



*Breast &
Cervical* **EARLY
CANCER EARLY
DETECTION**
Program of Alabama

**ALABAMA BREAST AND
CERVICAL CANCER
EARLY DETECTION
PROGRAM**

PROVIDER MANUAL

Revised January 2012

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APPENDICES

See our website at <http://www.adph.org/earlydetection> for the following materials:

- Coordinator Map and List
- Consent Forms
- Contract Template
 - Disclosure Statement
 - Immigration Statement
 - Checklists
- Current Eligibility Guidelines
- Income Guidelines
- Timeliness Algorithm
- Program Forms
- Reimbursement Table
- Web Enrollment System Guide

SECTION I: PROGRAM OVERVIEW

A. General Guidelines

The Alabama Breast & Cervical Cancer Early Detection Program (ABCCEDP) is a statewide program of the Alabama Department of Public Health (ADPH) aimed at providing breast and cervical cancer screening and diagnostic services to women who meet certain age, income and insurance coverage guidelines.

Eligible women **must** be referred and receive services by a participating provider. All ADPH county health department clinics throughout the state are participating providers, as well as some @400 hospitals, outpatient diagnostic centers and private physicians.

Available Services Table for Eligible Uninsured & Underinsured Women

Age Limits	Available Services
See current age eligibility guidelines on ABCCEDP website at: www.adph.org/earlydetection	Free Pelvic Exam, Pap Smear, clinical breast exam and screening mammogram. Will cover further diagnostic work up if an abnormality is found.
65+	If enrolled in Medicare Part A only... Free Pelvic Exam, Pap Smear, clinical breast exam and screening mammogram. Will cover further diagnostic work up if an abnormality is found.

Underinsured and **uninsured** means one of the following:

- No health insurance
- Health Insurance that does not cover 100% of a Pelvic Exam, Pap Smear or Clinical Breast Exam
- Health Insurance that provides a Pelvic Exam, Pap smear or Clinical Breast Exam but requires the payment of a deductible or coinsurance amount which the woman cannot pay.

Income Eligibility Guidelines 2011

(All sources of income for ALL household members including disability and child support payments)

*Based on DHHS Poverty Guidelines issued 01/2012

Household Size	Annual Income	Monthly Income
One	\$22,340	\$1,862
Two	\$30,260	\$2,522
Three	\$38,180	\$3,182
Four	\$46,100	\$3,842
Five	\$54,020	\$4,502
Six	\$61,940	\$5,162
Seven	\$69,860	\$5,822
Eight	\$77,780	\$6,482

For Each Additional Household Member Add \$660 per month or \$ 7,920 annually

Cervical Screening Limitations - Hysterectomy

- If the cervix is present, follow pap smear regime
- If the cervix is not present, perform a Pap smear (vaginal cuff) **ONLY if hysterectomy was** done as treatment for pre-cervical (CIN II or III) or cervical cancer.
- In the event that the woman does not know if she has a cervix following the hysterectomy, one initial exam can be reimbursed to determine if a cervix is present. If a cervix is not present, a Pap smear will not be reimbursed.

Mammograms

- It is usually not possible to have a mammogram done the same day as the clinical exams. It will probably be necessary to see a different provider/office/clinic to have the mammogram done as well. The clinical exam provider will schedule the mammogram and give the woman a “voucher” to take to the mammogram appointment to present for payment.
- The woman **MUST** have had a clinical breast exam to be referred for a mammogram.

Treatment for Diagnosed Breast or Cervical Cancer

The ABCCED Program cannot provide reimbursement for any treatment related services. However, clients who are diagnosed with breast, cervical or pre-cervical cancer (CIN II or III) **may** be eligible to apply for the AL Medicaid Breast and Cervical Treatment Program. Contact your ABCCEDP Area Screening Coordinator regarding any client diagnosed with breast or cervical cancer.

Additional Information or Complaints

Women with additional questions or complaints should contact the Screening Coordinator who covers her county.

SECTION II: INTRODUCTION

A. Purpose

The purpose of the provider manual is to provide standardized guidelines for breast and cervical cancer screening services for eligible Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) participants.

The manual contains ABCCEDP guidelines and operational references for clinics and health care providers participating in the program.

The purpose of the ABCCED program is to prevent unnecessary disease, disability and premature death due to cancer of the breast or cervix.

Each screening provider should have a designated staff member who is responsible for receiving ABCCEDP memorandums, programmatic updates, and for distributing this information to the appropriate staff. Screening providers must adjust to changes in program guidelines. Each screening provider must allow in-service training to existing staff members and to new employees to assure program compliance.

B. Overview

A combination of federal law and regulations imposed by the Centers for Disease Control and Prevention (CDC) and ABCCEDP govern the guidelines set forth in this manual.

Title XV of the Public Health Services Act, known as the "Breast and Cervical Cancer Mortality Prevention Act of 1990" (Public Law 101-354) established a program of grants to states for the detection and control of breast and cervical cancer. The grants are awarded to states via a cooperative agreement by CDC through a competitive application process. The purpose of the funding is to provide early detection screening and referral services for breast and cervical cancers with emphasis placed on women age 40 and older who are uninsured, under insured, of minority status and less than 200 percent of the federal poverty level.

The key to reducing illness and death from these cancers is early detection by widespread use of mammography and Papanicolaou test screening with timely follow-up and treatment, if necessary. Routine screening can detect many of these cancers at early stages when more treatment options are available and the likelihood of survival is improved. Nearly all cervical cancer deaths and more than 30 percent of breast cancer deaths could be prevented.

SECTION III: SCREENING ELIGIBILITY GUIDELINES

A. Priority Population

The Screening Provider determines a woman’s eligibility by applying the following guidelines:

- Women who meet current age eligibility guidelines (www.adph.org/earlydetection)
- Women at or below 200 percent of the Federal Poverty Guidelines (listed under Income Eligibility Guidelines)
- Women who are uninsured or under insured*.
- Women who have been **rarely or never** screened are also priority population
- **Patients with Medicare-Part B are not eligible for ABCCEDP services**

Men are **not** eligible for the ABCCEDP (or any other NBCCEDP) according to the law establishing the NBCCEDP. It is recognized that while men are at some risk of developing breast cancer, the percentage is very low (less than 1%) compared to women.

B. Income Eligibility Guidelines

Proof of income is not required. The woman’s declaration statement is sufficient.

At or below 200 percent of Federal Poverty Level determines program eligibility.

Household Size	Annual Income	Monthly Income
One	\$22,340	\$1,862
Two	\$30,260	\$2,522
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Four	\$46,100	\$3,842
Five	\$54,020	\$4,502
Six	\$61,940	\$5,162
Seven	\$69,860	\$5,822
Eight	\$77,780	\$6,482

Each additional household member add \$7,920 annually or \$660 monthly.

*** Based on DHHS Poverty Guidelines issued 01/2012**

C. Under insured Guidelines

A woman who meets the income requirements of the ABCCEDP is considered under-insured and eligible for services when she:

- Has medical insurance which does not cover ABCCEDP services or,
- When a required deductible or co-insurance represents a deterrent for receiving breast and cervical cancer screening services.
- When insurance does not reimburse the full amount of the established fees for covered services, does not provide coverage for screening services as recommended by the ABCCEDP or has a deductible or co-insurance the woman cannot afford to pay. These women will be entitled to the same coverage/services as eligible uninsured women.
- ABCCEDP cannot pay the co-pay for Medicare.

SECTION IV: PATIENT RIGHTS

A. Confidentiality of Patient Information

ABCCEDP health care providers will be required to

- Protect the use or disclosure of any woman's medical or social information of a confidential nature.
- Consider medical services to and information contained in medical records confidential.
- Disclose the woman's medical records to contracted ABCCEDP physicians or medical facilities accepting the woman.
- Disclose the woman's medical records to the ABCCEDP state office.
- Disclose in summary or other form, information which does not identify individuals or providers, if such information is in compliance with applicable federal and state regulations, and the exchange of individual medical record information is in keeping with established medical standards and ethics.

B. Informed Consent

- An informed consent documenting the woman's consent to receive breast and cervical cancer screening services must be signed prior to her receiving any ABCCEDP services. The consent form must be signed by the patient. The signed form must be kept in the woman's permanent medical record. This form can be printed from the program web page www.adph.org/earlydetection or from the web based Enrollment site which can be accessed through the web page above.
- The consent form is part of the Screening/Billing Form but may be downloaded from the ABCCED web page.



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PROVIDER CONTRACTING

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SECTION V: PROVIDER CONTRACTING PROCESS

All providers must execute an approved Public Health contract document PRIOR to the provision of services. Contracts are typically for two year periods of time, expiring every other June 30th. In addition to the executed contract, the following must also be provided:

All of the following are required with a contract

- Disclosure Statement
- Immigration Statement
- Applicable Check List (physician, anesthesiologist, mammogram facility or laboratory)
- Copy of all physician and certain licensed healthcare professional licenses.
- Copy of certain facility licenses
- Copy of current fee schedule on practice letterhead
- W-9 Form

Providers MUST notify the Area Screening Coordinator when any of the following takes place:

- The federal tax identification number changes.
- Changes in practice name, physical or mailing address, phone or fax numbers and contact personnel.
- If billing methodologies change from global, technical or professional or when billing methodologies are different for selected procedures.
- When the mailing address for the receipt of payments changes.
- When physicians leave or join a practice to include a copy of the current license.
- Upon expiration of any facility, physician or licensed healthcare professional license expiration, a copy of the renewed license must be faxed to the Screener. Note: All physician licenses in Alabama expire each December 31. Registered nurse licenses expire every other year on December 31. Mammogram facility certifications expire on different schedules.

SECTION VI: PROVIDER RESPONSIBILITIES

A. Primary Provider Screening Requirements

Program Requirements

- Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) providers must maintain current and applicable federal and/or state licenses.
- ABCCEDP screening providers include: county health departments, licensed medical providers, and non-profit health centers qualified to provide ABCCEDP screening services.
- All screening providers must agree to accept the program approved reimbursement fee as payment in full for services rendered. That reimbursement, by law, cannot be over the current Medicare reimbursement rate.

ABCCEDP providers must agree to provide:

- Basic screening components for breast cancer for women who meet current age eligibility, are uninsured or under insured and are at or less than 200% of the federal poverty level:
 1. Clinical Breast Exam (CBE)
 2. Referral for mammography Basic screening components for cervical cancer for women who meet current age eligibility, who are uninsured or under insured and are at or less than 200% of the federal poverty level:
 1. Pelvic examination
 2. Pap smear
- Development of referral resources for diagnostic and treatment services not funded by the ABCCEDP.
- **Appropriate and timely follow-up for all ABCCEDP participants according to CDC guidelines.**
- Patient education to include self breast exam
- Public education and community outreach by working with local partnerships.

Patient Enrollment

To enroll a woman as a participant in the ABCCEDP, the **screening** provider must:

- Determine eligibility based on income, age and insurance status
- Obtain a tracking number through the ABCCEDP web based Enrollment site @ www.adph.org/earlydetection. Obtain a signed ABCCEDP Informed Consent/Release of Information Form (found on ABCCEDP web site)
- Complete the screening/billing form(found on the ABCCEDP web site) for each woman and submit to the appropriate ASC
- Provide required screening and educational services.

Patient Education

Providers are required to provide women with information and educational services on the early detection of breast and cervical cancer. The purpose of the education component is to provide women with the information necessary:

- To understand the screening procedures used in the detection of breast and cervical cancer.
- To understand the technique for doing breast self examination (BSE) on a monthly basis.
- To motivate the woman to comply with recommended guidelines for screening as it relates to present appointment and future screening practices.
- To provide education and information appropriate for the woman's age, lifestyle, educational level and ability to understand. This instruction should be documented in the woman's record and she should be allowed an opportunity to ask questions and verbalize her understanding of the educational information presented.

Record Keeping

- The ABCCEDP requires that a copy of all ABCCEDP reimbursed screening and diagnostic reports be placed in the patient's permanent medical record maintained by the primary provider.
- The provider must document all education the provided to the woman
- The provider must establish a system for tracking women that notifies her when routine screening and/or follow up is due.

Visit Type

Initial services include:

- Recording medical history.
- Clinical breast examination (CBE), pelvic examination and Pap smear.
- Providing informational and educational services related to breast and cervical cancer.
- Breast self examination technique (BSE) instruction & reinforcement of monthly checks.
- Referral for mammography according to ABCCEDP guidelines.

Annual services include:

- Updating of medical history and reassessment of income eligibility.
- CBE, pelvic examination and Pap smear if indicated according to ABCCEDP guidelines.
- Referring for mammography according to ABCCEDP guidelines.

Repeat Pap Smear

- Repeat Pap smear in accordance with laboratory recommendations. (Note: A repeat Pap test will be covered when specimen adequacy is deemed unsatisfactory)

Abnormal Follow up

- The provider must make every effort to have timely follow-up, referral, and treatment for any abnormal result.
- A woman previously non responsive to abnormal follow up attempts shall not be denied future screening services.

Outside Referral

Refer in accordance with clinical guidelines to **contracted** ABCCEDP providers for any or all of the following services:

- Mammography
- Breast Ultrasound
- Colposcopy
- Surgical or GYN consult
- Fine needle aspiration
- Breast Biopsy(incisional, excisional, needle core, or stereotactic)

Referral for Abnormal Results

The primary screening provider who provides the CBE, pelvic examination, and Pap smear is responsible for **appropriate and timely** follow-up for diagnostic and treatment services. The primary screening provider is responsible for:

- Counseling (and documentation) each woman who has abnormal tests or exams.
- Referring or providing any additional diagnostic work-up and treatment needed. (Some diagnostic services are not funded by the ABCCEDP. **NO TREATMENT SERVICES ARE FUNDED BY THE ABCCEDP.**)
- Ensuring the woman has completed the recommended follow-up.
- Documenting attempts to contact women who need follow-up.
- Recording the woman's response to the provider's contact.
- Providing the ASC with information regarding the outcome of the woman's diagnostic tests and treatment needed **within 60 days** of scheduled follow-up appointments.
 - If this is not received the ASC will:
 - make 2 attempts to get the information from the primary provider.
 - contact referral provider and/or the woman for missing information
- Notifying the ASC if the woman needs assistance to identify and access available community resources beyond provider efforts.

Tracking And Follow-Up

Each health care provider and facility must:

- Utilize a tracking protocol that assures effective communications with the woman, health care providers and laboratory personnel.
- Maintain a record of pap smears and mammograms done to ensure results are received in a timely manner.
- Address barriers that women might have to following recommendations.
- Facilitate proper follow up for women with abnormal screening results, as well as annual re-screen.
- Maintain a screening system to notify women as screenings are due.

Missed Abnormal Follow-up Appointments

- Providers **must** contact the woman for missed appointments for diagnostic or treatment procedures. These should begin with a phone call, then a letter or post card, and finally a certified letter. This would usually occur over a 30-60 day time period.
- If after two months from the abnormal screening results, the woman does not respond to **documented** repeated phone contacts and/or a certified letter to schedule additional diagnostic procedures, the work-up disposition will be entered in the ABCCEDP data system as one of the following:
 - Lost to follow-up - if the woman cannot be contacted via phone, post card, or certified letter
 - Work-up refused - if the woman refuses additional diagnostic tests or does not show twice for scheduled follow-up appointmentsThe screening cycle will be closed at that time.
- A woman lost to previous follow up attempts shall not be denied future screening services

It is the screening provider's responsibility:

- to notify the ASC if there is a change in their FEIN #, mailing address, license status
- to notify the ASC when a change in billing methodologies from global, technical or professional takes place for any procedure
- to provide ASC with copies of new or renewed licenses for the facility, physicians and selected healthcare professionals
- to maintain a re-screening system to notify the woman as screens become due

B. REFERRAL PROVIDER REQUIREMENTS

All referral and consultant providers must agree to accept the ABCCEDP approved reimbursement fee as payment in full for services rendered.

Mammography Provider

All mammography providers for the ABCCEDP:

- Must be accredited by the ACR and certified by the FDA and in compliance with the MQSA.
- Must require their radiologists to record mammography findings using the ACR Breast Imaging Reporting and Data System (BI-RADS)
- Must maintain records and films of ABCCEDP women according to the MQSA requirements
- All providers must agree to accept the program approved reimbursement fee as payment in full for services rendered for ABCCEDP approved CPT codes as indicated on the reimbursement table.

Mammography providers must agree to provide **upon referral:**

- Screening mammograms for women over 40
- Diagnostic mammograms, if indicated
- Ultrasound, if available and indicated
- Other related diagnostic procedures which are approved for reimbursement by the ABCCEDP, if available and indicated
- Appropriate and timely follow-up for all ABCCEDP patients according to MQSA guidelines.

Reporting Requirements

To receive reimbursement the facility must submit to ASC by the 15th of the month:

- the original mammography voucher
- an invoice or bill with the patient's name
- the report of the screening or diagnostic exam performed
- the Health Insurance Claim Form(HIFA 1500 or the UB 92 for facilities)

It is the mammography provider's responsibility:

- to notify the ASC if there is a change in their FEIN #, mailing address, license status
- to notify the ASC when a change in billing methodologies from global, technical or professional takes place for any procedure
- to provide ASC with copies of new or renewed licenses for the facility, physicians and selected healthcare professionals
- to maintain a re-screening system to notify the woman as screens become due

Cytology Laboratories

- Any laboratory that performs procedures either directly, under contract or indirectly (under a global contract with a contracted provider) for ABCCEDP patients, must be currently certified under **CLIA**.
- All laboratory providers will require the pathologists to record Pap smear findings using the Bethesda System
- All providers must agree to accept the program approved reimbursement fee as payment in full for services rendered for ABCCEDP approved CPT codes as indicated on the reimbursement table.

Reimbursement Requirements

To receive reimbursement, the lab provider must submit to the ASC by the 15th of the month, for procedures performed the preceding month.

It is the laboratory provider's responsibility:

- to notify the ASC if there is a change in their FEIN #, mailing address, license status
- to notify the ASC when a change in billing methodologies from global, technical or professional takes place for any procedure
- to provide ASC with copies of new or renewed licenses for the facility, physicians and selected healthcare professionals
- to maintain a re-screening system to notify the woman as screens become due

Colposcopy Provider

- A colposcopy provider must be a physician, PA, or a CRNP who is certified in performing colposcopy and currently licensed in the State of Alabama.
- All providers must agree to accept the program approved reimbursement fee as payment in full for services rendered for ABCCEDP approved CPT codes as indicated on the reimbursement table.

Reporting Requirements

To receive reimbursement, the colposcopy provider must submit copies of the following to the referring screening provider and the ASC by the 15th of the month for procedures performed in the prior month:

- Completed Cervical Diagnosis and Follow-Up Form
- Report of pathological findings (when biopsy and or ECC is performed)
- Progress note showing date of colposcopy
- Completed HCFA 1500 or UB 92

It is the colposcopy provider’s responsibility:

- to notify the ASC if there is a change in their FEIN #, mailing address, license status
- to notify the ASC when a change in billing methodologies from global, technical or professional takes place for any procedure
- to provide ASC with copies of new or renewed licenses for the facility, physicians and selected healthcare professionals
- to maintain a re-screening system to notify the woman as screens become due

Consultation Providers

- All providers must agree to accept the program approved reimbursement fee as payment in full for services rendered for ABCCEDP approved CPT codes as indicated on the reimbursement table.

Reporting Requirements

The consultant must submit to the referring provide and the ASC:

- Completed Breast or Cervical Diagnosis and Follow-Up Form with recommendations
- Report of pathological findings and recommendations
- Completed HCFA 1500 or UB 92.

It is the consultant provider’s responsibility:

- to notify the ASC if there is a change in their FEIN #, mailing address, license status
- to notify the ASC when a change in billing methodologies from global, technical or professional takes place for any procedure
- to provide ASC with copies of new or renewed licenses for the facility, physicians and selected healthcare professionals
- to maintain a re-screening system to notify the woman as screens become due

SECTION VII. PRIMARY PROVIDER ENROLLMENT GUIDE

Instructions for enrolling a woman in the ABCCED Program can be found in the Appendix section of this manual as well as on the program web page, www.adph.org/earlydetection.



**SCREENING AND
DIAGNOSTIC
SERVICES**

SECTION VIII. SCREENING & DIAGNOSTIC SERVICES

A. Screening Visit Guidelines

The woman must meet the following requirements:

- Meet current age eligibility (www.adph.org/earlydetection)
- Meets income eligibility guidelines
- Is uninsured or under insured
- Is not a participant of a program that provides these services.
- Has not previously had a hysterectomy.
 - Exceptions:
 - 1) hysterectomy done for cervical neoplasia, or
 - 2) a supracervical hysterectomy was performed; leaving a cervix.
- In the event that the woman does not know if she has a cervix following the hysterectomy, **one initial pelvic exam** can be paid for to determine if there is a cervix. If there is a cervix, then a Pap can be done and paid.
- For a screening mammogram, she should not have had a mammogram with negative results in the past 12 months.
- A woman who meets current age eligibility guidelines and who by virtue of symptoms or physical findings, is considered to have a substantial likelihood of having breast disease is eligible to be referred for a diagnostic mammogram. The patient must be screened through the ABCCEDP to be eligible.

B. Office Visit Types

Routine Comprehensive Office Visits (one per 12 month period)

Services will include:

- Pap smear (frequency rate instructions below)
- Yearly pelvic examination.
- Yearly clinical Breast Exam (CBE).
- Yearly Screening Mammogram for women who meet current age eligibility (www.adph.org/earlydetection). These should be 12 months apart.

CPT Codes

- New Patient Screening-**CPT Code 99203**
- Established Patient Screening-**CPT Code 99213**

Partial Screening Visits

Services will include:

- New Patient Partial Screening – **CPT Code 99202**
(Pap smear and Pelvic Exam OR Clinical Breast Exam)
- Established Partial Screening – **CPT Code 99212**
(Pap smear and Pelvic Exam OR Clinical Breast Exam)

Follow-up Visits

Services will include:

- Follow-up Pap Smear OR Follow-up clinical Breast Exam

CPT Code

- Pap Smear or CBE - **CPT Code 99212**

See the Reimbursement Table for other Screening and Diagnostic Services & CPT Codes

By law, ABCCEDP services are free to the patient. Women should not be charged any fees for program services at any time.

C. Breast Screening Guidelines

Clinical Breast Exam Visit

- If the CBE must be repeated, no more than 3 repeat CBE visits will be paid in any 12 month period
- No reimbursement will be paid for any procedures related to breast implants other than those related to a breast cancer diagnosis
- No reimbursement will be made for cytology analysis of a breast discharge
Screening/Diagnostic Mammogram
- See Mammogram Ultrasound Screening/Diagnostic Guidelines

D. Cervical Screening Guidelines

Pap Smear Frequency

- Conventional Cytology
 - ABCCEDP will reimburse for annual screening with **conventional cytology**.
 - When a woman has had three consecutive normal cervical cancer screening tests within a five-year period, the screening interval will increase to once every 3 years.
- Liquid-based cytology
 - Providers may be reimbursed for **liquid-based cytology** for primary cervical cancer screening, up to the allowable Medicare rate.
 - The screening interval when using liquid-based tests is once every two years. Reimbursement for the liquid-based test is not provided more frequently than once every two years for women with normal results.
 - When a woman has had three consecutive normal cervical cancer screening tests within a five-year period, the screening interval will increase to once every 3 years.
- Abnormal screening
 - If a woman receives an abnormal screening at any time, policies related to the follow-up of abnormal Pap tests and reimbursement of diagnostic procedures should be followed.
 - Once a woman has completed recommended follow-up, she should again receive Pap tests following the above schedule.

Cervical Screening Guidelines Continued

- Repeat Pap smear **must not** be within 90 days of previous Pap to be paid
- No more than 4 repeat pap smears in a 12 month period will be paid
- A repeat Pap test will be covered when specimen adequacy is deemed unsatisfactory.
- No payment will be made for a **verifying** Pap smear
- Cervical Polyp removal is **not** reimbursable and will not be paid
- If a woman does not know whether she has a cervix, a pelvic exam is conducted and if there is no cervix, a **pap may not be done**; and, only the pelvic exam fee would be reimbursed.
- A Pap test result showing no endocervical cells, no endocervical component, or lack of endocervical cells should be considered an “unsatisfactory” specimen and Pap should be repeated.
- The presence of endometrial cells in a pap for a woman over 40 does not necessarily equate to a high risk indicator. As a general rule, further testing when endometrial cells are present in a negative pap smear will not be covered. However, case by case consideration is acceptable for possible exception.
- “Endometrial cells” and “specimen lost before evaluation” are the only Pap smear results that should be marked as “other” on the screening/billing form
- Hyperkeratosis, cervicitis, bacteria and vaginosis are considered to be negative Pap smears
- Atrophic atypia and atypia should be considered as ASC-US.
- **High risk** factors for which the ABCCEDP will allow for annual screening are:
 - If the patient has been previously treated for CIN II, CIN III, or cervical cancer found on colposcopic directed biopsy or on a LEEP/Cone procedure.
 - If the patient is immune-suppressed (such as those with renal transplants)
 - Infection with Human Immunodeficiency virus (HIV)
 - Diethylstilbestrol (DES) exposure in utero

E. Mammogram/Ultrasound Screening/Diagnostic Guidelines

- **Must meet current age eligibility** for a screening mammogram.
- Only one screening mammogram per 12 month period (annual mammogram may be performed no sooner than 10 months from last annual mammogram to be paid).
- If the woman has an abnormal CBE she should be scheduled for a diagnostic mammogram instead of a screening mammogram.
- No more than 3 diagnostic mammograms per woman will be reimbursed in a 12 month period
- A woman who by virtue of symptoms or physical findings, and is considered to have a substantial likelihood of having breast disease is eligible to be referred for a **diagnostic mammogram and/or ultrasound** if she meets age, income and insurance eligibility.
- An ultrasound of the breast will be reimbursed for a woman whose mammogram or CBE indicates a need for one.
- A woman due for screening who has breast implants should always have a diagnostic mammogram.

Four views instead of two are usually taken.

F. Diagnostic Services Guidelines

Breast Diagnostic Services

- **Breast Biopsies**
 - A biopsy may be reimbursed to a facility and a surgeon after **first notifying the ASC**, to make sure funds are available in that contract.
- **Stereotactic:** A stereotactic procedure may be reimbursed if ordered by the surgeon.
- **Breast Cytology:** The ABCCEDP will **not** pay for cytology testing of breast discharge or for medical workup for galactorrhea.
- A mass in the tail of Spence is appropriate for further medical referral.

Cervical Diagnostic Services

- **GYN Consult**
 - A referral may be made to a GYN for an abnormal Pap smear, only when appropriate and according to the Pap smear follow up guidelines.
 - GYN consults should only be made for abnormal findings related to **cervical cancer**.
- **Colposcopy**
 - A colposcopy may be reimbursed if the abnormal Pap meets the follow up recommendations.
 - Reporting for the colposcopy includes the follow-up form, a copy of the Pap smear with abnormal results which initiated the diagnostic procedure and a copy of the colposcopy examination report.
 - A second colposcopy can be paid for within a year, if a second Pap smear indicates a colposcopy is needed. This second Pap smear can be a follow-up Pap smear from the first colposcopy. No more than 2 colposcopies will be paid per woman in a 12 month period and must be at least 3 months apart.
 - -If other circumstances exist, the provider must call the ASC for prior approval of payment for additional procedures.
 - -The program will pay for one consult visit prior to the colposcopy and no more than one follow up visit after the colposcopy if needed.
 - Colposcopy done as a part of a LEEP **will not be reimbursed**.
 - A LEEP may be performed for diagnostic purposes only between the Pap smear result and the Colposcopy.
 - Referral of post menopausal women with LBC-LGSIL Paps for colposcopies may be covered if the provider believes the Colposcopy is preferable to a repeat Pap in 6 months.
- **Cervical Biopsies**
 - The ABCCEDP will reimburse for up to 2 cervical and 1 ECC biopsies, or 3 cervical biopsies collected during a colposcopy. The number of biopsies will be determined by the number of containers identified by the pathology laboratory.
 - Cervical polyp removal is **not** reimbursable with ABCCEDP funds.

SECTION IX. SCREENING & DIAGNOSTIC RESULTS

A. **Breast Cancer Screening**

- **Normal Result (CBE and Mammogram)**

When the CBE and mammogram (if performed) are both normal, it is the provider's responsibility to:

- Have a system in place to notify the woman of her mammogram results.
- Have a reminder system in place which allows the screening provider to notify the woman prior to the date due for routine annual re-screen.
- Maintain a record of women receiving a mammogram to ensure that results are received within two to three weeks of the screening test.

- **Abnormal Result (CBE or Mammogram)**

It is the responsibility of the screening provider to:

- Notify the women of results and establish a system for tracking these women for appropriate timely follow-up for diagnostic services and treatment as needed.

-Plan a diagnostic work-up so that the time from the screening mammogram or CBE (whichever occurs first) to final diagnosis is no more than 60 days.

- Refer to a surgeon any abnormal CBE or abnormal mammogram
- Maintain, as a part of the woman's permanent medical record documentation of all test results, related education, resulting recommendations and/or referrals with dates.
- Know that a normal mammogram does not rule out cancer if a woman has a mass on CBE.

- **Adequacy of Follow-up for Women with Abnormal Screening Results**

- A woman whose breast cancer screening was abnormal or suspicious must receive appropriate diagnostic procedures (as defined by the program's medical advisory committee) to arrive at a final diagnosis; and

- Women in whom breast cancer has been diagnosed must be referred for appropriate treatment.

- **Timeliness of Follow-up for Women with Abnormal Screening Results**

- The interval between initial screening and diagnosis of abnormal breast screenings should be 60 days or less.

- The interval between diagnosis and initiation of treatment for breast cancer should be 60 days or less.

NOTE: If a diagnosis of cancer or pre-cancer is made, the screening provider must assist with referral for treatment utilizing contracted surgeons for the area. The ASC is available to assist with this referral and to notify the Medicaid Liaison to start the Alabama Breast & Cervical Cancer Medicaid Treatment application process. The ABCCEDP cannot and will not pay for any treatment related services. This policy is stated in the guidelines of the Centers for Disease Control and Prevention, which controls the funding for the ABCCEDP.

Refer to **Diagnosis and Referral** for management of abnormal CBE or mammogram results.

B. Cervical Cancer Screening

• Normal Result

When the Pap smear result is normal it is the provider's responsibility to:

- Have a system in place to notify the woman when her next routine screening is due.
- Have a reminder system in place which allows the provider to notify the woman prior to the date due for a routine annual re-screen.

• Abnormal Result

It is the responsibility of the screening provider to:

- Notify the women of results and establish a system for tracking these women for appropriate timely follow-up for diagnostic services and treatment as needed.
- Maintain a record of women receiving Pap smears to ensure that a report of results is received within two to three weeks of the screening test
- Maintain as a part of the woman's permanent medical record documentation of all test results, related education, resulting recommendations and/or referrals with dates.
- Refer women in whom cervical cancer or pre-cancer has been diagnosed for appropriate treatment.
- **Plan a diagnostic work-up so that the time from an abnormal Pap to final diagnosis should be no more than 60 days.**

• Timeliness of Follow-up for Women with Abnormal Screening Results

- The interval between initial screening and diagnosis of abnormal cervical cancer screenings should be 60 days or less.
- The interval between diagnosis and initiation of treatment for invasive cervical cancer should be 60 days or less.
- The interval between diagnosis and initiation of treatment for cervical intraepithelial neoplasia should be 90 days or less.

NOTE: If a diagnosis of cancer or pre-cancer is made, the screening provider must assist with referral for treatment utilizing contracted surgeons for the area. The ASC is available to assist with this referral and to notify the Medicaid Liaison to start the Alabama Breast & Cervical Cancer Medicaid Treatment application process. The ABCCEDP cannot and will not pay for any treatment related services. This policy is stated in the guidelines of the Centers for Disease Control and Prevention, which controls the funding for the ABCCEDP

Reimbursement of HPV DNA Testing

HPV DNA is reimbursable only for:

- Follow-up of an ASC-US Pap result, or

- For surveillance at 1 year following an LSIL Pap test without evidence of CIN on colposcopy directed biopsy.

C. Guidelines for the Management of Abnormal Cervical Cytology.

Epithelial cell abnormalities - See schematic below

ASC-US:

Terminology	Required Management
ASCUS with HPV positive	Refer for Colposcopy with biopsy
ASCUS with HPV negative	Repeat pap at next routine screening interval

ASC-H:

Atypical Squamous Cells, cannot exclude a high grade squamous intraepithelial lesion (ASC-H)	Refer for Colposcopy with biopsy
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LSIL:

Terminology	Required Management
Low Grade Squamous Intraepithelial Lesion (LSIL): Mild Dysplasia (CIN 1)	Refer for colposcopy with biopsy

HSIL/CIN 2-3:

Terminology	Required Management
High grade squamous intraepithelial lesion: moderate dysplasia/severe dysplasia/carcinoma-in-situ (CIN 2-3)	Refer for Colposcopy with biopsy
Suspicious for Squamous Cell Carcinoma	Refer for Colposcopy with biopsy
Positive for Squamous Cell Carcinoma	Refer for Colposcopy with biopsy
Atypical Endocervical Cells	Refer for Colposcopy with biopsy
Atypical Glandular Cells	Refer for Colposcopy with biopsy
Atypical Endocervical Cells, favor neoplastic	Refer for Colposcopy with biopsy
Endocervical Adenocarcinoma in site	Refer for Colposcopy with biopsy
Endometrial cells present in menopausal woman; these cells may be associated with an endometrial lesion	Refer for Colposcopy with biopsy or further management
Atypical Endometrial Cells	Refer for Colposcopy with biopsy
Atypical Glandular Cells, favor neoplastic	Refer for Colposcopy with biopsy
Suspicious for adenocarcinoma; origin undetermined	Refer for Colposcopy with biopsy
Adenocarcinoma; origin undetermined	Refer for Colposcopy with biopsy

Adenocarcinoma, most likely of endocervical origin	Refer for Colposcopy with biopsy
Adenocarcinoma, most likely of endometrial origin	Refer for Colposcopy with biopsy
Malignant cells present, site of origin undetermined	Refer for Colposcopy with biopsy



PROGRAM FORMS

AND

DATA COLLECTION

SECTION X: ABCCEDP FORMS AND DATA COLLECTION

A. Purpose

The ABCCEDP has **mandatory** reporting requirements for the federal funds received and data elements that are required by the CDC. CDC will use the data from all states receiving screening money and report to Congress that the money is being properly used. The data collected from the ABCCEDP forms provides evidence to the funding agencies (the state legislature and the federal government) that the money they are providing is serving clients who are eligible and in need of the program.

These data elements are collected:

- To ensure the women receive breast and cervical cancer screening tests at appropriate intervals.
- To ensure the women are referred for timely follow-up and are provided diagnostic and treatment services, if necessary.
- To ensure that the program is reaching the in-need segment of the population.
- To collect data on race, ethnic origin, marital status, education, the referral source, and how the woman heard about the program.
- To ensure the women are sent reminders of screening times.
- To evaluate the effectiveness of the ABCCED Program.

B. Form Completion and Submission for Payment

General Information

Original screening /billing forms, HCFA and diagnostic/follow-up forms.

- Should be completed and mailed to the ASC with an invoice by the **fifteenth of each month** with a copy of Pap smear results.
- All forms can be printed from the ABCCEDP Enrollment web site. The original forms will be sent to the ASC.
- The original mammography voucher is given to the patient for her to give the mammography facility at the time of her visit.
- Copies of all forms must be kept in the woman's file.
- The program's patient consent form appears on the back of the Screening/Billing form. The consent must be signed and the original signed document maintained in the patient's medical record.

Screening/Billing Form and HCFA 1500 or UB 92

The purpose of the screening/billing form and HCFA or UB:

- To provide documentation of the screening and diagnostic work up plan.
- To be completed on all women receiving a partial, complete screening or re-screening at the time service

is provided.

- To serve as the monthly data report on provider activity and the documentation for billing.
- Generated by the primary provider at the time of the breast and or cervical screening.

The Screening/Billing form has questions that trigger a Referral/Follow-up if any of the following are marked. A Follow-up form would be generated and a referral made if:

Cervical Screening: Pap Smear Results: If any results other than Negative/Benign, patient should be referred to GYN for further evaluation.
Cervical Screening Disposition: response of further diagnostics test necessary.

Breast Screening: CBE Findings: If any results other than Negative/Benign, patient should be referred for further evaluation.
Mammogram Results: If any results other than Negative/Benign, patient should be referred for further evaluation.
Breast Screening Disposition: response of further diagnostics test necessary.

- Follow-up forms submitted without one of these triggers on the screening form will be questioned and reimbursement for the diagnostic procedures will not be made unless approved.

- The results of screening tests should be carefully recorded so that women receive adequate follow up and providers receive proper payment.
- If the result of the breast or cervical screening recommends a repeat exam in the near future, such as 3 to 6 months later, **do not** complete a follow-up form. At the time the woman returns for her repeat exam, a new screening form should be initiated.
- The follow-up form is for cases where immediate diagnostic tests/procedures are necessary to determine cancer status.

Mammography Voucher

The purpose of the mammography voucher is

- To show verification of payment by the program to the mammography facility
- To provide any identifying, or pertinent exam information to the mammography facility.
- To document that the mammogram has been performed on the correct patient.

The mammography voucher **must** be completed by the primary provider and original sent with the woman to the mammography facility. A copy is kept in the woman's chart. The mammography facility **must** forward this form, a HCFA 1500, with the woman's mammography report to the ASC when the facility bills for services.

Breast / Cervical Diagnostic/Follow-Up Form

The Breast or Cervical Diagnostic Follow-Up form is utilized when breast or cervical related diagnostic follow-up is required. The purpose of the forms is:

- To provide a mechanism for ABCCEDP women to be referred for further diagnostic testing.
- To provide documentation of the tests performed and track information needed for follow up.
- Provide information to the referring physician
- For the woman to take to the referral physician (original to referral physician and a copy for the woman's chart) at the time of the appointment.
- For the referral physician to complete the remainder of the form pertinent to the tests that are performed; forward the original form and HCFA to the ASC with the bill.
- The referral physician is also responsible for providing the primary provider with a copy of the tests results, final diagnosis, tumor size, and treatment if necessary.
 - **The completed follow up form, HCFA 1500, physician notes (if a GYN or surgeon) along with any biopsy, ultrasound or surgeon reports must be submitted to the ASC.**

C. How to Change Client Information

If there are changes in client information after you have submitted the screening forms or follow-up forms for the client, notify the ASC in writing of the change to be made. Include in your note the following, so that the correct record is changed:

- Name that is currently in ABCCED program records
- Social Security Number
- Date of Birth
- Medical Record Number
- CBE or Pap Smear Date
- Name that the current name will be changed to



Breast & Cervical
**CANCER EARLY
DETECTION**
Program of Alabama

CASE MANAGEMENT

AND

TREATMENT

SECTION XI. REFERRAL TO THE MEDICAID BREAST & CERVICAL CANCER TREATMENT PROGRAM

Purpose

Initiated in October of 2001, the Alabama Medicaid Agency program provides coverage for eligible women diagnosed with breast or cervical cancer to receive treatment for their cancer.

Eligibility

To apply for this program, the woman must

- Have a breast or cervical cancer diagnosis.
- Live in Alabama.
- Not have credible insurance that covers cancer treatment
- Be at or below 200% of the Federal Poverty Level.
- Complete the required application forms.

To remain eligible for this program, the woman must

- Be currently in active treatment or on long term therapy for her cancer and have her physician complete the recertification forms as they become due.
- Be under age 65
- Live in Alabama
- Not have become eligible for other insurance that would pay for cancer treatment.(ie: Medicare or SSI Medicaid)

The woman is eligible to **reapply** for this program if

- She has a re-occurrence or metastasis of breast or cervical cancer.
- She was terminated from the B & C Medicaid because she became eligible for SSI Medicaid benefits and is later terminated from that program and is still in active treatment or on long term therapy.

Cancer Diagnoses that are eligible for treatment must have a positive biopsy pathology result reading for

- Breast Cancer of either
- Ductal Carcinoma In-Situ
- Invasive Breast Cancer
- Lobular Carcinoma In-Situ
- Cervical Cancer of either
- CIN II/Moderate to Severe Dysplasia
- CIN III/Severe Dysplasia/CIS
- Invasive Cervical Cancer
- Squamous Cell Carcinoma

Provider Responsibilities for Referral to the Program

The ABCCEDP provider must send or fax the ASC or the ABCCEDP Medicaid Liaison the following information.

- A copy of the positive pathology biopsy report.
- The woman's demographic information.
- A statement as to whether the woman knows her diagnosis.
- The planned treatment schedule and date.

The Application Process

After the ABCCEDP ASC receives the required information from the provider

- The woman is sent the application with instructions to return the original application along with proof of citizenship and identity to the coordinator. This cannot be faxed.
- The application will be forwarded to the Medicaid Liaison, then to Medicaid for processing.
- Retro-active coverage for up to 3 months is available if requested and can be awarded beginning the first day of that month.
- The time frame from the time the application is sent to Medicaid and receiving an award date is usually no more than two weeks.
- Medicaid will notify the woman by letter when she has been approved or denied and if approved her card will be mailed.

Covered Services Information

The Breast and Cervical Treatment Program provides full Medicaid benefits including treatment for cancer.

Examples of some of these services are:

- Cancer surgery treatment
- Chemotherapy treatment
- Radiation treatment
- Long term therapy (ie: Tamoxifen, Arimidex, Femara, Herceptin, etc.)
- Breast Prosthesis
- Breast Reconstruction (Must get pre-approval from Medicaid and the time frame for doing this is 2 years from the date of surgery)

SECTION XII. CASE MANAGEMENT

The goal of case management for the ABCCEDP is to ensure that women enrolled in the program receive timely and appropriate rescreening, diagnostic, and treatment services. The need for case management initiation will be determined at initial enrollment or upon receipt of abnormal screening results or a diagnosis of cancer.

A. Individual Patient Case Management Process

Initiation of Services - The following circumstances would initiate ABCCEDP case management services.

- A provider requests that a specific woman receive case management services;
- A woman requests case management.
- A woman is identified as needing case management by the ABCCEDP staff

Provider Initiated - If at any time the provider is doing in-house case management and needs assistance, the ABCCEDP should be contacted for help. A Case Management Request form should be initiated and sent to the ASC, and the assessment would begin at that point. The ASC would, in turn, contact the Case Management Coordinator if needed. Providers will be encouraged to refer problem patients as soon as possible.

ABCCEDP Woman Initiated - Providers will be responsible for informing women of the availability of case management services when they are enrolled and or when abnormal results are received. The informed consent will address case management and the possibility of referral if abnormal screening results occur. The woman may at any time self refer if the provider does not initiate the process.

Program Initiated - The ASC will contact the Primary Care Provider (PCP) if there is evidence there is a woman with an abnormal result (as defined below) without completed follow up. Monthly overdue reports, information from the Screening and Billing form, and monthly review of the MDEs will alert the ASC of potential patients.

The ASC keeps a log of abnormal results as they are identified from initial or repeat exam data that is sent to them. After contacting the provider, and indeed there is no follow up scheduled and/ or completed, and the provider is in agreement, the ASC will contact the woman. If the provider prefers to continue with a plan of care, the ASC should document the PCP's plan on a CMR form and determine the next date the PCP will be contacted for follow up. That form will be placed in an ACTIVE file with that provider's name, in the ASC office, with a copy to the CM Coordinator (CMC).

The ASC will review those women with the provider staff on a monthly basis to determine if the CM process is completed. Once the process is complete, the CMR form will be documented and moved to an INACTIVE file with the provider's name. If no plan has been established, the PCP must indicate whether the ABCCEDP or they will manage the woman's follow up care. The ASC will document that information on the CMR form. If the ABCCEDP is to do the case management, the assessment process will be initiated and a woman's file will be established in the ASC's office. A copy of the woman's plan will be provided to

the primary provider to be included in the medical record.

Abnormal Results- Women who are screened by an ABCCEDP provider and have abnormal results should be assessed for case management needs. The following are defined as abnormal results:

- **Abnormal CBE-** suspicious for cancer. This includes clinical categories: (3) discrete palpable mass; (4) bloody or serous nipple discharge; (5) Nipple or areola scaliness; and (6) skin dimpling or retraction.
- **Mammography-**Abnormal results include ACR categories: (4) suspicious abnormality, biopsy should be considered; (5) highly suggestive of malignancy, appropriate action should be taken; and (6) assessment is incomplete, need additional imaging evaluation.
- **Pap Test-** Abnormal results include HSIL and squamous cell carcinoma.

A definitive diagnosis of cancer would also require immediate assessment, and in addition, require notification of the ASC. The ASC will notify the state ABCCEDP staff. If the provider believes case management can be accomplished in house, then the documentation may be done directly in the patient chart or on a CMR form and added to the chart.

B. Assessment

Assessment is the process of appraising the need for intervention based on information gathered by the case manager (CM) and objective evaluation of relevant data. Once the woman has been identified and it is determined that ABCCEDP will CM, the ASC will use the CMR form to assess the patient's support system, barriers to care and cultural concerns. Goals will be established, with the woman being encouraged to participate in this process. A copy of the form will be sent to the PCP and a copy maintained in the ABCCEDP patient file. The ASC should also assure that an ABCCEDP consent form has been signed and is on file either at the provider's office, or have the woman sign one at this point. A documented verbal consent for CM services is sufficient to proceed with plan of care, until the written consent is obtained. If the woman refuses case management, a copy of the CMR, with the appropriate documentation, will be sent to the provider and a copy maintained in the woman's file.

C. Planning

Planning for the woman's needs, based on the assessment, is the next essential step in the CM process. A written plan will be developed and documented by the ASC that will define goals, related time frames, and activities, as well as who is responsible for which activity. This can be accomplished on the phone with the woman being involved in the planning. The ASC will be responsible for informing the woman in advance whether or not a service is covered by the ABCCEDP. At this point a copy of the CMR form and the plan will be sent to the PCP, the CMC, and a copy maintained in the woman's ABCCEDP file.

D. Coordination

Coordination is basically a brokerage, coordination, and referral of services to meet the needs of the woman as outlined in the written plan. The ASC will work with the providers and the woman to assist with the coordination of services. These may be related but not limited to, the barriers to care

listed in the patient's assessment, such as transportation, need of an interpreter, child care or elder care, and emotional support.

E. Monitoring

The process of monitoring is an ongoing re-assessment of the quality of care and services provided to the woman and if those services are meeting the woman's needs. The plan will be updated monthly by the ASC to determine if new and continued needs are being met. A copy of the plan with the updated information will be sent to CMC. If there is a problem in obtaining the goals established in the woman's plan, the CMC should be contacted for additional help.

F. Resource Development

The CM should work with the woman to promote self-sufficiency and self-determination. To help accomplish this, the CM should work to assure that women gain the knowledge, skills and support needed to obtain necessary services. In addition, each county health department has an established local resource manual that should be utilized to assist in obtaining any financial resource for non-funded services.

Because of the number of individuals that may be involved in the case management process it is imperative that the professionals involved remain in communication with each other. That would involve the faxing, mailing, or phoning of all information and documentation that is available. **All efforts and activities of the case management process must be DOCUMENTED** and placed in the woman's chart.



GLOSSARY

ADPH	Alabama Department of Public Health
ABCCEDP	Alabama Breast and Cervical Cancer Early Detection Program
ASC	Area Screening Coordinator -The ASC is responsible for the coordination of screening services in designated counties.
BSE or SBE	Breast Self Examination
Central Office Staff	ABCCEDP staff at the State level
CBE	Clinical Breast Examination
CDC	Centers for Disease Control and Prevention
Contract	Legal binding agreement to ABCCEDP enrollees for payment of services rendered between the ADPH and Provider
Enrollee	An eligible woman enrolled in the ABCCED Program
Provider	Refers to a physician, hospital, rural health clinic, ADPH clinic, or laboratory that has agreed to participate in the ABCCEDP, and provide service to women who meet the eligibility requirements
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
Screening Cycle	Cycles begin with a CBE, pelvic examination, Pap smear, referral for mammography and typically conclude with a normal screening result. For a woman with an abnormal screening result, the screening cycle may not be completed until diagnostic work-up, final diagnosis, and treatment data are complete
Screening Provider or Provider	Refers to the health department and primary care facilities, or private primary providers under contract with the Alabama Department of Public Health to provide screening services
Screening Services	Screening services refers to clinical breast exam, Pap smear, pelvic exam, instruction in breast self examination, referral for screening mammogram (if age appropriate) and information and educational services relating to breast and cervical cancer.