) Income at or below 250% of poverty level
income table at: [https://
www.alabamapublichealth.gov/bandc/index.html](https://www.alabamapublichealth.gov/bandc/index.html)
- 4) Citizen of Alabama

Contact Information

Please fax/email form & pathology report to
your Regional Coordinator or for more
information, contact Kelli Hardy at
phone: (334) 206-2976
fax: (334) 206-3738
kelli.hardy@adph.state.al.us

Billing Forms to Submit for Surgeons or GYNs

Please submit claims with the following:

BREAST DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

Name: _____ Date of Birth: ____/____/____
 Social Security Number: _____ Referring Clinic/Provider: _____
 Physician/Surgeon: _____ Phone No: _____ Today's Date: ____/____/____

Reason for Referral: _____
 Insurance Status: No Insurance Underinsurance Insured Billed to Medicaid: _____ Yes

Repeat CBE/Surgical consultation:
 Result: Refused/Not done No intervention/routine follow-up Short term follow-up: _____ mos. Biopsy/FNA recommended
 Date Performed: ____/____/____
 Provider: _____

Fine Needle Aspiration/Cyst Aspiration
 Result: Refused/Not done No fluid or tissue obtained Non-suspicious Suspicious for neoplasm
 Date Performed: ____/____/____
 Provider: _____

Biopsy: Result: Refused/Not done Hyperplasia Stereotactic Other benign changes Core Needle Lobular Carcinoma In Situ (LCIS)* Carcinoma in situ* Invasive breast cancer*
 * Please contact your ABCCEDP Regional Coordinator as soon as a diagnosis of cancer is known. Normal breast tissue Other:
 Date Performed: ____/____/____
 Provider: _____

Other Tests Performed _____ Date Performed: ____/____/____
 If yes, specify: _____

Final Diagnosis: Breast Cancer not diagnosed Ductal Carcinoma In Situ (DCIS) Lobular Carcinoma In Situ (LCIS) Invasive Breast Cancer Other:
 Date Performed: ____/____/____

Status of Diagnostic Work-up:
 Work-up completed Work-up pending Lost to follow-up Irreconcilable*
 Work-up refused
 Date Performed: ____/____/____

* If the provider refers for short-term follow-up instead of following guidelines.

Treatment Status:
 Initiated Refused Pending Not indicated Lost to follow-up Updated (follow up information)

Treatment (not paid by Alabama Breast and Cervical Cancer Program)
 Mastectomy Lumpectomy Re-excision of the biopsy site Other:
 Treatment Date: ____/____/____
 Treatment Provider: _____

Case Management Needed: Yes Contact your regional coordinator

Further Treatment required: _____
 Referred to: _____ Phone No: _____ Appt. Date: ____/____/____
 ABCCEDP does not pay for treatment, but patient may be eligible for Medicaid Treatment Program.

CERVICAL DIAGNOSTIC AND FOLLOW-UP FORM
ALABAMA BREAST AND CERVICAL CANCER
EARLY DETECTION PROGRAM (ABCCEDP)

Tracking Number (required)

Name: _____ Date of Birth: ____/____/____
 Social Security Number: _____ Referring Clinic/Provider: _____
 Gynecologist: _____ Phone No: _____ Appointment Date: ____/____/____
 Reason for Referral: _____ Pap Result: _____ Date Performed: ____/____/____

Insurance Status: No Insurance Underinsurance Insured Billed to Medicaid: _____ Yes

Gynecologic Consultation Colposcopy no biopsy
 Diagnostic Col Knife Cone Colposcopy with biopsy and/or ECC
 Diagnostic ECC Diagnostic LEEP Date Performed: ____/____/____
 Other: _____ Provider: _____

Final Diagnosis: Date Performed: ____/____/____
 Normal/Benign/Inflammation Other Abnormalities
 HPV/Condylomata/Atypia Cervical Polyps
 CIN I/Mild Dysplasia CIN II/Moderate Dysplasia* CIN III/Severe Dysplasia/Carcinoma In Situ/Adenocarcinoma In Situ* VIN - Vulvar Intraepithelial Neoplasia VIN - Vaginal Intraepithelial Neoplasia Invasive Cervical Carcinoma*
 *Please contact your Area Screening Coordinator as soon as a cancer or pre-cancer diagnosis is known.

Status of Diagnostic Work-Up:
 Work-up completed Work-up pending Lost to follow-up Irreconcilable* Work-up refused
 Date Performed: ____/____/____

*If the provider refers for short-term follow-up instead of following guidelines for diagnostic work-up.

Treatment Status: Initiated Refused Pending Not indicated Lost to follow-up Updated (follow-up information)
 Date Performed: ____/____/____

Treatment (not paid by Alabama Breast and Cervical Cancer Program)
 Cryotherapy LEEP Laser Therapy Cone Biopsy Hysterectomy Other:
 Treatment Date: ____/____/____
 Treatment Provider: _____

Please Contact your Area Screening Coordinator to initiate Medicaid application if patient is eligible for the treatment Program.

Case Management Needed: Yes, Contact your Area Screening Coordinator

Further Treatment Required: _____
 Referred to: _____ Phone No: _____ Appt. Date: ____/____/____
 ABCCEDP does not pay for treatment, but the patient may be eligible for Medicaid Treatment Program.

Completed Breast Diagnostic Form

OR

Completed Cervical Diagnostic Form

HEALTH INSURANCE CLAIM FORM

INSURANCE INFORMATION: _____
 CLAIM INFORMATION: _____
 PATIENT INFORMATION: _____
 PROVIDER INFORMATION: _____
 SERVICE INFORMATION: _____
 CLAIM STATUS: _____

Claim Form

OFFICE
NOTE

Office Notes

PATHOLOGY
if applicable

Pathology Report

*****All forms, reimbursement rate table, eligibility guidelines etc. are available at:
alabamapublichealth.gov/bandcc/forms.html

Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP)				
FY25/FY26 Reimbursement Rate Table (updated on 01/31/2026)				
Effective for Dates of Service Beginning February 01, 2026, through January 31, 2027				
Current Procedural Terminology (CPT) Description	Procedure Code	Global (G) rate	Professional (26 or P) rate	Technical (TC) rate
Office Visits - New Patients				
New Patient Screening (Pap Smear, Pelvic Exam, AND Clinical Breast Exam); does not include Pap smear lab fee	99203	\$107.90		
New Patient Partial Screening (Pap Smear and Pelvic or Clinical Breast Exam); does not include Pap lab fee	99202	\$68.92		
Office Visits - Established Patients				
Established Patient Annual Screening (Pap Smear, Pelvic Exam, AND Clinical Breast Exam) does not include Pap Smear Cytology lab fee	99213	\$87.79		
Established partial screening (Pap smear and pelvic exam or clinical breast exam) does not include Pap smear lab fee	99212	\$54.33		
Referral patient (ex: referral for mammogram from other provider) or established - 5 min.	99211	\$21.98		
Consultations				
Consultation Visit - 20 minutes face-to-face with patient	99202	\$68.92		
Consultation Visit - 30 minutes face-to-face with patient	99203	\$107.90		
Breast Cancer Screening and Diagnostic Procedures				
Screening				
Screening Mammogram, bilateral	77067	\$113.05	\$33.36	\$79.68
Screening digital breast tomosynthesis, bilateral, used in addition to CPT code 77067	77063	\$46.87	\$26.41	\$20.46
Diagnostic				
Diagnostic Unilateral Mammogram, includes CAD	77065	\$111.11	\$35.81	\$75.30
Diagnostic Bilateral Mammogram, includes CAD	77066	\$140.63	\$44.10	\$96.53
Diagnostic digital breast tomosynthesis, unilateral or bilateral, used in addition to CPT codes 77065 and 77066	G0279	\$37.52	\$26.41	\$11.11
Mammary ductogram or galactogram, single duct	**77053	\$47.62	\$15.87	\$31.75
Magnetic resonance imaging (MRI), breast, without contrast, unilateral	**77046	\$191.42	\$63.03	\$128.39
Magnetic resonance imaging (MRI), breast, without contrast, bilateral	**77047	\$194.86	\$69.69	\$125.17
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, unilateral	**77048	\$299.27	\$92.08	\$207.19
Magnetic resonance imaging (MRI), breast, including CAD, with and without contrast, bilateral	**77049	\$304.93	\$100.66	\$204.27
Radiological examination, surgical specimen	76098	\$38.64	\$13.91	\$24.74
Ultrasound, complete examination of breast including axilla, unilateral	76641	\$90.13	\$32.07	\$58.06
Ultrasound, complete examination of breast including axilla, bilateral	76641BL	\$135.20	\$48.11	\$87.09
Ultrasound, limited examination of breast including axilla, unilateral	76642	\$75.30	\$29.81	\$45.49
Ultrasound, limited examination of breast including axilla, bilateral	76642BL	\$112.95	\$44.72	\$68.24
Ultrasonic guidance for needle biopsy, radiological supervision, and interpretation	76942	\$58.41	\$29.88	\$28.54
Breast Procedures				
		Non-facility Setting, Surgeon Fee *(NS)	Facility Setting, Surgeon Fee *(FS)	Facility Setting, Facility Fee *(FT)
Puncture aspiration of cyst of breast	19000	\$86.46	\$34.14	\$34.14
Puncture aspiration of each additional cyst of breast, used with CPT code 19000	19001	\$24.28	\$16.98	\$16.98
Biopsy of breast; percutaneous, needle core, not using imaging guidance	19100	\$144.99	\$56.15	\$56.15
Breast biopsy, open, incisional	19101	\$311.58	\$194.38	\$194.38
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, or nipple lesion; open; one or more lesions	19120	\$510.64	\$365.97	\$365.97
Excision of breast lesion identified by pre-operative placement of radiological marker. open; single lesion	19125	\$565.46	\$405.89	\$405.89
Excision of breast lesion identified by pre-operative placement of radiological marker; open; each additional lesion separately identified by a preoperative radiological marker	19126	\$130.37	\$130.37	\$130.37
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	19081	\$428.30	\$130.78	\$130.78
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion	19082	\$322.94	\$65.76	\$65.76
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	19083	\$425.27	\$123.37	\$123.37
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion	19084	\$317.37	\$61.64	\$61.64

Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	19085	\$640.15	\$143.60	\$143.60
Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion	19086	\$489.61	\$71.69	\$71.69
Placement of breast localization device, percutaneous; mammographic guidance; first lesion	19281	\$211.64	\$78.95	\$78.95
Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion	19282	\$147.35	\$39.51	\$39.51
Placement of breast localization device, percutaneous; stereotactic guidance; first lesion	19283	\$224.88	\$79.62	\$79.62
Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion	19284	\$161.94	\$40.07	\$40.07
Placement of breast localization device, percutaneous; ultrasound guidance; first lesion	19285	\$311.65	\$67.91	\$67.91
Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion	19286	\$253.29	\$34.10	\$34.10
Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion	19287	\$532.33	\$100.67	\$100.67
Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	19288	\$403.79	\$50.74	\$50.74
Fine needle aspiration biopsy without imaging guidance, first lesion	10021	\$90.99	\$43.06	\$43.06
Fine needle aspiration biopsy without imaging guidance, each additional lesion	10004	\$48.38	\$34.06	\$34.06
Fine needle aspiration biopsy including ultrasound guidance, first lesion	10005	\$119.91	\$58.83	\$58.83
Fine needle aspiration biopsy including ultrasound guidance, each additional lesion	10006	\$55.56	\$40.66	\$40.66
Fine needle aspiration biopsy including fluoroscopic guidance, first lesion	10007	\$305.88	\$74.70	\$74.70
Fine needle aspiration biopsy including fluoroscopic guidance, each additional lesion	10008	\$126.88	\$44.46	\$44.46
Fine needle aspiration biopsy including CT guidance, first lesion	10009	\$367.75	\$88.35	\$88.35
Fine needle aspiration biopsy including CT guidance, each additional lesion	10010	\$210.30	\$62.13	\$62.13
Fine needle aspiration biopsy including MRI guidance, first lesion	10011	\$367.75	\$88.35	\$88.35
Fine needle aspiration biopsy including MRI guidance, each additional lesion	10012	\$210.30	\$62.13	\$62.13
Breast Lab		Global (G) rate	Professional (26) rate	Technical (TC) rate
Laboratory Evaluation of Fine Needle Aspiration, first evaluation only	88172	\$49.94	\$31.63	\$18.31
Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s), each separate additional evaluation episode	88177	\$27.04	\$19.44	\$7.60
Interpretation and Report of Fine Needle Aspiration	88173	\$151.00	\$62.75	\$88.24
Surgical pathology, gross, and microscopic examination	88305	\$64.22	\$33.63	\$30.58
Surgical pathology, gross, and microscopic examination; requiring microscopic evaluation of surgical margins	88307	\$248.91	\$73.09	\$175.82
Morphometric analysis, tumor immunochemistry, per specimen, manual	88360	\$108.47	\$37.56	\$70.92
Morphometric analysis, tumor immunochemistry, per specimen, automated	88361	\$103.92	\$39.14	\$64.78
In situ hybridization (e.g., FISH), per specimen; initial single probe stain procedure	88365	\$151.16	\$38.85	\$112.31
In situ hybridization (e.g., FISH), per specimen; each additional single probe stain procedure	88364	\$113.40	\$30.50	\$82.90
In situ hybridization (e.g., FISH), per specimen; each multiplex probe stain procedure	88366	\$236.69	\$55.41	\$181.29
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, initial single probe stain	88367	\$94.53	\$30.04	\$64.49
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each additional probe stain	88373	\$57.81	\$23.13	\$34.68
Morphometric analysis, in situ hybridization, computer-assisted, per specimen, each multiplex stain procedure	88374	\$236.52	\$38.18	\$198.34
Morphometric analysis, in situ hybridization, manual, per specimen, initial single probe stain procedure	88368	\$131.00	\$38.56	\$92.44
Morphometric analysis, in situ hybridization, manual, per specimen, each additional probe stain procedure	88369	\$115.44	\$30.79	\$84.65
Morphometric analysis, in situ hybridization, manual, per specimen, each multiplex stain procedure	88377	\$341.40	\$58.81	\$282.60
Cervical Cancer Screening and Diagnostic Procedures				
Screening		Global (G) rate	Professional (26) rate	Technical (TC) rate
Lab fee for Pap test (Conventional); manual screening under physician supervision	88164	\$18.54		
Cytopathology (conventional Pap test), slides cervical or vaginal, reported in Bethesda System, manual screening and rescreening under physician supervision	88165	\$42.22		
Lab fee for Pap test (Conventional); requiring interpretation by physician	88141	\$21.98		
Lab fee for Pap test (LBC); manual screening under physician supervision	88142	\$20.26		
Lab fee for Pap test (LBC); manual screening and rescreening under physician supervision	88143	\$23.04		
Lab fee for Pap test (LBC); screening by automated system, under physician supervision	88174	\$25.37		
Lab fee for Pap test (LBC); screening by automated system and manual rescreening, under physician supervision	88175	\$26.61		
Human Papillomavirus, high-risk types	87624	\$35.09		
Self-collected HPV sample in clinical setting	87624	\$35.09		
Human Papillomavirus, types 16 and 18 only	87625	\$40.55		
Diagnostic				
Colposcopy of the cervix	57452	\$113.30		

Colposcopy with biopsy and endocervical curettage (surgical procedure only)	57454	\$150.60			
Colposcopy with biopsy(s) of the cervix	57455	\$145.25			
Colposcopy of the cervix with endocervical curettage	57456	\$135.92			
Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	58110	\$46.40			
Endometrial sampling (biopsy) with or without endocervical sampling	58100	\$88.68			
Colposcopy with loop electrode biopsy(s) of the cervix	57460	\$276.91			
Colposcopy with loop electrode conization of the cervix	57461	\$313.45			
Cervical Biopsy, single or multiple; Cervical Polyp Removal, single, or multiple	57500	\$135.11			
Endocervical curettage (not done as a part of a d&c)	57505	\$133.02			
Conization of cervix; cold knife or laser	57520	\$323.93			
Loop electrode excision procedure	57522	\$271.37			
Surgical pathology, gross, and microscopic examination	88305	\$64.22	\$33.63	\$30.58	
Surgical pathology, gross, and microscopic examination; requiring microscopic evaluation of surgical margins	88307	\$248.91	\$73.09	\$175.82	
Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	88331	\$89.58	\$55.20	\$34.38	
Pathology consultation during surgery, each additional tissue block, with frozen section(s)	88332	\$48.98	\$27.74	\$21.23	
Immunohistochemistry or immunocytochemistry, per specimen; first stain	88342	\$99.08	\$31.38	\$67.70	
Immunohistochemistry or immunocytochemistry, per specimen; each additional stain	88341	\$84.61	\$25.57	\$59.04	
Preoperative Laboratory and Radiographic Tests - Only Reimbursed When Biopsy is Planned/Performed					
Electrolyte Panel	80051	\$7.01			
Comprehensive Metabolic Panel	80053	\$10.56			
Hematocrit	85014	\$2.37			
Hemoglobin	85018	\$2.37			
Complete Blood Count Automated	85027	\$6.47			
Urinalysis	81005	\$2.17			
Urine Pregnancy Test	81025	\$8.61			
Routine ECG with interpretation and report	93000	\$13.95			
Chest X-ray AP & Lateral	71046	\$29.60	\$9.54	\$20.06	
Anesthesia for Breast Biopsy			Facility (F)	Doctor (D)	Nurse (N)
***Base Anesthesia Rate, 3 units	00400 Base	\$58.89	\$29.45	\$29.45	
One 15 Minute Unit	400	\$19.63	\$9.82	\$9.82	
Conscious Sedation Anesthesia, Breast or Cervical Procedure			Global (G)		
Conscious sedation anesthesia, first 10-22 minutes (below 10 minutes not payable)	99156	\$67.18			
Conscious sedation anesthesia, after 22 minutes, for each additional 15 minutes	99157	\$51.12			

1. Breast procedure fees: *i) NS - Non-facility setting, surgeon fee (NS) payable to the surgeon, and no facility fee paid towards the service. ii) FS - Facility Surgeon fee (FS) payable to the surgeon, when performed in a hospital setting. iii) FF - Hospitals get reimbursed with a facility fee.
2. **Preapproval from the Area Regional Coordinator is required before performing any of these procedures.
Breast MRI can be reimbursed in conjunction with a mammogram when a client has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater, as defined by risk assessment models as BRCAPRO. Breast MRI can be used to assess areas of concern on a mammogram or to evaluate a client with a history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed if done to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.
3. ***ABCCEDP Policy is to pay Base Rate, i.e., 3 units plus the number of 15-minute billed units. If MD and CRNA both bill, each is allowed half the unit cost. Max of 9 Facility units.

Note: A) Procedures not listed in this table are not covered by ABCCEDP. B) Providers need to discuss any non-covered services with clients before providing them.

C) Codes 19081-19086 should not be used in conjunction with 19281-19288 and vice versa.

D) Reimbursement Policy for Treatment-related services: ABCCEDP cannot pay for any treatment-related services; Codes 77061, 77062, and 87623 are not allowed.

Breast Only Codes	Cervical Only Codes	Breast and Cervical Codes
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Breast and Cervical Follow-Up

Primary screening providers are responsible for tracking patients with abnormal CBE, mammogram and HPV/Pap test results. Time between abnormal results and further evaluation should be 60 days or less. Time between cancer diagnosis and initiation of treatment should be 60 days or less. Quality Assurance audits are conducted yearly to assess screening providers' ability to adhere to ABCCEDP time guidelines. Audit outcomes are discussed with providers. Corrective Action plans are created when required.

1. **Providers are responsible for scheduling consultations, appointments and procedures as well as monitoring attendance and evaluation outcomes.** Missed appointments should be rescheduled within 30 days.
2. **Minimum of 3 attempts should be made to contact patients for follow-up.** Contact attempts can be made by phone calls, texts, emails, first class mail or certified letters and documented in patient chart. If there is no response after 3rd attempt, email the ABCCEDP Regional Coordinator the patient's name, DOB, type and dates of attempted contact.
3. **Abnormal CBE/Normal Diagnostic mammogram:** Diagnostic mammogram alone is not adequate follow-up. Must have either repeat CBE, breast ultrasound or surgical consult.
4. **BIRADS 0:** Additional views, comparison films and/or ultrasound in 60 days or less.
5. **BIRADS 4 or 5:** Surgical consultation in 60 days or less.
6. **Abnormal HPV/Pap testing results:** Follow current ASCCP algorithm guidelines for treatment. Further evaluation should occur in 60 days or less.

IMPORTANT REMINDERS

1. Patients are not to be charged for ABCCEDP visits.
2. Med-IT log-in is site specific and user specific. If the user works at several sites, then the user will need a log-in for each site.
3. ABCCEDP Consent Form must be signed once a year.
4. Patients must be enrolled into Med-IT on the day of their visit.
5. If a patient does not have a social security number, please leave it blank. Do not enter zeroes or any other numbers.
6. **DUPLICATES** – Always search Med-IT for patients before enrolling them into Med-IT to prevent duplicates. If duplicate accounts are found, use the oldest account. **ALWAYS report duplicate accounts to your ABCCEDP Regional Coordinator when found.**
7. Always search for patients in the following order:
 - DOB
 - Social security number
 - Name – (maiden, prior marriage, if two last names - search under both).
8. If a patient has two last names, put both last names in the last name box, no hyphen.
9. Always enter the Med-IT tracking number in the top right-hand corner of all forms.
10. If the patient's birth country is not listed in the drop-down box on the Med-IT enrollment screen, please notify your ABCCEDP Regional Coordinator. (see page 7)

Copies of the most up to date ABCCEDP Contracted Provider Manual, training packet, forms, videos, and all other resources may be found at:

<https://www.alabamapublichealth.gov/bandc/index.html>

Program Contact Information

Call toll-free – 1-877-252-3324



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**Cancer Screening
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