INTRODUCTION

Every Woman's Life (EWL) is pleased to release its *Program Manual (2010 edition),* which is effective June 30, 2009. Several important updates have been made that are noteworthy; they include:

- A new policy on consent forms was added.
- The federal core performance indicators were revised to include the indicator for mammograms over age 50.
- The Quality Assurance & Improvement section was enhanced.
- The Reimbursement for EWL Services policy was revised to allow providers to submit symptomatic women age 40-49 on a state invoice form.

Since 1998, the program has gradually evolved and strengthened its clinical and financial operations using a continuous quality improvement approach. We are proud of the many accomplishments and successes we have achieved over the past decade, including the ability to continually meet our annual target screening goal and exceed nationally recognized standards for quality care and fiscal accountability. The program currently receives both federal and state funds to serve women aged 18-64.

Over the years, we have strategically expanded and broadened the mission and philosophy of the program moving it from a breast and cervical cancer screening program to a program that focuses and embraces total women's health. In 2009, the program added nutrition and physical activity lifestyle interventions through the addition of the WISEWOMAN project. The positive and preventive health messages, such as good nutrition, healthy weight and increased activity that the WISEWOMAN project promotes, are strategically dispersed throughout this manual.

We are very excited about the prospect of new opportunities and program advancements that will further strengthen EWL in the future, and look forward to working with our providers and community partners to continue to enhance the quality of life for all Virginia women.

TABLE OF CONTENTS

Section: Data Collection, Reporting & Retention

1. Client Data Collection Forms
2. Technical Reporting Requirements
3. Retention and Disposition of EWL Records

Section: Enrollment

1. Eligibility
2. Federal Poverty Guidelines
3. Never/Rarely Screened
4. Informed Consent
5. Client Transfers

Section: Quality Assurance and Improvement

1. Federal Core Performance Indicators
2. State Core Performance Indicators
3. Planned Interventions to Enhance Provider Site Performance
4. Problem Focused Medical Record Review
5. Observational Site Visit
6. Medical Record Documentation

Section: Reimbursement

1. Reimbursement for EWL Services

Section: Services

1. Client Education
2. Cervical Services for Women Age 18-39
3. Breast Services for Women Age 18-39
4. Cervical Cancer Screening and Pelvic Examinations for Women Age 40-64
5. Breast Cancer Screening for Women Age 40-64
6. Managing Women with an Abnormal Cervical Screening Result
7. Managing Women with an Abnormal Breast Screening Result
8. Services for Women 65 Years of Age and Older
9. Routine Screening Services

Section: Treatment

1. Medicaid Treatment Act

Section: Appendix

Appendix A: Data Information Manual
Appendix B: Monthly Screening Log
Appendix C: Community Health Worker Monthly Activity Report
Appendix D: Matching Funds Form
Appendix E: Interstate Verification of Treatment Certification
Appendix F: Client Education Check List
Appendix G: Client Services Flow Sheet
Appendix H: Invoice/Client Screening List
Appendix I: BCCPTA Medicaid Application Form
Appendix J: Medicaid BCCPTA Policy
Appendix K: Medicaid – Frequently Asked Questions

Data Collection, Reporting & Retention

Take care of yourself, and in turn you take better care of your loved ones; Set a good example for your family, children and friends by making healthy choices.
www.win.niddk.nih.gov

Title: Client Data Collection Forms

Program Component: Data Collection, Reporting & Retention

Purpose: To identify the data collection forms that must be accurately completed for each client enrolled into EWL.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The EWL client data forms collect critical demographic and clinical information on each client enrolled and served through the program. Data fields listed on the forms are required by CDC for national reporting purposes, and are often referred to as the Minimum Data Elements (MDEs). For a detailed description of each data field, refer to the *Data Information Manual* in **Appendix A**.

The EWL program requires that providers complete and submit three data forms for each client served. The forms include the Eligibility Form, Breast Screening and Diagnostic Form, and the Cervical Screening and Diagnostic Form. The Refused/Lost to Follow-Up Form shall be submitted, when indicated. To view the client data forms, refer to the *Data Information Manual* in **Appendix A**.

Providers shall ensure the accuracy and completeness of all client data submitted. For information on how to submit the client data forms and receive payment for services provided, refer to the section - *Reimbursement.*

Under Construction: A web-based application is currently under development that will allow EWL providers to enter client data on-site, and will no longer require the use of paper data forms.

Title: Technical Reporting Requirements

Program Component: Data Collection, Reporting & Retention

Purpose: To define the EWL reporting requirements that provider sites must comply with to maintain authorization.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
All of the following reporting requirements must be submitted to the state EWL program by the specified deadline date:

1. Monthly Screening Log – This report captures the EWL providers' self reported new and re-screens each month during the grant period. Provider sites must complete and email the monthly screening log, which captures the number of new screens and re-screens for the previous month, by the 5th day of each month to the state EWL program. Refer to **Appendix B** for the Monthly Screening Log form.

2. Community Health Worker Monthly Activity Report – Community Health Worker (CHW) reports are an important indication of the outreach/inreach efforts at a participating provider site. Reports for the preceding month should be filled out by the CHW and faxed or emailed to the state EWL program by the 5th day of the following month. Refer to **Appendix C** for the CHW Monthly Activity Report.

3. Annual Renewal Application – Provider sites are required to submit a renewal application annually that includes contact information and corrective action plans for any deficiencies identified. Provider sites must submit the renewal application electronically to the state EWL program by the deadline date.

4. Match Report – Provider sites are required to match $1 of nonfederal resources for each $3 of federal funds they receive. The match report documents the provider's cash and in-kind donations and must be completed and electronically submitted by July 31st to the state EWL program. Refer to **Appendix D** for the Matching Funds Form.

Title: Retention and Disposition of EWL Program Records

Program Component: Data Collection, Reporting & Retention

Purpose: To delineate the retention and disposition schedule of EWL program records.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The Centers for Disease Control and Prevention (CDC) considers data collected as part of the National Breast and Cervical Cancer Early Detection Program a part of the patient medical record, and therefore, subject to state laws related to retention and disposition. EWL program records include forms used to collect demographic and clinical information on women enrolled and served through EWL, such as the Eligibility Form, Breast Screening and Diagnostic Form, Cervical Screening and Diagnostic Form and Refused/Lost to Follow-up Form.

Providers must follow the conditions for records retention and disposition for patient medical records outlined under the provisions of the *Virginia Public Records Act, Sections 42.1-76, et. Seq. of the Code of Virginia*. Adult patient medical records shall be retained for 10 years after last treatment then destroyed by shredding or pulping. Patient medical records for the deceased shall be retained 5 years after death or 10 years after the last treatment, whichever is greater then destroyed by shredding or pulping. Prior to the destruction of patient medical records, providers must make an effort to notify patients through a published notice or correspondence. For more information on record retention and disposition visit:
http://www.lva.virginia.gov/agencies/records/.

Enrollment

Did you know that eating 5 or more servings of fruits and vegetables every day might help reduce the risk of cancer?
www.fruitsandveggiesmatter.gov

Title: Eligibility

Program Component: Enrollment

Purpose: To define eligibility criteria for the EWL program.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
To enroll a woman as a participant in the Virginia EWL program the woman must be between 18-64 years of age, claim her primary residence in Virginia, have a household income that is 200% of the Federal Poverty Level or less, and have no health insurance or limited health insurance. Women aged 18-39 must be symptomatic for breast or cervical cancer, which includes, but is not limited to, an abnormal Pap test result or abnormal breast exam.

All women shall be screened annually for eligibility prior to enrollment or re-enrollment into EWL. To receive EWL funded services, the following requirements must be met[1]:

1. Female gender (self-declared)
2. Age – must be age 18-64 (self-declared)[2]
3. Income must be 200% of the Federal Poverty Level or less (self-declared)[3]
4. Primary residence in Virginia (self-declared)[4]
5. Uninsured or underinsured (self-declared) - Underinsured is defined as having:
   a. Health insurance that does not reimburse for EWL allowable procedures (e.g., mammogram, Pap test)
   b. Health insurance that requires a deductible that cannot be met
   c. Health insurance that requires out of pocket expenditures, which may prohibit the woman from obtaining health care (e.g., cannot afford co-pay or insurance only pays 20% of the procedure)
   d. Health insurance that does not provide <u>full</u> health care coverage (e.g., Plan First Family Planning Services)

The following women are <u>not</u> eligible for EWL services:

6. Women who have health insurance (see exceptions listed under 5)
7. Women who have Medicaid with full health care coverage
8. Women enrolled in Medicare with Medicaid as a supplement
9. Women enrolled in Medicare Part B

Men are <u>not</u> eligible to receive EWL screening and/or diagnostic services.

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[1] EWL providers may follow stricter eligibility guidelines, if funds are limited.
[2] EWL may serve eligible women over age 65 with state funds. Refer to the policy "Services for Women 65 Years of Age and Older" under the Services section.
[3] EWL providers may choose to verify and document income level if this practice coincides with their agency's policies and procedures.
[4] EWL providers may choose to verify and document Virginia residence if this practice coincides with their agency's policies and procedures.

Title: Federal Poverty Guidelines

Program Component: Enrollment

Purpose: To ensure use of current Federal Poverty Guidelines for the purpose of enrolling financially eligible women.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
As required by law, an annual update to the Federal Poverty Guideline (FPG) is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the *Consumer Price Index for All Urban Consumers.*

Each January, the updates to the FPG are published in the *Federal Register* by the Department of Health and Human Services. EWL will officially adopt and release the FPG updates to providers at that time with an effective date of ***February 1st.***

Title: Never/Rarely Screened

Program Component: Enrollment

Purpose: To concentrate outreach, recruitment and enrollment efforts on women never or rarely screened for cervical cancer.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
EWL defines a priority population, which includes women who have never been screened or have not been screened in the past five years for cervical cancer. Research indicates that women who have not had a Pap test in five or more years are more likely to be in the greatest need of medical care. For this reason, at least **20%** of all 40-64 year old women ***newly*** enrolled for cervical cancer screening should be women who have never had a Pap test or have not had a Pap test in the last 5 years. This indicator only applies to 40-64 year old women served with federal funds. Refer to the *Quality Assurance and Improvement Section; Federal Core Performance Indicators; #5.*

Title: Informed Consent

Program Component: Enrollment

Purpose: To ensure that enrolled women understand and consent to all EWL services prior to receiving these services.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2009

The provider site coordinator or designee shall ensure that a client's informed, voluntary, written consent is obtained prior to the client receiving any EWL services. If eligibility is determined off-site, the provider shall obtain the client's consent before providing EWL services.

Consent information must be communicated effectively to every client, including those who have language barriers or who have disabilities that impair communication. If the client does not understand the language of the consent form, the form must be interpreted. Consent must never be obtained in a manner that could be perceived as coercive. Informed consent is more than signing a form or giving permission. It is an ethical and legal obligation of health care providers that includes explaining to the client the risks of a particular treatment, medication, or procedure and describing possible alternatives. It is based on the right of every client to make sound decisions regarding her own medical care.

EWL does not provide a consent form. EWL providers shall use the official consent form that is approved and recognized by their organization. If EWL providers have questions or concerns about the appropriateness of their agency/organization's consent form, they must consult a qualified attorney for guidance.

Title: Client Transfers

Program Component: Enrollment

Purpose: To ensure that eligible women transferring from another Breast and Cervical Cancer Early Detection Program (BCCEDP) are provided appropriate EWL services.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2008
Revised Date: June 30, 2009

Policy:
The National BCCEDP (NBCCEDP) was created in response to the Breast and Cervical Cancer Mortality Prevention Act passed by Congress in 1990. The act established a program of cooperative agreements with States, tribes, and territories to increase the early detection and prevention of breast and cervical cancer among low income, uninsured, and underinsured women. Because this is a nationally-funded program, clients previously enrolled in a NBCCEDP screening program outside Virginia, but now live in Virginia, may be eligible for services under EWL. For example:

1. Women aged 40-64 previously enrolled in another BCCEDP who have recently relocated to Virginia and are requesting breast and cervical cancer screening services may be enrolled into EWL provided they meet the program's eligibility requirements.

2. Women aged 18-64 receiving breast and cervical diagnostic services under the NBCCEDP who relocate to Virginia and need diagnostic work-up completed shall be enrolled in EWL to complete the necessary diagnostic procedures.

   For women aged 18-39:

   a. If the diagnostic work up rules out cancer, the woman should be referred to a health care provider for age appropriate health screenings and medical care. If the woman is 39 years of age and meets EWL eligibility requirements, she may be scheduled for EWL services so that she is enrolled in EWL by the time she turns age 40. This scenario is based on the assumption that appointment slots are available for women aged 40-49.

   b. If breast or cervical cancer is diagnosed, the woman shall be referred to Medicaid for treatment under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

For women aged 40-64:

c. If the diagnostic work up rules out cancer, the woman may be enrolled for rescreening services 12 months following her initial screening date, if she meets EWL eligibility criteria.

d. If breast or cervical cancer is diagnosed, the woman shall be referred to Medicaid for treatment under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

3. Women who were previously diagnosed with cancer or a pre-cancerous condition while enrolled in another NBCCEDP funded program, but are now a Virginia resident, are covered by the Virginia BCCPTA.

   a. Provider Site Coordinators or their designee must verify that out-of-state transfers are eligible for the Virginia BCCPTA. They may use the *Interstate Verification of Treatment Certification* form found in **Appendix E** for this purpose**.**

   b. Once the verification process is complete, Provider Site Coordinators or their designee must complete the BCCPTA enrollment form and submit the form to their local DSS Office. Refer to the *Treatment Section; Medicaid Treatment Act policy*.

Quality Assurance and Improvement

Did you know? People who eat a healthy breakfast are more likely to control their weight and have lower cholesterol.
www.mayoclinic.com

Title: Federal Core Performance Indicators

Program Component: Quality Assurance and Improvement

Purpose: To define the core performance indicators used to measure a provider's performance over a period of time.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
There are six core performance indicators that are used to monitor a provider's performance to ensure quality services are delivered in a timely and efficient manner. The indicators focus on client recruitment, completeness of work-up, timeliness of diagnosis, and timeliness of treatment. Providers must meet the six core performance indicators. The six indicators are tracked and reported quarterly to EWL providers for information, educational and quality improvement purposes.

The six core performance indicators are listed below:

1. Work-Up Completed

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.
▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.

2. Screening to Diagnosis

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result, the time between the abnormal screening test result and final diagnosis will be no longer than 60 days.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal breast cancer screening test result and the final diagnosis.
▪ If there is an abnormal cervical cancer screening result*, the time between the abnormal screening test result and final diagnosis will be no longer than 60 days. *Defined as ASC-H, high grade SIL, squamous cell cancer, result unknown and presumed abnormal, Pap test from a non-program funded source, abnormal glandular cells, and any pap result [ASCUS, LSIL], which is marked as needing diagnostics.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal cervical cancer screening test result and the final diagnosis.

3. Treatment Started

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.
▪ If there is a final diagnosis of CIN II or worse, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.

4. Diagnosis to Treatment

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer or a pre-cancerous condition, the time between cancer diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.
▪ If there is a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS), the time between diagnosis and the initiation of treatment will be no longer than 90 days.	▪ No more than 20% of records will indicate a timeframe of greater than 90 days between a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS) and initiation of treatment.
▪ If there is a final diagnosis of invasive cervical cancer, the time between diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between final diagnosis of invasive cervical cancer and the initiation of treatment.

5. Never/Rarely Screened

Performance Indicator	Minimum Standard
▪ The provider will target for enrollment never or rarely screened women, defined as women who have never had a Pap test, or who have not had a Pap test within 5 years.	▪ A minimum of 20% of newly enrolled women who receive a Pap test will meet the criteria for having been never or rarely screened.

6. Mammograms Over 50

Performance Indicator	Minimum Standard
▪ The majority of mammograms provided should be to women between 50 and 64 years of age.	▪ A minimum of 80% of mammograms provided to program eligible women who are 40 to 64 years of age must be provided to women over age 50.

Title: State Core Performance Indicators

Program Component: Quality Assurance and Improvement

Purpose: To define the core performance indicators used to measure a provider's performance over a period of time.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
There are four core performance indicators that are used to monitor a provider's performance to ensure quality services are delivered in a timely and efficient manner. The indicators focus on completeness of work-up, timeliness of diagnosis, and timeliness of treatment. Providers must meet the four core performance indicators. The four indicators are tracked and reported quarterly to EWL providers for information, educational and quality improvement purposes.

The four core performance indicators are listed below:

1. Work-Up Completed

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.
▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ 90% of records will be complete.

2. Enrollment to Diagnosis

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result, the time between the date of enrollment and final diagnosis will be no longer than 60 days.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between the date of enrollment and the final diagnosis.
▪ If there is an abnormal cervical cancer screening result*, the time between the date of enrollment and final diagnosis will be no longer than 60 days. *Defined as ASC-H, high grade SIL, squamous cell cancer, result unknown and presumed abnormal, Pap test from a non-program funded source, abnormal glandular cells, and any pap result [ASCUS, LSIL], which is marked as needing diagnostics.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between the date of enrollment and the final diagnosis.

a. Treatment Started

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.
▪ If there is a final diagnosis of CIN II+, appropriate treatment will be initiated.	▪ 90% of records will indicate treatment was initiated.

b. Diagnosis to Treatment

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer or a pre-cancerous condition, the time between cancer diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.
▪ If there is a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS), the time between diagnosis and the initiation of treatment will be no longer than 90 days.	▪ No more than 20% of records will indicate a timeframe of greater than 90 days between a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS) and initiation of treatment.
▪ If there is a final diagnosis of invasive cervical cancer, the time between diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between final diagnosis of invasive cervical cancer and the initiation of treatment.

Title: Planned Interventions to Enhance Provider Site Performance

Program Component: Quality Assurance and Improvement

Purpose: To ensure quality services are delivered through EWL.

Responsible Person(s): Quality Assurance/Improvement (QA/I) Nurse and Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
Quality assurance and improvement incorporates the use of established standards, systems, policies and procedures to monitor, assess, and identify practical methods for improvement. To ensure quality services are provided, provider site visits or conference calls will be scheduled periodically to discuss areas in need of improvement, and to collaboratively develop action steps to improve provider performance. Site visits/calls will primarily be initiated when problems are identified through the *Quarterly Performance Indicator Report (QPIR).* Providers failing to meet the same performance indicator for two consecutive quarters will be scheduled a site visit/call within 60 calendar days after the release of the *QPIR*. Other data tracking reports or programmatic issues, such as customer service or communication problems, may also generate a provider site visit/call. Additionally, site visits/calls may be initiated by the provider site to solicit technical assistance/guidance on a particular issue/problem.

The purpose of the site visit/call is to allow state and provider site staff an opportunity to identify and thoroughly discuss the issues surrounding the problem(s), and to brainstorm and formulate realistic action steps to improve the provider's performance and ensure compliance with all program standards. Participants will include the state EWL team and provider site staff, including the medical director (or designee), nurse manager, coordinator/case manager, community health worker (if there is one) and fiscal administrator. For site visits, the state EWL team reserves the right to conduct a record review during the visit, if deemed necessary (*see Problem-Focused Medical Record Review Policy).*

Procedure:

1. The state EWL program will coordinate the date, time and place of the site visit/call through the provider site coordinator or designee.

2. At least 10 calendar days prior to the visit/call, an agenda will be electronically sent to the provider with a list of discussion topics.

3. During the site visit/call, participants will discuss the issues, strategize and formulate practical solutions, and develop an improvement plan that includes

objectives and activities, responsible staff, and a realistic timeframe for completion of the plan.

4. Within 30 calendar days of the site visit/call, the Provider Site Coordinator or designee will submit an improvement plan to the QA/I Nurse that lists the following for each issue identified:
    a. Specific goals, objectives and activities to improve performance
    b. Staff person(s) responsible for implementing the activities
    c. Realistic timeline for the completion of each objective/activities
    d. Reporting times to document progress on established goals

5. Within 30 days of receipt of the improvement plan, the QA/I Nurse will approve the plan.

6. Progress on the improvement plan will be tracked and will remain in effect until the provider meets program standards or the QA/I Nurse is satisfied with the provider's performance.

Title: Problem Focused Medical Record Review

Program Component: Quality Assurance and Improvement

Purpose: To assess compliance with EWL program standards and ensure quality services are delivered.

Responsible Person(s): Quality Assurance/Improvement (QA/I) Nurse, Provider Site Clinicians and Case Managers

Effective Date: June 30, 2009

Policy:
The *Problem Focused Medical Record Review* is used to gather information concerning a quality assurance or performance issue that is identified through data reports, such as the quarterly performance indicator *Quarterly Performance Indicator Report* or *CDC Feedback Report.*

To initiate a *Problem Focused Medical Record Review*, the QA/I Nurse will send a description of the issue/problem to the provider, and a list of the medical records to be reviewed during an on-site visit. In preparation for the visit, the provider site coordinator/case manager shall have the medical records ready for review.

Following the *Problem Focused Medical Record Review*, the QA/I Nurse will release a report within 30 calendar days of the review date. The report will summarize the issue/problem and the results of the review, and provide specific recommendations. The QA/I Nurse will follow up 6 months following the release of the report to assess and document the provider's progress.

Title: Observational Site Visit

Program Component: Quality Assurance and Improvement

Purpose: To ensure consistent and optimum health care is delivered through EWL.

Responsible Person(s): Quality Assurance/Improvement (QA/I) Nurse and Provider Site Coordinator or Designee

Effective Date: June 30, 2009

Policy:
Continually monitoring and assessing clinical services is an important component of quality assurance/improvement, and can ultimately help a program meet and/or exceed customer expectations and program outcomes. The purpose of the observational site visit is twofold and includes: 1) engaging providers in the quality improvement process helping them feel valued and appreciated, and 2) collecting qualitative data such as client education, safety and satisfaction, cultural sensitivity and appropriateness of interactions and materials, service accessibility, and clinic efficiency. The observational site visit will allow the QA/I Nurse to follow a client through a complete clinical visit. In addition, a formal medical record review and staff interviews will evaluate adherence to established policies and protocols.

The qualitative and objective data gathered during an observational site visit provides a comprehensive assessment of EWL services that will identify potential problems and problem-prone aspects of care as well as effective strategies for improving services. The observational site visit also provides an opportunity for the QA/I Nurse to solicit general feedback, offer training on specific policies, procedures, and protocols, offer hands-on-help with challenging cases or areas of concern, provide technical assistance to help providers enhance systems to improve care, and negotiate action steps to meet program requirements. An observational site visit will be conducted every three years for each authorized EWL provider. The schedule of visits will be maintained on the EWL website.

Procedure:

1. The provider site administrator and coordinator will be notified 60 days prior to the visit.

2. The list of medical records to be reviewed at the time of visit will be included with the notification.

3. The QA/I Nurse will use the Observational Site Visit Form, the Medical Record Review Form, and if needed, the Interview Form to gather relevant information.

4. Within 30 days of the visit, the QA/I Nurse will submit a written summary of the provider's strengths, and weaknesses and recommendations for improvement to the provider coordinator.
5. Within 30 calendar days of the site visit, the provider coordinator or designee will submit an improvement plan to the QA/I Nurse that lists the following for each issue identified:
    a. Specific goals, objectives and activities to improve performance
    b. Staff person(s) responsible for implementing the activities
    c. Realistic timeline for the completion of each objective/activity
    d. Reporting times to document progress on established activities

6. Within 30 days of receipt of the improvement plan, the QA/I Nurse will approve the plan.

7. Progress on the improvement plan will be tracked and will remain in effect until the provider meets program standards or the QA/I Nurse is satisfied with the provider's performance.

Title: Medical Record Documentation

Program Component: Quality Assurance and Improvement

Purpose: To ensure all client encounters are documented appropriately and in a timely manner.

Responsible Person(s): Provider Site Clinicians, Case Managers or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The medical record serves many purposes but its primary functions are to document and plan client care, and provide a permanent record of information about the services provided. From a risk management standpoint, the medical record serves as a legal document that completely and accurately reflects the care provided to the client. Although healthcare facilities embrace and follow standards for medical record documentation, these standards and procedures may vary slightly from one institution to the next.

The EWL program contracts with public health departments and private agencies/organizations, such as hospitals, free clinics and community health centers to provide breast and cervical cancer screening services. Documentation by Exception[1] is the standard for public health departments and shall be used to document all EWL client encounters. Private EWL providers shall follow the documentation policy endorsed by their individual agency or organization. All EWL providers (public and private) shall follow the medical record documentation policies endorsed by their agency/organization to record client:

- Assessments
- Interventions
- Clinical services
- Referrals
- Education
- Responses

Providers may use the Client Education Checklist **(Appendix F),** and Client Services Flow Sheet **(Appendix G)** to easily organize and document education and services provided to EWL enrolled women. These forms are ***optional*.**

[1] Documentation by Exception is a system of documenting exceptions to expected findings or disease progression. DBE is based on the premise that a client has manifested a normal response to all interventions unless an abnormal response is charted. Murphy, Ellen *Charting by Exception. AORN Journal, Nov. 2003*

Reimbursement

Small steps, big rewards: Walk during your lunch hour
www.smallstep.gov

Title: Reimbursement for EWL Services

Program Component: Reimbursement

Purpose: To define the payment policy for screening and diagnostic services provided under the auspices of the EWL program.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The EWL provider shall receive compensation for breast and cervical cancer screening and related services in the form of a per person capitation rate. The capitation rate is calculated using historical EWL program utilization data, case management fees, and the actual costs for services, which are based on Virginia Medicare reimbursement rates for approved CPT codes covered by the EWL program.

For services supported through federal funds, the capitation rate for a 12-month contract year and all renewals is $320 per woman aged 40-64. For counties and cities located in the northern Virginia area[1], the capitation rate is $350 per woman aged 40-64. The capitation rate includes the cost of providing breast and cervical cancer screening services, including short-term follow-up visits that occur within 12 months of the initial screening exam, plus the cost of diagnostic tests for the percentage of women who will need them. The capitation rate also supports case management services for managing women with abnormal breast and cervical screening results.

For services supported through state funds, the capitation rate for a 12-month contract year and all renewals is $400 per woman aged 18-39. For counties and cities located in the northern Virginia area, the capitation rate is $440 per woman aged 18-39. The capitation rate includes the cost of providing breast and cervical cancer diagnostic services, including any short-term follow-up visits that occur within 12 months of the initial diagnostic exam. The capitation rate also supports case management services for managing women with abnormal breast and cervical screening results.

To receive the approved capitation rate, EWL providers must submit an original invoice plus the three required data forms for each client (e.g., Eligibility Form, Breast Screening & Diagnostic Form, and Cervical Screening & Diagnostic Form). Screening information must be complete and all diagnostic information must be entered, if diagnostic tests were performed.

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[1] Northern Virginia cities and counties include: Cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William.

A copy of the Invoice/Client Screening List can be found in **Appendix H**. Refer to the *Data Information Manual* in **Appendix A** for the required client data forms.

Upon receipt of the invoice/client data packet, the EWL Data Manager will review the data forms for accuracy and completeness and will contact the provider site by fax or telephone to request any missing information. Provider sites shall respond to all requests for missing information in a timely manner. If missing information is not provided, invoices will be adjusted accordingly to reflect clients not approved for payment. For clients approved for payment, 'YES' will be entered on the Client Screening List; a 'NO' will be entered for clients not approved for payment. The EWL Program Director or designee will approve the invoice within 3 calendar days of its receipt, and forward to the agency Business Unit for payment processing. The approved number of clients will be emailed to the provider site. When a client(s) is denied for payment the reason for denial will be faxed.

Providers that fail to submit an invoice and the required client data forms to the state EWL program within **90 calendar days** of the date of the last screening exam (e.g., CBE, Pap test, mammogram) shall forfeit the right to payment.

Close out procedures issued each year for the month of June will include data form submission and reimbursement instructions that will vary from the standard reimbursement policy and procedure.

Providers shall submit an invoice/client data packet monthly, and adhere to the following goals for submission:

Quarter	**Date**	**Invoice Goal**	**Client Data Goal**
2nd quarter	**12/31**	**25% of total award**	**25%**
3rd quarter	**3/31**	**50% of total award**	**50%**
4th quarter	**6/29**	**100% of total award**	**75%**
	8/31	**----------**	**100%**

Procedure:

1. Complete all information on the required data forms, which include the Eligibility Form, Breast Screening and Diagnostic Form and Cervical Screening and Diagnostic Form.

2. Customize the EWL invoice with your organization's letterhead.

3. Complete an invoice for federal screens, if requesting payment for clients aged 40-64. See Appendix G – FEDERAL SCREENING INVOICE

    A. The approved capitation rate will only be paid for clients that have received a clinical breast exam, mammogram, pap test and pelvic exam, unless the procedure is marked – refused, not needed, or done recently. However, in order for payment to occur the client must have at least received a mammogram. For example, a client that receives a Pap test and clinical breast exam but no mammogram will not be reimbursed. Exception: The capitation rate will be approved for clients that received a mammogram elsewhere, and were referred into the EWL program for breast or cervical diagnostic testing to rule out cancer.

4. Complete an invoice for state screens, if requesting payment for clients aged 18-39. See Appendix G – STATE SCREENING INVOICE

    A. Providers will **not** be reimbursed for clients that receive a clinical breast exam to rule out the need for additional diagnostic testing. Providers will ***only*** receive reimbursement for clients that received diagnostic tests to rule out cervical or breast cancer.
    B. Symptomatic women age 40-49 may be submitted on a state invoice if they meet the requirements listed in the Services Section – Refer to *Cervical Services for Women Age 18-39 and Breast Services for Women Age 18-39.*
    C. Women aged 65 and older should be submitted on a state screening invoice.

5. Include the following information on the invoice:
    A. Invoice date
    B. Federal tax ID#
    C. Invoice # (state and federal screening invoice numbers must be different)
    D. Contract #
    E. Provider site name
    F. Amount of funds requested:
        1. List the number of clients you are requesting payment for and the requested amount in the appropriate space.
        2. Enter the total amount of funds awarded for a Community Health Worker on the Federal Screening Invoice. Health Departments do not need to submit an invoice for Community Health Worker funds.

G. Organization name and address where payment should be mailed

6. Complete the Client Screening List. Enter the invoice date and invoice number. List the client name and screening date of service, and number the client list. Attach clients 40-64 years of age to the **Federal Screening Invoice**; clients 18-39 years of age to the **State Screening Invoice.** Exception: providers may also submit symptomatic clients age 40-49 on a state invoice – refer to #4B.

7. Group follow-ups by age (e.g., 18-39 or 40-64) and list them on the Follow-Up Client Screening List. Attach this list to the Federal or State Screening Invoice, depending upon the age group.

   A. The Follow-Up Client Screening List should not be submitted to the state EWL office on a blank invoice marked "NA".

8. Mail the completed invoice/client data packet to:

Virginia Department of Health
Every Woman's Life
ATTENTION: DATA MANAGER
109 Governor Street, 8th Floor
Richmond, Virginia 23219

Services

The average adult loses about 10 cups of water daily. To maintain your body's fluid balance, you need to replace it each day.
www.eatright.org

Title: Client Education

Program Component: Services

Purpose: To ensure that all clients enrolled in EWL receive important health information emphasizing the importance and purpose of regular breast and cervical screening exams as well as healthy lifestyle behaviors.

Responsible Person(s): Provider Site Case Managers, Clinicians or Designee

Effective Date: June 30, 2007

Policy:
Client education is an essential and fundamental component of the EWL program. Health information provided assists clients in making positive lifestyle choices and decisions, and provides critical information about the importance of routine cancer screening exams. Case managers, clinicians or their designee shall:

1. Provide information that is culturally and linguistically appropriate and understandable for visually/hearing impaired women, about the purpose of clinical breast exams, mammograms and/or Pap tests when they enroll in the program. Emphasis should be placed on the message that routine screening lowers mortality from breast cancer and decreases a woman's chances of developing invasive cervical cancer, and

2. Provide information on other age appropriate cancer screenings (e.g., colorectal screening over age 50) to women enrolled in the program.

Case Managers, clinicians or their designee may also provide health information on key topics which encourage a healthy lifestyle (e.g., low fat diet, increased activity) to women enrolled in the program to lower the risk of chronic diseases, such as heart disease, high blood pressure and diabetes. Refer to the *New Day Resource Guide* for ideas on how to incorporate women's health messages into health care.

Title: Cervical Services for Women Age 18–39

Program Component: Services

Purpose: To ensure women age 18-39 with high-grade cervical abnormalities receive appropriate cervical diagnostic services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The EWL program provides cervical diagnostic services (e.g., colposcopy) to eligible women between the ages of 18-39 that are referred to the program as a result of a high-grade cervical abnormality test result. Women within this age range are typically screened and referred to the EWL program through family planning clinics or other health care providers. The EWL program **does not** cover routine cervical screening services, such as a Pap test, for this age group.

Cervical abnormalities that warrant cervical diagnostic and case management services include:

1. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)
2. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Positive HPV
3. Low-Grade Squamous Intraepithelial Lesion (LSIL) for women over age 20
4. High-Grade SIL (HSIL)
5. Atypical Glandular Cells (AGC)
6. Squamous Cell Carcinoma
7. Atypical Squamous Cells of Undetermined Significance (ASCUS) for women over age 20 - Depending on funding and the clinical care plan, ASCUS *may* warrant cervical diagnostic and case management services.

An abnormal cervical screening test result requires follow-up. *Refer to the policy - Managing Women with an Abnormal Cervical Screening Result*.

Note: In order to invoice for state funds, one of the abnormal cytology results listed above must be checked on the *Cervical Screening and Diagnostic Form* and immediate cervical diagnostic work-up must be marked 'yes'.

Title: Breast Services for Women Age 18-39

Program Component: Services

Purpose: To ensure women with breast symptoms 18-39 receive appropriate diagnostic services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The EWL program provides breast diagnostic services (e.g., diagnostic mammogram, ultrasound) to eligible women between the ages of 18-39 that are symptomatic for breast cancer. Symptomatic is defined as the presence of:

1. A discrete palpable mass
2. Bloody or serous nipple discharge
3. Nipple or areolar scaliness
4. Skin dimpling, retraction, or inflammation

Women within this age range are typically screened and referred to the EWL program through family planning clinics or other health care providers.

A clinical breast examination (CBE) must be performed on all symptomatic women to confirm the presence of breast symptoms. EWL clinicians or non-EWL clinicians may perform the CBE. If a non-EWL clinician performs the CBE, the provider site clinician/case manager must obtain the results of the exam. Once a CBE is performed and confirms the presence of breast symptoms, the client shall be referred for imaging studies as determined by the *NCCN 1.2009 Breast Cancer Screening and Diagnosis Guidelines.* These Guidelines can be found at *www.nccn.org*.

Women within this age group that have received an abnormal imaging result are also eligible to receive breast diagnostic services. An abnormal imaging result that warrants diagnostic services includes:

1. BIRADS 4 (Suspicious abnormality)
2. BIRADS 5 (Highly suggestive of malignancy

The EWL program **does not** cover routine breast screening services, such as a screening mammogram, for a*symptomatic* women within the ages of **18-39** group, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer or first degree relative with pre-menopausal breast cancer).

Note: In order to invoice for state funds, one of the breast symptoms listed above must be checked on the *Breast Screening and Diagnostic Form,* and additional breast procedures needed must be marked 'yes'.

Title: Cervical Cancer Screening and Pelvic Examinations for Women Age 40 - 64

Program Component: Services

Purpose: To ensure that eligible women are provided cervical cancer screening and clinical pelvic examinations.

Responsible Person(s): Provider Site Clinicians, Coordinators or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The EWL program promotes an *annual* gynecological exam, which includes a pelvic exam and Pap test. The pelvic exam includes a bimanual exam and vaginal inspection with speculum. The primary purpose of the Pap test is to identify pre-cancerous and cancerous cervical lesions at an early stage. Clinicians shall obtain a Pap test from women who have an intact cervix. The Pap test can be the conventional slide or liquid-based cervical cytology (LBT) method.

<u>Cervical Cancer Screening Intervals – Conventional</u>
The Coordinator or designee shall ensure Pap tests will be obtained on an annual basis unless the woman has had:

1. Three consecutive normal **conventional** Pap test results documented within a 60-month period. Once this occurs, the screening interval shall increase to once every three years.
    A. To calculate the time period for the three normal screening tests, the first test date should be considered "month 0," the second test would occur around month 12-24. The third Pap test would be between 24-36 months or twelve months from the second test.

<u>Cervical Cancer Screening Intervals – Liquid-Based</u>
The screening interval using the liquid-based test is every **two years**. The Coordinator or designee shall ensure a liquid-based Pap test is obtained on a biannual basis unless the woman has had:

1. Three consecutive normal **liquid-based** test results documented within a 60-month period. The screening interval shall increase to once every three years.
    A. To calculate the time period for the three normal screening tests, the first test date should be considered "month 0," the second test would occur around month 24, and the third around month 48.

Pap Test Reporting

Pap test results must be reported using the Bethesda System 2001.

Management of Other Pap Test Results:

1. Unsatisfactory Pap test result - Repeat in 2-4 months
2. Negative cytology with insufficient endocervical/transformation zone - Repeat cytology in 12 months
3. Negative cytology partially obscured by blood, inflammation or partial air-drying effect - Repeat in 12 months[1]

There may be clinical indications for repeating the Pap test earlier than 12 months:

1. A previous squamous abnormality (ASCUS or worse) without 2 subsequent negative Paps or a negative HPV test
2. A previous Pap with unexplained glandular abnormality
3. A positive high-risk /oncogenic HPV test within the past 12 months
4. Clinician inability to visualize the cervix or sample the endocervical canal
5. Similar obscuring factor in consecutive Pap tests
6. Insufficient previous screening[2]

HPV DNA Testing

HPV DNA testing is an allowable procedure if used in follow-up of an ASC-US result from the screening exam, or for surveillance at one year following an LSIL Pap test without evidence of CIN on colposcopy-directed biopsy. **It is not reimbursable as a screening test.** Providers should specify the high-risk HPV DNA panel since screening for low-risk genotypes of HPV is not permitted.

Pap Test Following a Hysterectomy

EWL program funds **cannot** be used to pay for cervical cancer screening in women with complete hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer. The presence of a cervix can be determined on physical exam. EWL program funds **can** be used to pay for an initial examination (i.e., pelvic exam) to determine if a woman has a cervix.

Abnormal Pap Test Result

An abnormal cervical screening test result requires follow-up. *Refer to the policy - Managing Women with an Abnormal Cervical Screening Result*.

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[1] Cervical cytology specimen adequacy: patient management guidelines and optimizing specimen collection. Davey DD, Cox JT, Austin RM, Birdsong G, Colgan TJ, Howell LP, Husain M, Darragh TM. Journal of Lower Genital Tract Disease, 2008 12(2):71-81.

[2] Ibid.

Title: Breast Cancer Screening for Women Age 40 - 64

Program Component: Services

Purpose: To ensure women between the ages of 40-64 are provided clinical breast exams and screening mammograms.

Responsible Person(s): Provider Site Clinicians, Coordinators or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The primary purpose of regular breast cancer screening is to detect pre-cancerous or cancerous lesions at the earliest stage, and refer promptly for treatment. The clinical breast examination and mammogram are two important tests used in breast cancer screening.

Clinical Breast Examination
The clinical breast examination (CBE) is an important contribution to breast cancer screening. The CBE can detect some cancers not found by mammography, though this happens infrequently. The more important role of the CBE is the opportunity for client education about breast health, normal breast composition, and the importance of regular check-ups and breast imaging. Clinicians shall perform at least one CBE annually on all clients enrolled in EWL. The CBE shall consist of a review of the client's clinical history, a visual inspection, and physical examination.

Screening Mammogram
Enrolled women shall receive an annual screening mammogram performed by a Radiological Technologist certified in mammography and read by a qualified Radiologist. The interval between screening mammograms shall not be less than 12 months. Mammogram results must be reported using the American College of Radiology Breast Imaging Reporting and Database System (BI-RADS). If a woman receives an abnormal screening test result, policies for follow-up of abnormal breast cancer screening results must be followed. *Refer to Services Section; Managing Women with an Abnormal Breast Screening Result.*

Digital Mammography
Digital mammography is an allowable procedure. EWL authorized providers may reimburse for this procedure at the digital mammography Medicare reimbursement rate.

Computer-Aided Detection (CAD)
CAD is not an allowable procedure under the EWL program.

Title: Managing Women with an Abnormal Cervical Screening Result

Program Component: Services

Purpose: To ensure women receive appropriate diagnostic and follow-up services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The management of women with abnormal cervical cancer screening test results relies on a body of scientific literature that is constantly growing and changing. EWL establishes clinical policies and protocols following standards established by nationally recognized organizations such as the American Society of Colposcopy and Cervical Pathology (ASCCP), and the American College of Obstetrics and Gynecology. All clinical policies and procedures are reviewed and approved annually by the EWL Medical Advisory Committee.

For the clinical management of abnormal cervical screening results, follow the *American Society of Colposcopy and Cervical Pathology's 2006 Consensus Guidelines*, which includes:

1. The Management of Women with Abnormal Cervical Cancer Screening Tests
2. The Management of Women with Cervical Intraepithelial Neoplasia or Adenocarcinoma
3. Inadequate/Limited Pap Results and Endometrial Cells on Pap

These guidelines can be found at *www.asccp.org*.

The use of LEEP or conization of the cervix may be performed as a *diagnostic* <u>*or*</u> *treatment* procedure based on ASCCP recommendations and algorithms.

1. LEEP or conization as a diagnostic procedure may be ordered for women with an abnormal Pap test result, an unsatisfactory colposcopy, stenotic os, etc.

2. If the LEEP or conization procedure yields a positive biopsy result for pre-cancer/cancer, and the procedure serves as both the diagnostic and treatment procedure, the client should be referred to Medicaid for retroactive Medicaid coverage under the BCCPTA. In this case, the LEEP or conization results should be recorded on the data form as both the diagnostic and treatment procedure, if no additional treatment is planned.

3. If the LEEP or conization procedure yields a positive biopsy result for pre-cancer/cancer and the client needs additional treatment, a referral should be made to Medicaid for treatment under the BCCPTA.

Case management services are required for the following abnormal cervical screening results:

a. Atypical Squamous Cells of Undetermined Significance +HPV
b. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)
c. Low Grade Squamous Intraepithelial (LSIL)
d. High Grade Squamous Intraepithelial Lesion (HGSIL)
e. Atypical Glandular Cells (AGC)
f. Squamous Cell Carcinoma

Title: Managing Women with an Abnormal Breast Screening Result

Program Component: Services

Purpose: To ensure women receive appropriate diagnostic and follow-up services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
The management of women with abnormal mammogram and/or clinical breast exam test results relies on a body of scientific literature that is constantly growing and changing. EWL establishes clinical policies and protocols following standards established by nationally recognized organizations such as the National Comprehensive Cancer Network (NCCN), and the American College of Radiology. All clinical policies and procedures are reviewed and approved annually by the EWL Medical Advisory Committee.

For the clinical management of abnormal breast screening results, follow the NCCN *v1.2009 Breast Cancer Screening and Diagnosis Guidelines***.** These guidelines can be found at *www.nccn.org*.

Case management services are required for the following abnormal breast screening results:

1. Clinical Breast Exam that is abnormal or suspicious for cancer. This includes the clinical categories of:
    A. Discrete palpable mass,
    B. Bloody or serous nipple discharge,
    C. Nipple or areolar scaliness, and
    D. Skin dimpling, retraction or inflammation.

2. Abnormal mammography results, include the following American College of Radiology categories:
    A. BIRADS – 3: Probably benign finding
    B. BIRADS – 4: Suspicious abnormality
    C. BIRADS – 5: Highly suggestive of malignancy

Title: Services for Women 65 Years of Age and Older

Program Component: Services

Purpose: To ensure that eligible women aged 65 and older receive services if eligible.

Responsible Person(s): Provider Site Case Manager or Designee

Effective Date: June 30, 2008

Policy:
Women aged 65 and older that are eligible to receive Medicare benefits, but not enrolled, should be encouraged to enroll.

Women aged 65 and older that do not qualify for Medicare may be eligible to receive EWL program screening and diagnostic services provided they meet the program's eligibility criteria. This includes women who:

1. Are not eligible to receive Medicare Part A or B

2. Receive Medicare Part A but cannot pay the premium to enroll in Medicare Part B

These women shall receive EWL services using state funds. Refer to the *Reimbursement Section; Reimbursement for EWL Program Services* policy for invoice instructions.

Women that are enrolled in Medicare Part B are not eligible for EWL services.

Title: Routine Screening Services

Program Component: Services

Purpose: To ensure that women are provided mammograms and Pap tests at regular intervals following their initial screening examinations.

Responsible Person(s): Provider Site Case Manager or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
Rescreening is the process of returning for a screening test within a predetermined interval level. EWL's goal is to achieve a rescreen rate of 65%, that is, 65% of the women screened in any given year should return within 12 to 18 months after their last screening. There must be at least 12 months between screening tests for the screening to be considered a rescreen.

Priority for mammograms and Pap tests should be given to eligible women previously screened through EWL. Providers shall also ensure that women who have completed treatment under the Breast and Cervical Cancer Prevention Treatment Act (BCCPTA) be contacted and re-enrolled, if eligible, into EWL to resume regular cancer screenings.

Providers shall develop and implement a reminder system to facilitate the tracking of women previously screened. The reminder system should be systematic and comprehensive (capturing mammography and Pap test screening examinations), and applied consistently following the state's defined re-screening intervals.

Treatment

Need a reason to kick the smoking habit? In just 20 minutes after quitting, blood pressure drops and the temperature of your hands and feet increases to normal.
www.cancer.org

Title: Medicaid Treatment Act

Program Component(s): Treatment

Purpose: To define the criteria and procedure for enrollment into the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

Responsible Person(s): Provider Site Coordinator or Case Manager

Effective Date: June 30, 2006
Revised Date: June 30, 2009

Policy:
Who Is Eligible?
Women who are screened through EWL, diagnosed with breast or cervical cancer or a pre-cancerous condition, and certified as needing treatment by an EWL provider, may be eligible for payment of that treatment by Medicaid under the **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).**

Pre-cancerous conditions of the breast and cervix are those that are defined by a health care professional as needing treatment. Pre-cancer of the breast may be defined by a biopsy finding of atypical hyperplasia-ductal or lobular, phylloides tumors, and papillomas with atypia. Pre-cancer of the cervix may be defined by a biopsy result of CIN 2 (also known as moderate dysplasia), and CIN 3 (also known as severe dysplasia).

Treatment is defined as all forms of treatment prescribed by a health care professional, including palliative care. The health care professional shall determine when the course of treatment is completed. Some clients will have a very short course of treatment while others may have a prolonged course of treatment.

Women that are seen by a non-EWL provider because of a symptom that is suspicious for cancer and referred to a EWL provider who later diagnoses breast or cervical cancer (or pre-cancerous condition) may be eligible for Medicaid treatment services under the BCCPTA.

Women that are screened by a EWL provider but later diagnosed with breast or cervical cancer (or a pre-cancerous condition) by a non-EWL provider may be eligible for Medicaid treatment services under the BCCPTA.

Women that have non-creditable health insurance, which includes a disease specific policy (e.g., cancer policy) and dental, vision, or prescription only policies with no other coverage may be eligible for treatment under the BCCPTA.

Women previously screened and diagnosed through another state's Breast and Cervical Cancer Early Detection Program, but now reside in Virginia, are eligible for treatment services under the Virginia BCCPTA.

When Medicaid eligibility is terminated because the woman no longer requires treatment, the woman is eligible for re-enrollment in the EWL program for breast and cervical cancer screening services as long as she meets the program's eligibility requirements. Re-enrolled women that are subsequently diagnosed with breast or cervical cancer (or a pre-cancerous condition) may be eligible for re-enrollment in Medicaid for the new cancer treatment, even if it is a recurrence of the previous cancer.

Who Is Not Eligible?

Women that have received a diagnosis for breast or cervical cancer (or pre-cancerous condition) and were not screened or diagnosed by a EWL provider for that condition are not eligible for payment of treatment services under the BCCPTA.

Women that are not U.S. citizens, receive SSI, are pregnant, or have a child under the age of 19 living with them will require further evaluation by the Department of Social Services (DSS). These women may not be eligible for treatment under the BCCPTA. Many qualified aliens who arrived in the U.S. after August 21, 1996 are banned from receiving Medicaid for 5 years beginning with their date of entry. The five-year ban does not apply to certain refugees, asylees, and certain other groups. The determination of Medicaid eligibility will lie with the DSS.

Women that have creditable health insurance coverage are not eligible for treatment under the BCCPTA. Creditable health insurance includes:

1. A group health plan
2. Health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan or health maintenance organization contract offered by a health insurance issuer
3. Medicare
4. Medicaid
5. Armed forces insurance
6. A medical care program of the Indian Health Service or tribal organization
7. A state health risk pool

Health insurance that does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits is still considered to be creditable health insurance. Similarly, if a woman has creditable health insurance, but a high deductible, she is not eligible for enrollment under the BCCPTA covered group.

The EWL provider shall assure that women who are not eligible for Medicaid benefits under the BCCPTA receive appropriate treatment services. The provider shall explore community resources, such as charity care, faith-based organizations, and health institutions that serve indigent populations to ensure treatment services are provided.

Other Information Related to the BCCPTA

The Deficit Reduction Act of 2005, effective February 8, 2006, requires all applicants and recipients of Medicaid that claim to be a U.S. citizen provide proof of identity and citizenship. The provision requires applicants to provide proof of citizenship and identity when applying for Medicaid on or after 7/1/06, and for all recipients of Medicaid at the time of their first re-determination of eligibility on or after 7/1/06. Provision of these documents is a one-time activity, and once provided, will not be required again.

A birth certificate can be used to document citizenship. If the applicant does not have a birth certificate and needs assistance in obtaining one, the applicant can request assistance from the DSS. A driver's license can be used to document identity. A passport (unexpired) or naturalization certificate can be used to document both citizenship and identity. Original documents must be provided to the DSS. For a complete list of acceptable documents to document citizenship and identity, refer to **Appendix K** or contact your local DSS office.

DSS will not notify EWL providers when a case has been approved or denied. DSS will send notices to the individual requesting benefits or the individual's authorized representative, but not the EWL provider. To verify if a EWL client is the recipient of Medicaid, you can call the toll free Medicall numbers (800-884-9730 or 800-772-9996) and follow the prompts. Note: you must be a Medicaid provider with a provider number to access the Medicall system. For information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information, visit http://virginia.fhsc.com, and follow the enrollment instructions to access the system.

The DSS will re-determine Medicaid eligibility on an annual basis. At the time of the annual re-determination, the woman must provide a statement from her health care professional verifying continued treatment for breast and/or cervical cancer is necessary.

Women shall receive full Medicaid coverage (i.e., coverage is not limited to the treatment of breast and cervical cancer) for as long as they are in cancer treatment. A co-pay is associated with Medicaid services and women are responsible for paying the co-pay, which is dependent upon the type of service they receive. For example, for an inpatient hospital stay the co-pay is $100.00 per admission and $1.00 per clinic visit.

Procedure:

The following procedures must take place once a woman is diagnosed with breast or cervical cancer or a pre-cancerous condition and is certified as needing treatment by a health care professional:

1. The coordinator/case manager will instruct the woman to gather the appropriate verification to document citizenship and identity, if they claim U.S. citizenship.

2. The woman will complete and sign the BCCPTA Medicaid Application Form **(Appendix I).** The coordinator/case manager must sign this form.

3. The coordinator/case manager will immediately forward the completed BCCPTA Medicaid Application Form to the county or city DSS office where the woman resides.

4. The coordinator/case manager will maintain contact with the woman to ensure that treatment has begun and that any barriers to receiving treatment are addressed.

5. The coordinator/case manager shall re-assess the woman's eligibility for re-enrollment into the EWL program when cancer treatment is completed.

6. For guidance on how to refer women who are currently receiving treatment under the BCCPTA in another state, territory, or tribal organization and relocate to Virginia and request continued Medicaid treatment coverage, refer to the *Enrollment Section – Client Transfers.*

For more detailed information on the Medicaid BCCPTA Policy, refer to **Appendix J.** For Frequently Ask Questions related to the BCCPTA, refer to **Appendix K.** For consultation on specific cases, contact the state EWL office.

Appendix

Portion Distortion! Twenty years ago, a typical restaurant portion of spaghetti and meatballs was about 500 calories. Today, a serving is over 1,000 calories! Split your meal with a friend or wrap up half and save for dinner tomorrow.
http://hp2010.nhlbihin.net/portion

Appendix A

DATA INFORMATION MANUAL

Every Woman's Life

A Virginia Department of Health Program

REVISED APRIL 2009

TABLE OF CONTENTS

DATA MANAGEMENT **1**

MDE DATA REPORTING **1**

EWL DATA FORMS **2**

ELIGIBILITY FORM **3**

- PERSONAL INFORMATION 3
- QUESTIONS FOR NEW CLIENTS ONLY 4
- OFFICE USE ONLY 5
- DATA FORM 7

BREAST SCREENING AND DIAGNOSTIC FORM **8**

- CLINICAL BREAST EXAMINATION (CBE) 8
- MAMMOGRAM 10
- BREAST DIAGNOSTIC PROCEDURES 11
- WORK-UP STATUS 12
- BREAST CANCER TREATMENT STATUS 13
- TIPS FOR COMPLETING THE BREAST SCREENING AND DIAGNOSTIC FORM 13
- DATA FORM 15

CERVICAL SCREENING AND DIAGNOSTIC FORM **16**

- PAP TEST AND PELVIC EXAM 16
- CERVICAL DIAGNOSTIC PROCEDURES 18
- WORK-UP STATUS 19
- CERVICAL CANCER TREATMENT STATUS 19
- TIPS FOR COMPLETING THE CERVICAL SCREENING AND DIAGNOSTIC FORM 20
- DATA FORM 22

REFUSED/LOST TO FOLLOW UP FORM **23**

- REFUSED 23
- LOST TO FOLLOW-UP 23
- WAIVER STATEMENT 24
- DATA FORM 25

RESCREENING **26**

SHORT TERM FOLLOW-UP **27**

- SHORT TERM FOLLOW-UP: PLANNED DELAY 27
- DIAGNOSTIC WORK-UP: UNPLANNED DELAY 28

DATA FORMS TO BE SUBMITTED **30**

DATA MANAGEMENT

Data compiled from the EWL screening forms are used to track the program's performance and compliance with EWL standards, including:

- Documenting the patient's eligibility for EWL services.
- Documenting screening and re-screening of program-eligible clients.
- Assuring that the clinical breast examination, the screening mammogram, the screening Pap test and other tests follow EWL medical guidelines and protocols.
- Documenting the timeliness of a client's completion of diagnostic work-up (or the client's refusal of workup or being lost-to-follow-up).
- Documenting the timeliness of a client's initiation of treatment (or refusal of treatment or being lost-to-follow-up), in the event that she is diagnosed with breast or cervical cancer.
- Assuring that the client is referred to Medicaid in the event that she is diagnosed with breast or cervical cancer and is eligible for Medicaid services under the BCCPTA.
- Assuring that all client documentation (i.e., MDE data forms) is routed in a timely fashion to the State EWL Office as required.

MDE DATA REPORTING

The Centers for Disease Control and Prevention requires that each state program, including the Virginia EWL, collect and report the minimum data elements (MDEs). These are required data fields that are relevant to client eligibility, quality assurance, and surveillance. Provider sites agree to collect and report to the EWL program all client data including:

- patient demographics
- patient contact information
- eligibility information
- date and results of breast and/or cervical screening visits
- referral for diagnostic workup
- date and results of diagnostic tests
- diagnosis
- cancer treatment information
- Medicaid enrollment (for cancer treatment)

The EWL program may collect additional data for administrative or research purposes.

EWL DATA FORMS

Below is a brief description of the data forms that are used by the EWL program:

- The *Eligibility Form*, which is the first form to be completed on a potential EWL client, documents that the client meets program requirements (e.g., age, residence and income/insurance status) and is eligible for program services. The *Eligibility Form* also contains information on how to contact the client (e.g., address, telephone number).

- The *Breast Screening and Diagnostic Form* allows clinicians to document the dates and results of the clinical breast exam and screening mammogram - or list the reason for the procedures not being performed. The clinician also documents if diagnostic workup is planned. These forms are also used for documenting diagnostic test dates of services and results that lead up to a final diagnosis. In addition, in cases of diagnosed cancer, the clinician must document treatment start date. If the client declines diagnostic workup and/or treatment, it is reported on the form under *Workup Status* or *Treatment Status*. If the patient is enrolled in Medicaid for payment of treatment services it is reported on this form.

- The *Cervical Screening and Diagnostic Form* allows clinicians to document the dates and results of the Pap test or list the reason for the procedure not being performed. The clinician also documents if diagnostic workup, including HPV testing, is planned. These forms are also used for documenting diagnostic test dates of services and results that lead up to a final diagnosis. In addition, in cases of diagnosed cancer, the clinician must document treatment start date. If the client declines diagnostic workup and/or treatment, it is reported on the form under *Workup Status* or *Treatment Status*. If the patient is enrolled in Medicaid for payment of treatment services it is reported on this form.

- The *Refused/Lost to Follow Up Form* is completed whenever a client refuses diagnostic tests or treatment or is lost to follow up. Any comments related to the refusal or lost to follow up can be documented on this form.

ELIGIBILITY FORM

For every woman enrolled in the EWL there must be an ***Eligibility Form*** *completed. You may either:*

- *Obtain the information over the phone or in a face-to-face interview as you screen the client for eligibility and enroll her in the program, or*
- *Ask the client to complete the form -- the form has been simplified for a low reading level.*

It is strongly recommended that the Case Manager assist the client in completing the Eligibility Form. **The Eligibility Form must be completed prior to the client's first screening service. Otherwise, she is not considered enrolled in the EWL program.**

Personal Information

Last Name, First Name, Middle Initial, and Maiden Name
Enter the client's full name, including middle initial and maiden if applicable, This aids our search for the client in the state database. We request client name and SSN on each of the forms in order to trace any form back to the client in case forms become separated.

SSN (or Alien ID)
Enter the client's social security number or alien identification number, if available. We request client name and SSN on each of the forms in order to trace any form back to the client in case forms become separated.

If SSN or Alien ID is not available, we recommend that you leave this field blank. However, most legal residents will have either a SSN or Alien ID. A client is not required to provide her SSN or Alien ID; however, we strongly encourage that you ask the client to provide it. *Not providing a valid ID may impede her ability to enroll in Medicaid should she be diagnosed with cancer and require treatment.* Encourage all clients to provide their SSN and relay to them that this information will be kept strictly confidential.

Date of Birth
Enter the client's date of birth as self reported. This aids our search for the client in the state database.

Age
A client's age should be calculated by subtracting the date of birth from the date the client was enrolled in the program. This is important in submitting clients for payment and determining whether they will be reimbursed using state or federal funds.

Client Contact Information
Enter the client's street address, city, county, state, and zip code of their current residence. This is used to determine specific areas in the state where clients are being served. Also provide the client's phone numbers and the best time to contact them for follow-up purposes.

Annual Income
Report the annual household income as the total combined income of all persons, including the client, living in the same household, regardless of whether or not the client is a dependent. If the client is unemployed and has no income, enter "0". Refer to the current Federal Poverty Guidelines for income thresholds.

Insurance Status
Report whether or not the client has medical coverage through a private insurer, Medicaid, or Medicare. A woman may be eligible if she has private insurance but can not meet her deductible or the insurance does not cover breast and cervical screening services.

Questions for New Clients Only

Referral Source
Report how the client heard about EWL. This section is important in that it allows the program to better target its outreach efforts. For sites that are conducting outreach via the Sisters Network (applies to certain geographic areas), or other organizations, please write the name of the organization after "Other".

Hispanic Ethnicity and Race
Ethnicity and race are required data fields. Ethnic identification refers to whether or not the client is of Spanish, Hispanic, or Latina origin. Both are mutually exclusive questions: for instance, a client who reports being Hispanic or Latina can also be White or Black. Encourage your clients to report on both race and ethnic origin. The client is permitted to record more than one racial group.

Language Spoken
Report what language the client primarily speaks every day. This information is used to conduct effective outreach programs as well as customize client education and health brochures.

Screening History
In order to identify clients who are never or rarely screened for breast or cervical cancer, you must ask the client if or when she last had a mammogram or Pap test prior to being enrolled in the program. Ask the client if she can recall the month and year, or just year, of her last Pap or mammogram. If the client cannot recall an approximate date but indicates that it was more than five years ago, check (✓) the box "more than 5 years ago". "Don't know" is also an option for clients who can not recall

the date of their last Pap test or mammogram. *Make every effort to collect at least the year of the last Pap test as this is used to determine rates of women never or rarely screened for cervical cancer*.

Office Use Only

The questions in the shaded box are for administrative (office) use only, to be completed by the case manager or other designated EWL staff. Inform your client that she does not complete the items in the shaded box.

Administrative Site
Administrative Site refers to the name of the organization which contracts with the Virginia Department of Health to administer the program at the local level. This is different from the screening provider site which performs the actual screening tests. There are fewer Administrative Sites than there are screening sites. An Administrative Site can have multiple screening sites.

Case Manager
Case Manager refers to the person designated as the client's case manager. S/he should be affiliated with the Administrative Site. This person should also take an active part in completing the data forms and ensuring by his or her signature that the information is complete and valid.

Enrollment Site
Enrollment Site is the site where you enrolled the client. Typically, it is a clinic, local health department or hospital. Do not use a temporary outreach site (e.g., church, salon, workplace) as an enrollment site -- instead refer to the site where the case manager, health educator, or outreach/enrollment coordinator works from permanently.

Enrollment Date
Enrollment Date refers to the date when the client was enrolled as a new client. For clients who are returning as rescreens, indicate the date when her eligibility was re-assessed.

Client ID
Each new client will automatically be assigned a unique five-digit identification number when we enter her information for the first time into the state database. Anytime a client returns for rescreening, the State EWL office will search the database for her name and retrieve her unique identifier. You may use "Client ID" for your own benefit. Otherwise, the State EWL office will fill in the blank with the program's unique identifier as assigned by the database.

Client Status
Indicate the client's status – active or inactive. If "active", indicate if the client is receiving screening services for the first time (e.g., New Screen) or is returning for

rescreening services (e.g., Rescreen). If "*active*" also provide additional detail and indicate if the client has a previous history of breast cancer (left or right breast) or if the client has had a hysterectomy by using the check boxes provided.

If "*inactive*", list the reason why the client is no longer active (e.g., has insurance, enrolled in Medicare, income too high, lost-to-follow-up) and the effective date when it was determined that she was inactive.

Note: *A client should be inactivated if there is no response to appointments made for rescreen services after reasonable attempts have been made to contact the client. Do not inactivate a client just because she has refused or is lost-to-follow-up for diagnostic procedures.*

Effective Date
If the client has been inactivated, record the date of the status change.

Detail
Provide further detail of a client's health history by indicating if the client has previously been diagnosed with breast cancer, or if she has had a hysterectomy due to cancer or non cancerous reasons.

Forms Submitted
If a client did not receive both breast and cervical services, one of these boxes should be checked. If a client only received cervical services, check (✓) the box that indicates "cervical record only, no breast form being submitted", and submit the *Eligibility* and *Cervical Screening and Diagnostic Form*. If a client only received breast services, check (✓) the box that indicates "breast record only, no cervical form being submitted", and submit the *Eligibility* and *Breast Screening and Diagnostic Form*. These fields were added to minimize paper work and data forms.

Eligibility Form
Every Woman's Life - Virginia Department of Health

PERSONAL INFORMATION			
Last Name	First Name	MI	Maiden Name
SSN (or alien ID) / /	Birth Date / /	Age	
Address	City	County	
State	Zip	Home Phone ( ) -	
Work Phone ( ) -	Cell Phone ( ) -	Best Time to Call:	

What is your household income before taxes? $ /Year

How many people live on this income? (including yourself)

Do you have Medicaid? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No ➔If YES ☐Part A or ☐Part B

Private insurance? ☐ Yes ☐ No ➔If YES, has deductible been met? ☐ Yes ☐ No

QUESTIONS FOR NEW CLIENTS ONLY

How did you hear about the Every Woman's Life program? ☐ Brochure ☐ Community Health Worker ☐ Family/Friend ☐ Health Fair ☐ Internet/Web ☐Radio/TV/Newspaper ☐ Other

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

Do you describe yourself as: (check ALL that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ Unknown

What language do you speak every day?

Have you ever had a pap test? ☐Yes ☐ No
➔If YES, when was your last Pap test? (month/year) / or ☐ More than 5 years ago ☐ Don't know

Have you ever had a mammogram? ☐Yes ☐ No
➔If YES, when was your last mammogram? (month/year) / or ☐ More than 5 years ago ☐ Don't know

OFFICE USE ONLY

Administrative Site: _____ Case Manager: _____
Enrollment Site: _____ Enrollment Date: _____ / _____/ _____
Client ID _____
Client Status: Active – check one: ☐ New Screen ☐ Rescreen ☐ Inactive due to:(list reason) _____
Effective Date _____ / _____/ _____
Detail: Previous Breast Cancer ☐L Br ☐ R Br ☐Hysterectomy for Cervical Cancer ☐Hysterectomy Non Cancer
☐ Cervical Record Only, no breast form submitted ☐ Breast Record Only, no cervical form submitted

BREAST SCREENING AND DIAGNOSTIC FORM

Enter the client's name and SSN, and the name of the administrative site at the top of the form to ensure that client data forms, if separated, can be matched. A EWL visit can fall within three categories: New Screen, Follow-up, or Rescreen. The visit type will determine payment – for example, only *New Screen* and *Rescreen* visits are authorized for payment).

1. Indication for Initial Mammogram

This field is used to report the purpose for the initial mammogram. There are six categories the CDC uses to determine if the client received a traditional screening cycle or another type. The indication for the initial mammogram gives more information about how many clients are being seen for initial screenings and how many are referred in for diagnostic work-up.

- (Screening) should be reported for an initial mammogram performed as part of a routine or annual screening and in the absence of symptoms or a recent positive CBE.

- (Evaluate Symptoms) should be reported for an initial mammogram performed as additional evaluation of a recent mammogram prior to this cycle, evaluation of current symptoms or abnormal CBE finding.

- (Referred) should be reported when a client has had a mammogram performed outside of the program and is referred to the program for diagnostic work-up. Referral date must be completed and a valid mammogram result should be reported – Complete Questions 7 through 11.

- (Not Done) should be reported when the client does not have an initial mammogram performed and goes directly to diagnostic work-up.

- Unknown

Clinical Breast Examination (CBE)

The CBE is part of the breast screening service and should be performed prior to the mammogram. If the CBE result is normal a *screening* mammogram should be performed; if the CBE result is abnormal a *diagnostic* mammogram or other diagnostic work up should be recommended.

2. Breast Symptoms
Indicate if the client reported any symptoms, including lumpiness, bleeding, scaling, discharge, retraction, etc. This is based on the client's self-report.

3. and 4. CBE Performed and Date
Indicate if the CBE was performed by checking "Yes" or "No" and enter the date when performed.

5. CBE Results
There are nine categories the CDC uses for the collection of CBE data at the clinical level. These categories are:

- ❑ Normal exam
- ❑ Benign finding (includes fibrocystic changes, diffuse lumpiness or nodularity)
- ❑ Discrete palpable mass*
- ❑ Bloody or serous nipple discharge*
- ❑ Nipple or areolar scaliness*
- ❑ Skin dimpling or retraction*
- ❑ Previous normal CBE in the past 12 months-CBE not performed
- ❑ CBE not performed, other or unknown reason
- ❑ CBE refused

*Any of the above findings requires immediate **diagnostic evaluation**. A diagnostic mammogram alone does not constitute an acceptable diagnostic evaluation. The diagnostic mammogram must be followed by a breast ultrasound, biopsy, FNA, or a referral to a surgeon or breast specialist.

- **"Previous normal CBE in the past 12 months-CBE not performed"** refers to a client who does not require a CBE because she had a previous normal CBE within the past 12 months. If the date of her last CBE exceeds more than 12 months, it is strongly recommended that the client have another CBE performed. If a client had a CBE elsewhere that was not normal, it is recommended that a repeat CBE and appropriate diagnostic work-up be done.

- In the case where a CBE was recommended by the provider but not performed, you should report **"CBE not performed, other or unknown reason"** or **"Refused"** in the CBE field. This refers to a client who refuses to have the CBE performed, who does not keep her screening appointment or could not be scheduled to have a clinical breast exam. Additional attempts should be made to reschedule the client.

6. CBE Funding Source
Indicate "Yes" to Question 5, if the CBE was fully or partially paid for by EWL funds.

Mammogram

7. Mammogram Type
Typically, a client who is asymptomatic and has no breast history will have what is referred to as a screening mammogram. In other cases, when the client is symptomatic or she is considered at risk, according to her health or family history, the initial mammogram ordered is "diagnostic" rather than screening.

8. Mammogram Date
Enter the date when the mammogram was performed.

9. Mammogram Results
There are eight categories used for the collection of mammogram results. These categories are:

- ❑ Negative
- ❑ Benign finding
- ❑ Probably benign
- ❑ Suspicious abnormality
- ❑ Highly suggestive of malignancy
- ❑ Assessment incomplete
  - ▪ Film comparison required
- ❑ Unsatisfactory, film cannot be interpreted (Repeat mammogram)
- ❑ Result unknown, presumed abnormal, from non-program funded source

- **Assessment Incomplete:** The radiologist is recommending additional imagery (magnification or additional views) be performed before arriving at a final interpretation. This differs from "incomplete assessment", which has no correspondence to the BI-RADS system. In the latter, the radiologist may want to review older films for comparison in order to better interpret a finding on the current mammogram.

  - o **Film Comparison Required:** This distinguishes between a mammogram result needing additional procedures and one that is "pending" a film comparison. This result should be checked if a film comparison is required to further evaluate an initial mammogram test result of "Assessment Incomplete". Do not check this option if the comparison was done as part of standard imaging evaluation. Note: The film comparison results should follow the same timeliness guidelines as other diagnostic procedures. An

"Assessment Incomplete" mammogram followed by a film comparison should have a final diagnosis within 60 days.

- **Unsatisfactory, film cannot be interpreted**: The mammogram is technically unsatisfactory and cannot be interpreted by the radiologist, in which case, the mammogram should be repeated. Unsatisfactory mammograms should be recorded on the form and submitted as is. The repeated mammogram should be reported and submitted on a new Breast Screening and Diagnostic Form.

- **Result unknown, presumed abnormal, from other funded source**: The client is being referred to the EWL for breast diagnostic workup on the basis of an abnormal mammogram that was performed by a non-EWL provider. The finding is presumed abnormal, and therefore workup is recommended. If the actual result from the outside mammogram is known, it should be fully reported in the mammogram section (complete the entire section); indicate "No" on Question 10 about the funding source. This result category should be reserved for screening test results that cannot be obtained.

10. Mammogram Funding Source
Report the mammogram as being paid for by the EWL ("Yes") if it was fully or partially funded by EWL funds.

11. Mammogram Provider
Record the name of the screening site where the mammogram was performed. Refrain from leaving the question blank or using acronyms or abbreviations.

12. Workup Recommendation
Specify if the radiologist recommended workup based on the mammogram and/or CBE finding. The clinician should follow the guidelines for recommended work-up for abnormal CBE and/or mammogram, as provided by EWL. If the recommendation is for short-term follow-up—i.e., repeat the mammogram in six months—enter "NO".

Breast Diagnostic Procedures

This section is for documenting diagnostic workup, the final diagnosis (if one is reached), and treatment information, if diagnosed with breast cancer. You must complete this section if you have an abnormal CBE and/or mammogram finding, or breast diagnostic workup is recommended.

Diagnostic work-up for abnormal breast findings include the following major diagnostic procedures:

13. Additional Mammographic Views (check (✓) whether views are unilateral or bilateral)

14. Ultrasound
15. Film Comparison

16. Fine Needle/Cyst Aspiration

17. Breast Biopsy/Lumpectomy

18. Repeat CBE/Surgical Consult

Indicate which diagnostic test was performed, the procedure date, the procedure site, result, and funding source for the test. If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the test as "refused". If the client refused a diagnostic test or is lost to follow up, complete the *Refused/Lost to Follow-Up Form*.

Work-Up Status

19. Final Diagnosis Status
Once work-up is completed, indicate the status of workup. Question 19 allows you to report clients that refuse workup or are lost to follow-up. If the client refused a diagnostic test, complete the *Refused/Lost to Follow-Up Form*.

A response of **"irreconcilable"** will be used for those cases, which after clinical review, it is determined that there is no sufficient way to document the clinical scenario on the EWL data form. An example would be: If the clinician refers a client for short-term follow-up instead of following the guideline for immediate diagnostic work-up, check (✓) irreconcilable.

In **all** cases of recommended work-up, you should complete Question 19, whether or not you have a final diagnosis.

20. Final Diagnosis Date
The "Final Diagnosis Date" refers to the date of service of the procedure which results in the final diagnosis of cancer (or not cancer). If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the procedure that provided the definitive diagnosis. For example, if both a diagnostic mammogram and ultrasound were performed and indicate a diagnosis of **"Not Cancer"**, the ultrasound is the procedure that ultimately provides the definitive diagnosis, more so than the diagnostic mammogram. You should record the date of service of the ultrasound for the Final Diagnosis Date.

21. Final Diagnosis
The diagnosis categories are: breast cancer not diagnosed, invasive breast cancer, ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS). **"Infiltrating carcinomas"** is considered invasive breast cancer. For all cases of in situ or invasive cancer, complete the "Treatment Status" section (see below).

Breast Cancer Treatment Status

22. Treatment Status
For all cases of cancer diagnosed, you should complete Question 22 on the status of treatment.

23. Treatment Status Date
Report the date treatment was started. **NOTE:** Oftentimes it may be a lumpectomy performed in the course of an excisional biopsy. Report the date of treatment as the date when the biopsy/lumpectomy was performed.

For both "Client Lost to Follow-Up" and "Treatment Refused", enter the date when the determination was made in the space provided. If the client refused treatment, complete the *Refused/Lost to Follow-Up Form*.

24. Medicaid Enrollment
Indicate if the client was enrolled in Medicaid under the provisions of the BCCPTA in Question 24. If the client was diagnosed with cancer, and not enrolled in Medicaid, indicate why in the space provided.

Form Completed By
The Case Manager, or designee, who completed the form must sign and date the *Breast Screening and Diagnostic Form*. If there are any questions regarding information on the form, the state EWL office will contact the individual who completed the form.

Tips for Completing the Breast Screening and Diagnostic Form

1. If the client is being referred to EWL for diagnostic workup on the basis of an abnormal CBE, which was performed elsewhere, record the date of the CBE, the result of the CBE, and that the CBE was not paid by EWL.

2. If you obtain more than one CBE result, or different results in each breast, record the worse of the two findings.

3. If the client is being seen for a repeat CBE only, check (✓) the "Follow-Up" box at the top of the form and complete Question 18-Repeat CBE.

4. If the mammogram is unsatisfactory, you should submit the Screening and Diagnostic Form with the unsatisfactory finding. The mammogram should be repeated and the information submitted. This will help in tracking the number of unsatisfactory results.

5. If the client is being referred to the EWL for diagnostic evaluation for a breast problem on the basis of an abnormal mammogram by an outside provider, obtain and record the results of the mammogram and indicate that the mammogram was not paid by EWL.

6. If the first mammogram of a screening cycle is a diagnostic mammogram, it should be documented as the initial mammogram.

7. If the diagnostic mammogram is recommended as *immediate* work-up for an abnormal screening mammogram result, it should be documented as an additional mam view.

8. If more than one mammogram result is reported—for example, different findings occur within the same breast, or different findings occur in the left and right breasts—report the worse of the two findings. The same applies to the final breast diagnosis.

9. If the result of the final, definitive diagnostic test (e.g., biopsy) is **"indeterminate"** and you indicate a final diagnosis of either cancer or no cancer, provide an explanation on how you reached this diagnosis. An indeterminate result will trigger a call from the State EWL Office unless an explanation is provided.

Breast Screening and Diagnostic Form
Every Woman's Life- Virginia Department of Health

Last Name	First Name	MI	Maiden Name
Admin Site	❑ New Screen ❑ Follow-Up ❑ Rescreen		SSN (or alien ID)

1. Indication for initial mammogram:
   - ❑ Routine screening mammogram
   - ❑ Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result
   - ❑ Initial mammogram done by a non-program funded provider, client referred in for diagnostic evaluation.
   - ❑ Initial mammogram not done. Client proceeded directly for other imaging or diagnostic work-up.
     Date client was referred into program for breast diagnostic workup: _____/_____/_____
   - ❑ Unknown

CLINICAL BREAST EXAM (CBE)

2. Does the client have breast symptoms? ❑ Yes ❑ No
3. Did the client have a CBE? ❑ Yes ❑ No
4. CBE date: _____ / _____ / _____ (mm/dd/yyyy)
5. What were the CBE results?
   - ❑ Normal exam
   - ❑ Benign finding (includes fibrocystic changes, diffuse lumpiness or nodularity)
   - ❑ Discrete palpable mass*
   - ❑ Bloody or serous nipple discharge*
   - ❑ Nipple or areolar scaliness*
   - ❑ Skin dimpling or retraction*
   - ❑ Previous normal CBE in the past 12 months – CBE not performed
   - ❑ CBE not performed, other or unknown reason
   - ❑ CBE refused
6. Was the CBE paid by EWL? ❑ Yes ❑ No

*Requires diagnostic mammogram and further diagnostic evaluation.

MAMMOGRAM

7. Mammogram type: ❑ Screening ❑ Diagnostic
8. Mammogram date: ____ / ____ / ____(mm/dd/yyyy)
9. What were the mammogram results?
   - ❑ Negative
   - ❑ Benign finding
   - ❑ Probably benign
   - ❑ Suspicious abnormality
   - ❑ Highly suggestive of malignancy
   - ❑ Assessment is incomplete
     - ❑ Film comparison required
   - ❑ Unsatisfactory, film cannot be interpreted (Repeat Mamm.)
   - ❑ Result unknown, presumed abnormal, from non-program funded source
10. Was the mammogram paid by EWL? ❑ Yes ❑ No
11. Where was the mammogram performed?_____
12. Are additional breast procedures needed? ❑Yes ❑ No ❑ Not yet determined

DIAGNOSTIC PROCEDURES

13. Additional Mam Views: ❑ Yes ❑ No
❑ Unilateral ❑ Bilateral
Procedure date ____/____/___(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Negative
- ❑ Benign findings
- ❑ Probably benign
- ❑ Suspicious abnormality
- ❑ Highly suggestive of malignancy
- ❑ Assessment incomplete
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

14. Ultrasound: ❑ Yes ❑ No
Procedure date ____/____/___(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal (WNL)
- ❑ Cystic mass
- ❑ Other benign abnormality
- ❑ Suspicious for malignancy
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

15. Film Comparison: ❑ Yes ❑ No
Procedure date ___/___/___(mm/dd/yyyy)
Procedure site:_____
Final Imaging Results:
- ❑ Negative
- ❑ Benign findings
- ❑ Probably benign
- ❑ Suspicious abnormality
- ❑ Highly suggestive of malignancy
- ❑ Unsatisfactory
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

16. Fine Needle/ Cyst Aspiration: ❑ Yes ❑ No
Procedure date ___/____/____(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Not suspicious for cancer
- ❑ Suspicious for cancer
- ❑ No fluid/tissue collected
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

17. Biopsy/ Lumpectomy: ❑ Yes ❑ No
Type of biopsy: ❑ Excisional ❑ Non Excisional
Procedure date ___/___/___(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal breast tissue
- ❑ Hyperplasia
- ❑ Other benign changes
- ❑ DCIS
- ❑ LCIS
- ❑ Invasive cancer
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

18. Repeat CBE/ Surgical Consult: ❑ Yes ❑ No
Procedure date ___/___/___(mm/dd/yyyy)
Procedure site:_____
Results:
- ❑ Normal (WNL)
- ❑ Benign finding
- ❑ Discrete palpable mass
- ❑ Bloody or serous nipple discharge
- ❑ Nipple or areolar scaliness
- ❑ Skin dimpling or retraction
- ❑ Refused (Complete Ref/LTFU Form)

Funding Source: ❑ EWL ❑ Other

WORK-UP STATUS

19. What is the status of the final diagnosis?
- ❑ Work-up complete
- ❑ Client lost to follow-up (Complete Refused/LTFU Form)
- ❑ Workup refused (Complete Refused/LTFU Form)
- ❑ Irreconcilable

20. Date of final diagnosis: / / (mm/dd/yyyy)

21. Final Diagnosis:
- ❑ Breast cancer not diagnosed
- ❑ Invasive breast cancer
- ❑ Ductal carcinoma in situ
- ❑ Lobular carcinoma in situ
- ❑ Reoccurrence of prior breast cancer

TREATMENT STATUS

22. What is the status of breast cancer treatment?
- ❑ Treatment started
- ❑ Client lost to follow-up (Complete Refused/LTFU Form)
- ❑ Treatment refused (Complete Refused/LTFU Form)
- ❑ Treatment not recommended

23. Date of treatment status: / / (mm/dd/yyyy)

24. Was the client enrolled in Medicaid for treatment?
❑ Yes ❑ No
If no, why not?_____

Form Completed by:

CERVICAL SCREENING AND DIAGNOSTIC FORM

Enter the client's name and SSN, and the name of the administrative site at the top of the form to ensure that client data forms, if separated, can be matched. A EWL visit can fall within three categories: New Client, Follow-up, or Rescreen. The visit type will determine payment – for example, only *New Client* and *Rescreen* visits are authorized for payment).

Pap Test and Pelvic Exam

1. Indication for initial Pap test

This field is used to report the purpose for the initial Pap test. There are six categories the CDC uses to determine if the client received a traditional screening cycle or another type. The indication for the initial Pap test gives more information about how many clients are being seen for initial screenings, and how many are referred in for diagnostic work-up.

- ❑ (Routine) should be reported for a Pap test performed as part of a routine screening schedule.
- ❑ (Surveillance) should be reported for a Pap test performed on a woman under management for a cervical abnormality detected in a previous cycle.
- ❑ (Referred) should be reported when a client has had a Pap test performed outside of the program, and is referred to the program for diagnostic work-up. Referral Date must be completed and a valid Pap test result should be provided – Complete Questions 2 through 8.
- ❑ (Not Done) should be reported when the client does not have a Pap test and goes directly to HPV testing or diagnostic work-up.
- ❑ Unknown

2. and 3. Pelvic Exam and Pap Test Date

Provide the dates when the pelvic exam and the Pap test were done.

4. Pap Test Results

The Pap test result must be coded following the 2001 Bethesda System for reporting cervical cytologic diagnoses.

Refer to http://www.cancer.gov/newscenter/bethesda2001

There are nine categories used for reporting Pap test results:

- ❑ Negative (for intraepithelial lesion or malignancy)
- ❑ ASC-US
- ❑ LGSIL
- ❑ ASC-H
- ❑ HGSIL
- ❑ Squamous cell carcinoma
- ❑ Abnormal Glandular Cells (AGC)
- ❑ Other results:_____
  Note: A Pap test result of Endocervical Adenocarcinoma in Situ (AIS) should be documented here.
- ❑ Result unknown, presumed abnormal, from non-program funded source

- **Result unknown, presumed abnormal, from other funded source**: The client is referred to EWL for cervical diagnostic workup on the basis of an abnormal Pap test that was performed by a non-EWL provider. The finding is presumed abnormal, and therefore work-up is recommended. If the actual result from the outside Pap test is known, it should be fully reported in the *Pap Test and Pelvic Exam* section (complete the entire section); enter "No" for the funding source – Question 8 and 10. The **result unknown, presumed abnormal, from other funded source** category should be reserved for screening test results that cannot be obtained.

5. Cervix Present

This indicates if the specimen was taken from the cervix or from the vaginal area. For women who have an intact cervix, the specimen will generally come from the cervix. The EWL does not reimburse Pap tests for women who have had a hysterectomy unless the hysterectomy was due to cervical cancer or dysplasia.

6. Specimen Type

Specimen Type indicates if the Pap test collection used a conventional, liquid-based technology (e.g., ThinPrep), or other method to collect the specimen.

7. Specimen Adequacy

Specimen Adequacy is either "satisfactory" or "unsatisfactory" according to the 2001 Bethesda System.

8. Pap Funding Source

If the Pap test was fully or partially paid by EWL, indicate 'Yes'.

9. HPV Test Result and Date

If an HPV test was done, indicate the result and date of the test.

10. HPV Test Funding Source
If the HPV test was fully or partially paid by EWL, indicate 'Yes'.
11. Pap Test Provider
Indicate the location where the Pap test was performed and the specimen collected—that is, the clinic, medical office or gynecological facility where the client had her Pap test performed—and not where the specimen was analyzed. Do not use initials or abbreviations.

12. Workup Recommendation
Specify if the clinician recommended workup based on the Pap test result. The clinician should follow the guidelines for recommended work-up for abnormal Pap test, as provided by EWL. If the recommendation is for short-term follow-up—i.e., to repeat the Pap test in six months or less—indicate "NO".

Cervical Diagnostic Procedures

This section is for documenting diagnostic workup, the final diagnosis (if one is reached), and treatment information, if diagnosed with cervical cancer or dysplasia. You must complete this section of the form if you have an abnormal Pap test finding, or cervical diagnostic workup is recommended.

13. and 14. Colposcopy
Diagnostic work-up for abnormal cervical findings include the following two diagnostic procedures - **Colposcopy without biopsy,** and **Colpsocopy-directed biopsy.** Indicate which diagnostic test was performed, the procedure date, the procedure site, result, and funding source for the test.

15. and 16. Other Procedures
Additional procedures may be performed. If there is a procedure not listed, check (✓) the "Other" box and enter the procedure name and CPT code. If a test was cancelled or not performed because the client refused or was a no-show, check (✓) "Refused". If the client refused a diagnostic test, complete the *Refused/Lost to Follow Up Form.*

***NOTE**: A verifying Pap test is not considered a diagnostic test and should not be documented in the "Diagnostic Procedures" section.*

***NOTE**: Procedures like loop electrode excision procedure (LEEP) and conization (cone biopsy) can be considered either treatment or a diagnostic test. If it is done for the purpose of diagnosing the cervical dysplasia, report it as a diagnostic test. If it is done to remove the area of abnormal cells, report it as treatment under the "Treatment Status" section.*

Work-Up Status

17. Final Diagnosis Status
Once work-up is completed, indicate the status of workup. Question 17 allows you to report clients that refuse workup or are lost to follow-up. If the client refused a diagnostic test, complete the *Refused/Lost to Follow Up Form*.

A response of **irreconcilable** should be used for those cases, which after clinical review, it is determined that there is no sufficient way to document the clinical scenario on the EWL data form. For example: If the clinician refers a client for short-term follow-up instead of following the guideline for immediate diagnostic work-up, check (✓) **irreconcilable**.

In **all** cases of recommended work-up, complete Question 17, whether or not you have a final diagnosis.

18. Final Diagnosis Date
The "Final Diagnosis Date" refers to the date of service of the procedure that results in the final diagnosis of cancer (or not cancer). If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the procedure that provided the definitive diagnosis.

19. Final Diagnosis
The diagnosis categories in Question 19 vary from normal or benign to invasive cervical cancer. In some cases, you may have only a diagnosis of Low Grade SIL or High Grade SIL based on a test other than a biopsy. If you have an alternative diagnosis (e.g., adenocarcinoma), check (✓) the "Other" box and enter the diagnosis.

For all cases of in situ (e.g.,CIN II, CIN III, HGSIL) or invasive cancer, complete the "Treatment Status" section (see below).

Cervical Cancer Treatment Status

20. and 21. Treatment Status and Date
For all cases of cancer diagnosed, complete Question 20 on the status of treatment.

Enter the date when treatment was started.

NOTE: *If a LEEP or conization was performed as both a diagnostic test and treatment to remove the abnormal cells, indicate the date of the procedure as the treatment start date.*

For both "Client Lost to Follow-up" and "Treatment Refused", report a date when the determination was made. Enter the date in Question 21. If the client refused treatment, complete the *Refused/Lost to Follow Up Form*.

22. Medicaid Enrollment
Indicate if the client was enrolled in Medicaid under the provisions of the BCCPTA.

Form Completed By
The Case Manager, or designee, who completed the form must sign and date the *Cervical Screening and Diagnostic Form*. If there are any questions regarding information on the form, the state EWL office will contact the individual who completed the form.

Tips for Completing the Cervical Screening and Diagnostic Form

1. If more than one screening result was obtained, record the worse of the two results.

2. If the "specimen adequacy" is unsatisfactory, submit the *Cervical Screening and Diagnostic Form* with the unsatisfactory finding. The Pap test should be repeated and the information submitted on a new form.

3. If the client is referred to EWL for diagnostic evaluation for a cervical problem on the basis of an abnormal Pap test by an outside provider, obtain and record the results of the Pap test and indicate that the Pap test was not paid by EWL.

4. A short-term follow-up or repeat Pap test is not a diagnostic test and should not be documented. Instead, check (✓) "NO" for Question 12 and report the repeat Pap test on a new *Cervical Screening and Diagnostic Form* as part of a new screening cycle.

5. Endometrial biopsy may be reported under the "Other Procedure" section. Endometrial biopsy will typically be performed to evaluate atypical glandular cells (e.g., AGUS) for possible adenocarcinoma or endometrial cancer. Although the EWL does not reimburse for endometrial biopsies, the program requires that abnormal glandular cells on the Pap test be evaluated.

6. If more than one result or final diagnosis is reported—for example, different findings on the colposcopy or biopsy—report the worse of the two findings.

7. If the result of the final, definitive diagnostic test (e.g., colposcopy-directed biopsy) is indeterminate, and you indicate a final diagnosis of either cancer or no cancer, document how you reached the diagnosis.

Cervical Screening and Diagnostic Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	Maiden Name
Admin Site	❑ New Screen ❑ Follow-up ❑ Rescreen		SSN (or alien ID)

PAP TEST AND PELVIC EXAM

1. Indication for Pap test:
   - ❑ Routine Pap test
   - ❑ Client under surveillance for a previous abnormal test
   - ❑ Pap test done by a non-program funded provider, client referred in for diagnostic evaluation
     Date client was referred into program for cervical diagnostic workup: _____/_____/_____
   - ❑ Pap test not done. Client proceeded directly for diagnostic work-up or HPV test.
   - ❑ Unknown

2. Pelvic exam date: _____ / _____ / _____ (mm/dd/yyyy)
3. Pap test date: _____ / _____ / _____ (mm/dd/yyyy)
4. What were the Pap test results?
   - ❑ Negative (for intraepithelial lesion or malignancy)
   - ❑ ASC-US
   - ❑ LGSIL
   - ❑ ASC-H
   - ❑ HGSIL
   - ❑ Squamous cell carcinoma
   - ❑ Abnormal Glandular Cells (AGC)
   - ❑ Other result: _____
   - ❑ Result unknown, presumed abnormal, from non-program funded source

5. Cervix present? ❑ Yes (Cervical) ❑ No (Vaginal)
6. Specimen Type: ❑ Conventional ❑ Liquid-based ❑ Other
7. Specimen adequacy? ❑ Satisfactory ❑ Unsatisfactory - Repeat Pap
8. Was the Pap test paid by EWL? ❑Yes ❑ No
9. HPV Test Result? ❑ Positive ❑ Negative ❑ Not Done
   HPV test date: _____ / _____ / _____ (mm/dd/yyyy)
10. Was the HPV test paid by EWL? ❑Yes ❑ No
11. Where was the Pap test/Pelvic exam performed?
    Facility/Clinic: _____
12. Was the client referred for immediate cervical diagnostic workup?
    ❑Yes ❑ No

DIAGNOSTIC PROCEDURES

13. Colposcopy without Biopsy
❑ Yes ❑ No
Procedure Date :___/___/___
Procedure site:_____
Results:
- ❑ Negative (WNL)
- ❑ Clearly defined lesion of CIN
- ❑ Abnormal, suspicious for cancer
- ❑ Abnormal, but not suspicious for cancer
- ❑ Unsatisfactory
- ❑ Refused (Complete Refused/LTFU Form)

Funding Source:
❑ EWL ❑ Other

14. Colposcopy-directed Biopsy
❑ Yes ❑ No
Procedure Date: __/___/___
Procedure site:_____
Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other non-cancerous abnormality
- ❑ Refused (Complete Refused/LTFU Form)

Funding Source:
❑ EWL ❑ Other

15. Other Procedure #1
❑ Yes ❑ No
Procedure Date: ___/___/___
- ❑ ECC
- ❑ LEEP
- ❑ Cone
- ❑ Other _____

Procedure site:_____
Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other non-cancerous abnormality
- ❑ Refused (Complete Refused/LTFU Form)

Funding Source:
❑ EWL ❑ Other

16. Other Procedure #2
❑ Yes ❑ No
Procedure Date: ___/___/___
- ❑ ECC
- ❑ LEEP
- ❑ Cone
- ❑ Other _____

Procedure site:_____
Results:
- ❑ Adenocarcinoma
- ❑ CIN I
- ❑ CIN II
- ❑ CIN III/CIS
- ❑ Invasive Carcinoma
- ❑ Negative (WNL)
- ❑ Other non-cancerous abnormality
- ❑ Refused (Complete Refused/LTFU Form)

Funding Source: ❑ EWL ❑ Other

WORK-UP STATUS

17. What is the status of the final diagnosis?
    - ❑ Work-up complete
    - ❑ Client lost to follow-up (Complete Refused/LTFU Form)
    - ❑ Work-up refused (Complete Refused/LTFU Form)
    - ❑ Irreconcilable
18. Date of final diagnosis: ____ / _____ / _____(mm/dd/yyyy)
19. Final diagnosis:
    - ❑ Normal/Benign Reaction/Inflammation
    - ❑ HPV/Condylomata/Atypia
    - ❑ CIN I/Mild Dysplasia (biopsy diagnosis)
    - ❑ CIN II/Moderate Dysplasia (biopsy diagnosis)
    - ❑ CIN III/Severe Dysplasia/Carcinoma in situ (Stage 0) (biopsy diagnosis)
    - ❑ Invasive Cervical Carcinoma (biopsy diagnosis)
    - ❑ Other: _____
    - ❑ Low grade SIL (biopsy diagnosis)
    - ❑ High grade SIL (biopsy diagnosis)

TREATMENT STATUS

20. What is the status of cervical cancer treatment?
    - ❑ Treatment started
    - ❑ Client lost to follow-up (Complete Refused/LTFU Form)
    - ❑ Treatment refused (Complete Refused/LTFU Form)
    - ❑ Treatment not recommended
21. Date of treatment status: _____ / _____ / _____(mm/dd/yyyy)
22. Was client enrolled in Medicaid for treatment? ❑ Yes ❑ No
    If no, why not?_____

Form Completed by:

REFUSED/LOST TO FOLLOW UP FORM

There are several reasons why a client may not receive the recommended screening, diagnostic or treatment services: (1) the service is not needed; (2) the client becomes “lost to follow-up”; or (3) the client refuses the service. The latter two are defined below. The *Refused/Lost to Follow Up Form* should be completed for these clients.

Refused

This section of the form is used to document clients who refuse screening, diagnostic, or treatment services either formally, by declaring so, or informally, by not keeping an appointment or canceling a scheduled appointment.

Refused Test/Treatment
Record the test or treatment the client refused.

Indicate Reason
Check (✓) the reason the client refused the test or treatment. If the refusal was due to another reason, check (✓) the “Other” box and document the reason on the line provided.

Case Management Interventions
Document any interventions used to contact the client. Several attempts should be made to contact a client to schedule follow-up diagnostic services and treatment. Three telephone attempts should be made on three different dates. If the Case Manager is still unable to reach the client, a certified letter should be sent, return receipt requested. If there is still no response from the client, the Case Manager has the option of inactivating the client from the program.

Client Response
Indicate the client’s response to the Case Manager’s interventions.

Lost to Follow-Up

If the Case Manager cannot successfully contact the client (e.g., the client died or moved without a forwarding address), the client is considered “lost to follow-up”. In this section, check (✓) the box to indicate if the client was lost to follow up for screening tests, rescreening tests, diagnostic tests, or treatment.

Case Management Intervention
Document the number of phone calls and/or certified letters sent by the Case Manager to the client.

Client Response
Record the client's response to the Case Manager's interventions.

Waiver Statement

For purposes of minimizing legal liability, attempts should be made to have the client sign the **Waiver Statement** on the bottom of the *Refused/Lost to Follow Up Form* or other substitute form officially recognized by your facility. *It is strongly suggested that you gather, document and report the details regarding the client's refusal to the State EWL office.*

Refused/Lost to Follow up Form
Every Woman's Life - Virginia Department of Health

Last Name	First Name	MI	SSN (or Alien ID)

REFUSED

Refused which test/treatment:_____

Indicate Reason:
☐ Fear of Procedure ☐ Illness, Injury or Hospitalization ☐ Too Busy/Time Conflicts ☐ Transportation Problems
☐ Financial Problems ☐ Disagrees with Recommendations ☐ Moved ☐ Other
_____

Case Management Interventions:_____

_____

Client Response:_____

_____

LOST TO FOLLOW UP

☐ Screening Tests ☐ Rescreening Tests ☐ Diagnostic Tests ☐ Treatment

Case Management Interventions:
# of Phone Calls:_____ # of Certified Letters:_____

_____

Client Response:_____

_____

Waiver Statement:

I certify that I have been advised as to the need for follow-up medical evaluation or treatment and the consequences of not getting this evaluation or treatment. I have decided to exercise my right to refuse any type of follow-up medical evaluation or treatment.

_____ _____/_____/_____

SIGNATURE **DATE**

_____ _____/_____/_____

WITNESS SIGNATURE **DATE**

RESCREENING

Re-Assess Eligibility

Each year, the eligibility of a client must be reassessed to ensure the client currently meets EWL eligibility criteria. Verify the client's:

- ☑ annual household income and household size (Note: revised Federal Poverty Guidelines are released by the state EWL office each June)
- ☑ age
- ☑ residence
- ☑ insurance status

Verify that address and telephone numbers are valid. Note any changes in name due to changes in marital status. Complete a new *Eligibility Form* yearly when the client returns for rescreening. Ignore **Questions For New Clients Only**.

Breast and Cervical Services

An annual rescreen is comprised of the same screening tests that were performed at the new screening, that is, the CBE, Pap test, and mammogram. Document the screening information on the screening and diagnostic forms, as you would a new screen. Check (✓) the "Rescreen" box at the top of the form.

SHORT TERM FOLLOW-UP

There are two types of short term follow-ups – planned and unplanned. In a planned short term follow up a new

Short Term Follow-Up: Planned Delay

When there is a planned delay before doing a related test or procedure, a **new** screening and diagnostic form should be completed. The delay is planned **by the physician**. The following scenario helps illustrate this point.

Scenario One: Short Term Follow-Up: Planned Delay
Carol had an initial screening mammogram in December with a result of "Probably Benign" (CBE was negative). The clinician instructed Carol to come back in March for a diagnostic mammogram on her left breast, which showed a negative result.

How to Report

- ☑ The initial mammogram in December should be recorded on the *Breast Screening and Diagnostic Form*. The result is "Probably Benign".
- ☑ It should be noted that diagnostic work-up is not planned.
- ☑ The diagnostic mammogram in March of the following year should be recorded on a *Breast Screening and Diagnostic Form*, with the Pap Test and CBE indicated as not performed. The type of mammogram performed is recorded as "Diagnostic".
- ☑ Once again, you should indicate that diagnostic work-up is not planned as the last question on the *Breast Screening and Diagnostic Form* under the mammogram section.

Explanation
For Carol, the results of the initial screening mammogram in December were "Probably Benign". The clinician recommended instead short term follow-up; this means that the clinician did not want any diagnostic tests done immediately, but wanted Carol to return at a later date for another screening test. Whenever there is a *planned* delay before doing a test, the repeat test must be recorded on a new screening and diagnostic form, regardless of whether the test occurs 3, 6, or 12-months from the date of the initial screening. Regardless of whether the repeat mammogram is called screening or diagnostic it should be documented on a new screening and diagnostic form.

Diagnostic Work-Up: Unplanned Delay

When the delay is unplanned or not recommended by the physician—that is, the client is the cause of the delay--the new test shall be considered diagnostic work-up. The following scenario illustrates this point.

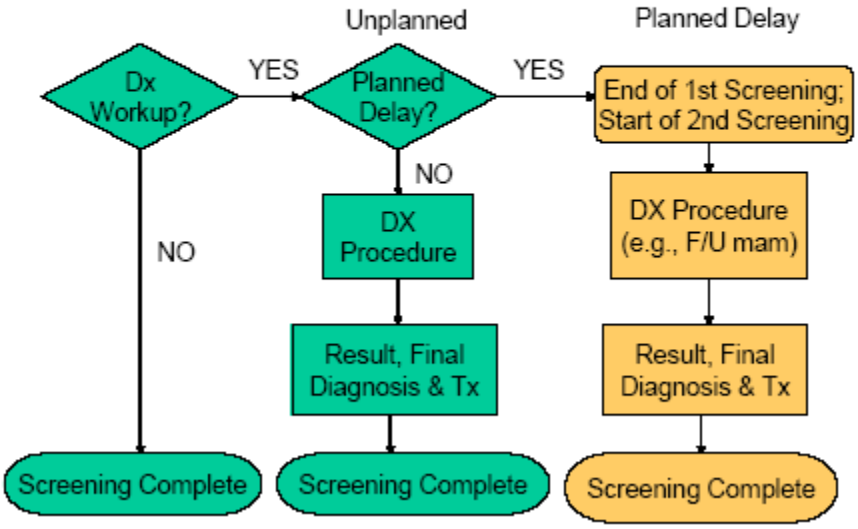
Scenario Two: Diagnostic Work-Up: Unplanned Delay
Jan has a screening mammogram in December. When the doctor read the film, she said that she wanted to do a diagnostic mammogram with additional views before deciding whether Jan needed further tests. Jan has left for Florida for the rest of the winter, so she had the diagnostic mammogram when she returned in March.

How to Report

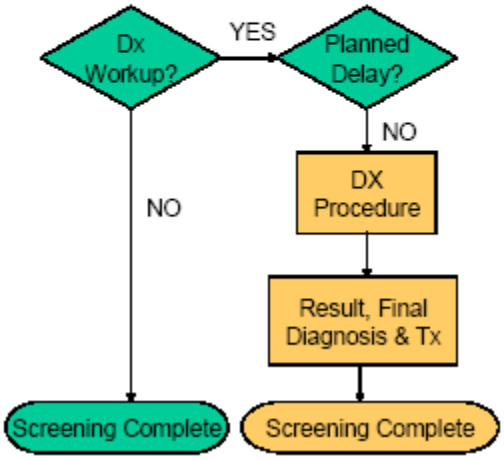
- ☑ The initial mammogram in December should be recorded on the *Breast Screening and Diagnostic Form*. The result is "Assessment Incomplete".
- ☑ Diagnostic work-up planned is noted as 'Yes' on the *Breast Screening and Diagnostic Form*.
- ☑ The additional mammographic views/diagnostic mammogram in March is recorded on the *Breast Screening and Diagnostic Form*.
- ☑ If there is a need for further diagnostic tests, the workup is not complete until all diagnostic tests are performed and recorded and a final diagnosis is determined.

Explanation
On the surface, this looks like the previous scenario, but there are two important differences. The doctor in the first scenario wanted Carol to wait a few months before having the second mammogram. In this scenario, the doctor wants Jan to have the diagnostic mammogram right away, but Jan is out of town. The second difference is that in the first scenario, the initial screening mammogram result was "Probably Benign". In this scenario, the result was "Assessment Incomplete", which implies that the radiologist needed further imaging tests before making a conclusion about the screening mammogram. The screening cycle is still open until all diagnostic work-up is completed. It is not the amount of time that passes between the test that is relevant, but rather the initial screening finding and the reason for why the amount of time passed: was it on purpose or could it have been done sooner if possible?

Short-Term Follow-up/Planned Delay



Diagnostic Work-up/Unplanned Delay



DATA FORMS TO BE SUBMITTED

New Screen and Rescreen

Submit a "complete data packet" per client for a new client or rescreen client. The data packet must include:

- ☑ Eligibility Form
- ☑ Breast and Cervical Screening and Diagnostic Forms

Note: If a client did not receive both breast and cervical services, only submit the form that is applicable and check (✓) the appropriate box on the Eligibility Form to indicate which forms are being submitted.

Short-Term Follow-Up

Complete and submit only the *Breast and Cervical Screening and Diagnostic Forms*. The *Eligibility Form* is valid for twelve months and does not need to be completed again before the next screen.

Appendix B

Monthly Screening Log

Provider Site:

(1) Fill in the number of federal and state screenings you were awarded for FY 2009-10 in the boxes to the right. **Federal** **State**

(2) Enter the number of new screens and re-screens each month for federal and state

(3) The Total, Cumulative Total, and Percent Screened will be **automatically** calculated for you.

(4) Enter the date you submit this screening log to VDH

(5) Submit the screening log by the 5th day of each month

(6) Email your screening log to beth.tanner@vdh.virginia.gov

FEDERAL

	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	TOTAL
# New Screens												0
# Rescreens												0
Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted												

STATE

	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	TOTAL
# New Screens												0
# Rescreens												0
Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted												

Appendix C

Community Health Worker Monthly Activity Sheet
Instructions

To be completed by: Community Health Worker

When: Reports are due by the 5th day of each month. They may be faxed or e-mailed to Beth Tanner at 804-864-7763 or beth.tanner@vdh.virginia.gov

Purpose: To provide information about the community health worker efforts and activities completed for EWL.

Fields:

Type: Please circle (or highlight if completing the document electronically) the letter indicating the type of activity you completed. You may indicate more than one "type" for an activity if needed (e.g. at a health fair you may do awareness and recruitment activities handing out information and making appointments).

A = Awareness (Activities to increase awareness might include handing out brochures in communities or health fairs, creating or putting up fliers, etc…)

E = Education (Educational activities might include speaking at a local group meeting, educating a client about healthy eating, providing training to lay health workers, etc…)

R = Recruitment/Follow-up (Recruitment and Follow-up activities might include sending out appointment reminders, making appointments for new women, following up with women that missed appointments, etc…)

P = Partnership (Partnership activities might include meeting with local community resources to provide additional services or materials to EWL women or similar activities)

Mode: The mode describes the method in which the type of activity was achieved (e.g. telephone calls, health fair, community, mail, training, speaker, etc…).

Setting: The setting describes where the activity took place (e.g. at the provider site, grocery store, church, school, etc…).

Description: The description should give specific details about the activity completed (e.g. who you met, who the audience was, what you did, etc…).

Outcome: The outcome should show the results of your activity (e.g. number of women you reached, etc…).

Time: Time indicates the approximate amount of time it took to complete the activity.

SAMPLE

Every Woman's Life - Community Health Worker Monthly Activity Report

SAMPLE

Last Name: Sally_____ First Name: Smith_____

Location: Your Provider Site_____

Month: March_____ Year: 2010

Type	Mode	Setting	Description	Outcome	Time
(A) E R P	Community	Grocery store	Distributed EWL brochures at local grocery store	Distributed information to 30 women	2 hours
A (E) R P	Speaker	Women's group	Spoke on the risk factors for breast cancer and the importance of breast cancer screenings	Spoke to a group of 15 women	1 hour
A E (R) P	Telephone	From provider site	Used provider site list to Make telephone calls to EWL eligible women to enroll new clients	Made appointments for 6 new women	3 hours
A E R (P)	Community	Extension office	Met with representative from extension to discuss nutrition education for clients	Partnership was established and another meeting has been scheduled	1 hour
A E (R) P	Mail	From provider site	Mailed reminder cards to clients with follow-up visits scheduled	Mailed cards to 20 women	2 hours
A (E) R P	Training	Church cafeteria	Provided training and education to volunteer lay health workers on how to use the "New Day for Women Resource Guide"	Trained 5 lay health workers	3 hours
(A) E (R) P	Health Fair	Local middle school	Distributed EWL brochures, talked to women about the EWL program and made appointments	Distributed 35 brochures, Spoke with 15 women, made 3 appointments	4 hours

A = Awareness *E = Education* *R = Recruitment/Follow-up* *P = Partnership*

Don't forget! CHW reports are due by the **5th day of each month**. If you do not have any activity for the month, please call or email to advise as such. Please fax your report to 804-864-7763 or email to Beth Tanner at beth.tanner@vdh.virginia.gov (phone 804-864-7761).

Every Woman's Life - Community Health Worker Monthly Activity Report

Last Name: _____ First Name: _____

Location: _____

Month: _____ Year: _____

Type	Mode	Setting	Description	Outcome	Time
A E R P					
A E R P					
A E R P					
A E R P					
A E R P					
A E R P					
A E R P					

A = Awareness *E = Education* *R = Recruitment/Follow-up* *P = Partnership*

Don't forget! CHW reports are due by the 5th day of each month. If you do not have any activity for the month, please call or email to advise as such. Please fax your report to 804-864-7763 or email to Beth Tanner at beth.tanner@vdh.virginia.gov (phone 804-864-7761).

Appendix D

Every Woman's Life
Matching Funds Form
Fiscal Year 2009-10

EWL providers are required to contribute matching funds – **non-Federal resources** - in the amount of $1 for each $3 of federal funds received. In the table below enter your **actual** matching funds for FY 2009-10 (June 30, 2009 – June 29, 2010) by **July 31, 2010.**

Non-Federal Cash Resources and Amounts:

Match Source	**Actual Amount By June 29, 2010**
• Cash donations	$
• Community fund-raising	$
• Komen grant award	$
• Avon grant award	$
• Other grants and awards	$

Non-Federal Non Cash Resources and Amounts:

Match Source	**Actual Amount By June 29, 2010**
• Donated vehicles and equipment (*e.g., vans for transportation, laboratory equipment, computers*)	$
• Donated clinical services (*e.g., professional salaries*)	$
• Donated non-clinical services (*e.g., clerical salaries*)	$
• Donated supplies (*e.g., educational materials, promotional materials*)	$
• Donated media time (*e.g., television, radio, print*)	$
• Donated professional time (*e.g., service on coalitions, advisory committees, advertising/marketing consultation*)	$

Revised January 2009

Appendix E

Interstate Verification of Treatment Certification

To be eligible for treatment under the Virginia Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA), women must receive a diagnosis of breast or cervical cancer or pre-cancer through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Enter all information. Sign, date and FAX the completed form to the following provider site located in Virginia:

Provider Site Name:
Provider Site FAX #:
Attention (contact name):

Transfer Confirmation	
Transfer From: *(enter name of state, tribal organization, or territory)*	Transfer To: Virginia
Patient Information	
First Name:	Last Name:
Screening Date:	Diagnosis Date:
Date Medicaid Eligible:	Date Treatment Started:
Screening Facility/Service Site: *(enter name of facility/service site where patient was screened)*	
Screening Facility/Service Site Contact Name:	
Screening Facility/Service Site Phone #:	

Certification:

I certify that the above information is correct and the individual has been screened for breast or cervical cancer and found to need treatment for breast or cervical cancer or pre-cancerous lesion.

_____ Date_____
(Screening BCCEDP Representative's Signature)

_____ Date_____
(Screening BCCEDP Representative) - Please Print Full Name

Every Woman's Life
A Virginia Department of Health Program

Appendix F

Every Woman's Life

CLIENT EDUCATION CHECKLIST

Client Name: _____

Enter the date and your initials in the appropriate box or write "NA", if not applicable. Initial and sign at the bottom of the page with your credentials.

	Date Completed Initials	Date Completed Initials	Date Completed Initials	Date Completed Initials	Date Completed Initials
Basic anatomy & physiology					
Risk factors					
Current recommended guidelines					
Benefits of early detection					
BSE procedures					
Importance of monthly breast self-exam					
Clinical breast & pelvic exam procedures					
Mammography procedures					
Importance of regular breast and cervical cancer screening					
Exit education/instructions					
Other					
Other					

Initials	Signature & Credentials	Initials	Signature & Credentials

Appendix G

Every Woman's Life

CLIENT SERVICES FLOW SHEET

Client Name: _____

Enter the date and your initials in the appropriate box or write "NA", if not applicable. Initial and sign at the bottom of the page with your credentials.

	Date Completed/ Initials	Date Completed/ Initials	Date Completed/ Initials
Screening Appointment Scheduled			
Pre-Appointment Instructions			
Directions to Provider Site			
Transportation Assistance			
Clinical Breast Exam			
Pap Test DOS			
Pap Report Received			
Patient Notified of Pap Result			
Mammogram DOS			
Mammogram Report Received			
Patient Notified of Mammogram Results			
Other			
Other			
Breast F/U Due			
Breast F/U Appointment Date			
Cervical F/U Due			
Cervical F/U Appointment Date			
Annual Mammogram Due			
Annual Pap Due			
Rescreen: 1st Reminder Sent			
Rescreen: 2nd Reminder Sent			
Rescreen: 3rd Reminder (Phone)			
Other			
Other			
Other			

Initials	Signature & Credentials	Initials	Signature & Credentials

Appendix H

Insert Provider Letterhead

Invoice Date: _____ Federal Tax ID#_____
Invoice #_____ Contract #_____
Submitted by: _____
Provider Site Name

TO: Virginia Department of Health
Virginia Every Woman's Life (EWL)
109 Governor Street, 8th Floor, West
Richmond, Virginia 23219
Attention: Data Manager

FEDERAL SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	**Description**	**Amount Requested**	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Breast & Cervical Services	Screening, diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients_____ $_____	# Clients_____ $_____	
CHW Support	Funds to support Community Health Worker[8]	$	$	
Other		$	$	

Send the approved amount to (*enter address in the space below*):

[8] Health Departments do not need to submit an invoice for CHW support.

Client Screening List – Federal

Invoice Date: _____ Invoice #_____

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>federal funds</u>**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Client Screening List – Follow-Up

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Insert Provider Letterhead

Invoice Date: _____ Federal Tax ID#_____
Invoice #_____ Contract #_____
Submitted by: _____
Provider Site Name

TO: Virginia Department of Health
Virginia Every Woman's Life (EWL)
109 Governor Street, 8th Floor, West
Richmond, Virginia 23219
Attention: Data Manager

STATE SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	**Description**	**Amount Requested**	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Breast & Cervical Services	Diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients_____ $_____	# Clients_____ $_____	
Other		$	$	

Send the approved amount to (*enter address in the space below*):

Client Screening List – State

Invoice Date: ____________________ Invoice #____________________________

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>state funds</u>**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Client Screening List – Follow-Up

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Appendix I

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: | WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐ SEPARATED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER: _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services *or be notified of the reason for any delay*.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____
Signature or Mark Date

_____ _____
Witness/Authorized Representative Date

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Appendix J

M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age *18* through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- *FAMIS Plus (MI Child Under Age 19);*
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used tc screen women for this program.

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI Pregnant Women, *FAMIS Plus,* or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI Pregnant Women, *FAMIS Plus,* or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), that must be initiated by a BCCEDP provider. The application includes the BCCEDP certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI Pregnant Women, *FAMIS Plus,* or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI Pregnant Women, *FAMIS Plus,* or SSI recipients covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

***E.* Entitlement**

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment

The aid category for BCCPTA women is "066".

***G.* Renewal**

Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

Appendix K

Medicaid FAQ Sheet

1. If a woman has private health insurance would she be eligible for the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)?

Answer: Medicaid states that the woman must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- group health plan
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer
- Medicare
- Medicaid
- armed forces insurance
- a medical care program of the Indian Health Service or of a tribal organization
- state health risk pool

There may be situations where a woman has creditable health insurance as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits. These women would not be eligible for coverage under the BCCPTA because they have creditable coverage. If a woman has creditable coverage, but a high deductible, she is still not eligible for treatment under the BCCPTA.

If a woman has a disease specific policy (e.g., dental, cancer, prescription, or vision only policy), but no other coverage, it is not considered creditable health insurance; the woman is eligible for treatment under the BCCPTA.

2. Can a woman be denied for BCCPTA if she is eligible for State and Local Hospital (SLH) Services?

Answer: No, a woman can only be denied for BCCPTA coverage if she is eligible for another Medicaid covered group. SLH is a state funded program; not Medicaid.

3. Are women who move to Virginia and participated in the NBCCEDP program in another state eligible for the BCCPTA?

Answer: Yes. Since the EWL program is part of the national BCCEDP, women receiving Medicaid under the Medicaid Treatment Act in other states, territories, tribal organizations or the District of Columbia can continue to receive these benefits in Virginia. Even though other states, territories, tribal organizations and the District of Columbia may have different program eligibility criteria (e.g., income $\leq$ 250%), and follow different Medicaid eligibility criteria, women transferred into Virginia will continue to be eligible for treatment. In contrast,

women receiving treatment under the BCCPTA in Virginia that move to another state may not be eligible for the BCCPTA in that state under their policy.

To initiate the transfer, EWL programs should verify, and if possible receive documentation, that the woman was enrolled in a NBBCEDP program and was receiving treatment under this state/program. Once this is verified, the EWL provider will need to complete a Medicaid application and forward it to their local Department of Social Services (DSS) office. Once treatment ends, the woman, if eligible for EWL, may be re-screened through the program. Women that are not eligible for EWL should be referred to other community resources for their routine cancer screening.

4. Do we have presumptive eligibility in Virginia?

Answer: Medicaid does not have presumptive eligibility in Virginia. Medicaid has streamlined the eligibility process for the BCCPTA but they do not approve and enroll anyone based on presumptive eligibility. Medicaid has an application and certification to determine if the individual meets the requirements of the BCCPTA covered group.

5. Are women who received treatment for breast and/or cervical cancer through the BCCPTA eligible for re-entry into BCCPTA if complications arise from their previous treatment?

Answer: If a woman is no longer under treatment and has been discharged from Medicaid, she is not eligible for re-entry into Medicaid for complications related to her treatment. She should apply for 'regular' Medicaid.

6. Is reconstructive surgery covered under the BCCPTA?

Answer: If a Medicaid provider obtains preauthorization for the surgery and determines it to be medically necessary it will be covered. To obtain preauthorization, the Medicaid provider will need to submit the required paperwork.

7. Is the cost of a wig allowable under the BCCPTA?

Answer: No, the BCCPTA does not cover the cost of a wig since it is considered a 'cosmetic' expense.

8. Do women enrolled in Every Woman's Life and trying to enter Medicaid for treatment need to provide proof of citizenship and identify?

Answer: Yes, this new rule applies to EWL enrolled women. The Deficit Reduction Act of 2005, which was signed into law by President Bush on February 8, 2006, implements a new requirement for all applicants and recipients of

Medicaid FAQ Sheet

Medicaid who claimed, at the time of application, to be US Citizens. This new provision requires individuals to provide documentation of citizenship and identity for all applicants who file an application for Medicaid on or after 7/1/06 and for all recipients of Medicaid at the time of their first redetermination of eligibility on or after 7/1/06. Provision of these documents is a one time activity; once provided, they will not be required again.

Citizenship can be documented in several ways but a birth certificate is probably the easiest. If the applicant does not have a birth certificate and needs assistance in obtaining one, the person can let the DSS eligibility worker know and assistance will be provided.

Documentation of identity must also be provided. The easiest way to document identity is with a driver's license.

If a woman has a passport or naturalization certificate, that would document both citizenship and identity.

Original documents must be provided to the DSS eligibility worker who will make a copy for the case file.

9. **The recent Deficit Reduction Act (DRA) of 2005 requires all applicants and recipients of Medicaid to be US Citizens. Does this new law mean that aliens (not being able to provide proof of citizenship) are no longer eligible for the BCCPTA?**

Answer: The DRA requires all applicants and recipients of Medicaid who claim to be U.S. citizens provide documentation of their citizenship and identity. Prior to July 1, 2006, applicants and recipients who declared they were U.S. citizens did not need to provide proof. Under this new Act, they must now provide documentation. There was NO change in eligibility requirements for non-citizens. If an alien is screened and diagnosed through the EWL program and needs Medicaid, as long as she is a qualified alien eligible for full Medicaid benefits, she will be eligible.

10. **Can the EWL provider obtain proof of citizenship and identity and fax a copy of this information along with the Medicaid application to DSS?**

Answer: Medicaid has agreed to the following documentation for **health department providers only**:

The EWL provider views the ORIGINAL documentation, copies it and annotates the copy(ies) with the words:

The original documentation was viewed by _____(name) an employee of _____(name of organization) on _____(date).

Medicaid FAQ Sheet

11. What documents can be used to document citizenship and/or identity?

Answer: The following documents can be used to document both citizenship and identity:

- U.S. Passport (unexpired)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N5-560 or N-561)

The following documents can be used to document citizenship only:
- U.S. Public Birth Record (i.e., Birth Certificate)
- Certification of Report of Birth
- American Indian Card (I-872)
- Final Adoption Decree
- Evidence of Civil Services Employment by the U.S. Government
- Official Military Record of Service
- Other: Extract of hospital record on hospital letterhead; life or health or other insurance record; a statement signed by the physician or midwife who was in attendance at the time of birth, and institutional papers from a nursing home or other institution or medical records.

The following documents can be used to document identity only:
- Driver's License Issued by State or Territory
- School Identification Card
- U.S. Military Card or Draft Record
- Other: Identification card issued by federal, state, or local government with the same information included on driver's licenses; Certificate of Degree of Indian Blood

12. Will DSS notify case managers when the final determination for BCCPTA eligibility is made?

Answer: This is not a feasible practice for DSS. However, they have provided some important resources in their response below that will assist you when a client fails to respond to your follow up calls for information.

"Medicaid policy requires notification to the applicant by local social service departments when enrollment is complete. Providers have access to a DMAS electronic system that allows them to see what benefits a Medicaid recipient who presents for services has as well as a toll-free provider hotline through DMAS when they have any questions about an individual's eligibility. With the number of providers, it is not feasible for DSS staff, whose primary responsibility is to address client needs, to notify providers when an individual qualifies for a service through Medicaid enrollment given the services already available to providers."

Medicaid FAQ Sheet

For Medicaid eligibility information, EWL providers are encouraged to visit the DMAS website, http://virginia.fhsc.com. Additionally, there are two toll free Medicall numbers (800-772-9996 or 800-884-9730) to call for eligibility information. To access the Medicall system, you must be a Medicaid provider with a provider number.

13. Is there a co-pay for Medicaid services?

Answer: Yes. Most Medicaid recipients other than pregnant women and children have co-pays for the Medicaid services they receive. Clients are responsible for the co-pay. Below is a list of co-pays for specific services:

a. Inpatient hospital $100 per admission
b. Outpatient hospital $ 3.00 per visit
c. Clinic visit $1.00 per visit
d. Physical office visit $1.00 per visit
e. Other physician visit $3.00 per visit
f. Eye Exam $1.00 per exam
g. Prescriptions $1.00 and $3.00
h. Home health visit $3.00 per visit
i. Rehabilitation service $3.00 per visit

Emergency Services are never subject to co-pays.

14. Does retroactive coverage under the BCCPTA only include the cost of diagnostics related to the breast and cervical cancer diagnosis or does it include all medical expenses (diabetes, heard disease, etc.) that are incurred by the woman?

Answer: Retroactive coverage includes all Medicaid covered services. If the woman already paid for a service Medicaid would have covered the provider may bill Medicaid and then reimburse the woman. Medicaid does not reimburse recipients for services only providers.

15. When completing a Medicaid application for clients enrolled with state funding, what date do we enter for the screening date at the bottom of the application? Is it the date of the abnormal Pap test or the date of EWL enrollment?

Answer: It is the date of the Pap test.

16. Is the race and marital status field required fields on the Medicaid Application Form?

Answer: Yes, race and marital status information is collected and reported to the Centers for Medicare and Medicaid Services.

17. Is there an annual re-enrollment into BCCPTA?

Answer: Yes, clients enrolled under the BCCPTA must complete a re-determination form, which is available at their local DSS office. They can either have the treating physician complete the certification section of the form or have the physician verify in writing that they continue to receive treatment for breast and cervical cancer.

18. How long does a legal resident need to work before they can be eligible for the BCCPTA?

Answer: One of the requirements to receive "full Medicaid benefits" is that the individual must have worked at least 40 qualifying quarters since being in the U.S. Legal residents that do not meet this work requirement will be deemed an "unqualified alien" by DSS.

19. What is Plan First?

Answer: Plan First is a Medicaid program that provides an annual physical exam, Pap test, lab services, contraceptives, and family planning education and counseling services to eligible women (and men) through the family planning office visit. Women with an abnormal Pap test or breast exam may be referred to EWL for further testing under the EWL state program. Women enrolled in Plan First qualify for EWL since Plan First does not provide full health care coverage. These women are considered underinsured (See Eligibility policy, 5.d).

20. Are incarcerated women eligible for Medicaid treatment under the BCCPTA?

Answer: No, as long as a woman is incarcerated she is ineligible for Medicaid in ANY covered group. Incarcerated women are not eligible for Medicaid coverage until they are released.