FISCAL YEAR 2016

POLICY
and
PROCEDURE
MANUAL

for

Breast and Cervical Cancer Services

Department of State Health Services
Division for Family and Community Health Services

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Introduction

General Information

PURPOSE OF MANUAL

The Department of State Health Services (DSHS) Policy and Procedure Manual for Breast and Cervical Cancer Services (BCCS) is a guide for DSHS contractors who deliver BCCS in Texas. The manual has been structured to provide contractor staff with information needed to comply with BCCS Administrative, Client Services and Community Activities, Reimbursement, Data Collection, and Reporting policies.

To provide BCCS services, contractors are required to be in compliance with specific federal and state laws outlined in the manual. The state rules that apply most specifically to BCCS in Texas are found in the Texas Administrative Code (TAC), Title 25 Part 1, Chapter 61.

PROGRAM AUTHORIZATION AND SERVICES

BCCS is authorized by the Public Health Service Act (PHS Act), Title XV, [42 U.S.C. 300k et seq.] and established by Public Law 101-354, the National Breast and Cervical Cancer Early Detection Program Reauthorization Act of 2007, and amended by 105-340, the Women's Health Research and Prevention Amendments of 1998. The program operates under the Texas Breast and Cervical Cancer Services rules, 25 TAC §§61.31 – 61.42.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gives states the option to provide Medicaid medical assistance to women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer.

The Title V Maternal and Child Health Services Block Grant, authorized by the Social Security Act, enables the BCCS program to provide funds for cervical dysplasia management and treatment services for BCCS-enrolled women.

In 2002, Texas began providing Medicaid to eligible women who are diagnosed with breast or cervical cancer by a DSHS BCCS program contractor, The 80th Texas Legislature adopted Human Resources Code §32.024 (y-1) which authorizes any health care provider to refer eligible women in need of treatment for breast or cervical cancer to Medicaid. Beginning September 1, 2007, any woman diagnosed with breast or cervical cancer who meets all eligibility requirements, as determined by DSHS BCCS policy for Medicaid for Breast and Cervical Cancer (MBCC), may receive Medicaid services.

BCCS enables women with low incomes to have access to high quality screening and diagnostic services for breast and cervical cancer. This is accomplished through an extensive network of contractors, and private and public stakeholders. With the addition of Title V Maternal and Child Health Block Grant funds, DSHS has expanded the Texas program to include cervical dysplasia management and treatment for eligible women.

BCCS CONTRACTOR RESPONSIBILITIES

Contractors shall provide and/or assure the provision of breast and/or cervical cancer screening, diagnostic and support services including tracking, follow-up, case management, and individual client education services. Although BCCS allows provision of diagnostic services, contractors must ensure that program focus and services are primarily for cancer screening, consistent with funding intent. Contractor requirements also include: program management, eligibility determination, initiation of or referral to treatment if clinically indicated, quality management, professional development, recruitment including public education and outreach and data collection, including tracking and follow-up. Collectively, these components will ensure the achievement of performance measures.

Contractors are responsible for the coordination of a client's services from screening to diagnosis. Contractors who have expended their awarded funds shall continue to serve their existing BCCS eligible clients who are currently in the process of an approved care plan. Contractors shall ensure that existing clients receive services from qualified breast and cervical cancer providers to continue client care. **Duplication of BCCS services by multiple contractors will not be reimbursed. Contractors should have procedures in place to verify clients are not receiving services with another BCCS contractor prior to services being rendered.**

All contractors must have an established referral relationship and sub-contract with a qualified provider of each service that the contractor does not provide. All sub-contractors information shall be submitted to DSHS Contract Development and Support Branch (CDSB) at cdsb@dshs.state.tx.us.

Program Management – The purpose of program management is to maximize available resources to implement and maintain BCCS components according to BCCS policies and procedures. Contractors are required to coordinate and administer program activities with supportive management systems.

Eligibility – Contractors are required to determine BCCS eligibility prior to enrolling women and again thereafter.

Screening/Diagnostic Services and Case Management – Contractors must provide a clinical breast examination (CBE) and mammogram to women receiving breast cancer screening. Contractors must provide a clinical breast examination (CBE), pelvic examination, and Pap test to women receiving cervical cancer screening. Each enrolled client will receive individualized education. Clients with abnormal screening or diagnostic test results will be provided with case management services (other than exceptions noted in case management services Section II - Chapter 8). Contractors are required to provide follow-up care to clients with abnormal results, provide dysplasia management and treatment to eligible women, and ensure initiation of treatment for clients with a breast or cervical cancer diagnosis.

Quality Management – Contractors are expected to ensure the quality of services by monitoring performance and identifying opportunities for improvement. Contractors must have policies and procedures to ensure healthcare providers follow evidence-based clinical guidelines and/or provide clinical services consistent with current nationally recognized standards of care.

Professional Development – Contractors are responsible for ensuring health care professionals provide BCCS services competently and with sensitivity to diverse patient cultures.

Recruitment – Contractors must establish and maintain outreach and inreach methods to recruit priority populations.

Data Collection – Contractors are required to comply with and utilize the DSHS integrated, web-based system Med-IT® to collect and process breast and cervical cancer data, including reports and billing in accordance with the business requirements of the program.

Partnerships – Contractors must establish and maintain partnerships with coalitions, community-based organizations and other health and human services agencies that further the goal of providing breast and cervical cancer services in the proposed service area.

Intimate Partner Violence – Intimate partner violence (IPV) describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. Contractors must have a written policy to provide annual staff training related to preventing intimate partner violence. For more information see:

http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html

http://www.womenshealth.gov/publications/our-publications/fact-sheet/screening-counseling-fact-sheet.html

PERFORMANCE MEASURES

Contractors are required to meet BCCS performance measures. The following performance measures are used to assess, in part, the contractor's effectiveness in providing BCCS services:

Screening Indicators

- A minimum of 20% of clients newly enrolled for cervical cancer screening should be women who have not had a Pap test in the last five years.

- A minimum of 75% of all NBCCEDP reimbursed mammograms/MRIs should be provided to program eligible women who are 50 years of age and older and not enrolled in Medicare-Part B.

Cervical Cancer Diagnostic Indicators

- A minimum of 90% of abnormal cervical screening results must have a complete follow-up with no more than 10% lost to follow-up, refused, and/or pending.
- The interval between initial screening and diagnosis of abnormal cervical cancer screenings should be 90 days or less for a minimum of 75% of the women with abnormal results.
- A minimum of 90% of HSIL, CIN II, CIN III, CIS, and invasive cervical cancer diagnoses must have started treatment.
- The interval between diagnosis and initiation of treatment for HSIL, CIN II, CIN III and CIS should be 90 days or less for a minimum of 80% of the women needing treatment.
- The interval between diagnosis and initiation of treatment for invasive cervical cancer should be 60 days or less for a minimum of 80% of the women diagnosed.

Breast Cancer Diagnostic Indicators

- A minimum of 90% of abnormal breast screening results must have a complete follow-up with no more than 10% lost to follow-up, refused, and/or pending.
- The interval between initial screening and diagnosis of abnormal breast cancer screenings should be 60 days or less for a minimum of 75% of women with abnormal results.
- A minimum of 90% of breast cancer diagnoses must have started treatment.
- The interval between diagnosis and initiation of treatment for breast cancer should be 60 days or less for a minimum of 80% of women needing treatment.

Administrative Indicators

- Contractors must serve a minimum of 150 unduplicated clients;
- Contractors must expend a minimum of 95% of the awarded funds;
- Contractors must submit Quarterly Match reports;
- Contractors must comply with and utilize DSHS integrated, web-based system

(Med-IT®) to collect and process breast and cervical cancer data, reports, and financial billing in accordance with the business requirements of the program; and;

- Contractors must enter client data, screening, diagnosis, and/or treatment data into Med-IT® within 30 days of each service provided.

STATE OFFICE RESPONSIBILITIES

In partnership with its contractors, BCCS is responsible for attaining the goals and objectives of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). BCCS achieves program goals and objectives through implementation and monitoring of the following program components: program management, screening and diagnostic services, case management, data management, quality assurance and quality improvement, evaluation, partnerships, and professional development.

Program Management – The purpose of program management is to maximize available resources to implement all BCCS components in accordance with established policies and procedures. The major management activities include:

- Completing annual work plan after final CDC award and submitting reports to CDC on time;
- Awarding and executing all contracts;
- Ensuring the expenditure of at least 95% of BCCS funds and meeting 100% match requirements;
- Performing utilization review of BCCS services provided, ensuring quality services and appropriate use of funding;
- Training all designated PPCU/PMU staff on program components and core performance indicators; and
- Updating and disseminating a BCCS Policy and Procedure Manual.

Screening and Diagnostic Services and Case Management– The purpose of screening and diagnostics is to reduce mortality from breast and cervical cancers by detecting pre-cancerous or cancerous lesions at their earliest stages. BCCS has established requirements for eligibility to ensure eligible women receive BCCS-funded services. Additionally, BCCS staff provides training and technical assistance to contractors to meet CDC standards.

Data Management – The purpose of data management is to ensure availability of high-quality data for program planning, quality assurance, and evaluation. The purpose is also to train and provide technical assistance to contractors.

Quality Assurance and Quality Improvement – The goal of quality assurance is to meet the national Minimum Data Elements (MDE) benchmarks. BCCS coordinates with the DSHS Performance Management Unit (PMU) to ensure timely quality assurance visits, appropriate review of findings, and implementation of plans to correct findings. Quality Management Branch policies and procedures can be found at:

http://www.dshs.state.tx.us/qmb/

Evaluation – The purpose of evaluation is to assess the quality, effectiveness, and efficiency of BCCS implementation and to gather useful information to aid in planning, decision-making and improvement.

Partnerships – The purpose of coalition and partnership building is to expand and maximize resources, coordinate BCCS activities, overcome obstacles to the recruitment of priority populations, and promote the delivery of comprehensive breast and cervical cancer screening services.

Professional Education – The purpose of professional education is to assure that BCCS healthcare and allied health professionals are trained on current breast and cervical cancer screening clinical guidelines.

DEFINITIONS

The following words and terms, when used in this manual, have the following meanings.

Breast Specialist – General surgeons, radiologists, and obstetrician-gynecologists who have completed specialized training for management of breast disease.

Centers for Disease Control and Prevention (CDC) – Federal agency responsible for protecting the health and safety of all Americans, and for providing essential human services, especially for those people who are least able to help themselves. The CDC issues, funds and develops policy for the National Breast and Cervical Cancer Early Detection Program.

Cervical Dysplasia (CD) Management and Treatment Services – Management and treatment services provided to women with biopsy-confirmed abnormal cervical test results.

Client – An individual who has been screened and has successfully completed the eligibility process.

Consultation – A type of service provided by a physician with expertise in a medical or surgical specialty, and who upon request of another healthcare provider assists with the evaluation and/or management of a patient.

Contractor – The entity Department of State Health Services (DSHS) has contracted with to provide services. The contractor is the responsible entity to DSHS even if there is a subcontractor that delivers all or a portion of the services.

Disease Surveillance (for BCCS and MBCC purposes) – Periodic monitoring for disease progression in order to quickly identify and treat pre-cancerous and cancerous conditions.

Department of State Health Services (DSHS) – The state agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

Diagnosis – The recognition of disease status determined by evaluating the history of the client, the disease process, and the signs and symptoms present. Determining the diagnosis may require microscopic (i.e. specimen evaluation), chemical (i.e. blood tests), and/or radiological examinations (i.e. x-rays).

Federal Poverty Level (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

Good Faith Effort –Making at least three (3) separate documented attempts to obtain treatment for clients with a pre-cancerous or cancerous breast or cervical diagnosis who do not meet the eligibility criteria for BCCS Title V Cervical Dysplasia and/or MBCC Presumptive. Examples of good faith efforts include, but are not limited to seeking service(s) for clients through: American Cancer Society, Susan G. Komen for the Cure, LIVE**STRONG** or other healthcare providers and facilities through pro-bono, sliding fee scale, reduced payment plan, or sponsorship assistance.

Health and Human Services Commission (HHSC) –The state agency that has oversight responsibilities for designated Health and Human Services agencies, including DSHS, and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program (CHIP), and Medicaid waste, fraud, and abuse investigations.

Health Service Region (HSR) – For administrative purposes, DSHS has grouped counties within a specified geographic area into 8 Health Service Regions.

Informed Consent – The process by which a health care provider ensures that the benefits and risks of a diagnostic test, procedure or treatment plan are explained to the patient in a manner that is understandable. This process allows the patient to participate and make sound decisions regarding their own medical care. The benefits and risks of alternative options or taking no action must be included.

In-reach - Activities that are conducted with the purpose of informing and educating existing clients within an organization about services they are not receiving, but may be eligible to receive.

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Medicaid for Breast and Cervical Cancer (MBCC) – Reference to the federal law (Breast and Cervical Cancer Prevention and Treatment Act of 2000) that authorizes states to provide medical assistance through Medicaid for treatment to eligible women who are screened under the scope of Title XV as provided for in Senate Bill 10, 80th Texas Legislature and are found to be in need of treatment for qualifying breast or cervical diagnoses.

Minimum Data Elements (MDE) – A set of standardized data elements developed by CDC to monitor clinical services provided to BCCS-enrolled women.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – A federal program administered by the CDC that awards funds to grantees to help women who are low-income, uninsured, and underserved to gain access to screening for early detection of breast and cervical cancer.

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of clients.

Patient Navigation – Patient Navigation services refer to an individualized approach for each BCCS enrolled woman with an abnormal screening (other than exceptions noted in patient navigation services, Section II, Chapter 8 - page 108), diagnostic result or diagnosis of cancer, which involves establishing, brokering, and sustaining a system of available clinical and essential support services.

Provider – An individual clinician or group of clinicians who provide services.

Referral – The process of directing or redirecting (as a medical case or a patient) to an appropriate clinical or non-clinical resource.

Underinsured – Having medical insurance which does not provide coverage for all medical needs and/or has high insurance deductibles, co-pays or co-insurance which the client is unable to meet.

ACRONYMS LIST	
Acronym	**Term**
AGC	Atypical Glandular Cells
ASC-H	Atypical Squamous Cells: Cannot exclude High-grade Squamous Intraepithelial Lesion
ASC-US	Atypical Squamous Cells of Undetermined Significance
BCCS	Breast and Cervical Cancer Services
CAD	Computer Aided-Detection
CCMF	Comprehensive Case Management Form
CD	Cervical Dysplasia (see definitions)
CDC	Centers for Disease Control and Prevention
CDSB	DSHS Contract Development and Support Branch
CIN	Cervical Intraepithelial Neoplasia
CLIA	Clinical Laboratory Improvement Amendments
CMB	DSHS Contract Management Branch
CMS	Centers for Medicare and Medicaid Services
DES	Diethylstilbestrol
DHHS	U.S. Department of Health and Human Services
DSHS	Department of State Health Services
EC	Endocervical
ECC	Endocervical Curettage
EMR	Electronic Medical Record
FPL	Federal Poverty Level
HIPAA	Health Insurance and Portability Accountability Act
HHSC	Health and Human Services Commission
HHS	Texas Health and Human Services
HPV	Human Papillomavirus
HSIL	High-grade Squamous Intraepithelial Lesion
HSR	DSHS Health Service Region
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	Limited English Proficiency
LSIL	Low-grade Squamous Intraepithelial Lesion
MBCC	Medicaid for Breast and Cervical Cancer
MDE	Minimum Data Elements
MED-IT	Online Medical Information Tracking
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NILM	Negative for Intraepithelial Lesion or Malignancy
QMB	DSHS Quality Management Branch
RFP	Request for Proposal
STL	South Texas Lab
TAC	Texas Administrative Code
TMHP	Texas Medicaid Healthcare Partnership
TWHP	Texas Women's Health Plan
TZ	Transformation Zone

Section I
Administrative Policies

CLIENT ACCESS

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services;
- Comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, and ensure services are accessible to persons with Limited English Proficiency (LEP) and speech or sensory impairments. http://www.lep.gov/;
- Have a policy in place that requires qualified staff to assess and prioritize client's needs;
- Provide referral resources for individuals that cannot be served or cannot receive a specific service; and
- Manage funds to ensure that established clients continue to receive services throughout the budget year.

ABUSE AND NEGLECT REPORTING

DSHS contractors shall comply with state laws governing the reporting of abuse and neglect. Contractors must have an agency policy regarding abuse and neglect. It is mandatory to be familiar with and comply with adult and child abuse and neglect reporting laws in Texas.

To report abuse or neglect, call **1- 800- 252- 5400** or use the secure website: **http://www.txabusehotline.org/**

CLIENT RIGHTS

CONFIDENTIALITY

All contracting agencies must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy. Information about HIPAA can be found at: **http://www.hhsl.gov/ocr/hipaa/**

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties.

The client's preferred method of follow-up for clinic services (cell phone, email, work phone) and preferred language must be documented in the client's record (See Client Health Record - Section II, Chapter 3).

Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means (kept private and not shared without permission) and any applicable exceptions such as abuse reporting (See Abuse and Neglect Reporting - Section I, Chapter 2).

NON-DISCRIMINATION

DSHS contractors must comply with state and federal non-discrimination laws and regulations, including without limitation:

- Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
- Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681 *et seq.*);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq*.);
- Administrative rules for HHS agencies as set forth in the Texas Administrative Code.

More information about non-discrimination laws and regulations can be found in the HHSC Civil Rights Office website at: http://www.hhsc.state.tx.us/about_hhsc/civil-rights/.

Contract Terms and Conditions

To ensure compliance with non-discrimination laws, regulations, and policies, contractors must:

- Sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations;

- Have a written policy that states the contractor does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or sexual orientation (not all bases apply to all programs);
- Ensure that all contractor staff is trained in the contractor's non-discrimination policies, including policies for serving clients with LEP, and HHS complaint procedures;
- Notify all clients and applicants of contractor's non-discrimination policies and complaint procedures; and
- Notify the HHSC Civil Rights Office of any discrimination allegation or complaint related to its programs and services no later than ten (10) calendar days after receipt of the allegation or complaint.

Send notices to:

HHSC Civil Rights Office
701 W. 51st Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885

Limited English Proficiency

To ensure compliance with civil rights requirements related to LEP, contractors must:

- Take reasonable steps to ensure that persons with LEP have meaningful access to its programs and services, and not require them to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter at the client's request, and the family member or friend does not compromise the effectiveness of the service nor violate client confidentiality, and
- Make clients and applicants with language service needs, including persons with LEP and disabilities, aware that the contractor will provide an interpreter free of charge.

Civil Rights Posters

Contractors must prominently display the following three posters in client common areas, including lobbies and waiting rooms, front reception desk, and locations where clients apply for services:

"Know Your Rights" [English] [Spanish]
Size: 8.5" x 11" (standard size sheet of paper).
Posting Instructions: Post the English and Spanish versions of this poster next to each other.
Questions: Contact the **HHSC Civil Rights Office**.

"Need an Interpreter" [Language Translation] [American Sign Language]
Size: 8.5" x 11" (standard size sheet of paper).
Posting Instructions**:** Post the "Language Translation" version and "American Sign Language" version next to each other.
Questions: Contact the **HHSC Civil Rights Office**.

"Americans with Disabilities Act"
[English B] [Spanish B]
Size: 8.5" x 11" (standard size sheet of paper).
Posting instructions: Post with other civil rights posters.
Questions: Contact the **HHSC Civil Rights Office**.

The posters are located at:
http://www.hhsc.state.tx.us/about_hhsc/civil-rights/brochures-posters.shtml

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

Civil Rights Survey

Contractors can use the Self-Assessment for Civil Rights Compliance to conduct a self-assessment concerning civil rights compliance, and have copies available of the survey.

The survey can be downloaded from the Quality Management Branch (QMB) website at: http://www.dshs.state.tx.us/qmb/contractor.shtm

Questions concerning the self-assessment can be directed to the DSHS Quality Management Branch.

TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay.

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the contractor's ability to provide services or if the client's behavior jeopardizes the safety of himself or herself, clinic staff, or other clients.

Any policy related to termination of services must be included in the contractor's policy and procedures manual.

RESOLUTION OF COMPLAINTS

Contractors must ensure that clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner.

Contractors' policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received. If an aggrieved client requests a hearing, a contractor shall not terminate services to the client until a final decision is rendered.

Any client complaint must be documented in the client's record.

RESEARCH (HUMAN SUBJECT CLEARANCE)

Contractors considering clinical or sociological research using BCCS clients as subjects, the use of BCCS client records, or any data collection from BCCS clients, must obtain prior approval from their own internal Institutional Review Board or the Texas Department of State Health Services Institutional Review Board (IRB).

Contractors should first contact BCCS to initiate a research request. Next, contractors should complete the most current version of the DSHS IRB application and submit it to BCCSProgram@dshs.state.tx.us. The DSHS IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from BCCS and the DSHS IRB prior to instituting any research activities. The contractor must also insure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained. Further information on the DSHS IRB may be found at: **http://www.dshs.state.tx.us/irb.**

PATIENT RECORDS MANAGEMENT

DSHS Contractors must have an organized and secure patient record system. The contractor must ensure that the record is organized, readily accessible, and available to the patient upon request with a signed release of information. The record must be kept confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use and inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility, as well as during transfer between clinics and in between home and office visits.

The written consent of the patient is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law; see **http://www.dshs.state.tx.us/hivstd/policy/laws.shtm**.

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, patients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in Title 1, Part 15 TAC §354.1003 (relating to Time Limits for Submitted Claims) and Title 22, Part 9 TAC §165 (relating to Medical Records). Contractors must follow contract provisions and the DSHS Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of DSHS and as required by law. DSHS guidelines for medical record retention are available at:
http://www.dshs.state.tx.us/records/medicalrec.shtm

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that all staff are hired, trained, and evaluated appropriately for their job position. Personnel policies and procedures must include job descriptions, a written orientation plan for new staff, and performance evaluation process for all staff. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Contractors must show evidence that employees meet all required qualifications and are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling, and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.

Contractors must ensure that all medical services (including screening & eligibility, direct client care, QA/Quality Management, and oversight of clinical services) are provided under the supervision, direction, and responsibility of a Medical Director who is a Texas licensed physician.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- Training needs;
- Quality assurance indicators; and
- Changing regulations/requirements.

Contractors must also include orientation and in-service training for all personnel, including volunteers. There must be documentation of initial employee orientation and continuing education.

FACILITIES AND EQUIPMENT

DSHS contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the following:

Hazardous Materials –

- The handling, storage, and disposing of hazardous materials and waste according to applicable laws and regulations;
- The handling, storage, and disposing of chemical and infectious waste, including sharps; and
- An orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety –

- Schedule for testing and maintenance of fire safety equipment; and
- Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment –

- Maintain documentation of the maintenance, testing, and inspection of medical equipment, including AED's. Documentation must include:
    - Assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
    - Reports of any equipment management problems, failures, and use errors;
    - An orientation and education program for personnel who use medical equipment; and
    - Manufacturer recommendations for care and use of medical equipment.

Smoking Ban –

Written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must also comply with this policy.

Emergency Action Plan –

- *Maintain written and/or oral emergency action plans.*
    - An emergency action plan must be in writing, kept in the workplace, and available to employees for review.
    - An employer with 10 or fewer employees may communicate the plan orally to employees.

For additional resources on facilities and equipment visit **http://osha.gov/**.

QUALITY MANAGEMENT

Organizations that embrace Quality Management (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations discover a very powerful management tool. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on the four core Quality Management principles:

- The client;
- Systems and processes;
- Measurements; and
- Teamwork.

Contractors must have a Quality Management program individualized to their organizational structure and based on the services provided. The goals of the quality management program should ensure availability and accessibility of services, quality and continuity of care.

A Quality Management program that provides ongoing evaluation of services must be developed, implemented and have a comprehensive plan for:

- Internal review, measurement and evaluation of services;
- Analysis of monitoring data; and
- Development of strategies for improvement and sustainability.

Contractors who subcontract for the provision of services they do not provide must also address in the comprehensive plan how the quality of subcontracted services will be evaluated and how compliance with DSHS policies and basic standards will be assessed with the subcontracting entities.

The Quality Management Committee, whose membership consists of key leadership of the organization (including the Executive Director/CEO, Texas licensed Medical Director, Clinical Director , and a representative from nursing, eligibility, billing and case management), annually reviews and approves the quality work plan for the organization.

The Quality Management Committee must meet at least quarterly to:

- Receive reports of monitoring activities;
- Make decisions based on the analysis of data collected;
- Determine quality improvement actions to be implemented; and
- Reassess outcomes and goal achievement.

Minutes of the discussion and actions taken by the committee must be maintained and made available during Quality Assurance/Quality Improvement site reviews.

The comprehensive quality work plan at a minimum must:

- Include clinical and administrative standards by which services will be monitored;
- Include process for credentialing and peer review of clinicians;
- Identify individuals responsible for implementing monitoring, evaluating and reporting;
- Identify individuals responsible for results of internal monitoring and/or monitoring activities;
- Establish timelines for quality monitoring activities;
- Identify tools/forms to be utilized; and
- Outline reporting to the Quality Management Committee.

Although each organization's quality program is unique, the following activities must be undertaken by all agencies providing client services:

- On-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care;
- Tracking and reporting of adverse outcomes;
- Annual client satisfaction surveys, including an evaluation process;
- Annual review of facilities to maintain a safe environment, including an emergency safety plan; and
- Annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current.

Data from these activities must be presented to the Quality Management Committee. Plans to improve quality should result from data analysis and reports submitted by the committee, and should be documented.

Information on DSHS's Quality Management Branch, as well as policies and review tools, are located at http://www.dshs.state.tx.us/qmb/default.shtm.

CARE IN AMBULATORY SURGICAL CENTERS:

- Contractors are responsible for ensuring clients receive services that are of high quality and safe;
- Ambulatory surgical centers providing services for BCCS clients must be CMS certified, state licensed, and JCAHO accredited as applicable; see the directory of licensed ambulatory surgical centers at: http://www.dshs.state.tx.us/HFP/apps.shtm#directoryASC;
- The contractor must ensure that its subcontractor maintains certification to receive BCCS funds.

MAMMOGRAPHY QUALITY ASSURANCE - All BCCS Contractors and subcontractors providing mammography services must:

- Possess a current Certification of Mammography Systems from DSHS Regulatory Licensing Unit, Mammography Certification Program (each mammography unit must be fully accredited or undergoing accreditation); and

- Possess a current mammography facility certificate from the appropriate agency certifying compliance with the U.S. Food and Drug Administration Mammography Quality Standards, Final Rules, 21 CFR Part 900.

The DSHS Regulatory Licensing Unit, Mammography Certification Program can be contacted at (512) 834-6688 for certification questions. Information on inspection results, escalated enforcement, or "cease and desist" status may be directed to the Custodian of Records at (512) 834-6688, extension 2202. **The BCCS program will not reimburse for services provided by a mammography provider with "escalated enforcement" status or "cease and desist" status.**

CYTOLOGY QUALITY ASSURANCE – Contractors and subcontracting entities for screening and diagnostic cytology services must have current documentation that the agency meets all quality assurance standards required by the BCCS program as established under state and federal laws.

All cytology laboratories providing services to BCCS contractors/subcontractors must:

- Possess a current, unrevoked, and unsuspended registration certificate issued by the U.S. Department of Health and Human Services (DHHS) under the terms of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88);
- Use the 2001 Bethesda System for Reporting Cervical/Vaginal Cytological Diagnoses; and
- The lab must have a mechanism for expedited notification of Pap tests which are CIN III or greater, such that the clinic is notified no later than the next business day after the case is signed out.

HPV Quality Assurance

Contractors must assure the following for all HPV tests:

- Must be for high-risk oncogenic types, and
- Must be FDA approved and clinically validated.

NOTE: BCCS funds cannot be used for reimbursement of HPV genotyping

UTILIZATION REVIEW

To ensure clients receive high quality care and funds are expended according to program policies, BCCS performs utilization review of billed services. Contractors not in compliance with utilization guidelines may be required to refund the BCCS program for services inappropriately billed at the end of the fiscal year.

Section II
Client Services and Community Activities

GENERAL ELIGIBILITY

For an individual to receive BCCS services, three (3) general criteria must be met:

- Gross household income at or below 200% of the adopted Federal Poverty Level (FPL)**;** and
- Applicant is a Texas resident; and
- Not eligible for other programs/benefits providing the same services.

Other eligibility factors:

- BCCS is the payer of last resort, and shall only be used if no other funding sources are available.
- Undocumented applicants who meet the general eligibility criteria are eligible for the BCCS program.
- Applicant must meet age-specific eligibility criteria for screening and diagnostic services.
- Applicants seeking BCCS services may be dual eligible for other DSHS funded programs providing the same or similar services, such as Expanded Primary Healthcare or DSHS Family Planning (e.g. Pap tests and clinical breast exams). In such cases, it is up to the contractor to determine the best use of funds within their agency to meet the client's needs.

Enrollment Date - Clients are eligible to start receiving services beginning with the date the completed application is submitted and the client is determined eligible. **No presumptive eligibility can be made for screening and diagnostic services**. Services rendered prior to the date the client is determined eligible will not be reimbursed.

NOTE: The clinical criteria related to eligibility are in the breast and cervical clinical guidelines chapters – Section II, Chapters 4-6.

CONTRACTOR RESPONSIBILITIES

Contractors must develop a policy to determine BCCS eligibility. The policy shall be available during Quality Assurance (QA) visits and must address the following:

- What documents will be requested for verification of household income at or below 200% FPL (income must be recorded in client record and Med-IT);
- Use of the DSHS Family & Community Health Services (FCHS) Division Individual Eligibility Form (Form EF05-14215) or the Household Eligibility Form (Form EF05-14214) and the Household Eligibility Worksheet (Form EF05-13227);(Appendix A); or;
- Use of a comparable paper or electronic screening and eligibility tool with required DSHS information. If a comparable eligibility screening tool is being used, it must be reviewed and approved by DSHS staff before use. Contractors must use DSHS eligibility screening forms until approval to use a comparable form is received. Contractor must maintain/retain proof of approval and shall make the approval available during QA visits.

Contractor eligibility policy must also ensure that:

- Clients do not have access to insurance or screening and diagnostic resources;
- Client insurance status is assessed before each clinical service;
- BCCS eligibility is determined prior to enrollment and annually thereafter;
- Clients age 65 and over do not meet eligibility unless client is ineligible or unable to pay premiums for Medicare Part B.

If a client cannot afford the additional expense of Medicare Part B Premiums, Medicaid-sponsored Medical Savings Programs may pay Medicare premiums, deductibles, and coinsurance amounts for eligible Medicare beneficiaries. The Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, the Qualified Individuals (QI-1), and the Qualified Disabled Working Individuals (QDWI) are all called Medical Savings Programs. The following link provides program information, updates, qualifications, and application information: **http://www.tdi.state.tx.us/CONSUMER/hicap/hicapnews400.html**. More information about Medicare reference the following website: **http://www.medicare.gov/**

SCREENING AND ELIGIBILITY DETERMINATION

Use the Family & Community Health Services (FCHS) Division Individual Eligibility Form (Form EF05-14215) or the Household Eligibility Form (Form EF05-14214) and the Household Eligibility Worksheet (Form EF05-13227) (Appendix A) or a comparable DSHS approved screening and eligibility tool.

- The applicant is responsible for completing the Family & Community Health Services (FCHS) Division Individual Eligibility Form (Form EF05-14215) or the Household Eligibility Form (Form EF05-14214).If assistance is needed to complete the form, the contractor shall provide knowledgeable staff to assist.
- One form may be completed for all household members being screened for eligibility when using the Household Eligibility Form (Form EF05-14214). To expedite the process, it is acceptable to fill out the form once and photocopy the form for the number of household members needed. The household member's name listed under the household composition chart in Part II can be highlighted/circled to indicate the intended client record in which the form will be filed. Each BCCS eligible client, who is a legal adult, is required to sign and date the form. The signature and date of anyone assisting the applicant to complete the form are also required. The form is filed in the client record.
    - Contractor completes the DSHS Household Eligibility Worksheet (Form EF05-13227), or a comparable screening and eligibility tool containing the same information approved by DSHS.

Special circumstances may occur in the disclosure of information, documentation of pertinent facts, or events surrounding the applicant's application for services that make decisions and judgments by the contractor's staff necessary. These circumstances must be documented on the Family & Community Health Services (FCHS) Division Individual Eligibility Form (Form EF05-14215) or the Household Eligibility Form (Form EF05-

14214), the DSHS Household Eligibility Worksheet (Form EF05-13227), if applicable, filed in the client record.

Special circumstances must also be documented in the Med-IT Data System in the notes section of the enrollment screen.

Household Composition – Establishing household size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of household members. A household is defined as a person living alone or a group of two or more persons related by birth, marriage (including common law), or adoption, which reside together and are legally responsible for the support of the other person.

The contractor has discretion to document special circumstances in the calculation of household composition. Additionally, if a separate household group is established within the applicant's household based on the documentation gathered, document the basis used for determining separate households on the DSHS Eligibility Forms EF05-14214 or EF05-14215, DSHS Household Eligibility Worksheet (Form EF05-13227) if applicable, and in the Med-IT Data System.

Residency – To be eligible for BCCS, an individual must be physically present within the geographic boundaries of Texas (there is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purposes of BCCS eligibility) and:

- Has the intent to remain within the state, whether permanently or for an indefinite period; and
- Does not claim residency in any other state or country; and/or
- If less than 18 years of age his/her parent, managing conservator, or guardian is a resident of Texas.

Income – To be eligible for BCCS services, applicants must provide verification of **gross** household income at or below 200% FPL. If the applicant is unable to provide verification, income may be self-declared by the applicant. Documentation of why an applicant self-declared income must be in the client record and in the Med-IT Data System.

Note: <u>Applicants seeking Medicaid for Breast and Cervical Cancer (MBCC) may not self-declare income.</u> This includes women who have been diagnosed with a qualifying cancer by BCCS contractors or other health care providers**.** Any applicant who will be assisted by a BCCS contractor to apply for MBCC must have verification of income documented in her client record and on the eligibility screen in Med-IT.

Calculation of Applicant's Federal Poverty Level Percentage

1. Determine the applicant's **household** size.
2. Determine the applicant's **total monthly income** amount.

3. Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
4. Multiply by 100%.

The maximum monthly income amounts by household size are based on the **Department of Health and Human Services federal poverty guidelines**. The guidelines are subject to change around the beginning of each calendar year.

Count income already received and any income the household expects to receive.

- Count terminated income in the month it was received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Income Deductions - Dependent care expenses and payments made by a member of the household group shall be deducted up to the allowable amount:

- Legally obligated child support payments;
- $200.00 per child per month for children under age 2;
- $175.00 per child per month for children age 2-17; and
- $175.00 per dependent adult with disabilities per month age 18 and over.

When income is received in lump sums more than once a year or at longer intervals than monthly, at irregular intervals, (i.e. contract labor, seasonal employment, lump sums, etc.) the total amount received will be divided over the period of time the income is expected to cover household expenses in order to determine a monthly income. For seasonal income, count the total income for the months worked in the overall calculation of income.

If actual or projected income is not received monthly or at irregular intervals, convert it to a monthly amount using one of the following methods:

(1) weekly income x 4.33;

(2) every two weeks x 2.17;

(3) twice a month x 2.0 ;(4) annually ÷ 12.

The table below details sources of earned and unearned income that contribute to the calculation of gross household income as well as income that is exempt from being counted.

Types of Income	Countable	Exempt
Alimony*	X	
Adoption Payments		X
Cash Gifts and Contributions*	X	
Child Support Payments*	X	

Child's Earned Income		**X**
Crime Victim's Compensation *		**X**
Disability Insurance Benefits	**X**	
Dividends, Interest, and Royalties*	**X**	
Educational Assistance*		**X**
Energy Assistance		**X**
Foster Care Payment		**X**
In-kind Income		**X**
Job Training		**X**
Loans (Non-educational)*	**X**	
Lump-Sum Payments*	**X**	**X**
Military Pay*	**X**	
Mineral Rights*	**X**	
Pensions and Annuities*	**X**	
Reimbursements*	**X**	
RSDI /Social Security Payments*	**X**	
Self-Employment Income*	**X**	
SSDI	**X**	
SSI Payments	**X**	
TANF	**X**	
Unemployment Compensation*	**X**	
Veteran's Administration*	**X**	**X**
Wages and Salaries, Commissions*	**X**	
Worker's Compensation*	**X**	

Explanation of countable income provided below

Alimony – Count support payment(s) to a divorced person by a former spouse.

Cash Gifts and Contributions – Count unless they are made by a private, non-profit organization on the basis of need and total $300.00 or less per household in a federal fiscal quarter (Janaury – March, April – June, July – September, October – December). If these contributions exceed $300.00 in a federal quarter, count the excess amount as income in the month received. Count periodic cash support payments from friends or relatives if received more than three times a year.

Child Support Payments – Count income after subtracting the maximum dependent care deduction from the total monthly income the household receives.

Disability Insurance Payments/SSDI – Countable. Social Security Disability Insurance is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest and Royalties – Countable. Exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

Educational loans, grants – includes money received as scholarships by students for educational purposes. Count only that part actually used for current living costs.

In-Kind Income – Exempt. An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational) – Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments – Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay- Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights – Countable. A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc…

Pensions and Annuities – Countable. A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Public assistance or welfare payments – Count TANF, refugee assistance, SSI, and/or general assistance (cash payments from a county or city).

Reimbursements – Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI/Social Security Payments – Count the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income – Count total gross earned, minus the allowable costs of producing the self-employment income.

Terminated Employment – Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments – Count the gross benefit less any amount being recouped for a UIB overpayment.

VA Payments – Count only the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions – Count the actual (not taxable) gross amount.

Worker's Compensation – Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

ADJUNCTIVE ELIGIBILITY

An applicant is considered adjunctively (automatically) **financially** eligible for BCCS services at an initial or renewal eligibility screening if she or a member of her household **<u>is currently enrolled</u>** in at least one of the programs listed below. An applicant must be

able to provide proof of active enrollment in the adjunctively eligible program and contractors must verify enrollment. If an applicant's current enrollment status cannot be verified during the eligibility screening process, adjunctive eligibility cannot be granted and the contractor would then proceed with determining eligibility according to the usual process.

PROGRAM	ACCEPTED DOCUMENTATION
Children's Health Insurance Program (CHIP) Perinatal	CHIP Perinatal benefits card
Medicaid for Pregnant Women	"Your Texas Benefits" card (Medicaid card)*
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	WIC verification of certification letter, printed WIC-approved shopping list or recent WIC purchase receipt with remaining balance
Supplemental Nutrition Assistance Program (SNAP)	SNAP eligibility letter
Texas Women's Health Program (TWHP)	"Your Texas Benefits" card (Medicaid card)*

*Note: Presentation of the "Your Texas Benefits" card does not completely verify current eligibility in the Medicaid for Pregnant Women program. To verify eligibility, contractors can go to www.YourTexasBenefitsCard.com, call TMHP at 1-800-925-9126, or access TexMedConnect on the TMHP website at www.tmhp.com to enter or give the applicant's Medicaid ID number (PCN) as listed on the card.

A copy of the accepted documentation must be kept in the client's record and available during QA reviews.

CLIENT FEES

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill clients for services outside the scope of BCCS allowable services, if the service is provided at the client's request and the client is made aware of his/her responsibility for paying the charges prior to services being rendered.

Continuation of Services

Contractors who have expended their awarded funds must continue to serve their existing eligible clients who are currently in the process of a care plan. It is allowable to obtain other funding to pay for these services.

Contractors who have expended their BCCS and/or Cervical Dysplasia (CD) Management and Treatment funds are not required to enroll new BCCS or CD clients. However, it is allowable to offer services at full-pay or on a sliding scale basis.

MED-IT® DATA AND BILLING SYSTEM

Before entering a woman into the Med-IT® database, contractors must determine whether the woman has ever received services funded by BCCS and has an existing Med-IT® ID (a unique number assigned to each BCCS client) by doing a client search. This process can be completed by entering patient identifiers, which may include name, date of birth, and/or social security number.

Minimum PC Requirements for Med-IT® are:

- Any internet connection – for optimum performance and response time, contractor locations should have access to a broadband connection with a minimum of 1 MB upload speed and 2 MB download speed; and
- Microsoft Internet Explorer 11.0.

GENERAL INFORMED CONSENT

Contractors must obtain the client's written, informed, voluntary general consent to receive services prior to receiving any clinical services. A general informed consent explains the types of services provided and how client information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a client does not receive services, a new general consent must be signed prior to resuming delivery of services.

All women who are enrolled in BCCS or referred to a BCCS contractor for diagnostic evaluation must sign a general informed consent that authorizes the contractor to enter or view protected health information and client data in the statewide database. If this statement is not included in the general consent, an additional consent must be developed for the client to sign and include with the general consent in the patient health record.

All women referred to a BCCS contractor with a qualified breast or cervical cancer diagnosis that results in a completed application for medical assistance for MBCC must also sign a general informed consent that addresses case management, confidentiality, and authorization to enter or view protected health information and client data in the statewide database.

CLINICAL INFORMED CONSENT

Consent information must be effectively communicated to every client in a manner that is understandable by that client and allows her to participate and make sound decisions regarding her own medical care. Communication must be in compliance with Limited English Proficiency regulations and address any disabilities that impair communication. Only the client may consent. For situations when the client is legally unable to consent (i.e., a minor or an individual with development disability), a parent, legal guardian or caregiver must consent. Consent must never be obtained in a manner that could be perceived as coercive.

In addition, the contractor must obtain the client's informed consent for procedures as required by the Texas Medical Disclosure Panel. DSHS contractors should consult a qualified attorney to determine the appropriateness of the consent forms utilized by their health care agency.

TEXAS MEDICAL DISCLOSURE PANEL CONSENT

The Texas Medical Disclosure Panel (TMDP) was established by the Texas Legislature to:

- Determine which risks and hazards related to medical care and surgical procedures must be disclosed to patients (or persons authorized to consent) by health care providers/physicians; and
- Establish the general form and substance of such disclosure.

TMDP has developed a list of procedures that require full and specific disclosure (List A) for certain procedures. More information about the TMDP can be found at: **http://www.dshs.state.tx.us/hfp/tmdp.shtm**

List A Procedures can be found at the following Texas Administrative Code (TAC) link: **http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=7&ch=601&rl=2**

With regard to conization of the cervix, a List A procedure, the TMDP **required Disclosure and Consent Form** for contractors who directly perform the procedure can be found at: **http://info.sos.state.tx.us/fids/200504268-1.html**

The required disclosures for conization of the cervix are:
a. Hemorrhage with possible hysterectomy to control;
b. Sterility;
c. Injury to the bladder;
d. Injury to rectum; or
e. Failure of procedure to remove all of cervical abnormality.

For all other procedures not listed on List A, the physician must disclose, through a procedure specific consent, all risks that a reasonable patient would want to know about. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

BCCS CONTRACTOR CLINICAL RESPONSIBILITIES

Contractors are required to:

- Accept appropriate referrals for breast and cervical cancer diagnostic services;
- Provide follow-up and navigation of clients with abnormal results (as stated in Introduction –page ii);
- Assist eligible clients in applying for MBCC, including eligible clients diagnosed outside the BCCS program;
- Ensure BCCS-enrolled clients who are not MBCC eligible have access to treatment, which may include Cervical Dysplasia (CD) treatment services;
- Make a “Good Faith Effort” as defined by BCCS to identify treatment services;
- Communicate with clinical providers regarding the benefits and requirements of the BCCS program; and
- Provide and document monitoring and oversight of subcontractors and subcontracted services to ensure compliance with DSHS policies and standards.

PATIENT HEALTH RECORD (MEDICAL RECORD)

Contractors must ensure that a patient health record (medical record) is established for every client who obtains BCCS services.

All patient health records must be:

- Complete, legible, and accurate documentation of all clinical encounters, including those by telephone;
- Written in ink without erasures or deletions or documented within an Electronic Medical Record (EMR);
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry;
  - Electronic signatures are allowable to document provider review of care. However, stamped signatures are not allowable.
- Readily accessible to assure continuity of care and availability to patients; and
- Systematically organized to allow easy documentation and prompt retrieval of information.

The patient health record must include:

- Client identification and personal data (including documentation of eligibility);
- Preferred language/method of communication;
- Patient contact information with the best way to reach patient in such a manner that facilitates continuity of care, assures confidentiality, and adheres to HIPAA* regulations;
- Medical history;
- Physical examination;
- Laboratory and other diagnostic tests orders, results, and follow-up;
- Assessment or clinical impression;
- Plan of care, including education/counseling, treatment, special instructions,

scheduled visits; and referrals;
- Informed consent documentation;
- Refusal of services documentation;
- Medication and other allergic reactions recorded prominently in specific location;
- Problem list; and
- Client education

Note A client health record does not have to be established for presumptive eligibility determination of Medicaid for Breast and Cervical Cancer (MBCC) applicants or CD treatment services *only* applicants. For these women, the BCCS contractor shall establish a Case Management Record as determined in Section II – Chapter 8 Case Management Services.

**Health Insurance Portability and Accountability Act of 1996*

BREAST CANCER SCREENING SERVICES

Breast Cancer Screening Services Eligibility – Screening refers to procedures such as clinical breast examination (CBE) and mammogram for women who present without symptoms suspicious for breast cancer.

BCCS reimbursement guidelines for mammography screening:

- Ages 50 and older: Women should be screened annually;
- Ages 40-49: Asymptomatic women ages 40-49 may be screened every two years.
    - Women ages 40-49 considered high risk *per established breast cancer risk assessment tools* (e.g., BRCAPRO, Gail Model) may be screened annually.

      Note: Contractors must document high-risk assessment and any screening guideline exceptions for women ages 40-49 within Med-IT cycle notes.
- Ages under 40: Asymptomatic and without a history of breast cancer are not eligible for breast cancer screening services.

COMPONENTS OF BREAST CANCER SCREENING

The contractor must provide a complete breast cancer screening, which includes at least a clinical breast examination (CBE), mammogram, individualized client education, tobacco use assessment and Quit Line referral, if indicated. CDC performance measures require that the CBE precede the screening mammogram, which should occur within 60 days.

Clinical Breast Examination (CBE) – CBEs must be performed by a physician, physician's assistant, nurse practitioner, certified nurse midwife, or additionally a qualified registered nurse with specialized training as required under standing delegation orders (SDO). The specialized RN CBE training must be documented in the personnel record (e.g. an educational certificate/degree or continuing education). Complete documentation of the CBE must be included in the patient health record and Med-IT. A second CBE is not required for women referred to a BCCS contractor after an abnormal CBE or screening mammogram.

A breast health history must be included as part of the breast cancer screening. The health history includes:

- Date and time intervals of previous mammograms;
- Date and results of the last CBE;
- Date and results of any previous breast surgery;
- Date of last menstrual period;
- Medication history, including current or previous use of hormones (hormone replacement therapy, oral contraceptives, etc.);

- Other risk factors for breast cancer (personal history of breast cancer, or family history of first degree relatives with breast cancer); and
- Description of breast symptoms, if any.

Screening Mammogram – Breast tissue must be present to perform screening or diagnostic mammograms.

Screening Mammogram: Special Circumstances
Additional views as used with a diagnostic mammogram (4-6 specified diagnostic views) can be used under the following special circumstances:
- Women with cosmetic or reconstructive breast implants; and/or
- Women with history of breast cancer and lumpectomy (partial mastectomy).

Screening Magnetic Resonance Imaging (MRI)
Effective September 1, 2014, breast MRI may be reimbursed by BCCS in conjunction with a screening mammogram after program approval. Contractors must request approval using the Breast MRI Pre-Authorization Request Form (see Appendix G). MRI may be reimbursed for clients with:
- A BRCA mutation;
- A first-degree relative who is a BRCA carrier;
- A lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO and the Gail Model that are largely dependent on family history;
- radiation therapy to the chest when they were between the ages of 10 and 30 years; or
- Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or have first-degree relatives with one of these syndromes.

Magnetic Resonance Imaging: Restrictions
- Breast MRI must never be performed alone as a breast cancer screening tool.
- Breast MRI cannot be reimbursed to assess the extent of disease in women already diagnosed with breast cancer.
- All breast MRI procedures require pre-authorization.
- Pre-authorization form must be received **a minimum of three (3) business days** prior to the anticipated procedure date. See Appendix G.
- MRI procedures must be performed in facilities with dedicated breast MRI equipment able to perform MRI-guided breast biopsies.

Imaging Reports – Screening mammogram/MRI
Radiology facilities must prepare a written report of the results of each radiologic examination, including screening mammography and MRI. This report must include the following:
- The name of the client and an additional client identifier;

- The name of the physician who interpreted the mammogram; and
- An overall final assessment of findings utilizing the BIRADS system of classification.

The mammography BIRADS system of classification can be found at http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/BIRADS/01%20Mammography/02%20%20BIRADS%20Mammography%20Reporting.pdf.

The MRI BIRADS system of classification can be found at http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/BIRADS/03%20MRI/08%20%20BIRADS%20MRI%20Reporting.pdf.

Client Education – For every woman who receives breast cancer screening and/or diagnostic services through BCCS, the contractor must effectively communicate and document the following information during the initial visit and update during follow-up visits as indicated by the client's risk assessment:

- Risk factors for breast and cervical cancer;
- Signs and symptoms of breast and cervical cancer;
- Importance of cancer screening at regular intervals;
- Limitations of screening, including limitations of imaging in women with dense breasts;
- BCCS services may change from year to year; and
- Tobacco cessation information and quit line referral, if appropriate.

Tobacco Assessment and Quit Line Referral - All women receiving BCCS services must be assessed for tobacco use. Women who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit Line is 1-877-YES-QUIT or 1-866-228-4327 (Hearing Impaired). The assessment and referral should be performed by agency staff and documented in the clinical record.

FOLLOW-UP OF NORMAL SCREENING RESULTS

When both the CBE and screening mammogram/MRI results are normal (BI-RADS Category 1 or 2), no further diagnostic workup is required. The clinician must notify a woman of findings, reinforce the need for continued routine screening examination and provide the expected interval for her next routine screening examination. In order for breast or cervical cancer screening to be most effective, the screening must be conducted at *regular intervals.* Contractors must attempt to notify each woman in writing of her regular screening due date.

Rescreening Eligibility
Rescreening is the process of returning for a breast and/or cervical cancer screening test at a predetermined interval (as per program guidelines) when no symptoms are present. Women may return for rescreening if they continue to meet BCCS financial and clinical eligibility requirements. Women with a history of cancer may return for rescreening when they conclude their cancer treatment, have been released by their physician to return to a schedule of routine screening, and continue to meet BCCS financial and clinical eligibility requirements.

Exceptions to Rescreening – Contractors **are not required to rescreen a woman** if the contractor has documented that she:

- Cannot be located or has moved from the contractor's service area;
- No longer meets the BCCS financial or clinical eligibility;
- Has Medicare Part B or other adequate health insurance which provides coverage for breast and/or cervical cancer screening and diagnostic testing;
- Refuses (in writing or verbally) to return for BCCS services;
- Received a BCCS-funded breast cancer screening within the previous 12 months; or
- Is age 40-49 and received a BCCS-funded breast cancer screening within the last 24 months.

FOLLOW-UP OF ABNORMAL SCREENING RESULTS

Abnormal CBE (Suspicious for cancer): Abnormal CBE results require a **minimum** follow-up of **two (2)** diagnostic evaluations/tests, which can include diagnostic mammogram, breast ultrasound, breast MRI, biopsy or referral to a breast specialist/surgeon for consultation.

Abnormal Screening Mammogram/MRI Results at minimum require the following:

BIRADS	Assessment	Follow-up Recommendation
0	Incomplete	Additional breast imaging required. (Diagnostic mammogram views, diagnostic breast ultrasound, breast MRI.)
1	Negative	No further diagnostic workup is required. (Abnormal CBE results require diagnostic referral.)
2	Benign	No further diagnostic workup is required. (Abnormal CBE results require diagnostic referral.)
3	Probably Benign	Radiologist recommendation required for the next screening or diagnostic examination; **AND,** diagnostic referral if CBE results are abnormal

4	Suspicious	Breast specialist consultation with tissue sampling (biopsy) required
5	Highly Suggestive of Malignancy	Breast specialist consultation with tissue sampling (biopsy) required.

Transgender Clients

Although there are limited data regarding the risk for breast cancer among transgender women, evidence has shown that long term hormone use does increase the risk for breast cancer among women whose biological sex was female at birth. Transgender women (male-to-female), *who have taken or are taking hormones* and meet all program eligibility requirements are eligible to receive breast cancer screening and diagnostics.

- BCCS recommends that grantees and providers counsel all eligible women, including transgender women, about the benefits and harms of screening and discuss individual risk factors to determine if screening is medically indicated.

Transgender women are eligible under federal law to receive appropriate cancer screening. The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Preventive care recommendations can be found at http://transhealth.ucsf.edu/trans?page=protocol-screening#S2X and include:

Transwomen, past or current hormone use:

- Breast screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use > 5 years, positive family history, BMI > 35).

BREAST CANCER DIAGNOSTICS

Eligibility

Women age 18 to 40: Women who are symptomatic with a CBE and/or mammogram/breast MRI suggestive of cancer may be eligible for breast cancer diagnostic assessment services.

Women over age 40: Can be enrolled in BCCS for diagnostic assessment if they have an:

- Abnormal clinical breast examination; and/or
- Abnormal mammogram; and/or
- Abnormal breast MRI

Women with a history of breast cancer can be enrolled for diagnostic assessment if they have an:

- Abnormal clinical breast exam; and/or
- Abnormal mammogram; and/or
- Abnormal breast MRI.

COMPONENTS OF BREAST CANCER DIAGNOSTICS

Breast Imaging - Diagnostic Mammogram, Ultrasound and MRI

Radiology facilities must prepare a written report of the results of each diagnostic examination, including diagnostic mammography, ultrasound and MRI. This report must include the following:

- The name of the patient and an additional client identifier;
- The name of the physician who interpreted the mammogram; and
- An overall final assessment of findings utilizing the BIRADS system of classification.

The mammography BIRADS system of classification can be found at http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/BIRADS/01%20Mammography/02%20%20BIRADS%20Mammography%20Reporting.pdf**.** The ultrasound BIRADS system of classification can be found at http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/BIRADS/02%20Ultrasound/05%20%20BIRADS%20US%20Reporting.pdf. The MRI BIRADS system of classification, can be found at http://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Resources/BIRADS/03%20MRI/08%20%20BIRADS%20MRI%20Reporting.pdf

Consultations

Consultations (as defined in the Introduction, page vii) for follow-up of abnormal screening and diagnostic results must be made to physicians with expertise in managing breast problems, including performing invasive diagnostic procedures. General surgeons, radiologists, and obstetricians -gynecologists who have completed specialized training for management of breast disease may be considered breast specialists. Consultations **must** involve direct examination of the client. Nurses, midwives, nurse practitioners, physician assistants, and primary care physicians do NOT qualify as breast specialists. Consultations should be billed using office visit codes.

Note: Interpretation of other images and imaging reports by a radiologist as a second opinion without direct examination of the client **cannot** be reported or billed as a consultation.

Contractors must have policies and procedures to ensure healthcare providers follow evidence-based clinical guidelines and/or provide clinical services consistent with current nationally recognized standards of care.

Reimbursement Following Complications of Breast Biopsy Procedures

Contractors may request reimbursement for treatment costs associated with patient complications related to breast biopsy procedures that occur in the immediate post-procedure or post-operative period. Contractors may be reimbursed through a voucher system for approved charges up to $3000 per occurrence from awarded contract funds. To request reimbursement, contractors must email the Breast and Cervical Diagnostic Procedure Complication Reimbursement Request Form (Appendix F1) and supporting documents to BCCS program staff at BCCSprogram@dshs.state.tx.us.

Supporting Documents include:

- The client's Med-IT® ID and date of service when treatment procedure(s) were performed on the client in question;
- A narrative summary detailing the breast biopsy procedure performed and any related complications which have been documented in the Case Management or Cycle Note section of the client's Med-IT record;
- All emergency room, surgical, and progress notes, etc. for the client related to complications of the procedure;
- The procedure note and/or operative report, etc. for the initial procedure; and
- A completed paper CMS-1500 form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the DSHS BCCS Program)

Breast Cancer Diagnostic Algorithms for Primary Care Providers*

BCCS has received permission to share the California Department of Public Health's Breast Cancer Diagnostic Algorithms for Primary Care Providers with Texas BCCS contractors.

These algorithms are intended for informational purposes only. Healthcare providers should use the breast diagnostic algorithms as an adjunct to clinical decision-making; they are not intended to replace clinical judgment with regard to individual cases.

They are included with the recognition that other approaches exist, and that deviations do not indicate non-adherence to medical standards of care.

Inclusion of the algorithms in the BCCS Policy and Procedure Manual does not

guarantee BCCS reimbursement, endorsement, or approval of any procedures and/or treatment recommendations. Questions regarding use of the algorithms, clinical and/or care decisions should be directed to your Medical Director.

The California Department of Public Health's Breast Cancer Diagnostic Algorithms for Primary Care Providers, Fourth Edition is available online by clicking here or copying/pasting the link below into your web browser.

http://qap.sdsu.edu/screening/breastcancer/bda/

*Cancer Detection Section, California Department of Public Health. (2011). Breast cancer diagnostic algorithms for primary care providers (4th ed.). Sacramento, CA: Author.

CERVICAL CANCER SCREENING

Eligibility

Applicants ages 21-64 who meet general and clinical eligibility requirements may be enrolled in BCCS for cervical cancer screening services.

Transgender men (female-to-male) who have a cervix may receive BCCS cervical cancer screening services if other eligibility criteria is met. Transgender women (male-to-female) are not eligible for cervical services.

Components of Cervical Cancer Screening

The clinical components of cervical cancer screening are pelvic examination, Pap test, clinical breast exam (CBE), client education, tobacco assessment, and quit line referral, if indicated. Human papillomavirus (HPV) DNA testing is only reimbursable as a screening test per the NBCCEDP/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines. The contractor must document the CBE and cervical cancer screening components in the client's record and Med-IT. Contractors must follow breast diagnostic policies and procedures for cervical cancer screening clients who have an abnormal CBE.

Contractors must have policies and procedures to ensure healthcare providers follow evidence-based clinical guidelines and/or provide clinical services consistent with current nationally recognized standards of care.

Clinical components of cervical cancer screenings must be performed by a physician, physician's assistant, nurse practitioner, certified nurse midwife, or a qualified registered nurse with specialized training as required under standing delegation orders (SDO). The RN's specialized training for cervical cancer screening must be documented in the personnel record (e.g. an educational certificate/degree; or continuing education).

A complete cervical health history must be included as part of cervical cancer screening and documented in the client record. The health history includes:

- Date and results of the last pelvic examination and Pap test;
- Date and results of any past diagnostic procedure(s) and/or treatment(s) for cervical disease;
- Date of last menstrual period and pregnancy history;
- Medication history, including current or previous use of hormones (hormone replacement therapy, oral contraceptives, etc.);
- Risk factors for cervical cancer; and
- Description of present pelvic symptoms.

NBCCEDP/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines and Eligibility*:

- Cervical cancer screening begins at age 21 years;
- Cervical cytology (Pap smear) alone every three (3) years for clients between the ages of 21 and 29 years;

- Cervical cytology (Pap smear) alone every three (3) years **or** cervical cytology and HPV co-testing every five (5) years for clients between the ages of 30 and 65 years.
- Continue screening clients who had a hysterectomy for CIN disease for 20 years, even if this extends screening past age 65 years
- Continue screening clients who have had cervical cancer indefinitely as long as they are in reasonable health
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.

Special Circumstances
Clients with special circumstances, who are considered high-risk (e.g. HIV+, immunosuppressed or were exposed to Diethylstilbestrol (DES) in utero) may be screened annually or more frequently as determined by the clinician.

Applicants who meet financial and age criteria and have had a hysterectomy are eligible for cervical cancer screening and diagnostic services if the hysterectomy was due to cervical cancer or cervical intraepithelial neoplasia (per NBCCEDP/ACS/ASCCP/ASCP Cervical Cancer Screening Guidelines). In this situation, BCCS funds can be used for a vaginal pap if the cervix is absent.

Applicants who have had a hysterectomy for benign disease and the cervix is still present may be eligible for cervical cancer screening and diagnostic services. BCCS funds can be used to pay for an initial examination, i.e. pelvic examination, to determine if the cervix is present.

*Clinicians may follow ACOG (American Congress of Obstetricians and Gynecologists) recommendations for cervical cancer screening for pregnant women.

Cytology Reports
The 2001 Bethesda System for Reporting Cervical/Vaginal Diagnoses must be used for reporting cytology results. The components of a cytology report using the Bethesda system are:

- **Specimen adequacy**
  - <u>Satisfactory for evaluation</u>
  - <u>Unsatisfactory for evaluation</u> – The client must have a repeat Pap test within two (2) to four (4) months after the unsatisfactory Pap smear. The underlying condition should be treated (if applicable) prior to performing the repeat Pap test.
    - BCCS will not reimburse for specimen rejected/not processed (also applies to Endocervical Curettage [ECC] specimens)
    - BCCS will reimburse for specimen processed and examined, but determined to be unsatisfactory for evaluation of epithelial abnormality, (also applies to Endocervical [ECC] specimens)

- **General categorization**
  - Negative for Intraepithelial Lesion or Malignancy

- Epithelial Cell Abnormality: See Interpretation/Results (*specify 'squamous' or 'glandular' as appropriate*)
- Other: See Interpretation/Results

- **Interpretation/Results**
  - Negative for intraepithelial lesion or malignancy
  - Other
    - Endometrial cells (*in a woman > 40 years of age*)
  - Squamous Cell
    - Atypical squamous cells
      - of undetermined significance (ASC-US)
      - cannot exclude HSIL (ASC-H)
    - Low grade squamous intraepithelial lesion (LSIL) encompassing: HPV/mild dysplasia/CIN 1
    - High grade squamous intraepithelial lesion (HSIL) encompassing: moderate and severe dysplasia, CIS/CIN 2 and CIN 3 with features suspicious for invasion (*if invasion is suspected*)
    - Squamous cell carcinoma
  - Glandular Cell
    - Atypical glandular cells -NOS [state endocervical, endometrial]
    - Atypical glandular cells, favor neoplastic [state endocervical, endometrial]
    - Endocervical adenocarcinoma *in situ*
    - Adenocarcinoma [state endocervical, endometrial or NOS]
  - Other Malignant Neoplasms

HPV Quality Assurance
Contractors must assure the following for all HPV tests:
- Must be for high-risk oncogenic types;
- Must be FDA approved and clinically validated;
- BCCS funds may not be used for HPV genotyping.

Client Education
For every client who receives cervical cancer screening, rescreening and/or diagnostic services through the BCCS program, the contractor must effectively communicate and document the following information during the initial visit and update during follow-up visits as indicated by the client's risk assessment:

- Risk factors for breast and cervical cancer;
- Signs and symptoms of breast and cervical cancer;
- Importance of screening at regular intervals;
- Information on HPV and safe sex practices;
- Information on the HPV vaccine;
- BCCS services and eligibility may change from year to year; and
- Tobacco cessation.

Tobacco Assessment and Quit Line Referral

All clients receiving BCCS breast and cervical cancer screening and/or diagnostic services should be assessed for tobacco use. Clients who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit line is 1-877-YES-QUIT or 1-866-228-4327 (Hearing Impaired). The assessment and referral must be performed by agency staff and documented in the clinical record.

Follow-Up of Normal Cervical Screening Results
A negative Pap test (normal test) needs no further diagnostic workup. The clinician must notify a client of findings, reinforce the need for continued routine screening examinations, and provide the expected interval for the next routine screening examination. In order for breast and cervical cancer screening to be most effective, the screening must be conducted at *regular intervals*. Contractors must attempt to notify each client, in writing, of their regular screening due date.

Rescreening Eligibility
Rescreening is the process of returning for a breast and/or cervical cancer screening test at a predetermined interval (as per program guidelines) when no symptoms are present. Clients may return for rescreening if they continue to meet BCCS financial and clinical eligibility requirements. Clients with a history of cancer may return for rescreening when they conclude their cancer treatment, have been released by their physician to return to a schedule of routine screening, and continue to meet BCCS general and clinical eligibility requirements.

Exceptions to Rescreening – **Contractors are not required to rescreen a client** if the contractor has documented that the client:

- Cannot be located or has moved from the contractor's service area;
- No longer meets the BCCS financial or clinical eligibility ;
- Has Medicare Part B or other health insurance which provides coverage for breast and/or cervical cancer screening;
- Refuses (in writing or verbally) to return for BCCS services;
- Received cervical cancer screening within the previous three (3) years or five (5) years (per the age guidelines above); or
- Is currently following a plan of care for the treatment of cervical dysplasia (the client may be eligible to receive Cervical Dysplasia and Treatment Services)

CERVICAL CANCER DIAGNOSTICS

Eligibility
Applicants ages 18-64 who meet BCCS general and clinical eligibility requirements may be enrolled in BCCS for diagnostic services. BCCS funded diagnostics services must be delivered according to ASCCP guidelines.

Follow-up of Abnormal Pelvic Examinations and Pap Tests

When the pelvic exam and/or cervical cancer screening test (Pap test) results are

abnormal, further diagnostic follow-up is required. A normal Pap test does not rule out cancer if a woman has a cervical lesion on pelvic examination. A colposcopy and/or cervical biopsy are allowed if determined appropriate by the clinician after an abnormal pelvic exam.

BCCS contractors must follow the algorithms for the management of the specific type of abnormal result and in consideration of special populations (e.g. pregnant women and clients age 20 years and younger or at high risk).

Components of Cervical Cancer Diagnostics

Diagnostic Procedures -Tests performed to confirm or rule out cancer when screening tests yield abnormal results include: colposcopy, cervical biopsy, endocervical curettage (ECC), and diagnostic excisional procedures. CBE is not required when a client is referred to BCCS after an abnormal pelvic exam or abnormal Pap test.

Cervical cancer diagnostic procedures must be performed by qualified clinicians, such as physicians, physician's assistants, nurse practitioners, or certified nurse midwives who have had specialized training.

Clinical Utilization Restrictions for Diagnostic Excisional Procedures – Diagnostic LEEP conization, laser conization, and cold knife conization cannot be performed on the following clients:

- Any age in the absence of HSIL, ASC-H or higher abnormality; or
- Any age with histology CIN I or lesser abnormality for a duration less than two years and in the absence of HSIL or atypical glandular cells (AGC) on Pap tests.

Note: Ambulatory Surgical Centers and anesthesia services can be utilized for diagnostic LEEP and cold knife conization:

- For LEEP, the standards of care indicate that this is primarily an office-based procedure. The BCCS program will monitor utilization with the expectation that less than 20% of LEEP will be performed in an Ambulatory Surgical Center.
- For cold knife conization, the standards of care indicate that this procedure should be performed in an Ambulatory Surgical Center. The BCCS program will monitor the use of facility/anesthesia services for this procedure.

The BCCS program encourages contractors to develop subcontracts with practitioners with specialized training in the management of cervical disease who perform LEEP as an office-based procedure.

Consultations - Consultations (as defined in the Introduction, page vi) for follow-up of abnormal cervical screening and diagnostic results must be performed by healthcare providers with specialized training in the management of cervical disease, including skill performing invasive diagnostic procedures. A consultation can only be performed by a healthcare provider who did not perform the original screening examination. If that healthcare provider is not a licensed physician, appropriate protocols must be

established and documented for that provider. Consultations must involve direct examination of the client and are billed using office visit codes.

Client Education – see page 37.

OFFICE-BASED PROCEDURES PERFORMED IN AN AMBULATORY SURGICAL CENTER

Special circumstances may arise that necessitate an office-based diagnostic procedure being performed in an ambulatory surgical center. These services require pre-authorization PRIOR to the client receiving services in an ambulatory surgical center or other outpatient facility. Contractors must submit the Office-based Procedures Performed in an Ambulatory Surgical Center Pre-authorization Form along with any supporting documentation to BCCSprogram@dshs.state.tx.us **a minimum of three (3) business days prior to the anticipated date of the procedure**. BCCS will not reimburse for any office-based procedures performed in an ambulatory surgical center that have not received pre-authorization. Evidence of pre-authorization approval must be made available to DSHS review staff during Quality Assurance/Quality Improvement on-site visits.

ACCESS TO TREATMENT

The following treatment options are available for eligible clients with a qualifying diagnosis:

- The Title V program provides funds for Cervical Dysplasia Management and Treatment services for clients who have a qualifying diagnosis and who are not eligible for MBCC. For a description of qualifying diagnoses, see the chapter entitled “Cervical Dysplasia Management and Treatment”.
- Medicaid for Breast and Cervical Cancer (MBCC) provides Medicaid coverage to applicants who have qualifying breast or cervical cancer diagnosis and meet all other MBCC eligibility criteria. See chapter entitled “Medicaid for Breast and Cervical Cancer (MBCC)” and Appendix E, for Texas MBCC Qualifying Diagnosis Guidance.

Reimbursement Following Complications of LEEP and LEEP Conization Procedures

Contractors may request reimbursement for treatment costs associated with patient complications related to LEEP and LEEP conization procedures. Contractors may be reimbursed through a voucher system for approved charges up to $3000 per occurrence from awarded contract funds. To request reimbursement, contractors must email the Breast and Cervical Diagnostic Procedure Complication Reimbursement Request Form (Appendix H1) and supporting documents to BCCS program staff at BCCSprogram@dshs.state.tx.us.

Supporting Documents include:

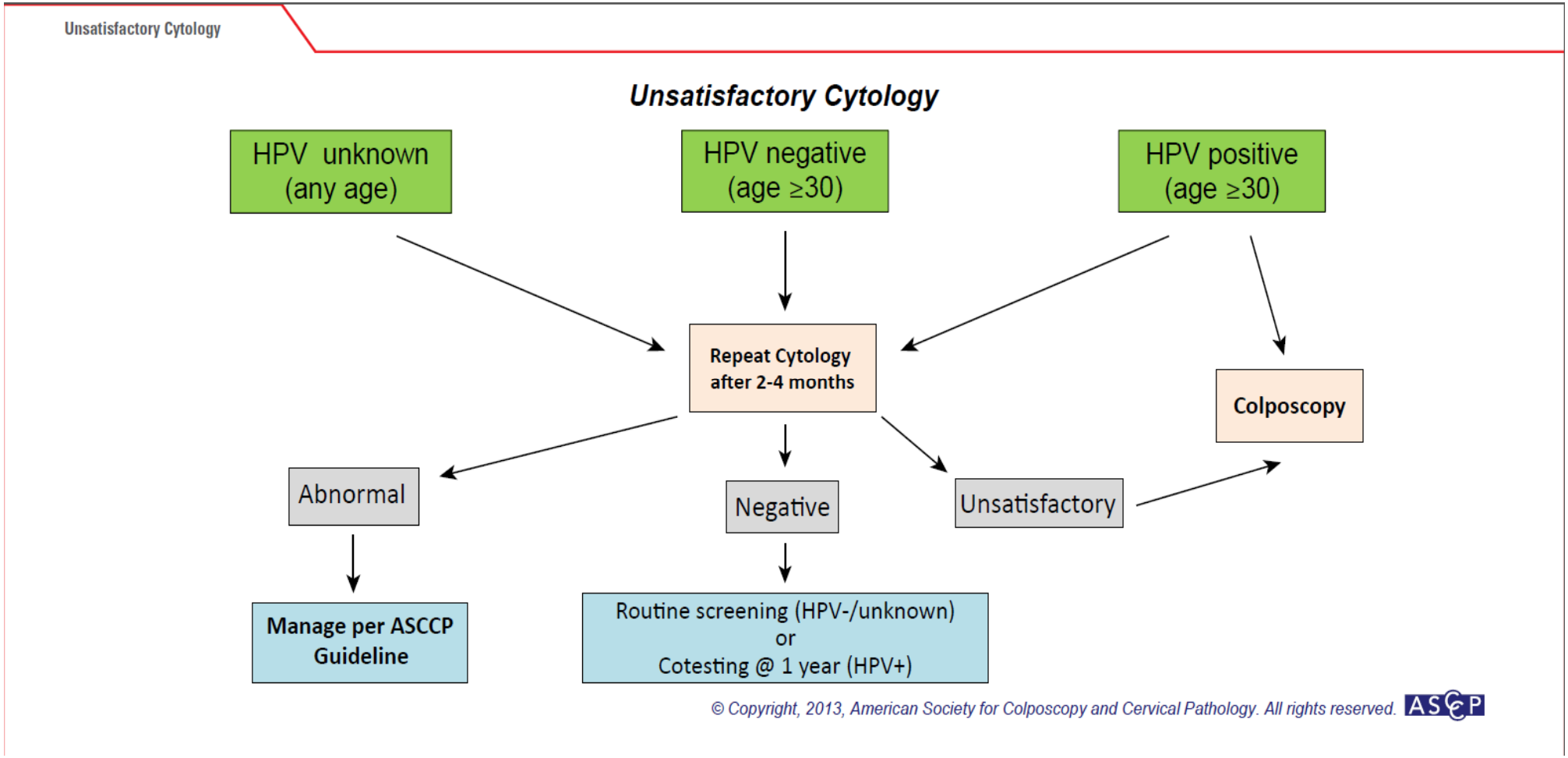
- The client's Med-IT number and date of service when treatment procedure was performed on the client in question;
- A narrative summary detailing the LEEP/LEEP conization procedure performed and any related complications which have been documented in the Case Management or Cycle Note section of the client's Med-IT record;
- All emergency room, surgical, and progress notes for the client related to complications of the procedure;
- The procedure note and/or operative report for the initial procedure; and
- A completed paper CMS-1500 form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the DSHS BCCS Program).

Algorithms for the Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors

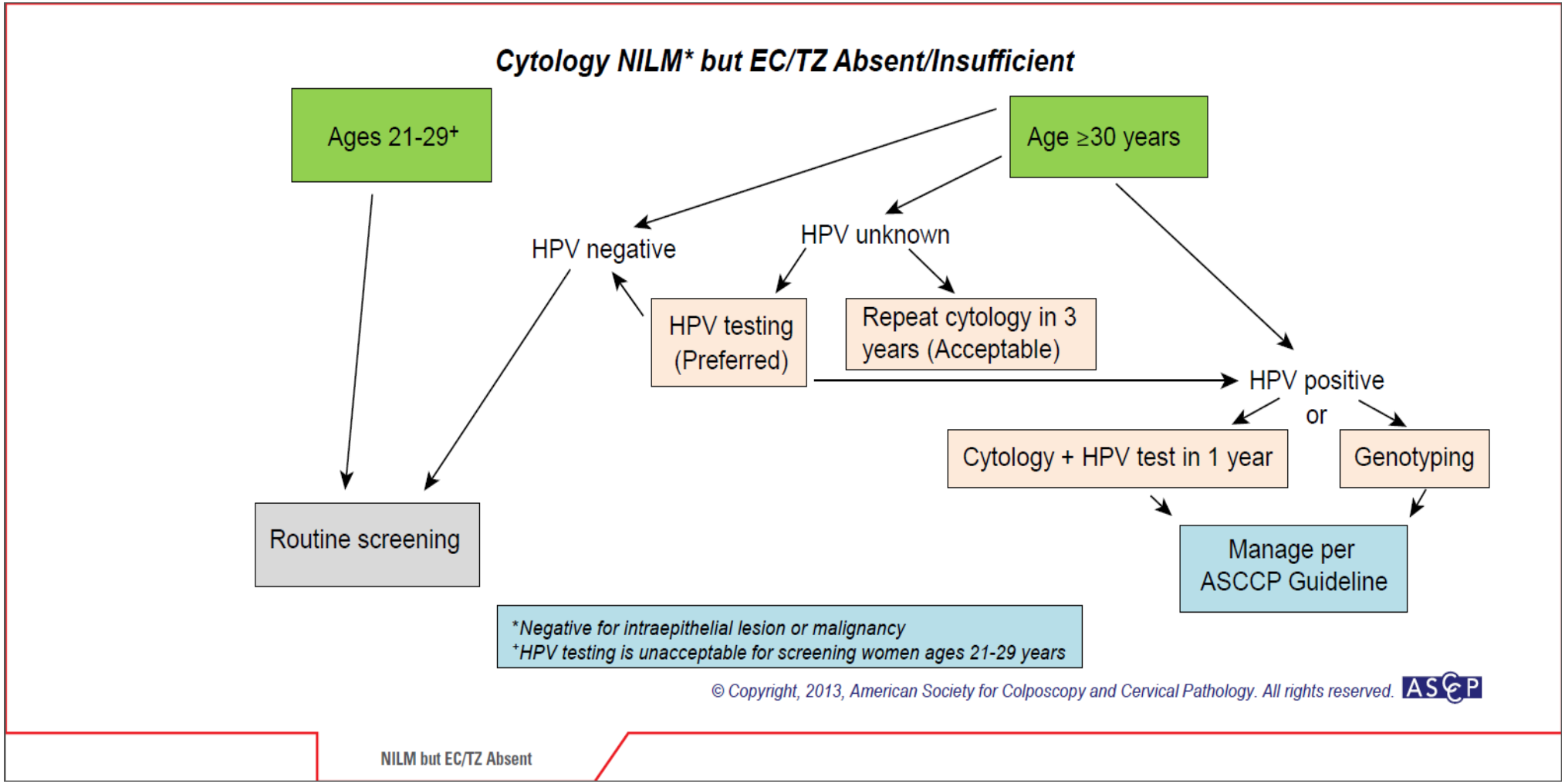
The American Society of Colposcopy and Cervical Pathology (ASCCP) established guidelines for management of abnormal cervical cancer screening tests. Reimbursement is based upon compliance of the algorithms. The algorithms below are for clients utilizing BCCS cervical screening and diagnostic services.

Algorithm Acronyms	
AGC	Atypical Glandular Cells
ASC-H	Atypical Squamous Cells: Cannot exclude High-grade Squamous Intraepithelial Lesion
ASC-US	Atypical Squamous Cells of Undetermined Significance
CIN	Cervical Intraepithelial Neoplasia
EC	Endocervical
HSIL	High-grade Squamous Intraepithelial Lesion
HPV	Human Papillomavirus
LSIL	Low-grade Squamous Intraepithelial Lesion
NILM	Negative for Intraepithelial Lesion or Malignancy
TZ	Transformation Zone

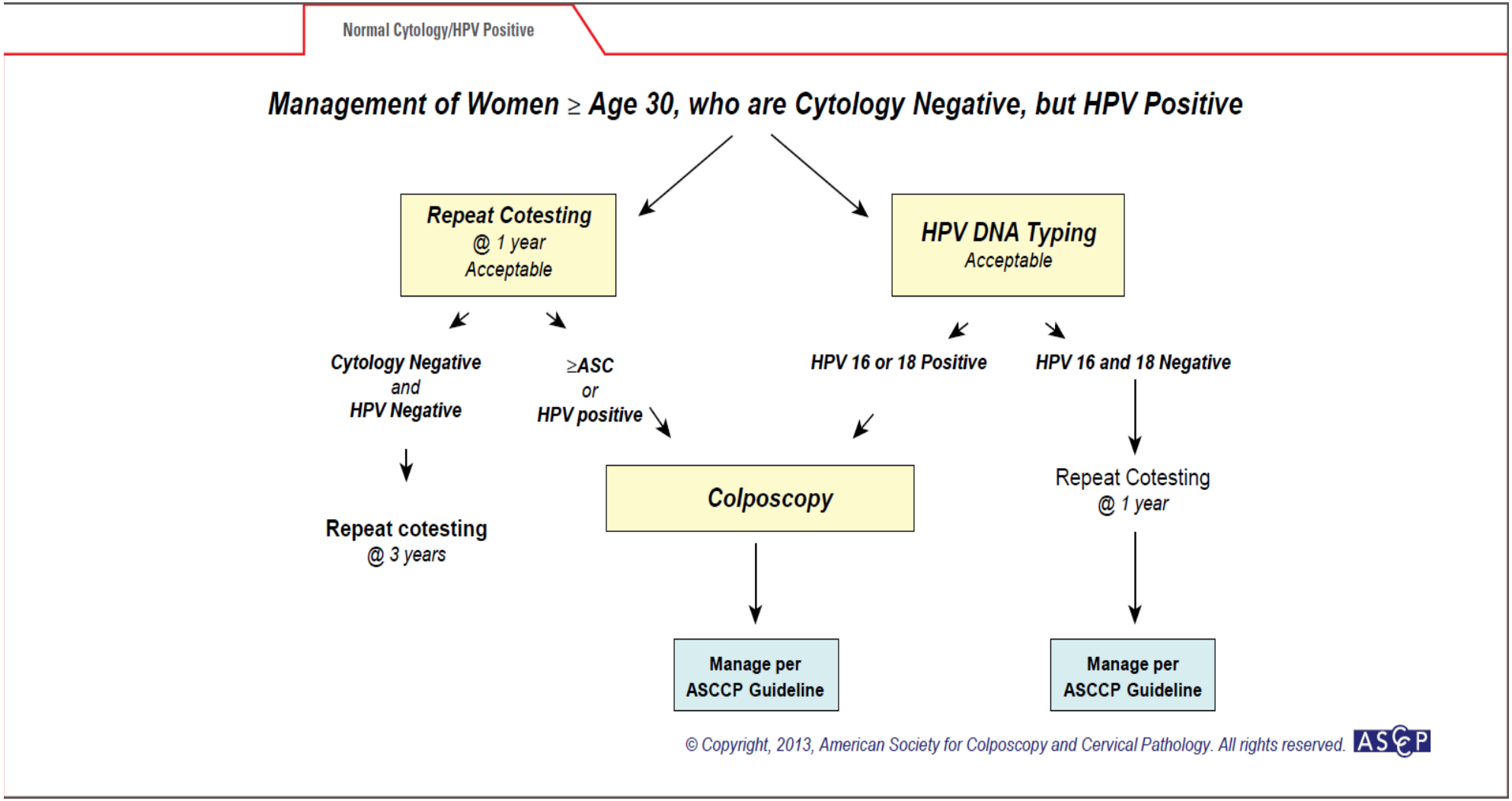
Reprinted from *The Journal of Lower Genital Tract Disease* Volume 17, Number 5, with the permission of ASCCP © American Society for Colposcopy and Cervical Pathology 2013.
No copies of the algorithms may be made without the prior consent of ASCCP.



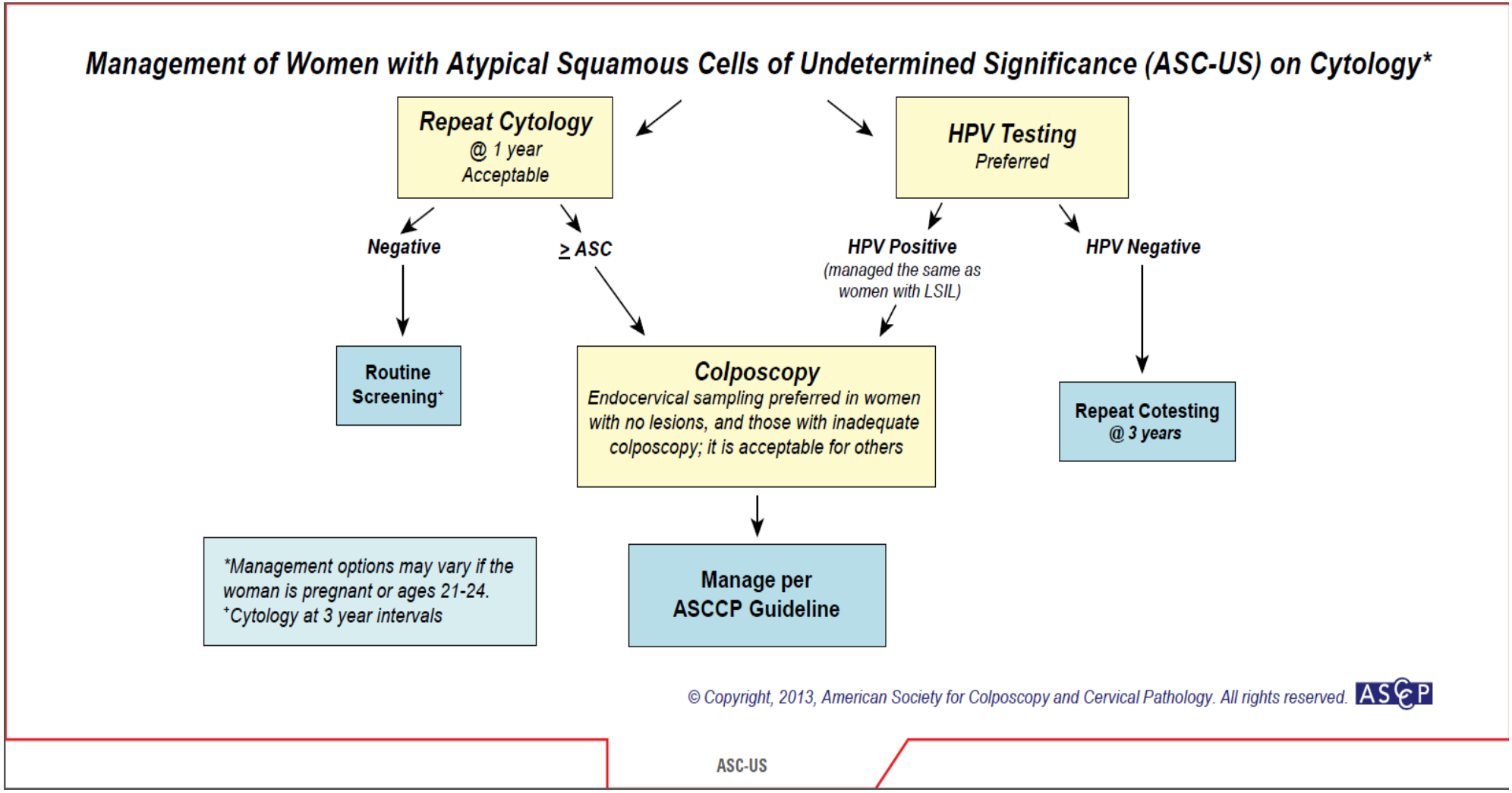
BCCS Notes:
1. A repeat Pap test must be performed two (2) to four (4) months after the unsatisfactory Pap test. The underlying condition should be treated (if applicable) prior to performing the repeat Pap test.
2. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only



BCCS Notes:
1. Genotyping is not reimbursable by BCCS per CDC policy.
2. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only.

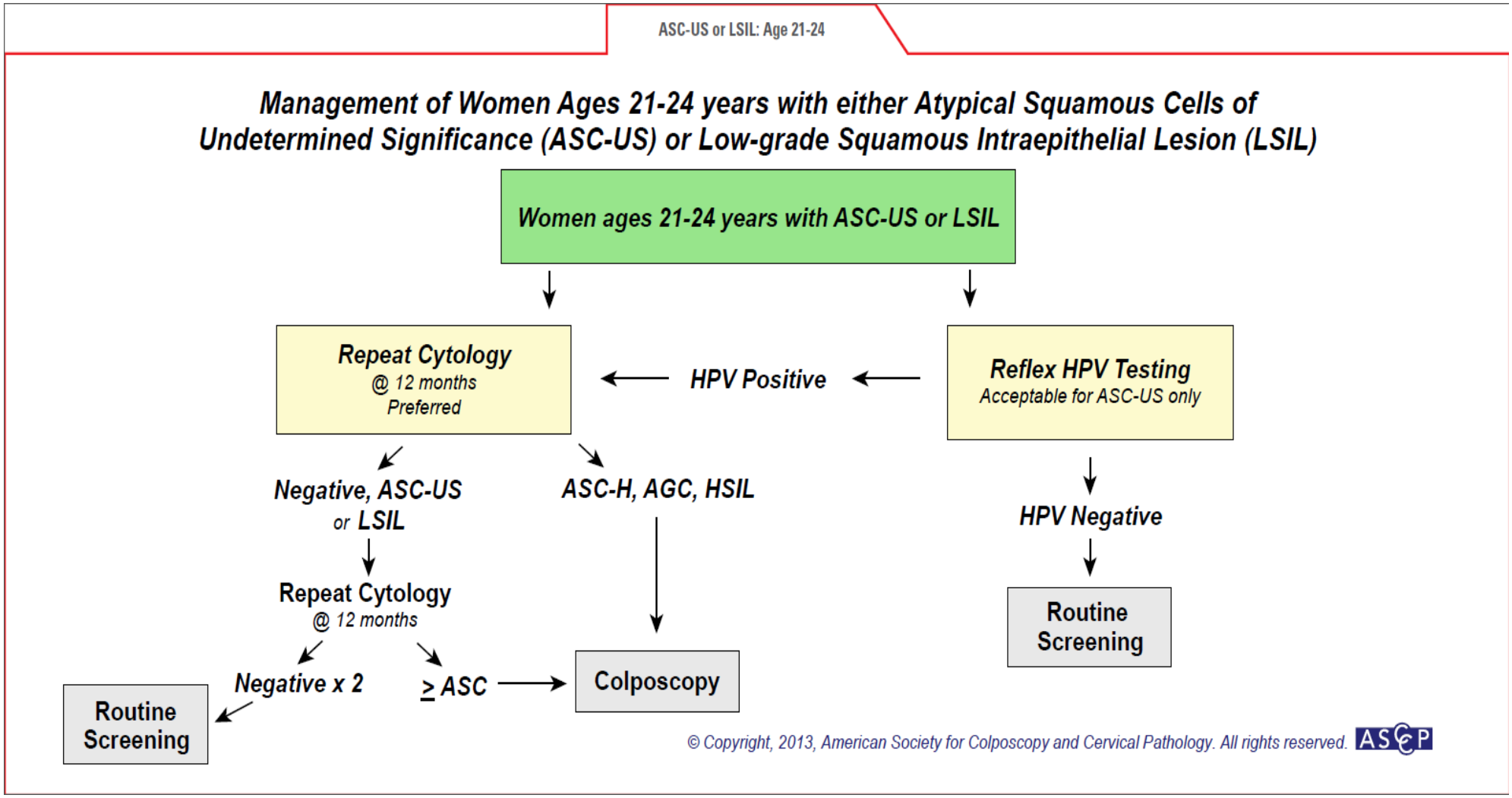


BCCS Notes:
1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only.
2. HPV DNA Typing (genotyping) is not reimbursable by BCCS per CDC policy.

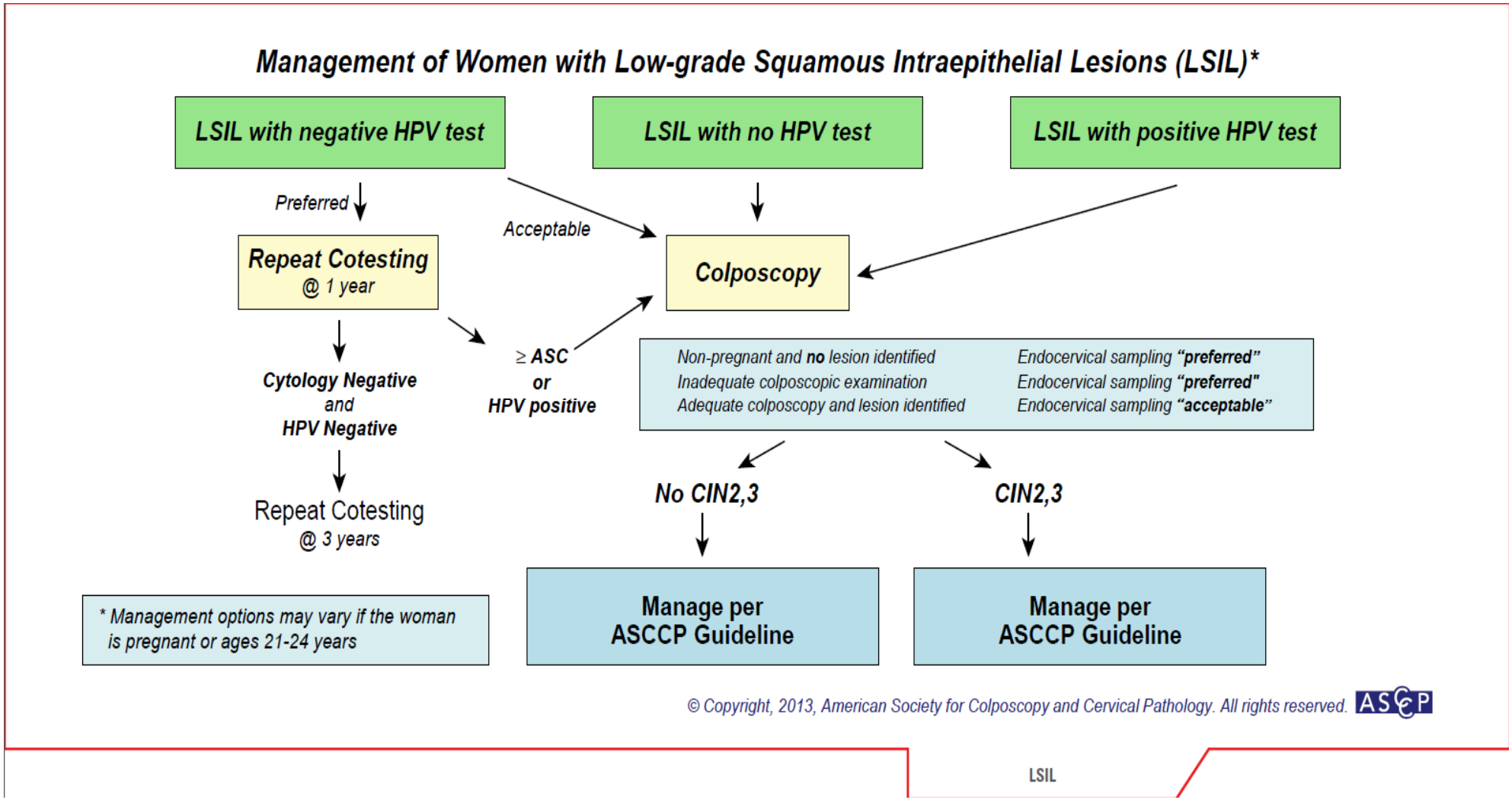


BCCS Notes:

1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only.
2. BCCS will reimburse for repeat cytology at 1 year or HPV testing following initial ASCUS Pap, but not both. If clinician choses HPV testing, BCCS will reimburse for repeat co-testing in 3 years as indicated.



BCCS Notes:
1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only.

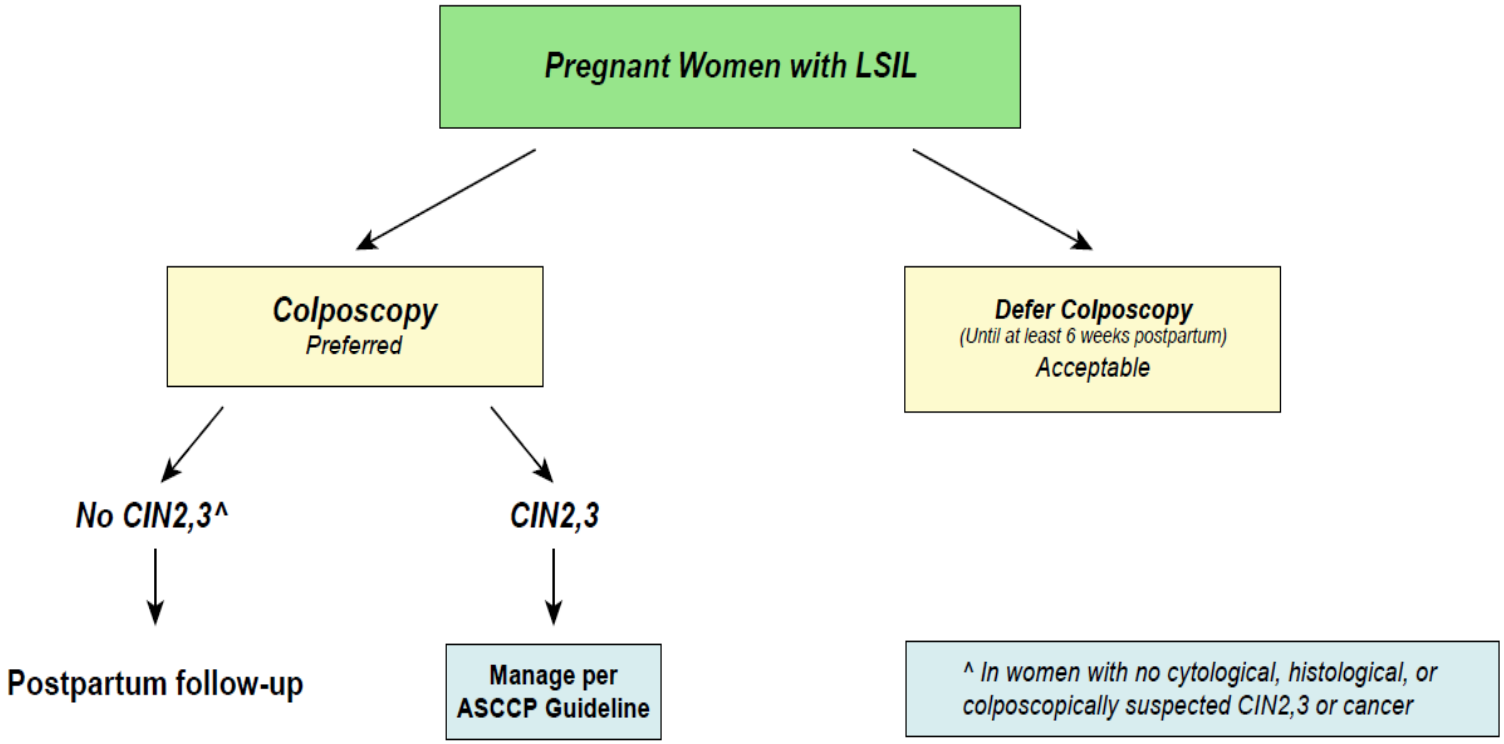


BCCS Notes:

1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only.

LSIL Pregnant Woman

Management of Pregnant Women with Low-grade Squamous Intraepithelial Lesion (LSIL)



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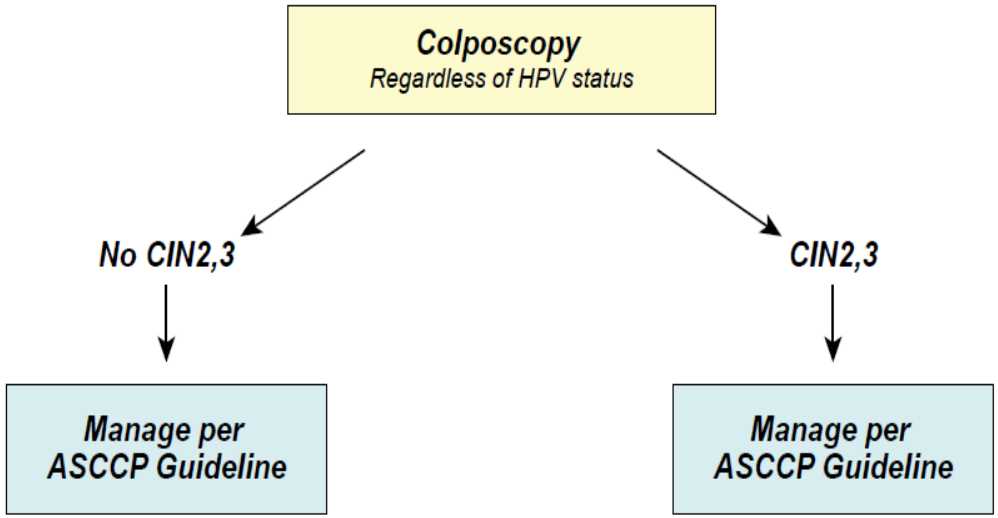
Management of Women with Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H)*



* Management options may vary if the woman is ages 21-24.

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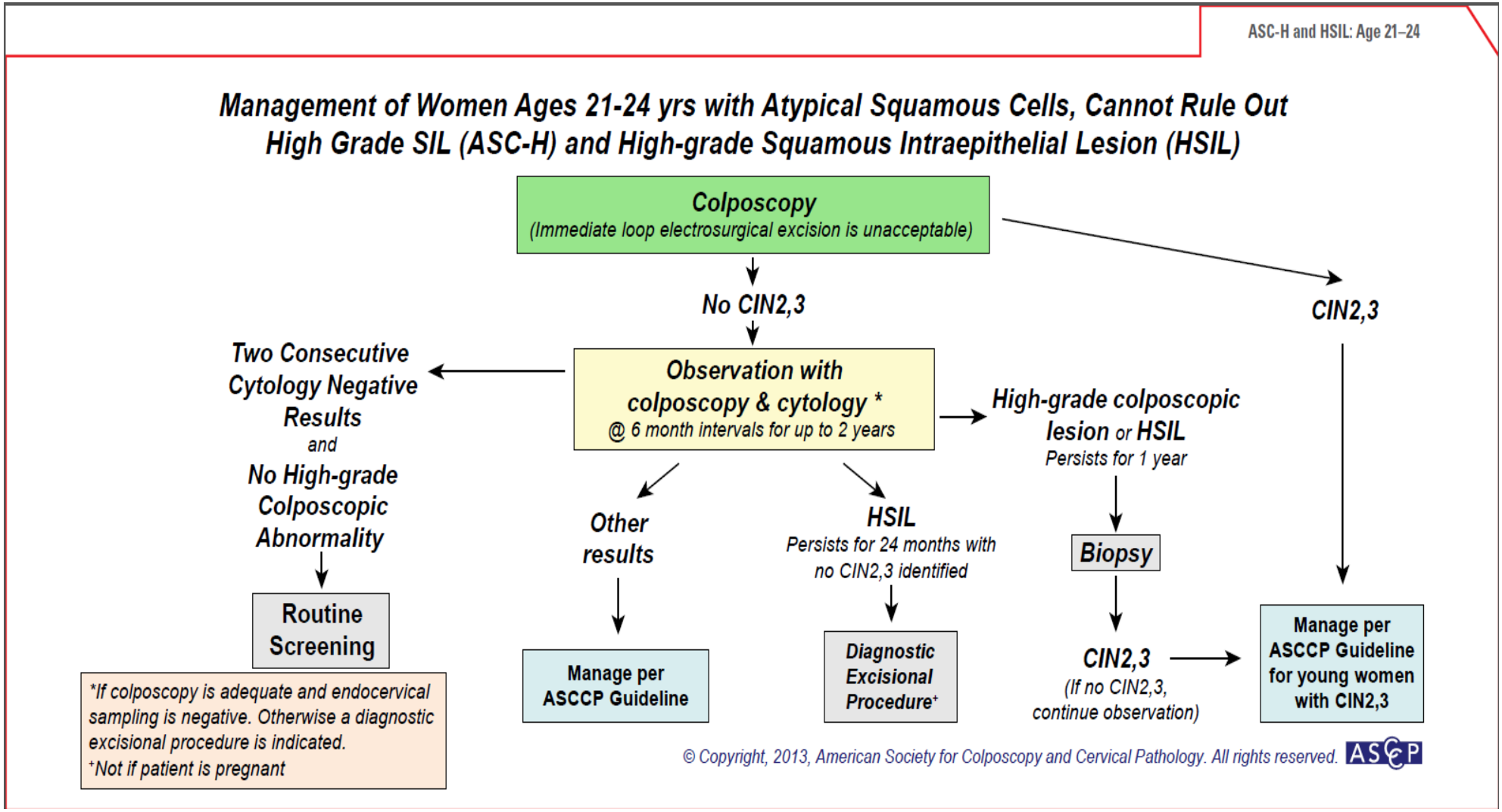
ASC-H


ASC-H and HSIL: Age 21–24
Management of Women Ages 21-24 yrs with Atypical Squamous Cells, Cannot Rule Out High Grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion (HSIL)
Colposcopy
(Immediate loop electrosurgical excision is unacceptable)
No CIN2,3
CIN2,3
Two Consecutive Cytology Negative Results
and
No High-grade Colposcopic Abnormality
Observation with colposcopy & cytology *
@ 6 month intervals for up to 2 years
High-grade colposcopic lesion or HSIL
Persists for 1 year
Other results
HSIL
Persists for 24 months with no CIN2,3 identified
Biopsy
Routine Screening
Manage per ASCCP Guideline
Diagnostic Excisional Procedure+
CIN2,3
(If no CIN2,3, continue observation)
Manage per ASCCP Guideline for young women with CIN2,3
*If colposcopy is adequate and endocervical sampling is negative. Otherwise a diagnostic excisional procedure is indicated.
+Not if patient is pregnant
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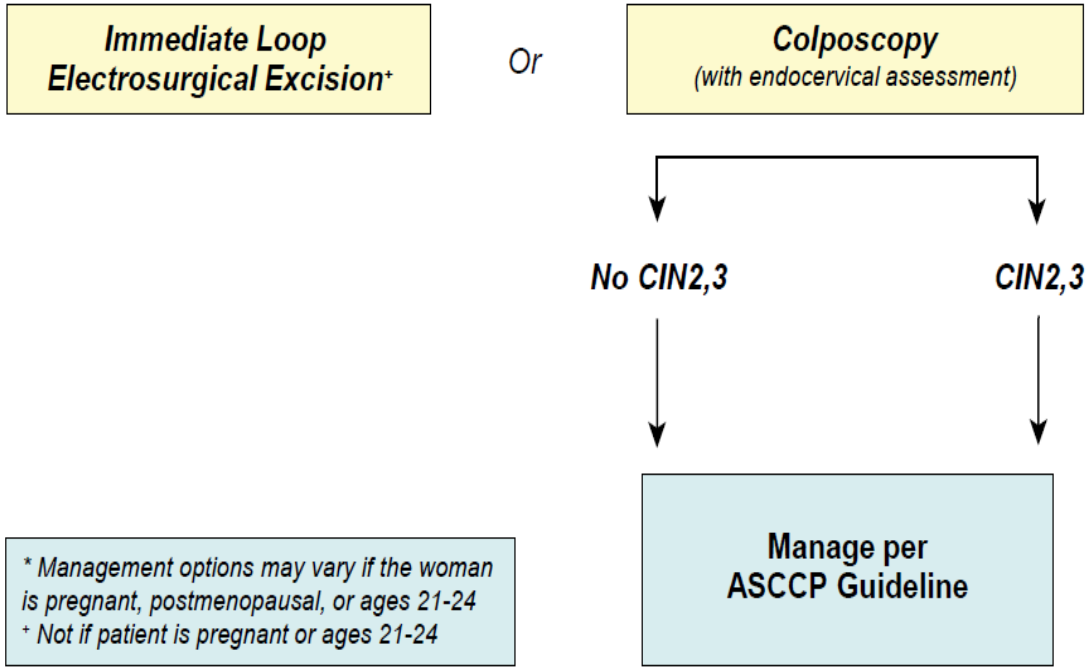
Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)*



* Management options may vary if the woman is pregnant, postmenopausal, or ages 21-24
+ Not if patient is pregnant or ages 21-24

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HSIL

AGC

Initial Workup of Women with Atypical Glandular Cells (AGC)

All subcategories
(except atypical endometrial cells)

↓

Colposcopy (with endocervical sampling)
and **Endometrial sampling** (if ≥ 35 yrs or at risk for endometrial neoplasia*)

Atypical Endometrial Cells

↓

Endometrial and
Endocervical Sampling

↓

No Endometrial Pathology

↓

Colposcopy

*Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.

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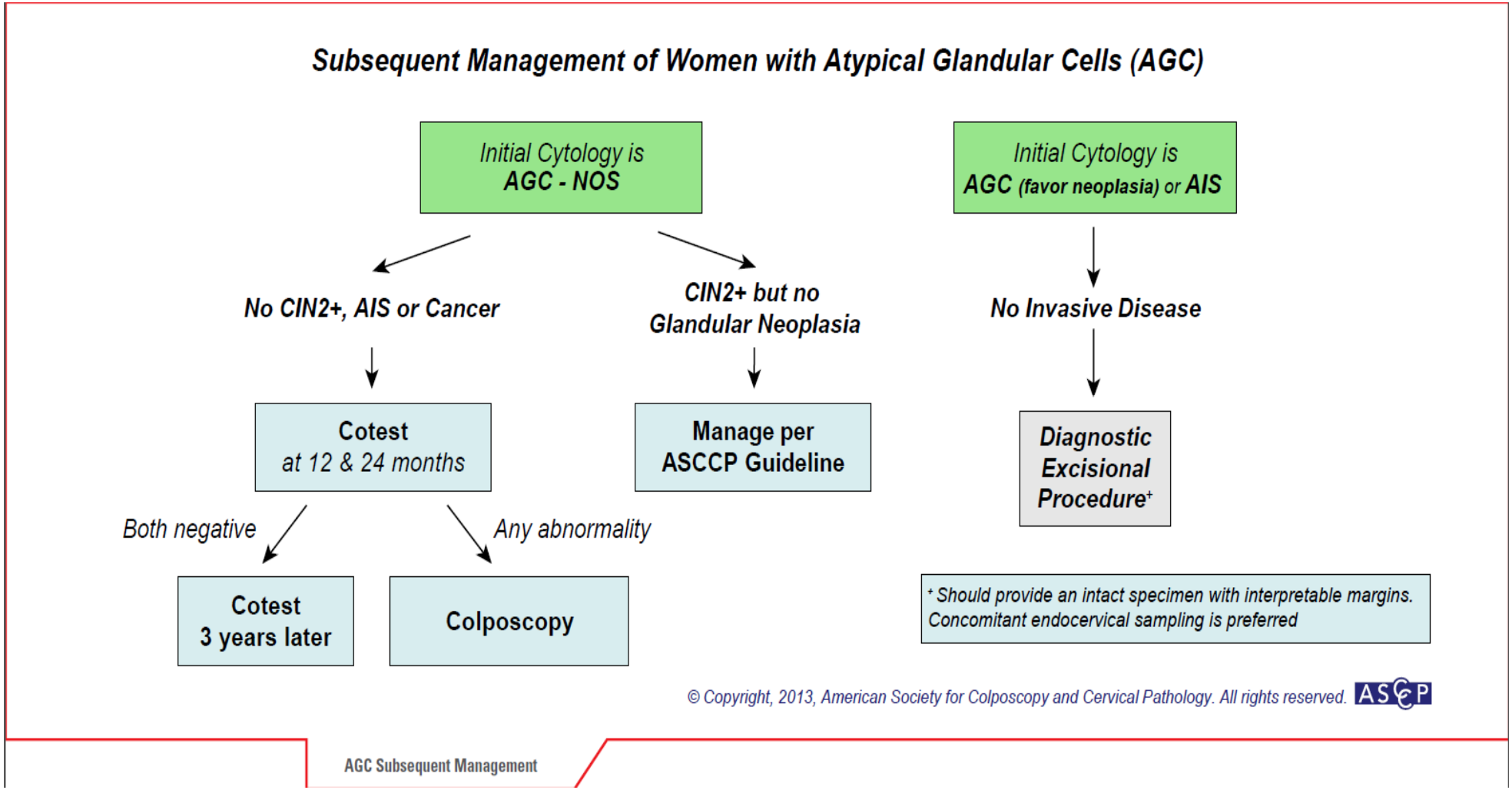


BCCS Notes:
All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only

CERVICAL DYSPLASIA MANAGEMENT

Eligibility

Applicants who meet BCCS general eligibility criteria and have a definitive, biopsy-confirmed diagnosis of one of the following diagnoses qualify for cervical dysplasia management and treatment.

- CIN I, CIN II, CIN II-III; or
- High-grade dysplasia (severe dysplasia/CIN III) or CIS

Contractors must assess clients with severe dysplasia/CIN III/CIS for MBCC eligibility before using CD funds to pay for treatment services.

Components of Cervical Dysplasia Management and Treatment

Cervical dysplasia management and treatment services may include:
- Follow-up testing and observation without treatment, e.g. cytology (Pap tests), HPV testing, colposcopy.
- Treatment using excision or ablation, e.g. cryotherapy, cervical conization.
- Case Management – see Case Management Services Chapter (Section II, Chapter 8).

Clinical Utilization Guidelines for Therapeutic Excisional Procedures

Therapeutic LEEP conization, laser conization, and cold knife conization cannot be performed on the following clients:
- Any age in the absence of HSIL, ASC-H or higher abnormality; or
- Any age with histology of CIN I or lesser abnormality, for a duration of less than two years, and in the absence of HSIL or atypical glandular cells (AGC) on Pap tests.

Ambulatory surgical centers and anesthesia services can be utilized for therapeutic (treatment) LEEP and cold knife conization:
- For LEEP, the standards of care indicate that this is primarily an office-based procedure. BCCS will monitor utilization and encourage utilization with the expectation that less than 20% LEEP will be performed in an ambulatory surgical center.
- For cold knife conization, the standards of care indicate that this procedure should be performed in an outpatient facility. BCCS will monitor the use of facility/anesthesia services for this procedure.

BCCS encourages contractors to develop subcontracts with practitioners who have specialized training in the management of cervical disease and perform LEEP as an office-based procedure. Contractors must have policies and

procedures to ensure healthcare providers follow evidence-based clinical guidelines and/or provide clinical services consistent with current nationally recognized standards of care.

Reimbursement for Cervical Dysplasia Management & Treatment Services

CDC strictly prohibits reimbursement of treatment with CDC funding. Cervical Dysplasia Management and Treatment services must not be billed with BCCS screening and diagnostic codes.

Reimbursement for cervical dysplasia services is limited to the codes which begin with “CD”, ‘FCD”, and “CDF” listed separately in the BCCS Reimbursement Rates and Billing Guidelines Appendix. These codes must be billed in the Med-IT system. Cervical dysplasia funds may not be used to reimburse for BCCS cervical screening or diagnostic services.

LABORATORY SERVICES FOR CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT

BCCS Contractors must submit specimens for program covered laboratory testing to a US CLIA certified laboratory, and adhere to all quality management requirements for cytology quality assurance as stated in Section I, Chapter 7.

For guidance on cervical dysplasia treatment and surveillance services billing, follow the Cervical Dysplasia Med-IT user guide handout located at http://www.dshs.state.tx.us/bcccs/MedITInformation.aspx.

Office-based Procedures Performed in an Ambulatory Surgical Center

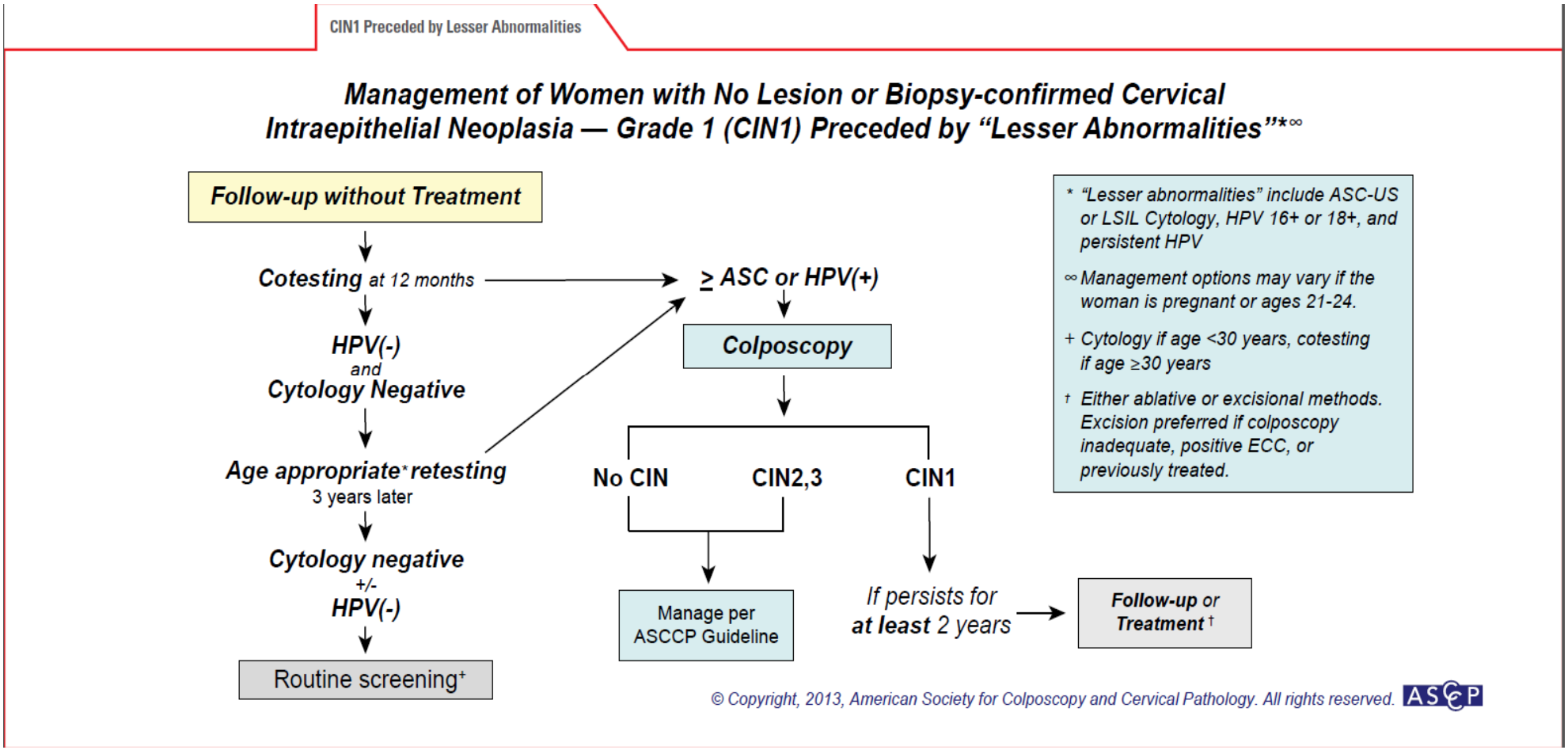
Special circumstances may arise that necessitate an office-based diagnostic procedure being performed in an ambulatory surgical center. These services require pre-authorization prior to the client receiving services in an ambulatory surgical center or other outpatient facility. Contractors must submit the Office-based Procedures Performed in an Ambulatory Surgical Center Pre-authorization Form along with any supporting documentation to BCCSprogram@dshs.state.tx.us **a minimum of three (3) business days prior to the anticipated date of the procedure**. BCCS will not reimburse for any office-based procedures performed in an ambulatory surgical center that have not received pre-authorization. Evidence of pre-authorization approval must be made available to DSHS review staff during Quality Assurance/Quality Improvement on-site visits.

Algorithms for the Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors

The American Society of Colposcopy and Cervical Pathology (ASCCP) established guidelines for management and treatment of abnormal cervical cancer diagnostic tests. Reimbursement is based upon compliance of the algorithms. The algorithms below are for clients utilizing BCCS cervical dysplasia management and treatment services.

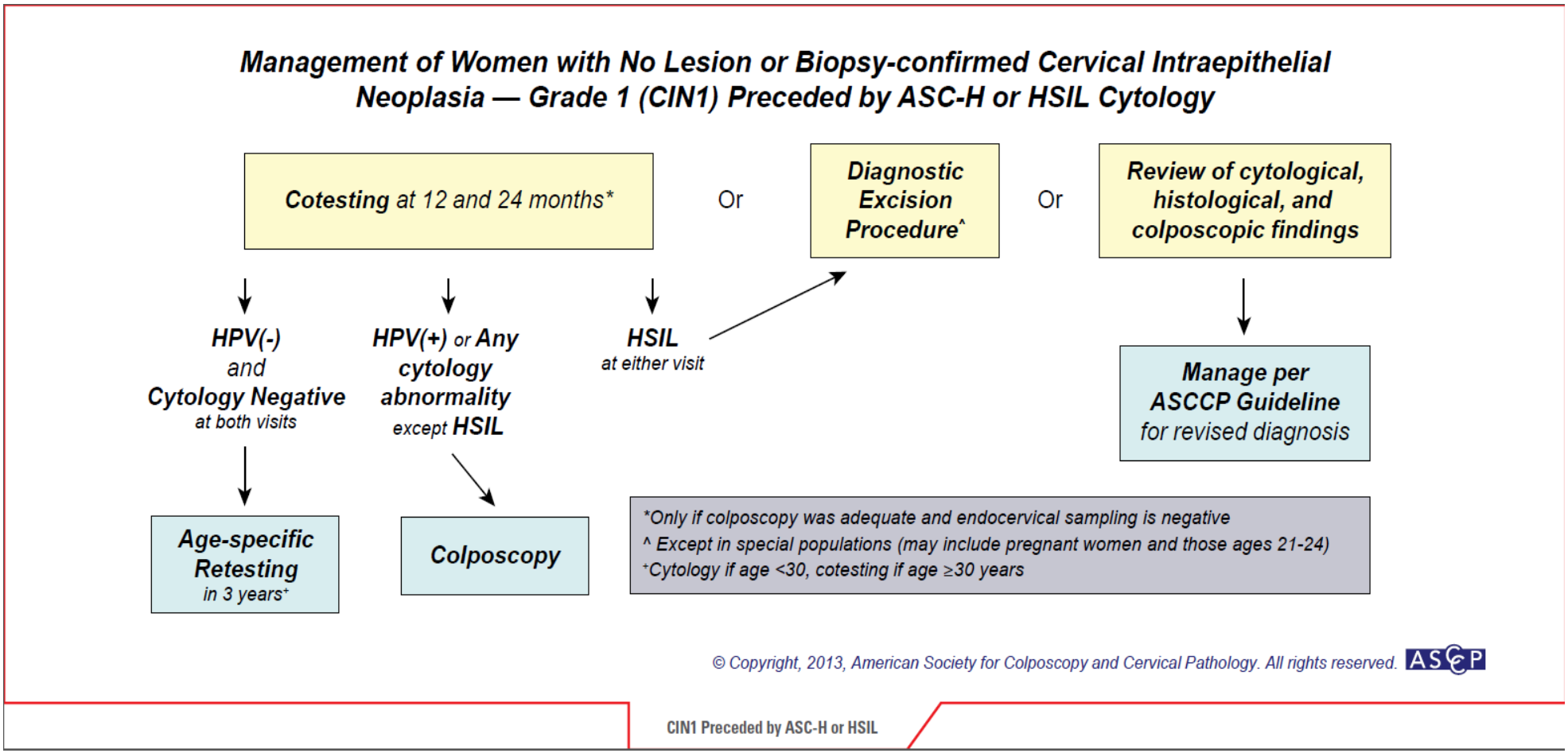
Algorithm Acronyms	
AGC	Atypical Glandular Cells
ASC-H	Atypical Squamous Cells: Cannot exclude High-grade Squamous Intraepithelial Lesion
ASC-US	Atypical Squamous Cells of Undetermined Significance
CIN	Cervical Intraepithelial Neoplasia
EC	Endocervical
HSIL	High-grade Squamous Intraepithelial Lesion
HPV	Human Papillomavirus
LSIL	Low-grade Squamous Intraepithelial Lesion
NILM	Negative for Intraepithelial Lesion or Malignancy
TZ	Transformation Zone

Reprinted from *The Journal of Lower Genital Tract Disease* Volume 17, Number 5, with the permission of ASCCP © American Society for Colposcopy and Cervical Pathology 2013. No copies of the algorithms may be made without the prior consent of ASCCP.



BCCS Notes:

1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only

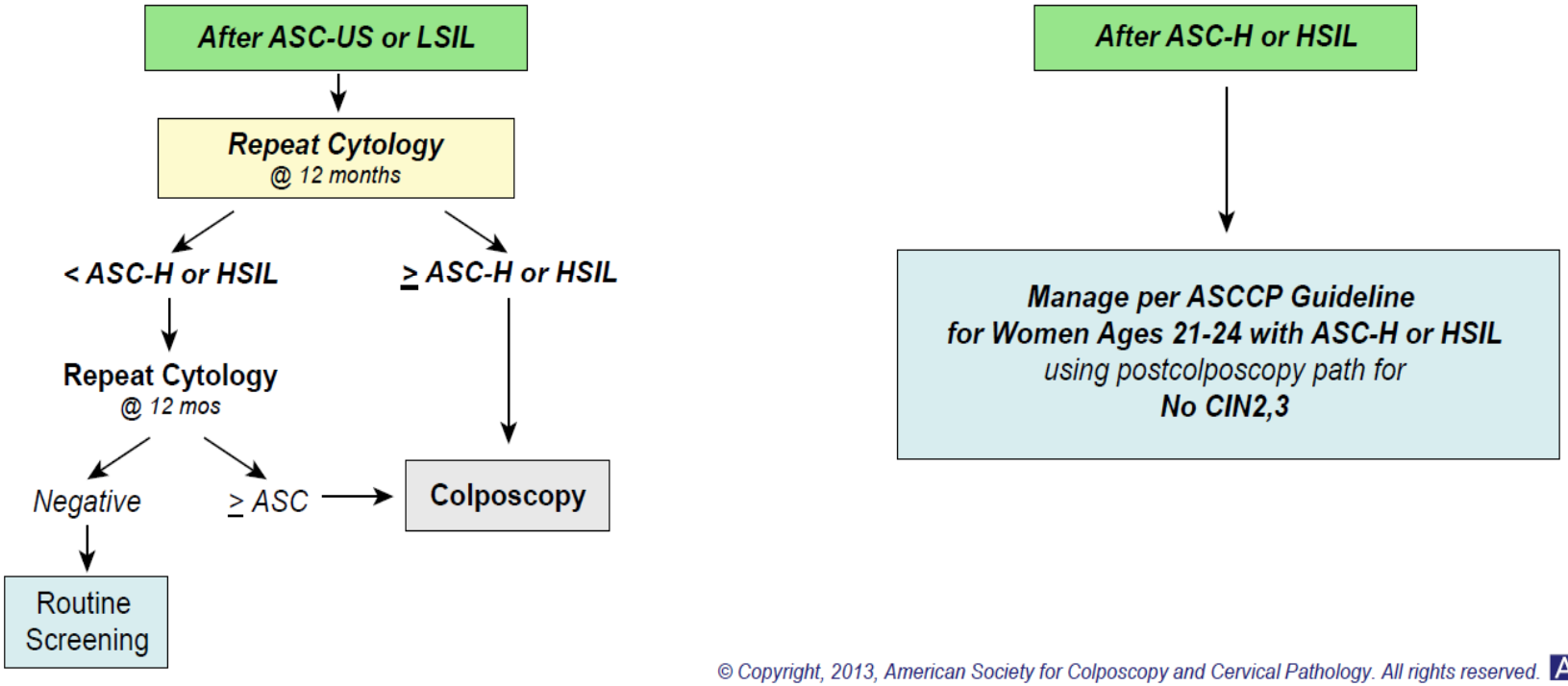


BCCS Notes:

1. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only

CIN1: Age 21-24

Management of Women Ages 21-24 with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 1 (CIN1)



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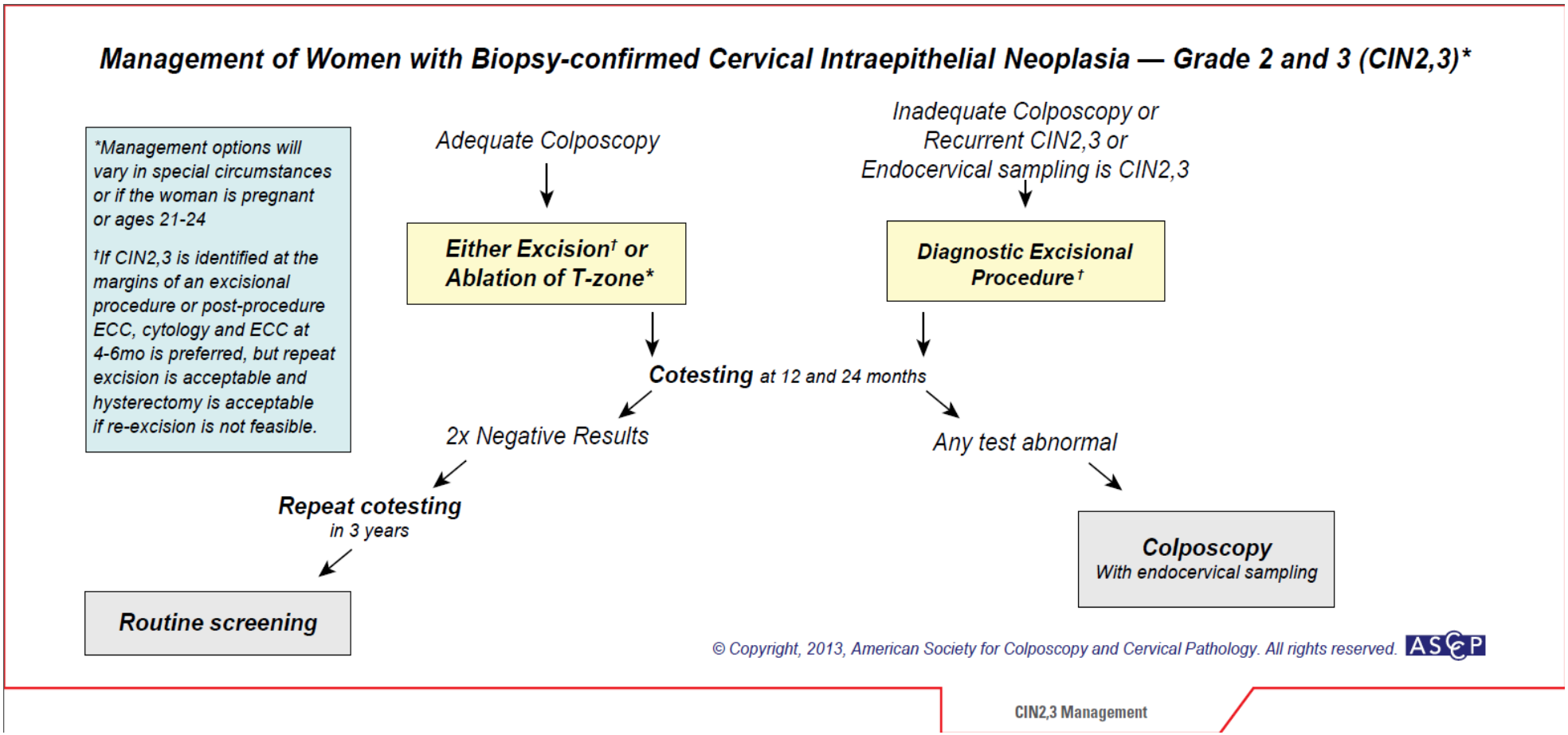
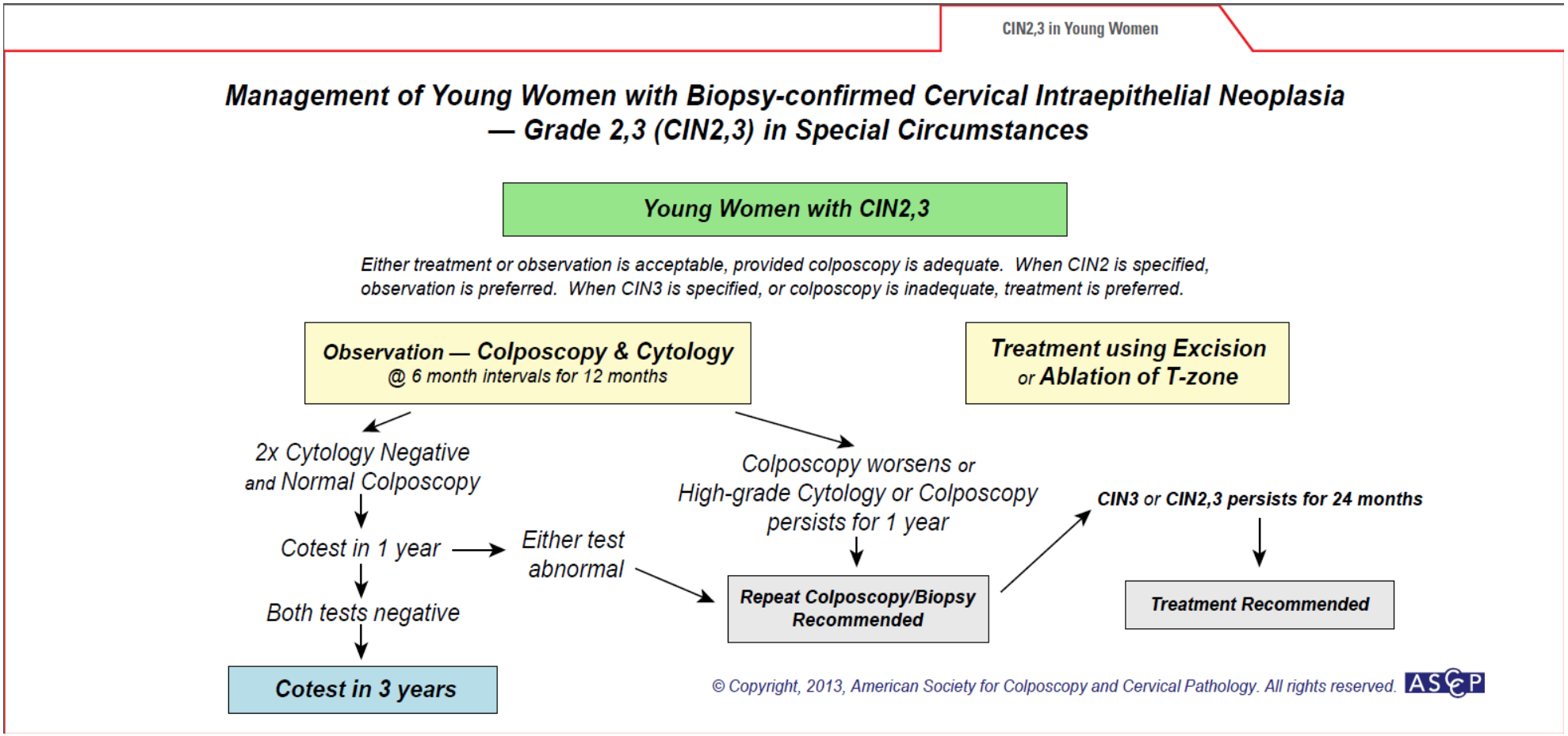
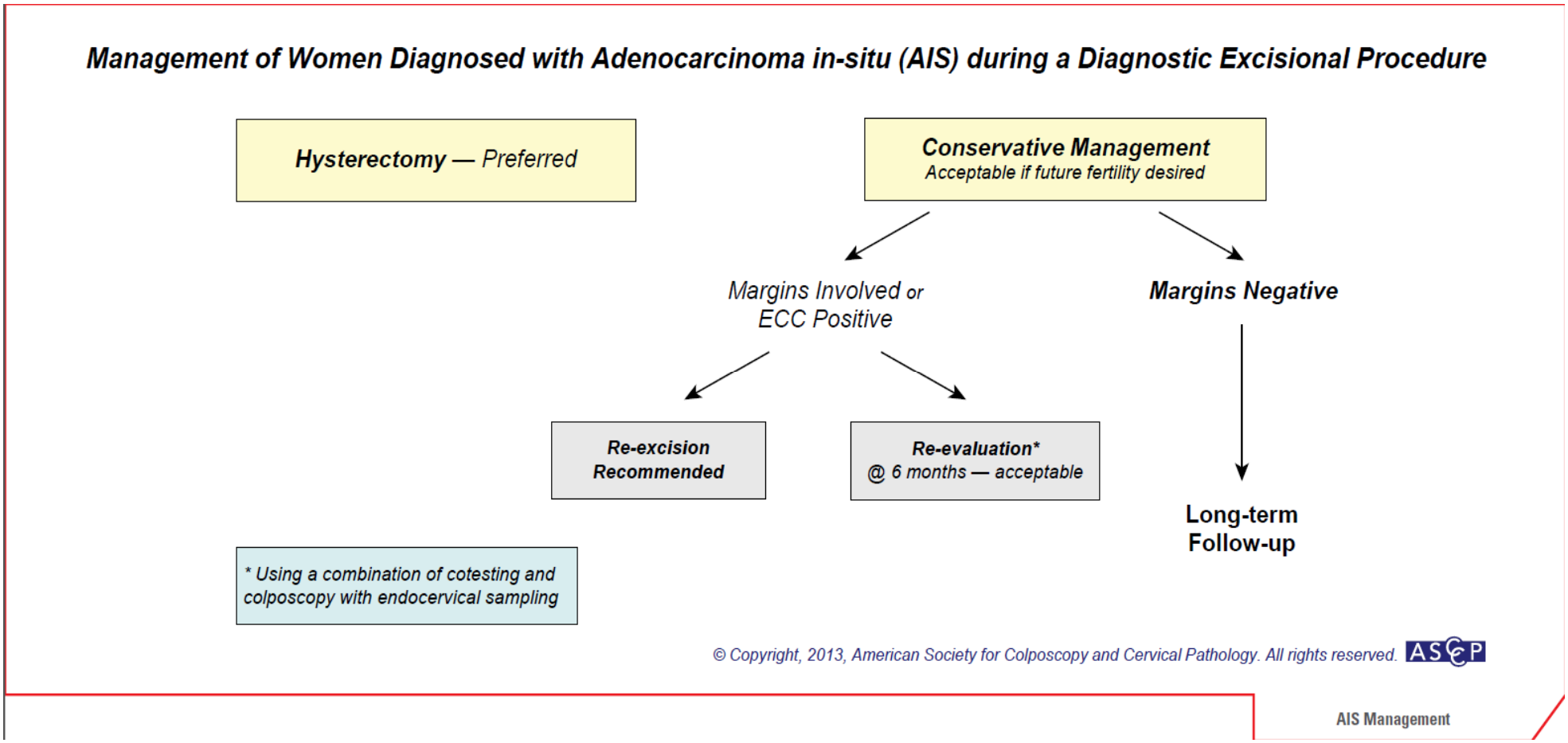


BCCS Notes:
1. Hysterectomy is not reimbursed by BCCS.
2. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only



BCCS Notes:
1. See Clinical Utilization Guidelines for Therapeutic Excisional Procedures.
2. All HPV tests must be FDA approved, clinically validated and for high-risk oncogenic types only



BCCS Notes:
1. Hysterectomy is not reimbursed by BCCS.
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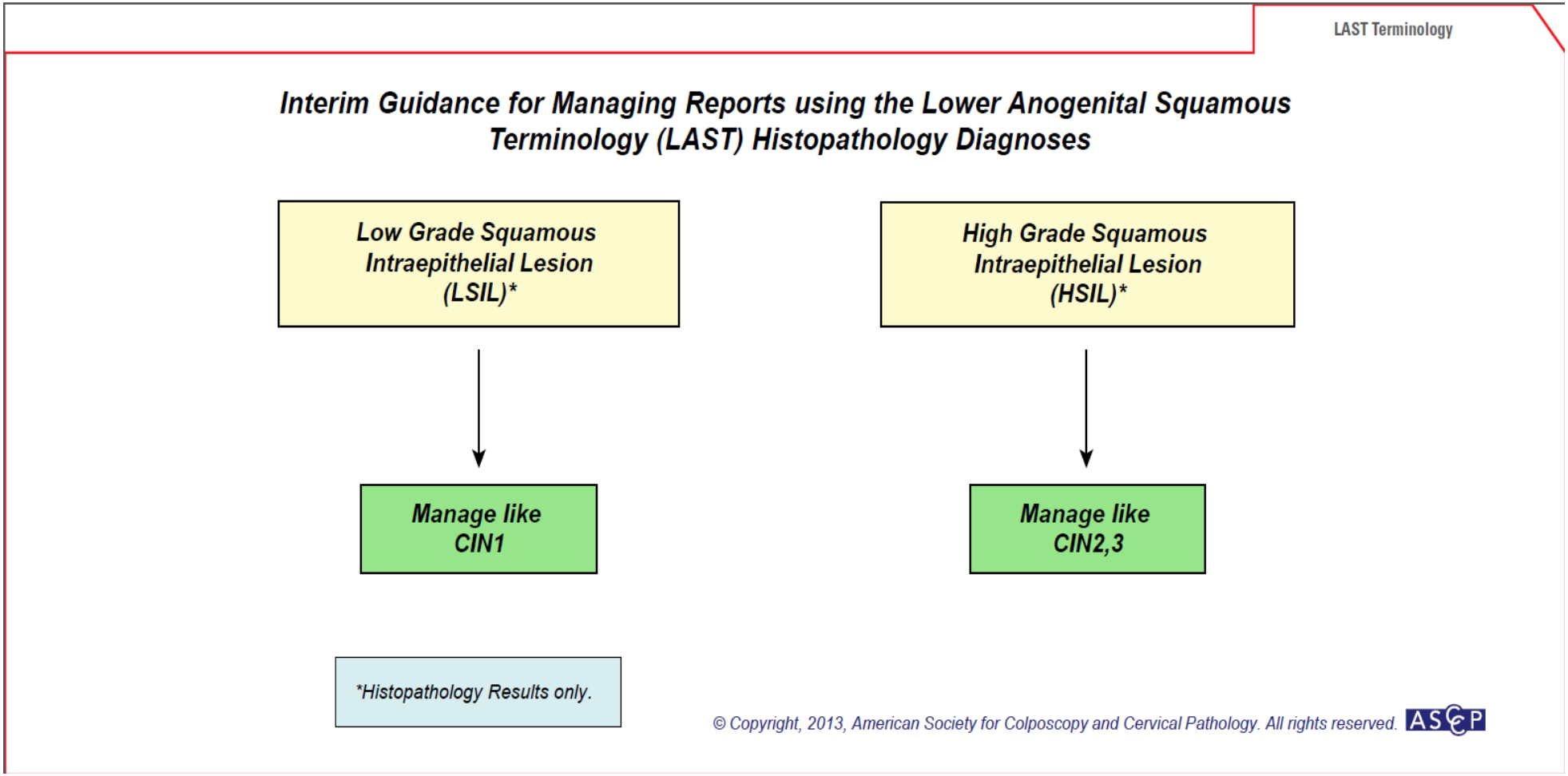

BCCS Notes:

1. BCCS requires contractors to use laboratories which report cytology and histology results using the 2001 Bethesda System (see Quality Management, Section I, Chapter 7).

MEDICAID FOR BREAST AND CERVICAL CANCER

The Health and Human Services Commission (HHSC) administers the Medicaid for Breast and Cervical Cancer (MBCC) Program, a special Medicaid program authorized by federal and state laws to provide access to cancer treatment services through full Medicaid benefits to qualified women. BCCS Contractors are responsible for assisting women with completion of the Form H1034, Medicaid for Breast and Cervical Cancer application, determining presumptive eligibility for qualified women, and assessing case management needs. HHSC is responsible for determining the final eligibility, an effective date of coverage and notifying the client of their approval and Medicaid identification number.

Eligibility – To qualify for MBCC, under the scope of Title XV as provided for in Senate Bill 10, 80th Texas Legislature, applicants who need treatment must meet all of the following criteria:

- Be diagnosed by a BCCS contractor or diagnosed by any physician and referred to a BCCS contractor for the application process;
- Have a qualifying diagnosis:
    - For ***primary cancers***, terms such as “compatible with” and “consistent with” do not qualify as definitive diagnoses. If the pathologist is certain the finding is breast or cervical cancer as described above, then it must be clearly stated in the final pathology report.
    - According to National Comprehensive Cancer Network Guidelines (NCCN), inflammatory breast carcinomas (IBC) require a biopsy to evaluate the presence of cancer in breast tissue and dermal lymphatics; a diagnosis of IBC is based on clinical findings. Dermal lymphatic involvement is neither required for, nor sufficient by itself to assign a diagnosis of IBC, therefore a diagnosis of IBC is based on clinical findings. Pathology reports using terms such as “compatible with” and “consistent with” in addition to documentation which supports a clinical diagnosis of IBC should be submitted for review.
    - Primary qualifying diagnosis of CIN III, severe cervical dysplasia, cervical carcinoma in-situ, invasive cervical cancer, ductal carcinoma *in situ* (DCIS) or invasive or infiltrating breast cancer;
    - Metastasis related to the primary qualifying diagnosis;
    - Recurrence of the primary qualifying cancer diagnosis;
    - **See Appendix E**, Texas Medicaid for Breast and Cervical Cancer (MBCC) Qualifying Diagnosis Guidance for further information; and
- Be at or below 200% of the federal poverty level; and
- Not be insured, that is, she must not otherwise have creditable coverage (Creditable coverage is health care coverage that covers treatment for breast or cervical cancer, including current enrollment in Medicaid or Medicare Part A, Part B, or Part A & B) Note: If the woman is enrolled in the Texas Women’s Health Program [TWHP] at the time of diagnosis, she will be dis-enrolled from TWHP in order to be enrolled in MBCC by Medicaid eligibility staff; and

- Be under age 65; and
- Be a U.S. citizen or eligible immigrant; and
- Be a Texas resident.

Need Treatment – An applicant is considered to "need treatment" if, in the opinion of the treating health professional, diagnostic evaluations indicate that the applicant is in need of cancer treatment services. The treating health professional may be the individual who conducts the evaluations or any other health professional with whom the individual consults.

Clients receiving hormonal treatment and/or breast reconstruction are considered to be receiving treatment and ***may remain eligible*** for MBCC benefits if the client had active treatment paid for by Medicaid. Clients with triple negative receptor breast cancer (TNRBC) receiving active disease surveillance are also considered to be receiving treatment and ***may remain eligible*** for MBCC benefits if active treatment was paid for by MBCC. Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression in order to quickly treat cancerous and precancerous conditions arising from the presence of a previously diagnosed TNRBC.

Verification of Citizenship and Identity – As part of Public Law 109-171, Deficit Reduction Act of 2005, individuals declaring to be a United States (U.S.) citizen or nationals of the U.S. must provide evidence of citizenship when applying for or receiving Medicaid benefits. Documented verification must establish both citizenship and identity.

The Medicaid citizenship and eligible immigrant status rules apply to MBCC. In general, to be eligible for Medicaid an individual must either be a citizen or an eligible immigrant.

Documentation of Eligible Immigrants – Information on citizenship guidelines for:

1) Qualified aliens who were admitted into the U.S. before Aug. 22, 1996 and
2) Legal Permanent Residents (LPR) who were admitted into the U.S. on or after Aug. 22, 1996 can be found at https://www.dads.state.tx.us/handbooks/texasworks/A/300/300.htm

If an applicant states that she is a citizen or legal immigrant, indicate on the last page of Form H1034 that she is **presumptively eligible**. If the BCCS Contractor (or health provider) is uncertain whether a woman meets citizenship and eligible immigrant requirements, the completed H1034 should be submitted for processing and determination, along with any citizenship or immigration documents the woman provides**.** If an applicant states that she does not meet citizenship requirements, an MBCC application may not be submitted.

If contractors submit applications to DSHS which are known to be ineligible for MBCC, DSHS may withhold or recover payment.

Presumptive Eligibility – Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before a full citizenship or legal immigrant eligibility determination is complete. Presumptive eligibility facilitates the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer.
The earliest date presumptive eligibility may begin is the day after the client received a biopsy-confirmed qualifying diagnosis.

BCCS Contractors or a BCCS Subcontractor that is a Medicaid provider shall be responsible for determining if a woman is presumptively eligible for MBCC. In situations where a BCCS contractor or subcontractor is unsure about a diagnosis, the first step should be:

1. Review Appendix E, Guidelines for Determination of Qualifying Diagnosis;
2. If still unclear, the contractor should consult with their Medical Director or physician/provider staff regarding the diagnosis;
3. Collect and review documents to ensure a qualifying medical diagnosis financial status, age, citizenship and identity requirements are met; and
4. Assist with the medical assistance application (Form H1034) process.

Note: It is not appropriate for a DSHS BCCS Contractor to submit a diagnosis to the DSHS BCCS Clinical team or BCCS Staff for evaluation prior to submitting an MBCC application.

Coverage – The earliest date a woman may be enrolled in full Medicaid coverage through MBCC is the day after she received a biopsy-confirmed qualifying diagnosis. Coverage may continue through the duration of her cancer treatment. MBCC services are not limited to the treatment of breast or cervical cancer. If a client has a question about their Medicaid benefits or wants to locate a Medicaid provider in their area, they can call the TMHP Medicaid Client Help Line at 1-800-335-8957.

A client can continue to receive full Medicaid benefits as long as they meet the eligibility criteria and provide proof from their treating physician that they are receiving active treatment for breast or cervical cancer by returning Form H1551, Treatment Verification, along with Form H2340, Medicaid for Breast and Cervical Cancer Renewal, to HHSC before the end of the 6-month coverage renewal period.

If the client's cancer is in remission and the physician determines that the client only requires routine health screenings (e.g. annual breast examinations, mammograms and pap tests as recommended by the American Cancer Society

and/or the US Preventative Services Task Force), the client is not considered to be receiving treatment and MBCC coverage would not be renewed. If a client is later diagnosed with a new breast or cervical cancer, recurrence of breast or cervical cancer, or metastasis related to the primary qualifying diagnosis, she may re-apply for MBCC.

BCCS Contractor Responsibilities – BCCS Contractor (or BCCS Subcontractor that is a Medicaid provider) will be responsible to:

- Determine BCCS eligibility (financial and Texas residency);
- Verify the final biopsy-confirmed diagnosis is a qualifying condition for medical assistance.
- Verify that analysis of all biopsies have been performed by a US CLIA certified laboratory;
- Verify the date of specimen collection is documented (specimen collection date is typically found on the Pathology report, Operative record, or Procedure note);
- Assist with the completion of the medical assistance application, Form H1034;
- Determine client presumptive eligibility;
- Complete Med-IT data entry and billing, including the Final Diagnosis and Treatment Screen for clients diagnosed with BCCS funds. The specific name of the treatment facility will be needed to facilitate closing out the cycle in Med-IT and for CDC reporting. Contact the Med-IT Data System Helpdesk (med-ithelpdesk@dshs.state.tx.us) to add facilities to Med-IT.

  NOTE: Contractors must enter all referred-in MBCC clients and existing BCCS clients into the Med-IT Data System prior to submitting the completed MBCC application to DSHS.

Following:

- Fax completed medical assistance application and the following documentation to DSHS/BCCS (see Contact Information below):
  - Form H1034;
  - **Final** biopsy confirmed report for the qualifying diagnosis, preliminary or temporary reports of qualifying diagnoses will not be accepted;
    - A cervical pathology report of CIN II - CIN III, does not qualify as a definitive diagnosis for the MBCC program. It is advisable to consult with the pathologist for determination of either CIN II or CIN III when a contractor receives this result. If a definitive CIN II or CIN III cannot be made, refer the client to Cervical Dysplasia Management and Treatment;
  - Any other supportive documents that may be necessary to verify the date of specimen collection and need for cancer treatment. (e.g. operative record, procedure note or progress notes);

- Citizenship and identity verification-write out Driver's License and Alien ID numbers on the copy of the identification cards;
- If the diagnosis is more than a year old submit **both** of the following:
  - Physician letter/office visit note specifying need for active treatment and form H1551; and
  - Recent medical tests supporting the need for active treatment.

- To support a metastatic or recurrent cancer diagnosis, send:
  - Final biopsy-confirmed report of the *original* breast or cervical cancer diagnosis.
  - Diagnostic report(s) (e.g. CT scan, biopsy report, etc.) which indicate disease is "compatible with" and/or "consistent with" an original qualifying breast or cervical cancer diagnosis. For example, a diagnosis such as "metastatic adenocarcinoma consistent with the prior breast primary" would be acceptable. Many metastatic or recurrent cancers may look the same; the primary does not need to be explicitly diagnosed.

NOTE: Do not highlight information on the pathology report or any supporting documents being faxed as it prevents the information necessary to review application from being readable.

- Fax completed MBCC application and all supporting documents to: (512) 776-7203

- Email client's Med-IT ID number to DSHS/BCCS to confirm receipt of the application and supporting documents:

  Email Address: MBCCApps@dshs.state.tx.us
  Subject line: Verify Receipt of MBCC Application

- The name on the medical assistance application (H1034) must match the name on the client's social security card or legal identification. If names differ from the medical assistance application (H1034) or the pathology report, contractors must provide clarification.

- Do not fax bills, tax forms, or other financial statements or information. Contractors shall retain proof of income in client record and document financial eligibility in Med-IT.

- **BCCS does not assist with or collect documents for MBCC applications following submission to HHSC.**

Biopsy Services Provided Outside the United States:

Pathology specimens (original slides) collected and evaluated outside the U.S must be reviewed by a US CLIA certified lab in order to determine a biopsy confirmed diagnosis. The BCCS program and the client cannot be billed for the reading and interpretation of the specimen submitted to a US CLIA lab.

Options for specimen transport are:
- Client transported; or
- Lab-to-lab transported.

Timeframe – BCCS contractors must submit the medical assistance application (Form H1034) and other required documents to the DSHS BCCS MBCC Coordinator no later than two (2) working days from the date the presumptive eligibility determination is made (certification date at the bottom of page 7 of the application).

DSHS/BCCS Contact Information – For additional information and/or questions regarding MBCC, contact the Department of State Health Services Preventive and Primary Care Unit, Breast and Cervical Cancer Services at:

Email Address: MBCCapps@dshs.state.tx.us
Subject Line: MBCC Information/Question(s)

DSHS/BCCS State Office Responsibilities – DSHS/BCCS program staff are responsible for reviewing the clinical documents and other required documents and submitting the information to the HHSC Medicaid Unit within two working days of receipt of the complete application package.

HHSC MBCC Eligibility Staff Responsibilities – HHSC is responsible for determining the final eligibility and notifying the client. Typically, final eligibility will be determined by HHSC Medicaid Unit within two (2) to three (3) working days of receipt of a presumptive eligibility application packet. Eligibility for all applications will be determined within 45 calendar days of receipt of the application packet.

For assistance with client eligibility and citizenship determination, call 2-1-1 or 1-877-541-7905.

Medicaid Reinstatement – A client previously enrolled in Medicaid under MBCC, and who is no longer on Medicaid, but is still in active treatment, or is in need of active treatment, for the original cancer may re-apply for MBCC. The BCCS contractor will help the client by:

- Obtaining a letter from the treatment provider indicating that the client is receiving or needs active treatment for the original qualifying diagnosis or obtain a completed Form H1551(Treatment Verification Form);
- Assist with completing a new medical assistance application (Form H1034);
- Faxing the following documents to the DSHS/BCCS MBCC Coordinator:
  - Form H1034;
  - The letter from the treatment provider or Form H1551(Treatment Verification form) indicating the need for active treatment;
  - The pathology report for the original qualifying diagnosis;
  - Recent medical tests and progress notes supporting the need for active treatment, if available; and
  - Citizenship and identity verification.
- Emailing DSHS/BCCS to confirm receipt of the fax.

Fax Number:	(512) 776-7203
Email Address:	MBCCapps@dshs.state.tx.us
Subject line:	Verify Receipt of MBCC application

State-to-State Transfer- State-to-State transfers are handled directly by HHSC. Please complete the following steps:

- **<u>Do not</u> complete Form H1034.**
- **<u>Have client</u> call 2-1-1 or 1-877-541-7905**

Client requests Out-of-State MBCC application Form H2340-OS AND Out-of-State treatment verification Form H1550. 2-1-1 will send the documents to the client to complete and return to HHSC.

PATIENT NAVIGATION RECORD

BCCS contractors must establish a patient navigation record for:

- Every BCCS enrolled client with an abnormal screening (exceptions noted below) or diagnostic result;
- Every client with a qualifying breast or cervical cancer diagnosis referred to a BCCS contractor who meets the MBCC eligibility criteria; and
- Every client referred to BCCS for Cervical Dysplasia Management and Treatment who is not eligible for MBCC.

Exceptions:

Patient navigation is not required for the following abnormal screening results:

- Clients with an abnormal CBE and/or screening mammogram followed by two normal diagnostic assessments/tests, e.g. diagnostic mammogram, breast ultra sound, or referral to a breast specialist for a consultation where no further diagnostics are required.
- Clients with initial ASC-US unless colposcopy is indicated.

Components of the patient navigation record are:

- Patient navigation assessment and service plan - Using the Comprehensive Case Management Form (CCMF - sample in Appendix C1), the assessment and service plan should be recorded electronically using the Med-IT Data System; under screening cycles; Patient Navigation. The filled in form may be printed from the BCCS website (**http://www.dshs.state.tx.us/bcccs/default.shtm**) under the Forms tab, for the client to sign. A copy of the signed CCMF must be maintained in the client's record. CCMF (Appendix C1) is the required assessment document for the BCCS program and cannot be altered or modified;
- General informed consent that addresses patient navigation, confidentiality, and authorization to enter or view data in the statewide database;
- Pathology report from a US CLIA certified lab with a definitive (final) biopsy confirmed qualifying diagnosis for MBCC applicants;
- Specimen collection date is typically found on the pathology report. If the date is unclear, the collection date will also be found on the operative record or procedure note for MBCC applicants;
- Financial eligibility documents - Any client who will be assisted by a BCCS contractor to apply for MBCC must provide income verification. The BCCS contractor's internal financial eligibility policy will identify the documentation required to be kept in the client's medical record.
- Citizenship documentation for MBCC applicants- Clients whose citizenship eligibility is indeterminate may submit MBCC applications for final HHSC determination (Expanded citizenship guidelines in Section II, Ch. 7).

- The patient navigation record will be maintained according to State laws, including those governing records retention. Patient navigation records are subject to review during Quality Assurance Review visits.

Client Education – The contractor must provide and document breast/cervical cancer information to every client who receives breast/cervical cancer screening and/or diagnostic services through BCCS. The following information must be explained and communicated effectively to each client in their primary language and may be supplemented with printed or audio-visual materials:

- Review any questions regarding screening(s)/diagnosis(es);
- Information on the limitations of screening procedures, including imaging limitations with dense breasts;
- Importance of screening at regular intervals;
- Required to complete the current check-up;
- Description of possible results of tests and/or medical procedures;
- Date of next appointment and a telephone number to call for questions and/or to schedule next appointment; and
- Eligibility may change from year to year, and is redetermined annually.

PATIENT NAVIGATION SERVICES

BCCS patient navigation services are provided to clients with abnormal screening results. Clients must be assessed for their need of patient navigation services and provided with such services accordingly. Examples of screening results which would require a patient navigation assessment would be BIRADS 3, 4, or 5 for mammograms; and LSIL, and high-grade lesions for Pap Tests.

Patient navigation involves establishing, brokering, and sustaining a system of available clinical and essential support services, and conclude when a client initiates treatment, refuses treatment, or is no longer eligible.

Patient navigation does not include eligibility determination.

The goal of BCCS patient navigation services is to ensure that clients receive timely and appropriate services. Assessment of medical, education, and essential support needs and the provision of related services when necessary, assist in attaining this goal. The outcome of patient navigation and the progress toward reaching this goal is evaluated by the performance measures outlined in this manual and the DSHS contract.

Patient Navigators and/or Case Managers are responsible for identifying and accessing resources for cancer treatment services for BCCS enrolled women in need, regardless of their ability to pay. Patient navigation services are

reimbursable per BCCS policy and Reimbursement Rates and Billing Guidelines (Appendix B).

The Texas MBCC Program was implemented to provide Medicaid benefits to uninsured clients, under the age 65, who have a qualifying breast or cervical cancer diagnosis and require treatment. Regardless of whether or not they were diagnosed by a BCCS Contractor, they are eligible for assistance with completing the application for MBCC and patient navigation services performed by a BCCS contractor.

BCCS Contractors may choose to provide patient navigation for women referred to them with a breast or cervical cancer diagnosis that is determined to be ineligible for MBCC. If patient navigation is initiated, BCCS Contractors shall follow the client until treatment is initiated and may **not** bill DSHS for the patient navigation services provided. If patient navigation will not be initiated, the client should be provided with information about available local resources and **referred back to the diagnosing health professional**. In this situation, patient navigation may not be billed to DSHS.

For clients who are accurately screened as Presumptively Eligible for MBCC and HHSC has deemed ineligible, the BCCS contractor may choose to follow the women until treatment is initiated. If the contractor chooses not to follow the client, they should be provided with information about local resources and referred back to the diagnosing health professional. **If presumptive eligibility was inaccurate, DSHS may choose to deny any reimbursement for services associated with the MBCC application**.

Patient navigation Components – Patient navigation components include assessment, planning, coordination, monitoring, evaluation, and resource development.

Assessment – Assessment is a cooperative effort between the client and case manager to examine and document the client's need for services (screening, diagnostic, treatment, and essential support services) through a process of gathering critical information from the client. The assessment includes consent and assurance of confidentiality between the client, the case manager, and the contractor.

All BCCS-enrolled clients with abnormal screening results (except for the exceptions noted at the beginning of Section II, Chapter 8) must receive a BCCS needs assessment using the Comprehensive Case Management Form and the Med-IT Data System Patient Navigation screen, unless the client refuses. Assessment components include: client information, other contact information, the need for social resources, other services the client has accessed, education needs, counseling issues, consent for patient navigation, and confidentiality. The assessment is to be conducted within 30 days from the date of referral for diagnostic procedures or prior to the initiation of the first diagnostic service, whichever is sooner. The assessment should be conducted in a face-to-face

interview format, if possible. The assessment date is the date the case manager completed the needs assessment. For non-face-to-face assessments, the client should sign and date the Comprehensive Case Management Form (CCMF); Appendix C, upon their next visit to the agency.

Planning – Planning is a cooperative effort between the client and case manager to develop an individual service plan to meet the client's immediate, short-term, and long-term needs as identified in the assessment.

The plan includes needs identified in the assessment, services planned related to those needs, timeframes for providing the services, referral, outcome, and follow-up. As applicable, timeframes must be consistent with BCCS required screening and diagnostic intervals. The service plan must be documented in the Med-IT Data System Patient Navigation screen and the client's progress notes. Services must be completed no later than 30 days from the date of the planned activity or prior to initiation of treatment.

Coordination – Coordination is the implementation of the service plan, including the appropriate use of available resources to meet the needs of the client.

Implementation of planned services and ongoing case manager-client consultation is documented in the Med-IT Data System Patient Navigation screen and the client's progress notes. Coordination of services may include scheduling appointments, making referrals, and obtaining and disseminating appropriate reports.

Monitoring – Monitoring is key to ensuring achievement of the desired goal of accurate and timely access to services. Monitoring is the ongoing assessment of the client's service plan to ensure that the client's needs are met. As additional needs are identified, they are recorded in the Med-IT Data System patient navigation screen and the client's progress notes. The case manager must document that the planned service or initiation of treatment took place within 30 days of the planned service date.

In addition to monitoring clients who are receiving patient navigation services, BCCS contractors must establish a system to monitor abnormal screening or diagnostic results for the purpose of identifying clients who need to have patient navigation initiated.

Patient navigation is considered complete when:

- Diagnosis resolved and no treatment is needed;
- When a referral appointment for treatment has been attended;
- Client is documented as lost-to follow up or refused services; or
- A "Good Faith Effort" has been made according to BCCS Policy ; and
- Documentation has been entered into the Med-IT system.

Note: "Good Faith Effort" – Making at least three (3) separate documented attempts to obtain treatment for clients with a pre-cancerous or cancerous breast or cervical diagnosis who do not meet the eligibility criteria for BCCS Title V Cervical Dysplasia and/or MBCC Presumptive. Examples of good faith efforts include, but are not limited to seeking service(s) for clients through: American Cancer Society, Susan G. Komen for the Cure, LIVESTRONG or other healthcare providers and facilities through pro-bono, sliding fee scale, reduced payment plan, or sponsorship assistance.

Resource Development – Resource development is the establishment of formal and informal agreements to maximize availability and access to essential screening, support, diagnostic, and treatment services. Documentation must be maintained in a resource directory developed specifically for detailing services that support BCCS-enrolled women with unmet needs.

Evaluation – Evaluation is the process of assessing the effectiveness of patient navigation activities. This should be conducted at the client and agency levels through client satisfaction surveys and with internal quality assurance reviews.

Requirements for Patient Navigation Compliance

- At a minimum, all clients with a screening (other than exceptions noted in patient navigation services) or diagnostic abnormal result must receive a BCCS needs assessment within 30 days of receipt of the result or prior to the initiation of the first diagnostic service. Examples of screening results which would require a patient navigation assessment would be: BIRADS 3, 4, 5 for mammograms and adult LSIL, and high grade lesions for Pap tests;

- All clients referred to a BCCS contractor with a qualifying breast or cervical diagnosis, who have completed the Medicaid for Breast and Cervical Cancer (MBCC) application and have met the eligibility requirements shall receive a BCCS needs assessment within 30 days from the date the BCCS contractor determines the client met the eligibility requirements;

- All clients referred to a BCCS contractor with a qualifying cervical dysplasia diagnosis, who are BCCS eligible and who are MBCC ineligible, shall receive a BCCS needs assessment within 30 days from the date the BCCS contractor determines the client has met the cervical dysplasia services eligibility requirements;

- The needs assessment must include client consent for patient navigation services using the DSHS Comprehensive Case Management Form (CCMF), Appendix D1;

- Contractor must ensure that monitoring of abnormal diagnostic results is conducted and documented at the contractor level;

- Contractor must contact the client with abnormal screening and non-cancerous diagnostic results no later than thirty (30) days following receipt of an abnormal result. All screening and diagnostic services must be documented; including procedure specific consent, if applicable

- Contractor must contact the client who has a cancer diagnostic result no later than two (2) weeks following the receipt of a cancer diagnostic result. All diagnostic services must be documented; including procedure specific consent, if applicable.

- Contractors must assure patient navigation occurs with each BCCS-enrolled client with abnormal results (except for the exceptions noted in patient navigation record paragraph) or diagnosis of cancer until the cycle is closed or a referral appointment for treatment is confirmed;

- Within one month after the client and case manager completes the patient navigation plan for a diagnosis of cancer or cervical dysplasia, the case manager must follow-up and document that the service was actually implemented;

- As additional needs are identified, they are recorded on the plan and the accompanying services and time frames are indicated;

- Contractors must develop and maintain a resource directory containing information on services that could support women with unmet needs who are eligible for BCCS, which may include Marketplace (www.Healthcare.gov) referral materials.

Client Contact Attempts by Contractor

Contact attempts can be made by:
- Office visit,
- Telephone,
- Home visit, and/or
- Mail.

Attempts to contact the client must be written or presented verbally (when appropriate) in the client's primary language, if limited English proficient, including appropriate provisions for the visually and hearing impaired.

Client Refusal of Services

The contractor must attempt to obtain in writing and document in the client record informed refusal from the client if the client fails to keep appointments or refuses recommended procedures. If the client cannot, or will not, sign an informed refusal the contractor must document verbal refusal. Before closing the client record as a refusal, a thorough review of the client's plan, recommendations, and case manager's actions must be conducted to ensure proper closure.

Client Is "Lost to Follow-up"

Before a contractor can consider a client as "lost to follow-up," the contractor must have at least three separate documented attempts to contact the client, with the last attempt sent by certified mail. The contractor must allow sufficient time between contact attempts for the client to reply/respond to the contractor.

Contractors must monitor the performance measures of:

- Time from an abnormal screen to diagnosis; and
- Time from diagnosis to treatment when determining whether a client is classified "Lost to Follow-up" or "Refused."

A contractor may continue to follow/track a client's progress for medical/quality of care issues, but for the BCCS program these cases should have a determination of the client's status before the performance measure timeframe is exceeded.

COMMUNITY EDUCATION

To provide inreach, outreach, and education to the community, each contractor must establish a comprehensive outreach and education plan. This plan will include the determination of the priority population, a recruitment work plan, effective recruitment methods, and evaluation of the effectiveness of recruitment strategies. Contractors should have an array of materials and resources to aid in community awareness. Contractors must develop and maintain relationships with local partners/collaborators that can assist in the recruitment of the priority population.

Contractors must include in their outreach plans how they plan to do the following:

- Implement strategies to enroll clients in BCCS including:
  - Identifying the priority populations to receive information;
  - Identifying the population at highest risk for developing breast and/or cervical cancer; and
  - Establishing relationships with internal and external partners to reach eligible clients in the priority populations.
- Implement strategies to raise community awareness of MBCC including:
  - Educating partners such as subcontractors, other health care providers, community organizations, coalitions, and local advocacy groups about MBCC and how to appropriately refer a non-BCCS diagnosed client for MBCC screening; and
  - Educating clients diagnosed with breast or cervical cancer about MBCC eligibility requirements and how to apply for services.
- Provide information to each eligible woman in her primary language;
- Provide access to information that is culturally sensitive, linguistically appropriate, and also available to the visually and hearing impaired;
- Conduct outreach activities specifically for clients age 50-64 years if less than 75% of all mammograms are provided to women ages 50-64, or the projected number of women to be screened is not reached for this age group;
- Conduct outreach activities specifically for clients who have rarely or never received cervical cancer screening if less than 20% of clients newly enrolled for cervical cancer screening have not had a pap test in the last five years or the projected number of women ages 40-64 years is not reached;
- Collect information describing how clients learned about BCCS, and enter data into the Med-IT Data system using the “Learned of Program” function on the enrollment screen; and
- Submit the agency’s comprehensive outreach and education plan within 30 days after the start of each contract term. Submit plans to BCCSprogram@dshs.state.tx.us.
- Complete contractor progress report surveys detailing inreach, outreach and education as requested by BCCS staff.

Section III
Reimbursement and Reporting

Billing Procedures for BCCS Contractors

BCCS client data shall be entered into Med-IT no later than 30 days after provision of each service. Requests for reimbursement will be generated periodically as one of the automated functions of the Med-IT Data System. BCCS services and procedures that have met business rules will be marked approved to pay and submitted electronically to DSHS for processing through the State Comptroller. Paid claims will be deposited into the contractor's direct deposit account. Contractors may only be reimbursed for services listed in the BCCS Reimbursement Rates and Billing Guidelines (see Appendix B).

Completed MBCC applications shall not be submitted to DSHS until all client data and case management billing has been entered into Med-IT.

Funding for Screening Mammograms/MRI

Reimbursement for screening mammograms/MRI for asymptomatic women ages 40-49 may be allowed with CDC funding [not to exceed 25% of BCCS funded mammograms/MRIs]. These services must be billed using the B codes in the Reimbursement Rates and Billing Guidelines.

BCCS funds may not be used for breast cancer screening in clients under the age of 40.

Funds for Cervical Dysplasia (CD) Management and Treatment

Cervical dysplasia funds should be used for cervical dysplasia management and treatment services for women who meet BCCS eligibility criteria and have a definitive diagnosis (biopsy confirmed) of:

- CIN I, CIN II, CIN II-III; or
- CIN III or CIS if the client does not meet eligibility criteria for Medicaid for Breast and Cervical Cancer (MBCC). CIN III/CIS results should always be screened for MBCC eligibility **prior** to CD treatment enrollment. See Cervical Dysplasia Management and Treatment Chapter, Section II, Chapter 6.

REPORTING

Financial Reconciliation Report (FRR) – This form replaces Form 270 Advance or Reimbursement Form**.** FRR is to be submitted no later than 60 days after the end of the contract term, or 30 days after the last pay file is run, whichever is later. The FRR does require a signature. Send completed and signed scanned form to CDSB@dshs.state.tx.us A copy of the form can be found on the FCHS web page: https://www.dshs.state.tx.us/chscontracts/all_forms.shtm

Report Name: Financial Reconciliation Report (FRR)				
Submission Date: No later than sixty (60) days after the end of the contract term, or thirty (30) days after the last pay file is run, whichever is later.				
Submit Copy to:				
Name of Unit/Branch	**Signature Required**		**Accepts Email or Fax**	**# Copies**
	Yes	**No**		
Contract Development and Support Branch (CDSB)	X		Email preferred	1
Instructions: FRR does require a signature (scanned or fax accepted), and needs to only be sent to CDSB.				

Email Addresses:	Contract Development and Support Branch	cdsb@dshs.state.tx.us
Fax Numbers:	CDSB	(512) 458-7521
	PPCU	(512) 458-7203
Mail Codes:	Please use mail coders on all mail coming into DSHS to ensure accurate delivery.	
	Contract Development and Support Branch	Mail Code 1914
	Preventive and Primary Care Unit	Mail Code 1923
Updated 7/30/15		

Match Report – Matching funds refer to non-Federal resources (money and/or in-kind contributions). The CDC requires the BCCS to provide $1 in match for every $3 CDC funding awarded. See below for examples of acceptable match items. All BCCS contractors must secure, budget, expend, and report non-Federal match. Match reports are submitted to the Contract Development and Support Branch (CDSB) on a quarterly basis. This form can be found at:
http://www.dshs.state.tx.us/chscontracts/all_forms.shtm
See below for instructions on completing the report. Contractors must maintain and submit back-up documentation to support matching contributions.

Report Name: Quarterly Matching Contribution Report				
Submission Date: Quarterly, within 30 days following the end of each quarter				
Submit Copy to:				
Name of Unit/Branch	**Signature Required**		**Accepts Email or Fax**	**# Copies**
	Yes	**No**		
Contract Development and Support Branch (CDSB)		X	Email preferred	1
Instructions: Quarter Matching Contribution report does not require original signature				

Instructions for completing the Quarterly Match Report

1. The contractor organization name must appear as it does on the DSHS contract.

2. Indicate the current budget period (09/01/YY – 02/29/16)

3. Indicate the reporting quarter

Match Report Quarters:	Due Dates
1st Sep 1 – Nov 30	30 days following end of qtr.
2nd Dec 1 – Feb 29	30 days following end of qtr.

4. Indicate the base award, all additional awards (if applicable) and total funding for reporting year.

5. Indicate the match projected for the approved base award. If your organization received additional funding, indicate the match projected for additional funds. Indicate "N/A" if no additional funds were awarded. Total match projected for both base award and additional awards and note it on the "Total Match".

6. Type in the name/signature of the person authorized to verify the match information (i.e., that reported match is correct and auditable).
7. List each item by category (program component), detailed description of service provided, funding source [e.g., another (non-federal) grant, local government,

donation from individual or organization], and amount of each match item. Items must be those that would be paid by the BCCS, are directly allocable to BCCS activities, and cannot include indirect or overhead costs. Indicate total amounts for each quarter and cumulative totals.

Examples of acceptable match items by category (not all-inclusive)

Screening/Diagnostic Services:
- Clinical breast and pelvic examinations;
- Office visits and/or breast consultations;
- Clinical procedures approved for reimbursement by the program;
- Difference between usual and customary charges and Medicare reimbursement rates approved by the program

Case Management Services:
- Staff time conducting face-to-face and telephone contact with clients who have abnormal breast or cervical findings to provide case management activities such as assessment, planning, and monitoring; and local travel required for follow-up of individual clients

Public Education/Information:
- Staff time conducting breast and/or cervical cancer media campaigns

Client Education:
- Staff time spent providing breast and cervical cancer education to program clients;
- Educational materials provided to individual clients such as videotapes, and pamphlets

Outreach:
- Staff time spent conducting outreach and recruitment activities to increase the number of women screened by the program;
- Staff's local travel necessary to conduct outreach and recruitment activities

Data Collection:
- Staff time for data collection and reporting;
- Costs of local program data tracking software and other tools

Quality Assurance:
- Staff time to review client records to assess compliance with program requirements

Professional Development/Professional Education:

- Expenses paid by contractor to attend breast/cervical cancer-related training, workshops, or conferences (e.g., break out travel, per diem, conference fees, and CEU fees)

Costs associated with the above activities (e.g., staff time, postage, supplies) may be reported as match if they are directly allocable to those activities. Items that are not directly allocable to program activities and are defined as overhead or indirect costs are not allowable as match. Treatment costs are not allowable as match.

Supporting information must be included on the form or attached separately to document the method used to calculate match amounts. See examples on next page.

Category	Description of Services	Funding Source(s) and Amount of Each	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Cumul. Total Qtrs. 1-4
1. Screening and Diagnostic Services	Difference between usual and customary charges and BCCS Medicare rates	N/A	$20,000	$30,000	$35,000	$40,000	$125,000
	Facility charges for excisional breast biopsies	Memorial Hospital	$7,000	$5,500	$2,000	$4,000	$18,500
2. Case Management Services	Case management of clients with abnormal screening and/or diagnostic results	X funding source 10 clients x $100 each	$500	$800	$700	$1,000	$3,000
3. Public Information and Outreach	Breast cancer pamphlets for quarterly health fair	Komen Foundation 1,000 pamphlets @ $.50 ea.	$500	$500	$500	$500	$2,000
4. Client Education	Staff time to conduct face-to face-interviews with clients	Y funding source Health Educator salary = $30,000 x 10% = $3,000 x 20% fringe = $20+$3,000 = $3,020	$1,200	$2,400	$2,000	$3,020	$8,620
5. Data Collection	Staff time to conduct data collection and reporting	Kellogg Foundation Office assistant salary = $25,000 x 10% = $2,500 x 20% fringe = $500 = $3,000	$3,000	$3,000	$3,000	$3,000	$12,000
6. Quality Assurance	Staff time for reviewing BCCC client records	Client Fees R.N. salary =$50,000 x 5% = $2,500 x 20% fringe = $500 +$2,500 = $3,000	$3,000	$2,500	$3,000	$3,000	$11,500
7. Professional Education	Attendance at breast cancer conference	City Funding Source Travel expenses for 1 nurse				$500	$500
8. Program Management	Staff time processing billing	County Funds Accountant salary = $40,000 x 5% = $2,000 x 20% fringe = $400+$2,000 = $2,400	$2,400	$2,400	$2,400	$2,400	$9,600
Grand Total			$37,600	$47,100	$48,600	$57,420	$190,720

SAMPLE

BREAST AND CERVICAL CANCER SERVICES
QUARTERLY MATCH REPORT

1. Contractor Name
_____
2. Budget Period _____ 3. Quarter ____1 ____ 2 ____ 3 ____ 4

4. Total Funding Award for Current Budget Period: Base Award _____ Additional Funding Award _____ Total Award _____

5. Total Match Projected for Current Budget Period: Base Match _____ Match for Additional Funding: _____ Total Match _____

6. Date Match Report Submitted _____ Name of Person Submitting Report _____

7. In the table below, list your actual match contributions for each quarter. Describe each service, the funding source(s) for each service, and the total match for each quarter. Indicate the cumulative totals in the appropriate spaces. Use additional pages if necessary.

SAMPLE

Category	Description of Services	Funding Source(s) and Amount of Each (Federal Funds are not approved for as a match source)	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Cumul. Total Qtrs. 1-4
1. Screening and Diagnostic Services							
2. Case Management							
3. Public Information and Outreach							
4. Client Education							
5. Data Collection							
6. Quality Assurance							
7. Professional Education							
8. Program Management							
Grand Total							

SAMPLE

Section IV
Appendices

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form

TEXAS Department of State Health Services

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address		
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP	
SSN (optional)	Date of Birth	Age	Race	Ethnicity	Sex

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that you have received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid for Pregnant Women ☐ TWHP ☐ None

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible. Minors should include parent(s)/legal guardian(s).

How many people are in your household? ☐

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

Eligibility effective date / /

1. Texas resident	☐ Yes	☐ No	
2. Total monthly household income	$		
3. Household FPL	%		
4. Proof of income	☐ Yes	☐ Waived	
5. Verification of adjunctive eligibility	☐ Yes	☐ No	☐ n/a
6a. Presumptively eligible	☐ Yes	☐ No	☐ n/a
6b. Full eligibility met	☐ Yes		
6c. Full eligibility met date	/ /		

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$_____
DSHS FP	☐	☐	☐	$_____
EPHC	☐	☐	☐	$_____
PHC	☐	☐	☐	$_____
Title V/MCH	☐	☐	☐	$_____

Notes:

Name of Agency _____ Signature – Agency / Staff Member _____ Date _____

DSHS Family & Community Health Services Division
INDIVIDUAL Eligibility Form Instructions

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

a) Check all the boxes that apply.

b) Check *yes* or *no*.

c) Check all the boxes that apply:

- *CHIP (Children's Health Insurance Program) Perinatal*
- *Medicaid for Pregnant Women*
- *SNAP (Supplemental Nutrition Assistance Program)*
- *TWHP (Texas Women's Health Program)*
- *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
- *None*

If you selected one of these benefits or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services.)

PART II – HOUSEHOLD INFORMATION

Fill in the box with the number of people in your household. This number will include you and anyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

1st column: The name of the person receiving the money.
2nd column: The name of the agency, person, or employer who provides the money.
3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). *(MBCC clients are not required to report changes in income, household, and residency)*

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months *(not applicable to MBCC)*.

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

Read the **Rights and Responsibilities** above. Check *yes* or *no*.
Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

PART V – PROVIDER ELIGIBILITY CERTIFICATION (to be completed by provider)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility.*

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible.* Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Formulario para la participación INDIVIDUAL

TEXAS Department of State Health Services

PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)	Número telefónico		Correo electrónico		
Domicilio en Texas (nombre de la calle o número de apartado postal)	Ciudad	Condado	Estado	Código postal	
Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Edad	Raza	Origen étnico	Sexo

a) Por favor contáctenme por: (marque todo lo que corresponda) ☐ Correo postal ☐ Teléfono ☐ Correo electrónico

b) ¿Tiene usted cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? ☐ Sí ☐ No

**Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que usted haya recibido.*

c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid para mujeres embarazadas ☐ TWHP ☐ Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable. Los menores de edad deben incluir al padre, a la madre o al tutor legal.

¿Cuántas personas viven en su casa? ☐

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de Derechos y Responsabilidades en la sección de *Instrucciones* de este formulario. ☐ Sí ☐ No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso de los apoyos recibidos.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

PART V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

Eligibility effective date / /

1. Texas resident	☐ Yes	☐ No	
2. Total monthly household income	$		
3. Household FPL	%		
4. Proof of income	☐ Yes	☐ Waived	
5. Verification of adjunctive eligibility	☐ Yes	☐ No	☐ n/a
6a. Presumptively eligible	☐ Yes	☐ No	
6b. Full eligibility met	☐ Yes		
6c. Full eligibility met date	/ /		

7. Is the client eligible for the following program(s)?

	Yes	No	n/a	Co-payment amount (if applicable)
BCCS	☐	☐	☐	$_____
DSHS FP	☐	☐	☐	$_____
EPHC	☐	☐	☐	$_____
PHC	☐	☐	☐	$_____
Title V/MCH	☐	☐	☐	$_____

Notes:

Name of Agency _____ Signature – Agency / Staff Member _____ Date _____

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)

Instrucciones para llenar el formulario para la participación INDIVIDUAL

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque "*sí* " o "*no*.

c) Marque todas las casillas que correspondan:

- *CHIP (Programa de Seguro Médico Infantil) Perinatal*
- *Medicaid para mujeres embarazadas*
- *SNAP (Programa de Asistencia de Nutrición Suplemental)*
- *TWHP (El Programa de Salud para la Mujer de Texas)*
- *WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)*
- *Ninguno*

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidád adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene las casillas con el número de personas que hay en su familia. Este número le incluye a usted y a cada persona que viva con usted y de la que usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

1.ª columna: El nombre de la persona que recibe el dinero.

2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.

3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedírsele que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). *(Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)*

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses *(no aplicable para clientes de MBCC)*.

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004).

Lea los Derechos y Responsabilidades siguientes. **Marque** *"sí"* o *"no"*.

Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

PARTE V – PROVIDER ELIGIBILITY CERTIFICATION (debe ser completada por el proveedor)

(1) Check the appropriate box (*yes* or *no*) for Texas resident. (2) Total the *amount received per month* to fill in the *Total monthly household income* box. (3) Calculate the client's household FPL using the applicable DSHS program policy (include applicable deductions) and fill in the *Household FPL* box. Check the appropriate box (*yes, no, waived,* or *n/a*) for (4) *Proof of* income and (5) *Verification of adjunctive eligibility.*

If client is presumptively eligible, fill in the light gray box. (6a) Check the appropriate box (*yes, no,* or *n/a*) for *Presumptively eligible.* Once the client completes the requirements for full eligibility, (6b) check *Yes* for *Full eligibility met* and fill in the (6c) *Full eligibility met date* box.

(7) Check the appropriate box (*yes*, *no*, or *n/a*) for each program regarding the client's eligibility. If yes, fill in the client's co-payment amount for the program based on their household and income information.

Use the space provided in *Notes* to document other appropriate information concerning eligibility and screening.
Fill in the *Eligibility effective date* box in the top right corner of Part V. Fill in the *Name of Agency*, sign, and date.

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PART I - APPLICANT INFORMATION

Name (Last, First, Middle)	Telephone Number		Email Address	
Texas Residence Address (Street or P.O. Box)	City	County	State	ZIP

a) Please contact me by: (check all that apply) ☐ Mail ☐ Phone ☐ Email

b) Do you – or anyone in your household – have comprehensive health care coverage (Medicaid, Medicare, CHIP, health insurance, VA, TRICARE, etc.)? ☐ Yes ☐ No

**If yes, DSHS' authorized representative will submit a claim for reimbursement from your insurer for any benefit, service or assistance that anyone in your household has received.*

c) Which benefits or health care coverage do you receive? (check all that apply)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid for Pregnant Women ☐ TWHP ☐ None

PART II - HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

Name (Last, First, Middle)	SSN (optional)	Date of Birth	Sex	Race	Ethnicity	Relationship
1.						
2.						
3.						
4.						
5.						
6.						

PART III - INCOME INFORMATION

List all of your household's income below. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Name of person receiving money	Name of agency, person, or employer who provides the money	Amount received per month

PART IV - APPLICANT AGREEMENT

I have read the **Rights and Responsibilities** statements in the *instructions* section of this form. ☐ Yes ☐ No

The information that I have provided, including my answers to all questions, is true and correct to the best of my knowledge and belief. I agree to give eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment.

I authorize release of all information, including income and medical information, by and to the Texas Department of State Health Services (DSHS) and Provider in order to determine eligibility, to bill, or to render services to my household or me.

Signature – Applicant _____ Date _____

Signature – Person who helped complete this application _____ Relationship to Applicant _____ Date _____

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Form Instructions

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PART I - APPLICANT INFORMATION

Fill in the boxes with your information.

a) Check all the boxes that apply.

b) Check *yes* or *no*.

c) Check all the boxes that apply:

- *CHIP (Children's Health Insurance Program) Perinatal*
- *Medicaid for Pregnant Women*
- *SNAP (Supplemental Nutrition Assistance Program)*
- *TWHP (Texas Women's Health Program)*
- *WIC (Special Supplemental Nutrition Program for Women Infants and Children)*
- *None*

If you selected one of these benefit or health care coverage programs and you are able to provide proof of current enrollment, you may be adjunctively (automatically) eligible for a DSHS Family & Community Health Services Division program and able to skip Part II and III on this application, if your agency does not collect a co-pay. (Exception -- Adjunctive eligibility does not apply to applicants seeking Title V services)

PART II – HOUSEHOLD INFORMATION

Fill in the first line with your information. Fill in the other lines for everyone who lives with you for whom you are legally responsible.

How to determine your household:

- If you are married (including common-law marriage), include yourself, your spouse, and any mutual or non-mutual children (including unborn children).
- If you are not married, include yourself and your children, if any (including unborn children).
- If you are not married and you live with a partner with whom you have mutual children, count yourself, your partner, your children, and any mutual children (including unborn children).

Applicants 18 years and older are adults. Do not include any children age 18 and older, or other adults living in the house, as part of the household. Minors should include parent(s)/legal guardian(s) living in the house.

PART III - INCOME INFORMATION

List all of your household's income in the table. Include the following: government checks; money from work; money you collect from charging room and board; cash gifts, loans, or contributions from parents, relatives, friends, and others; sponsor's income; school grants or loans; child support; and unemployment benefits.

Fill in the table with the following information:

1st column: The name of the person receiving the money.

2nd column: The name of the agency, person, or employer who provides the money.

3rd column: The amount of money received per month.

PART IV - APPLICANT AGREEMENT

Read the **Rights and Responsibilities** above. Check *yes* or *no*.
Sign and date on the lines. If a person helped you complete the application, he/she should sign, state the relationship to you, and date on the lines.

Rights and Responsibilities:

If the applicant omits information, fails or refuses to give information, or gives false or misleading information about these matters, he/she may be required to reimburse the State for the services rendered if the applicant is found to be ineligible for services. The applicant will report changes in his/her household/family situation that affect eligibility during the certification period (changes in income, household/family members, and residency). *(MBCC clients are not required to report changes in income, household, and residency)*

The applicant understands that, to maintain program eligibility, he/she will be required to reapply for assistance at least every twelve months *(not applicable to MBCC)*.

The applicant understands he/she has the right to file a complaint regarding the handling of his/her application or any action taken by the program with the HHSC Civil Rights Office at 1-888-388-6332.

The applicant understands that criteria for participation in the program are the same for everyone regardless of sex, age, disability, race, or national origin.

With few exceptions, the applicant has the right to request and be informed about information that the State of Texas collects about him/her. The applicant is entitled to receive and review the information upon request. The applicant also has the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 522.023 and 559.004)

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Nombre (apellido, primer nombre, segundo nombre)	Número telefónico		Correo electrónico	
Domicilio en Texas (nombre de la calle o número de apartado postal)	Ciudad	Condado	Estado	Código postal

a) Por favor contáctenme por: (marque todo lo que corresponda) ☐Correo postal ☐ Teléfono ☐ Correo electrónico

b) ¿Tiene usted o alguien de su familia cobertura médica integral (Medicaid, Medicare, CHIP, seguro médico, VA, TRICARE, etc.)? ☐ Sí ☐ No

**Si contestó que sí, el representante autorizado del DSHS presentará una reclamación de reembolso ante su compañía de seguro médico por las prestaciones, los servicios o la asistencia que cualquier persona en su hogar haya recibido.*

c) ¿Qué tipo de prestaciones o de cobertura médica tiene? (marque todo lo que corresponda)

☐ CHIP Perinatal ☐ SNAP ☐ WIC

☐ Medicaid para mujeres embarazadas ☐ TWHP ☐ Ninguno

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Nombre (apellido, primer nombre, segundo nombre)	Número de Seguro Social (SSN) (opcional)	Fecha de nacimiento	Sexo	Raza	Origen étnico	Relación
1.						
2.						
3.						
4.						
5.						
6.						

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere abajo todos los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Nombre de la persona que recibe el dinero	Nombre de la agencia, la persona o el empleador que provee el dinero	Cantidad recibida al mes

PARTE IV - ACUERDO DEL SOLICITANTE

He leído las declaraciones de **Derechos y Responsabilidades** en la sección de *Instrucciones* de este formulario. ☐ Sí ☐ No

La información que aquí proporciono, incluidas mis respuestas a todas las preguntas, es verídica y correcta, según mi leal saber y entender. Acepto darle al personal que determina el derecho a la participación cualquier información que sea necesaria para comprobar mis declaraciones respecto a mi derecho a la participación. Entiendo que dar información falsa podría dar por resultado la descalificación y el reembolso.

Autorizo al Departamento Estatal de Servicios de Salud de Texas (DSHS) y al Proveedor a que dispongan libremente de toda la información que proporciono, incluida la información sobre los ingresos y la médica, con el fin de que determinen mi derecho a la participación y a que paguen o presten servicios a mi familia o a mí.

Firma del solicitante _____ Fecha _____

Firma de la persona que ayudó a completar esta solicitud _____ Relación con el solicitante _____ Fecha _____

División de Servicios de Salud Familiar y Comunitaria del Departamento Estatal de Servicios de Salud (DSHS)
Instrucciones para llenar el formulario para la participación FAMILIAR

Use with HOUSEHOLD Worksheet (Form EF05-13227)

PARTE I - INFORMACIÓN DEL SOLICITANTE

Llene las casillas con su información personal.

a) Marque todas las casillas que correspondan.

b) Marque *"sí"* o *"no"*.

c) Marque todas las casillas que correspondan:

- *CHIP (Programa de Seguro Médico Infantil) Perinatal*
- *Medicaid para mujeres embarazadas*
- *SNAP (Programa de Asistencia de Nutrición Suplemental)*
- *TWHP (El Programa de Salud para la Mujer de Texas)*
- *WIC (Programa de Nutrición Suplemental Especial para Mujeres, Niños y Bebés)*
- *Ninguno*

Si usted seleccionó uno de estos programas de prestaciones o de cobertura médica y puede proporcionar un comprobante de inscripción actualizado, usted podría de manera adjunta (automáticamente) tener derecho a la participación de un programa de la División de Servicios de Salud Familiar y Comunitaria del DSHS y saltar a las Partes II y III de esta solicitud, si su agencia no cobra un copago. (Excepción: elegibilidád adjunto no se aplica a los solicitantes de los servicios del Título V.)

PARTE II - INFORMACIÓN DE LA FAMILIA

Llene la primera línea con su información personal. Llene las demás líneas con los datos de cada persona que vive con usted y de quien usted sea legalmente responsable.

Cómo determinar qué personas componen su familia:

- Si usted es casado (incluso en matrimonio de hecho), inclúyase a usted mismo e incluya a su cónyuge y a todos los hijos, tanto los habidos en común como los no habidos en común (incluidos los no nacidos).
- Si usted no es casado, inclúyase a usted mismo e incluya a sus hijos, de tenerlos (incluidos los no nacidos).
- Si usted no es casado y vive con su pareja con la cual tiene hijos en común, inclúyase a usted mismo e incluya a su pareja, a sus hijos y a los hijos que hayan tenido en común (incluidos los no nacidos).

Los solicitantes de 18 años de edad o más se consideran adultos. No incluya a ningún hijo de 18 años de edad o más ni a ningún otro adulto que viva en su casa como parte de la familia. Los menores de edad deben incluir al padre, a la madre o al tutor legal que vivan en la casa.

PARTE III - INFORMACIÓN SOBRE LOS INGRESOS

Enumere en la tabla todos y cada uno de los ingresos de la familia. Incluya los siguientes: cheques del gobierno; dinero del trabajo; dinero que obtiene por el cargo de alojamiento y comida; regalos en efectivo, préstamos o contribuciones de los padres, familiares, amigos y otros; ingresos que recibe de un patrocinador; becas o préstamos escolares; manutención de menores e ingresos por desempleo.

Llene la tabla con la siguiente información personal:

1.ª columna: El nombre de la persona que recibe el dinero.

2.ª columna: El nombre de la agencia, la persona o el empleador que provee el dinero.

3.ª columna: La cantidad de dinero recibida al mes.

PARTE IV - ACUERDO DEL SOLICITANTE

Lea los **Derechos y Responsabilidades** siguientes. Marque *"sí"* o *"no"*.
Firme y escriba la fecha en las líneas correspondientes. Si alguna persona le ayudó a usted a llenar la solicitud, también debe firmar, declarar cuál es su relación con usted y escribir la fecha en las líneas correspondientes.

Derechos y Responsabilidades:

Si el solicitante omite información, no la proporciona o se niega a proporcionarla, o da información falsa o engañosa sobre estas cuestiones, podría pedírsele que reembolse al Estado el importe de los servicios recibidos si se encontró que el solicitante no cumple con los requisitos para recibir los servicios. El solicitante deberá informar de cualquier cambio en la situación de su hogar o familia que afecte el derecho a la participación durante el periodo de certificación (cambios en los ingresos, en los miembros del hogar o la familia y el lugar de residencia). *(Las clientes de MBCC no tienen que informar de cambios en los ingresos ni en el hogar o el lugar de residencia)*

El solicitante entiende que, para mantener el derecho a participar del programa, se le pedirá que vuelva a solicitar la ayuda al menos cada doce meses *(no aplicable para clientes de MBCC)*.

El solicitante entiende que tiene el derecho a presentar una queja con respecto al manejo de su solicitud o a cualquier acción llevada a cabo por el programa, ante la Oficina de Derechos Civiles de la HHSC, al teléfono 1-888-388-6332.

El solicitante entiende que los criterios para la participación en el programa son iguales para todos sin importar el sexo, la edad, la discapacidad, la raza o el lugar de nacimiento.

Con unas cuantas excepciones, el solicitante tiene derecho a pedir y a ser notificado sobre la información que el estado de Texas reúne sobre él. El solicitante tiene derecho a recibir y revisar la información al así pedirlo. El solicitante también tiene derecho a pedirle a la agencia estatal que corrija cualquier información que se determine que es incorrecta. Consulte http://www.dshs.state.tx.us para obtener más información sobre la Notificación de privacidad. (Fuente: Código Gubernamental, secciones 552.021, 522.023 y 559.004)

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet

PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action ☐ Adjunctive ☐ Presumptive ☐ Supplemental ☐ Approved ☐ Denied	Client/Case #	Type of Determination ☐ New ☐Re-certification
Texas resident ☐ Yes ☐ No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

	Notes
1.	
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income *(if applicable)*
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			Household FPL **%**

PART IV– PROGRAM ELIGIBILITY

1. ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**2.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**3.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH
4. ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**5.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH	**6.** ☐ BCCS ☐ EPHC ☐ DSHS FP ☐ PHC ☐ Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date

DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet Instructions

PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information. Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

Program Eligibility by 2016 Federal Poverty Level (FPL)

Effective March 1, 2016

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	$1,832	$1,980	$2,475
2	2,470	2,670	3,338
3	3,108	3,360	4,200
4	3,747	4,050	5,063
5	4,385	4,740	5,925
6	5,023	5,430	6,788
7	5,663	6,122	7,653
8	6,304	6,815	8,519
9	6,946	7,509	9,386
10	7,587	8,202	10,253
11	8,228	8,895	11,119
12	8,870	9,589	11,986
13	9,511	10,282	12,853
14	10,152	10,975	13,719
15	10,794	11,669	14,586

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
  - up to $200 per child per month for children under age 2;
  - up to $175 per child per month for children age 2 and older;
- adults with disabilities;
  - up to $175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BCCS OFFICE VISITS	
99201	**Office Visit - New Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes**	**$44.57**
99202	**Office Visit - New Patient; *expanded problem focused* history, exam, straightforward decision-making; 20 minutes**	**$76.12**
99203	**Office Visit - New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes**	**$110.46**
99204	**Office Visit - New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes.**	**$168.12**
99205	**Office Visit - New Patient; *comprehensive* history, exam, high complexity decision-making; 60 minutes.**	**$211.24**
99211	**Office Visit - Established Patient; *evaluation and management*, may not require physician; 5 minutes**	**$20.29**
99212	**Office Visit - Established Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes**	**$44.57**
99213	**Office Visit - Established Patient; *expanded problem focused* history, exam, low-complexity decision-making; 15 minutes**	**$73.97**
99214	**Office Visit - Established Patient; *detailed* history, exam, moderate complexity decision-making; 25 minutes**	**$109.86**

- Office visits should only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN
- The CPT code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making
- 99204, 99205, and 99214 are uncommon office visits for the typical services provided through the BCCS program. Utilization review is performed on office visits
- No more than 1 BCCS office visit is billable on the same day
- 99204 and 99205 must meet the criteria for the code. These codes are not appropriate for screening visits
- 99211 does not require physician presence, although client evaluation and/or management are required; 99211 cannot be billed for client phone calls or patient navigation.
- Consultation visits are billed using office visit codes and may be billed on the same day as the BCCS office visit
- Global fee periods apply to certain diagnostic surgical procedures. Office visits are not allowed to be billed separately during the global fee periods
- Global fee periods do not apply to consultations with a breast or cervical specialist
- See specific diagnostic CPT codes for any global fee periods that may apply
- Mammography facilities cannot bill for office visits
- Neither the program, nor the patient, can be billed for "no show" visits

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
77053	**Mammary ductogram or galactogram, single duct, Global Fee**	**$59.05**

- May be billed with 77055, G0206, 77056, G0204, 76641, 76642
- Billable for clients with spontaneous nipple discharge and BI-RADS 1-3 after diagnostic mammogram
- May not be billed with screening mammograms (77057, G0202, B7057, B0202) or MRI (77058, B7058, 77059, B7059)
- BCCS performs utilization review on this service

77058	**Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral, Global Fee**	**$550.88**
77059	**Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral, Global Fee**	**$550.88**

- May only be reimbursed for clients with one or more of the following:
  -BRCA mutation;
  -a first-degree relative who is a BRCA carrier;
  -a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model;
  -radiation therapy to the chest between the ages of 10-30 years;
  -Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes.
- May not be used alone as a breast cancer screening tool
- May not be billed without breast screening mammogram
- May be reimbursed with 77057, G0202
- May not be billed with B7059, B7059 or B0202
- May be billed with diagnostic mammograms used for additional views.
- Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy
- Preauthorization is required

B7058	**Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral (Age 40-49)**	**$545.05**
B7059	**Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral (Ages 40-49)**	**$545.05**

- May only be reimbursed for clients with one or more of the following:
  -BRCA mutation;
  -a first-degree relative who is a BRCA carrier;
  -a lifetime risk of 20-25%, or greater, as defined by risk assessment models such as BRCAPRO/Gail Model;
  -radiation therapy to the chest between the ages of 10-30 years;
- May not be used alone as a breast cancer screening tool
- May not be billed without breast screening mammogram
- May be reimbursed with B7057 and B0202
- May not be reimbursed with 77058, 77059, 77057 or G0202
- May be billed with diagnostic mammograms used for additional views
- Must be performed in a facility with dedicated breast MRI equipment that can perform MRI guided breast biopsy. Preauthorization is required

-Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or first-degree relatives with one of these syndromes.

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
77057	**Screening Mammogram, Bilateral, Global Fee**	**$83.71**
G0202	**Screening Mammogram, Digital, Bilateral, Global Fee**	**$136.59**
77055	**Diagnostic Mammogram, Unilateral, Global Fee**	**$91.32**
G0206	**Diagnostic Mammogram, Digital, Unilateral, Global Fee**	**$131.16**
77056	**Diagnostic Mammogram, Bilateral, Global Fee**	**$117.41**
G0204	**Diagnostic Mammogram, Digital, Bilateral, Global Fee**	**$166.31**

- A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants and/or a history of breast cancer/lumpectomy
- A screening mammogram, on occasion, may precede the Clinical Breast Exam, i.e. mobile mammograms
- An imaging/mammography/radiology facility cannot be reimbursed for an office visit when a mammogram is the only service provided
- Computer Aided Detection (CAD) in breast cancer screening or diagnostics is specifically not allowed by BCCS

B7057	**Screening Mammogram, Bilateral, Global Fee (Age 40-49)**	**$83.71**
B0202	**Screening Mammogram, Digital, Bilateral, Global Fee (Age 40-49)**	**$136.59**

- Must be used to bill screening mammograms for women 40 to 49 years of age
- Women in this age group may receive a mammogram every two (2) years or annually if high risk per risk assessment tool – see breast clinical guidelines
- The guidelines for 77057 apply to B7057. The guidelines for G0202 apply to B0202

19000	**Puncture Aspiration of Breast Cyst**	**$116.22**

- 19000 may be billed once per breast regardless of the number of lesions
- 19000 may be billed with 76942

- Pathology (88305 or 88173) may not be reimbursed with 19000
- Office visit codes on the day of the procedure are not payable (Global Fee Period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES	
19100	**Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Office)**	**$155.76**
F9100	**Breast biopsy, percutaneous, needle core, not using imaging guidance, one or more lesions (Physician in Facility)**	**$73.18**
100FX	**Facility fee for needle core biopsy**	**$267.04**

- 19100 and F9100 may only be billed once per breast, regardless of the number of specimens
- 19100 cannot be billed with 00400 or 100FX
- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 100FX may be billed with F9100; but only once
- 00400 may be billed with F9100 and 100FX for the total anesthesia units provided, up to the 8 unit maximum
- 88305 may be billed for up to 6 biopsy specimens per breast
- Office visit codes on the day of the procedure are not payable (Global Fee Period 000)

19101	**Incisional Breast Biopsy; one or more lesions (Physician in Office)**	**$350.51**
F9101	**Incisional Breast Biopsy; one or more lesions (Physician in Facility)**	**$229.90**
101FX	**Facility fee for incisional breast biopsy**	**$1,187.77**

- 19101 and F9101 may be billed only once (per breast) regardless of the number of lesions
- 76098 (if indicated) may be billed for each lesion, up to the maximum of 3 per breast
- 88305 may be billed for up to 6 biopsy specimens per breast
- 101FX may be billed once with F9101
- 19101 cannot be billed with 00400
- 00400 may be billed with F9101 for the total anesthesia units provided, up to the 8 unit maximum
- Cannot bill with 76641, 76642, 76942, screening/diagnostic mammogram or MRI codes
- May be billed with image guided preoperative placement of breast localization devices 19281-F9288 and their associated facility codes
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19120	**Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Office)**	**$507.68**
F9120	**Excision of abnormal breast tissue, duct, nipple or areolar lesion; one or more lesions (Physician in Facility)**	**$427.27**
120FX	**Facility fee for excisional breast biopsy**	**$1,187.77**

- May be billed only once per breast regardless of the number of lesions
- 120FX may be billed once with F9120. 76098 may be billed if indicated for each lesion up to the maximum of 3 per breast
- 88305 may be billed for up to 6 biopsy specimens per breast
- 00400 cannot be billed with 19120
- 00400 may be billed with F9120 for the total anesthesia units provided, up to the maximum of 8
- May not be used with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- May be billed with imaging guided preoperative wire placement (19281-F9288 and associated facility codes)
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)

19125	**Excision of abnormal breast tissue, duct, nipple or areolar lesion, single lesion; identified by preoperative placement of radiological marker (Physician in Facility)**	**$564.25**
125FX	**Facility fee for excision of abnormal breast tissue, duct, nipple or areolar lesion/preoperative placement of radiological marker, single lesion.**	**$1,187.77**
19126	**Excision of abnormal breast tissue, duct, nipple or areolar lesion, each additional lesion (Physician in Facility)**	**$168.68**

- 19125 may be billed only once per breast, regardless of the number of lesions
- 19126 may only be billed for up to 2 additional lesions.
- 125FX may be billed once with 19125
- 76098 may be billed if indicated for each lesion, up to the maximum of 3
- 88305 may be billed for up to 6 biopsy specimens per breast
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- May not bill with 76641, 76642, 76942 or codes for screening/diagnostic mammogram and MRI
- 19125 may be billed with image guided preoperative wire placement (19281-F9288 and associated facility codes), if needed
- For 19125-Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)
- For 19126-Codes related to another service are always included in the global period of the other service (Global fee period ZZZ)

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES	
19081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *first lesion*; Global Fee (Physician in Office)**	**$683.12**
F9081	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *first lesion*; Global Fee (Physician in Facility)**	**$175.32**
19082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *each additional lesion* (Physician in Office)**	**$560.70**
F9082	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *stereotactic guidance*; *each additional lesion* (Physician in Facility)**	**$87.67**
812FX	**Facility fee for percutaneous breast biopsy using *stereotactic guidance; one or more lesions***	**$576.80**

- 19081 and F9081 can only be billed once per breast, regardless of the number of lesions
- 19082 and F9082 may be billed up to the maximum of 2 additional lesions per breast
- May not be billed with 19281-F9288 or associated facility codes
- 88305 may be billed for up to 6 biopsy specimens per breast
- 76098 may be billed for each lesion up the maximum of 3, if indicated
- 000400 cannot be billed with 19081 or 19082. May be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 812FX may be billed with once with F9081 and F9082
- Office visits not reimbursable on day of procedure. (Global fee period 000)

19083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance*; *first lesion* (Physician in Office)**	**$667.11**
F9083	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance*; *first lesion* (Physician in Facility)**	**$172.35**
19084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance*; *each additional lesion* (Physician in Office)**	**$539.73**
F9084	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *ultrasound guidance*; *each additional lesion* (Physician in Facility)**	**$82.60**
834FX	**Facility fee for percutaneous breast biopsy using *ultrasound guidance; one or more lesions***	**$576.80**

- 19083 and F9083 may only be billed once per breast regardless of the number of lesions
- 19084 and F9084 may be billed up to the maximum of 2 additional lesions per breast
- May not be billed with 19281-F9288 or associated facility codes
- 88305 may be billed for up to 6 biopsy specimens per breast
- 00400 cannot be billed with 19083 or 19084
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 834FX may be billed once with F9083 and F9084

• 76098 may be billed for each lesion up the maximum of 3, if indicated	• Office visits not reimbursable on day of procedure

CPT CODE	CODE DESCRIPTIONS	RATE
	BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES	
F9085	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance; first lesion* Global Fee (Physician in Facility)**	**$209.17**
F9086	**Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; *magnetic resonance guidance; each additional lesion* Global Fee (Physician in Facility)**	**$98.79**
856FX	**Facility fee for percutaneous breast biopsy using *MRI guidance, one or more lesions***	**$576.80**

• F9085 may only be billed once per breast regardless of the number of lesions • May only be performed in a facility with dedicated breast MRI equipment. • Preauthorization is required • F9086 may be billed up to the maximum of 2 additional lesions per breast • May not be billed with 19281-F9288 or associated facility codes • 88305 may be billed for up to 6 biopsy specimens per breast	• 76098 may be billed for each lesion up the maximum of 3, if indicated • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum • Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes • 856FX may be billed once with F9085 • Office visits not reimbursable on day of procedure

19281	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *first lesion* (Physician in Office)**	**$246.33**
F9281	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *first lesion* (Physician in Facility)**	**$106.52**
19282	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *each additional lesion* (Physician in Office)**	**$172.37**
F9282	**Preoperative placement of breast localization device, percutaneous; *mammographic* guidance; *each additional lesion* (Physician in Facility)**	**$53.93**

• May only be billed with incisional/excisional biopsy and their associated facility codes • Facility fees are included with the primary procedure code • 19281 and F9281 may only be billed once per breast regardless of the number of lesions • Additional lesions may be billed up to a maximum of 2 per breast • Cannot be billed with 19081-F9086 or their associated facility codes	• Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes • 00400 cannot be billed with 19281 or 19282 • 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum • Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
19283	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *first lesion* (Physician in Office)**	**$280.74**
F9283	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *first lesion* (Physician in Facility)**	**$106.88**
19284	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *each additional lesion* (Physician in Office)**	**$207.50**
F9284	**Preoperative placement of breast localization device, percutaneous; *stereotactic* guidance; *each additional lesion* (Physician in Facility)**	**$54.29**

- May only be billed with incisional/excisional biopsies and their associated facility codes
- Facility fees are included with the primary procedure code
- 19283 and F9283 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 00400 cannot be billed with 19283 or 19284
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure. (Global fee period 000)

19285	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *first lesion* (Physician in Office)**	**$457.92**
F9285	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *first lesion* (Physician in Facility)**	**$90.94**
19286	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *each additional lesion* (Physician in Office)**	**$389.82**
F9286	**Preoperative placement of breast localization device, percutaneous; *ultrasound* guidance; *each additional lesion* (Physician in Facility)**	**$45.97**

- May only be billed with incisional/excisional biopsies and their associated facility codes
- Facility fees are included with the primary procedure code
- 19285 and F9285 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or MRI codes
- 00400 cannot be billed with 19283 or 19284
- 00400 may be billed with facility codes to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure. (Global fee period 000)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
F9287	**Preoperative placement of breast localization device, percutaneous; *magnetic resonance* guidance; *first lesion* (Physician in Facility)**	**$143.06**
F9288	**Preoperative placement of breast localization device, percutaneous; *magnetic resonance* guidance; *each additional lesion* (Physician in Facility)**	**$69.85**

- Codes using magnetic resonance imaging may only be performed in a facility with dedicated breast MRI equipment
- Facility fees are included with the primary procedure code
- Preauthorization is required
- May only be billed with incisional/excisional biopsies and their associated facility codes
- F9287 may only be billed once per breast regardless of the number of lesions
- Additional lesions may be billed up to a maximum of 2 per breast
- Cannot be billed with 19081-F9086 or their associated facility codes
- Cannot be billed with 76641, 76642, 76942, screening/diagnostic mammograms or screening MRI codes
- 00400 may be billed with to reflect anesthesia units provided, up to the 8 unit maximum
- Office visits not reimbursable on day of procedure

00400	**Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified.**	**$22.88**

- Bill for the total number of units provided up to the maximum of 8 units
- Total Units = (3 base units plus time units)
- One time unit equals 15 minutes
- 00400 may only be billed with allowable BCCS facility codes

76098	**Radiological examination, surgical specimen**	**$16.65**

- May be billed to reflect each lesion present, up to the maximum of 3 per breast

76641	**Ultrasound, *complete* examination of breast including axilla, unilateral**	**$110.86**
76642	**Ultrasound, *limited* examination of the breast including axilla, unilateral**	**$91.29**

- May not be billed with 76942.
- 76641 used when four quadrants of the breast are examined
- 76642 used when fewer than four quadrants of the breast are examined
- May be billed to reflect each breast examined

76942	**Ultrasonic guidance for needle biopsy, radiological supervision and interpretation**	**$61.61**

- May be billed to reflect each lesion present, up to the maximum of 3 per breast
- May only be billed with 19000.May not be billed with 76641, 76642.

CPT CODE	CODE DESCRIPTIONS	
BILLING GUIDELINES – BREAST SCREENING & DIAGNOSTIC SERVICES		
10022	**Fine Needle Aspiration, with imaging guidance**	**$145.56**
• FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer. May be reimbursed for evaluation of abnormal lymph nodes for breast cancer staging and may not be reimbursed to evaluate a breast mass	• 10022 may be billed with 88173 • BCCS performs utilization review on this service	
88173	**Cytopathology Interpretation and Report of Fine Needle Aspiration**	**$153.81**
• FNA is not a suitable diagnostic method to definitively determine a final diagnosis of breast cancer • 88173 may be billed to evaluate the aspirate of each abnormal lymph node for the purpose of breast cancer staging	• 88173 may <u>only</u> be billed with 10022 • 88173 requires cytologic expertise	
88305	**Surgical pathology, gross and microscopic examination of breast biopsy not requiring microscopic evaluation of surgical margins**	**$74.01**
• 88305 may be billed for up to 6 biopsy specimens per breast		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
87624	**HPV, high-risk type**	**$47.76**
• Used for cytology and HPV co-testing every 5 years for women ages 30 and over and management of specific abnormal Pap tests • Must be ordered by a provider and not done as part of lab protocol • When a conventional Pap test result is ASC-US, a follow-up office visit may be billed to collect the reflex HPV test	• When a liquid based Pap test result is ASC-US, the HPV test can be done on the original specimen and a follow-up visit for HPV testing cannot be billed • Refer to cervical algorithms for indications for HPV testing • HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
88141	**Pap Test – physician's interpretation (Bethesda System)**	**$33.01**
• Each laboratory may develop their own policy for indications for the pathologist's review of Pap slides • Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review	• Bill with 88142, 88143, 88164, 88174, 88175 as the technical Pap test service • The BCCS program monitors utilization. No greater than 5% of Pap tests provided by a contractor should require physician (pathologist) review	
88142	**Pap Test – liquid based, cytologist's interpretation (Bethesda System)**	**$27.57**
• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines		
88143	**Pap Test-cytopathology, cervical, collected in preservative fluid, automated thin layer prep; manual screening and rescreening under physician supervision**	**$27.57**
• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines		
88164	**Pap Test – cytologist's interpretation (Bethesda System)**	**$14.38**
• As indicated. Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines		
88174	**Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system under physician supervision**	**$29.08**
• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines		
88175	**Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system and manual rescreening under physician supervision**	**$36.05**
• Pap tests are subject to frequency guidelines. See Cervical Clinical section of Policy Manual and Cervical Clinical Guidelines		
88305	**Surgical pathology, gross and microscopic examination of cervical biopsy**	**$74.01**
• May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy		
88307	**Surgical Pathology, gross and microscopic examination (cervix, conization)**	**$310.43**
• May be billed with 57461, 57520, 57522 and their associated facility codes	• May be billed for up to 4 specimens per cervical conization procedure	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57452	**Colposcopy**	**$112.17**

- May be billed only once regardless of the number of lesions
- Office visit codes on the day of the procedure are not payable (Global fee period 000)

57454	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)**	**$157.43**
F7454	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)**	**$140.77**
454FX	**Facility fee for colposcopy with cervical biopsy(s) and endocervical curettage**	**$61.50**

- 57454 and F7454 may be billed only once regardless of the number of lesions
- 88305may be billed for up to 5specimens to reflect 4 biopsy sites on the cervix & one (1) ECC biopsy
- May not be billed with 88307
- May not be billed with colposcopy: 57452, 57455, 57456, 57460, 57461 or their associated facility codes
- 00940 cannot be billed with 57454
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum
- 454FX may be billed once with F7454
- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- BCCS performs utilization review of F7454 and 454FX. Preauthorization is required

57455	**Colposcopy with biopsy(s) of the cervix (Physician in Office)**	**$147.28**
F7455	**Colposcopy with biopsy(s) of the cervix (Physician in Facility)**	**$114.68**
455FX	**Facility fee for colposcopy with biopsy(s) of the cervix**	**$64.72**

- May be billed only once, regardless of the number of lesions
- 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on cervix
- May not bill with 88307
- May not be billed with colposcopy: 57452, 57454, 57456, 57460, 57461 or their associated facility codes
- F7455 may be billed once with 455FX
- 00940 cannot be billed with 57455
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum
- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- BCCS performs utilization review of F7455 and 455FX. Preauthorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57456	**Colposcopy with endocervical curettage (Physician in Office)**	**$138.62**
F7456	**Colposcopy with endocervical curettage (Physician in Facility)**	**$106.75**
456FX	**Facility fee for colposcopy with endocervical curettage**	**$62.21**

- May be billed only once regardless of the number of lesions
- 88305 may only be billed once
- May not be billed with 88307
- 00940 cannot be billed with 57456
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum
- May not be billed with colposcopy: 57452, 57454, 57455, 57460, 57461 or their associated facility codes
- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- F7456 may be billed once with 456FX
- BCCS performs utilization review of F7456 and 456FX.
- Preauthorization is required

57460	**Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)**	**$289.62**
F7460	**Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)**	**$167.92**
460FX	**Facility fee for colposcopy with loop electrode biopsy(s)**	**$171.98**

- May be billed only once, regardless of the number of lesions
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57461 or their associated facility codes
- 00940 cannot be billed for 57460
- 00940 may be billed to reflect anesthesia provided, up to the 8 unit maximum
- 88305 may be billed for up to 4 specimens to reflect multiple biopsy sites on the cervix
- May not bill with 88307
- F7460 may be billed once with 460FX
- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- BCCS performs utilization review of F7460 and 460FX. Preauthorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57461	**Colposcopy with loop electrode conization of the cervix (Physician in Office)**	**$327.93**
F7461	**Colposcopy with loop electrode conization of the cervix (Physician in Facility)**	**$194.28**
461FX	**Colposcopy with loop electrode conization of the cervix (Facility Fee)**	**$184.85**

- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460 and their associated facility codes
- 57461 may be billed only once and may not be billed with F7461, 461FX or anesthesia
- 88307 may be billed for up to 4 specimens
- 88305 may not be billed with 57461 or F7461
- F7461 may be billed once with 461FX
- 00940 may not be billed with 57461
- 00940 may be billed for the total units of anesthesia provided, up to the 8 unit maximum
- No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility

57500	**Biopsy(s) of cervix (Physician in Office)**	**$131.40**

- 88305 may be billed with 57500 for up to 4 specimens to reflect multiple biopsy sites on cervix
- May not be billed with 88307
- Office visit codes on the day of the procedure are not payable (Global fee period 000)

57505	**Endocervical curettage (Physician in Office)**	**$104.60**

- May be billed only once
- 88305 may be billed once with 57505
- May not be billed with 88307
- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
57520	**Conization of the cervix; excision by cold knife or laser (Physician in Facility)**	**$283.58**
520FX	**Facility fee for conization of the cervix (excision by cold knife or laser method)**	**$1,011.63**

- 57520 may be billed only once
- 88307 may be billed with 57520 for up to 4 specimens
- May not be billed with 88305
- 00940 may be billed for the units of anesthesia provided, up to the 8 unit maximum
- 57520 must be performed in a certified ambulatory surgery center or day surgery facility
- 520FX may be billed once with 57520
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090)
- BCCS performs utilization review of this service

57522	**Conization of cervix (LEEP); (Physician in office)**	**$270.33**
F7522	**Conization of cervix (LEEP); (Physician in Facility)**	**$251.13**
522FX	**Facility fee for Conization of cervix (excision by LEEP method)**	**$1,011.63**

- 57522 may be billed only once and may not be billed with F7522, 522FX or anesthesia
- May not be billed with colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or associated facility codes
- 88307 may be billed for up to 4 specimens
- May not be billed with 88305
- F7522 may be billed only once with 522FX
- 00940 may be billed with F7522 for the total units of anesthesia provided, up to the 8 unit maximum
- No greater than 20% of conization LEEPs should be done in a certified ambulatory surgical center or day surgery facility
- Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090). BCCS performs utilization review of this service

00940	**Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.**	**$22.88**

- Bill for the total number of units provided up to a maximum of 8 units
- Total Units = (3 base units plus time units). One time unit equals 15 minutes
- 00940 may only be billed with allowable BCCS procedures performed in a facility

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL SCREENING & DIAGNOSTIC SERVICES		
58110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)**	**$49.58**
F8110	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)**	**$42.70**
811FX	**Facility fee for endometrial sampling performed in conjunction with colposcopy**	**$48.98**

- Must be billed with a colposcopy: 57452, 57454, 57455, 57456, 57460, 57461 or their associated facility codes
- 811FX may be billed once with F8110
- 00940 may not be billed with 58110
- 00940 may be billed to reflect anesthesia, up to the maximum of 8 units
- F8110/811FX require preauthorization
- Code related to another service and is always included in the global period of the other service (Global fee period ZZZ)
- Utilization review is performed on this service

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES		
93000	**ECG**	**$17.38**

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions.(ASA Grade 2 or 3)
- For BCCS diagnostic services only
- Refer to the American Society of Anesthesiologists for (ASA) grades.
- Utilization review is performed on this service

80048	**Basic Metabolic Panel (Chem 6)**	**$11.51**
88053	**Comprehensive Metabolic Panel (Chem 12)**	**$14.37**

- Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA Grade 2 or 3)
- For BCCS diagnostic services only
- 88048 may not be billed with 88053
- No greater than 7% clients receiving anesthesia should undergo these tests. Utilization review is performed on these services

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PRE-OPERATIVE LABORATORY PROCEDURES FOR DIAGNOSTIC SERVICES		
81025	**Urine Pregnancy Test**	**$8.61**
• Performed only prior to procedures utilizing general anesthetic for women of child-bearing age. **May not be used as routine pregnancy screening**	• For BCCS diagnostic services only • BCCS performs utilization review on this service • Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline.	
85025	**CBC, automated with differential**	**$10.58**
85027	**CBC, automated**	**$8.81**
• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grade 2 or 3) • For BCCS diagnostic services only	• 85025 cannot be billed with 85027 • No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services	
85610	**Prothrombin Time (PT)**	**$5.35**
85730	**Partial Thromboplastin Time (PTT)**	**$8.17**
85384	**Fibrinogen**	**$11.56**
• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3) • For BCCS diagnostic services only	• 8610, 85730 and 85384 may be billed together • No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services	
71010	**Chest X-Ray, AP (1 View)**	**$23.59**
010FX	**Facility fee for Chest X-Ray, AP (1 view)**	**$10.48**
71020	**Chest X-Ray, AP and Lateral (2 views)**	**$30.64**
020FX	**Facility fee for Chest X-Ray, AP and Lateral (2 views)**	**$14.41**

• Performed only prior to procedures utilizing general anesthetic for patients with co-morbid conditions. (ASA grades 2 or 3) • For BCCS diagnostic services only	• 71010 and 010FX cannot be billed with 71020 or 020FX • No greater than 7% clients receiving anesthesia should undergo these tests. BCCS performs utilization review on these services

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
44410	**Medicaid for Breast and Cervical Cancer (MBCC) Comprehensive Visit**	**$122.31**

• 44410 may only be billed for a client diagnosed with breast or cervical cancer by a non-BCCS provider who is referred to your agency for completion of the MBCC application • No BCCS screening or diagnostic funds were used for the cancer diagnosis • 44410 may only be billed by one BCCS contractor, **one time only per cancer diagnosis**, upon completion of the MBCC assessment, service plan, and application • Note: Completed MBCC applications shall not be submitted to DSHS until all client data and patient navigation billing has been entered into Med-IT • 44410 reimbursement requires completion of the Med-IT patient navigation module	• 44410 may only be billed with 44413 and may not be billed with any other codes, including patient navigation codes: 99910, 99913, 88810, and 88813 • May not be billed for a reinstatement, renewal, or client transferring from another state • **<u>If a contractor deliberately submits a MBCC application for a client that they knew was not eligible, DSHS may withhold or recover payment</u>** • A contractor who submitted an application that they presumed eligible for MBCC and was later denied by HHSC will not have to return the fee

44413	**Medicaid for Breast and Cervical Cancer (MBCC) Telephone call (or in-person visit)**	**$29.36**

• May be billed up to a maximum of 3 follow-up phone calls
• Note: Completed MBCC applications shall not be submitted to DSHS until all client data and patient navigation billing has been entered into Med-IT

99910	**Patient Navigation for abnormal breast cancer screening (abnormal CBE or mammogram, diagnostic tests required)**	**$121.31**

• 99910 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan • 99910 reimbursement requires completion of Med-IT patient navigation module	• May not bill with 44410, 44413, 88810 or 88813 • May not be billed for a reinstatement, renewal, or client transferring from another state

99913	BCCS Follow-up Visit (telephone)	$29.36
• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities • May not bill with 44410, 44413, 88810 or 88813		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – PATIENT NAVIGATION SERVICES		
88810	Patient Navigation for abnormal cervical cancer screening (diagnostic test required)	$121.31
• 88810 may only be billed by one BCCS contractor, one time only per problem, and upon completion of the assessment and service plan • 88810 reimbursement requires completion of Med-IT patient navigation module	• May not bill with 44410, 44413, 99910 or 99913 • May not be billed for a reinstatement, renewal, or client transferring from another state	

88813	Follow-up Visit (telephone)	$29.36
• May be billed up to a maximum of 3 follow-up phone calls or in-person visits to conduct patient navigation activities • May not bill with 44410, 44413, 99910 or 99913		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD202	Office Visit - New Patient; *expanded problem focused* history, exam, straightforward decision-making; 20 minutes	$76.12
CD203	Office Visit - New Patient; *detailed* history, exam, straightforward decision-making; 30 minutes	$110.46
CD204	Office Visit - New Patient; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes.	$168.12
CD211	Office Visit - Established Patient; *evaluation and management*, may not require physician; 5 minutes	$20.29
CD212	Office Visit - Established Patient; *problem focused* history, exam, straightforward decision-making; 10 minutes	$44.57
CD213	Office Visit - Established Patient; *expanded problem focused* history, exam, low-complexity decision-making; 15 minutes	$73.97
CD214	Office Visit - Established Patient; *detailed* history, exam, moderate complexity decision-making; 25 minutes	$109.86

• Office visits may only be billed for face-to-face interactions with a licensed, qualified provider, i.e. MD, APN, PA, or RN • The "CD" code billed for an office visit should be based on the level of complexity of the history, exam, and decision-making • CD204 & CD214 are uncommon office visits for typical services provided under Title V dysplasia • Utilization review is performed on office visits • No more than 1 office visit s billable on the same day • CD211 does not require physician presence, although client evaluation and/or management are required; CD211 is not billable for client phone calls.	• Global fee periods apply to certain management and treatment procedures. Office visits are not allowed to be billed separately during some global fee periods • See specific CD, FCD and FCX management & treatment procedure codes for any global fee periods that may apply • Neither BCCS, nor the patient, can be billed for "no show" visits NOTE: CD202 corresponds to 99202 CD203 corresponds to 99203 CD204 corresponds to 99204 CD212 corresponds to 99212 CD213 corresponds to 99213 CD214 corresponds to 99214

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD810	**Patient Navigation for "Referred-In" to Dysplasia Treatment Services**	**$121.31**

• CD810 may be billed for patient navigation services for a client who was referred-in for cervical dysplasia management & treatment • CD810 may not be billed with 88810 or 88813	• CD810 may only be billed by one BCCS contractor, one time only, per problem, and upon completion of the assessment and service plan • NOTE: CD810 corresponds to 88810

CD624	**HPV, high-risk types**	**$47.76**

• Use for management of dysplasia per dysplasia algorithms • Must be ordered by a provider and not done as part of lab protocol	• HPV tests must be for high-risk oncogenic types, FDA approved and clinically validated • NOTE: CD624 corresponds to 87624

CD141	**Pap Test – Physician's interpretation**	**$33.01**

• May be billed as the professional component with CD142 and CD164 as applicable • Each laboratory may develop their own policy for pathologist review of cervical Pap slides	• No greater than 5% of Pap tests provided should require pathologist review • BCCS performs utilization review of this service

CD142	**Pap Smear – liquid based**	**$27.85**
• Use for management of dysplasia per cervical dysplasia algorithms • NOTE: CD142 corresponds to 88142		
CD164	**Pap Smear– conventional**	**$14.53**
• Use for management of dysplasia per dysplasia algorithms • NOTE: CD164 corresponds to 88164		

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD452	**Colposcopy**	**$112.17**
• May be billed only once • Office visit codes on the day of the procedure are not payable (Global fee period 000). • NOTE: CD452 corresponds to 57452		

CD455	**Colposcopy with biopsy(s) of the cervix (Physician in Office)**	**$147.28**
FCX55	**Colposcopy with biopsy(s) of the cervix (Physician in Facility)**	**$114.68**
FCD55	**Facility fee for colposcopy with biopsy(s) of the cervix**	**$64.72**

• May be billed only once • CD305 may be billed with CD455 and FCX55 up to 4 times to reflect multiple biopsy sites on the cervix • Cannot be billed with colposcopy codes • FCD55 may be billed once with FCX55 • CD940 cannot be billed with CD455	• CD940 may be billed to reflect anesthesia, up to the maximum of 8 units • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review on FCX55/FCD55. Preauthorization is required • NOTE: CD455 corresponds to 57455 FCX55 corresponds to F7455 FCD55 corresponds to 455FX

CD456	**Colposcopy with endocervical curettage (Physician in Office)**	**$138.62**
FCX56	**Colposcopy with endocervical curettage (Physician in Facility)**	**$106.75**
FCD56	**Facility fee for colposcopy with endocervical curettage**	**$62.21**

• May be billed only once	• FCD56 may be billed once with FCX56

• CD305 may be billed only once with CD456 and FCX56. • Cannot be billed with colposcopy codes • CD940 cannot be billed with CD456 • CD940 can be billed to reflect anesthesia provided, up to the maximum of 8	• Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review on FCX56/FCD56. Preauthorization is required • NOTE: CD456 corresponds to 57456 FCX56 corresponds to F7456 FCD56 corresponds to 456FX

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD460	**Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Office)**	**$289.62**
FCX60	**Colposcopy with loop electrode biopsy(s) of the cervix (Physician in Facility)**	**$167.92**
FCD60	**Facility fee for colposcopy with loop electrode biopsy(s) of the cervix**	**$171.98**

• May be billed only once • CD305 may be billed with CD460 and FCS60 up to 4 times to reflect multiple biopsy sites on the cervix • May not be billed with colposcopy codes • FCD60 may be billed once with FCX60 • CD940 cannot be billed with CD460	• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units • Office visit codes on the day of the procedure are not payable (Global fee period 000) • BCCS performs utilization review on FCX60/FCD60. Preauthorization is required • NOTE: CD460 corresponds to 57460 FCX60 corresponds to F7460 FCD60 corresponds to 460FX

CD461	**Colposcopy with loop electrode conization of the cervix (Physician in Office)**	**$327.93**
FCX61	**Colposcopy with loop electrode conization of the cervix (Physician in Facility)**	**$194.28**
FCD61	**Facility fee for colposcopy with loop electrode conization of the cervix**	**$184.85**

• May be billed only once • CD307 may be billed up to 4 times to reflect multiple biopsy sites on the cervix • May not be billed with colposcopy codes • FCD61 may be billed once with FCX61 • CD940 cannot be billed with CD461	• CD940 can be billed to reflect anesthesia, up to the maximum of 8 units • Office visit codes on the day of the procedure are not payable (Global fee period 000) • NOTE: CD461 corresponds to 57461 FCX61 corresponds to F7461 FCD61 corresponds to 461FX • BCCS performs utilization review of FCX61 AND FCD61. Pre-authorization is required

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD454	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Office)**	**$157.43**
FCX54	**Colposcopy with cervical biopsy(s) and endocervical curettage (Physician in Facility)**	**$140.77**
FCD54	**Facility fee for colposcopy with biopsy(s) and endocervical curettage**	**$61.50**

- May be billed only once
- May not be billed with colposcopy codes
- CD305 may be billed up to 5 times to reflect 4 biopsy sites on the cervix and one (1) ECC biopsy
- CD940 cannot be billed with CD454
- CD940 may be billed to reflect anesthesia, up to the maximum of 8 units.

- FCD54 may be billed once with FCX54
- Office visit codes on the day of the procedure are not payable (Global fee period 000)
- BCCS performs utilization review on FCX54/FCD54. Preauthorization is required
- NOTE: CD454 corresponds to 57454
  FCX54 corresponds to F7454
  FCD54 corresponds to 454FX

CD505	**Endocervical curettage (Physician in Office)**	**$104.60**

- May be billed only once.
- CD305 may be billed once with CD505.
- May not be billed with CD307.

- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010).

CD511	**Cryotherapy: cryocautery, initial or repeat**	**$149.47**

- There is no pathology associated with CD511 because a biopsy is not performed with this procedure
- Decision to repeat is based upon provider medical decision-making and adherence to algorithms

- Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)
- NOTE: CD511 corresponds to 57511
- BCCS performs utilization review of this service

CD513	Cervical Cautery with laser ablation	$149.40
• There is no pathology associated with CD513 because a biopsy is not performed with this procedure • Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable (Global fee period 010)	• NOTE: CD513 corresponds to 57513 • BCCS performs utilization review of this service	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
FCX20	Cervical Conization with cold knife or laser (Physician in Facility)	$ 283.58
FCD20	Facility fee for Cervical Conization with cold knife or laser	$1,011.63
• FCX20 must be performed in a certified ambulatory surgical center or a day surgery facility • FCX20 may be billed only once • FCD20 may be billed with FCX20 for the facility fee • CD307 may be billed with FCX20for up to 4 specimens per cervical conization procedure • Cannot be billed with CD305	• CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum • Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) • NOTE: FCX20 corresponds to 57520 FCD20 corresponds to 520FX • BCCS performs utilization review of this service	

CD522	Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Office)	$270.33
FCX22	Cervical Conization with Loop Electrode Excision (LEEP) (Physician in Facility)	$251.13
FCD22	Facility fee for Cervical Conization with Loop Electrode Excision (LEEP)	$1,011.63
• CD522 may be billed only once and cannot be billed with FCX22, FCD22, or CD940 • CD522 and FCX22 may not be billed with CD452, CD454, CD455, CD456, CD460, CD461 or their associated facility codes • CD307 may be billed with CD522 or FCX22for up to 4 specimens • May not be billed with CD305 • FCD22 may be billed once with FCX22. • CD940 may be billed for the total units of anesthesia provided during the procedure, up to the 8 unit maximum • No greater than 20% of conization LEEPs should be done in a certified, ambulatory surgical center or a day surgery facility	• Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable (Global fee period 090) • NOTE: CD522 corresponds to 57522 FCX22 corresponds to F7522 FCD22 corresponds to 522FX • BCCS performs utilization review of this service	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD811	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Office)**	**$49.58**
FCX81	**Endometrial sampling (biopsy) performed in conjunction with colposcopy; (list separately in addition to code for colposcopy) (Physician in Facility)**	**$42.70**
FCD81	**Facility fee for endometrial sampling (biopsy) performed in conjunction with colposcopy**	**$48.98**

- May be billed only once
- CD811 must be billed with a colposcopy
- Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater if:
  - Client 35 or more years of age, or
  - At risk for endometrial neoplasia (see BCCS algorithms).
- CD940 cannot be billed with CD811
- CD940 may be billed to reflect anesthesia, up to the maximum of 8 units

- FCD81 may be billed once with FCX81
- Code related to another service and is always included in the global period of the other service (Global fee period ZZZ).
- Utilization review is performed on this service
- Pre-authorization is required for FCX81/FCD81

CD940	**Anesthesia for vaginal procedures (including biopsy of cervix); not otherwise specified.**	**$22.88**

- Bill for the total number of units provided, up to the 8 unit maximum.
- Total Units= (3 base units plus time units). One time unit equals 15 minutes

- CD940 may only be billed with allowable facility codes FCD20 or FCD22.
- NOTE: CD940 corresponds to 00940

CD305	**Surgical Pathology - cervical biopsy**	**$74.01**

- May be billed for up to 5 specimens to reflect 4 biopsy sites on the cervix and 1 ECC biopsy
- May only be billed once with CD505
- NOTE: CD305 corresponds to 88305

CD307	**Surgical Pathology – cervical conization**	**$310.43**

- May be billed for up to 4 specimens per cervical conizations procedure.
- NOTE: CD307 corresponds to 88307

CD930	ECG	$17.38
• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grade 2 or 3) • For CD treatment services only	• Utilization review is performed on this service • CD930 corresponds to 93000	

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD048	Basic Metabolic Panel (Chem 6)	$11.51
CD053	Comprehensive Metabolic Panel (Chem 12)	$14.37
• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) • CD048 cannot be billed with CD053 • For CD treatment services only	• Utilization review is performed on this service • CD048 corresponds to 80048 • CD053 corresponds to 88053	

CD125	Urine Pregnancy Test	$8.61
• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) • For CD treatment services only	• Utilization review is performed on this service • CD125 corresponds to 81025 • Contractors may be required to reimburse BCCS for CD125 billing not in accordance with billing guideline.	

CD025	CBC, automated with differential	$10.58
CD027	CBC, automated	$8.81
• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) • For CD treatment services only • CD025 corresponds to 85025	• CD025 cannot be billed with CD027 • CD027 corresponds to 85027	

CD610	Prothrombin Time (PT)	$6.35
CD730	Partial Prothrombin Time (PTT)	$8.17
CD384	Fibrinogen	$11.56

• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) • For CD treatment services only • CD610, CD730 and CD384 may be billed together • BCCS performs utilization review on this service	• CD610 corresponds to 85610 • CD730 corresponds to 85730 • CD384 corresponds to 85384

CPT CODE	CODE DESCRIPTIONS	RATE
BILLING GUIDELINES – CERVICAL DYSPLASIA MANAGEMENT AND TREATMENT SERVICES (CD)		
CD710	**Chest X-Ray, AP (1 view)**	**$22.82**
FCD01	**Facility fee for Chest X-Ray, AP (1 view)**	**$12.87**
CD720	**Chest X-Ray, AP and Lateral (2 views)**	**$28.26**
FCD02	**Facility fee for Chest X-Ray, AP and Lateral (2 views)**	**$16.45**

• Performed only prior to procedures utilizing general anesthetic for clients with co-morbid conditions. (ASA grades 2 or 3) • For CD treatment services only • CD710 and FCD01 cannot be billed with CD720 or FCD02 • BCCS performs utilization review of these services	• CD710 corresponds to 71010 • FCD01 corresponds to 010FX • CD720 corresponds to 71020 • FCD02 corresponds to 020FX

Texas Department of State Health Services
Breast and Cervical Cancer Services
Comprehensive Case Management Form

Contractor, Clinic Name:	Case Manager:	Patient ID Number:	Chart Number:

CLIENT INFORMATION

Name:	Date of Birth:	Social Security No.:	Daytime Phone:

Screening/Diagnosis results:	Other Contact Information:			
	Name:	Address:	Phone:	Relationship:

ASSESSMENT DATE:

Social Resources Assessment	Medical Care/Service Status	Education and Counseling Assessment
☐ Social Support (e.g., Family, Church, Friends) ☐ Other	☐ Medical home ☐ Transportation ☐ Language barrier ☐ Unable to leave work ☐ Child care ☐ Making appointment ☐ Financial resources ☐ Alternative healing ☐ Other	☐ Concern about procedure (e.g., discomfort, pain) ☐ Embarrassment ☐ Fear of cancer ☐ Overwhelmed by information ☐ Feelings of anger, sadness ☐ Relationship with spouse/friends ☐ Intimacy/sexual concerns ☐ Body image ☐ Cost of procedures ☐ Loss of employment ☐ Other

SERVICE PLAN DATE:

Identified Need	Service/Referral	Provider	Date of Initial Svc./Ref.	F/U Date	Outcome of Service/Referral

STATEMENT OF UNDERSTANDING

I understand, and agree, to have ongoing assessment for needs and care coordination planning, and may need additional evaluation because my test results are abnormal.

Signed:_____ Date:_____

TEXAS Department of State Health Services

Departamento Estatal de Servicios de Salud de Texas
Programa para el control del cáncer cervical y del cáncer del seno
Formulario de información comprehensiva para la administración de casos

Contratista, Nombre de la clínica:	Administrador del caso:	Número de identificación del paciente:	Número del expediente:

INFORMACIÓN DEL CLIENTE

Nombre:	Fecha de nacimiento:	Número de Seguro Social:	Teléfono durante el día:

Resultados de exámenes o diagnóstico:	Información sobre otra persona de contacto:			
	Nombre:	Dirección:	Teléfono:	Relación:

INFORMACIÓN DE EVALUACIÓN

Evaluación de los recursos sociales	Estatus de atención médica/servicios	Evaluación de educación y asesoramiento
☐ Apoyo social (por ejemplo: familia, iglesia, amigos) ☐ Otro	☐ Hogar médico ☐ Transportación ☐ Barrera de idiomas ☐ No puede salir del trabajo ☐ Cuidado de niños ☐ Hacer una cita ☐ Recursos económicos ☐ Curación alternativa ☐ Otro	☐ Preocupación sobre el procedimiento (por ejemplo: incomodidad, dolor) ☐ Vergüenza ☐ Miedo al cáncer ☐ Abrumada por la información ☐ Sensaciones de enojo, tristeza ☐ Relación con su cónyuge/sus amigos ☐ Preocupación sobre las relaciones sexuales o la intimidad ☐ Imagen del cuerpo ☐ Costo del procedimiento ☐ Perdida del empleo ☐ Otro

FECHA DEL PLAN DE SERVICIOS

Necesidad identificada	Servicio/Envío	Proveedor	Fecha del servicio/ envío inicial	Fecha de	Resultado del servicio/envío

DECLARACIÓN DE ENTENDIMIENTO

Entiendo que puedo tener la evaluación continua de las necesidades y la planificación de coordinación de la atención, y estoy de acuerdo con la evaluación adicional si alguno de mis resultados son anormales.

Firma:_____ Fecha:_____

Instructions for Completing the BCCS Comprehensive Case Management Form

Note: Contractors must use this form to assess needs. The use of this form for planning services is voluntary. Contractors must document case management services in Med-IT. Contractors may document the client's case management services in the client's medical record in addition to Med-IT.

Contractor, Clinic Name: Enter the name of the BCCS contractor and the clinic name if different from the contractor.

Case Manager: Enter the name of the case management staff completing the assessment and plan. If more than one person makes entries on the form, the primary person responsible for case management services should be listed in the box and all others will make initials next to the item assessed or planned.

Patient ID Number: Enter the assigned BCCS client number.

Chart Number: Enter the client's chart number.

CLIENT INFORMATION
Enter the client's first and last name, date of birth, social security number, and daytime telephone number in the appropriate spaces.

Enter the screening or diagnostic result that prompted this assessment for case management services.

Enter the contact information for the individual identified by the client as the person most likely to know how to contact them if you are unable to locate them.

ASSESSMENT DATE
Enter the date the assessment is completed.

Under **Social Resources**, **Medical Care/Service Status**, and **Education and Counseling Assessment**, mark the box next to each item if the client identifies it as an issue, problem or need with which they require assistance. For more detailed information, document in Med-IT and the client's medical record.

For identified needs not listed, mark "Other" and enter additional needs that are identified during the assessment or planning phases.

SERVICE PLAN DATE
Enter the date the written plan is developed.

Under **Identified Need**, enter the needs whose boxes were marked during the Assessment phase.

In the **Service/Referral** column, enter the planned service or referral, and the name of the entity/person providing the service or the name of the entity/person the client is being referred to in the **Provider** column.

Enter the date the service is scheduled to begin under **Date of Initial Service/Referral**. If the service is an appointment, enter the appointment date.

Enter the date the case manager followed up on the status of the service in the **Follow-Up Date** column.

Enter the outcome, e.g., completed, rescheduled, or no show, in the **Outcome of Service/Referral** column.

STATEMENT OF UNDERSTANDING
The client's signature and date of signature are required at the time the assessment is completed.

For Traditional BCCS-Enrolled Clients Who Have Abnormal Screening Or Diagnostic Results					
Initiation of Patient Navigation	Assessment of Essential Support and Social Resources	Patient Navigation Plan	Patient Navigation and Follow-up on Diagnostic Tests	Completion of Patient navigation	Patient navigation CPT Code used in Med-IT Data System
Patient navigation must be initiated with receipt of an abnormal result. With an abnormal result (other than the exceptions noted in patient navigation record paragraph) the client must be informed and understand the screening and follow-up process.	Assessment must be conducted within 30 days of the abnormal result or before the next diagnostic service.	Notes must be recorded and follow-up documented within 30 days of the date of the service plan.	The Patient Navigator and/or Case Manager and client must discuss how diagnostic services will be arranged. This must be completed in accordance with Requirements for patient navigation compliance.	When a referral appointment for treatment has been attended, or a “good faith effort” as defined by BCCS is completed, or a client is documented as lost-to-follow-up or refused services, the treatment appointments must be documented in the patient navigation note section of the Med-IT Data System.	Abnormal breast cancer screening, (abnormal CBE or mammogram, diagnostic tests required) **99910** Abnormal cervical cancer screening (diagnostic test required) **88810**

Patient Navigation (PN) for Clients with a Qualifying Diagnosis Referred to a BCCS Contractor for Assistance in Applying for Medicaid for Breast and Cervical Cancer (MBCC)					
Initiation of PN	PN Assessment	PN Plan	PN and Follow-up on Diagnostic Tests	Completion of PN	PN CPT/Med-IT Billing
Patient navigation must be initiated upon completion of the assessment of MBCC eligibility criteria and medical assistance application, Form H1034.	Assessment must be conducted within 30 days of the presumptive determination of MBCC eligibility. Patient navigation will include an assessment of medical, financial and social support resources and needs.	Assessment and follow-up must be documented within 30 days of the date of the service plan. .	Not Applicable	PN is complete when a referral appointment for treatment has been attended, referral appointment for treatment was completed, a “good faith effort,” as defined by BCCS is completed, client is documented as lost-to-follow-up or refused services, or HHSC determines that the woman is ineligible for MBCC and the BCCS contractor decides not to follow her to initiation of treatment.	MBCC Referred-In **44410** MBCC Telephone Contact **44413**

For Clients with Cervical Dysplasia Referred to a BCCS Contractor for Management and Treatment					
Initiation of PN	PN Assessment	PN Plan	PN and Follow-up on Diagnostic Tests	Completion of PN	PN CPT Codes/Med-IT Biling
PN must be initiated upon determination of need for cervical dysplasia management and treatment services.	Assessment must be conducted within 30 days of BCCS eligibility determination.PN will include an assessment of medical, financial and social support resources and needs.	Assessment and follow-up must be documented within 30 days of the date of the service plan.	Not Applicable	PN is complete when a referral appointment for treatment has been attended, a “good faith effort” as defined by BCCS is completed, or client is documented as lost-to-follow-up or refused services.	The contractor may bill BCCS for cervical dysplasia PN services. “Referred-In” Cervical Dysplasia Management and Treatment Services CPT code **CD810**

- **Incomplete MBCC applications may not be submitted to DSHS.**
- **If a contractor deliberately submits an MBCC application for a client that they know is not eligible, DSHS may withhold or recover payment**

1. **MBCC Application (H-1034)**

□ **Answer all questions and fill-in every blank on the H-1034:**

□ Verify client's legal name, date of birth, and social security number are correct
□ Verify presumptive eligibility has been met
□ Client has a biopsy-confirmed, qualifying diagnosis
See *MBCC Guidelines for Determination of Qualifying Diagnosis*
□ Date of diagnosis matches the collection date on the biopsy pathology report
□ Unpaid Medical Bills – Indicate yes or no, and months if applicable
□ Do not mark in "For DSHS Use Only" section

□ **Attach copies of supporting documents:**
□ **Final** pathology report with biopsy-confirmed, qualifying diagnosis (no highlighting)
□ Documents to verify identity, U.S. citizenship, or legal immigrant status
For questions, email the HHSC/MBCC Eligibility Specialist at cbs_mbcc@hhsc.state.tx.us
□ If insurance termed or insurance does not cover cancer treatment:
- Copy of insurance card and
- Letter or Explanation of Benefits from insurance company

□ If reinstatement or qualifying diagnosis more than 1 year ago:
- Physician letter specifying active treatment needed or form H1551, **and**
- Recent medical documentation supporting need for active treatment

□ Do not fax tax forms, pay stubs, or any other financial documents
- Client may not self-declare income; financial documents must be kept with client chart.

2. **Med-IT**

□ **Enter client and case management in Med-IT:** See Med-IT handouts for instructions
□ Med-IT ID # _____
□ Client's name, social security number, date of birth, and country of birth are correct
□ Enrollment status is correct:
- "Active"-Client received BCCS services prior to the cancer diagnosis
- "MBCC"-Client never received BCCS services and was diagnosed by a non-BCCS provider and "referred in"for MBCC application only

□ See BCCS Reimbursement Rates & Billing Guidelines.

3. □ **Fax H-1034 to DSHS BCCS at 512-776-7203**

□ Send additional information requested by DSHS BCCS staff
□ DSHS BCCS nurse consultants review and fax to HHSC MBCC
□ BCCS does not assist with or collect documents for MBCC applications following submission to HHSC

4. **Confirm receipt with DSHS BCCS nurse consultants**
□ Email MBCCApps@dshs.state.tx.us

5. **MBCC Application Status/Medicaid Number**

□ Clients may call 2-1-1 or use www.yourtexasbenefits.com.
□ Select "View my case details" when registering.

Medicaid for Breast and Cervical Cancer
Guidelines for Determination of Qualifying Diagnosis

The Department of State Health Services is providing the following guidance to healthcare providers and Breast and Cervical Cancer Services (BCCS) contractors to facilitate their determination of qualifying diagnoses for Medicaid for Breast and Cervical Cancer (MBCC). Analysis of all biopsies must be performed by a US CLIA certified laboratory.

Cervical Cancer Qualifying Diagnoses

Qualifying pre-cancerous cervical diagnoses must be biopsy-confirmed*:
◀High-grade dysplasia (CIN III/severe dysplasia)
◀Carcinoma or adenocarcinoma *in situ*

Qualifying malignancies of the cervix must be biopsy-confirmed*:
◀Squamous cell carcinoma
◀Invasive endocervical adenocarcinoma
◀Invasive cervical cancer
◀Malignant neoplasia
◀Sarcoma
◀Adenoid cystic carcinoma
◀Adenocarcinoma
◀Small cell carcinoma
◀Invasive neoplasm
◀Melanoma
◀Glassy cell carcinoma
◀Adenosquamous carcinoma

*Cervical biopsy or endocervical sampling of CIN III, severe dysplasia, carcinoma or adenocarcinoma in situ, or cervical malignancy qualifies as "biopsy confirmed".

Breast Cancer Qualifying Diagnoses

A ***qualifying pre-cancerous breast diagnosis***[1] is biopsy-confirmed:
◀Ductal carcinoma *in situ* (DCIS)

Qualifying breast cancer diagnoses must be biopsy-confirmed.
On the pathology report, the diagnosis and/or the specimen description must include at least one of the following phrases: ***"breast cancer," "breast carcinoma"*** *or* ***"breast malignancy"***

Examples of the majority of breast cancer types:

1. Ductal Carcinomas:
   - ◀Invasive
   - ◀Inflammatory
   - ◀Mucinous (colloid)
   - ◀Scirrhous
   - ◀Comedo
   - ◀Medullary
   - ◀Papillary or Micropapillary
   - ◀Tubular
   - ◀Cribiform
2. Lobular Carcinoma[1]:
   - ◀Invasive
3. Nipple Carcinoma:
   - ◀Paget's disease
4. Other Carcinomas:
   - ◀Carcinoma, NOS (not otherwise specified)
   - ◀All Phyllodes tumors
   - ◀Primary lymphoma
   - ◀Apocrine
   - ◀Carcinoma with endocrine differentiation
   - ◀Undifferentiated carcinoma
   - ◀Sarcoma
   - ◀Secretory
   - ◀Metaplastic
   - ◀Adenoid cystic carcinoma

[1]The diagnosis of lobular carcinoma in situ (LCIS) is not considered a qualifying precancerous or breast cancer diagnosis for referral to MBCC.

Breast and Cervical Cancers
For ***primary cancers***, terms such as "compatible with" and "consistent with" do not qualify as definitive diagnoses. If the pathologist is certain the finding is breast or cervical cancer as described above, then it must be clearly stated in the final pathology report.

Medicaid for Breast and Cervical Cancer
Guidelines for Determination of Qualifying Diagnosis

For ***metastatic*** or ***recurrent cancers***, an unequivocal diagnosis of malignancy is required. However, since many metastatic or recurrent cancers may look the same, the primary does not need to be explicitly diagnosed when the applicant has a documented history of a primary breast or cervical cancer Terms such as “compatible with” and “consistent with” a breast or cervical cancer are acceptable. For example, a diagnosis such as “metastatic adenocarcinoma consistent with the prior breast primary” would be acceptable.

According to National Comprehensive Cancer Network Guidelines (NCCN), inflammatory breast carcinomas (IBC) require a biopsy to evaluate the presence of cancer in breast tissue and dermal lymphatics; a diagnosis of IBC is based on clinical findings. Dermal lymphatic involvement is neither required for, nor sufficient by itself to assign a diagnosis of IBC; therefore a diagnosis of IBC is based on clinical findings. Pathology reports using terms such as “compatible with” and “consistent with” in addition to documentation which supports a clinical diagnosis of IBC should be submitted for review.

Texas Department of State Health Services
Breast and Cervical Cancer Services
Breast and Cervical Diagnostic Procedure
Complication Reimbursement Request Form

CONTRACTOR INFORMATION

Agency Name:	Clinic Name:	
Case Manager Name:	Phone Number:	Email Address:

CLIENT INFORMATION

Name (Last, First, MI):	Date of Birth:	Med-IT ID #:	Date of Service:
Complication Occurred Following Which Procedure:			
☐ LEEP ☐ LEEP Conization	☐ Breast Biopsy	☐ Percutaneous ☐ Excisional ☐ Incisional	

TREATMENT/ASSESSMENT OF COMPLICATION

List Medical Care/Services Received by Client Following Complication:	Date of Service:

NARRATIVE:

FOR DSHS USE ONLY – DO NOT WRITE IN THIS AREA		
☐ APPROVED	☐ DENIED	REASON:
Reviewer(s):		Date:

Texas Department of State Health Services
Breast and Cervical Cancer Services

Office-based Procedures Performed in an Ambulatory Surgical Center Pre-Authorization Request Form

Agency Name:	Region #:	Clinic Name:
Case Manager/Contact Name:	Phone Number:	Email Address:

CONTRACTOR INFORMATION

CLIENT INFORMATION

Name (Last, First, MI):	Date of Birth:	Med-IT ID #:

History and Physical Information Check all that apply to this client

☐ **Abnormal Pelvic Exam**	☐ **History of Cervical Cancer**	☐ **Obesity/Body Habitus**
☐ **Cervical Stenosis**	☐ **Vaginal Stenosis/Atrophy**	☐ **Other:**

Symptoms Check all that apply

☐ **Bleeding** ☐ **Discharge** ☐ **Mass** ☐ **Pain** ☐ **Other:** ☐ **None**

Recent Screening/Diagnostic Procedures Received through BCCS or prior to being referred to BCCS for the requested procedure(s) Check all that apply

☐ **Pap Test** **Date:** **Result:**	☐ **Colposcopy** **Date:** **Result:**	☐ **Biopsy** **Date:** **Result:**	☐ **Specialist/Surgical Consultation** **Date:** **Result:**

REQUESTED PROCEDURE(S)

Anticipated Date of Procedure(s):

List below all CPT Codes from the BCCS Reimbursement and Billing Guidelines you are requesting pre-authorization for. All requested procedures should include the procedure code for the physician and the facility fee.
ALL REQEUSTS RECEIVED WITHOUT A FACILITY FEE LISTED WILL BE DENIED.

COMMENTS:

FOR DSHS USE ONLY – DO NOT WRITE IN THIS AREA		
☐ **APPROVED**	☐ **DENIED**	**REASON:**
Reviewer(s):		**Date:**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Texas Department of State Health Services
Breast and Cervical Cancer Services

Breast MRI Pre-Authorization Request Form

CONTRACTOR INFORMATION

Agency Name:	Region #:	Clinic Name:
Case Manager/Contact Name:	Phone Number:	Email Address:

CLIENT INFORMATION

Name (Last, First, MI):	Date of Birth:	Med-IT ID #:

History and Physical Information Check all that apply to this client

☐ BRCA Mutation	☐ 1st-degree relative BRCA carrier[1]	☐ Lifetime breast cancer risk ≥ 20-25%[2]	☐ Chest radiation therapy between 10 and 30 years	☐ Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome, or family members with syndrome

☐ History of breast cancer	☐ Mastectomy ☐Right ☐ Left ☐ Lumpectomy ☐ Right ☐ Left	☐ Treatment Completed	☐ Yes – Date (MM/DD/YYYY): ☐ No
Symptomatic	☐ Yes ☐ Right ☐ Left ☐ No	☐ Lump/Mass ☐ Pain ☐ Nipple Discharge ☐ Edema ☐ Skin changes ☐ Nipple inversion ☐ Other:	

Recent Screening/Diagnostic Procedures Received through BCCS or prior to being referred to BCCS for an MRI procedure. Check all that apply

☐ Mammogram	☐ Screening Date: Result: ☐ Diagnostic Date: Result:	☐ Ultrasound Date: Result:	☐ Biopsy Date: Result:	☐ Specialist/Surgical Consultation Date:

PROCEDURE INFORMATION

Will requested procedure(s) be performed in a facility with dedicated breast MRI equipment & capable of performing breast MRI-guided biopsies ☐ YES ☐ NO

Requested Procedure(s) Check all that apply **Anticipated Date of Procedure(s):**

☐ 77058	☐ B7058	☐ 77059	☐ B7059	☐ F9085	☐ F9086	☐ 856FX	☐ F9287	☐ F9288

[1]First-degree relative = Mother, Sister, Child [2]Must be calculated using a reputable risk-assessment tool. List tool used in the comments section below.

COMMENTS:

FOR DSHS USE ONLY – DO NOT WRITE IN THIS AREA		
☐ APPROVED	☐ DENIED	REASON:
Reviewer(s):		Date:

Patient Education	**American Cancer Society** 1-800-227-2345 www.cancer.org ➢ Guide to Quitting Smoking; ➢ Prescription Questions; ➢ Cancer education classes.	**Beyond the Brochure: Alternative Approaches to Effective Health Communication** http://www.cdc.gov/cancer/nbccedp/pdf/amcbeyon.pdf ➢ CDC Manual that provides guidance to more effective: Health communication: ➢ Techniques; ➢ Strategies; ➢ Healthcare messaging.	**Susan G. Komen Breast Cancer Foundation** **1-877-465-6636** ➢ Education Helpline; ➢ Breast Cancer Information.	**National Cancer Institute Cancer Information Service** 1-800-422-6237 TTY: 1-800-332-8615 www.nci.nih.gov ➢ What is cancer; ➢ Understanding treatment; ➢ Prevention of cancer; ➢ Free booklets on cancer; ➢ Information & website in Spanish.	**Cancer Prevention and Control** (http://www.cdc.gov/cancer) ➢ Cancer information ➢ Information in Spanish ➢ Website in Spanish
Patient Advocacy/ Support	**American Cancer Society** 1-800-227-2345 www.cancer.org ➢ Access to Health Care; ➢ Clinical Trials; ➢ Stories of Hope; ➢ Financial Issues; ➢ Finding support groups.	**National Cancer Institute Cancer Information Service** 1-800-422-6237 TTY: 1-800-332-8615 www.nci.nih.gov ➢ Clinical trials ➢ Support ➢ How to find treatment ➢ Coping with cancer	**Susan G. Komen Breast Cancer Foundation** **1-877-465-6636** ➢ Finding breast services via an affiliate.	**Cancer Prevention and Control** http://www.cdc.gov/cancer Survivorship information	**LIVESTRONG Foundation** **http://livestrong.org/** ➢ Patient Navigation ➢ Survivorship ➢ Clinical trial information ➢ One-on-one support ➢ Information for family members

Clinical Information	**Susan G. Komen Breast Cancer Foundation** **1-877-465-6636** ➢ Grants for providers.	**National Cancer Institute Cancer Information Service** 1-800-422-6237 TTY: 1-800-332-8615 www.nci.nih.gov ➢ Clinical trials; ➢ Research/funding; ➢ Cancer statistics; ➢ Cancer information; ➢ Drug dictionary; News Release; ➢ Grants; Provider training.	**The Community Guide** (http://www.thecommunityguide.org) ➢ Strategies for providers to improve care ➢ Reminder systems ➢ Patient Incentives ➢ Funding/grants ➢ Research ➢ Education program development ➢ Patient publications	**Cochrane Collaboration** http://www.cochrane.org/ Objective evidence-based strategies to improve healthcare delivery: ➢ Case management; ➢ Provider reminder systems ; ➢ Provider feedback

Evidenced-Based Outreach Strategies	**Cancer Control PLANET** http://cancercontrolplanet.cancer.gov/ CDC/ACS sponsored website that provides step-by-step strategies in developing a cancer control plan based upon current research.	**Community Health Worker Programs Materials—A Handbook for Enhancing Community Health Worker Programs: Parts I & II** http://www.cdc.gov/cancer/nbccedp/training/community.htm Handbook is for people who develop or manage community health worker programs in established health care settings and community outreach Programs.	**Outreach to Increase Screening for Breast and Cervical Cancer** ftp://ftp.cdc.gov/pub/Publications/Cancer/nbccedp/training/outreach.htm 3 Part program designed to help improve and develop an outreach campaign for cervical/breast cancer screening includes: ➢ Training resources; ➢ Lesson plan(s)	**Center for Sustainable Outreach** http://www.usm.edu/csho/non-managed_care_toolkit.html The Center for Sustainable Health Outreach (CSHO) Offers various toolkits & resources for a Community Health Worker program.

Evidence Based Interventions to Improve Screening Rates	**Cancer Control PLANET** http://cancercontrolplanet.cancer.gov/ CDC/ACS sponsored website that provides step-by-step strategies in developing a cancer control plan based upon current research.	**Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees** http://www.cdc.gov/cancer/nbccedp/pdf/pruguide.pdf Manual developed by Prudential Center for Healthcare Research that offers step-by-step strategies to improve mammography screening rates.	**The Community Guide** www.thecommunityguide.org ➢ Client-based strategies; ➢ Helping clients to make informed decision	**Cochrane Collaboration** http://www.cochrane.org/ Objective evidence-based strategies to improve healthcare delivery: ➢ Breast cancer; ➢ Gynecologic cancer; ➢ Various health conditions; ➢ Case management; ➢ Provider reminder systems ➢ Training resources