



Every Woman's Life

# Program Manual

A Virginia Department of Health Program

# Data Collection, Reporting & Retention



**Title:** 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, 2010

**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).

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. To view the client data forms and instruction sheets, refer to **Attachment A**.

Providers must 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, 2010

**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 for the previous month by the 5<sup>th</sup> day of each month to the state EWL program. Refer to **Attachment B** for the Monthly Screening Log form.
2. Community Health Worker Monthly Activity Report – Community Health Worker (CHW) reports document the important outreach/inreach activities performed by the CHW at participating provider sites. Reports for the preceding month should be filled out by the CHW and faxed or emailed to the state EWL program by the 5<sup>th</sup> day of the following month. Refer to **Attachment C** for the CHW Monthly Activity Report.
3. Annual Renewal Application – Provider sites are required to submit a renewal application annually that includes 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 every \$3 of federal funds they receive. Matching funds may be cash, in-kind, or donated services or equipment. Matching funds may not include (1) payment for treatment services or the donation of treatment services, (2) services assisted or subsidized by the Federal government, or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the provider and will be subject to audit. There is no match requirement for state funds. The match report documents the provider's cash and in-kind donations and must be completed and electronically submitted by July 31<sup>st</sup> to the State EWL program. Refer to **Attachment D** for the Matching Funds Form.

**Title:** Medical Record Management

**Program Component:** Data Collection, Reporting & Retention

**Purpose:** To delineate the composition, retention and disposition of the client medical record.

**Responsible Person(s):** Provider Site Coordinator or Designee

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**Policy:**

The provider must maintain a permanent client medical record that is in compliance with JCAHO quality assurance guidelines for documentation. Electronic records are acceptable as medical records. The record should include all relevant clinical documents, including but not limited to, copies of the clinical breast exam, pelvic exam, cervical cytology and screening mammogram results, and copies of the results of any diagnostic work-up performed. EWL providers should follow the medical record documentation policies endorsed by their agency/organization.

Providers must follow the conditions for records retention and disposition of client medical records outlined under the provisions of the *Virginia Public Records Act, Sections 42.1-76, et. Seq. of the Code of Virginia*. Adult client medical records should be retained for at least 6 years after last treatment then destroyed by shredding or pulping. For more information on record retention and disposition visit: <http://www.lva.virginia.gov/agencies/records/>.

The provider must have an organized and secure client record system that is readily accessible and available to the client upon request with a signed release of information, and to the state EWL office for examination within a reasonable time. When information is requested, providers should release only the specific information requested. Upon request, clients transferring to another provider or out-of-state program must be provided with a copy or summary of their record to expedite continuity of care.

EWL program information (eligibility, demographic and clinical information) on women enrolled and served through EWL must be entered into WeBCCast. Program information that is not entered into WeBCCast must be filed in the client's medical record. At this time, information on the following program forms cannot be entered into WeBCCast and must be filed in the client's medical record, or in the case of an electronic record the information must be filed in a separate EWL program record. This includes the following EWL program forms:

1. Client Participation Agreement,
2. Client Needs Assessment (if applicable),
3. Client Care Plan (if applicable),

4. Client Transfer Form (if applicable),
5. BCCPTA Medicaid Application (if applicable).

The provider must maintain client/record confidentiality in accordance with state and federal laws, rules, and regulations. The provider and all sub-contractors should conform to all relevant rules and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

# Enrollment



**Title:** Priority Populations

**Program Component:** Enrollment

**Purpose:** To define the program's priority populations to ensure providers concentrate their outreach/recruitment activities on women who are most in need of EWL services.

**Responsible Person(s):** Provider Site Coordinator, Community Health Worker or Designee

**Effective Date:** June 30, 2010

**Policy:**

EWL defines the priority populations as:

- a. Minority Women – Providers are expected to enroll and screen racial and/or ethnic minority women (e.g., African American, Asian, Hispanic) at or above the rate proportional to the presence of minorities in their defined service area. According to recent Census data, 27% of Virginia residents are racial/ethnic minorities. While white women are more likely than other racial/ethnic groups to be diagnosed with breast cancer, black women are more likely to die from the disease. Black women are also more likely to be diagnosed with breast cancer at a younger age and a later stage. Cervical cancer incidence rates are higher for black and Hispanic women as compared to white women. Mortality rates from cervical cancer for black and Hispanic women are almost double that of white women (Source: Virginia Cancer Registry 2002-2006 and the Centers for Disease Control).
- b. Economically Deprived Women – Includes women who are at or below 100% of the federal poverty level. It has been well documented that economically deprived women have more barriers to accessing health care and preventive screenings than those of higher incomes. Studies by the American Cancer Society (ACS) have documented that mortality rates are higher for low income women diagnosed with breast cancer. A study from The National Cancer Institute (NCI) reports that cervical cancer continues to be a more serious threat to women with low incomes and educational levels. Women in high poverty census tracts were 20 percent more likely to be diagnosed with late-stage disease and a lower survival rate than women in census tracts with low poverty levels.
- c. Never/Rarely Screened Women - 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 cervical cancer screening 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 cervical cancer screening test or have not had a cervical cancer screening 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 Performance Indicators;#5*.

- d. Women Over Age 50 – As age increases so does a woman's risk of breast cancer. About 1 out of 8 invasive breast cancers are found in women younger than 45, while about 2 out of 3 invasive breast cancers are found in women age 55 or older (Source: American Cancer Society).

The program expects providers to concentrate their outreach and recruitment efforts on the priority populations to ensure women with the greatest need receive EWL services. Women recruited within the priority population must meet all program eligibility requirements for enrollment.

**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 gross 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 cervical cytology result or abnormal breast exam.

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

1. Female gender (self-declared)
2. Age – must be age 18-64 (self-declared)
  - a. 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. Income must be 200% of the Federal Poverty Level or less (self-declared)
  - a. **For eligibility purposes, the program uses an applicant’s self-declared gross income to determine eligibility.** Gross income means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: 1) monetary compensation for services, including wages, salary, commissions or fees, 2) net income from nonfarm self-employment, 3) net income from farm self-employment, 4) Social Security, 5) dividends or interest on savings or bonds or income from estates or trusts, 6) net rental income, 7) public assistance or welfare payments, 8) unemployment compensation, 9) government civilian employee or military retirement or pensions or veterans payments, 10) private pensions or annuities, 11) alimony or child support payments, 12) regular contributions from persons not living in the household, 13) net royalties, and 14) other cash income (includes cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources).
  - b. EWL providers may choose to verify and document income level if this practice coincides with their agency’s policies and procedures.

---

<sup>1</sup> EWL providers may follow stricter eligibility guidelines, if funds are limited.

4. Primary residence in Virginia (self-declared)
  - a. EWL providers may choose to verify and document Virginia residence if this practice coincides with their agency's policies and procedures.
5. Uninsured or underinsured (self-declared) - Underinsured is defined as having:
  - a. Health insurance that does not reimburse for EWL allowable procedures (e.g., screening mammogram)
  - 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 full health care coverage (e.g., Plan First Family Planning Services)

The following women are **not** 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 who have Medicare Part A and Part B
10. Women who receive Social Security Disability benefits including Medicare Part A and B. Women who receive Social Security Disability benefits must receive benefits for two years before they are automatically eligible for Medicare Part A and B.
11. Women who receive Supplemental Security Income (SSI) and receive Medicaid

Men are **not** eligible to receive EWL screening and diagnostic services.

**Title:** Federal Poverty Guidelines

**Program Component:** Enrollment

**Purpose:** To ensure the 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:** Client Participation Agreement

**Program Component:** Enrollment

**Purpose:** To ensure that applicants provide accurate personal information to determine program eligibility, understand their responsibility as an EWL participant, and consent to all EWL services prior to receiving these services.

**Responsible Person(s):** Provider Site Coordinator or Designee

**Effective Date:** June 30, 2010

The Provider Site Coordinator or designee should obtain the client's informed and voluntary agreement to participate in the program prior to receiving any EWL services by having the client carefully read and sign the Client Participation Agreement (**Attachment E**). The Client Participation Agreement must be signed each time a client's eligibility is determined (e.g., at the time new clients are enrolled, active clients are rescreened or inactive clients that change their status to active are re-enrolled). For clients who do not understand the language of the Agreement, have language barriers or who have disabilities that impair communication, the Agreement must be read or interpreted to the client. Agreement to participate in the program must never be obtained in a manner that could be perceived as coercive. The Agreement should be filed in the client's medical record.

The brochure "*What you need to Know about Every Woman's Life*" should be provided and the contents explained to all clients at the time of enrollment.

**Title:** Client Transfers

**Program Component:** Enrollment

**Purpose:** To ensure that 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, 2010

**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 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 ages 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 and there are appointments available.
2. Women ages 18-64 in need of or receiving breast and cervical diagnostic services under the NBCCEDP who relocate to Virginia and need diagnostic work-up completed should be enrolled in EWL to complete the necessary diagnostic procedures. Provider Site Coordinators or their designee must verify these out-of-state transfers received services (e.g., screening and/or diagnostic) under another BCCEDP. Providers may use the *Client Transfer* form found in **Attachment F** for this purpose. File the form in the client's medical record.

**For women ages 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 ages 40-49.
- b. If breast or cervical cancer is diagnosed, the woman should be referred to Medicaid for medical assistance under the Virginia Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

**For women aged 40-64:**

- a. 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 and appointment slots are available (especially in the case of women ages 40-49).
  - b. If breast or cervical cancer is diagnosed, the woman should be referred to Medicaid for medical assistance under the Virginia BCCPTA.
3. Women who were previously diagnosed with cancer or a pre-cancerous condition while enrolled in another NBCCEDP funded program and in need of or receiving treatment, but are now a Virginia resident, are covered by the Virginia BCCPTA.
- a. Provider Site Coordinators or their designee must verify these out-of-state transfers are eligible for the Virginia BCCPTA. They may use the *Client Transfer* form found in **Attachment F** for this purpose. File the form in the client's medical record.
  - b. Once the verification process is complete, Provider Site Coordinators or their designee must complete the Virginia 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



**Title:** Federal Performance Indicators

**Program Component:** Quality Assurance and Improvement

**Purpose:** To define the 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, 2010

**Policy:**

There are six core performance indicators that are used to monitor a provider's performance to ensure quality services are delivered to the priority population 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 performance indicators. The six indicators are tracked and reported quarterly to EWL providers for informational, educational and quality improvement purposes. Additionally, there are three non-core performance indicators that are routinely tracked to ensure the program is reaching and serving women within the priority population.

The six core performance indicators are listed below:

**1. Work-Up Completed**

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.</li></ul>	<ul style="list-style-type: none"><li>▪ A minimum of 90% of records will be complete.</li></ul>
<ul style="list-style-type: none"><li>▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.</li></ul>	<ul style="list-style-type: none"><li>▪ A minimum of 90% of records will be complete.</li></ul>

**2. Screening to Diagnosis**

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>▪ 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. <i>For women referred into the program for diagnostic evaluation after an abnormal screen received outside of the program, the interval will begin on the referral date for diagnostic testing, rather than the date of the initial outside screen.</i></li></ul>	<ul style="list-style-type: none"><li>▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal breast cancer screening test result or referral date and the final diagnosis.</li></ul>
<ul style="list-style-type: none"><li>▪ 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 90 days. <i>For women referred into the program for diagnostic evaluation after an abnormal screen received outside of the program, the interval will</i></li></ul>	<ul style="list-style-type: none"><li>▪ No more than 25% of records will indicate a timeframe of greater than 90 days between an abnormal cervical cancer screening test result or referral date and the final diagnosis.</li></ul>

<p><i>begin on the referral date for diagnostic testing, rather than the date of the initial outside screen.</i></p> <p>*Defined as squamous cell cancer, atypical glandular cells (AGC), high grade SIL, LSIL, ASC-H, result unknown and presumed abnormal, positive cervical cytology result from a non-program funded source, and any cervical cytology result [ASCUS, LSIL], which is marked as needing diagnostics.</p>	
--	--

### 3. Treatment Started

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"> <li>If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.</li> </ul>	<ul style="list-style-type: none"> <li>A minimum of 90% of records will indicate treatment was initiated.</li> </ul>
<ul style="list-style-type: none"> <li>If there is a final diagnosis of CIN II, CIN III/CIS or invasive cancer, appropriate treatment will be initiated.</li> </ul>	<ul style="list-style-type: none"> <li>A minimum of 90% of records will indicate treatment was initiated.</li> </ul>

### 4. Diagnosis to Treatment

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>

### 5. Never/Rarely Screened

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"> <li>The provider will target for enrollment never or rarely screened women, defined as women who have never had a cervical cancer screening test, or who have not had a cervical cancer screening test within 5 years.</li> </ul>	<ul style="list-style-type: none"> <li>A minimum of 20% of newly enrolled women who receive a cervical cancer screening test will meet the criteria for having been never or rarely screened.</li> </ul>

### 6. Mammograms Over 50

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"> <li>The majority of screening mammograms provided should be to women between 50 and 64 years of age.</li> </ul>	<ul style="list-style-type: none"> <li>A minimum of 80% of screening mammograms provided to program eligible women who are 40 to 64 years of age must be provided to women over age 50.</li> </ul>

### 7. Re-Screen (non-core)

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"><li>The provider will give priority to eligible women ages 50-64 previously enrolled and screened through EWL.</li></ul>	<ul style="list-style-type: none"><li>A minimum of 65% of women screened in any given year should return within 12-18 months after their last mammogram screening. There must be at least 12 months between mammogram screening tests for the screening to be considered a rescreen. Note: Clients with abnormal mammogram results or diagnosed with breast cancer are not included in the calculation of the rescreen rate.</li></ul>

### 8. Very Low-Income Women Served (non-core)

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"><li>The provider will give priority to eligible very low-income women that are defined as having an annual gross income at or below 100% of the Federal Poverty Level.</li></ul>	<ul style="list-style-type: none"><li>A minimum of 60% of women served will be at or below 100% of the Federal Poverty Level.</li></ul>

### 9. Minority Women Served (non-core)

Performance Indicator	Minimum Standard
<ul style="list-style-type: none"><li>The provider will give priority to eligible minority women (e.g., African American, Latino, Asian etc.) that claim a non-Caucasian racial and ethnic status.</li></ul>	<ul style="list-style-type: none"><li>Providers will serve a higher percentage of minority women that is proportionate for their service area.</li></ul>

**Title:** State Performance Indicators

**Program Component:** Quality Assurance and Improvement

**Purpose:** To define the 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, 2010

**Policy:**

There are four 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 performance indicators. The four indicators are tracked and reported quarterly to EWL providers for informational, educational and quality improvement purposes.

The four performance indicators are listed below:

**1. Work-Up Completed**

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.</li></ul>	<ul style="list-style-type: none"><li>A minimum of 90% of records will be complete.</li></ul>
<ul style="list-style-type: none"><li>If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.</li></ul>	<ul style="list-style-type: none"><li>A minimum of 90% of records will be complete.</li></ul>

**2. Referral to Diagnosis**

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>If there is an abnormal breast cancer screening result, the time between the referral date and final diagnosis will be no longer than 60 days.</li></ul>	<ul style="list-style-type: none"><li>No more than 25% of records will indicate a timeframe of greater than 60 days between the referral date and the final diagnosis.</li></ul>
<ul style="list-style-type: none"><li>If there is an abnormal cervical cancer screening result*, the time between the referral date and final diagnosis will be no longer than 90 days.</li></ul> <p>*Defined as squamous cell cancer, atypical glandular cells (AGC), high grade SIL, LSIL, ASC-H, result unknown and presumed abnormal, positive cervical cytology result from a non-program funded source, and any cervical cytology result [ASCUS, LSIL], which is marked as needing diagnostics.</p>	<ul style="list-style-type: none"><li>No more than 25% of records will indicate a timeframe of greater than 90 days between the referral date and the final diagnosis.</li></ul>

### 3. Treatment Started

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.</li></ul>	<ul style="list-style-type: none"><li>▪ A minimum of 90% of records will indicate treatment was initiated.</li></ul>
<ul style="list-style-type: none"><li>▪ If there is a final diagnosis of CIN II, CIN III/CIS or invasive cancer, appropriate treatment will be initiated.</li></ul>	<ul style="list-style-type: none"><li>▪ A minimum of 90% of records will indicate treatment was initiated.</li></ul>

### 4. Diagnosis to Treatment

<b>Performance Indicator</b>	<b>Minimum Standard</b>
<ul style="list-style-type: none"><li>▪ 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.</li></ul>	<ul style="list-style-type: none"><li>▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.</li></ul>
<ul style="list-style-type: none"><li>▪ 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.</li></ul>	<ul style="list-style-type: none"><li>▪ 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.</li></ul>
<ul style="list-style-type: none"><li>▪ 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.</li></ul>	<ul style="list-style-type: none"><li>▪ 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.</li></ul>

**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

**Revised Date:** June 30, 2010

**Policy:**

Monitoring and assessing clinical services are important components of quality assurance/improvement, and can ultimately help a program meet and/or exceed customer expectations and program outcomes. The purpose of the routine observational site visit is to:

1. Assess the accessibility and quality of services provided,
2. Evaluate clinic flow and efficiency,
3. Train providers on program policies, procedures and protocols,
4. Conduct a medical record review to verify actual care provided compared to outcomes reported,
5. Provide technical assistance to help providers enhance systems to improve care,
6. Solicit general feedback, and
7. Negotiate an action plan in response to any proposed recommendations.

The information 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.

An observational site visit will be conducted every two years for each authorized EWL provider. The observational site visit will allow the QA/I Nurse to follow a client through a complete clinical visit. A formal medical record review will also be conducted to evaluate adherence to established clinical and case management protocols. The review can help determine whether an identified problem is related to the delivery of care or data collection and reporting. For the medical record review, the State EWL office will generate a random list of 20 records, which will include five clients who received a diagnostic work-up.

**Procedure:**

1. The provider site director and coordinator will be notified 60 calendar days prior to the site visit.
2. A 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 and Medical Record Review Tool to gather relevant information.
4. Within 30 calendar days of the site visit, the QA/I Nurse will submit a written summary to the provider director and coordinator that lists their strengths, weaknesses and any recommendations for improvement.
5. Within 30 calendar days of receiving the written summary and recommendations, the provider coordinator or designee will submit a written response that details their plans to address the recommendations.
6. Within 30 calendar days of receipt of the provider's 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:** Problem-Focused Site Visit/Call

**Program Component:** Quality Assurance and Improvement

**Purpose:** To provide a collaborative approach to problem solving and program improvement to enhance and strengthen the quality of services delivered through EWL.

**Responsible Person(s):** EWL State Team and Provider Site Coordinator or Designee

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**Policy:**

A problem-focused site visit/call will only occur when a specific problem has been identified by the EWL state office or the provider. The site visit/call will be scheduled to discuss a specific area(s) in need of improvement and to collaboratively develop an action plan 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 a customer service or communication problem, may also generate a provider site visit/call. Problem-focused 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 clarify the scope of the problem and its primary or root causes, and brainstorm options for resolving the problem to ensure the program complies with all program standards and expectations. The problem-focused site visit/call will include the state EWL team and key provider site personnel such as the director (or designee), coordinator, case manager(s), community health worker (if there is one), fiscal administrator, and any other staff directly affiliated with the EWL program.

**Procedure:**

1. The state EWL office will coordinate a mutually agreeable 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 and any supporting documentation will be electronically sent to the provider.
3. During the site visit/call, participants will discuss the problem, strategize and formulate practical solutions, and develop an improvement plan.
4. Within 30 calendar days of the site visit/call, the Provider Site Coordinator or designee will submit the improvement plan to the designated state EWL staff person and list 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 calendar days of receipt of the improvement plan, the state EWL office will finalize and 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 state EWL office is satisfied with the provider's performance.

# Reimbursement



**Title:** Reimbursement for EWL Services

**Program Component:** Reimbursement

**Purpose:** To define the payment policy for screening, diagnostic and other related 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, 2010

**Policy:**

The EWL provider will 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 procedural data (e.g., type and number of screening and diagnostic procedures performed) times the actual costs for procedures, which is based on current Virginia Medicare reimbursement rates, plus case management fees for women with abnormal screening results.

For services supported through federal funds, the current capitation rate for a 12-month contract year is \$320 per woman aged 40-64. For counties and cities located in the northern Virginia area<sup>1</sup>, 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 approved 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 current capitation rate for a 12-month contract year 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 approved 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., Client 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.

---

<sup>1</sup> 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 **Attachment G**. Refer to **Attachment 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 must 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. 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 the required data and request payment for a client within **90 calendar days** of the date of the client’s last screening exam (e.g., CBE, cervical cancer screening test, screening mammogram) will forfeit the right to payment.

It is expected that providers will submit an invoice/client data packet monthly, and adhere to the following goals for submission:

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

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

**Procedure:**

1. Complete all information on the required data forms, which include the Client 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 services, if requesting payment for clients aged 40-64. See **Attachment G – FEDERAL SCREENING INVOICE**.
  - A. Ideally, the approved capitation rate will be paid for clients that have received a clinical breast exam, screening mammogram, cervical cancer screening test and pelvic exam, unless the procedure is marked – refused, not needed, or done recently. Some clients may not need all four screening exams each year, however, in order to receive payment the client must have at least

received a screening mammogram. For example, a client that receives a cervical cancer screening test and clinical breast exam but no screening mammogram will not be reimbursed. Exception: The capitation rate will be approved for clients that received a screening 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 services, if requesting payment for clients aged 18-39. See **Attachment G – STATE SCREENING INVOICE.**

A. Providers will **not** receive the capitation rate for clients that receive a clinical breast exam to rule out the need for additional diagnostic testing. Providers will **only** receive the capitation rate 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. Eligible women aged 65 and older may 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:

i. List the number of clients you are requesting payment for and the requested amount in the appropriate space.

ii. Enter the total annual dollar amount requested in the row marked “CHW” and request payment by December 31. Health Departments **do not** need to submit an invoice for Community Health Worker funds.

iii. For other related services (e.g., travel) that have been pre-approved, providers should enter the total dollar amount requested in the row marked “other” and a description of the request, and attach any supporting documentation.

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 women 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, 8<sup>th</sup> Floor*  
*Richmond, Virginia 23219*

# Services



**Title:** Client Education

**Program Component:** Services

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

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

**Effective Date:** June 30, 2007

**Revised Date:** June 30, 2010

**Policy:**

Client education is an essential and fundamental component of the EWL program. Health information provided during the clinic visit 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 should:

1. Provide information that is culturally and linguistically appropriate and understandable for visually/hearing impaired women, about the purpose of clinical breast exams, screening mammograms and/or cervical cancer screening 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.
2. Provide information on other age appropriate cancer screenings (e.g., colorectal screening over age 50) to women enrolled in the program.
3. Provide information on the health risks associated with smoking and other tobacco products to users, and encourage them to contact *QuitNow Virginia* (phone based treatment program) for coaching and effective smoking cessation techniques.

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.

**Title:** Cervical Services for Women Age 18–39

**Program Component:** Services

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

**Responsible Person(s):** Provider Site Clinicians

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**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 an abnormal cervical screening result. Women within this age range are typically screened through family planning clinics or other health care providers and referred to the EWL program. The EWL program **does not** cover routine cervical screening services for this age group.

EWL providers that are faced with limited appointments for women within this age range and need to prioritize services should use the priority listing below to schedule appointments.

Cervical abnormalities that warrant cervical diagnostic and case management services include **(in order of priority):**

1. Squamous Cell Carcinoma
2. Atypical Glandular Cells (AGC)
3. High-Grade SIL (HSIL)
4. Low-Grade Squamous Intraepithelial Lesion (LSIL) for women over age 20
5. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)
6. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Positive HPV
7. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Negative HPV for women over age 20
8. Women age 30 and older with a negative cytology screening result and +HPV 16/18

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 18-39 year old women with breast symptoms receive appropriate diagnostic services through EWL.

**Responsible Person(s):** Provider Site Clinicians

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**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 through family planning clinics or other health care providers and referred to the EWL program.

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 (e.g., discrete palpable mass, nipple discharge, skin changes, scaliness or dimpling), the client must be referred for imaging studies as determined by the *NCCN v1.2010 Breast Cancer Screening and Diagnosis Guidelines*. These Guidelines can be found at [www.nccn.org](http://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 *asymptomatic* women between the ages of **18-39**, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer, test positive for the BRCA1 or BRCA2 mutation, or have a 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 and Case Managers

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**Policy:**

The EWL program promotes an **annual** gynecological exam, which includes a pelvic exam and, if needed, a cervical cancer screening test. The pelvic exam includes a gynecologic history, counseling and expectations, external exam (inspection of clitoris, labia, and vaginal opening), speculum exam (vaginal inspection and specimen collection), bimanual exam (check of tubes, ovaries and uterus), and rectal exam. The primary purpose of the cervical cancer screening test is to identify pre-cancerous and cancerous cervical lesions at an early stage. Clinicians should obtain a cervical cancer screening test from women who have an intact cervix. The screening test can be the conventional slide or liquid-based cervical cytology method (LBT).

Cervical Cancer Screening Intervals – Conventional or Liquid-Based

The screening interval for cervical cancer screening is every **two years**. The Case Manager or designee must ensure a cervical cancer screening test is obtained on a biannual basis unless the woman has had:

1. Three consecutive normal test results documented within a 60-month period. In this case, the screening interval can 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.
2. An abnormal cervical cytology screening result in the past 12 months.

Refer to **Attachment H** for the EWL Cervical Cancer Screening Guidelines. To ensure the cervical screening intervals are followed, providers should review a client’s medical record or refer to the list of clients with negative cervical cytology results generated by WeBCCast prior to the clinic visit.

Reporting Cervical Cancer Screening Test Results

Cervical cancer screening test results must be reported using the Bethesda System 2001.

### 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 result 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. Until recently, the Digene Hybrid Capture 2 test was the only FDA approved test available. In March 2009, two new HPV tests became available, specifically, Cervista HPV HR and Cervista 16/18. Currently HPV-DNA testing is permitted with both the Digene Hybrid Capture 2 (the preferred test by EWL) and the Cervista HPV HR test. The CPT code 87621 includes both the Digene Hybrid Capture 2 and Cervista HPV HR test. The HPV genotyping test, Cervista 16/18, is **not** an allowable procedure for EWL reimbursement.

EWL providers should review lab reports for add-on HPV tests and challenge charges when not medically ordered. Only women over the age of 20 with ASC-US cytology results should have reflex HPV testing.

### Cervical Cancer Screening Following a Hysterectomy

The presence of a cervix can be determined on physical exam. EWL funds **can** be used to pay for an initial examination (i.e., pelvic exam) to determine if a woman has a cervix. EWL 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. EWL funds **can** be used to pay for cervical cancer screening in women that self-report they do not know the reason for the hysterectomy (e.g., uterine versus cervical cancer) and no medical record is readily available to document the reason.

Discontinue cervical cancer screening for women who have had a hysterectomy for dysplasia (CIN) after a ten year history of normal/negative cytology tests which must include three recent consecutive tests which were technically satisfactory and interpreted as normal/negative.

Women treated for cervical cancer with hysterectomy must have a biennial cervical cancer screening test indefinitely or until no longer eligible for EWL services (e.g., age 65 or over). The client should then continue screening as a Medicare eligible client.<sup>1</sup>

### Abnormal Cervical Cancer Screening Test Result

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

The EWL provider and sub-contractor(s) must contract with facilities that meet EWL quality standards and requirements; specifically cytology laboratories which have current Clinical Laboratory Improvement Amendments of 1988 (CLIA) certification.

**Title:** Breast Cancer Screening for Women Age 40 - 64

---

<sup>1</sup> CA: Cancer Journal for Clinicians 2009; 59:27-41.

**Program Component:** Services

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

**Responsible Person(s):** Provider Site Clinicians

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**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 to achieve better outcomes. The clinical breast examination and screening mammogram are two important tests used in breast cancer screening. Refer to **Attachment H** for EWL Breast Cancer Screening Guidelines.

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 that it provides the clinician an opportunity to educate the client about breast health, normal breast composition, and the importance of regular check-ups and breast imaging. Clinicians should perform at least one CBE annually on all clients enrolled in EWL. The CBE should consist of a review of the client's clinical history, a visual inspection, and physical examination. For CBE core competencies, refer to **Attachment I**.

Screening Mammogram

Enrolled women should receive an annual screening mammogram performed by a Radiological Technologist certified in mammography and read by a qualified Radiologist. The interval between screening mammograms should 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.

The provider and sub-contractor(s) must contract with facilities that meet EWL quality standards and requirements; mammography facilities which meet the Mammography Quality Standard Act (MQSA) criteria and have current FDA approval.

**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, 2010

**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*. The ASCCP guidelines can be found at [www.asccp.org](http://www.asccp.org). Refer to **Attachment J** for a summary of the cervical diagnostic guidelines.

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

1. Squamous Cell Carcinoma
2. Atypical Glandular Cells (AGC)
3. High-Grade SIL (HSIL)
4. Low-Grade Squamous Intraepithelial Lesion (LSIL) for women over age 20
5. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)
6. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Positive HPV
7. Atypical Squamous Cells of Undetermined Significance (ASCUS) with Negative HPV for women over age 20
8. Women age 30 and older with negative cytology screening result +HPV 16/18

**Management of Other Cervical Cancer Screening Test Results:**

1. Unsatisfactory cervical cytology 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<sup>1</sup>. There may be clinical indications for repeating the cervical cancer screening test earlier than 12 months:

---

<sup>1</sup> 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.

- a. A previous squamous abnormality (ASCUS or worse) without 2 subsequent negative cervical cancer screening tests or a negative HPV test
- b. A previous cervical cancer screening test with unexplained glandular abnormality
- c. A positive high-risk /oncogenic HPV test within the past 12 months
- d. Clinician inability to visualize the cervix or sample the endocervical canal
- e. Similar obscuring factor in consecutive cervical cancer screening tests
- f. Insufficient previous screening<sup>2</sup>

### LEEP or Conization

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

1. LEEP or conization as a diagnostic procedure may be ordered for women with an abnormal cervical cancer screening 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.

---

<sup>2</sup> Ibid.

**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, 2010

**Policy:**

The management of women with abnormal screening 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 endorsed annually by the EWL Medical Advisory Committee.

For the clinical management of abnormal breast screening results, follow the NCCN *v1.2010 Breast Cancer Screening and Diagnosis Guidelines*. These guidelines can be found at [www.nccn.org](http://www.nccn.org). Refer to **Attachment K** for a summary of the breast diagnostic guidelines.

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
  - 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 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 afford the premium to enroll in Medicare Part B

These women may 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 A and Part B are **not** eligible for EWL services.

**Title:** Rescreening

**Program Component:** Services

**Purpose:** To ensure that women are provided mammograms and cervical cancer screening tests according to EWL program screening guidelines following their initial screening examinations.

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

**Effective Date:** June 30, 2006

**Revised Date:** June 30, 2010

**Policy:**

Priority for EWL program services should be given to eligible women previously enrolled and screened through the program. Providers must reach a rescreen target goal of  $\geq 65\%$ , which means at least 65% of women who received a screening mammogram in any given year should return within 12-18 months for their next screening mammogram. For yearly screening mammograms, there must be at least 12 months between screening tests.

Providers should 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.

**Title:** Referrals

**Program Component:** Services

**Purpose:** To ensure that all clients enrolled in EWL receive the appropriate referrals based on their medical, social and economic needs.

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

**Effective Date:** June 30, 2010

**Policy:**

The provider site case manager, clinician or designee must broker both medical and supportive referrals to optimize a client's health outcomes. During the referral and appointment phase of the clinic visit, case managers, clinicians or their designee should:

1. Set an appointment for a screening mammogram if the exam is not performed on site. If an appointment cannot be set, at a minimum a referral for a screening mammogram should be provided. Contact information for the screening mammography site (e.g., facility and contact name and phone number), travel directions and procedural directions to prepare for the screening mammogram should be provided in writing to the client. Document the screening mammogram referral/appointment in the client's medical record.
2. Provide referrals and, if possible, establish appointments for additional diagnostic procedures for clients with abnormal screening results to ensure they receive timely and appropriate breast and cervical diagnostic services. Case managers should provide information explaining the need for the additional diagnostic tests and any procedural directions in writing to increase a client's level of understanding. All referrals should be documented in the client's medical record.
3. Provide other social or supportive referrals (e.g., transportation to/from medical appointments) to ensure clients with abnormal screening results receive the recommended services. These referrals should be documented in the client's care plan and address those needs identified in the client's needs assessment.
4. Provide referrals for other medical or cancer screening services (e.g., colorectal screening) that are identified as needed. Document referrals in the client's medical record.
5. Refer tobacco users to the QuitNow Virginia toll free phone service (1-800-QUIT-NOW) to receive self-help materials, a list of community resources and comprehensive counseling. Document referral in the client's medical record.

6. Provide referrals that will promote and encourage a healthy lifestyle (e.g., low fat diet, increased physical activity) to women enrolled in the program to lower the risk of chronic diseases, such as overweight/obesity, heart disease, stroke, high blood pressure and diabetes. Document referral in the client's medical record.

**Title:** Cancellation of Services

**Program Component:** Services

**Purpose:** To ensure continuity of care for all EWL enrolled women after a provider ceases to be an authorized EWL provider.

**Responsible Person(s):** Provider Site Coordinator or Designee

**Effective Date:** June 30, 2010

**Policy:**

EWL providers may cancel an existing contract upon 30 days written notice to the State EWL office. Any contract cancellation notice does not relieve the provider of the obligation to deliver and/or perform on all outstanding orders issued prior to the effective date of cancellation.

Upon termination of the contract, the provider is responsible for facilitating continuity of care for clients enrolled into the EWL program during their contracted period. This includes:

1. The completion of any outstanding diagnostic work up that is in progress at the time the contract is terminated.
2. Written notification to all enrolled clients that their status as an EWL provider has ended, and good faith efforts to transfer management of the client's care to another EWL provider (if possible) or to arrange for health care services outside of the EWL network of providers.
3. The transfer of program records (with client consent) to the new health care provider.
4. The entry of all screening cycle data (including follow-up and diagnostic testing) into WeBCCaST for all clients enrolled during the contract period.

# Case Management



**Title:** Case Management for Women with Abnormal Screening Results

**Program Component:** Case Management

**Purpose:** To ensure that women with an abnormal breast and cervical screening result receive timely and appropriate diagnostic and treatment services to optimize health outcomes.

**Responsible Person(s):** Provider Site Case Managers

**Effective Date:** June 30, 2010

**Policy:**

Case management involves establishing, brokering and sustaining a system of essential support services for women to identify and overcome barriers that interfere with diagnosis and treatment. Through effective case management, client barriers, such as transportation, scheduling and lack of understanding about the need for or nature of follow up procedures can be overcome ensuring that the client will receive the appropriate support and services in a timely manner. All EWL enrolled women with an abnormal breast and cervical screening result or cancer diagnosis require case management. Refer to **Attachment L** for a diagram that delineates the case management process. Case management should include the following components:

1. **Assessment** – Involves the cooperative effort between the case manager and client to identify the client's need for essential support to complete the recommended follow-up. Each client should be assessed for: a) level of understanding, b) special teaching needs, and c) compliance with follow-up. Refer to the *Case Management Needs Assessment* policy.
2. **Planning** – Includes the development of a written care plan to ensure the client obtains the recommended services. The care plan should be individualized and based on the findings from the needs assessment. Periodically, evaluate and revise the care plan, if needed. Refer to the *Case Management Care Plan* policy.
3. **Coordination** - The case manager should provide the appropriate referrals to ensure clients with abnormal screening results receive timely and appropriate breast and cervical diagnostic and treatment services as well as other supportive services identified in the assessment. All referrals should be documented in the client's care plan. The case manager can assist the client by scheduling appointments for referrals or by contacting resources that will help the client meet her health goals.
4. **Monitoring** – Involves the ongoing assessment of clients and resources to determine if: a) the client's needs are being met, b) there is a need for additional services or resources, c) there are additional barriers to care or treatment that have been identified, and d) the services/resources needed continue to be available. The case manager should communicate regularly with the client to ensure all services

are received (e.g., the case manager should follow-up on client appointments and obtain referral results). Case managers should record updated information in the care plan as the result of the routine assessments.

5. **Resource Development** – Case management should encourage client self-sufficiency and self-responsibility by ensuring that the client gains the knowledge, skills and support needed to obtain the necessary services. Client education must address the purpose of follow-up procedures and the expected outcomes and should be promoted and tailored for each client. To be effective, case managers should maintain a current list of resources within their community and maintain relationships with all referral sources.
6. **Evaluation** - Involves assessing a client's satisfaction with the services provided including the accessibility and timeliness of referral services as well as the effectiveness of the care plan.

Case management services should be discontinued when clients are found to be without cancer, when treatment is initiated, when the client refuses treatment or is lost to follow-up.

**Title:** Case Management Needs Assessment

**Program Component:** Case Management

**Purpose:** To ensure that all clients with an abnormal breast and cervical screening result are evaluated for barriers to follow-up care.

**Responsible Person(s):** Provider Site Case Managers

**Effective Date:** June 30, 2010

**Policy:**

The needs assessment is an effective tool that can be used to identify barriers that may prevent clients from receiving the services they need. The needs assessment can reveal a client's individual strengths as well as medical, psychological, financial, legal, and social needs.

When a case manager receives notification of a client's abnormal breast and/or cervical screening result, the case manager must interview the client within 5 business days of receiving the abnormal finding or prior to the initiation of the first diagnostic service to identify if any barriers are present and, if present, to discuss and offer options and services that are individualized to meet the client's needs. The result of the interview must be documented on the Case Management Needs Assessment and Care Plan form (**Attachment M**) or documented on the needs assessment form that is approved by the case manager's agency. File the completed form in the client's medical record.

If the needs assessment identifies barriers to diagnostic and follow-up care, a case management care plan is required. In contrast, if no barriers are identified a case management care plan is not needed.

**Title:** Case Management Care Plan

**Program Component:** Case Management

**Purpose:** To ensure that all clients identified as having barriers to follow-up care receive a care plan that promotes self-determination, independence and empowerment and facilitates and ensures appropriate follow-up.

**Responsible Person(s):** Provider Site Case Managers

**Effective Date:** June 30, 2010

**Policy:**

One of the essential roles and responsibilities of the case manager is to arrange for and coordinate the appropriate services to meet the needs and health goals of the client with identified barriers. This includes the development and implementation of a care plan that involves the client, caregiver and/or family to identify and access the resources that are necessary to meet the client's needs. The case manager is responsible for identifying resources based on the client's needs and advocating on behalf of the client to ensure all needed services and follow-up care is received.

The Case Management Needs Assessment and Care Plan form (**Attachment M**) or a care plan that is approved by the case manager's agency can be used to address issues and barriers to follow-up care and establish a mutually acceptable action plan with the client, caregiver or family member. The ultimate goal of the individualized care plan is to incorporate the client's choices and preferences for the service arrangements being developed and empower the client to ensure they are involved in all aspects of the care plan. The care plan should be developed 5 business days after the needs assessment is completed, and reassessed and updated periodically or when the client's circumstances change.

The case manager should monitor all case management services and changes in the client's needs and ensure that all services specified in the care plan are received and the client's needs are fully met. File the care plan in the client's medical record.

**Title:** Tracking System

**Program Component:** Case Management

**Purpose:** To ensure that all clients receive appropriate and timely screening, diagnostic and follow-up services.

**Responsible Person(s):** Provider Site Case Managers

**Effective Date:** June 30, 2010

**Policy:**

Tracking screening and diagnostic services throughout a client's cycle, starting with the initial screening examination or test, through a final diagnosis and referral for treatment, if indicated, and later rescreening at appropriate intervals, is essential and ensures women receive the timely, appropriate and complete care they need. Both human resources (e.g., case managers) and technical systems (e.g., tickler systems) are required to effectively track the delivery of care to clients. The timely identification of clients screened and their test results is important in coordinating screening and diagnostic services.

To meet the program's expectations, case managers should establish and maintain a client tracking system that will:

1. Collect, edit and manage information to track a client's receipt of screening and diagnostic services and, when appropriate, treatment referrals.
2. Be compatible with the resources and capabilities of the agency.
3. Ensure client confidentiality.
4. Be efficient. Case managers should periodically review and assess the client tracking system to determine its effectiveness. An efficient client tracking system will prevent incomplete follow-up and unnecessary delays, and reduce duplication of services.

Client tracking systems may consist of a tickler file (3x5 cards), notebook system, or more sophisticated computerized system. Regardless of the client tracking system chosen, it must be realistic, easy to use, and compatible with agency resources.

Other methods or tools that can be used to supplement and support the client tracking system include physician prompts, automated client reminder systems, and client reminder cards.

**Title:** Tracking and Follow-Up

**Program Component:** Case Management

**Purpose:** To ensure all EWL enrolled women receive timely and appropriate care and minimize the number of women who are lost to follow-up or refuse services.

**Responsible Person(s):** Provider Site Case Managers

**Effective Date:** June 30, 2010

**Policy:**

A critical component of case management is to ensure that women receive timely notification of their screening results, and timely and appropriate rescreening, diagnostic and/or treatment services. For this reason, providers are expected to maintain an efficient tracking system that will enable them to track client results, notify clients of tests results, and follow-up with clients with abnormal results.

**Notification of Normal Screening Results**

Providers should communicate normal cervical screening test results to clients in writing or by telephone within **10** business days of receipt. Providers are **not** required to notify the client of normal screening mammography results since mammography providers are required to notify clients within 30 days under MQSA regulations enacted by the FDA.

**Notification of Abnormal Screening Results**

Providers should notify a client of an abnormal screening test result within **5** business days of receipt. Three attempts to notify the client should be made by phone on three separate days. If unsuccessful, a letter should be sent. If there is no response to the letter, a certified letter should be sent to the client. All dates and efforts to contact the client as well as follow-up recommendations should be documented in the client's medical record.

**Follow-up for Rescreening**

Providers are expected to develop and implement a client reminder system to facilitate the tracking of women previously screened. The client reminder system should capture mammography and cervical cancer screening examinations and should follow the program's defined screening intervals. Women that are eligible for rescreen services should be notified and reminded they need to return for rescreening at least two months in advance of the rescreen due date. For clients that do not respond, at least one additional reminder should be made. Once a rescreen appointment is established, providers may choose to remind clients at different intervals prior to the actual rescreen appointment to reduce no-show rates. Clients that do not respond to the rescreen reminders, refuse services or fail to show for the rescreen appointment should be inactivated in WeBCCast after a reasonable amount of time.

### **Follow-up for Diagnostic Test Results**

Securing diagnostic services for uninsured/underinsured women can sometimes be challenging. For clients in need of additional diagnostic procedures, providers are expected to track test results to ensure they receive the recommended care in a timely manner. Providers are expected to work with each client so they understand the need for follow-up and know where and how to access these services. Clients that refuse diagnostic procedures or do not respond to repeated attempts to arrange/schedule diagnostic procedures or fail to show for scheduled diagnostic procedures may be inactivated. However, before inactivating a client as lost to follow-up, a minimum of three separate attempts via telephone, email, fax, text messaging, regular or certified mail or through a home visit, should be made to contact the client. Contacts should be made at various times of the day and various days of the week. Clients that refuse diagnostic services or fail to respond after three reasonable attempts at contact should be considered lost to follow-up and inactivated in WeBCCast.

All diagnostic test results should be received within 5 business days of the test result. Diagnostic test results may be received by phone, in writing or computer accessed.

# Staffing



**Title:** EWL Provider Site Staff

**Program Component:** Staffing

**Purpose:** To delineate the roles, responsibilities and qualifications of EWL provider site staff.

**Responsible Person(s):** Provider Site Director, Administrator and Coordinator

**Effective Date:** June 30, 2010

**Policy:**

There are three primary staffing roles associated with EWL that are essential to the coordination and delivery of program services. They include a Coordinator, Case Manager, and Clinician. Trained, qualified staff to fulfill all three roles is required to ensure quality services are delivered in a timely and appropriate manner.

The Coordinator provides oversight for EWL services and serves as the official contact for the project. The Coordinator may meet the qualifications of a case manager or can be a health care professional with experience and/or knowledge of women's health. If the Coordinator is unavailable or on extended leave (more than 15 business days), providers must continue to ensure that all EWL requirements are met. The Coordinator is responsible for assuring:

- a. All provider site staff affiliated with EWL is in compliance with EWL program policies and procedures.
- b. All provider site staff affiliated with the program receives information/materials disseminated from the State EWL office in a timely manner.
- c. The screening goal is met, and all screening and non-screening funds are spent.
- d. Screening/re-screening services are accomplished in a timely and efficient manner.
- e. All core performance indicators are met or exceeded.
- f. All clients who complete treatment under the BCCPTA and meet EWL eligibility criteria are reenrolled into the program to receive the appropriate screening services.
- g. All client data is entered into the WeBCCast system in a timely manner and requests for reimbursement are submitted to the State EWL office monthly.
- h. All reporting and data requirements are met.

- i. All staff changes and contact information is reported to the State EWL office within 30 business days of the change.

The Case Manager(s) may be an RN, MD, PA, NP or LSW. The Case Manager may also serve as the Coordinator. If the Case Manager is unavailable or on extended leave (more than 15 business days), providers must continue to ensure that all EWL requirements are met. The Case Manager is responsible for:

- a. Coordinating care for all EWL enrollees with an abnormal screening result until a final diagnosis is made, and if needed, treatment is initiated by:
  - i. Completing a client needs assessment to identify any client barriers, such as transportation, scheduling, and lack of understanding of the nature or purpose of a follow-up procedure.
  - ii. Developing a comprehensive care plan and providing appropriate referrals for clients with identified needs to remove service barriers so the client can take action on recommendations and receive the follow-up procedures they need.
- b. Ensuring all women receive the appropriate breast and cervical re-screening services through the use of client tracking and reminder systems.
- c. Providing age appropriate referrals for other medical or cancer screening services as well as referrals to promote and encourage a healthy lifestyle.

Providers must also have access to licensed and trained Clinician(s) or subcontract for the services they provide. Clinicians obtain or review current health history, provide the physical assessment, order screening and diagnostic studies, make the final diagnosis, and oversee the clinical care of EWL clients according to established clinical guidelines. Clinicians may assist with collecting and entering clinical information into the WeBCCast system. Providers must ensure clinician availability to avoid any lengthy delays (i.e., more than 30 calendar days) in service delivery. If a provider anticipates a clinician shortage or is faced with an unexpected vacancy they should make every effort to fill the shortage in a timely manner to avoid any disruption in service.

Providers may request supplemental funds to support a Community Health Worker (CHW). Support for a CHW is optional and is contingent upon funding. A CHW is defined as an individual who works within the community setting to provide culturally and linguistically appropriate health information and education to prospective and enrolled women. If funded, providers are responsible for designating a supervisor for the CHW. A CHW training manual is available to providers, and can be accessed by visiting: [www.vahealth.org/breastcancer](http://www.vahealth.org/breastcancer). The primary goals of the CHW are to:

- a. Target recruitment efforts to ensure outreach to the priority populations.
- b. Conduct “in-reach” activities, such as encouraging enrolled women to keep

appointments for follow up testing, making reminder calls for rescreens, and offering resources as needed to encourage client follow-up.

- c. Maintain or improve compliance with core performance indicators (e.g., enrolling never/rarely screened women and women over age 50).
- d. Incorporate women's health concepts (e.g., nutrition, physical activity, smoking cessation) into program services.

Providers should also designate a Director, Administrator, and Fiscal/Billing Coordinator. Official correspondence, including contract notifications, renewals, modifications, and program policy changes will be sent to the Director. The Administrator and Fiscal/Billing Coordinator, in collaboration with the Coordinator, will ensure subcontractors are paid for services rendered in a timely manner, and track and reconcile program expenditures to ensure all screening and non-screening funds are spent.

**Title:** Training and Technical Assistance

**Program Component:** Staffing

**Purpose:** To ensure the EWL provider site workforce has the necessary knowledge, skills and attitudes to perform their jobs competently and with sensitivity for diverse client cultures.

**Responsible Person(s):** Provider Site Director, Administrator and Coordinator

**Effective Date:** June 30, 2010

**Policy:**

To maintain a qualified and competent workforce, EWL will periodically assess learning needs through provider performance, surveys and training evaluations, and require that all staff affiliated with the program receive training that is appropriate to their role. Training requirements include:

- a. New Coordinators and other essential staff (Case Managers, Clinicians Fiscal/Billing Coordinators, Community Health Workers) are required to complete the EWL orientation training. Completion of the EWL orientation training will be tracked by the State EWL Office.
- b. Coordinators or substitute designees are required to attend all mandatory EWL conference calls, webinars and face-to-face meetings. Attendance will be tracked by the State EWL Office.
- c. Clinicians are required to attend clinical trainings related to their area of expertise to ensure quality care is provided to EWL enrollees and to maintain licensure.

EWL provider site staff must have Internet access and the ability to participate in multimedia training events using technology such as polycom, web casts, webinars etc.

Technical assistance on program policies and procedures is available to providers by the State EWL office during regular business hours (8am-5pm, Monday-Friday). Additionally, the State EWL office will maintain an up-to-date web site with information on training events, recruitment materials, manuals, facts sheets, reports, tools and other information to assist providers with day-day operations.

# Treatment



**Title:** Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

**Program Component(s):** Treatment

**Purpose:** To define who is eligible for medical assistance under the BCCPTA and the referral procedure.

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

**Effective Date:** June 30, 2006

**Revised Date:** September 27, 2010

**Policy:**

Women who are screened and/or 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 or histology finding of atypia where excision is recommended. Other lesions where excision may be considered due to cancer risk are ductal carcinoma-in-situ (DCIS), lobular carcinoma-in-situ (LCIS), radial sclerosing lesions, phyllodes tumors, and papillomas. Pre-cancer of the cervix may be defined by a biopsy result of CIN 2 (moderate dysplasia), and CIN 3 (severe dysplasia).

Treatment is defined as all forms of treatment prescribed by a health care professional, including palliative care. The health care professional must 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 eligible for the BCCPTA must be age 18-64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by an EWL provider and referred to a local Department of Social Services (DSS) office for Medicaid eligibility determination. They must not have creditable health insurance coverage for treatment of breast or cervical cancer. Eligible women include:

1. Women who are screened and diagnosed with breast or cervical cancer or a precancerous condition by an EWL provider and are eligible for the BCCPTA.
2. Women who are screened by an EWL provider but later diagnosed with breast or cervical cancer or a pre-cancerous condition by a non-EWL provider and are eligible for the BCCPTA.

3. Women who are screened by a non-EWL provider or seen by a non-EWL provider because of a symptom that is suspicious for cancer and referred to an EWL provider who later diagnoses breast or cervical cancer or a pre-cancerous condition.
4. Women who are diagnosed with breast or cervical cancer or a pre-cancerous condition through another state's Breast and Cervical Cancer Early Detection Program and relocate to Virginia before treatment started or during treatment.
5. Women previously enrolled under the BCCPTA and upon re-enrollment into EWL 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 even if it is a recurrence of the previous cancer.

Women who are **not eligible** for the BCCPTA include:

1. Women who have received a diagnosis for breast or cervical cancer or pre-cancerous condition and were not screened or diagnosed by an EWL provider for that condition.
2. Women age 65 and older. Women age 65 and older may qualify for another Medicaid covered group for aged individuals if they meet Medicaid income guidelines (80% FPL) and do not exceed the resource limit of \$2,000. In all cases, the final determination of Medicaid eligibility will be made by DSS.

Women referred to Medicaid for enrollment into the BCCPTA must meet Medicaid's non-financial eligibility requirements, including:

1. Must be age 18-64.
2. Must be a Virginia resident.
3. Must be a US citizen or meet alien requirements:
  - a. Documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. However, the Department of Medical Assistance Services completes a data match with the Social Security Administration (SSA) in order to obtain citizenship and identity verification, and local department of social services eligibility workers will go ahead and enroll the woman in Medicaid while the match is being completed. If the data match fails to provide verification, the individual may be required to provide documentation of her citizenship and identity in order for her Medicaid coverage to continue. The individual will be notified by DSS if she is required to provide documentation.
  - b. Women who are **not** U.S. citizens will require further evaluation by the DSS and may not be eligible for treatment under the BCCPTA. Many qualified

aliens who arrived in the U.S. after August 21, 1996 have been 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.

4. Must **not** be eligible for Medicaid under another mandatory covered group. Women who receive SSI, are pregnant, or have a child under the age of 18 living with them will require further evaluation by DSS. These women may be eligible to receive medical assistance under Medicaid's Low-Income Families with Children (LIFC), Medically Indigent (MI) Pregnant Women, FAMIS Plus, or SSI. Medicaid determination may take up to 45 calendar days to complete. If the woman does **not** qualify for any of these covered groups she may qualify for medical assistance under the BCCPTA.
5. Must **not** have creditable health insurance coverage. Creditable health insurance includes:
  - a. A group health plan
  - b. 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
  - c. Medicare
  - d. Medicaid
  - e. Armed forces insurance
  - f. A medical care program of the Indian Health Service or tribal organization
  - g. 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 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.

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

**In all cases, the final determination of Medicaid eligibility will be made by DSS.**

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

### Notification of BCCPTA Eligibility

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 Medicaid 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 Medicaid system. For information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information, visit <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> and follow the enrollment instructions to access the system.

### Annual Renewal

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.

### Entitlement

Women will 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. Medicaid coverage may begin on the first day of the application month or up to 3 months prior to the month of application providing all Medicaid eligibility criteria are met.

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 an EWL health care professional:

1. Complete the BCCPTA Medicaid Application Form (**Attachment O**). The EWL client and coordinator/case manager must sign the form.
2. The coordinator/case manager will immediately forward the completed BCCPTA Medicaid application form to the county or city DSS office where the woman resides. File a copy of the form in the client's medical record.
3. 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.

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

For guidance on women diagnosed with breast or cervical cancer or a pre-cancerous condition that are transferring to Virginia refer to the *Enrollment Section – Client Transfers*.

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

# **ATTACHMENT A**



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

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Maiden Name</b>
<b>Admin Site</b>	<input type="checkbox"/> New Screen <input type="checkbox"/> Follow-Up <input type="checkbox"/> Rescreen		<b>SSN (or alien ID)</b>

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: Date of referral \_\_\_/\_\_\_/\_\_\_  
 Initial mammogram not done. Client only received CBE or proceeded directly for other imaging or diagnostic work-up\*  
 Unknown  
**\*This includes refused mammograms.**

CLINICAL BREAST EXAM (CBE)	MAMMOGRAM
2. Does the client have breast symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Did the client have a CBE? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. CBE date: ___/___/___ (mm/dd/yyyy) 5. What were the CBE results? <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding (includes fibrocystic changes, diffuse lumpiness or nodularity) <input type="checkbox"/> Discrete palpable mass* <input type="checkbox"/> Bloody or serous nipple discharge* <input type="checkbox"/> Nipple or areolar scaliness* <input type="checkbox"/> Skin dimpling or retraction* <input type="checkbox"/> Previous normal CBE in the past 12 months – CBE not performed <input type="checkbox"/> CBE not performed, other or unknown reason <input type="checkbox"/> CBE refused 6. Was the CBE paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>*Requires diagnostic mammogram and further diagnostic</b>	7. Mammogram type: <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic 8. Mammogram date: ___/___/___(mm/dd/yyyy) 9. What were the mammogram results? <input type="checkbox"/> Negative <input type="checkbox"/> Benign finding <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Assessment is incomplete <input type="checkbox"/> Film comparison required <input type="checkbox"/> Unsatisfactory, film cannot be interpreted ( <b>Repeat Mamm.</b> ) <input type="checkbox"/> Result unknown, presumed abnormal, from non-program funded source 10. Was the mammogram paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Where was the mammogram performed? _____ 12. Are additional breast procedures needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not yet determined

**DIAGNOSTIC PROCEDURES**

13. Additional Mam Views: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Negative <input type="checkbox"/> Benign findings <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Assessment incomplete <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	14. Ultrasound: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal (WNL) <input type="checkbox"/> Cystic mass <input type="checkbox"/> Other benign abnormality <input type="checkbox"/> Suspicious for malignancy <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	15. Film Comparison: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Final Imaging Results: <input type="checkbox"/> Negative <input type="checkbox"/> Benign findings <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious abnormality <input type="checkbox"/> Highly suggestive of malignancy <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other
16. Fine Needle/ Cyst Aspiration: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Not suspicious for cancer <input type="checkbox"/> Suspicious for cancer <input type="checkbox"/> No fluid/tissue collected <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	17. Biopsy/ Lumpectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of biopsy: <input type="checkbox"/> Excisional <input type="checkbox"/> Non Excisional Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal breast tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other benign changes <input type="checkbox"/> DCIS <input type="checkbox"/> LCIS <input type="checkbox"/> Invasive cancer <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	18. Repeat CBE/ Surgical Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure date ___/___/___(mm/dd/yyyy) Procedure site: _____ Results: <input type="checkbox"/> Normal (WNL) <input type="checkbox"/> Benign finding <input type="checkbox"/> Discrete palpable mass <input type="checkbox"/> Bloody or serous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Skin dimpling or retraction <input type="checkbox"/> Refused Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other

WORK-UP STATUS	TREATMENT STATUS
19. What is the status of the final diagnosis? <input type="checkbox"/> Work-up complete <input type="checkbox"/> Client lost to follow-up <input type="checkbox"/> Workup refused <input type="checkbox"/> Irreconcilable 20. Date of final diagnosis:   ___ / ___ / ___ (mm/dd/yyyy) 21. Final Diagnosis: <input type="checkbox"/> Breast cancer not diagnosed <input type="checkbox"/> Invasive breast cancer <input type="checkbox"/> Ductal carcinoma in situ <input type="checkbox"/> Lobular carcinoma in situ <input type="checkbox"/> Reoccurrence of prior breast cancer	22. What is the status of breast cancer treatment? <input type="checkbox"/> Treatment started <input type="checkbox"/> Client lost to follow-up <input type="checkbox"/> Treatment refused <input type="checkbox"/> Treatment not recommended 23. Date of treatment status:   ___ / ___ / ___ (mm/dd/yyyy) 24. Was the client enrolled in Medicaid for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____ Form Completed by: _____

## Breast Screening and Diagnostic Form Instruction Sheet

Please use this form to refer to the numbered fields on the Breast Screening and Diagnostic Form. These instructions offer clarification and guidance for completing those fields. Contact the EWL Data Manager at 804-864-7758 or [carol.bazzichi@vdh.virginia.gov](mailto:carol.bazzichi@vdh.virginia.gov) if you have additional questions.

### 1. Indication for Mammogram

- Report the reason for performing the *current* mammogram.
- If client was referred for diagnostic procedures, include the referral date- this will be used to calculate time from screening to dx.
- Select *Initial mammogram not done-CBE only...* if client refused mammogram or requires other imaging and/or dx procedure.

**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 Result

- Select *Normal* to indicate a normal, within normal limits (WNL), or a negative CBE.
- Select *Benign findings* when CBE findings are not a concern for cancer.
- If the CBE is abnormal and suspicious for breast cancer, select the appropriate symptom. **Immediate diagnostic procedures are needed even if CURRENT mammogram result is negative or benign.**

**6. CBE Paid:** Indicate "Yes" if the CBE was fully or partially paid for by EWL funds.

**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. and 9. Mammogram Date and Result:** Enter the date when the mammogram was *performed*.

- Select *Assessment Incomplete* (BI-RADS 0) if the radiologist is recommending additional imagery 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.
- If review of prior mammogram is needed, select *Film comparison required* and then record the film comparison result (See #13-18.)

**10. and 11. Mammogram Paid and Location:** Indicate "Yes" if the mammogram was fully or partially paid for by EWL funds and document the location (subcontractor) where the mammogram was performed.

**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".

**13-18. Diagnostic Procedures:** Indicate which diagnostic test was performed, the procedure date, the procedure site (subcontractor), 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" **and** include a note as to why the client did not complete the tests.

### 19. Final Diagnosis Status

- 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 breast cancer is diagnosed.
- If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the final diagnosis as "refused" **and** include a note as to why the client did not complete the tests.

**20. Final Diagnosis Date:** 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:** "Infiltrating carcinomas" is considered invasive breast cancer. For all cases of in situ or invasive cancer, complete the "Treatment Status" section. 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.

**22. Treatment Status:** If treatment was not started include a note as to why the client did not have treatment initiated.

### 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.

**24. Medicaid Enrollment:** If the client was diagnosed with cancer, and not enrolled in Medicaid, indicate why in the space provided.

### Additional Notes

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



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

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Maiden Name</b>
<b>Admin Site</b>	<input type="checkbox"/> <b>New Screen</b> <input type="checkbox"/> <b>Follow-up</b> <input type="checkbox"/> <b>Rescreen</b>		<b>SSN (or alien ID)</b>

**PAP TEST AND PELVIC EXAM**

1. Indication for Pap test: <input type="checkbox"/> Routine Pap test <input type="checkbox"/> Client under surveillance for a previous abnormal test <input type="checkbox"/> 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: ____/____/____ <input type="checkbox"/> Pap test not done. Client proceeded directly for diagnostic work-up or HPV test. <input type="checkbox"/> Unknown	
2. Pelvic exam date: ____ / ____ / ____ (mm/dd/yyyy) 3. Pap test date: ____ / ____ / ____ (mm/dd/yyyy) 4. What were the Pap test results? <input type="checkbox"/> Negative (for intraepithelial lesion or malignancy) <input type="checkbox"/> ASC-US <input type="checkbox"/> LGSIL <input type="checkbox"/> ASC-H <input type="checkbox"/> HGSIL <input type="checkbox"/> Squamous cell carcinoma <input type="checkbox"/> Abnormal Glandular Cells (AGC) <input type="checkbox"/> Other result: _____ <input type="checkbox"/> Result unknown, presumed abnormal, from non-program funded source	5. Cervix present? <input type="checkbox"/> Yes (Cervical) <input type="checkbox"/> No (Vaginal) 6. Specimen Type: <input type="checkbox"/> Conventional <input type="checkbox"/> Liquid-based <input type="checkbox"/> Other 7. Specimen adequacy? <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory - <b>Repeat Pap</b> 8. Was the Pap test paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. HPV Test Result? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done HPV test date: ____ / ____ / ____ (mm/dd/yyyy) 10. Was the HPV test paid by EWL? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Where was the Pap test/Pelvic exam performed? Facility/Clinic: _____ 12. Was the client referred for <b>immediate</b> cervical diagnostic workup? <input type="checkbox"/> Yes <input type="checkbox"/> No

**DIAGNOSTIC PROCEDURES**

13. Colposcopy without Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ Procedure site: _____ Results: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Clearly defined lesion of CIN <input type="checkbox"/> Abnormal, suspicious for cancer <input type="checkbox"/> Abnormal, but not suspicious for cancer <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refused  Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	14. Colposcopy-directed Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other <b>non-cancerous</b> abnormality <input type="checkbox"/> Refused  Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	15. Other Procedure #1 <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ <input type="checkbox"/> ECC <input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Other _____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other <b>non-cancerous</b> abnormality <input type="checkbox"/> Refused  Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other	16. Other Procedure #2 <input type="checkbox"/> Yes <input type="checkbox"/> No Procedure Date: ____/____/____ <input type="checkbox"/> ECC <input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Other _____ Procedure site: _____ Results: <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> CIN I <input type="checkbox"/> CIN II <input type="checkbox"/> CIN III/CIS <input type="checkbox"/> Invasive Carcinoma <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Other <b>non-cancerous</b> abnormality <input type="checkbox"/> Refused  Funding Source: <input type="checkbox"/> EWL <input type="checkbox"/> Other
--	--	--	---

**WORK-UP STATUS**

**TREATMENT STATUS**

17. What is the status of the final diagnosis? <input type="checkbox"/> Work-up complete <input type="checkbox"/> Client lost to follow-up <input type="checkbox"/> Work-up refused <input type="checkbox"/> Irreconcilable  18. Date of final diagnosis: ____ / ____ / ____ (mm/dd/yyyy)  19. Final diagnosis: <input type="checkbox"/> Normal/Benign Reaction/Inflammation <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> CIN I/Mild Dysplasia (biopsy diagnosis) <input type="checkbox"/> CIN II/Moderate Dysplasia (biopsy diagnosis) <input type="checkbox"/> CIN III/Severe Dysplasia/Carcinoma in situ (Stage 0) (biopsy diagnosis) <input type="checkbox"/> Invasive Cervical Carcinoma (biopsy diagnosis) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Low grade SIL (biopsy diagnosis) <input type="checkbox"/> High grade SIL (biopsy diagnosis)	20. What is the status of cervical cancer treatment? <input type="checkbox"/> Treatment started <input type="checkbox"/> Client lost to follow-up <input type="checkbox"/> Treatment refused <input type="checkbox"/> Treatment not recommended  21. Date of treatment status: ____ / ____ / ____ (mm/dd/yyyy)  22. Was client enrolled in Medicaid for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No  If <b>no</b> , why not? _____  Form Completed by: _____
--	--

## Cervical Screening and Diagnostic Form Instruction Sheet

Please use this form to refer to the numbered fields on the Cervical Screening and Diagnostic Form. These instructions offer clarification and guidance for completing those fields. Contact the EWL Data Manager at 804-864-7758 or [carol.bazzichi@vdh.virginia.gov](mailto:carol.bazzichi@vdh.virginia.gov) if you have additional questions.

### 1. Indication for Pap test

- Report the reason for performing the *current* Pap test.
- If client was referred for diagnostic procedures, include the referral date- this will be used to calculate time from screening to dx.
- Select *Pap test not done...* if client refused Pap test or requires dx procedures.

2. and 3. **Pelvic Exam and Pap test Dates:** Enter the dates when these procedures were performed.

### 4. Pap test Result

- Select *Negative (for intraepithelial lesion...)* if result is reactive, infection, inflammation or hyperkeratosis.
- Select *Atypical squamous cells of undetermined significance (ASC-US)* for results of atypia or atrophic atypia.
- An example of *Other* Pap test Result is endometrial cells.

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:** Select type of Pap test used.

7. **Specimen Adequacy:** Select adequacy of Pap test. If unsatisfactory, repeat Pap test.

8. **Pap tests Paid:** Indicate “Yes” if the Pap test was fully or partially paid for by EWL funds.

### 9. and 10. HPV Test Result and Date

- Report the result of high risk HPV test performed as a follow-up to a Pap test result of *LSIL* or *ASC-US*. Screening HPV test is not reimbursable. If the Pap test result was *ASC-US* and HPV test result is *positive*, immediate work-up and colposcopy is recommended.
- Enter the date when this procedure was performed.

11. **Pap test Location:** Document the location (subcontractor) where the Pap test was performed.

12. **Workup Recommendation:** Specify if the clinician recommended workup based on the Pap test and/or HPV test results. The clinician should follow the guidelines for recommended work-up for an abnormal Pap test, as provided by EWL. If the recommendation is for short-term follow-up—i.e., repeat the Pap test in six months—enter “NO”.

13-16. **Diagnostic Procedures:** Indicate which diagnostic test was performed, the procedure date, the procedure site (subcontractor), 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” **and** include a note as to why the client did not complete the tests.

### 17. Final Diagnosis Status

- 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 cervical cancer/dysplasia is diagnosed.
- If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the final diagnosis as “refused” **and** include a note as to why the client did not complete the tests.

18. **Final Diagnosis Date:** 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:

- 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.
- For final diagnosis of squamous cell carcinoma or invasive adenocarcinoma, select *Invasive Cervical Carcinoma*.

### 20. Treatment Status:

- If treatment was not started include a note as to why the client did not have treatment initiated.
- 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.

### 21. Treatment Status Date

- Report the date treatment was started.
- For both “Client Lost to Follow-Up” and “Treatment Refused”, enter the date when the determination was made in the space provided.

22. **Medicaid Enrollment:** If the client was diagnosed with cancer, and not enrolled in Medicaid, indicate why in the space provided.

### Additional Notes

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



Every Woman's Life  
A Virginia Department  
of Health Program

## Client Eligibility Form

### 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:	

1. What is your household income before taxes? \$ /Year

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

3. Do you have Medicaid?  Yes  No Medicare?  Yes  No → If YES  Part A or  Part B

4. Private insurance?  Yes  No → If YES, has deductible been met?  Yes  No

5. Do you now smoke cigarettes?  Every day  Some days  Not at all  Don't know  Don't want to answer

6. Are you planning, thinking, or not thinking about quitting smoking in the next 30 days?  
 Planning  Thinking  Not thinking  Don't smoke cigarettes  Don't want to answer

7. What is the highest grade of school you completed?  <9th  Some high school  High school graduate or equivalent  Some college or higher  Don't know  Don't want to answer

### QUESTIONS FOR NEW CLIENTS ONLY

8. 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:

9. Ethnicity:  Hispanic  Non Hispanic  Unknown

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

11. What language do you speak every day? \_\_\_\_\_

12. 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

13. 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: \_\_\_\_\_

14. Enrollment Site: \_\_\_\_\_ 15. Enrollment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

16. Client Status: Active – check one:  New Patient  Rescreen

17.  Inactive due to: (list reason) \_\_\_\_\_ 18. Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

19. Detail: Previous Breast Cancer  L Br  R Br Hysterectomy for: Cervical Cancer  Non Cancer  Unknown

20.  Cervical record only, no breast form submitted  Breast record only, no cervical form submitted

21. Client referred to Virginia Quit Line?  Yes  No

\*\*\*Note: For questions 1 through 21, please refer to the Client Eligibility Form Instruction Sheet for guidance and additional information.

## Client Eligibility Form Instruction Sheet

Please use this form to refer to the numbered fields on the Client Eligibility Form. These instructions offer clarification and guidance for completing those fields. Contact the EWL Data Manager at 804-864-7758 or [carol.bazzichi@vdh.virginia.gov](mailto:carol.bazzichi@vdh.virginia.gov) if you have additional questions.

- 1. Household Income**
  - Report the annual household income as the total combined gross 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.
- 2. Number of People:** Report the total number of all persons in the household including the client.
- 3. Medicaid/Medicare**
  - Report whether or not the client has medical coverage through Medicaid or Medicare.
  - A woman may be eligible if she has Medicaid Part A *only*.
- 4. Insurance Status**
  - Report whether or not the client has medical coverage through a private insurer.
  - 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.
- 5. Smoke Cigarettes:** If the client is a current smoker, indicate how often.
- 6. Quitting smoking**
  - If the client is a current smoker, indicate whether they are interested in quitting.
  - This question is used to help determine the participant's readiness to change (Not thinking = Precontemplation; Thinking = Contemplation; Planning = Preparation) and will be used to refer the client to the Virginia Quit Line.
- 7. Education Level:** Report the highest level of school that the client completed.
- 8. 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 other organizations, please write the name of the organization after "Other".
- 9. and 10. 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 clients to report on both race and ethnic origin. The client is permitted to record more than one racial group.
- 11. 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.
- 12. and 13. Screening History**
  - 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.
- 14. 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.
- 15. 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.
- 16. and 17. 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 or diagnostic services after reasonable attempts have been made to contact the client.
- 18. Effective Date:** If the client has been inactivated, record the date of the status change.
- 19. 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.
- 20. 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.
- 21. Virginia Quit Line Referral:** Indicate if the client was referred to the Virginia Quit Line. Select Yes if you used any of the three referral methods (card, brochure or fax).

# **ATTACHMENT B**



# **ATTACHMENT C**

## **Community Health Worker Activity Sheet**

### **Instructions**

**To be completed by:** Community Health Worker

**When:** Reports are due by the 5<sup>th</sup> day of each month. They may be faxed or e-mailed to Morgan Blake at 804-864-7763 or Morgan.Blake@vdh.virginia.gov.

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

#### **Fields:**

**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. three women were scheduled for an appointment...).

**# Women Reached:** The number of women with whom you had 1:1 contact

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

**SAMPLE**



Every Woman's Life

**SAMPLE**

Community Health Worker Monthly Activity Report

Name: Suzie Smith Location: Richmond, VA

Month July Year 2010

Mode	Setting	Description	Outcome	# Women Reached	Time
<i>Health Fair</i>	<i>Farmer's Market</i>	<i>Distributed information about EWL, mammography and Pap test.</i>	<i>Distributed 50 informational packets</i>	<i>Set EWL appointments for 10 women</i>	<i>2 hours</i>
<i>Community</i>	<i>Patient's home</i>	<i>Home visit with woman with abnormal Pap who was reluctant to schedule follow up coloposcopy.</i>	<i>Discussed importance of timely follow-up. Patient scheduled appointment.</i>	<i>One woman</i>	<i>1.5 hours</i>
<i>Community</i>	<i>Mt. Sinai Baptist Church</i>	<i>Met with minister about inserting EWL brochure in church bulletins.</i>	<i>Minister was agreeable. Brochures to be inserted on 9/5/10.</i>	<i>n/a</i>	<i>1 hour</i>
<i>Telephone calls</i>	<i>Health Dept. clinic</i>	<i>Called previous EWL clients to re-establish eligibility.</i>	<i>Left 15 voice mails. Scheduled 5 appointments.</i>	<i>Spoke directly with 5 women on phone.</i>	<i>45 min.</i>

CHW reports are due by the 5<sup>th</sup> day of the month. Please fax your report to 804-864-7763 or email to Morgan Blake at [Morgan.Blake@vdh.virginia.gov](mailto:Morgan.Blake@vdh.virginia.gov)



Every Woman's Life

### Community Health Worker Monthly Activity Report

Name \_\_\_\_\_ Location \_\_\_\_\_

Month \_\_\_\_\_ Year \_\_\_\_\_

Mode	Setting	Description	Outcome	# Women Reached	Time

CHW reports are due by the 5<sup>th</sup> day of the month. Please fax your report to 804-864-7763 or email to Morgan Blake at [Morgan.Blake@vdh.virginia.gov](mailto:Morgan.Blake@vdh.virginia.gov)

# **ATTACHMENT D**

Every Woman's Life Program  
Matching Funds Form  
Fiscal Year 2010-2011

Non-federal matching funds in the amount of \$1 for every \$3 of federal funds awarded is required. Matching funds may be cash, in-kind, or donated services or equipment. Matching funds may not include (1) payment for treatment services or the donation of treatment services, (2) services assisted or subsidized by the Federal government, or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the provider and will be subject to audit. Please provide in the table below your **actual** matching funds for FY 2010-11 (June 30, 2010 – June 29, 2011) by **July 31, 2011**.

**Provider Name** \_\_\_\_\_

**NON-FEDERAL CASH RESOURCES AND AMOUNTS:**

Source	Actual Amount For FY 2010-11
• Cash donations	\$
• Community fund-raising	\$
• Other grants or awards (e.g., Komen, Avon). <b>Specify each grant individually and the dollar amount received.</b>	\$

**NON-FEDERAL NON-CASH RESOURCES AND AMOUNT:**

Source	Actual Amount For FY 2010-11
• 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)	\$



Every Woman's Life

*A Virginia Department  
of Health Program*

# **ATTACHMENT E**



Every Woman's Life

## Client Participation Agreement

Client Name (please print): \_\_\_\_\_

The Every Woman's Life program encourages women to be screened for breast and cervical cancer. The goal of screening is to detect cancer in its earliest stage so that it can be treated. Screening for breast cancer involves a free breast examination and a breast X-ray called a mammogram. Screening for cervical cancer involves a free pelvic examination. During the pelvic exam some cells will be taken from your cervix and sent to a lab to see if they are normal.

As a participant in the program:

- You will get the breast and cervical screening tests that are right for you.
- If you need more tests, your case manager will help you get these tests. Most of these tests will be at no cost to you, but you may need to pay for some tests not allowed by the program. Your case manager will work with other clinics to make sure you get all the tests that you need.
- If you are diagnosed with breast or cervical cancer you may get your treatment paid by Medicaid.
- You should come to all of your screening and follow up appointments. If you cannot make an appointment or no longer want to be in the program, you should call your case manager.

### **Agreement:**

- I agree to get the screening tests and any other tests that I may need.
- I agree to keep all appointments. If I cannot come to an appointment, I will call my case manager.
- I confirm that the personal information that I have given is correct.
- I understand that my personal information is private and will only be used to determine my eligibility for the program and by the case manager to help me get the tests that I need.
- I agree that my health information can be shared with the program.
- I understand that my participation is voluntary and that I may drop out of the program at any time.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Every Woman's Life

## Acuerdo de participación para las clientas

Nombre de la clienta (letra de imprenta): \_\_\_\_\_

El programa Every Woman's Life (La vida de cada mujer) alienta a las mujeres a someterse a una prueba de detección sistemática de cáncer de mama y cervical. El objetivo de la prueba sistemática es la detección del cáncer en sus etapas iniciales para poder tratarlo oportunamente. La prueba sistemática de cáncer de mama incluye un examen gratuito de mama y una radiografía especial llamada mamografía. La prueba sistemática de detección de cáncer cervical incluye un examen ginecológico gratuito. Durante el examen ginecológico, se extraen algunas células del cuello uterino y se envían a un laboratorio para analizarlas y determinar si son normales.

Con su participación en el programa:

- Le administrarán las pruebas sistemáticas de detección de cáncer de mama y cervical más apropiadas para usted.
- Si necesita más exámenes, el administrador de su caso le ayudará a obtenerlos. La mayoría de estas pruebas son gratuitas, pero podría ser necesario pagar por las que no están cubiertas por el programa. En colaboración con otras clínicas, el administrador de su caso se va a cerciorar de que se le administren todas las pruebas necesarias.
- Si le han diagnosticado cáncer de mama o cáncer cervical, Medicaid podría cubrir el costo de su tratamiento.
- Debe asistir a todas sus citas para las pruebas sistemáticas de detección o de tratamiento. Si no puede asistir a una cita o no desea continuar en el programa, comuníquese con el administrador de su caso.

### **Convenio:**

- Acepto someterme a todas las pruebas sistemáticas de detección y a cualquier otro examen que pueda llegar a necesitar.
- Acepto asistir a todas mis citas. Si no puedo asistir a una cita me comunicaré con el administrador de mi caso.
- Confirmando que he proporcionado la información personal correcta.
- Entiendo que mi información personal es privada y sólo se utilizará para determinar si reúno los requisitos para el programa y por el administrador de mi caso para ayudarme a obtener las pruebas que necesite.
- Acepto que mi información médica pueda compartirse con el programa.
- Entiendo que mi participación es voluntaria y que puedo retirarme del programa en cualquier momento.

Firma de la clienta \_\_\_\_\_ Fecha \_\_\_\_\_

Firma del testigo \_\_\_\_\_ Fecha \_\_\_\_\_



## Every Woman's Life

### 고객 참여 동의서

고객 이름(정자체): \_\_\_\_\_

모든 여성의 삶 프로그램은 여성들에게 유방암과 자궁경부암 선별 검사를 받도록 권장합니다. 검사의 목표는 암을 초기 단계에 발견하여 치료하는 것입니다. 유방암 선별 검사에는 무료 유방 검사와 유방조영상이라는 유방 X-레이 검사가 포함됩니다. 자궁경부암 선별 검사에는 무료 골반 검사가 포함됩니다. 골반 검사를 하는 동안, 자궁경부에서 약간의 세포를 채취하여 검사실로 보내 정상 여부를 검사할 것입니다.

이 프로그램의 참가자로서,

- 귀하는 자신에게 적합한 유방 검사와 자궁경부암 선별 검사를 받게 될 것입니다.
- 추가 검사가 필요한 경우, 케이스 매니저가 추가 검사를 받도록 도와드릴 것입니다. 이러한 대부분의 검사는 무료일 것이나, 프로그램에서 허용하지 않는 일부 검사에 대해서는 귀하가 부담해야 할 수 있습니다. 케이스 매니저가 다른 클리닉과 협력하여 귀하께 필요한 모든 검사를 받을 수 있도록 도와드릴 것입니다.
- 유방암 또는 자궁경부암의 진단을 받은 경우, Medicaid에서 치료비를 지급하게 할 수도 있을 것입니다.
- 모든 선별 검사를 받기 위해 내원하고 진료 예약을 지켜야 합니다. 진료 예약을 할 수 없거나 더 이상 프로그램에 참여하고 싶지 않은 경우, 담당 케이스 매니저에게 연락해야 합니다.

#### 동의서:

- 본인은 선별 검사와 필요할 수 있는 일체의 기타 검사를 받는 데 동의합니다.
- 본인은 모든 진료 예약을 지킬 것에 동의합니다. 진료 예약에 올 수 없는 경우, 담당 케이스 매니저에게 연락할 것입니다.
- 본인은 제공한 개인 정보가 정확함을 확인합니다.
- 본인은 개인정보가 비밀로 유지되고 프로그램 자격 여부를 결정하는 데에만 사용할 것이며 필요한 테스트를 받도록 돕기위해 케이스 매니저가 사용할 것임을 이해합니다.
- 본인은 자신의 건강 정보를 이 프로그램과 공유할 수 있음에 동의합니다.
- 본인은 참여가 자발적이고 언제든지 프로그램에서 탈퇴할 수 있음을 이해합니다.

고객 서명: \_\_\_\_\_ 날짜: \_\_\_\_\_

증인 서명: \_\_\_\_\_ 날짜: \_\_\_\_\_



Every Woman's Life

## Thỏa Thuận Tham Gia của Khách Hàng

Tên họ khách hàng (xin viết chữ in): \_\_\_\_\_

Chương trình Đời sống Phụ nữ (Every Woman's Life) khuyến khích phụ nữ đi tầm soát về ung thư vú và cổ tử cung. Mục tiêu việc tầm soát là nhằm phát hiện ung thư trong giai đoạn sớm nhất để có thể chữa trị. Tầm soát ung thư vú liên quan đến việc khám nghiệm vú miễn phí và chụp hình quang tuyến X vú, được gọi là chụp X quang vú (mammogram). Tầm soát ung thư cổ tử cung liên quan đến việc khám nghiệm khung xương chậu miễn phí. Khi khám nghiệm khung xương chậu, một số tế bào sẽ được lấy từ cổ tử cung của quý vị và gửi đến phòng xét nghiệm để xem các tế bào này có bình thường hay không.

Với tư cách là người tham gia chương trình:

- Quý vị sẽ nhận các xét nghiệm tầm soát vú và cổ tử cung thích hợp với quý vị.
- Nếu quý vị cần làm thêm các xét nghiệm khác, quản lý viên hồ sơ của quý vị sẽ giúp quý vị nhận được các xét nghiệm này. Đa số các xét nghiệm này là miễn phí, nhưng quý vị có thể sẽ cần chi trả cho một số xét nghiệm mà chương trình không cho phép làm. Quản lý viên hồ sơ của quý vị sẽ làm việc với các y viện khác để đảm bảo là quý vị nhận được tất cả những xét nghiệm mà quý vị cần.
- Nếu bác sĩ chẩn đoán là quý vị bị ung thư vú hoặc ung thư cổ tử cung, Medicaid có thể chi trả cho phí chữa trị của quý vị.
- Quý vị cần đi đến tất cả các buổi hẹn tầm soát và theo dõi của quý vị. Nếu quý vị không thể giữ một buổi hẹn nào đó hoặc không còn muốn tham gia trong chương trình, quý vị cần gọi báo cho quản lý viên hồ sơ của quý vị biết.

### **Thỏa thuận:**

- Tôi đồng ý làm các xét nghiệm tầm soát và bất kỳ các xét nghiệm nào khác mà tôi cần.
- Tôi đồng ý giữ tất cả các buổi hẹn. Nếu tôi không đến được buổi hẹn, tôi sẽ gọi báo cho quản lý viên hồ sơ của tôi biết.
- Tôi xác nhận là thông tin cá nhân mà tôi đã cho là chính xác.
- Tôi hiểu là thông tin cá nhân của tôi là riêng tư và chỉ sẽ được sử dụng để xác định tính đủ điều kiện tham gia chương trình của tôi và để quản lý viên hồ sơ giúp tôi nhận được các xét nghiệm mà tôi cần.
- Tôi đồng ý là chương trình này có thể có thông tin y tế của tôi.
- Tôi hiểu là sự tham gia của tôi là tự nguyện và tôi có thể rút ra khỏi chương trình bất kỳ lúc nào.

Chữ ký khách hàng: \_\_\_\_\_ Ngày (tháng/ngày/năm): \_\_\_\_\_

Chữ ký nhân chứng: \_\_\_\_\_ Ngày (tháng/ngày/năm): \_\_\_\_\_

# **ATTACHMENT F**

## Client Transfer

**Purpose:** This form is used to collect information on women transferring from another NBCCEDP funded program to the Virginia BCCEDP who are in need of diagnostic services or treatment under the Virginia Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

**Instructions:** The transferring program should enter all client information on the form. If certain client information (e.g., date treatment started) is not available at the time the form is completed, enter "unknown." Sign, date and FAX the completed form to the following provider site located in Virginia:

Provider Site Name:  
 Provider Site Contact Name:  
 Provider Site FAX #:

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

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

\_\_\_\_\_ Date \_\_\_\_\_

(Screening BCCEDP Representative's Signature)

\_\_\_\_\_ Date \_\_\_\_\_

(Screening BCCEDP Representative) - Please Print Full Name



# **ATTACHMENT G**

## Insert Provider Letterhead

Invoice Date: \_\_\_\_\_  
 Invoice # \_\_\_\_\_  
 Submitted by: \_\_\_\_\_

Federal Tax ID# \_\_\_\_\_  
 Contract # \_\_\_\_\_

*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 <sup>1</sup>	\$ _____	\$ _____	
Other		\$ _____	\$ _____	

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

<sup>1</sup> Health Departments do not need to submit an invoice for CHW support.  
 EWL Invoice\_ Effective 6/30/08





## *Insert Provider Letterhead*

Invoice Date: \_\_\_\_\_  
 Invoice # \_\_\_\_\_  
 Submitted by: \_\_\_\_\_

Federal Tax ID# \_\_\_\_\_  
 Contract # \_\_\_\_\_

*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)*:





# **ATTACHMENT H**

**EWL Cancer Screening Guidelines  
2010-2011**

<b>Breast</b>	<b>EWL Protocol</b>	<b>Cervical</b>	<b>EWL Protocol</b>
<b>Age to start mammography screening</b>	<ul style="list-style-type: none"> <li>• Target population is 50-64               <ul style="list-style-type: none"> <li>➢ 40-49, if slots available</li> <li>➢ More than 80% of screening mammograms must be provided to women over age 50</li> </ul> </li> </ul>	<b>Age to start screening</b>	<ul style="list-style-type: none"> <li>• Target population is 50-64               <ul style="list-style-type: none"> <li>➢ 40-49, if slots available</li> <li>➢ A minimum of 20% newly enrolled women who receive a Pap test will meet the criteria for having been never or rarely screened</li> </ul> </li> </ul>
<b>Intervals of screening – previous mammogram normal</b>	<ul style="list-style-type: none"> <li>• Annual</li> <li>• At least 65% of EWL patients should be rescreened annually</li> </ul>	<b>Intervals of screening – previous cytology normal</b>	<ul style="list-style-type: none"> <li>• Every <b>two</b> years- Conventional <b>or</b> Liquid-based Cytology               <ul style="list-style-type: none"> <li>➢ Every <b>three</b> years after three consecutive negative cervical cytology results</li> </ul> </li> </ul>
<b>Above average risk?</b>	<ul style="list-style-type: none"> <li>• Not currently assessing risk</li> </ul>	<b>Pelvic Exam</b>	<ul style="list-style-type: none"> <li>• Mandatory - part of EWL physical exam</li> </ul>
<b>Age to stop screening</b>	<ul style="list-style-type: none"> <li>• Program does not enroll women over the age of 65.</li> </ul>	<b>Age to stop screening</b>	<ul style="list-style-type: none"> <li>• Program does not enroll women over the age of 65.</li> </ul>
<b>Clinical breast exam</b>	<ul style="list-style-type: none"> <li>• Mandatory-part of the EWL physical exam</li> </ul>	<b>HPV DNA for screening</b>	<ul style="list-style-type: none"> <li>• Not reimbursable for screening</li> </ul>
<b>Teach Self breast exam (BSE)</b>	<ul style="list-style-type: none"> <li>• Optional</li> </ul>	<b>If hysterectomy was indicated for :</b> <ul style="list-style-type: none"> <li>• Benign reasons (i.e. treating uterine fibroids):</li> </ul>	<ul style="list-style-type: none"> <li>• No screening               <ul style="list-style-type: none"> <li>• unless cervical remnants are present</li> </ul> </li> </ul>
<b>Digital Mammography</b>	<ul style="list-style-type: none"> <li>• Optional</li> <li>• Reimbursable</li> </ul>		
<b>MRI for screening average risk women</b>	<ul style="list-style-type: none"> <li>• Not reimbursable</li> </ul>	<b>If hysterectomy was indicated as treatment for:</b> <ul style="list-style-type: none"> <li>• CIN I, II, III/CIS</li> <li>• Cancer indications</li> </ul>	<ul style="list-style-type: none"> <li>• Biennial screening until a ten year history of negative results and three most recent are technically satisfactory and negative</li> <li>• If cancer-continue biennial screening indefinitely</li> </ul>

# **ATTACHMENT I**

# Core Competencies of Clinical Breast Examination

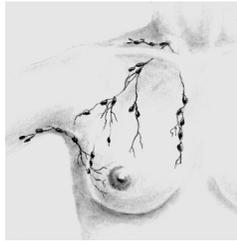
## HISTORY



Cancer Detection Programs:  
Every Woman Counts

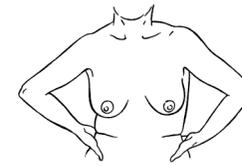
- ⌘ Health history questions regarding age, family history, personal history, reproductive history
- ⌘ Review patient's concerns or symptoms
- ⌘ Assess actual and perceived risk

## LYMPH NODE EXAM



- Clavicular  
Palpate deep above & below the clavicle
- Axillary  
Palpate in a diamond pattern
  - ⌘ Deep at the apex
  - ⌘ Medially along pectoralis muscle
  - ⌘ Laterally along subscapular muscle
  - ⌘ High under humeral head

## VISUAL INSPECTION

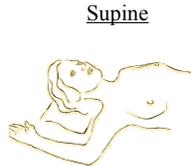


- In sitting position check for:
- ⌘ Symmetry
  - ⌘ Skin changes
  - ⌘ Nipple changes
  - ⌘ Dimpling
  - ⌘ Venous Pattern

## PATIENT POSITIONING

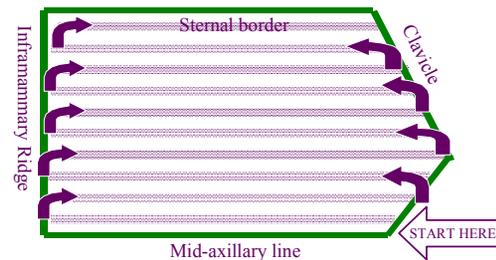


- ⌘ Hip elevated 90°
- ⌘ Knees flexed
- ⌘ Support lower back or shoulder
- ⌘ Back of hand on forehead



- ⌘ Elbow - 90° angle

## PERIMETER & PATTERN (VERTICAL STRIP)



## PALPATION



JAMA, Vol. 282, No 13, Oct. 1999

Pads of three middle fingers

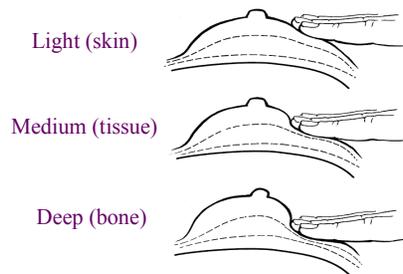


Dime size circles



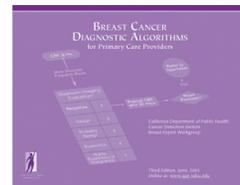
Slide or walk between palpations without lifting fingers

## PRESSURE



JAMA, Vol. 282, No 13, Oct. 1999

## PLAN OF ACTION & PATIENT ED



- ⌘ Determine next steps for abnormal results
- ⌘ Stress importance of adherence to f/u
- ⌘ Emphasize rescreening
- ⌘ Impart cultural sensitivity
- ⌘ Discuss/teach BSE

## DOCUMENTATION

- ⌘ Patient concerns
- ⌘ Exam findings
- ⌘ Plan of action
- ⌘ Referrals made
- ⌘ Patient education
- ⌘ Results notification (tests/procedures)

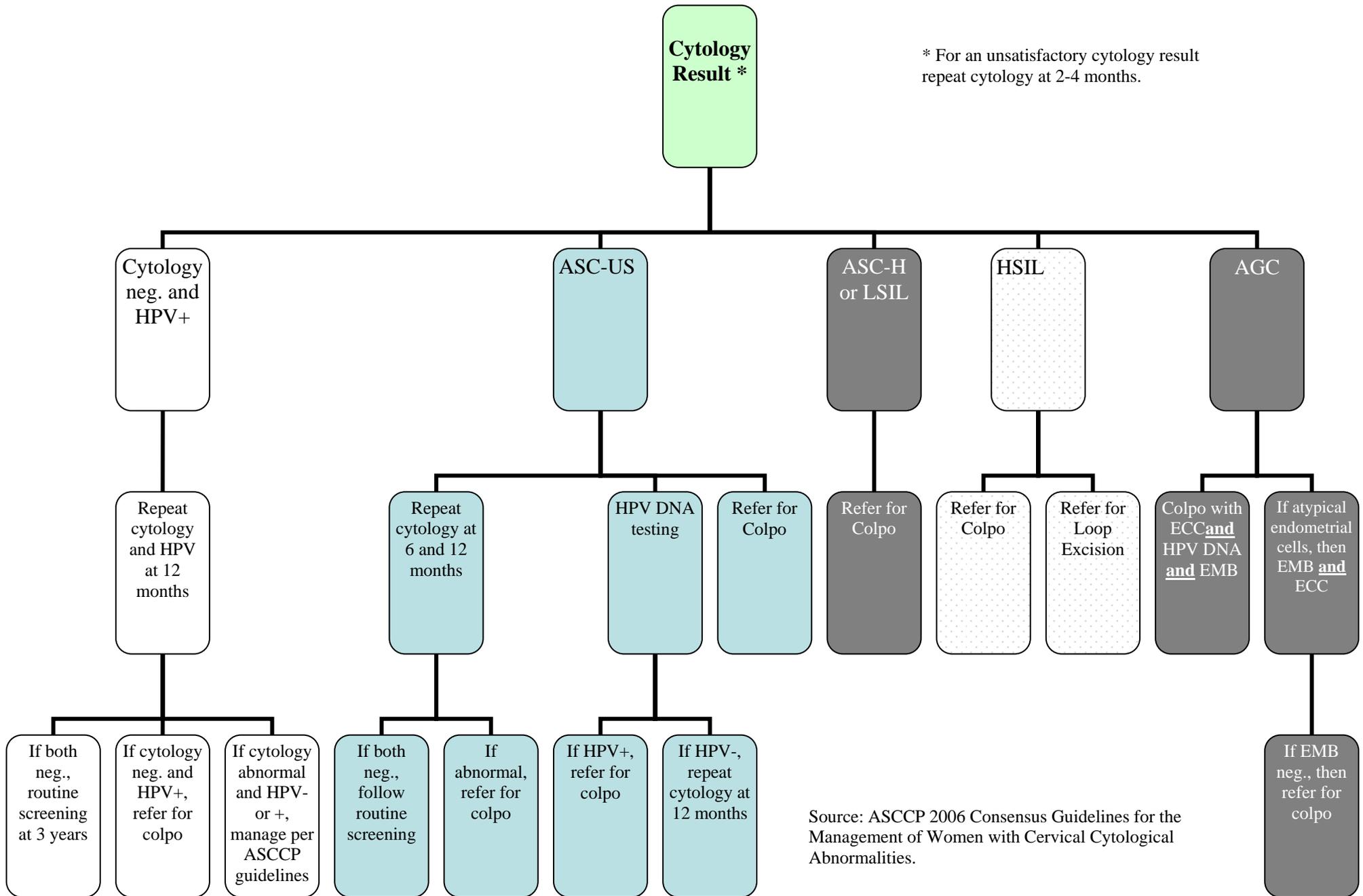


### Discrete Mass

- ✓ Location
- ✓ Size
- ✓ Shape
- ✓ Margins
- ✓ Mobility
- ✓ Consistency
- ✓ Tenderness

# **ATTACHMENT J**

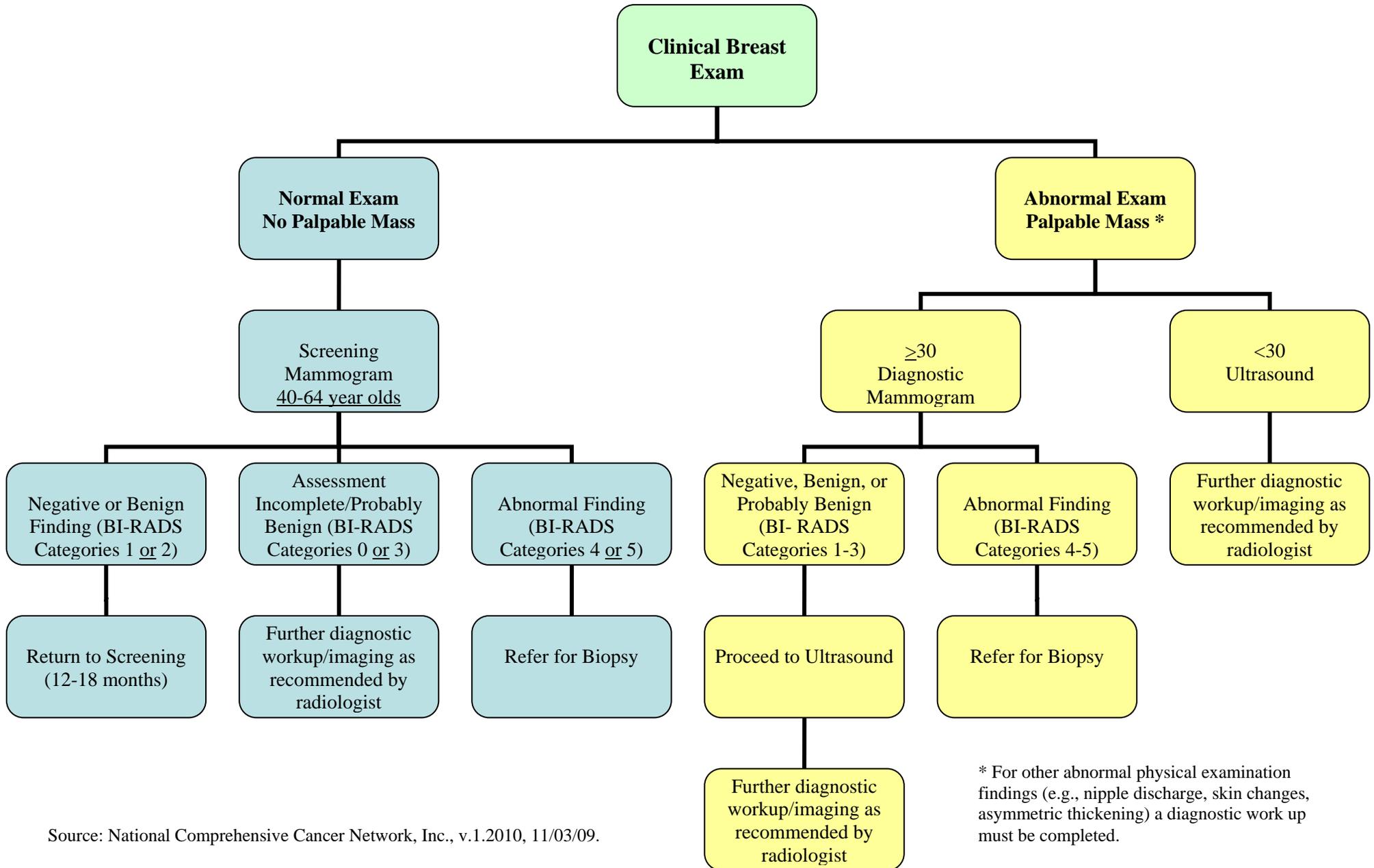
# Attachment J – Cervical Diagnostic Guidelines



Source: ASCCP 2006 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities.

# **ATTACHMENT K**

# Attachment K – Breast Diagnostic Guidelines



Source: National Comprehensive Cancer Network, Inc., v.1.2010, 11/03/09.

# **ATTACHMENT L**

# CASE MANAGEMENT PROCESS

**EWL Case Manager Receives Notification of Abnormal Test Result**  
(e.g., abnormal CBE or mammogram, HSIL, AGC, LSIL)

1. Notify client of result within 5 business days of receipt.
2. Assess client's need for case management services (complete needs assessment).
3. If case management is needed, complete care plan:
  - o Plan follow up care with client and arrange referrals
  - o Document client contacts and follow-up received in care plan
  - o Review and update care plan at appropriate intervals to assure timely follow up
4. Track results of any diagnostic tests ordered.
5. Monitor follow-up care to ensure the client receives all procedures in a timely manner.

**Final Diagnosis Received**

**Not Cancer**

Notify client

Schedule for short term follow-up or rescreening

**Cancer**

Notify client

Review care plan with client and revise as needed

**Eligible for Medicaid Treatment Act**

**No**

Find alternative treatment options

**Yes**

- Complete Medicaid application and refer to local DSS office
- Provide treatment resources

- Maintain contact with client until treatment ends
- Re-enroll in EWL, if eligible

# **ATTACHMENT M**

**Every Woman's Life**  
**CASE MANAGEMENT NEEDS ASSESSMENT AND CARE PLAN**

Client Name:	Client Social Security No:
Day Phone:	Alternate Contact Person: Phone No:
Case Manager Name:	Today's Date:
Provider Name:	
Abnormal Breast Result (date and result):	Abnormal Cervical Result (date and result):

NEEDS ASSESSMENT	
I feel that I will have the support of my family and/or friends if I need it.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I may have problems getting to follow-up appointments if they are recommended for me.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If follow-up tests/services are recommended for me, I may need help in understanding them.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there other issues that would prevent you from receiving follow-up care?	<input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, explain: _____ _____ _____ _____

CARE PLAN				
	Problem	Plan	Client Contacts*	Outcome
<input type="checkbox"/>	Inadequate social support			
<input type="checkbox"/>	Lacks access to services			
<input type="checkbox"/>	Lacks understanding of services needed			
<input type="checkbox"/>	Other barriers			

\* Record date and type of contact (1-telephone, 2-office visit, 3-home visit, 4-mail, 5-certified mail, 6-email, 7-text message)

**Case Management Outcome:**    **Diagnostic work-up completed**    **Refused**    **Lost to follow-up**

Case Manager	Date:
--------------	-------

# **ATTACHMENT N**

# 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. 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

# Medicaid FAQ Sheet

eligible for EWL, may be re-screened through the program. Women who are not eligible for EWL should be referred to other community resources for their routine cancer screening.

### **3. Do we have presumptive eligibility in Virginia?**

**Answer:** Virginia does not have presumptive eligibility. Virginia has streamlined the eligibility process for the BCCPTA.. Medicaid has an application and certification to determine if the individual meets the requirements of the BCCPTA covered group.

### **4. 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.

### **5. 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.

### **6. 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.

### **7. 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; documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. However, the Department of Medical Assistance Services completes a data match with the Social Security Administration (SSA) in order to obtain citizenship and identity verification, and local department of social services eligibility workers will go ahead and enroll the woman in Medicaid while the match is being completed. If the data match fails to provide verification, the individual may be required to provide documentation of her citizenship and identity in order for her Medicaid coverage to continue. The individual will be notified by DSS if she is required to provide documentation.

## Medicaid FAQ Sheet

### **8. Do the Medicaid citizenship and identity requirements mean that aliens (not being able to provide proof of citizenship) are no longer eligible for the BCCPTA?**

**Answer:** Documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. Non-citizens who are in this country legally have always been required to provide immigration documentation. If a non-citizen 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.

### **9. 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.”*

*For Medicaid eligibility information, EWL providers are encouraged to visit the DMAS website, <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>. Additionally, there are two toll free Medicaid numbers (800-772-9996 or 800-884-9730) to call for eligibility information. To access the Medicaid system, you must be a Medicaid provider with a provider number.*

### **10. Is it the responsibility of EWL providers to notify DSS if a client who has been approved for BCCPTA decides not to become a Medicaid recipient?**

**Answer:** No, if a client has been approved for BCCPTA but decides to decline Medicaid services she will need to directly notify DSS of her decision.

### **11. 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:

## Medicaid FAQ Sheet

- 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.

**12. 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 received during the three months prior to the month the Medicaid application was filed. 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.

**13. 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 cervical cancer screening test or the date of EWL enrollment?**

**Answer:** It is the date of the cervical cancer screening test.

**14. Are the race and marital status fields 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.

**15. 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.

## Medicaid FAQ Sheet

### **16. 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 who do not meet this work requirement will be deemed an “unqualified alien” by DSS and Medicaid payment will be limited to treatment for emergency services.

### **17. What is Plan First?**

**Answer:** Plan First is a Medicaid program that provides an annual physical exam, cervical cancer screening, 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 cervical cancer screening result 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.

### **18. 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.

### **19. Who should we contact with BCCPTA-related questions?**

**Answer:** For DSS related questions (e.g., questions about the BCCPTA application form or DSS eligibility worker decisions/actions) contact the DSS program consultant that is assigned to your regional office (see attached listing). For BCCPTA/EWL policy-related questions, contact the State EWL office.

### **20. Are the women who are enrolled under the BCCPTA most likely to receive care under a fee for service plan or managed care plan?**

**Answer:** Women enrolled under the BCCPTA are currently excluded from managed care. They can only receive care from fee for service providers.

*Revised 9/27/10*

**DSS Medical Assistance Program Consultants Assignments 12-10-2008**

CENTRAL Central Regional Office  Sherry Sinkler-Crawley 804-662-9756  <a href="mailto:sherry.sinklercrawley@dss">sherry.sinklercrawley@dss</a> Fax: 804-662-7023		EASTERN Eastern Regional Office  Lynn Brodnax 757-491-3980 <a href="mailto:lynn.brodnax@dss.virginia.gov">lynn.brodnax@dss.virginia.gov</a> Fax: 757-552-1832		NORTHERN Northern Regional Office  Don McBride 540-347-6326 donald.mcbride@dss.virginia.gov Fax: 540-347-6331		PIEDMONT Piedmont Regional Office  Judy Ferrell 540-857-7972 judith.ferrell@dss.virginia.gov Fax: 540-857-6535		WESTERN Western Regional Office  Sharon Craft 276-676-5639 sharon.craft@dss.virginia.gov Fax: 276-676-5621	
AGENCY	FIPS	AGENCY	FIPS	AGENCY	FIPS	AGENCY	FIPS	AGENCY	FIPS
Amelia	007	Accomack	001	Alexandria	510	Albemarle	003	Bland	021
Buckingham	029	Brunswick	025	Arlington	013	Alleghany/Covington	005/580	Bristol	520
Caroline	033	Chesapeake	550	Clarke	043	Amherst	009	Buchanan	027
Charles City	036	Dinwiddie	053	Culpeper	047	Appomattox	011	Carroll	035
Cumberland	049	Franklin City	620	FairfaxCo/FallsChurch/Fairf	059/610/600	Bath	017	Dickenson	051
Essex	057	Gloucester	073	Fauquier	061	Bedford Co/City	019/515	Floyd	063
Fluvanna	065	Greensville/Emporia	081/595	Frederick	069	Botetourt	023	Galax	640
Goochland	075	Hampton	650	Fredericksburg	630	Campbell	031	Giles	071
Hanover	085	Isle of Wight	093	Greene	079	Charlottesville	037	Grayson	077
Henrico	087	James City Co.	095	Harrisonburg-Rockingham	660/165	Charlottesville	540	Lee	105
Hopewell	670	Mathews	115	King George	099	Craig	045	Montgomery	121
King and Queen	097	Norfolk	710	Loudoun	107	Danville	590	Norton	720
King William	101	Northampton	131	Louisa	109	Franklin County	067	Patrick	141
Lancaster	103	Prince George	149	Madison	113	Halifax	083	Pulaski	155
Lunenburg	111	Southampton	175	Manassas City	683	Henry-Martinsville	089/690	Radford	750
Middlesex	119	Suffolk	800	Manassas Park	685	Highland	091	Russell	167
New Kent	127	Surry	181	Orange	137	Lynchburg	680	Scott	169
Northumberland	133	Sussex	183	Page	139	Mecklenburg	117	Smyth	173
Nottoway	135	Williamsburg	830	Prince William	153	Nelson	125	Tazewell	185
Powhatan	145	York/Poquoson	199/735	Rappahannock	157	Pittsylvania	143	Washington	191
Prince Edward	147	Newport News	700	Shenandoah	171	Roanoke City	770	Wise	195
Richmond Co.	159	Petersburg	730	Spotsylvania	177	Roanoke Co-Salem	161/775	Wythe	197
Westmoreland	193	Portsmouth	740	Stafford	179	Rockbridge-BuenaVista-Lex	163/530/678		
Chesterfield/Col. Heights	041/570			Warren	187	Shenandoah Valley(Staunt	015/790/820		
Richmond City	760								
Virginia Beach	810			Winchester	840				
Home Office Glenn Rainey 804-726-7377 <a href="mailto:glenn.rainey@dss.virginia.gov">glenn.rainey@dss.virginia.gov</a> Fax: 804-726-7357									
AGENCY	FIPS								

1/25/2010

<b>Brenda Wolfert, Medicaid Supervisor, DMHMRSAS Medicaid Technicians (434) 947-2754</b>					
DMHMRSAS Facility	FIPS	DMHMRSAS Facility	FIPS	DMHMRSAS Facility	FIPS
Southwestern VA Trng Ctr	984	Central VA Trng Ctr	990	Eastern State Hospital	994
Southeastern VA Trng Ctr	985	Western State Hospital	991	Hiram Davis Med Ctr	996
Northern VA Trng Ctr	986	Southwestern VA MH Inst	992	Catawba Hospital	997
Southside VA Trng Ctr	989	Piedmont Geriatric Hosp	993		

# **ATTACHMENT O**

**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.
- ◆ 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:

**If you are not registered to vote where you live now, would like to register to vote today?**

- Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)
- I do not want to apply to register to vote today.

**IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. 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 to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, First Floor, 1100 Bank Street, Richmond, VA 23219. Telephone: 804-864-8901, toll free: 800-552-9745.

# **ATTACHMENT P**

**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 to 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 10<sup>th</sup> 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.