

TENNESSEE BREAST AND CERVICAL SCREENING
PROGRAM

PROGRAM MANUAL

REVISED

SEPTEMBER 2010

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SECTION I. Introduction

Overview

In 1990, Congress enacted Public Law 101-354, “Breast and Cervical Mortality Prevention Act.” This law directs CDC to offer grants to states to establish screening and diagnosis programs to increase early detection of these cancers. The objective is to reduce morbidity and prevent mortality from breast and cervical cancer. States receiving funding must provide breast and cervical cancer screenings to eligible women; provide appropriate services and/or referrals for both diagnosis and treatment; develop and disseminate information and education to health professionals, the general public and women in the target groups; establish mechanisms to monitor the quality of screening procedures; and evaluate program implementation according to NBCCEDP guidelines.

The Ten Components for State NBCCEDP Programs

1. **Management** – to maximize available resources to implement all program components with the established policies and procedures.
2. **Screening** – to detect precancerous and cancerous conditions at the earliest stages to reduce mortality and morbidity.
3. **Tracking and Follow-up** – to assure compliance with recommended screening/rescreening, diagnostic and treatment protocols.
4. **Case Management** – to assure that women enrolled receive timely and appropriate diagnostic, treatment and rescreening services.
5. **Quality Assurance and Improvement** – to ensure the quality of services delivered through TBCSP.
6. **Professional Education** – provide professional, including allied health, training to increase knowledge, attitudes and skills so that women receive appropriate and high quality services.
7. **Public Education** – increase awareness in priority populations of the need and availability of services and motivate women to seek these services.
8. **Coalitions and Partnerships**- to expand resources, coordinate activities, overcome obstacles, and promote comprehensive service delivery.
9. **Surveillance** – use relevant surveillance data to plan, monitor and evaluate program activities.
10. **Evaluation** – to assess the quality, effectiveness and efficiency of a program compared to a set of standards or objectives.

CDC initially funded the Tennessee program in 1994 with an expanded grant award in 1996 to begin screening services. The purpose of TBCSP is to reduce morbidity and mortality by providing high quality breast and cervical cancer screenings and diagnostic services to eligible women.

The target group is Tennessee women who are older, have low incomes, and are uninsured or underinsured. Special emphasis is placed on outreach and service to African Americans, Hispanics and Appalachian Whites who are historically underserved and those women who have never had or rarely get these screening tests.

Clinical breast exams, mammography, pelvic exams and Pap tests are offered to women who meet income guidelines and eligibility criteria. Referrals are made for approved diagnostic services and follow-up care. Each patient is tracked through a data base system to assure they receive necessary services and return for annual re-screens. As part of the national program, data is submitted semiannually to CDC to document our success in reaching and serving these women.

In 2002, the program was moved from the Department of Health – Bureau of Health Informatics to the Bureau of Health Services to better align it with the regional health system and to mobilize the resources of the local health departments for implementing a quality program in Tennessee.

With the passage of the federal Affordable Care Act (ACA) of 2010, the program will begin redirecting program emphasis from direct service to outreach, education and patient navigation services to assure that all women get benefits covered by national health insurance policies. Redirection will occur over the next four years and continue until ACA is fully implemented.

TBCSP ROLES AND RESPONSIBILITIES JUNE 2005

Central Office Role and Responsibilities

- Develop and maintain policies and procedures manual
- Data management from regional systems and metros
- Grant writing/progress reports
- Periodic data system submittals to CDC
- Data entry and billing for referral providers metros and 330 sites
- Monitoring referral providers with regions
- Technical assistance and consultation with the field and providers
- Contract/fiscal monitoring
- Patient and Provider education materials development
- QM system specific to this program
- Establish and maintain a Medical Advisory Committee
- Provide for medical consultation

Regional Office Roles and Responsibilities

- Establish an effective screening plan thru LHDs or 330 sites
- Submit required PTBMIS data collected from counties
- Designate a full time regional coordinator for TBCSP to
 1. coordinate activities of the participating LHDs and 330 sites
 2. review and expand referral network as indicated
 3. train LHD and referral providers in program requirements
 4. monitor regional service delivery and data collection
 5. target and track outreach to specific groups in the appropriate age range
 6. assure that community education is provided
 7. facilitate internal and external QA and use information for continuous improvement
 8. verify claims from referral providers before processing for payment
 9. participate in of regional coalitions
 10. serve as the link to Central Office for program management and collection of missing data on women enrolled in the program
 11. provide case management to all diagnosed women entering treatment
 12. assist with presumptive eligibility when indicated
 13. assist with TennCare provider network, authorization and appeals as indicated

Local Health Department Roles and Responsibilities

- Identify counties that will provide the service.
- Advertise the service and provide screening
- Complete PTBMIS data entry
- Refer when indicated and follow up to collect and report outcome of referral services
- Track and notify those who have normal screens to return according to the periodicity schedule
- Assist with regional provider network development
- Assist with case management of diagnosed women as needed or requested by the regional coordinator

Assist with presumptive eligibility when requested

Medical Advisory Committee

The Medical Advisory Committee is made up of Tennessee specialists in the diagnosis and treatment of breast and cervical cancer. Members have been selected representing the three grand regions of the state and specialties involved in accurate diagnosis of breast and cervical cancer. These include breast specialists, radiologists, surgeons, gynecological practitioners and oncologists. The committee is chaired by the Medical Director for the Bureau of Health Services and meets on an as needed basis, usually by conference call. The following is the job description provided to those who agree to serve on a volunteer basis with the program.

JOB DESCRIPTION

As a voluntary member of the TN Breast and Cervical Screening Program Advisory Committee, I understand that my role is to:

1. Attend orientation to the program and federal guidelines
2. Review current program policies and procedures and recommend changes as indicated.
3. Assist with drafting new policies and procedures as they relate to screening and diagnosis.
4. Review special diagnostic requests with consideration to CDC policies and program limits.
5. Consult with the TDH Medical Consultant on other matters related to the program or clients.

SECTION 2 **ELIGIBILITY GUIDELINES**

Tennessee Breast and Cervical Cancer Early Detection and Prevention Program (TBCSP) is required to provide cancer screening services to women who meet specific eligibility guidelines.

GENERAL ELIGIBILITY

- A resident of Tennessee

- At or below 250% Federal Poverty Level (FPL) for family size
 AND
- Uninsured - “defined as those women who have no private health insurance, TennCare or Medicare coverage or have exhausted their annual or lifetime benefits.
 OR
- Underinsured - defined as those women who either do not have coverage for breast or cervical screening or do not have coverage for diagnosis and treatment of breast or cervical cancer. Women with health insurance that covers TBCSP services are not considered underinsured even if they state that they are unable to pay applicable co-pays and deductibles for services.

- Meet the age requirements for breast screening

- Meet the age requirements for cervical screening

DETERMINING INCOME STATUS

The program follows Federal Poverty Level (FPL) guidelines which are adjusted annually. Changes in the FPL go into effect each year, usually by March each year. The FPL chart is sent electronically to the regional coordinators when we receive it.

- Verbal declaration of income and insurance status is sufficient for TBCSP screening services.

- If self employed – use prior year net income to establish financial eligibility based on family size.
 - e.g., if a family of 3 has a gross income of \$45,000 but business expenses are \$20,000; their net income is \$25,000.

- Women whose family income is up to 250% of the federal poverty level (FPL) are eligible for screening and diagnostic services for breast and cervical cancer detection.

- Child support is not considered income for the mother, according to DHS policy and should not be counted in determining income

BREAST SCREENING ELIGIBILITY

1. **Primary target group – women 50 to 64** who meet the general eligibility guidelines
2. **Secondary target group – women between 40 and 49** who meet the general eligibility guidelines AND have a mother, sister or daughter (first degree relative) with breast cancer; have a personal history of breast cancer or has a Clinical Breast Exam (CBE) that is suspicious for breast cancer. These conditions make a woman high risk for breast cancer.
3. **Tertiary target group - women 18 – 39** who meet the general eligibility guidelines and have one or more of the following positive symptoms suspicious for breast cancer:
 - Discrete palpable mass
 - Nipple discharge
 - Skin changes or
 - Nipple changes

WOMEN UNDER 40 WITH ONE OR MORE OF THE ABOVE SYMPTOMS MUST BE PRIOR AUTHORIZED FOR SERVICES—PRIMARY CARE CENTERS (330 SITES) CALL CENTRAL OFFICE. COUNTY HEALTH DEPARTMENTS CALL REGIONAL COORDINATORS.

CERVICAL SCREENING ELIGIBILITY

1. **Primary target group – women 40 - 64** who meet the general eligibility guidelines.
2. **Secondary target group - women 18 – 39** who meet general eligibility guidelines may be enrolled in TBCSP if they are in need of further diagnostic services **after the initial Pap results are received.*** TBCSP does not pay for initial Pap or the Pap tests that may be required following diagnosis for this age group.

*If the Pap test result indicates an abnormality, women can be referred for diagnosis only (colposcopy, endometrial biopsy or endocervical sampling)

SPECIAL CERVICAL SCREENING CIRCUMSTANCES

TBCSP will only cover Pap tests every two (2) years following ASCCP guidelines after three (3) consecutive normal Pap tests in a 60 month time period documented in the data collection system,

Women who have had a hysterectomy due to cervical neoplasia or cervical cancer are eligible for annual vaginal Pap tests covered by TBCSP. Pap tests are not covered for women who had a hysterectomy for any other reason.

TBCSP will cover a pelvic exam to determine if a woman has a cervix if this is in question.

WOMEN WHO ARE NOT ELIGIBLE

- Women on Medicare-Part B and/or on Medicaid/TennCare
- Asymptomatic women 18 – 39 are not eligible for mammography (NBCCEDP policy). Asymptomatic women are those without specific signs or symptoms that are positive for breast cancer.
- Women younger than 40 are not eligible for cervical screening.
- Women with other gynecological cancers are not eligible for TBCSP or Medicaid/TennCare presumptive eligibility.
- Men are not eligible for TBCSP services according to the federal law establishing the program. It is recognized that while men are at some risk of developing breast cancer, the percentage is very low (less than 1%) as compared to women. (NBCCEDP policy)

SPECIAL TARGET GROUPS

- The program emphasizes outreach and screening to historically underserved populations. These include Appalachian White, African-American and Hispanics in Tennessee.
- The program is especially interested in screening women who have never or rarely had these screening tests since they are at highest risk for breast and cervical cancer.
 - For breast cancer = never had or 2 or more years since last mammogram.
 - For cervical cancer = never or 5 or more years since last Pap test.

SECTION 3 PRESUMPTIVE ELIGIBILITY GUIDELINES FOR TREATMENT

The TBCSP regional or local coordinator reviews and enrolls any woman as a Medicaid presumptive eligibility case who meets the program general eligibility requirements and is diagnosed with breast or cervical cancer or precancerous conditions for these diseases. DHS Form # 2768 is faxed (615-313-2254) or scanned and sent electronically to the central DHS office immediately following completion of the forms.

Eligibility:

General program eligibility must be met. (250% of poverty, uninsured/underinsured) Verbal declaration is acceptable at the local health department.

Women must be participants in the TBCSP program. Screening a woman for eligibility is considered “participating in the program” for those diagnosed elsewhere.

Program participation can be established in four different ways:

1. The woman has been screened and diagnosed through the local health department.
2. The woman has been screened and diagnosed through an affiliated provider (participating primary care center-330 site or private provider).
3. The woman has been screened and diagnosed by a private provider not affiliated with the program but referred to the program for presumptive eligibility and case management.
4. The woman has had insurance coverage, is diagnosed with breast or cervical cancer and has been notified that her insurance will no longer cover her medical services. **She can be presumed eligible and enrolled in the program IF she meets the general eligibility guidelines and is in treatment.**

The medical specialist diagnosing the woman (a surgeon, radiologist, breast specialist or gynecologist) must provide hard copy reports to assist in determining presumptive eligibility. Screening sites affiliated with TBCSP will refer diagnosed women to the regional or local coordinator and share relevant medical information for presumptive eligibility.

Enrollment of Women diagnosed by TBCSP :

- Only the regional or local coordinator can complete the presumptive eligibility requirements for TennCare coverage.
- Participating primary care centers refer diagnosed women and submit the necessary documentation to the regional or local coordinator for presumptive eligibility.
- Non- participating providers must also refer the woman to the regional or local coordinator and provide the necessary documentation.

The coordinator completes the following steps:

1. Call referral provider/doctor for verbal confirmation of diagnosis and request hard copy of the patient information to be faxed to the regional or local office if you do not have this documentation.
2. Complete and forward to DHS Central Office, **DHS Form # 2768** either by fax (615-313-2254) or scan and send electronically.
3. Give the woman one copy and keep a copy for the medical record
4. Provide TennCare advocacy and case management until TennCare enrollment is completed and treatment is started.

Enrollment Women NOT diagnosed by TBCSP:

For women diagnosed by another source other than TBCSP, the regional or local coordinator must open a medical record and review screening and diagnostic reports to verify the presence of breast or cervical cancer. Program forms do not need to be sent to Central Office because no services for screening and diagnosis were paid for by TBCSP.

1. Complete the PTBMIS registration screen and code the program as BCS. Use the 6 BCS code as the payor. Use TCPRES as the service code.
2. Have patient sign release of information form.
3. Call referral provider/doctor for verbal confirmation of diagnosis and request hard copy of the patient information to be faxed to the regional office if the patient is not already enrolled in the TBCSP program.
4. Complete and forward to DHS Central Office, **DHS Form # 2768** either by fax (615-313-2254), .or scan and send electronically.
5. Give the woman one copy and keep a copy for the medical record
6. Provide TennCare advocacy and case management until TennCare enrollment is completed and treatment is started.

Presumptive Eligibility

Presumptive eligibility starts the day the regional or local coordinator completes the Presumptive Eligibility Form and faxes it to DHS; coverage lasts 45 days from that date. The woman **MUST** go to the county DHS office to complete registration for Medicaid coverage OR she will be dropped from TennCare after the 45 day period.

Presumptive Eligibility for Inconclusive Diagnosis

A woman can be enrolled in PE for inconclusive diagnosis from routine diagnostic procedures. She will receive TennCare coverage during the 45 day PE period until further tests establish a final diagnosis. TBCSP is responsible for case management during this PE period.

If she is not diagnosed with breast or cervical cancer, she will not complete the process for enrollment with DHS and will be dropped from TennCare.

Medical Record and Patient Case Management:

A medical record must be opened on all presumptive eligible women. If a woman was screened and diagnosed by TBCSP, a medical record is already opened. If the woman was referred in by another provider, a medical record must be opened by completing the patient registration screens so that TennCare Advocacy codes can be entered into the system. Provide case management using TennCare Advocacy to assure that the woman gets enrolled in TennCare and begins treatment. Document all contacts using TennCare Advocacy codes.

DHS Verification of TennCare Eligibility:

After completing presumptive enrollment, advise the woman that she must go to the county DHS county office as soon as possible, preferably in the first 14 days so that there is no break in coverage, with the following papers:

- Social security card
- Driver's License or proof of identity
- A check stub or other proof of income
- Information about insurance coverage from employer
- Or a completed DHS form # TN-A008 showing income and insurance information.

DHS is responsible for final verification that a woman is eligible for continued coverage after the 45 day presumptive eligibility period. Documented income information (pay stub or income tax return) is required by DHS to verify that the woman does not qualify for any other Medicaid category except the MA-Z category.

Emphasize that failure to go to the DHS office as soon as possible might result in a break in medical treatment and/or denial of TennCare coverage.

Annual Verification of Treatment for Continued TennCare Coverage

TennCare annually reviews cases enrolled for treatment. The enrolled woman is sent a letter explaining to her that her medical provider must complete the enclosed treatment plan form and return it to the TennCare office within a certain time period. There are two circumstances where the woman might be notified that she is being dropped from TennCare coverage.

1. She did not respond to the first letter, did not give the treatment plan form to her provider or
2. She responded to the first letter, had her provider complete and mail the form to TennCare but the medical review decided that she is no longer in active treatment for cancer.

When the treating physician returns the treatment plan form within the designated time period, the material is reviewed by a medical team at TennCare to verify that the woman is in active treatment.* (Periodic office visits including medical tests and lab work are **NOT** considered active medical treatment by TennCare).

TBSCP staff are frequently contacted to assist women who are notified that they are being dropped from TennCare coverage

1. Advise her of her appeals rights and file the appeal.

2. If she has the treatment plan form, she should send it immediately to her treating physician.
3. Request a new form from TennCare if needed.
4. She can request a second review and contact her provider to send in the paperwork ASAP.

* TennCare has not issued a definition of “active treatment” because it is decided on a case by case basis after review by the TennCare medical team.

TennCare Bureau Statement on

Women with Breast or Cervical Cancer

<http://www.tennessee.gov/tenncare/mem-categories.html#Womencancer>

Brief Description

The Breast and Cervical Cancer Prevention (BCCP) category is an optional Medicaid category that covers women who have been screened through a Centers for Disease Control and Prevention (“CDC”) approved Breast and Cervical Cancer Early Detection Program (“BCCP”) and found to need treatment for breast and/or cervical cancer. In Tennessee the state program is operated by the Tennessee Department of Health (DOH), through the **county health departments**, and called the "TN Breast and Cervical Screening Program."

Tennessee women who are uninsured or whose insurance does not cover treatment for **breast or cervical cancer**, who are under age 65, and who have been determined by the County Health Department to need treatment for breast or cervical cancer are eligible to enrollee in TennCare Medicaid.

Monthly Income Limit

The screening guidelines required by the CDC Breast and Cervical Cancer Early Detection Program requires screened eligible’s to be below 250 percent of the federal poverty level.

Resource Limit

None

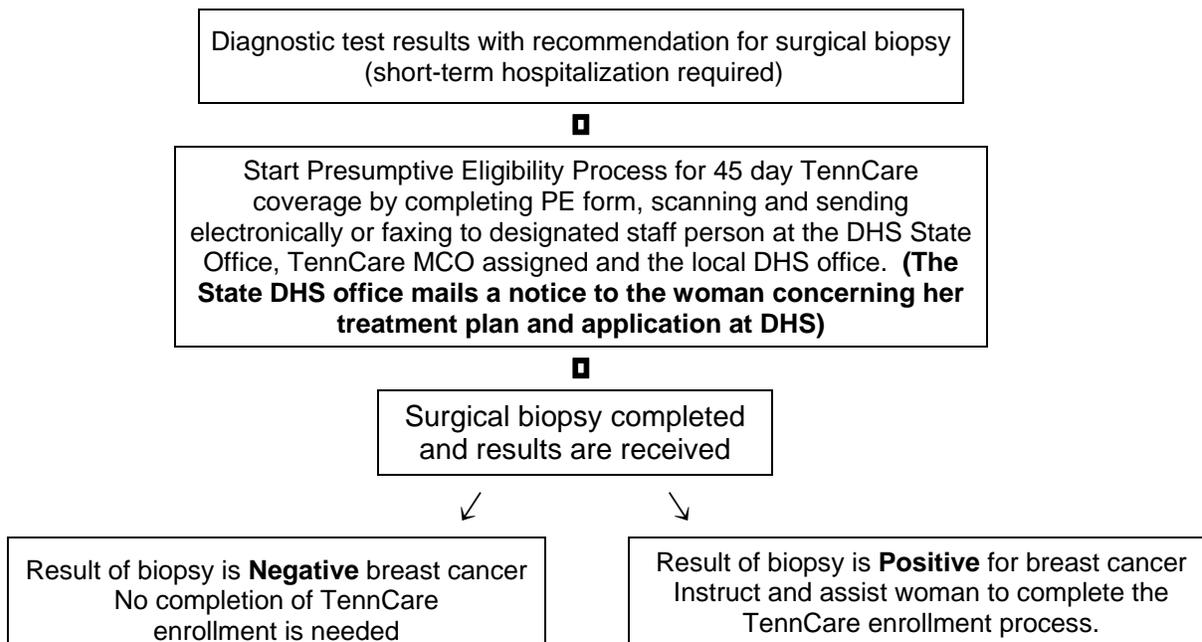
Comments

HOW TO APPLY - Presumptive eligibility is an established period of time (45 days) during which certain women identified by the DOH as being uninsured and needing treatment for breast or cervical cancer—are eligible for Medicaid. During this period of time the presumptively eligible person must complete an application for Medicaid in order to stay on the program. All applicants must complete a written application for Medicaid and be interviewed by a worker with the county office of the Department of Human Services (DHS).

Presumptive eligibility lasts for a period of 45 days. During the presumptive eligibility period, the enrollee must go to the DHS office to complete her enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for the optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer. A redetermination of eligibility will occur at least every 12 months at the DHS office and will be based on the need for continuing treatment for breast or cervical cancer, as determined by the woman’s treating physician.

The **effective date of eligibility** is the date an application is approved at the Department of Health or at any alternative sites chosen by the Department of Health.

Presumptive Eligibility Process
for Breast Pre-cancerous Conditions
revised August 2007

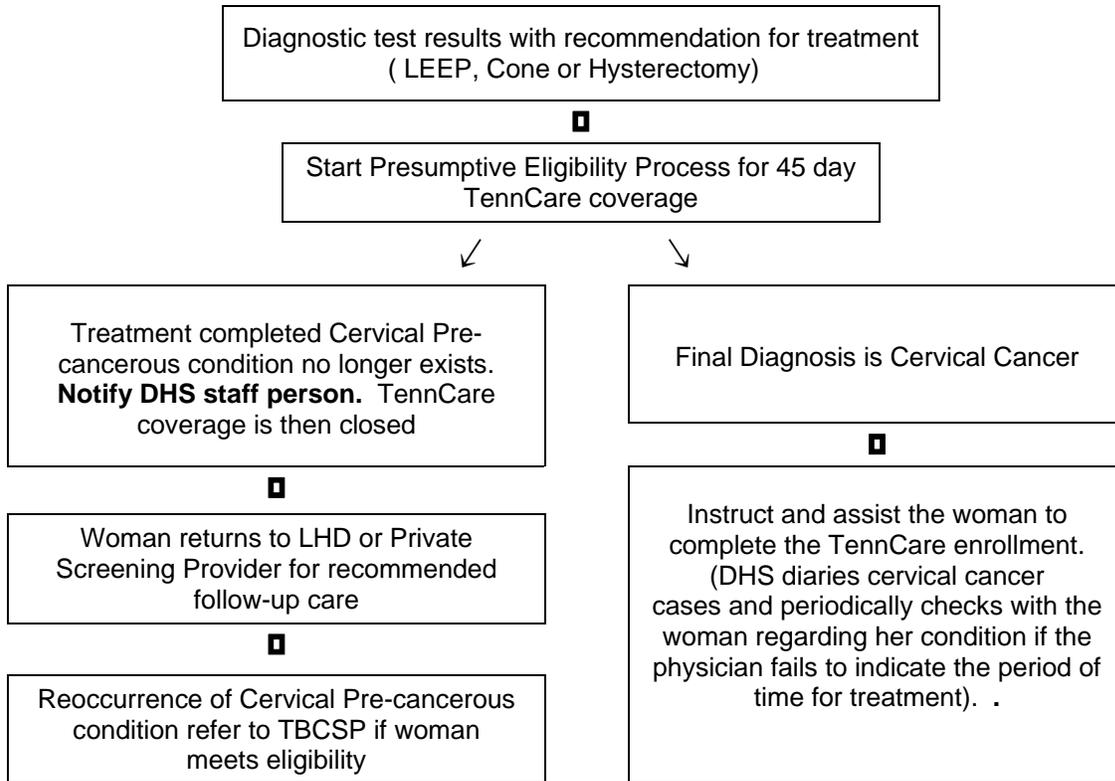


Instructions

- 1) The woman's diagnostic test results indicate that a surgical biopsy is recommended.
- 2) If the woman needs short-term hospitalization to obtain the biopsy, you will start the Presumptive Eligibility (PE) process. The woman is on PE for 45 days. Within that time, the biopsy result should be received. Be sure to send completed PE form to DHS staff person (scanned and electronic mail or fax number 615-313-2522) and the local DHS office.
Note: If woman qualifies for another category of TennCare then local DHS will notify Central Office and the woman is closed out of the TBCSP PE. All further diagnostic test or treatment that is needed will be covered by that category of TennCare.
- 3) When the biopsy result is **negative**, you will notify the woman not to complete enrollment. No further treatment is indicated.
- 4) If the biopsy result is **positive**, instruct and assist the woman to complete the TennCare enrollment. This allows for treatment and further services to be reimbursed through TennCare.
- 5) **Do not let the surgeon's office schedule surgery or further treatment until PE and TennCare MCO is finalized.**

If the physician orders (outpatient procedure in the physicians office) either a Fine Needle Aspiration (FNA) or Stereotactic biopsy, then the TBCSP program will cover the reimbursement.

**Presumptive Eligibility Process
for Cervical Pre-cancerous Condition**
revised August 2007



Instructions

- 1) The woman's diagnostic test results indicate that further treatment is recommended.
- 2) Start the Presumptive Eligibility (PE) process. The woman is on PE for 45 days in which time the treatment procedure is performed.
- 3) If the woman has a final diagnosis of cervical cancer, then the TennCare enrollment process is completed. Treatment coverage and any further follow-up is covered by TennCare.
- 4) After treatment for a pre-cancerous cervical condition, if further treatment is not indicated, notify the DHS State Office (615-313-4873). TennCare application will not be completed and the woman then returns to the LHD or Private Screening Provider for recommended follow-up care.
- 5) If there is a reoccurrence of the cervical pre-cancerous condition, refer to TBCSP if the woman meets eligibility criteria.

Revised August 2007

DHS Presumptive Eligibility Guidelines And Form



**STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES**
CITIZENS PLAZA BUILDING
400 DEADERICK STREET
NASHVILLE, TENNESSEE 37248

Telephone: 615-313-4700 FAX: 615-741-4165
TTY: 1-800-270-1349
www.state.tn.us/humanserv/

PHIL BREDESEN
Governor

VIRGINIA T. LODGE
Commissioner

MEMORANDUM

MA-07-13

TO: All District, County and Area Offices, Division of Appeals and Hearings, and Family Assistance Service Centers
FROM: Marcia Garner, Director, Medicaid/TennCare Policy Unit
DATE: April 18, 2007
SUBJECT: Breast and Cervical Cancer Processing: State Office and County Office Responsibilities

Breast and Cervical Cancer Cases (BCC) – MA Z - cases are tracked to ensure receipt of appropriate benefits. In preparation for conversion to VIP, this memorandum is a clarification for processing BCC cases. Counties are to ensure that all BCC cases are being processed according to the following procedures.

Department of Health:

1. DOH will fax the completed presumptive eligibility (PE) form to the BCC program specialist in State Office (SO).
2. Upon approval of BCC PE, provides a DHS application for assistance
3. Instructs the BCC PE individual to apply for assistance at the DHS local county office within 45 days from the date of PE approval.
4. Instructs the BCC PE individual that she must provide a treatment plan to the DHS State Office program specialist within 45 days from the date of PE approval.

DHS County caseworker:

1. Will process the BCC client's DHS application through the ACCENT system;
2. Will document in CLRC whether or not the BCC individual qualifies for any category of Medicaid, other than BCC (MA Z);
3. Will e-mail the BCC program specialist at State Office in the MEU, prior to the 45th day following the date of PE approval, providing the following information:
 - a. District
 - b. County Name and County Number
 - c. Applicant's Last Name
 - d. Applicant's First Name
 - e. Applicant's SSN

- f. Applicant's DOB

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- g. Date the Application for Assistance was filed with DHS
- h. Application processed on ACCENT: Yes/No
- i. Eligible in another Medical Assistance (MA) category: Yes/No
- j. Eligible category
- k. Processing County Caseworker ID

BCC Program Specialist in the MEU at State Office:

1. Receives the faxed PE form from DOH (with or without documentation)
2. Checks interChange for existing medical coverage
3. Process PE
 - a) Verify County code
 - b) Verify MCO code
4. Assigns 7870-Case number
5. Data entries required in the BCC ACCESS file are:
 - a) District
 - b) County
 - c) Last Name
 - d) First Name
 - e) SSN
 - f) DOB
 - g) PE Begin Date
 - h) Diagnosis: Breast or Cervical
 - i) DHS Application for Assistance Filed within 45 day PE period: Yes/No
 - j) Date the Application for Assistance was filed with DHS
 - k) Application processed on ACCENT: Yes/No
 - l) Eligible in another Medical Assistance (MA) category: Yes/No
 - m) Eligible Category
 - n) Processing County Caseworker ID
 - o) Treatment Plan Submitted: Yes/No
 - p) Treatment Plan Date
 - q) Treatment Plan Update Due
 - r) interChange Open Date
 - s) interChange End Date
6. Enter case information on ACCENT 1610 (can only be done in SO)
 - Put the begin and end date of the PE period on interChange.
7. Verifies that the BCC case is on interChange (day after receipt from DOH)
8. Creates a paper file in SO using end date on PE form
9. Mails an initial letter to the BCC individual that provides instructions to:
 - a) go to DHS county office to file an application for assistance within 45 days from the PE approval, if the individual has not already filed an application;
 - b) submit a treatment plan to the BCC program specialist (self-addressed envelope included); and
 - c) submit a biopsy report to the BCC program specialist.

10. Holds the BCC file in a "45-day" file

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11. On the 45th day, the BCC Program Specialist will check ACCENT prior to taking one of the following actions:
- a) If an application for assistance has been filed and the BCC individual is found to be eligible for another category of Medicaid and the BCC coverage will expire at the end of 45 days.
 - b) If an application for assistance has been filed and
 - (1) the BCC individual is found to be ineligible for another category of Medicaid, AND
 - (2) the BCC individual has presented a current treatment plan that requires on-going medical treatment for BCC,the individual file is moved to an on-going caseload and the coverage is extended on interChange, OR
 - c) If an application for assistance has been filed and
 - (1) the BCC individual is found to be ineligible for another category of Medicaid, AND
 - (2) the BCC individual presents a current treatment plan that states that the treatment has been successful (primarily cervical cancer) and no additional treatment is required and the BCC coverage will expire at the end of 45 days.

Questions concerning this memorandum are to be routed through the Medicaid-TennCare Field Support Unit by e-mail at Medicaid-TennCare.FieldSupport.DHS@state.tn.us or by phone at 1-866-482-3886.

MG/JKS/CB/cn

APPENDIX L

MA Z Category - Women Diagnosed with Breast/Cervical Cancer

I. INTRODUCTION

With the passage of Public Law 106-354 2(b) (1) on October 2000, Medicaid coverage could be extended to women who have pre-cancerous/cancerous breast or cervical cancer. The Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease and Prevention Control (CDC), made available matching funds equal to the Federal Medical Assistance Match used in providing Medical eligibility for uninsured children, for women who have been diagnosed with Breast and/or Cervical cancer.

Effective July 1, 2002 these women may qualify for Medicaid in a new category (MA Z) - Medicaid in Tennessee for women with Breast/Cervical Cancer. These Women will receive screening for cancer by the Tennessee Breast and Cervical Screening Program (TBCSP). These centers are located throughout the State. A list of locations and telephone numbers are provided at the end of this section. There is a presumptive eligibility requirement for Medicaid for women who have been screened and determined to have a pre-cancerous or cancerous condition.

A. COVERAGE GROUP

Women who qualify for this category can have continuous Medicaid Coverage if:

1. They are uninsured

Uninsured is defined as individuals without "creditable coverage". Creditable coverage includes:

- Other health insurance including individual plans
- Group health plans
- Medicare
- Medicaid
- Military health plans
- Medical care programs of the Indian Health Services or tribal organization
- State risk pools
- Federal employee health plans
- Public health plans
- Health plans under section 5 (e) of the Peace Corps Act.

2. Under age 65

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3. Have been determined to have breast or cervical cancer, including precancerous conditions and are participants of the TBCEDP program.
4. They are not otherwise eligible for Medicaid under some other category.
5. They are a citizen or qualified alien.

B. PRESUMPTIVE ELIGIBILITY COVERAGE

Determination of Presumptive Eligibility

The TBCSP will establish eligibility for presumptive coverage. They will complete form HS-2768 and fax it to the county office.

What Presumptive Eligibility (PE) Covers

Eligibility coverage under presumptive eligibility allows recipients full Medicaid benefits for a limited time. It provides:

- Medicaid coverage not limited to treatment of breast and cervical cancer.
- Allows enrollment in Medicaid/TennCare for a limited period of time before a full Medicaid application is processed.
- Presumptive eligibility is used to facilitate eligibility in the MA Z category if the applicant is not eligible in any other category, so that treatment can be started.

Eligibility Begin Date

Eligibility for Presumptive Medicaid begins on the day TBCSP determines a need for a referral for treatment. The presumptive period ends on the 45th day.

C. Technical Requirements

- 1) Must be- a U. S. citizen or qualified alien.
- 2) Must be a resident of Tennessee.
- 3) Must be in need of treatment for breast or cervical cancer.

D. Financial Requirements

Income and resources are not taken, into account for the MA Z category. However, this information is necessary for determination of other Medicaid categories.

II. RESPONSIBILITY OF TBCEDP

TBCEDP will provide screening services, including clinical breast examinations, mammograms, pelvic examinations and Pap test. The TBCSP will also provide funds for post screening diagnostic services, such as surgical consultations and biopsy, to ensure that all women with abnormal results receive timely and adequate referrals.

- Pay for screening and diagnostic services
- Determine if the individual is uninsured
- Verify if the individual is under age 65
- Determine presumptive eligibility and fax form (HS-2768) to the correct DHS office.

III. DHS RESPONSIBILITY

DHS has two roles in providing coverage for women who have been diagnosed with Breast/Cervical cancer.

A. Presumptive Eligibility - County Offices

The term "presumptive eligibility period" means an individual's coverage will begin the date the preliminary findings are submitted from TBCSP and they will be eligible for full Medicaid services from that date. Eligibility for presumptive Medicaid will last 45 days.

TBCSP will fax the presumptive eligibility form HS-2768 to the correct DHS central office and instruct the participants to go their local DHS office to apply for Medicaid. The participants will be instructed to take their copy of the PE form.

- (a) The Eligibility Counselor (EC) will use the presumptive form HS-2768 to verify the individual's diagnosis and check the TennCare system for any already existing coverage. The EG will fax the original copy to the State Office Medicaid Unit: 615-313 6639.
- (b) The Eligibility Counselor will mail the applicant a DHS page 1 application (form HS-01 69) along with a verification checklist and an appointment to apply. Before MA Z coverage can be approved for ongoing coverage she must to be screened for other Medicaid categories (except MA D).

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- (c) Explain during interview, if applicant is diagnosed with cancer, that a copy of her treatment plan will be requested if Medicaid is to continue.
- (d) Medicaid Policy staff will add the presumptive eligibility coverage to the TennCare system.
- (e) The Eligibility Counselor **must** notify the Medicaid Policy Unit (Gloria Carter - De93MEB) if the Medicare application is approved or denied.

B. State Office Staff - Medicaid Policy Unit

The Medicaid Policy Unit is responsible for keying presumptive eligibility onto the TennCare system and determining any ongoing coverage, If all other Medicaid categories are denied.

- (a) Once form HS-2768 is received in the Medicaid Policy Unit, presumptive, coverage is entered onto the TennCare system.
- (b) Check the TennCare system to assure if the coverage segment is added.
- (c) Maintain the presumptive form and any correspondence in the Medicaid Policy Unit.
- (d) Close the Medicaid eligibility segment if the individual is determined Medicaid eligible on ACCENT.
- (e) If Medicaid is denied for all other Medicaid categories and the applicant has been diagnosed with breast/cervical cancer:
 - Request the county office to provide verification of the treatment plan.
 - Upon receipt of verification, continue eligibility in the MA Z category.
 - If the condition is benign or they fail to provide verifications, this will result in case closure of PE case on the 45th day.
- (f) Once the oncologist determines the patient is cancer free or in remission, the MA Z case will be closed. An application will be mailed, giving the patient an opportunity to apply for Medicaid in other Medicaid categories, or for TennCare Standard.

IV. FREQUENTLY ASKED QUESTIONS AND ANSWERS

Q. If a woman is treated for breast or cervical cancer during the first period of eligibility and is subsequently determined to have cancer that has spread to parts of her body, would she be covered?

A. Yes. If the recurrent metastasized cancer is either a known or presumed complication of breast or cervical cancer, and the woman is still in her first period of eligibility (i.e. she is still receiving treatment for the initial breast or cervical cancer diagnosis); then she would continue to be eligible for additional treatment. If her first treatment period is over and her Medicaid eligibility has been terminated, she must be re-certified through TBCSP to renew her eligibility for the treatment of recurrent breast or cervical cancer.

Q. What is the scope of coverage under this option?

A. During the period of eligibility, a woman is entitled to full Medicaid coverage.

Q. Will our state cover experimental treatments?

A. Tennessee will not cover experimental treatments.

Q. When does presumptive eligibility begin?

A. Presumptive eligibility begins on the date the DHS eligibility worker enters the woman's information into the system which indicates that she has breast/cervical cancer or pre-cancerous conditions.

Q. When does presumptive eligibility end?

A. Presumptive eligibility is for 45 days. However, if the PE period ends and the patient has been diagnosed with breast or cervical cancer and completed the required DHS enrollment at the county office, coverage will begin in the MAZ category.

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**Public Health Use Only
For Breast Cancer Patients**

ACS Reach to Recovery Program

Can Contact Me: Yes No

Signed : _____

Date : _____

State Office Use Only

Case #: _____

Program Code: _____

**PRESUMPTIVE ELIGIBILITY SCREENING GUIDE
(Breast or Cervical Cancer)**

Diagnosis: _____ **Verified:** Yes No

Date of Diagnosis: _____

Name: _____ **Race:** A B N O W
Ethnicity: _____
Primary Language: _____

Address: _____

City: _____ **County:** _____ **Zip:** _____

Phone Number: _____

Date of Birth: / / **Social Security Number:** - -

Estimated Income: _____

Medicaid Category: _____ **MCO:** _____ **MCO Code:** _____

Eligibility Begin Date: / / **Eligibility End Date:** / /

TBCSP Provider Signature: _____ **Date:** _____

This individual has been screened and found to be in need of treatment for breast/cervical cancer by a contracted provider of the Tennessee Breast/Cervical Cancer Early Detection Program (TBCSP)



What to Bring with You to the DHS Office

Versión en español acompaña esta carta

Are you applying for or getting **Families First, Medicaid, TennCare Standard, and/or Food Stamps**?

Please be on time for your appointment!

What if you cannot keep your appointment? Please call your worker for another time.
What if you do not keep this appointment? Your benefits may be late or stopped.

This is the list that shows what to bring with you.
If you are **applying for more than one person**, you will need this information for each of them.

What if you have trouble getting some of the information needed? **Let your worker know.**
He or she will be glad to help you.

- ♥ **Social Security Numbers** are needed for any person applying for help.
We need Social Security numbers ONLY for people who are applying.
We do not need Social Security numbers for people who are NOT applying.
- ♥ **Papers that show:**
 - \ **Identity** - for all family members in your household.
Proof can be papers like a Driver's License, Voter's Registration card, or Health Department Shot Record. You may bring copies.
 - \ **Age** - for all family members in your household.
Proof can be papers like a Birth Certificate, Hospital Records, Baptismal Records, or School records. You may bring copies.
 - \ **Citizenship or Alien Status** - for family members in your household who want to receive benefits. If you or anyone else in your home does not want to receive benefits, then you do not have to tell us that person's citizenship or alien (immigration) status.
Proof for people born in the US can be papers like a birth certificate, passport, or baptismal record.
INS (immigration) papers are needed for people who were not born in the US.
 - \ **Where you live** - Proof can be: Rent Receipts, Mortgage Book, Property Tax Statement, Utility Bill(s), and Homeowners or Rental Insurance.

Are you temporarily living out-of-state? Tell us why. Bring proof that Tennessee is still your home. For TennCare, you must prove Tennessee is your permanent home **and** you are coming back.

- \ **Income** - Proof can be papers like the "Proof of Income and Insurance" page that came with this letter.
You can also bring Check Stubs, W-2 forms, Award Letters, or a letter from your employer.
You must bring this proof for each adult family member.

Rev: 27Aug02

TennCare Information Line: 1-800-669-1851

Be sure to tell TennCare of any address change.

Failure to tell TennCare of your address change could result in loss of your TennCare benefits.

TN A009.7

Are you using the Proof of Income and Insurance that came with this letter? You can make copies if needed. You can get more copies at DHS **before** your appointment.

If you or your spouse have 1 or more full-time or part-time jobs, you must have **each** employer complete the bottom half of the form.

What if a family member works for himself or herself? We need proof of their income.

This can be a copy of their last income tax return. It could be their last IRS quarterly estimate of income.

- \ **Resources** - Proof of things you own like:

- Bank Accounts
- Certificates of Deposits (CDs)
- Savings Bonds
- Property
- Automobiles
- Trucks
- Boats
- Motorcycles
- Recreation Vehicles

- \ **Cost of Utilities** - Proof can be Utility Bills.

- \ **Life Insurance** - Bring a copy of your policies.

- \ **Any health insurance you have** - Bring the policy or a copy of your policy.

This includes:

- Any group health insurance policy.
Examples of this would be:
 - Coverage available to you from your job or your spouse's job
 - COBRA
 - Medicare
 - TRICARE
 - Coverage you bought from a professional association
 - Coverage you bought through a school.
- A health insurance policy you bought yourself
- A policy that only covers certain things, like cancer, or says it will not cover certain things

- ♥ **If anyone has a physical or mental problem** - We will tell you if we need your medical records. We may ask you to have a medical exam. We will pay for that exam.

- ♥ **If you want or get Families First and one or both parents of the children are not in the home**

- Bring, any information you have to show where that parent(s) is.

- ♥ **If you want or get Families First because one or both parents are dead** - Bring proof such as a Death Certificate or Funeral Home Notice.

- ♥ **If you or anyone in your home has lost or quit a job** - Bring proof. This can be a letter saying you would get unemployment checks. It can be a layoff notice or letter from the employer.
- ♥ **If you or anyone in your home gets an unemployment check** - Bring any papers you have that show how much you will get. It should also show how long you will get it.,
- ♥ **Other Information** - Your worker may ask for more information after you meet. Your worker will explain what is needed and how to get it. Your worker can help you get it.

Rev: 27Aug02

TennCare Information Line: 1-800-669-1851

Be sure to tell TennCare of any address change.

Failure to tell TennCare of your address change could result in loss of your TennCare benefits.

SECTION 4 SCREENING PROVIDER ROLE AND RESPONSIBILITIES

TBCSP screening providers include county health departments and community based primary care centers (330sites) affiliated with the TBCSP program.

Providers Must:

1. Maintain current and applicable federal and/or state licenses
2. Agree to accept the program approved reimbursement rate as payment in full for services rendered. The rate is set annually based on the current Medicare Part B reimbursement rate adjusted for Tennessee.
3. Provide the basic screening components for breast and cervical cancer following all program eligibility guidelines:
4. Refer to TBCSP affiliated providers for screening or diagnostic services, if indicated.
 - Assist the woman by contacting the office and scheduling an appointment
 - Assure that the referral provider knows the woman is enrolled in TBCSP and that the program will be covering charges according to the reimbursement schedule.
 - Send a referral sheet specifying the requested tests/services.
 - Follow up to see that the woman kept the appointment
 - Collect and enter results in PTBMIS if a local health department
 - Collect and submit a Transmittal Sheet with results to Central Office if a 330 site.
5. Provide appropriate and timely follow-up for all TBCSP participants according to TBCSP guidelines established by CDC.
6. Provide patient education
7. Expand public education and community outreach to minority groups and the never or rarely screened woman by working with county partners.

Program Enrollment

The screening provider must:

- Determine eligibility based on income, age and insurance status. This can be by self declaration.
- Obtain a signed TBCSP Informed Consent/Release of Information Form. (PH# 3558)
- Local health departments enter patient information electronically into the patient case management system (PTBMIS).
- Screening providers who are not local health departments open the case following their system requirements, complete the Transmittal Sheet and send a hardcopy to Central Office after results of the screening tests have been received from the Lab or referral provider. Transmittal sheets must be received within 30 days of service.

Patient Education

TBCSP screening providers are required to provide women with information and educational services on the early detection of breast and cervical cancer and to document this in the medical record. The purpose of the education component is to provide patients with the information necessary:

- To understand the screening procedures used in the detection of breast and cervical cancer.
- To motivate the patient to comply with recommended guidelines for screening as it relates to present appointment and future screening practices.
- To reinforce the importance of rescreening at recommended intervals (NBCCEDP policy)

Education should be appropriate to the woman's age, lifestyle, educational level and ability to understand. This instruction should be documented in the medical record. The woman should be allowed an opportunity to ask questions and should be asked to verbalize her understanding of the educational information presented.

Initial Visit

Initial screening services include:

- Reviewing and documenting eligibility for the program
- Recording medical history if indicated
Performing clinical breast examination (CBE), pelvic examination and Pap test
- Providing information and educational services related to breast and cervical cancer
- Referral for mammography according to TBCSP guidelines.

Annual Established Patient Visit

The screening provider is responsible for maintaining an annual re-screening system to notify patients as screens become due.

Annual screening services include:

- Check for continuing eligibility
- Updating of medical history
- Performing of CBE, pelvic examination and Pap test
- Referring for mammography according to TBCSP guidelines

Outside Referral by TBCSP for Special Services: Refer in accordance with clinical guidelines to affiliated TBCSP referral providers for the following services:

- Mammography
- Breast Ultrasound
- Fine needle aspiration
- Breast Biopsy
- Colposcopy
- Gyn Consult

Referral to TBCSP After an Abnormal Screening: Women are referred in for diagnostic services after an abnormal clinical breast exam, mammogram or Pap test. Establish eligibility according to guidelines and refer for diagnostic services.

Record Keeping

The TBCSP requires that a copy of all TBCSP reimbursed screening and diagnostic reports are placed in the patient's permanent medical record maintained by the screening provider.

Local health departments have the capability to submit this information electronically as of July 2003 and therefore hard copy is not necessary. We cannot pay claims until we have the documentation of service and results.

Tracking and Follow-Up

Each screening provider should utilize a tracking protocol that assures effective communications between the woman, the provider(s) and laboratory personnel. Such protocol will facilitate proper follow up for women with abnormal screening results, as well as annual re-screening. Local health departments will use the PTBMIS system to alert women about annual re-screens and to provide follow up for patients with abnormal result.

The screening provider who provides the CBE, pelvic examination, and Pap test is responsible for **appropriate and timely** follow-up for necessary diagnostic and treatment services. TBCSP algorithms for timeliness and adequacy which were

approved by the Medical Advisory Committee are contained in the appendix. The screening provider is responsible for:

- Entering/reporting abnormal results from any screening procedure (CBE, mammogram, ultrasound, Pap test) within 10 days of receipt.
- Counseling each woman who has abnormal tests or exams.
- Referring or providing for any additional diagnostic work-up needed.
- Recording relevant information in the medical record.
- Assuring that outcome information on a woman's diagnostic tests and recommendations are received and recorded within 60 days of her initial screening visit.
- Assuring that those women who are diagnosed with cancer, receive or begin treatment within 60 days of the final diagnosis.
- Assisting with Medicaid/TennCare enrollment if a woman is diagnosed with cancer; providing case management as necessary or requested.
- Submitting appropriate data collection forms to Central Office.

Women Who Are Not Following Through with Referrals

If the woman with abnormal results fails to show for appointments for diagnostic or treatment procedures, the primary screening provider must:

- There should be three contacts, one of which should be a certified letter. The dates of the three contacts must be recorded in the medical record.
- If after 60 days (two months) from the abnormal screening results, the woman does not respond to **documented** repeated (at least 3 attempts) phone contacts, postcards and/or a certified letter to schedule additional diagnostic procedures, the work-up disposition will be entered in the TBCSP data system as one of the following:
 - **Lost to follow-up** - if the woman cannot be contacted via phone, post card, or certified letter.
 - **Work-up refused** - if the woman refuses additional diagnostic tests or does not show X 2 for scheduled follow-up appointments.

Date of last contact (phone, face-to-face or certified letter) must be included on the data form. The screening cycle is then closed.

Breast Cancer Screening

Normal Results (Both CBE and Mammogram):

- contact to return for an annual re-screening prior to the annual due date
- If the re-screening is a follow up from a prior abnormality and it is normal, notify the woman. Re-screening is usually scheduled 3 to 6 months after the initial work up..

Abnormal Result (CBE or Mammogram)

- Notify woman of results
- Provide appropriate, timely follow-up for diagnostic services and treatment.
- **Whenever a diagnostic work-up is scheduled, the time from mammogram to final diagnosis must be no more than 60 days.**
- Either an abnormal CBE or abnormal mammogram requires a referral for further diagnostic work up.
- If cancer is diagnosed, the screening provider must refer the woman to the regional coordinator for enrollment with TennCare/Medicaid under presumptive eligibility procedures.

Special Note:

- A normal mammogram does not rule out cancer if a woman has suspicious symptoms on CBE; one other diagnostic method in addition to the mammogram is required to rule out cancer. (see Appendix “Timeliness and Adequacy of Follow-Up Algorithm”).

Cervical Cancer Screening

Normal results

- Contact for re-screening according to program guidelines
- If the Pap test is a follow up from a prior abnormality and the lab result is normal, notify the woman.

Abnormal Results

- Notify woman of results.
- Assist with scheduling appointments with affiliated TBCSP referral providers as indicated by the screening recommendations.
- Provide case management as indicated.
- **Whenever a diagnostic work-up is scheduled, the time from an abnormal Pap to final diagnosis must be no more than 90 days.**
- If cancer is diagnosed, the screening provider must refer the woman to the regional coordinator who will assist with Presumptive Eligibility
- If a pre-cancerous condition is diagnosed, the screening provider must refer the woman to the regional coordinator who will assist with enrollment in TennCare/Medicaid under presumptive eligibility procedures.

SPECIAL NOTES:

1. Women younger than 40 who have abnormal results from an annual Pap Test can be enrolled in TBCSP for diagnostic evaluations if they meet the general eligibility requirements. If cancer is diagnosed, TBCSP will continue to work with the woman to assure that she enrolled in Medicaid/TennCare presumptive eligibility and receives the treatment she needs.
2. Pelvic abnormalities not related to the cervix are not covered by the program.
3. If the Pap result is abnormal (primarily Atypical Glandular Cells (AGC) or other glandular abnormality results) the program will pay for a gynecological consultation and endometrial biopsy (EMB).

The federal policy is as follows:

Endometrial Biopsy (EMB) is indicated whenever the Pap test shows AGC in a woman over age 35 or in women with other risk factors (e.g., abnormal bleeding, diabetes, polycystic ovary syndrome). Since endometrial cancer (like colon cancer or ovarian cancer) is not part of the NBCCEDP, **EMB is only covered by the program for the follow-up of abnormal Pap test results (primarily with AGC and other glandular abnormality results).**

SECTION 5 **REFERRAL PROVIDER NETWORK**

The regional network of specialists in screening and diagnosis is established by the regional coordinator. The network should include:

- Mammography Providers or Breast Centers
- Laboratories
- Radiologists
- Surgeons (Breast surgeons preferred)
- Gynecologists
- Hospitals or outpatient surgery centers
- Colposcopy clinics or a nurse or physician trained to provide colposcopy

Program Requirements for Referral Provider Designation

- Be licensed in the state of Tennessee
- review the referral provider recruitment packet,
- sign a letter of agreement with the TBCSP Program,
- complete a W-9 form to be entered into the state vendor system and
- agree to accept the TBCSP reimbursement rates adjusted annually

Enrolling a Referral Provider

The regional coordinator should contact the office manager and give them the recruitment packet to complete and return to the regional office. Stress that they must provide an ACCURATE bill payment address on the W-9 and the Letter of Agreement – not the physical address of the office.

The recruitment packet consists of:

A cover letter from the regional coordinator

The TBCSP Letter of Agreement form

The W -9 Tax Payer Identification Number form

The Automatic Deposit form – also called the ACH form

These forms and a “Change of Personal/Company Information Form” are included in the appendices and can be copied for enrolling a new or renewing provider.

After the completed forms are returned, check for accuracy and completeness, make a copy for your files or scan and keep electronically and send the original to Central Office.

Central Office Processing of New or Renewing Vendors

New Vendors

When Central Office receives new referral provider paperwork, we perform the following steps. These steps take at least one month to complete after the paperwork is received.

- Review for accuracy and completeness
- Verify state license in the state electronic system

- Submit new referral provider paperwork to TDH Bureau of Administrative Services (BAS) for updating the Dept of Finance and Administration (F and A) database for state vendors.
- When TBCSP is notified that it is in the F and A database, we send the required paperwork to PTBMIS to load into the Central Office file.
- Regional systems administrators are notified to upload the changes to the vendor file by PTBMIS.

Renewing Vendors

When the paperwork pertains to an existing referral provider, Central Office first checks to make sure the correct name and bill payment address are in the F and A system. Referral providers who have changed their legal name or contracted with a different bill processing company MAY need to submit a “new referral provider packet” and then Central office follows the steps listed above.

If it is just an address change and that address is listed in the F and A system, TBCSP can request the change in PTBMIS and system administrators are notified.

Mammography Providers

All mammography providers for the TBCSP must be accredited by the American College of Radiology (ACR) and certified by the Federal Drug Administration (FDA) and in compliance with the Mammography Quality Standards Act (MQSA).

Mammography providers provide the following services upon referral from a screening provider:

- Screening mammograms for women 50 or older
- Screening mammograms for women 40-49 with first degree family member or personal history of breast cancer
- Diagnostic mammograms, if indicated
- Ultrasound, if indicated
- Other related diagnostic procedures which are approved for reimbursement by the TBCSP, if available and indicated.
- Appropriate and timely follow-up for all TBCSP women according to guidelines.

Laboratories

Any laboratory that performs procedures either directly or indirectly for women enrolled in TBCSP must be currently certified under the Clinical Laboratory Improvement Act (CLIA). All laboratories will report findings from Pap tests using the Bethesda 2001 guidelines.

Referral for Additional Diagnostic Procedures (Breast and Cervical)

Enrolled women are referred using a standard referral form to a referral provider affiliated with TBCSP for the following screening and/or diagnostic services:

- Diagnostic Mammography
- Breast Ultrasound
- Surgical Consultation; Gynecology consult
- Fine Needle Aspiration
- Stereotactic Breast Biopsy
- Aspiration of a Cyst of the Breast
- Colposcopy

Reporting/Documentation Requirements

- All referral providers must provide appropriate and timely reporting of diagnostics and include results, recommendations for further diagnosis/treatment and a final diagnosis, if indicated.
- Information must be submitted to the screening provider within 10 days of the initial referral or sooner.
- No payments for referral services will be processed until appropriate and complete reporting is provided.
- Failure to provide timely diagnostic information may result in termination of the letter of agreement between TBCSP and the referral provider.

Communication and Consultation

. The regional coordinator for TBCSP located in the Health Department Regional Office is the first point of contact to discuss service problems or other issues. If needed, the regional coordinator will contact the Central Office staff for assistance.

SECTION 6 CONFIDENTIALITY AND PATIENT **INFORMATION FORMS**

TBCSP providers will be required to protect the usage or disclosure of any medical or social information of a confidential nature in compliance with HIPAA requirements.

TBCSP will periodically develop summary information and reports. Such information will be developed in compliance with applicable federal and state regulations. Any exchange of individual medical record information must be in keeping with program policy and established medical standards and ethics.

Standard Release of Information Form (PH# 1788)

This public health form must be signed and kept in medical records of local health department providers. Other providers must follow their own policies and procedures regarding release of information. These records may be disclosed to physicians or medical facilities as well as TBCSP central office staff.

Informed Consent Form (PH# 3558)

All women are required to sign this form prior to receiving any TBCSP services. This form gives the woman specific information about the program and services covered and it is required by NBCCEDP. Give one copy to the woman and place the original in the permanent medical record.

Referral Form (PH# 2126)

This is an optional public health form that can be used for referral to outside referral providers affiliated with the program.

Other Required Program forms-Transmittal Sheet

LHDs submit electronically and therefore do not have to send transmittal sheets. Regions should follow the established procedures for data entry. See Section 7 for instructions on data entry into PTBMIS.

**DEPARTMENT OF HEALTH
TBCSP
INFORMED CONSENT/INFORMATION**

The Tennessee Breast and Cervical Screening Program (TBCSP), is a cooperative effort between clinics and doctors, the Department of Health and the U.S. Centers for Disease Control and Prevention to encourage screening for breast and cervical cancer. The purpose of the screening is to detect cancer in the earliest stage so that it can be treated and cured. Screening for breast cancer involves a breast examination and a breast x-ray called a mammogram. Screening for cervical cancer involves a pelvic examination and a lab test of cells from the cervix (opening of the uterus) called a Pap test.

- ◆ You will be able to receive a FREE clinic/doctor visit, Pap test and/or mammogram, if you meet the program breast or cervical screening requirements, income eligibility requirements of the program and have no insurance or these services are not covered fully by your insurance.
- ◆ If you have an abnormal screening result, the clinic/doctor will work with the program to help you obtain further diagnostic tests and treatment. The program can pay for limited diagnostic services but cannot pay for treatment. If you need treatment, you might be eligible for Medicaid and we will help you with this.
- ◆ If you have abnormal screening results, the TBCSP program and/or service may need to work with you to make sure you get the services you need (Case Management) from other providers.
- ◆ The screening provider will let you know when you are due for your next Pap test and/or mammogram, usually a year after your first screening.

CONSENT FOR SERVICES / RELEASE OF INFORMATION

I have read the above and understand the explanation about the Tennessee Breast and Cervical Screening Program and hereby consent to receive the health services as indicated. Any information released to the program will remain confidential, which means that the information will be available only to the employees of the Department of Health working with this program and myself. The information will be used only to meet the purposes of the program described above and any published reports which result from this program will not identify me by name.

I understand that my participation in this program is voluntary and that I may drop out of the program and withdraw my consent to release information at anytime.

Patient Signature _____

Print Name _____

Clinic/Health Department _____

Witness Name _____

Date _____



**DEPARTAMENTO DE SALUD
TBCSP
INFORMACIÓN Y CONSENTIMIENTO**

El Programa de Detección del Cáncer Cervical y de las Mamas del Estado de Tennessee (TBCSP), es un programa cooperativo entre clínicas y médicos, el Departamento de Salud y los Centros para el Control y Prevención de Enfermedades de los Estados Unidos, para promover el escrutinio y detección del cáncer cervical y de las mamas. El propósito del escrutinio es el de detectar el cáncer en su etapa incipiente para que pueda ser tratado y curado. El escrutinio del cáncer incluye un examen de las mamas y una aplicación de rayos-X que se conoce por el nombre de mamografía. El escrutinio del cáncer cervical incluye un examen pélvico y otro examen de laboratorio de las células de la cerviz (cuello del útero) denominado “Examen Papanicolau.”

- ♦ Usted podrá recibir en forma totalmente GRATUITA una consulta en la clínica o con el médico, o si estos servicios no estuvieran totalmente cubiertos por su seguro.
- ♦ Si el resultado del escrutinio médico al que Ud. Fue sometida fuera positivo, la clínica o el médico trabajarán conjuntamente con el programa para ayudarle a que sea sometida a otros exámenes de diagnóstico y a los correspondientes tratamientos. El programa puede pagar por servicios limitados de diagnóstico, pero **no paga por el tratamiento. En el caso de que Ud. necesitara recibir tratamiento, usted podría ser elegido para recibir los beneficios del Medicaid y nuestra oficina le ayudaría con los trámites correspondientes.**
- ♦ Si el resultado del escrutinio médico al que Ud. fue sometida fuera positivo, el programa TBCSP y/o su correspondiente servicio, trabajará conjuntamente con Ud. para asegurar que reciba los servicios necesarios (Administración de Casos) de otros proveedores médicos.
- ♦ Abastecedor de la investigación le hará saber la fecha en que deba someterse a su próximo examen “Papanicolau” y/o a una mamografía, lo que generalmente se hace un año después de haberse sometido a su primera escrutinio médico.

CONSENTIMIENTO PARA RECIBIR SERVICIOS/ENTREGA DE INFORMACIÓN

Leí y comprendo perfectamente la explicación que antecede, relacionada con el Programa de Detección de Cáncer Cervical y de las Mamas del Estado de Tennessee, y por la presente doy mi consentimiento para recibir los servicios médicos, tal como sean indicados. Cualquier información dada a conocer al programa habrá de ser considerada como confidencial, lo que significa que dicha información estará solamente a mi disposición y a disposición de los empleados del Departamento de Salud que trabajen con este programa. La susodicha información será utilizada solamente para cumplir con los propósitos del programa antes descrito y cualquier informe relacionado con este programa que fuera publicado, no habrá de identificarme por mi nombre.

Comprendo el hecho de que mi participación en este programa es voluntaria y que en cualquier momento que lo desearé puedo abandonar este programa y retirar mi consentimiento para la entrega de cualquier información al respecto.

Paciente Firma _____

Clínica/Departamento de Salud _____

Nombre _____

Nombre del Testigo _____

Fecha _____

SECTION 7 DATA COLLECTION

All states are required to collect and report specific data about the screening and diagnostic services provided to eligible women. These data elements help the CDC with surveillance of the incidence of cancer and help the program by setting benchmarks for timely service and assuring that women with suspicious screening results receive timely diagnosis.

- **Make copies of the Breast and Cervical Transmittal Sheets that are located in the Appendices.**

Screening providers who are local health departments

- enter information in the PTBMIS screens
- Central Office provides error reports to the Regional Coordinators about cases with missing data elements
- Error reports are sent at least monthly.
- Regional coordinators can also print missing data reports that are part of the PTBMIS reports system.

Screening Providers Who Are 330 Sites

- Use copies of the transmittal sheets to record and submit data on screening and diagnostic services
- Screening sites in Shelby and Davidson counties send transmittal sheets to the regional office
- All other 330 site screening providers send transmittal sheets to Central Office
- Providers will not be reimbursed until data is entered
- Central Office will send error reports at least monthly to collect missing data

Required Submittal of Data to CDC

- Submitted to CDC twice each year in April and October.
- Reflect the enrollment and screening/diagnostic status of all enrollees for the most recent 6-month period.
- Used to evaluate the effectiveness of TN's program and to document we are achieving targets.

Data Entry into PTBMIS

County health departments enter patient specific information directly into the patient registration and data management system called PTBMIS. The basic registration screens are the same as for any client coming to the health department. There are two special screens in addition to these for program enrollees.

- The BCF screen is completed with breast screening information
- The CCF screen is completed with cervical screening information.

These screens are also used to report results from various tests and to record the final diagnosis and close the case.

The electronic transfer of data from each region to Central Office is what is used to submit the semi-annual data reports required by CDC. The Minimum Data Elements (MDEs), as they are called, inform both the CDC and the state on the activities and accomplishments of the program.

The following abbreviated instructions can be used as a guide for data entry. For the complete detailed manual, contact Central Office.

The PTBMIS system has a reports function to review and collect missing data before established deadlines. The following pages also contain abbreviated instructions for generating and printing these reports.

PTBMIS COMMANDS (CHEAT SHEET)

Com.	Parameter	Function
PLF	Last, First	Finds patient by Last Name, First Name
PS	nnnnnnnnn	Finds patient by Social Security Number
PB	mmddccyy	Finds patients by Date of Birth
P	Last,(DOB)	Finds Patient by Last Name (or Last Name & DOB)
A	Patient #	Finds Patient by PTBMIS patient number
BCF		Breast Cancer screen; command brings up a blank screen, or open cycle, for current patient
BCF Patient #		Brings up BCF screen for patient specified
CCF		Cervical Cancer screen; command gives blank screen, or open cycle, for current patient
CCF Patient #		Brings up CCF screen for patient specified
DBCF		Displays all BCF cycles for current patient
DBCF Patient #		Displays all BCF cycles for patient specified
DCCF		Displays all CCF cycles for current patient
DCCF Patient #		Displays all CCF cycles for specified patient
DELIG		Displays list of current patient's eligibility records
BTR		Creates an authorization record for current patient
DBTR		Displays a list of authorization for current patient
TL		Also displays a list of authorization for current patient
CLA Auth #		Creates a new claim for patient with authorization #
DCL		Displays a list of claims for current patient
U		Updates the current screen; saves data
R		Displays the Registration screen for the current patient
V		To view what is in the patient record
NCCF/NBCF		Add notes to patient record
DNCCF/DNBCF		Read notes in patient record

There is always a space between the command and any parameters that are entered after it, but never a space between the parameters themselves.

Correct: PLF Jones,Bridgette or P Jones,04171946
 Incorrect: PLF Jones, Bridgette or P Jones, 04181946

PTBMIS CHEAT SHEETS

TO OPEN THE AS 400:

1. click on the icon
2. enter your DC # and password hit ENTER
3. enter DC# and password again
4. continue to hit ENTER until you get the opening screen

You are now ready to find a patient

TO FIND A PATIENT ALREADY IN THE SYSTEM:

There are three ways to identify a patient. We highly recommend that you use all three methods to assure that you do not duplicate a case. Remember that women are notorious about changing their names.

- | | |
|-----------------------------------|-------------------------------------|
| 1. Enter PLF last name of patient | To locate by name |
| 2. Enter PS and SS number | To locate by social security number |
| 3. Enter PB and birth date | To locate by birth date |

With each method you use, a list of patients in the system will appear who have that last name, birth date or social. If the patient is listed, use the tab key to move the cursor down and select it by hitting "X"

Follow the steps on the next pages for data entry into the BCF and CCF screens.

IF A PATIENT IS NOT LISTED AFTER YOU SEARCH BY ALL THREE METHODS:

Enter "A" at the blinking cursor and hit ENTER. This will give you a blank registration screen. Follow the steps on the next pages for registration and data entry into the BCF and CCF screens.

This is the basic registration screen for all patients seen in the local health department. Anything highlighted **MUST** be filled in. In most cases, women will already be entered into the system prior to seeing the nurse. If you are filling this in, please note the following:

SS # = must add a "0" before SS#
 999999999 if unknown or not given
 Race = select from the drop down menu
 Sex = F
 Migrant = N
 Marital Status = U(nknown)
 Hispanic = Y or N
 Primary Language = E

REGISTRATION SCREEN

Patient No.	Date Updated	Reg. Date	Reg. Type
Tracking	Immun	Medicaid	Fam. No.
Name	Balance	Birth Dat	Age
Alias			
Address			
City	State	Zipcode	County
Hphone	Wphone	Contact	
SSN	Rac	Sex	Migrant
Occupation	Educ	School	Mar. St.
Is Patient Confidential Contact?	Patient Status	Census	Hispan
Address			
City	State	Zipcode	
Emergency Contact		Phone	
Responsible Party	Relationship to Resp Party	Phone	
Name		SSN	
Address			
City	State	Zipcode	DOB
Note:			
Allergies:			
Patient Type	WIC No.	Folder (Y/N)	Cons
MCR	Provider		
Completed By:	Tape No. for Purged Records		
4/08/05 09:38:17			

When you have completed the first page for registration, hit ENTER. This second page will open.

Complete the USA Born? As indicated. Hit enter and proceed to the next page.

REGISTRATION SCREEN 2

U			
Patient No.	Date Updated	Birth Date	Y Born?
Name			
Date of Entry into Country		HSIS Entry/Update Date	
Country of Origin		HSIS Sent Date	
Proficient in English (Y/N)	Preferred Language		
Ethnicity	SSI (Y/N)	Client Status	
Seasonal Farmworker	Homeless	Refugee	Civil Rights
AFDC/TANF	Food Stamps	Registered to Vote?	VFC Payor
Release of Info	Patient Signature		
Active Admission in Case Mgmt	Active EL in Managed Care		
Active TR in Managed Care			
Longitude	Latitude		
Care-Give Guardian Pat#	SSN		
Birth Mother Pat#	SSN	Age at Birth	
First Name	Maiden		
Father`s Name			
4/20/05 12:47:07			

When you complete the second page of the registration, press ENTER and then type "FI" on the command line and press ENTER again. The FI Screen appears. Fill it in as you see in the highlighted boxes below. Hit ENTER.

FI SCREEN

```

U
Patient No.                Effective Date                Eligibility
Patient Name              Updated
Responsible Name         Birthdate
Responsible Addr.        User ID

Notes
Refer Phys:              Attend Phys:              Prior Auth:
Employer Name           Phone
Emancipated Minor (Y/N): Sliding Scale (Y/N):    Number in Family
Collection Status:      Billing Cycle:            Residen NP      Proof NP
Employed:                Student:                --In-Patient Monthly Allowance
Verification Source NP   MC                      Personal      Adjustments
  Family Member Income Per      Family Member Income Per

1
3
5
Pri Payor                2
                          Total Annual Income:      Taxable:
                          Policy/ID Number          Coverage Dates
                          -
                          -
                          -
                          -
                          -

4/08/05  10:22:14
  
```

At the cursor, type in FID ,5BCS and the following screen will appear. Complete this as indicated putting in the unique number for your region as the Plan Code and entering the patient's social for the policy number. You have now completed the registration screens.

FID ,5BCS SCREEN

U			
Patient No.	Name:		DOB:
			Last Updated:
Payor:		Priority:	Effective :
			Through :
Notes:	User ID		Sent Date :
Total Income:	Adjustments:	Net Income:	Family Size:
Eligibility Reason:	Case No:		
Plan Code BCS000			Claim Filing Ind:
Policy Num Social Security Number		Policy Type:	Copay:
Group Number:		Name:	
PPO/HMO:	Assign Benefits:	Signature Sourc B	Supplemental Ins:
BC/BS Coordinated Home Care:		Insurance Co. Type:	
Insur. Name:			Relat. to Ins I
Address:		Sex:	DOB:
City:	St:	Zip:	Phone:
Insured Employer/School:			
Insured SSN:	Insured ID#:		
Copay Percentage:	Deductible Code:	Benefits Exhausted:	
Riders:			
	4/08/05	10:29:14	

Some sites use the transmittal sheets to record information and then enter in PTBMIS at a later time; others complete these screens at the time of the patient visit.

Type "DBCF" on the command line. If you get the message that nothing is found, enter "BCF" and the following blank screen will appear. BCF Screen now consists of two screens depending on if there is work up plan or not. If the work up plan is "NO" and there are no diagnostics, only the first screen will be completed and the cycle will close. If the workup plan is "Yes" and there are diagnostic procedures, BCF will go to the second screen which contains fields for diagnostic procedures. All highlighted items must be completed. All this information is on the transmittal sheet.

If you have referred for a mamm but do not have the mamm results, for example, use the drop down menu to code as pending. After you receive the results you can change the results and either close the case or enter information about other procedures done to reach a diagnosis.

BCF SCREEN – FIRST SCREEN

On the first screen the red boxes are information that will be there, you don't have to fill out. The yellow boxes have to be filled out. The field of (330#) to be filled out only for 330 sites and not the counties.

Pat No.	<input type="text"/>	Enc Dt	<input type="text"/>	Srv Dt	<input type="text"/>	Entry Dt	<input type="text"/>
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	Service Site	<input type="text"/>	Date Sent	<input type="text"/>
BCF Cycle No:	<input type="text"/>	330#:	<input type="text"/>				
PREV MAM?	<input type="text"/>	DATE OF PREV MAM:	<input type="text"/>		PAP TEST THIS VISIT?	<input type="text"/>	
BREAST SYMPTOMS:	<input type="text"/>	BRST SELF EXAM:	<input type="text"/>		BRST CANCER HIST:	<input type="text"/>	
REASON FOR MAM:	<input type="text"/>	BRST DX REFERRED IN DATE:	<input type="text"/>				
SCREENING	PROC DATE	CHG PGM	RESULT DATE	RESULTS	TYPE		
BREAST EXAM:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
INITIAL MAMMOGRAM:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
WORKUP PLANNED:	<input type="text"/>	SHORT-TERM FOLLOW-UP:	<input type="text"/>		NEXT SCREENING MAMMOGRAM:	<input type="text"/>	

BCF SCREEN – SECOND SCREEN

On the second screen the red boxes are information that will be there, you don't have to fill out. The yellow boxes have to be filled out.

Pat No.	<input type="text"/>	Enc Dt	<input type="text"/>	Srv Dt	<input type="text"/>	Entry Dt	<input type="text"/>
Name	<input type="text"/>			Service Site	<input type="text"/>	Date Sent	<input type="text"/>
BCF Cycle No:	<input type="text"/>	330#:	<input type="text"/>				
DIAGNOSTIC WORKUP	PROC DATE	CHG PGM	RESULT DATE	RESULTS			
ADDITIONAL MAMMOGRAM:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
ULTRASOUND:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
ADDITIONAL ULTRASOUND:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
FILM COMPARISON (Y/N):	<input type="text"/>						
FINAL IMAGING OUTCOME:			<input type="text"/>	<input type="text"/>			
REPEAT BREAST EXAM:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
BIOPSY:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
FINE NEEDLE ASPIRATION:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	NOTES	<input type="text"/>	<input type="text"/>
PHYSICIAN CONSULTATION:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
ADDITIONAL PHYS CONSULT:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
OTHER PROCEDURE CODE:	<input type="text"/>						
DIAGNOSIS: DX DISP:	<input type="text"/>	DX DATE:	<input type="text"/>	FINAL DIAG:	<input type="text"/>		
TREATMENT: TX DISP:	<input type="text"/>	TX DATE:	<input type="text"/>				

Once you have entered BCF information, type "DCCF" on the command line. If no screen appears, type "CCF" and a blank screen for recording cervical screening information will appear.

Again, all necessary information is contained on the transmittal sheet. If you are waiting for the Pap results, this can be coded as pending using the drop down menu.

Other follow up diagnostic procedures can be added as needed until you receive a final diagnosis.

CCF SCREEN – FIRST SCREEN

On the first screen the red boxes are information that will be there, you don't have to fill out. The yellow boxes have to be filled out. The field of (330#) to be filled out only for 330 sites and not the counties.

Pat No.		Enc Dt		Srv Dt		Entry Dt	
Name				Service Site		Date Sent	
CCF Cycle No:		330#:					
PREVIOUS PAP?		DATE OF PREVIOUS PAP:					
REASON FOR PAP:		CERVICAL DX-REFERRED IN DATE:					
				RSLT		SPEC	SPEC
SCREENING		PROC DATE	CHG PGM	DATE	RSLT	TYPE	ADQCY
PELVIC/RECTAL EXAM:							
PAP SMEAR:							
PAP RESULT OTHER:							
HPV:							
WORKUP PLANNED:		SHORT-TERM FOLLOW-UP:		NEXT SCREENING PAPSMEAR:			

BCF SCREEN – SECOND SCREEN

On the second screen the red boxes are information that will be there, you don't have to fill out. The yellow boxes have to be filled out.

Pat No.		Enc Dt		Srv Dt		Entry Dt	
Name				Service Site		Date Sent	
CCF Cycle No:		330#:					
DIAGNOSTIC WORKUP		PROC DATE	CHG PGM	RESULT DATE	RESULTS		
COLPO W/BIOPSY and/or ECC (Y/N):							
LOOP ELECTROSURGICAL EXCISION (LEEP):							
COLD KNIFE CONE:							
ENDOCERVICAL CURETTAGE ALONE (ECC):							
OTH PROC :							
FINAL DIAG OTHER:					NOTES:	N	
DIAGNOSIS:	DX DISP:	DX DATE:		FINAL DIAG:			
TREATMENT:	TX DISP:	TX DATE:					

PTBMIS SYSTEM REPORTS

Cervical Screening Reports

On Screen Report Command	Print Report Command	Report Name	Description
SCCF1	PCCF1	CCF1 Cervical Treatment Date Overdue Report	Lists all patients with a colpo result who do not have a treatment disposition date within a user defined number of days from the diagnostic disposition date.
SCCF2	PCCF2	CCF2 Cervical Treatment Date Overdue Report	Lists all patients with a Pap test date and a workup planned of "Y" or "P" who do not have a diagnosis disposition date within a user defined number of days from the Pap test procedure date.
SCCF3	PCCF3	CCF3 Cervical treatment Date Overdue Report	Lists all patients with a Pap test date but no result recorded within a user defined number of days.

PTBMIS SYSTEM REPORTS

Breast Screening Reports

On screen report Command	Print screen Command	Report Name	Description
SBCCCF	PBCCCF	BCCF Open Cycle Report	Lists all patients with open cycles for specified program (BCF or CCF) and cosite
SBCF1	PBCF1	BCF1 Abnormal Screening Result; No Workup Planned	Lists all patients with no workup planned, who have a trackable result for CBE and/or initial Mammogram. (Based on CBE if there is no initial mammogram; if both CBE and mammogram, based on trackable result in initial mammogram)
SBCF2	PBCF2	BCF2 Breast Diagnostics Overdue Report	Lists all patients who have a trackable result for CBE and/or mammogram, but have no diagnostic procedures within a user defined number of days.
SBCF3	PBCF3	BCF3 Breast Diagnostics Overdue Report	Lists all patients who have a CBE or Mamm and a workup planned of "Y" or "P" but the diagnosis disposition date is missing within a user defined number of days
SBCF4	PBCF4	BCF4 Breast Treatment Date Overdue Report	Lists all patients who have a final diagnosis present but no treatment disposition date within a user defined number of days for the diagnosis disposition date.
SBCF5	PBCF5	BCF5 Breast Result Missing Data Report	Lists all patients with a CBE or mammogram with no results reported within a user defined number of days.

SECTION 8 CASE MANAGEMENT

All TBCSP enrolled women with an abnormal screening result or with a diagnosis of cancer, will be provided case management services up to and through initiation of treatment if indicated.

Women with an abnormal screening result or a diagnosis of cancer.

Abnormal screening results are defined as:

- **Clinical Breast Exam (CBE) – abnormal**, any CBE ranked 3, 4, 5 or 6 on the transmittal sheet. (palpable mass – benign; palpable mass – suspicious; bloody or serous nipple discharge; skin dimpling, retraction or scaliness)
- **Mammography – abnormal results** include the American Academy of Radiology (ACR) categories: (4) suspicious abnormality, biopsy should be considered; (5) highly suggestive of malignancy, appropriate action should be taken; and (6) assessment is incomplete, need additional imaging evaluation.
- **Pap test – any test with abnormal results** from the Bethesda 2001 lab reports
- **Pelvic Exam – abnormal results only apply to women with cervical /endocervical abnormalities or uterine bleeding.**

Additional circumstances for case management including:

- Previous history of abnormal screening results
- Results requiring short-term follow up (eg. ASCUS, LSIL, ACR 3 – probably benign, short term follow up indicated)
- Lack of response to rescreening reminder system after a normal screen
- Lack of timely response at any stage of the screening and diagnosis process
- Requested by the woman or the referral provider
- Women diagnosed with cancer and enrolled in presumptive eligibility

Definition

- The process of tracking individual program participants and following up to ensure that short term rescreening, diagnosis and treatment has occurred.
- Includes assistance and advocacy to establish appointments, select providers, arrange for transportation or translation if needed, and enrollment in TennCare/Medicaid presumptive eligibility, when indicated.
- Concludes when a woman begins treatment or is no longer eligible for TBCSP.
- Some women will continue in case management services based on need for advocacy services above and beyond what is normally provided for participants in TBCSP. The regional coordinator will decide “need” in these circumstances. In these cases, staff would provide continuing case management services through TennCare Advocacy activities.

Individual medical records, PTBMIS information and summary reports from the TBCSP database will be used to monitor the effectiveness of individual case management services. Periodic reports will be produced and sent to the regional coordinator and affiliated primary screening providers for program monitoring and management.

**MINIMUM REQUIRED FOLLOW-UP FOR CERVICAL CANCER
SCREENING RESULTS (Normal and Abnormal)**

Must always have a Pap test result even if done elsewhere as it determines follow-up.

Pelvic Exam Result:	These are options a clinician may choose based on individual cases
Normal/Benign Finding	Routine
Abnormal – not suspicious for cancer	Routine
Abnormal – cervical/endocervical or uterine bleeding	Gyn consult
Pap Test Results:	These are options a clinician may choose based on individual cases
Negative – for Intraepithelial Lesion/Malignancy	May treat underlying cause Repeat Paps as needed
Atypical Squamous Cells Undetermined Significance (ASC-US)	Repeat Paps every 4-6 months HPV DNA Testing per Family Planning Guidelines Colposcopy
Atypical Squamous Cells Cannot Exclude High Grade SIL (ASC-H)	Colposcopy Treatment if indicated
Low Grade SIL (including HPV changes)	HPV DNA Testing per Family Planning Guidelines Colposcopy Treatment if indicated
High Grade SIL	Colposcopy Treatment if indicated
Squamous Cell Carcinoma	Colposcopy Treatment as indicated Gyn referral
Atypical Glandular Cells of undetermined significance (AGUS)	Colposcopy Endocervical sampling Endometrial sampling Treatment if indicated Short term follow-up

**MINIMUM REQUIRED FOLLOW-UP FOR BREAST CANCER
SCREENING RESULTS (Normal and Abnormal)**

Must always have a CBE result even if done elsewhere as it determine follow-up.

Clinical Breast Exam Result:	These are options a clinician may choose based on individual cases
Normal	<ul style="list-style-type: none"> • Routine
Benign Finding – not suspicious for cancer	<ul style="list-style-type: none"> • Routine or Short-Term
Abnormal – suspicious for cancer <ul style="list-style-type: none"> • Discrete Palpable Mass – suspicious or benign • Bloody or Serous Nipple Discharge • Skin Dimpling, Retraction or Scaliness 	Any Two of the Following but <i>Must Include: FNA or Biopsy or Surgical Consultation or CBE by Physician as one of the two.</i> <ul style="list-style-type: none"> • Diagnostic Mammogram with or without Additional Views. • Ultrasound • FNA • Biopsy (Stereotactic or Open) • Surgical Consultation • CBE by Consultant
Mammography Result:	These are options a clinician may choose based on individual cases
Negative Finding BIRADS 01	<ul style="list-style-type: none"> • Routine unless CBE Abnormal and suspicious for Breast Cancer. <i>Same Follow-up is Required as for Abnormal CBE Suspicious for Breast Cancer.</i>
Benign BIRADS 0	<ul style="list-style-type: none"> • Routine unless CBE Abnormal and suspicious for Breast Cancer. <i>Same Follow-up is Required as for Abnormal CBE Suspicious for Breast Cancer.</i>
Probably Benign BIRADS 03	<ul style="list-style-type: none"> • Short-interval follow-up with further imaging studies unless CBE Abnormal Suspicious for Breast Cancer • Referral to a surgeon is appropriate if a women is high risk (first degree relative with breast cancer, history of multiple biopsies, diagnosis of atypia on breast biopsy)
Suspicious Abnormality BIRADS 04	<ul style="list-style-type: none"> • Completion of further mammography evaluation with spot compression or magnification • Ultrasound • <i>Referral to surgeon (Must be done)</i>
Highly Suggestive of Malignancy BIRADS 05	<ul style="list-style-type: none"> • Further mammographic evaluation with spot compression or magnification • Ultrasound • <i>Referral to surgeon (Must be done)</i>
Assessment is Incomplete BIRADS 06	<ul style="list-style-type: none"> • Additional mammographic views • Ultrasound

SECTION 9 QUALITY ASSURANCE

Quality assurance activities are to ensure that all screening and diagnostic services are provided according to the TBCSP Program Guidelines and Standards of Care. All providers will receive a copy of the Guidelines with periodic updates. These Guidelines will be used as the basis for quality assurance activities including site visits and medical record reviews. Quality assurance visits will be conducted every other year unless regional program data or management changes indicate a need for formal review more frequently.

METHODS FOR CONDUCTING QUALITY ASSURANCE ACTIVITIES

Patient Tracking and Follow up

- The program's data collection and management system will be used continuously for program monitoring and management.
- Error Reports will be sent at least monthly. These reports are specific to timeliness and completeness of patient information requirements set by CDC and will be sent to regional coordinators for review and follow up.
- Screening providers who are not local health departments will receive the same reports on their program compliance.

Monitoring Site Visits

- A system for monitoring screening and referral providers based on risk assessment, longevity with the TBCSP Program and past site visit reports and/or data submission issues will be used to establish a site visit schedule. In general sites will be formally reviewed every other year.
- Site visits will consist of face to face contact with the providers including a discussion of issues; review of a minimum of 10 medical records at each site; observation of clinic services; review and assurance that a network of referral providers is in place and adequate for the provision of screening and diagnostic services; and other items as indicated. A systematic site visit audit tool is used.
- Following the site visits which will be conducted by central and regional office staff associated with TBCSP, a site visit report will be written and submitted to the agency with timeliness for corrective action specified if indicated.

STANDARDS OF CARE

There are five standards of care that will be monitored for compliance on an annual basis.

- Standard 1. Eligibility criteria must be met in order to reimburse for services delivered.

- Standard 2. Screening and diagnostic services will be performed according to CDC and TBCSP guidelines.

- Standard 3. Follow up will be conducted through initial screening, rescreening, diagnosis and treatment.

- Standard 4. All required data will be collected and submitted according to CDC and Program guidelines.

- Standard 5. Reimbursement for services provided will be in accordance with program guidelines. Data must be received/entered before claims can be paid.

RESPONSIBILITY FOR QUALITY ASSURANCE

Central Office is primarily responsible for ensuring that a systematic quality assurance system is in place and followed. The TBCSP Public Health Nurse Consultant responsible for quality assurance will work with the regional coordinators to arrange site visits and monitor affiliated screening providers in each region according to the annual established schedule.

MINIMUM DATA ELEMENTS REPORTS

The Central Office submits all data collected to the Centers for Disease Control two times each year. The file is analyzed to see if we are meeting the national requirements for timeliness and accuracy of data collection based on eleven performance indicators.

Core Indicator
Percentage of initial program Pap tests provided to never/rarely screened women
Percentage of abnormal Pap tests with complete follow-up
Percentage of abnormal Pap tests where the time between the Pap test and final diagnosis was > 60 days
Percent of final diagnosis of HSIL, CIN II, CIN III/CIS, or invasive cervical carcinoma where treatment has been started
Percent of final diagnosis of HSIL, CIN II, or CIN III/CIS where the time between the date of final diagnosis and the date of treatment initiation is > 90 days
Percent of final diagnosis of invasive cervical carcinoma where the time between the date of final diagnosis and the date of treatment initiation is > 60 days
Percentage of NBCCEDP funded mammograms provided to women 50 years of age and older
Percentage of abnormal breast screenings with complete follow-up (goal: >= 90%)
Percentage of abnormal breast screenings where the time between the screening and final diagnosis was > 60 days
Percentage of final diagnosis of breast cancer where treatment has been started
Percentage of final diagnosis of breast cancer where the time between the date of final diagnosis and the date of treatment initiation is > 60 days

At least once a year, the state performance on these measures is broken out by region and regional coordinators receive a report of their regional performance on these same eleven measures.

SECTION 10 REIMBURSEMENT GUIDELINES

Reimbursable Services

- CDC reviews and annually approves CPT codes related to screening and diagnosis that are allowable for reimbursement.
- Rates are established using the state's Medicare rate for specified CPT codes and sent to screening and diagnostic providers each year.
- If you have questions about whether a code is reimbursed please call Central Office. (615-253-4788) Some additional procedure related codes are reimbursed after review and approval by Central Office.
- Screening providers are reimbursed for administrative and data collection activities above and beyond what are normally required for new and established patients.
 1. CPT code # 99080A is used for a new enrollee fee (FIRST TIME / ONE TIME ONLY)
 2. 99080B is used for referral, tracking, follow up and data collection on women referred for diagnostic evaluations. You can only bill a maximum of three (3) times in a cycle for case management (99080B) on any given patient. A cycle for this program is from the date the case is opened, until a final diagnosis is received.

Uncovered Services

- No CPT codes other than the ones listed will be reimbursed without review and approval by Central Office.
- National guidelines specifically state that TBCSP funds CANNOT be used for treatment services.
- Services for men cannot be covered with federal dollars as established by federal law. (See Section 11 – Collaborations and Partnerships for additional information).

GENERAL REIMBURSEMENT GUIDELINES

Covered Breast Services

1. **Clinical Breast Exam (CBE) visit**
2. **Screening Mammograms**

- Only one screening mammogram will be paid for on an annual basis.
- A screening mammogram is a mammogram that is done according to the recommended periodicity schedule for women over 50 without family history or other signs and symptoms suspicious for cancer.

- Women between the ages of 40 – 49 with a first degree family member (mother, sister or daughter) or personal history of breast cancer are eligible for a screening mammogram.

3. Diagnostic Mammograms

- All women regardless of age, who meet the general eligibility guidelines, can be referred for a diagnostic mammogram when there is at least one of the specified signs or symptoms suspicious for cancer. Symptomatic women age 18 - 39, must be prior approved by the regional or Central Office.
- If the screening mammogram and the diagnostic mammogram are done at the same time, only the diagnostic mammogram can be billed to the program.

4. Ultrasound

5. Stereotactic procedure

6. Biopsy, FNA

- ### 7. Surgeon Referral and CBE Consultation – reimbursed when at least one of the following are documented and reported:
- a. abnormal CBE
 - b. abnormal BI-RADS category of 3,4,5,6
 - c. an abnormal ultrasound

Covered Cervical Services

1. Pap Test Visit – ONLY covered for women 40 - 64.

2. Repeat Pap tests

- a. TBCSP will pay for up to 4 Pap Tests in a 12 month period for women over age 40.

3. Colposcopy – reimbursed upon receipt of an abnormal Pap result.

- a. The program will not reimburse for Pap tests done at the same time as the colposcopy.
- b. Colposcopy as part of a LEEP will not be reimbursed since LEEP is considered treatment. Women needing LEEPs should be enrolled the TennCare/Medicaid under presumptive eligibility. (See Section 3 - Presumptive Eligibility)

4. Endocervical curettage

5. Endometrial Biopsy – when Pap test result is AGUS

6. Cervical biopsies - as part of a colposcopy

7. Biopsy of cervical polyps

8. HPV II High Risk Testing - reimbursed

- a. ONLY when the Pap test result is ASCUS for women over age 40.
- b. Women younger than 40 are NOT covered for HPV testing.

Second Opinion- some women want to seek a second opinion before agreeing to a medical recommendation. In these cases, if a woman is referred to one of the TBCSP providers, the program can pay for this consultation.

OTHER REIMBURSEMENT RELATED GUIDELINES

TBCSP SCREENING AND DIAGNOSTIC SERVICES ARE FREE TO ENROLLED WOMEN WHO MEET ELIGIBILITY. The eligible age group is women age 40 and above for cervical services and 50 and above for breast services. Women under 40 who have signs and symptoms for breast abnormalities or a lab result requiring additional diagnostics can be referred into the program for diagnostic services. No other charges should be billed to the patient.

All bills for reimbursement must be submitted on an **original HCFA 1500 or UB 92** form.

Bills will not be paid to any vendor unless the required data is submitted to correspond with that date of service. Bills will be held until the data is received.

PTBMIS Managed Care System for Processing Claims

The following pages are abbreviated instructions for authorizing payment through the PTBMIS system called "Managed Care". For more detailed instruction, contact the regional office PTBMIS staff or Central Office.

A sample BC1 Report is also included. This report is provided by the Bureau of Administrative Services after claims that have been authorized for payment at the regional level are transferred electronically and reviewed and approved for payment by the Bureau of Administrative Services (BAS). The BC1 Report is used to cross check with the claims authorization reports; duplicate claims will be dropped before the BC1 report is issued. Any questions regarding the BC1 reports should be referred to Central Office.

INSTRUCTIONS FOR MANAGED CARE AUTHORIZATION

** Each patient has both a CCF/BCF screen but ONE managed care eligibility #.
“Managed Care Authorization” is PTBMIS language for the software component that allows us to process bills for payment.

PROCEDURE FOR AUTHORIZATION

- **PLF** or **A** (pt last/first name or patient number <enter>
- Type in command line **BTR** this will generate a new screen
- You select the procedures you wish to authorize and you specify the vendor
- Enter your provider number
- Tab and enter a “?” in the Provider Referral to field <enter>
- Pop up window with “Select from BCF/CCF Refer to Provider” appears
- Tab to vendor you want and put an “X” next to the vendor number or you can type in part of the vendor name in the “**Find characters** <enter> *(the first occurrence of those letters will appear in the list. If you don’t see the vendor you want. Keep hitting <enter>*
- The patient’s authorization screen appears.
- Tab over to **Auth units** and type in the number of units you wish to authorize by each procedure to be authorized.
- If the procedure you wish to authorize is not on the screen, tab to the last line on the screen and key in the relevant procedure.
- Tab over to the ‘**Auth units**’ field and key in the quantity authorized.
- Authorized number is assigned by the system and you will use this number in the authorized number field when you key in the claim.

PROCEDURE FOR ENTERING A CLAIM

- When the bill comes in for the authorized service
- Key the bill into the managed care claim screen
- After you update the BTR screen, the system assigns an authorization number.
- To enter the relevant claim key “**CLA**” in the command line followed by a space and then the **authorization number** (CLA auth-no)
- On the claim screen enter the following:
 - **Admission date of service**
 - **Date of discharge** (usually the same date as date of service)
 - Enter “**3**” in the **Setting** field (3 means clinic) if it is other setting use the **ALT**
and **F1** key to get the help window and select appropriate one) F3 key will remove help screen.
 - Enter 5 digit **Cosite number**
 - Enter **Diagnosis Code** (ICD-9) from providers claim

- Enter date you received the claim from the outside provider in the **Date Invoice Read** field.
- Enter in the **Type of Service “G”** as the type of service
- Enter the **Procedure(s), the units billed and the amount of the claim of that procedure**. Computer system will show ‘Computed and ‘Allowed Amt’.
- After the procedure from the claim are keyed, the ‘authorization provider’ will enter their initials in the **Approval Block 3 (Central Office is the highest level)**
- The date authorized should be entered immediately below the authorized initial field.
- Last step: Enter a ‘Y’ in the ‘OK to Release Encumbrance’ field to send the claim to the Central Office.

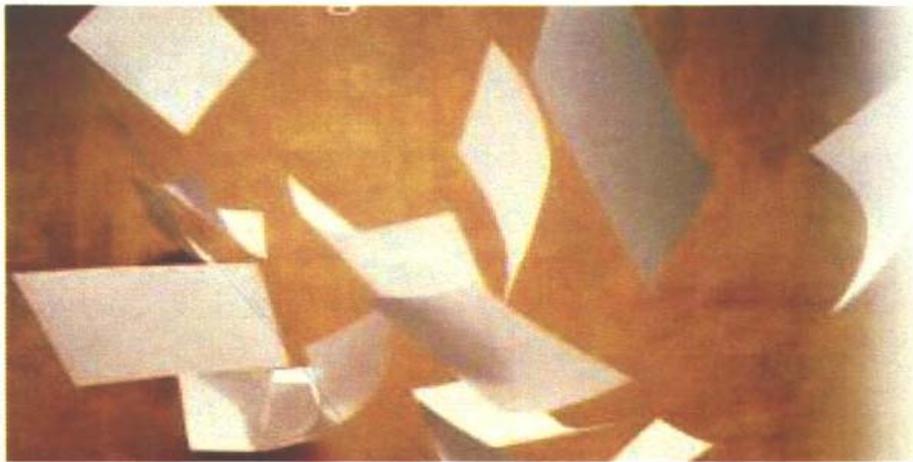
PROCEDURE TO DISPLAY AUTHORIZATION

- Command to display patient authorization is ‘**DBTR**’
- Use ‘**DCL**’ command to display all the authorizations for the current patient
- **Tab** to the Auth. Screen you wish to see and the type an ‘**X**’ <enter>
- **REMEMBER TO ALWAYS CHECK HERE FIRST TO AVOID DUPLICATION OF CLAIMS**
- Metros/Regions will probably do the authorizations and claims at the same time.

PAYING THE CLAIM

- Each week, your System Admin will run a job that sends all the claim information to the business administration office in Nashville.
- BA will upload the data to STARS
- Treasury will cut check or transfer money electronically to vendor.

BCS – Managed Care





Managed Care Authorization

- Everyone with an updated 'BCF' or 'CCF' screen is **AUTOMATICALLY** enrolled in managed care
- Patients enrolled in BCF will be assigned a managed care case number
 - Even if patient has both BCF and CCF screens, she will have only one managed care eligibility.



Authorizations

- New command: BTR
- BTR command will generate new screen
 - You select the procedures you wish to authorize
 - You specify the 'vendor'



Entering Claims

- When the bill comes in for the authorized service
 - You will issue the 'CLA' command
 - Key the bill into the managed care claim screen
- CSS program staff are familiar with the managed care module, including the claim screen



Entering Claims

- After you update the BTR screen, the system will assign an authorization number
- To enter the relevant claim, key 'CLA' followed by a space and then the authorization number
 - (CLA auth-no)



Displaying Authorizations

- The command to display patient authorizations is '**DBTR**'
- Use this command to show all the authorizations for the current patient.



Displaying Claims

- The command to display claims is 'DCL'
 - Screen will display all of the claims for the current patient



Paying the Claims

- Each week, your Sys Adm will run a job that sends all the claim information to the business administration office in Nashville
- BA will upload the data to STARS
- Treasury will cut check or transfer money electronically to vendor

The next page contains a sample copy of the BC1 Report which is sent out by the Bureau of Administrative Services after the electronic transfer of authorized claims has been sent by the region. You should use this report to verify that all claims approved on the CLAUTH report, were processed for payment as listed on the BC! Report. If there are questions, please contact Central Office.

EDISON PAYMENTS FOR MEDICAL SERVICES

10:19 TUESDAY, SEPTEMBER 21, 2010 1

RECORDS WITH INVALID VENDOR NUMBERS
ELIMINATED FROM DATA '2010-09-21' 'API'

VNDNO	SUFFIX	SEQNO	REFDOC	CHECKREC	CHECK2	PCODE	PATNO	VOUCHER	CSEQ	ENTDATE	AUTHNO	PROACC	ADMDATE	PROC	UNITS	BILLED	NET	TYPE	COSITE	COST2	AGOBJ	SSN	LNAME	FNAME	MI	NLINE
V562017400	00	590		B	B0	B	0013973982	000017093	01	20100903	017511	S10006374	20100409	88305TC	5	81000	28820	G	03101	18	205	018421665				
V562017400	00	590		B	B0	B	0013973982	000017093	01	20100903	017511	S10006374	20100409	88305TC	5	81000	28820	G	03101	18	205	018421665				
V620853409	00	241		B	B0	B	0004450605	000023027	01	20100902	023392	6651	20100816	99203	1	16100	9048	G	02703	18	205	261596290				
VNDNO	SUFFIX	SEQNO	SVDT	SERVDATE	DATESERV	SRVCDT	AMOUNTIN	REG	ALLOT	COST	KEY	POID	DNET	DESC	TCD	DMI	FUND	FTDL	OBJ	MRVS						
V562017400	00	590	18361	040910	20100409	0410	28820	13	34352	500	1300001709301B0410	13B1709301	2.88													
V562017400	00	590	18361	040910	20100409	0410	28820	13	34352	500	1300001709301B0410	13B1709301	2.88													
V620853409	00	241	18490	081610	20100816	0810	9048	04	34352	500	0400002302701B0810	04B2302701	0.90													
VNDNO	SUFFIX	SEQNO	RVS	MODI	INVC	CURSFX	REFSUF	ZIPCODE	VENDOR	ADDRESS	CITY	STATE	DEPT	RTP	AMOUNT	VOUC	DOCDAT	DESC1	DATERCV							
V562017400	00	590			1300001709301B0410	00							343	T	288.20	2010P1	2010-0		2010-09-21							
V562017400	00	590			1300001709301B0410	00							343	T	288.20	2010P1	2010-0		2010-09-21							
V620853409	00	241			0400002302701B0810	00	J		J	T	343	T	90.48	2010P1	2010-0			2010-09-21								
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V562017400	00	590						?																		
V562017400	00	590						?																		
V620853409	00	241	PO BOX 3854	SEE SUFFIX 03 - ADDRESS 4 *	PO BOX NO LONGER VALID *	383033854	N	?			0															

SECTION 11 OTHER REQUIRED PROGRAM COMPONENTS

PROFESSIONAL EDUCATION

The statewide program is required to develop a professional education plan for breast and cervical cancer screening, diagnosis and treatment. This will be a priority of future annual initiatives.

Regional Coordinators are required to:

- Review program eligibility, data collection forms and presumptive eligibility for Medicaid/TennCare coverage of those diagnosed with the office manager.
- Educate the referral providers about the availability of program resources for use in their office. These include program pamphlets and in-service training materials.
- Review the regional screening and referral provider list and update/expand the network as indicated by service demand and/or attrition.
- Provide clarification about program requirements and policies and procedures as indicated by data reports and other communication from Central Office.
- Emphasize that the program is especially interested in providing services to the never or rarely screened woman.

PUBLIC EDUCATION AND OUTREACH

Program experience indicates that many women do not seek preventive health care after they stop having children. Historically underserved women do not access or follow up on health care advice. This results in higher disease and death rates from these preventable diseases for women of color, other racial/ethnic groups and women with low incomes or no insurance coverage.

Thus the national program has two objectives – first to educate all women about the importance of annual screening through out their lives and second, to make special effort to outreach underserved populations in ways that are culturally sensitive and specific.

The Central Office will:

- Develop a statewide plan and resources for implementing best practices for public education and outreach.
- Develop and distribute materials specific to breast and cervical cancer screening to all screening partners.
- Maintain a 1-800 line for information and referral.
- Partner with other state and national groups committed to educating the public about the importance of early detection.
- Monitor the impact these public campaigns have on increasing screening rates.

Regional Coordinators for TBCSP are expected to:

- Work with existing coalitions for breast and cervical cancer/women's health to increase community awareness among all women about preventive health care.
- Participate in developing and implementing regional activities during October and January, the national awareness months for these diseases.
- Monitor impact of local and regional public education activities.
- Identify underserved populations and/or areas of the region and design special outreach activities as indicated.

COALITIONS AND PARTNERSHIPS

This is one of the ten required program components. The purpose is to develop reciprocal relationships with groups and individuals interested in sharing resources to achieve common goals.

TBCSP regional coordinators are required, as part of their role, to either affiliate with a regional coalition for breast and cervical cancer / women's health screening or to develop one that supports regional efforts for outreach, screening and referral. The Regional Health Council implemented by the Department of Health can function as the TBCSP coalition if the members have an interest in this issue. The objectives for these regional coalitions are to:

- Develop strong community partnerships that emphasize education, outreach to specific target groups and reinforcement that early preventive screening is critical to good health.
- Participate in the national campaign months of October and January using statewide suggested community based activities or developing region specific activities.
- Communicate to eligible women and women who are historically underserved that screening and treatment services are available.
- Share resources, set regional targets for activities and support each other's efforts for prevention and early intervention.

Central Office will provide guidance for coalition development and training if indicated.

Tennessee Cancer Coalition (TC2)

Central Office is a partner in a statewide coalition to reduce cancer in TN with a special emphasis on women's cancers through the state's cancer control plan. Regional coordinators are encouraged to participate in the regional coalitions for TC 2 and to attend the annual Cancer Summit sponsored in one of the three grand regions each year.

Susan G. Komen for the Cure Affiliates

There are six Komen affiliate organizations in Tennessee. Central Office submits grant applications to the state's Komen affiliates on behalf of the regions for financial support of direct services. Copies of funded grants are sent to the respective regional coordinators for implementation and collaboration during the funding period.

Breast Screening and Diagnostic Services for Men

Under certain circumstances, the Komen affiliates request that we provide diagnostic services for uninsured men who have symptoms suspicious for breast cancer. When such cases arise either from TDOH primary care clinics or by referral from a private provider, they follow these procedures:

1. Contact your Central Office regional liaison and inform them of the potential case. Central Office will contact the appropriate Komen affiliate office for verbal approval to use Komen funds to cover services.
2. Complete registration in PTBMIS if necessary.
3. Refer to a regional mammography provider for a diagnostic workup. Specify that we (TBCSP) can cover diagnostic services at the Medicare rate based on the approved CPT codes. Remind them that we (TBCSP) cannot assist with treatment and they (the regional medical community) will be responsible for establishing treatment options in the event breast cancer is diagnosed.
4. Contact the Komen affiliate to discuss their plans for assisting with treatment access in the event that breast cancer is diagnosed.
5. When bills for these services are received, send them immediately to Central Office. We will process and pay them with assistance from the Bureau's fiscal office to assure that costs are posted to the Komen revenue.
6. Do not complete data sheets for these services since these cases are not included in the data base for the TBCSP.

Reach for Recovery Program of the American Cancer Society (ACS)

TBCSP has established a referral system to the Reach to Recovery Program for those women diagnosed with breast cancer. When a woman is enrolled in TennCare for presumptive eligibility, she is asked about interest in participation in this program. If she indicates that she would like contact, and it is indicated on the Presumptive Eligibility form, Central Office forwards the appropriate information to the ACS contact. ACS matches the woman with a volunteer who has been through treatment for breast cancer; she serves as a mentor and friend to support the newly diagnosed woman.

APPENDICES:

Appendix
Evaluation of Common Breast Problems
Family Planning Cervical Cancer Screening Guidelines
Policies:
Ductogram / Galactograms
ER / PR HER 2 Receptors
Management and Referral of Women under 40
Management and Referral of Women for screening MRI
Stereotactic Biopsies
Cervical Diagnostic Procedures
HPV Screening
Management of Menopausal and Postmenopausal Women With AS-CUS
Program Materials:
Breast Algorithms
Presumptive Eligibility Form
2010 Poverty Guidelines For Tennessee
Authorization To Vender
W – 9 Form
Letter of Agreement
Change of Personal / Company Information Form
Reimbursement Schedule 2010
Breast Transmittal Sheets
Cervical Transmittal Sheets

EVALUATION OF COMMON BREAST PROBLEMS: A PRIMER FOR PRIMARY CARE PROVIDERS

Prepared By The Society of Surgical Oncology

and

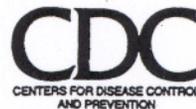
The Commission on Cancer of The American College of Surgeons

for

The Centers for Disease Control and Prevention



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service





**EVALUATION OF COMMON BREAST PROBLEMS:
A PRIMER FOR PRIMARY CARE PROVIDERS**

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*Blake Cady, M.D., Glenn D. Steele, Jr. M.D., Ph.D.,
Monica Morrow, M.D., Bernard Gardner, M.D.,
and David P. Winchester, M.D.*

This document is a modification of an algorithm developed by Barbara L. Smith, MD, PhD, et al that can be found in: Diercks DB, Cady B. Lawsuits for failure to diagnose breast cancer: Tumor biology in causation and risk management strategies. *Surgical Oncology Clinics of North America* 1994;3:125-139. August 1995



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INTRODUCTION

The Centers for Disease Control and Prevention (CDC) believe that guidelines for the evaluation and management of common breast problems can be useful to primary care providers in state breast cancer screening programs. To draft the guidelines, CDC convened a group of general surgeons with extensive experience in the evaluation and management of breast abnormalities. The surgeons represented the Society of Surgical Oncology and the Commission on Cancer of the American College of Surgeons. The governing bodies of both organizations approved the guidelines that were developed.

The draft guidelines were then circulated to other experienced professionals in breast evaluation, representing the fields of diagnostic radiology, obstetrics and gynecology, and surgery, as well as individuals active in state breast cancer screening programs.

The guidelines here are organized so that they will be useful to physicians, physician assistants, and nurse practitioners in evaluating women with common breast problems.

MEDICAL HISTORY

Risk Assessment

Evaluation should begin with a thorough risk assessment but should recognize that approximately 75% of women with newly diagnosed breast cancer have no identifiable risk factors. The most obvious risk factor is age—breast cancer incidence increases as age increases. A family history should identify any first-degree relatives (mother, sisters or daughters) with breast cancer and the age at which cancer developed. Patients who have a first-degree relative diagnosed with premenopausal breast cancer have a considerably greater risk (3 to 4-fold) of developing breast cancer than the general population. If a premenopausal first-degree relative had bilateral cancer, or if more than one first-degree relative had breast cancer, the risk for the woman may be 8 to 10 times the risk for the general population. It is critical that the examiner obtain a specific history from the patient about previous biopsies, the pathology discovered, and the presence of a previous breast cancer. For a woman with a personal history of breast cancer, the risk of developing a new primary breast cancer is approximately 0.5% to 1% per year of her remaining life. The examiner should also obtain information regarding child birth, such as parity and age at first live birth. A woman who has no children, or whose first full-term pregnancy occurred after age 35 may have a substantially increased risk of breast cancer. Other risk factors include early age at menarche and late cessation of menses.

Symptom Assessment

Patients by definition should be asymptomatic in the screening setting. Many patients do present with symptoms, however. Thus, the examiner should inquire about common symptoms, such as breast mass, breast pain, skin or nipple changes, and nipple discharge. The patient should be asked about the duration of the symptom and whether it is associated with the menstrual cycle. The following features of nipple discharge are suspicious for benign or malignant breast neoplasm and necessitate prompt referral of the patient to a surgical consultant: 1) spontaneous; 2) unilateral; 3) occurring in an older patient; 4) confined to one duct; or 5) clear, serous, bloody, or serosanguinous.

BREAST PHYSICAL EXAMINATION

Examination of the breast is inherently subject to interobserver variation and interpretation. However, certain elements in the examination should be noted: 1) It should be conducted unhurriedly in a setting that allows for minimal distraction and adequate patient privacy. Examination gowns should be adjusted to minimize unnecessary or unintended exposure of the patient. 2) The patient should be examined in both the upright and supine positions. 3) The approximate size (measured with a ruler), location, mobility, and consistency of any mass should be recorded. Any associated skin changes such as dimpling, retraction, erythema or nipple scaling should be noted. 4) Each nipple should be gently squeezed to examine discharge. 5) The lymph nodes in the axillae should be examined. The assessment should state whether the nodes are clinically negative (normal size, soft, and mobile). If the nodes are suspicious, the assessment should indicate their consistency, and whether the nodes are single or multiple, and whether movable or fixed. 6) The breast examination should be completely documented, even if the examination is normal.

A *clinically suspicious mass* is one that is discrete or firm, which may or may not be fixed to adjacent tissue. It is usually unilateral and nontender, but may be sensitive. However, breast cancers are known to present clinically in a highly variable manner.

METHODS FOR SCREENING AND DIAGNOSIS OF BREAST CANCER

Screening Guidelines

Screening Mammography

Conclusive scientific data are not available to define precisely the appropriate age groups for screening mammography. Several national organizations recommend mammography every 1 to 2 years for women aged 40 to 49 years, but others do not support this

position. Scientific data support the recommendation of annual screening mammography in women aged 50 to 74 years. Controversy exists concerning the frequency of examination for women 75 years and older. There is little to be gained by the routine use of screening mammography for women younger than age 40.

Physical Examination

Examination of the breast should be part of all routine physical examinations for women older than age 30 and should be encouraged at younger ages. Physical examination by primary care providers such as internists, family practitioners, gynecologists, and nurse practitioners should include the breast.

Breast Self-Examination

The role of breast self-examination in the early detection of breast cancer is not clear. Pressure from physicians and nurses for the woman to perform self-examination may not result in its practice and frequently causes patient anxiety. Breast self-examination should be taught, demonstrated, and encouraged but not unduly emphasized. On the other hand, if a patient values the role of breast self-examination in breast cancer screening, the practice should be reinforced and encouraged. If a woman finds a mass during breast self-examination, she should be seen promptly for the appropriate clinical and imaging evaluation.

Diagnostic Evaluation

Diagnostic Mammography

The workup of a patient with a solid, dominant mass should include a diagnostic bilateral mammogram, and may also include either aspiration or ultrasonography. Keep in mind that in this situation, the primary purpose of the mammogram is to screen the normal surrounding breast and the opposite breast for nonpalpable cancers, and not to make a diagnosis of the palpable mass.

The usefulness of mammography in younger women is greatly limited by the increased density of the breast. Mammography for a palpable mass should not be performed on women under the age of 30 because of the rarity of cancer and the ineffectiveness of the examination among women in this age group. Exceptions may occur, such as a young woman with a clinically suspicious breast mass whose mother had premenopausal breast cancer, or after cancer has been diagnosed, to inspect the remaining breast tissue. **It should be emphasized that a normal mammogram at any age does not eliminate the need for further evaluation of a palpable mass.**

Ultrasonography

The chief value of an ultrasound is to differentiate solid from cystic masses. Ultrasonography may be useful when a palpable mass is partially or poorly seen on a mammogram, especially in young women. Ultrasonography can diagnose a simple cyst if four criteria are fulfilled: 1) round or oval shape, 2) sharply defined margins, 3) lack of echoes, and 4) posterior acoustic enhancement. A mural nodule in a cyst may be visualized by ultrasonography and should arouse suspicion of the rare diagnosis of intracystic carcinoma or carcinoma adjacent to a cyst.

Because of the inconsistent depiction of microcalcifications, ultrasound is contraindicated for routine breast cancer screening.

Other Imaging Modalities

There is no role for thermography in breast cancer screening or diagnostic evaluation. The role of magnetic resonance imaging (MRI), computerized tomography, positron emission tomography, or other imaging modalities for screening or diagnosis of breast lesions has not yet been determined. None of these techniques has currently accepted indications for their use except MRI in the detection of silicone implant ruptures that cannot be recognized or excluded using other imaging techniques.

Fine Needle Aspiration

Fine needle aspiration (FNA) for cytologic analysis represents a useful extension of the clinical evaluation of a palpable mass. FNA can accomplish cyst aspiration, in which the intent is both diagnostic and therapeutic, by eliminating a fluid-filled cyst, or can be diagnostic for solid masses, by aspirating tissue for cytologic evaluation.

Every palpable mass should be considered for needle aspiration to diagnose and treat cysts and to submit aspirated cellular material for cytologic examination. Physicians and patients need to understand the limitations of FNA; the false-positive rate is negligible but the false-negative rate may be as high as 15% to 20%. Any residual mass must be excised if not eliminated by aspiration of a cyst.

Stereotactic Biopsy

There are two types of stereotactic biopsy: a) stereotactic cutting needle biopsy to obtain a core of tissue for histology, and b) the less frequently used stereotactic needle aspiration for cytology. Currently, the role of stereotactic biopsy is not totally defined. Its indiscriminate use in all breast lesions detected by mammography is unjustified. Its use in obvious cancers to confirm the diagnosis before surgical excision is probably unjustified.

The principle use of stereotactic biopsy is to obtain tissue from a lesion that is probably benign but has changed during repeated mammograms, and the patient wishes to avoid

more extensive surgery. Lesions with smooth outlines that have increased in size, where the risk of cancer is less than 10% but not zero, may be appropriate for stereotactic biopsy. Stereotactic core cutting biopsy often removes only a piece of the lesion; the same area of concern may be present in subsequent mammograms.

One of the newest uses of stereotactic core cutting biopsy is for suspicious clustered calcifications. These lesions have only a 20% risk of being a cancer, and one-half of these cancers are in situ. The biopsy, which involves obtaining multiple tissue cores, should be followed immediately with a specimen mammogram to prove removal of some of the clustered calcifications. Use of this biopsy method may decrease the number of excisional biopsies done for lesions which have a low risk of being cancer. However, this procedure is known to miss cancers; its use is open to some question until further data can be obtained.

Stereotactic biopsy is a method to get tissue for pathologic examination while avoiding an open surgical biopsy. Whether it will ultimately be found to be cost-effective depends on how frequently it is used and the savings that are actually achieved.

Open Surgical Biopsy

Whether performed on palpable lesions or on nonpalpable lesions after mammographic localization, the ultimate test of a mass in the breast is an open surgical excisional biopsy. At present, excisional biopsies of lesions suspicious for cancer should be performed to satisfy the requirement of a "lumpectomy," that is, they should be removed with at least a 1 centimeter margin of normal tissue. Palpable lesions that are almost certainly benign but require removal need only minimal margins. In fact, fibroadenomas can be simply shelled out of the surrounding compressed breast tissue.

Because the exact location within the breast of nonpalpable lesions found by mammography is uncertain, excision of these lesions, which requires needle localization, is necessarily more extensive than what is needed for palpable lesions. All needle localization biopsies should have a mammogram of the specimen to be sure that the lesions seen on the screening and localization mammograms were actually removed. The biopsy should be performed in such a way that the entire lesion (or all the calcium) visualized on the localization mammogram is removed by the surgical excision.

All biopsies or lumpectomies for palpable or nonpalpable breast lesions should be performed in such a way as to keep a single, intact tissue specimen. Biopsy should **not** be done piecemeal. In addition, the borders or margins of the breast tissue specimen should be coated with ink so that the histologic margins around any cancer found can be accurately defined.

EVALUATION AND MANAGEMENT OF COMMON BREAST PROBLEMS

Thorough communication with patients about all management options and their associated risks, all test results, as well as written documentation of these discussions, is of the utmost importance to the provision of quality care.

Palpable Mass

Cyst

Cysts are commonly found in the pre- and perimenopausal age groups. It may not be possible to distinguish a solid from a cystic mass by physical examination alone, in which case ultrasound and/or cyst aspiration can be diagnostic. A palpable mass suspected to be a cyst can be confirmed most rapidly and easily by aspiration; however, if the primary care provider does not routinely perform aspirations, the patient should be referred to a surgeon. If a cyst is aspirated, the patient should be reexamined for cyst recurrence in approximately six weeks. If a cyst rapidly recurs after aspiration, the patient should be referred for a surgical consultation.

If the mass does not disappear completely with aspiration, or if the aspirated fluid is grossly bloody, the fluid should be sent for cytologic analysis and the patient should be referred for radiologic and surgical consultation. Cyst fluid should be otherwise discarded.

The most efficient and cost-effective method of diagnosing a cyst should be used. If a woman has a physical examination of the breast that reveals a probable cyst, simple aspiration can be performed at that time, for it is both diagnostic and therapeutic. If the cyst is painful, aspiration should relieve that symptom. On the other hand, if the woman is in the radiology department and is found to have a mass on mammography suggestive of a cyst, confirmatory ultrasound can be done. If the cyst is obviously benign and nonpalpable, the patient should be informed but no intervention recommended, unless an ultrasound-guided aspiration is done for pain relief.

Solid Mass

A patient with a discrete solid mass should be referred to a surgeon even when the mammogram is negative. Surgical biopsy is the procedure of choice for any solid, dominant, persistent mass. There should be few exceptions.

Young women in their teens or twenties with a palpable mass most likely have a fibroadenoma. FNA or ultrasonography may be performed to complete the diagnostic evaluation but these women should have excision of the mass. **Regardless of the age of a woman, a clinically suspicious lesion should be evaluated completely. All palpable, discrete, solitary, noncystic masses should be excised.**

An area of thickening that is not a discrete mass and judged to be: 1) clinically negative by the surgeon; 2) negative cytologically (no malignant cells seen in the aspiration specimen); and 3) negative mammographically may be closely observed by the surgeon every 2-3 months until resolution or excision (negative triad). However, the surgeon and patient should recognize the possibility of an occasional delayed breast cancer diagnosis.

Vague Nodularity

There may be a discrepancy between what the patient perceives as a breast mass and what the examiner finds on careful physical examination of the breast. Where the patient feels a "lump," the examiner may find only slightly lobulated breast tissue. The patient may note the "lump" during the premenstrual phase. It may be a diffuse, poorly defined thickening that may or may not be matched in the opposite breast, or an area of irregularity or prominence such as normal, but nodular breast tissue. The areolar margin and the area beneath the inframammary fold may contain a number of small palpable nodules of normal breast tissue that are not suspicious and do not require biopsy. If the patient is concerned or anxious, it is good medical practice to advise her to return bimonthly or quarterly for reexamination until she and the examiner are convinced of the benign nature of the change. In menstruating women, return visits should occur at midcycle. If the mass persists after 3 months and can be distinguished from the remaining breast tissue, the patient should be referred to a surgeon.

If the patient or examiner is uncertain about the nature of a vague mass, an FNA, mammogram, and/or an ultrasound should be considered. Imaging should be performed before aspiration as FNA may produce bleeding that can cause difficulty in interpreting the mammogram or ultrasound.

Nonpalpable Mammographic Abnormality

Refer the patient to a surgeon if her mammography results are reported as American College of Radiology (ACR) categories¹ four (*suspicious abnormality*) or five (*highly suggestive of malignancy*). If further mammographic evaluation with spot compression or magnification is suggested, or if ultrasound is advised (*assessment is incomplete*), these imaging studies should be completed prior to surgical referral, since many equivocal mammographic abnormalities may be resolved with additional radiologic workup.

If the mammogram result is ACR category three (*probably benign—short interval follow-up suggested*), the lesion is almost certainly benign, and there is only a maximum 2% possibility of cancer. Follow-up for these patients may include sequential imaging stud-

1. The American College of Radiology recognizes five levels of concern based on mammography: 1) negative; 2) benign finding; 3) probably benign finding—short interval follow-up suggested; 4) suspicious abnormality—biopsy should be considered; 5) highly suggestive of malignancy.

ies; the radiologist should determine the interval and type of follow-up. The low but measurable risk for a delayed diagnosis of breast cancer should be clearly communicated to the patient. If she is unwilling to accept this risk or is a high-risk patient, she should be referred to a surgeon. However, the patient should have a careful breast examination before the decision is made to follow with sequential mammograms, because clinical signs associated with the mammographic abnormality may mandate a biopsy.

Nonpalpable cysts detected by mammography and confirmed to be simple cysts by ultrasonography need not be aspirated except for relief of pain. A nonpalpable cyst not fulfilling complete criteria for a simple cyst may be aspirated with image guidance. If the mass has suspicious characteristics by ultrasound, an imaging-directed biopsy, either percutaneous or surgical, should be performed.

A decision as to what form of biopsy is appropriate for any given nonpalpable lesion found on mammography or ultrasound may be made by a surgeon in consultation with the radiologist and in accordance with the patient's wishes. The biopsy options that should be discussed with the patient include: 1) stereotactic or ultrasound-guided FNA; 2) stereotactic, large core needle biopsy; or 3) open surgical biopsy after needle localization.

Breast Pain

Breast pain is a common and often nonspecific symptom. The most common cause of a painful mass is a cyst. However, symptoms of pain or discomfort do not preclude a diagnosis of malignancy. A common cause for delay in the diagnosis of breast cancer is a failure to recognize the potential significance of a painful mass. Pain associated with a mass does not eliminate the possibility of cancer.

If results of the physical examination and mammography are negative, the most likely explanation of breast pain are "fibrocystic" changes or menstrual cycle influences. An explanation of the effects of hormonal cycling will reassure most patients. A trial of non-narcotic analgesics such as ibuprofen, acetaminophen, or aspirin and the use of a brassiere that provides good support are suggested. The elimination of caffeine, chocolate, or salt from the diet has no scientifically proven benefit, although some women may experience relief of pain with caffeine and sodium restriction. There is no role for therapy with male hormones. Refer the patient to a surgeon if there is persistent localized pain that is not responsive to conservative measures.

Nipple Discharge

The patient with a suspicious nipple discharge (characterized in the section on Symptom Assessment), should be referred to a surgeon, even in the absence of a palpable mass. Patients with any nipple discharge and a palpable mass should be referred to a surgeon.

Diagnostic mammography for a suspicious nipple discharge should be performed even though the yield is low. If a nonsuspicious nipple discharge is present, diagnostic mammography is of no benefit, but screening mammography should be recommended as appropriate for the patient's age.

Cytologic analysis of nipple discharge is rarely useful and is not cost-effective. Galactography (injection of contrast medium into spontaneously discharging ducts to delineate intraluminal abnormalities) is not widely available and is of questionable value. Medical workup of galactorrhea may be appropriate for profuse, persistent milky discharge, but pituitary adenomas are rare.

A spontaneous, bloody nipple discharge occurring in the third trimester of pregnancy may be regarded as a physiologic event that does not require evaluation unless it persists for several months after delivery. Milky, green, gray, or black discharge expressed from several ducts is not suspicious for cancer, and referral of the patient is not necessary, especially if the discharge is bilateral.

Skin or Nipple Changes

Patients complaining of any skin breakdown on the nipple-areola complex should be referred to a surgeon. Paget's disease of the nipple (the presence of in situ or invasive breast cancer with involvement of the nipple) may be the source of this symptom. Although eczema may involve the areola, it is rare.

The Persistently Worried Patient With a Negative Workup

Such a patient should be referred to a surgeon for a second opinion.

Breast Examinations That Are Difficult

The patient should be referred to a surgeon for evaluation when the breast examination is difficult because she: 1) has had a reduction mammoplasty or augmentation implantation; 2) has extremely large or dense multinodular breasts; 3) has had multiple biopsies with multiple scars; 4) is pregnant or lactating.

Physical diagnosis of breast cancer in pregnant or lactating women may be extremely difficult. Any pregnant or lactating woman with a clinically suspicious lesion should be referred to a surgeon without delay. Approximately 1 in 2,000 pregnant or lactating women has breast cancer, and 1% to 2% of breast cancers are diagnosed in pregnant women. Ultrasound imaging of a palpable mass or thickening can confirm a fluid-filled or complex mass (e.g. cyst or galactocele), a solid mass requiring biopsy, or a drainable abscess.

High-Risk Patients

Patients with a history of breast cancer should have oncologic follow-up with regularly scheduled clinical and imaging examinations. Patients at high risk of developing breast cancer as indicated by a family history of breast cancer among premenopausal first-degree relatives, diagnosis of atypia on breast biopsy, or multiple previous biopsies, may require different screening regimens. In such instances, a referral to a physician who is expert in the diagnosis of breast cancer is appropriate.

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APPENDIX 1

Management of Common Breast Problems

*Prepared by the Society of Surgical Oncology and the
Commission on Cancer of the American College of Surgeons*

Thorough communication with patients about all management options, their risks, and all test results, as well as written documentation of these discussions, is of the utmost importance to the provision of quality care.

Palpable Mass

Cyst

- Ultrasound or cyst aspiration useful to differentiate between solid and cystic mass.
- With aspiration, if mass does not disappear or fluid is bloody, send for cytology and refer to surgeon. Fluid can otherwise be discarded. Re-examine breast in six weeks for recurrence. If cyst recurs refer to surgeon. Otherwise, follow routinely.

Solid

Refer patient to surgeon for solid, dominant, persistent mass as biopsy is almost always indicated.

A normal mammogram does not eliminate need for further evaluation of a clinically suspicious mass. However, if mass is clinically benign on breast exam, and this is confirmed by cytologic exam and mammography, patient may be followed by a surgeon every three months until biopsy or resolution of problem.

Women <30 most likely have cyst or fibroadenoma. Ultrasound or needle aspiration may be used to confirm. Refer to surgeon for solid, dominant, persistent mass as biopsy is almost always indicated.

Vague Nodularity

If significant doubt exists about nature of mass, consider mammogram or ultrasound first and then fine needle aspiration (FNA) for cytologic exam. If mass appears benign—slightly lobulated breast tissue, or poorly defined thickening not matched in opposite breast—recheck bi-monthly or quarterly. If mass persists after 3 months and can be distinguished from remainder of breast tissue, refer to surgeon.

Abnormality of mammography — nonpalpable

- For American College of Radiology (ACR) categories **four** (*suspicious abnormality—biopsy should be considered*) and **five** (*highly suggestive of malignancy*), refer to surgeon.
- For ACR category **three** (*probably benign—short term followup suggested*), patient may be followed with sequential imaging at an interval suggested by the radiologist. Clearly communicate to woman need for clinical and imaging followup.

- If further mammographic/ultrasound evaluation advised (*assessment is incomplete*), obtain recommended imaging studies to better characterize the abnormality.
- Nonpalpable simple cysts confirmed by ultrasound do not need aspiration except for pain relief. Cysts having suspicious characteristics need to be biopsied.
- Nipple discharge, particularly if bilateral or multiductal, or milky, green, gray, or black, is not suspicious for cancer and needs no referral. If milky discharge is profuse, medical work-up for galactorrhea may be indicated.

Breast Pain

- Perform clinical breast examination (CBE) and mammography, if age-appropriate.
- If exam and mammography negative, fibrocystic change is most likely. Reassure patient, offer a trial of a non-narcotic analgesic, and recommend use of a well-supporting brassiere.
- If conservative measures do not relieve pain symptoms, referral to surgeon is indicated.

Skin/Nipple Change and Nipple Discharge

- Women with skin breakdown on the nipple or areola should be referred to a surgeon.
- Patient with palpable mass and any nipple discharge should be referred to a surgeon.
- If discharge suspicious for neoplasm (*spontaneous; unilateral; confined to single duct; occurring in older patient; clear, bloody, serous, or serosanguinous*) send patient for mammography and surgical consult.

The Worried Patient with a Negative Workup

- Refer patient to a surgeon for a second opinion.

Difficult Breast Examinations

- May refer woman to surgeon if she has had reduction or augmentation mammoplasty; if breasts very large or multinodular; if multiple biopsies severely scar breasts.
- All women who are pregnant or lactating and have a breast mass or area of patient concern should be referred to a surgeon.

High Risk Patients

- Consult breast cancer specialist for a woman with prior history of breast cancer, strong first-degree family history, or previous history of atypia or multiple biopsies.
- Such a woman may need a special follow-up regimen.

APPENDIX 2

Breast Cancer Screening

*Prepared by the Society of Surgical Oncology and the
Commission on Cancer of the American College of Surgeons*

Screening Mammography

- Scientific data support a recommendation for annual screening for women aged 50-74. Conclusive scientific data are not available to precisely define guidelines for other age groups. Several national organizations recommend screening mammography every 1-2 years for women 40-49; other organizations recommend that screening mammography begin at age 50 years.

Physical Examination

- Breast examination should be performed annually as a part of a woman's routine physical examination if over 30, and should be encouraged for younger women as well.

Breast Self-Examination

- Role of breast self-examination (BSE) in early detection of breast cancer is not clear. BSE should be taught, demonstrated, and encouraged, without placing undue emphasis on it.

CERVICAL CANCER SCREENING GUIDELINES

POLICY

All federal (Title X) and state guidelines are to be followed when collecting Pap tests. Guidelines for Pap management and Pap test follow-up must also be followed. On November 3, 2003, the Office of Population Affairs released Program Instruction Series, OPA 03-01 entitled "Screening for Cervical and Colorectal Cancer and Sexually Transmitted Diseases (STD)". These instructions acknowledged the standards of the American Cancer Society (ACS), the American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force (USPSTF) regarding onset and frequency of Pap testing. Through OPA Program Instruction Series 03-01, permission was given for agency medical directors to change their medical protocols and practice to reflect the current national standard. The current national standard for Pap testing is as follows:

1. Annual cervical cytology screening should begin approximately 3 years after initiation of sexual intercourse, but no later than age 21 years.
2. Women younger than 30 years should undergo annual cervical cytology screening with conventional cytology or every 2 years with liquid-based cytology.
3. Only ACOG recommends annual screening for all women under age 30 beginning 3 years after the initiation of sexual intercourse, but no later than age 21 years.
4. Women age 30 years and older who have had three consecutive negative cervical cytology screening test results and who have no history of CIN 2 or CIN 3, are not immunocompromised, are not HIV infected, and were not exposed to diethylstilbestrol (DES) in utero may extend the interval between cervical cytology examinations to every 2-3 years.
5. Both liquid-based cytology and conventional cytology are acceptable for screening.
6. Women who have undergone hysterectomy with removal of the cervix for benign indications and who have no prior history of CIN 2 or CIN 3 or worse may discontinue routine cytology testing.

In addition, the 2006 Consensus Guidelines released October 1, 2007, recommend that women 20 years of age or younger have less aggressive Pap follow-up. This is because this age group almost always clears the cervical cancer precursors, i.e., high risk types of human papilloma virus (HPV). Also, cervical cancer is virtually nonexistent in this age group. By over treating minor cervical cytological changes such as ASC-US and LSIL, healthy childbearing can be compromised. The Tennessee Pap and HPV testing guidelines reflect this recommendation.

The 2006 Consensus Guidelines also stated that HPV testing should be limited to high risk types only. There is no merit in testing for low-risk HPV. Within this guidance document, reference to HPV testing refers to high risk HPV only.

OPA Program Instruction Series 03-01 also noted that, "Clinical protocols should continue to take into account individual client risks, use of specific methods of contraception, as well as current national standards of care." Likewise, the 2006 Consensus Guidelines recognized the need for individualizing care. Guidelines should never be a replacement for clinical judgment.

Also, this guidance does not preclude the importance of a complete physical examination, STD screening, and preventive health teaching. Always counsel clients to avoid high risk sexual behavior.

DEFINITIONS

The Pap test is an effective screening test for cervical cancer and its precursors. It is safe, inexpensive, widely available, and can detect abnormal cervical cells long before the disease becomes invasive or progressive. There are two types of Pap tests: the conventional Pap smear and the liquid-based Pap test. Within these Guidelines, we will differentiate the two types for the reader. Conventional Pap smear will mean the standard classic Pap smear slide. Liquid-based Pap test will mean the use of a brush and cytology liquid to transport cervical material to the laboratory. Pap test will mean either test.

Adolescence is a term that defines a transitional period of physical and psychological development between youth and maturity. As such, adolescence has been defined as through age 20 by the American Academy of Pediatrics and the American Medical Association. For the purposes of cervical cancer screening in Tennessee, adolescence can be defined as through age 20. This is in keeping with EPSDT screening in Tennessee as well as the 2006 Consensus Guidelines. No client age 21 or older shall be defined as an adolescent for the purposes of cervical cancer screening.

Cervical cancer screening can be performed at the following visits:

1. Initial visit.
2. Annual visit.
3. Readmission (if not done within the past year).
4. Postpartum if it has been at least six weeks since delivery.
5. Visit specifically for Pap follow-up.

Frequency of cervical cancer screenings is as follows:

1. Annually with conventional Pap smear for women through age 20 years.
2. Every two years with liquid-based cytology Pap test for women age 21 and older with normal Pap results.
3. Women age 30 and older, who have had 3 consecutive satisfactory and normal Pap tests (either conventional or liquid), may be tested every 3 years. This is a regional decision. (The TN Breast and Cervical Screening Program has begun to implement this 3 year interval for its enrollees.)
4. Women with a history of DES exposure, are HIV+, or are immunocompromised by organ transplantation, chemotherapy or chronic corticosteroid treatments will be screened and followed in the same manner as other women in their age group.
5. Women with an abnormal Pap result (either type) generally have special Pap frequency requirements. See the appropriate algorithm.

Exceptions to the cervical cancer screening schedule are:

1. Clients who have had a documented Pap test (either type) within the previous year with another provider.
2. Clients who are menstruating or who have douched or had sexual intercourse within the past 48 hours. In these situations, the Pap test (either type) can be delayed. An appointment for the Pap should be made within 3-6 months.
3. Clients who request to delay the physical exam and Pap test until a later date. The exam and Pap test can be delayed 3-6 months. An appointment should be scheduled for the exam and test.
4. Always document why the Pap test was delayed.

For management of abnormal Pap tests or positive HPV results, see the attached algorithms.

SCHEDULING AND TRACKING OF PAP TESTS AND HPV TESTS

The following should be discussed with the client prior to the Pap test visit. The choice of staff member who provides this information is a regional decision.

1. Avoid douching for 2 days before the exam.
2. Avoid sexual intercourse for 2 days before the exam.
3. Avoid putting anything into the vagina for 2 days before the exam
4. Make appointment for Pap test 1-2 weeks after the end of menses.
5. Whenever possible, have any abnormal vaginal secretions treated before the Pap test is scheduled. (Health care provider may need to make this decision at the time of the exam.)

When a client gives a history of abnormal Pap tests results, send for these records. The client will need to sign the appropriate release of information in order for the health department to send for and receive these. Pap management will reflect consideration of these records, and may include (but is not limited to) consult with the assigned health officer and referral for further follow-up.

If a Pap test is not taken or an HPV test is not done when indicated (regardless of the reason), the client's chart should be flagged, and the reason noted in the chart. The nurse should indicate the scheduled return appointment date for continued cervical cancer screening.

Once the Pap test or HPV test has been taken, it should be documented in the client's record, entered into the tracking system, and the flag removed.

If the Pap test is not collected at the return visit, the flag remains on the chart. Be sure to document why the Pap test or HPV test was not taken. Assure that the client has another appointment. The flag will remain on the chart.

The Pap test should not be repeated before 6 months from the previous Pap test unless the Pap report was unsatisfactory. In this case, the Pap can be repeated as soon as possible allowing time for any needed treatment, but no longer than 4 months. However, colposcopy may be ordered or repeated anytime it is indicated.

TECHNIQUES FOR AVOIDING UNSATISFACTORY CONVENTIONAL PAP SMEARS

Causes of an Unsatisfactory Pap Smear	Appropriate Responses
Smear too bloody (excess red blood cells)	Repeat Pap smear when client not bleeding; test for chlamydia.
Smear too inflammatory (excess white blood cells)	Diagnose & treat infection; repeat Pap smear as soon as practical but within 4 months.
Cells are air dried	Fix slide within 2-5 seconds, spraying from 10-12 inches.
Cells are cytolized	Avoid water from douching or overly moist speculum,

Scanty cellular material	Use firmer scrape to obtain more cellular material.
Cellular material too thick	Spread more evenly over slide or use 2 slides for heavy material.
Cells too atrophic	Prescribe vaginal estrogen cream.
Foreign material	Avoid medications, lubricants, swab fibers etc.

PAP TEST/HPV TEST REPORT PROCESS

Upon return from the laboratory, all Pap test reports and HPV tests are reviewed by the designated local Public Health Nurse (PHN).

A tracking system is established by regional policy and maintained at each site for follow-up of abnormal Pap tests and HPV tests. If a region can demonstrate that a computerized tracking system is in place that facilitates assurance that Pap test results and HPV results are followed, that region will be exempt from the requirement of a manual tracking system. In this circumstance, written regional policies concerning the use of such a computerized tracking system must be in place and documentation must be made available upon request that would enable quality management staff to determine whether or not the system is being utilized in accordance with policy.

The attempts to contact the client may include phone calls, direct contact during a Family Planning clinic visit or a home visit, or by mail. Clients may also be contacted during any clinic visit, i.e., WIC visit, primary care visit, etc. Flag the chart or use the note field on the PTBMIS screen to alert staff that at the next clinic visit, Pap test or HPV follow-up is indicated. (It is suggested that when a letter is returned undeliverable, check the correctness of the address. If the address is correct, call the emergency contact to get a forwarding address. If a forwarding address is unavailable, flag the chart.)

The designated PHN is responsible for recording Pap test and HPV results in accordance with regional policy. "Negative for intraepithelial lesion or malignancy" laboratory results slips may be discarded once results are posted. HPV tests that are negative for high-risk HPV may also be discarded once results are posted. Refer to Policy and Procedures Manual, 5.3 C, Tennessee Department of Health, Bureau of Health Services. Disposal of negative slips should be a regional decision, covered by regional policy.

MINIMUM REQUIREMENTS FOR PAP TEST AND HPV FOLLOW-UP

Federal Title X Guidelines state, "a procedure must be established to allow for client notification and adequate follow-up of abnormal laboratory results." Pap test and HPV follow-up guidelines are to be used when clients have stated that they may be contacted by phone or at home. Use the regional policy for notifying confidential clients.

Abnormal Pap test and positive HPV tests are reviewed by the nurse-practitioner or physician. Follow-up orders are given to the assigned public health nurse(s) for follow-up and tracking. Recommendations by the pathologist are taken into consideration. Follow-up and tracking must comply with regional protocols and must be documented in the chart and/or in the electronic record (i.e., tracking).

CLIENT NOTIFICATION

A regional policy for notification of "Negative for intraepithelial lesion or malignancy" or "negative for high-risk HPV" must be established.

For Pap test results indicating the presence of an organism or condition that the practitioner or physician wishes to address or treat (such as yeast, numerous red blood cells or shift in bacterial flora), a minimum of two documented attempts to contact the client are required.

Clients, who have been referred to colposcopy and subsequently return to the health department, are managed in accordance with the instructions given by the colposcopist.

A regional policy for notification of "negative for intraepithelial lesion or malignancy" or "negative for high-risk HPV" must be established.

For Pap test results indicating the presence of an organism or condition that the practitioner or physician wishes to address or treat (such as yeast, numerous red blood cells or shift in bacterial flora), a minimum of two documented attempts to contact the client are required.

For Pap test reports indicating atypical squamous cells of undetermined significance or greater, two documented attempts to contact the client are required.

For Pap test reports or HPV tests indicating the need for referral to colposcopy, a minimum of two documented attempts to contact the client are required. The sequence of attempts to contact the client proceeds as follows:

1. First attempt: Phone call, letter sent by first class mail, or direct contact during a clinic or home visit.
2. Second attempt: Registered letter or direct contact in clinic or by home visit.
3. Regional policy determines the type of documentation related to the sending of the letters. Also regional policy determines whether further follow-up should occur if the client does not respond.
4. Clients with the epithelial cell abnormalities of high grade squamous intraepithelial lesion (HSIL), squamous cell carcinoma, atypical glandular cells, endocervical adenocarcinoma in situ, or any other malignant neoplasm are to be contacted within 5 working days from the receipt of the lab report or the call from lab.
5. Within 6 weeks of the date the Pap test or the HPV test was reported by the lab, clinics should have an appropriate referral in place (client informed and appointment made). Clinics are to document and facilitate any recommended follow-up. Clinics must not coerce clients to undergo any consultation or procedure. However, clients must understand the importance of follow-up and the possible consequences of failure to comply with recommendations.

INTERPRETATION OF PAP TESTS

The Bethesda System 2001 for Reporting Cervical Cytology

The Bethesda System, first developed in 1988, was designed to be a uniform system of terminology that would provide clear guidance for clinical management. It was modified in

1991 after actual laboratory and clinical experience with the Bethesda System itself. In 2001 the system was modified again to adjust for increased utilization of new technologies and recent findings from research studies. As of April 2002, more than 20 national and international societies have endorsed the 2001 Bethesda System.

On every Pap test report, the Bethesda System addresses the following categories:

1. Specimen Adequacy
2. General Categorization (optional)
3. Interpretation/Result
4. Automated Review and Ancillary Testing
5. Educational Notes and Suggestions (optional)

The following statements can be found under each category:

1. Specimen Adequacy

- a. Satisfactory for evaluation (note the presence/absence of endocervical/transformation zone component)
- b. Unsatisfactory for evaluation because (specify reason)
- c. Specimen rejected/not processed because (specify reason)
- d. Specimen processed and examined, but unsatisfactory for evaluation of epithelial cell abnormality because of (specify reason)

5. General Categorization (optional)

- a. Negative for intraepithelial lesion or malignancy
- b. Epithelial cell abnormality (see below)
- c. Other

6. Interpretation/Result

- a. Negative for Intraepithelial Lesion or Malignancy
- b. Organisms: Trichomonas, fungal organisms, shift in flora suggestive of bacterial vaginosis, bacterial changes consistent with Actinomyces, cellular changes consistent with herpes simplex virus
- c. Other non-neoplastic findings (optional): reactive cellular changes associated with inflammation including typical repair, radiation, intrauterine contraceptive device, glandular cells status post-hysterectomy, atrophy
- d. Epithelial cell abnormalities
 - Atypical squamous cells of undetermined significance (ASC-US)
 - Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
 - Low-grade squamous intraepithelial lesion (LSIL) encompassing human papillomavirus/mild dysplasia/ cervical intraepithelial neoplasia (CIN 1)
 - High-grade squamous intraepithelial lesion (HSIL) encompassing moderate and severe dysplasia, carcinoma in situ, CIN 2 and CIN 3
 - Squamous cell carcinoma
 - Atypical glandular cells (AGC) (specify endocervical, endometrial, or “not otherwise specified” – NOS)
 - Atypical glandular cells, favor neoplastic (specify endocervical or NOS)
 - Endocervical adenocarcinoma in situ (AIS)
 - Adenocarcinoma

- Other such as endometrial cells in a woman > age 40
- a. Automated Review and Ancillary Testing
 - a. Statement will define what type of automated review or ancillary test was used
5. Educational Notes and Suggestions (Optional)
 - a. Statement will be self-explanatory

TennCare clients may have MCOs that require Pap tests collected on their clients be sent to particular laboratories with which they have contracts. Some grantees contract with a laboratory of their choice. It should be noted that some laboratories use a modified Bethesda System. Regions should be aware of minor differences in their systems (mainly descriptive) and have on file the exact wording of the laboratory's alternative/modified Bethesda System.

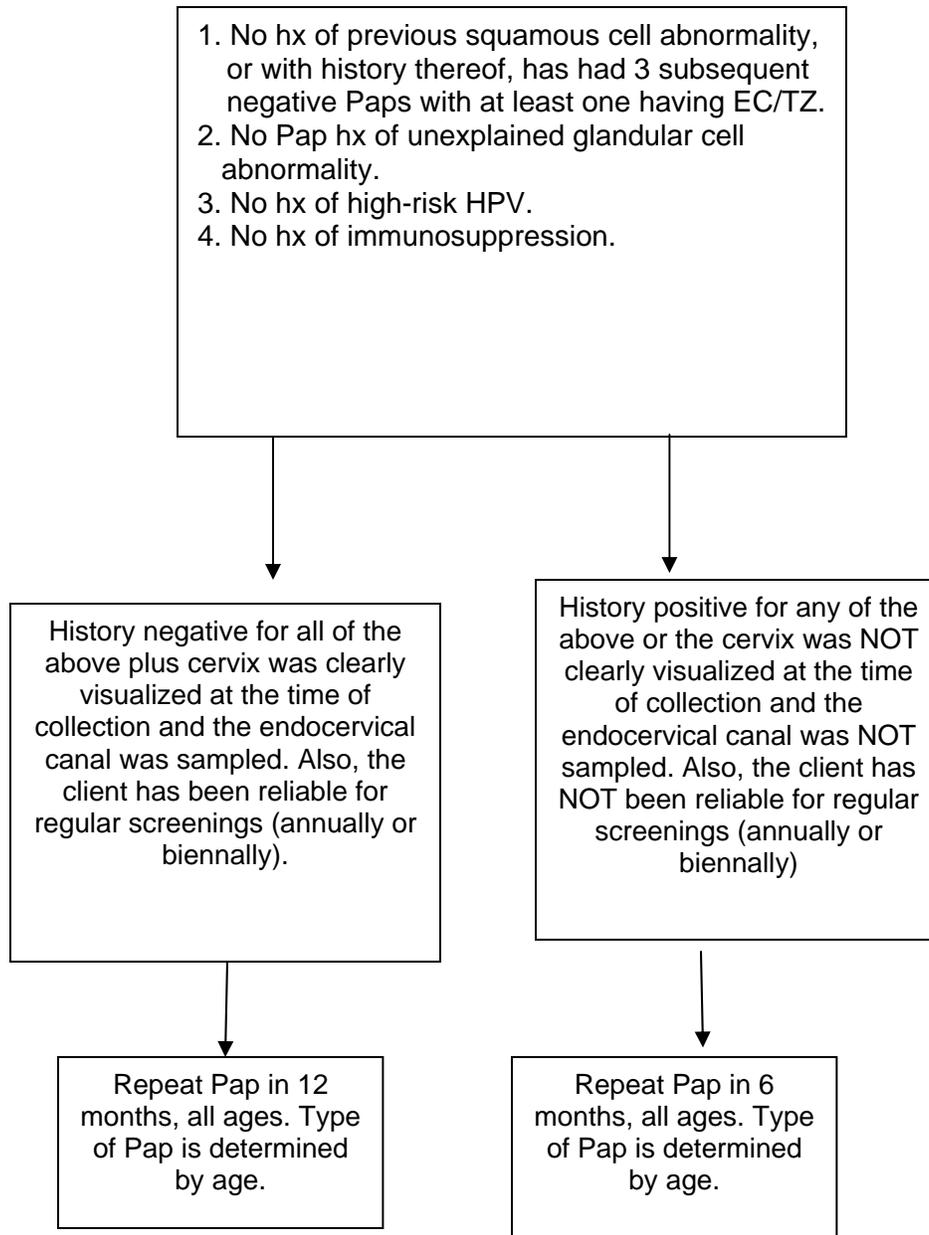
ATTACHMENTS

Management of PapTest Findings – These decision algorithms are intended to provide public health staff with a simple visual tool for Pap test follow-up.

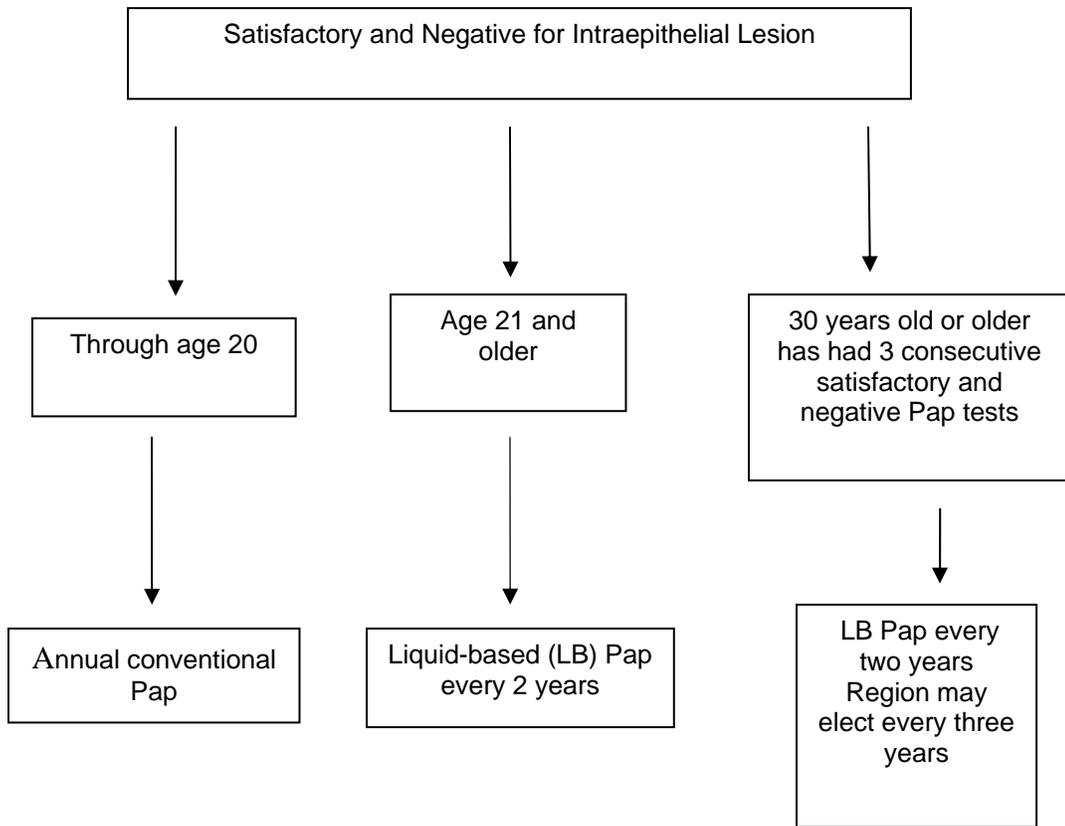
REFERENCES

1. American College of Obstetricians and Gynecologists, ACOG Practice Bulletin, Cervical Cytology Screening, Number 45, August 2003.
2. American College of Obstetricians and Gynecologists, ACOG Committee Opinion Number 330, April 2006
3. American College of Obstetricians and Gynecologists, ACOG Committee Opinion Number 300, October 2004.
4. American Journal of Clinical Pathology, Volume 118, No. 5, ASCCP Patient Guidelines – Pap Test Specimen Adequacy and Quality Indicators, pages 714-718.
5. CA A Cancer Journal for Clinicians, Volume 52, No. 6, American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer, pages 342-362, November/December 2002.
6. Journal of the American Medical Association, Volume 287, No. 16, The Bethesda System, pages 2114-2119, April 24, 2002.
7. Journal of the American Medical Association, Volume 287, No. 16, 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities, pages 2120-2129, April 24, 2002.
8. U.S. Preventive Services Task Force, Screening for Cervical Cancer – Recommendations and Rational, www.ahrq.gov, January 2003.
9. American Journal of Obstetrics and Gynecology, 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests, pages 346-355, October 2007.

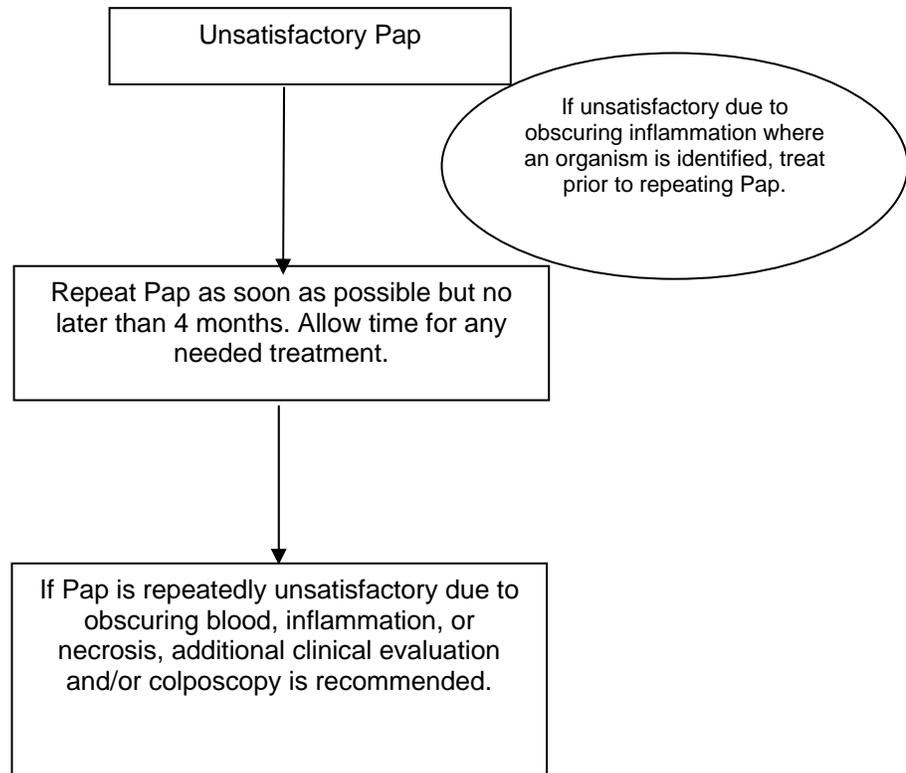
**Management Guidelines for
Satisfactory Pap Test
With No Endocervical/Transformation Zone Component (EC/TZ)**



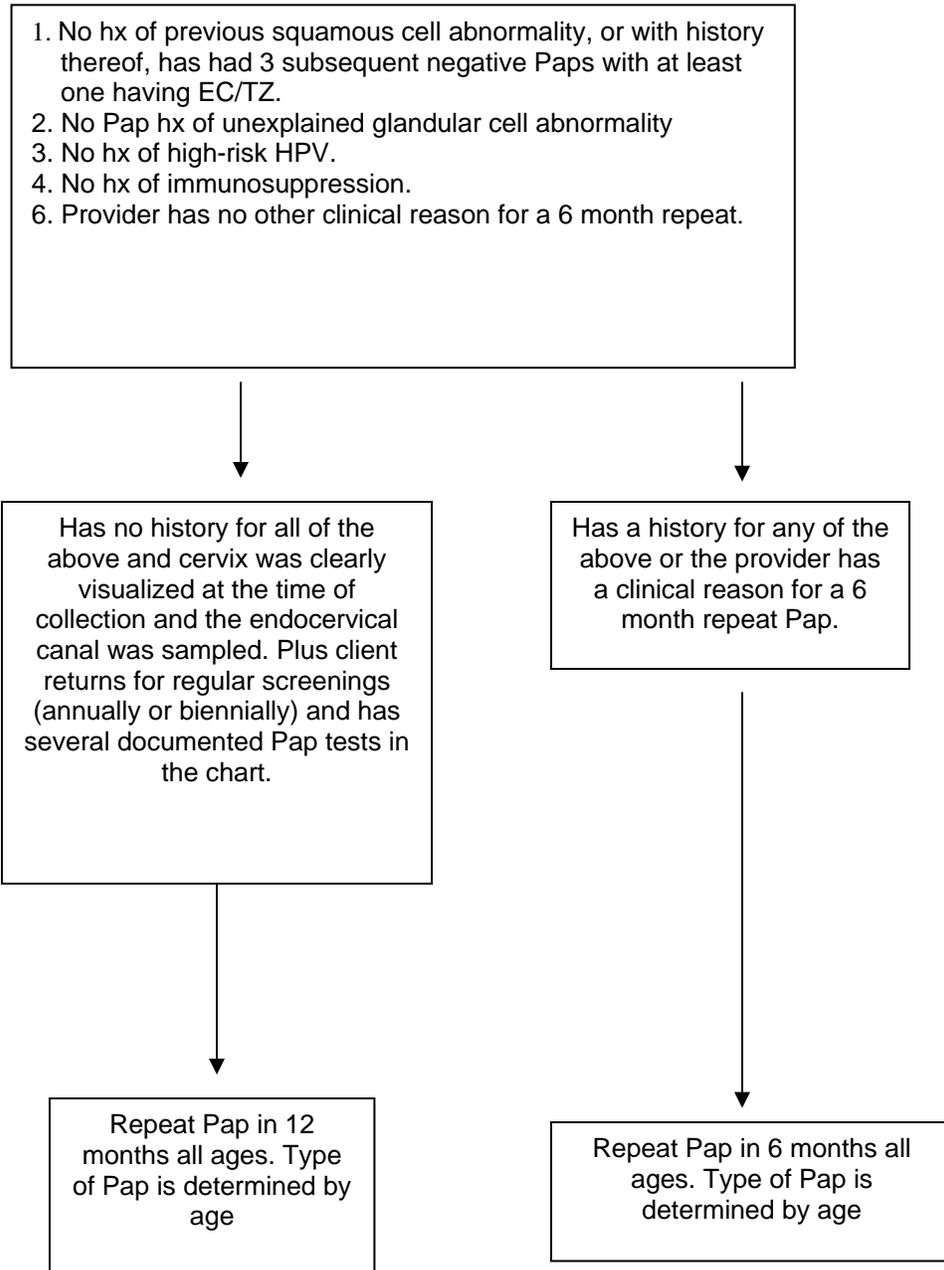
Management Guidelines for Women with Satisfactory Pap Test



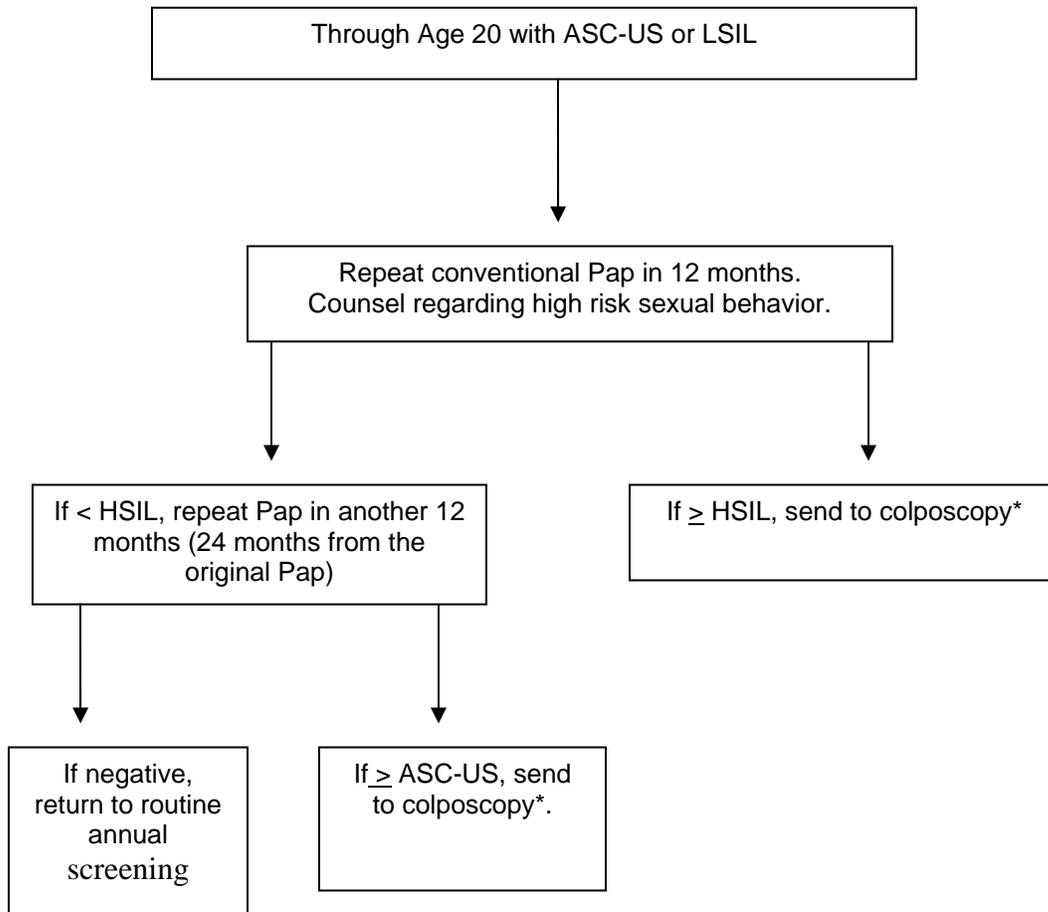
Management Guidelines for Women with Unsatisfactory Pap Test Results



**Management Guidelines for
Women with Pap Negative for Intraepithelial Lesion
With Numerous Red Blood Cells, Inflammatory Cells,
Reactive/Inflammatory Epithelial Cells, Air-Drying
Or Other Factors**

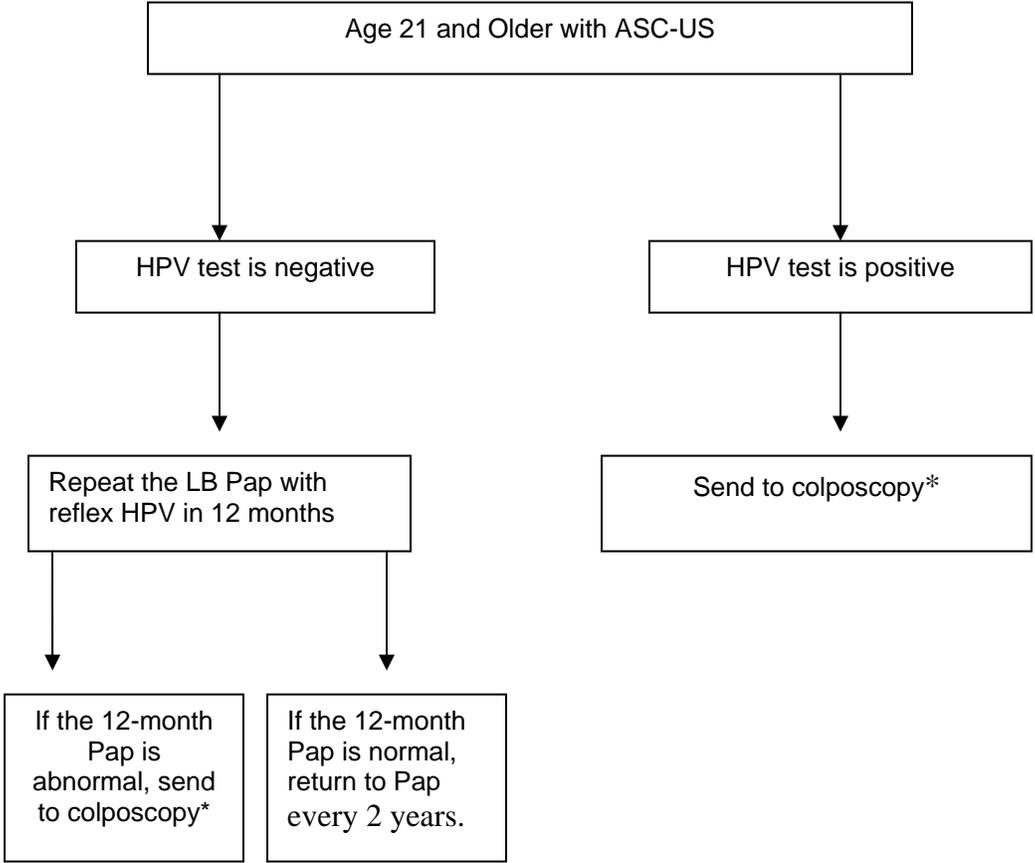


**Management of Women Through Age 20 Years with
ASC-US or LSIL**



***The goal in this age group is to avoid excisional treatment. The colposcopist may elect to repeat the colposcopy and Pap every 6 months for 24 months if no CIN 2 or 3 was found on the colposcopy. After colposcopy, management is directed by the colposcopist.**

**Management of Women Age 21 and Older with ASC-US
(Pap will be Liquid-based with Reflex HPV Test for ASC-US Results Only)**



***After colposcopy, management is directed by the colposcopist**

Management of Women HSIL or ASC-H, All Ages



Colposcopy*

Management of Women Age 21 and Older with LSIL including Women Who are Post Menopausal



Colposcopy*

Management of Women with Atypical Glandular Cells, All Ages



Send to a referral site capable of colposcopy* and endometrial sampling, as it may be needed

***After colposcopy, management is directed by the colposcopist.**

GUIDELINES FOR HPV DNA TESTING

POLICY

The Tennessee Department of Health, Title X Family Planning Program promotes Pap test screening for the detection of cervical cancer or its precursors. Recent studies have shown that the conventional Pap smear test and the liquid-based Pap test are both proficient in identifying clients at risk. These studies have also shown that Human Papilloma Virus (HPV) DNA testing for high risk types of HPV does enhance Pap test follow-up since high risk HPV types are known causative agents of cervical cancer. The Tennessee Department of Health, Title X Family Planning Program offers HPV DNA testing in the situations described below. Only high risk types of HPV are significant. There is no indication for low-risk types of HPV. When HPV is referenced in this document, the reference is to high risk types only.

TESTING FOR THE HUMAN PAPILLOMA VIRUS (HPV)

Thirteen HPV types have been identified in the pathogenesis of high-grade squamous intraepithelial lesions (HSIL) and invasive cervical cancer. These are types 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68. HPV detection and identification of these high-risk types is made possible through signal amplification assay technology. This technology utilizes antibody capture and chemiluminescent signal detection. The basic steps of the assay are as follows:

1. Clinical specimens are combined with a base solution that disrupts the virus and releases the HPV DNA.
2. The HPV DNA is combined with RNA creating an RNA:DNA hybrid. (Each RNA is specific to an HPV type and multiple types are tested at once so that the presence of all high-risk types can be searched for in that particular patient's sample.)
3. These RNA:DNA hybrids are then captured onto a solid particle that is coated with universal capture antibodies specific for the RNA:DNA hybrids for HPV.
4. These captured hybrids can then be detected with multiple antibodies conjugated to alkaline phosphatase (an enzyme) resulting in a signal that can be amplified at least 3000-fold.
5. The bound alkaline phosphatase is then detected with a chemiluminescent dioxetane substrate. Alkaline phosphatase breaks down the substrate and light is produced. The light is measured on a luminometer in relative light units (RLUs), and the amount of light detected is directly proportional to the amount of HPV DNA present in the sample.

CANDIDATES FOR HPV TESTING

Women age 21 and older will receive HPV testing for the triage of ASC-US Pap. HPV testing is also used as a 12 month follow-up to colposcopy for an LSIL Pap for this same age group if deemed appropriate by the colposcopist (no CIN 2 or 3). HPV tests should not be collected in less than 12 month intervals.

Should an HPV test be collected inadvertently as a follow-up to an ASC-US or LSIL Pap in an adolescent woman through age 20, the result should not influence Pap follow-up. HPV testing is not recommended in this age group.

COLLECTING THE HPV SPECIMEN

In Tennessee, women age 21 and older will receive a liquid-based Pap test with reflex HPV testing for the triage of an ASC-US Pap. Thus, the HPV test is run by the laboratory using the liquid. It is unlikely that the HPV test would be collected using the cervical sampler kit. However should a kit be required, the following collection procedures would be used.

Each kit contains one cervical sampler brush with scored shaft and one transport tube with transport media. The manufacturer recommends that if a Pap test is also being collected; collect the Pap test before obtaining the specimen for the HPV test. In a setting where colposcopy is being performed, collect the HPV specimen before applying acetic acid or iodine. Remove any excess mucous from the cervical os and surrounding ectocervix with a cotton or Dacron swab. Insert the cervical sampler brush 1-1.5 centimeters into the os of the cervix until the largest outer bristles of the brush touch the ectocervix. Rotate the brush 3 full turns in a counter clockwise direction. DO NOT INSERT THE BRUSH COMPLETELY INTO THE CERVICAL CANAL. Remove the brush from the canal and insert it into the transport tube. The tube contains the necessary transport media. Avoid touching the brush to the outside of the tube or to any other object. Snap off the shaft of the brush at the score line and cap the tube securely. (See the package instructions for a diagram of collecting the HPV specimen.) Do not use the cervical brush with pregnant women.

ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE IN WOMEN AGE 21 AND OLDER

In this age group, women receive a liquid-based (LB) Pap test with reflex HPV test for the triage of ASC-US. If the results are negative, then the test is repeated every 2 years. If it is ASC-US, the HPV test is run reflexively by the laboratory. If the HPV test is positive the client is referred to colposcopy. If the HPV test is negative, the clients return in 12 months for another LB Pap with the reflex option. At the 12 month point, if the Pap is abnormal, the client will go to colposcopy.

ADOLESCENTS WITH ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE (ASC-US) or LOW GRADE SQUAMOUS INTRAEPITHELIAL LESION (LSIL)

Atypical squamous cells of undetermined significance (ASC-US) and low grade squamous intraepithelial lesions (LSIL) are abnormalities that generally identify women who have recently been exposed to HPV. HPV is more common in adolescent women than older women. However, the risk of cervical cancer in an adolescent is virtually zero. This is because the immune system most likely will clear the HPV. Therefore, the preferred method of follow-up of an adolescent with ASC-US or LSIL is a follow-up Pap in 12 and 24 months with referral to colposcopy if the 12 month Pap is greater than or equal to HSIL or the 24 month Pap is greater than or equal to ASC-US. HPV testing is not appropriate for women through age 20. If an HPV test is inadvertently done in this age group, the results should not influence management.

FINDINGS NOT REQUIRING HPV TESTING

None of the following Pap test results require HPV DNA testing because they will be referred to colposcopy:

Atypical Squamous Cells Cannot Exclude High-Grade SIL (ASC-H) for all ages
Low-Grade Squamous Intraepithelial Lesion (LGSIL) ages 21 years and older
High-Grade Squamous Intraepithelial Lesion (HGSIL) for all ages
Atypical Glandular Cells (AGC) for all ages

REFERENCES

1. American College of Obstetricians and Gynecologists, ACOG Practice Bulletin, Cervical Cytology Screening, Number 45, August 2003.
2. Journal of the American Medical Association, Volume 287, No. 16, The Bethesda System, pages 2114-2119, April 24, 2002.
3. Journal of the American Medical Association, Volume 287, No. 16, 2001 Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities, pages 2120-2129, April 24, 2002.
4. American Journal of Obstetrics and Gynecology, Consensus 2006 Consensus Guidelines for the Management of Women with abnormal cervical cancer screening Tests, Pages 346-355, October 2007.
5. CA A Cancer Journal for Clinicians, Volume 52, No. 6, American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer, pages 342-362, November/December 2002.
6. American Journal of Clinical Pathology, Volume 118, No. 5, ASCCP Patient Guidelines – Pap Test Specimen Adequacy and Quality Indicators, pages 714-718.
7. Tennessee Family Planning Clinical Guidelines, Tennessee Department of Health, *Pap Smear Screening Guidelines*, January 2007.
8. HC Cervical Sampler kit, Package Instructions, Digene Corporation, November 2001.
9. U.S. Preventive Services Task Force, Screening for Cervical Cancer – Recommendations and Rationale, www.ahrq.gov, January 24, 2003.
10. Digene Corporation, www.digene.com.

POLICIES:

Ductograms/Galactograms for Women With Nipple Discharge: June 2008 (revised)

Ductograms are not covered services of the Tennessee Breast and Cervical Screening Program.

Background:

Ductography (also called galactography or ductogalactography) is a special test for patients with nipple discharge. It is basically a mammogram with contrast medium injected into spontaneously discharging ducts to determine abnormalities that are causing the nipple discharge. The majority of nipple discharges are due to benign causes. Cancerous lesions are only diagnosed 10% of the time using this method.

- Papillomas, which are benign tumors that grow inside the breast ducts, are the most common cause of nipple discharge.
- It is difficult to differentiate between carcinoma and papilloma by performing a ductogram.
- The majority of women who receive this procedure require surgery to remove the duct that is causing the problem.

Suspicious Nipple Discharge:

- Bloody or clear, watery serous nipple discharge suspicious for benign or malignant breast neoplasm necessitates prompt referral to surgical consultant.

The patient with any nipple discharge and palpable mass should always be referred to a surgeon because there are two symptoms present.

Non-Suspicious Nipple Discharge:

- Milky, Green, Gray, or black discharge expressed from several ducts is not suspicious for cancer and referral of the patient is not necessary, especially if the discharge is bilateral.
- Cytologic analysis of nipple discharge is not a covered service. It is rarely useful and it is not cost-effective.

Conclusion:

Ductograms are not an approved screening or diagnostic test for breast cancer according to National Breast and Cervical Cancer Early Detection Program; therefore, it is not a covered service of the state program.

References:

1. Ductogram/Galactogram: Imaging the breast ducts, Imaginis.com.
2. Evaluation of Common Breast Problems: A primer For Primary Care Providers.

Medical Advisory Committee
Approved August 2008

EstrogenReceptor (ER/PR and HER 2)Testing

DATE: September 4, 2009

TO: Regional Coordinators

FROM: Mary Jane Dewey

SUBJECT: Payment for ER/PR and HER 2 lab tests

We have recently reviewed CMS Medicare Publication #100-04 involving claims processing for biopsy specimens. It provides guidance to clarify payment for labs when specimens are collected during a hospital procedure but tested at a later date.

The specimens collected during biopsy for women diagnosed with breast cancer can be collected during the biopsy so as not to require a second short stay hospitalization for the woman. Most surgeons and/or pathologists have standing orders that if the biopsy is positive for Br Ca, run the ER/PR and HER2 tests on the collected specimens immediately.

The TN Breast and Cervical Screening Program cannot cover the cost of these tests and they should not be ordered until after the woman is an active patient enrolled with a TennCare MCO for treatment. We cannot cover the cost because it is related to treatment decisions and the program is forbidden by federal law, from paying for treatment.

Surgeons can continue to collect the specimen during biopsy but the lab work to test these specimens for ER/PR or HER 2 compatibility cannot be processed until at least 15 days after the biopsy date. After this time lag, the cost will be a TennCare/MCO covered service.

Please inform the surgeons and pathologists that you work with accordingly.

Management and Referral of Breast Diagnostics for Women Under 40 Years of Age
June 2007

Policy

The program provides breast diagnostic services for women under 40 if the clinical breast exam (CBE) is suspicious for cancer or other symptoms suspicious for cancer are present. The regional coordinator or central office must approve breast diagnostic services for women under 40.

Background

The most common breast problems in women under the age of 40 are nipple discharge, a palpable mass suspicious for cancer or pain with other breast symptoms.

Palpable masses can be classified as cysts, solid masses or vague nodularity. Cysts are commonly found in the pre-and perimenopausal group and may be confirmed by ultrasound and/or cyst aspiration. A woman with a discrete solid mass should be referred to a breast specialist or surgeon for a complete evaluation. Vague nodularity is a diffuse, poorly defined thickening that may or may not be matched in the opposite breast, or an area of irregularity or prominence such as normal, but nodular breast tissue.

If the screening provider chooses to accept responsibility, the woman may return for follow-up visits bimonthly or quarterly for reexamination prior to referral to a surgeon. In menstruating women, return visits should occur at midcycle.

Program Procedures

Women under 40, who have an abnormal breast exam must be referred for diagnostics that confirm or rule out a cancer diagnosis within 60 days of the first abnormal result.

1. Refer for a diagnostic mammogram, ultrasound a repeat CBE by a breast specialist or a surgical consultation..
2. When women are under 35 an ultrasound is preferred because of the high density of breast tissue.
3. If an excisional biopsy is recommended requiring anesthesia, the screening provider must refer the woman to the Regional Coordinator so she can receive presumptive eligibility for TennCare prior to the excisional biopsy.

Conclusion:

TBCSP recommends that providers read and refer to “Evaluation of Common Breast Problems” as it contains all the necessary information on how to manage these women. If there is any doubt about the nature of a breast problem, it is always best to refer to the surgeon to determine the course of diagnostic testing and/or follow-up.

References

1. The Evaluation of Common Breast Problems, Monica Morrow, MD American Family Physician, April 15, 2000
2. Evaluation of Common Breast Problems: A Primer for Primary Care Providers Prepared by the Society of Surgical Oncology and The Commission on Cancer of The American College of Surgeons for The Centers for Disease Control and Prevention.

Management and Referral of Women for Screening Breast Magnetic Resonance Imaging (MRI)

June 2008

Policy: The Tennessee Breast & Cervical Screening Program (TBCSP) does not reimburse for breast MRI. The program will enroll women in presumptive eligibility for TennCare who meet at least one of the following criteria.

- **Women who carry a documented BRCA mutation**
- **Untested women with a first degree relative who has a BRCA mutation**
- **Women with >25% estimated lifetime risk of developing breast cancer calculated from family and personal history (first degree relative with pre-menopausal breast cancer) as defined by BRCAPRO or other recognized risk models.**
- **Radiation to chest between age 10 and 30 years.**
- **Women who have been treated for breast cancer or had a mastectomy of one breast and have returned to TBCSP for annual screening.**

Background:

In March 2007, the American Cancer Society (ACS) published new guidelines for breast screening with MRI. These guidelines defined MRI as an important tool when combined with mammography to diagnose women who are very high risk much earlier than using mammography alone. MRI alone will not detect some cancers that mammography is able to do.

Breast MRI is also used to plan the management of women who are already diagnosed with breast cancer. TBCSP will not pay for MRI's when women are already diagnosed with breast cancer; this should be covered by TennCare as part of disease treatment.

Program Procedures:

1. A request for MRI with supporting documentation of eligibility because one of the above categories and a contact phone number must be submitted to the TBCSP central office.
2. The TBCSP medical director and/or the breast specialists on the medical advisory committee will review the case and approve or disapprove the procedure the physician making the request will be contacted to clarify, if necessary. If approved, the woman will be enrolled in TennCare through presumptive eligibility to confirm or rule out breast cancer.

References:

1. ACS Advises MRI's for Some at High Risk of Breast Cancer. Article date: 2007/03/28
2. Radiology Rounds: New Guidelines for Breast MRI. April 2007 Volume 5, Issue 4.

Medical Advisory Committee
Approved August 2008

Stereotactic Biopsy for Women

March 2007 (revised)

Background

Stereotactic breast biopsy is performed by a radiologist or surgeon using a specialized table to locate non-palpable abnormalities. The table is located in the x-ray department of a hospital, outpatient center, doctor's office or breast center.

The Procedure

- Is non-invasive
 - Uses imaging techniques without general anesthesia
 - Women may be sedated with an oral tranquilizer prior to the procedure
 - A local anesthetic is used at the site of the insertion of the needle
- Women are usually able to return home an hour or so after the procedure with a small dressing at the site of the biopsy.

Excisional Biopsies

Excisional biopsies are usually requested after the results of a stereotactic biopsy are received. Since an excisional biopsy requires the use of a hospital facility and general anesthesia, the woman must be enrolled in TennCare presumptive eligibility to have these services provided. Excisional biopsies are not covered by the program.

On rare occasions, the surgeon plans a stereotactic biopsy to be followed on the same day by an excisional biopsy. They must be enrolled in TennCare and the stereotactic biopsy, in this case, is billed to TennCare.

Conclusion:

1. Stereotactic biopsies are a diagnostic procedure. The TBCSP pays for this procedure based on the Cigna Medicare Part B Fee schedule.
2. If an excisional biopsy is also planned for the same day as the Stereotactic biopsy, the woman must be enrolled in TennCare through the presumptive eligibility process so that associated costs will be covered.

References

1. Physician qualification for stereotactic breast biopsy: A revised statement by the American College of Surgeons
2. Stereotactic Image-Guided Breast Biopsy by Priscilla D. Wong, MD and Methods of Breast Biopsy, Imaginis.com
3. Associated CPT codes, Descriptions and Reimbursement Rate.

Cervical Diagnostic Procedures

July 1, 2005

Policy

A LEEP or cold-knife conization of the cervix for women with a diagnosis of HSIL may be reimbursed as a diagnostic procedure, when the American Society of Colposcopy and Cytopathology (ASCCP) Consensus Conference on Management of Abnormal Cervical Cytology Reports (2001) recommendations are followed.

Procedures

All primary screening providers must receive prior authorization for this service on an individual client basis. Medical information that would substantiate the requested procedure should be faxed to the attention of the Program Director at (615) 741-3806. The medical information should include but not be limited to previous Pap test results, colposcopy results and notes from the physician requesting the procedure. The medical advisor for the TBCSP will review the information submitted and respond within five (5) working days.

Background

On June 1, 2004, the CDC issued a new policy based on the proceedings of the American Society of Colposcopy and Cytopathology (ASCCP) Consensus Conference on Management of Abnormal Cervical Cytology Reports (2001). The policy allows for the use of NBCCEDP (i.e., federal) funds for loop electrode excision procedure (LEEP), laser conization, and cold-knife conization under certain conditions as a diagnostic procedure.

ASCCP Recommendations and Clinical Flow Chart: Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)

Satisfactory Colposcopy: When no lesion or only biopsy-confirmed CIN I is identified after satisfactory colposcopy in women with HSIL Pap test reports, it is recommended that, when possible, a review of the cytology, colposcopy, and histology results be performed. If the review yields a revised interpretation, management should follow guidelines for the revised interpretation; if a cytological interpretation of HSIL is upheld or if review is not possible, a diagnostic excisional procedure is preferred in non-pregnant patients. A colposcopic reevaluation with endocervical assessment is acceptable in special circumstances such as when CIN 2 or 3 is not found in a young woman of reproductive age or during pregnancy when invasive cancer is not suspected.

Unsatisfactory Colposcopy: When no lesion is identified after unsatisfactory colposcopy in women with HSIL, a review of the cytology, colposcopy, and histology results should be performed when possible. If the review yields a revised interpretation, management should follow guidelines for the revised interpretation. If a cytological interpretation of HSIL is upheld, review is not possible, or biopsy-confirmed CIN I is identified, a diagnostic excisional procedure is recommended in non-pregnant patients. Ablation is unacceptable.

Referral and Billing

Women do not need Presumptive Eligibility for this procedure as a ***diagnostic procedure only***. Once the medical advisor for the program and the Program Director authorize the services as a diagnostic procedure, the appointment can be scheduled.

The following are the CPT codes associated with LEEP as a diagnostic procedure.

CPT code	Description
57522	Loop electrode excision
57522F	Facility payment for LEEP
88305	Biopsy of the cervix
88307	Surgical pathology evaluation
85025	Complete CDC
81001	Urinalysis
84703	Qualitative hCG
36415	Venipuncture
00400	Anesthesia

If the specimen is sent to a pathology lab that is not a TBCSP provider or one that frequently turns the case over to collections (Quest, Lab Corp) the facility performing the LEEP should bill for the procedure and pay the appropriate lab.

Women who have a confirmed diagnosis **where a LEEP is recommended for treatment**, must be enrolled through presumptive eligibility in TennCare.

TBCSP Guidelines for HPV Screening

March 2007

POLICY:

Menopausal and post menopausal women * enrolled in TBCSP may be tested for HPV when the screening Pap test result is ASCUS. Follow the Family Planning guidelines for HPV testing on younger women before referral to TBCSP for colposcopy.

DISCUSSION:

Human Papillomavirus (HPV) has been associated with the development of cervical intraepithelial neoplasia (CIN) and invasive cancer of the cervix. Recent prospective studies have shown that patients with abnormal Pap smears and HPV positive for high-risk types are much more likely to have CIN 2, 3 and cervical cancer than patients with abnormal Pap smears who are negative for high-risk HPV types.

HPV testing has been proposed as an adjunctive test in women with ASC-US to identify those at high-risk for cervical cancer, who should go on to receive definitive colposcopy. HPV testing of women with ASC-US can be used to identify women at highest risk of underlying cervical dysplasia, and minimize the number of unnecessary colposcopic examination in women who have no disease.

Younger women often clear the disease on their own; TBCSP follows the Family Planning guidelines by not accepting referrals until the recommended time period has passed and repeat testing indicates a continuing problem.

Medical research has indicated that older women with ASC-US Paps have about a 1 in 5 chance of having a positive HPV result. There is no benefit in waiting to run the HPV test for older women * with an ASC-US Pap result.

PROCEDURE:

1. Determine eligibility for cervical screening following program guidelines.*
2. If using conventional technique, perform the Pap test in conjunction with a pelvic exam. If the Pap test result is ASC-US, have the woman return promptly for high risk HPV testing.
3. If liquid based technique is used, perform the Pap test. If the Pap is ASC-US, the lab should test for high risk HPV; if it has not been done, request high risk HPV testing.

Women, who have an ASC-US Pap result and test positive for HPV, whether using the conventional or liquid based technique, should be referred for colposcopy.

*** In general, TBCSP establishes age forty (40) as the age of eligibility for women needing cervical cancer screening. Clinics do not have to institute special procedures or questions to determine if a woman is menopausal or not. Simple self-declaration of menopausal status is sufficient.**

MANAGEMENT:

Menopausal and post menopausal women with a test result of ASC-US and negative test for high risk HPV, refer for Pap tests according to the annual schedule.

Menopausal and post menopausal women with a test result of ASC-US and positive test for high risk HPV, refer for a colposcopy.

It is not necessary to wait a prescribed amount of time between the ACS-US Pap result and the HPV typing for the menopausal or post menopausal woman.

Women with medical history of immunosuppression and index Pap test result of ASCUS, refer directly for colposcopy. HPV status will not help determine need for colposcopy.

REIMBURSEMENT:

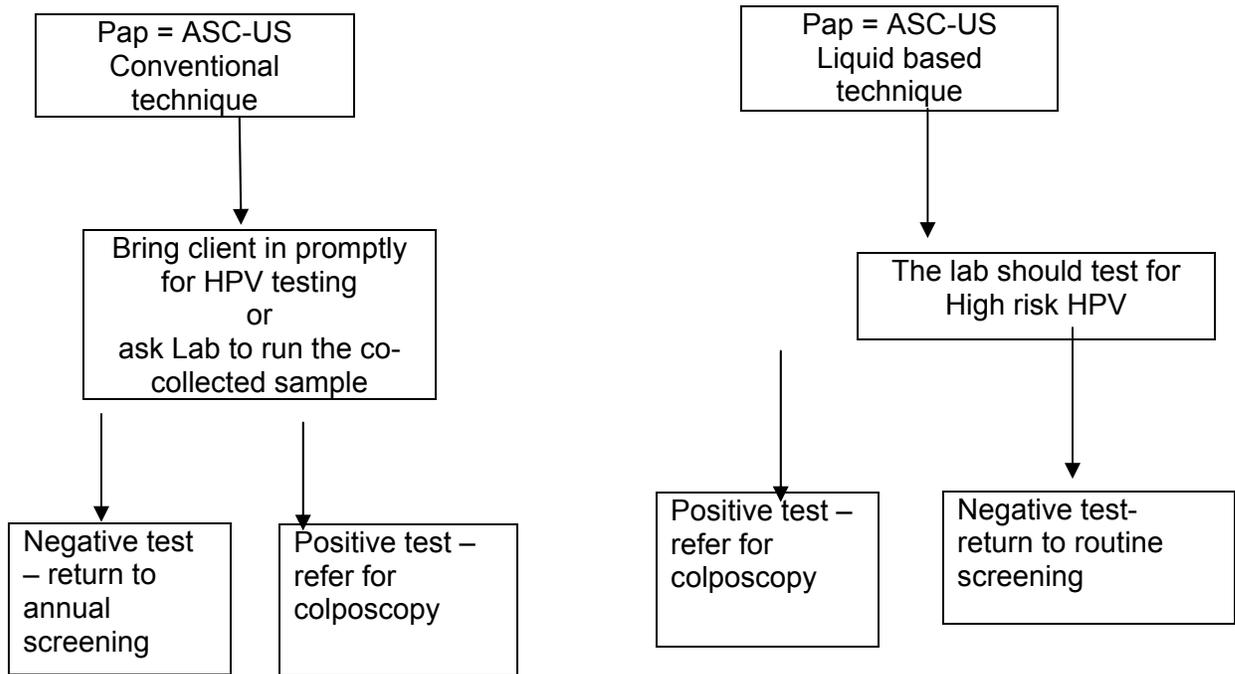
Clinics that use the liquid based technique will **only be reimbursed once every two years** according to CDC policy.

HPV typing is not allowed for all liquid based technique Pap tests – only for those that have an ASC-US result.

Reimbursement will be made according to the state adjusted Medicare rates as listed on the TBCSP Fee Schedule.

Management of Menopausal and Post Menopausal Women with an ASC-US Pap Result

TN Breast and Cervical Screening Program
March 2007



PROGRAM MATERIALS

BREAST ALGORITHMS

ALGORITHM #1 - PALPABLE MASS - SOLID OR INDETERMINATE

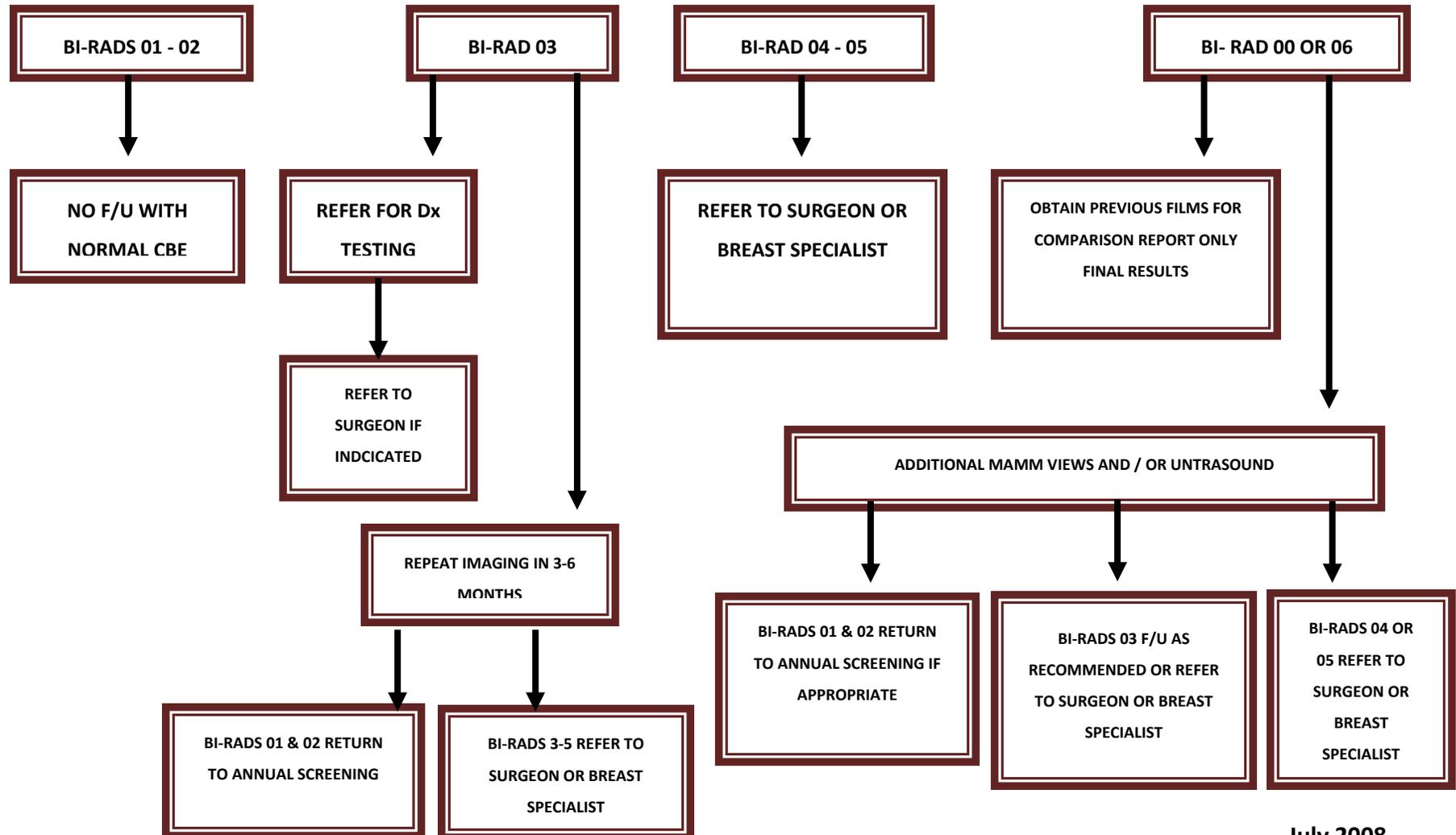


IF A MASS HAS NOT RESOLVED WITHIN A 30 DAY PERIOD FROM INITIAL FINDING, REGARDLESS OF MAMMOGRAM RESULTS, THE PATIENT MUST BE REFERRED TO A SURGEON OR BREAST SPECIALIST FOR ADDITIONAL EVALUATION.

Note: Modified from California Department of Health Services, CBE Algorithms, 2005

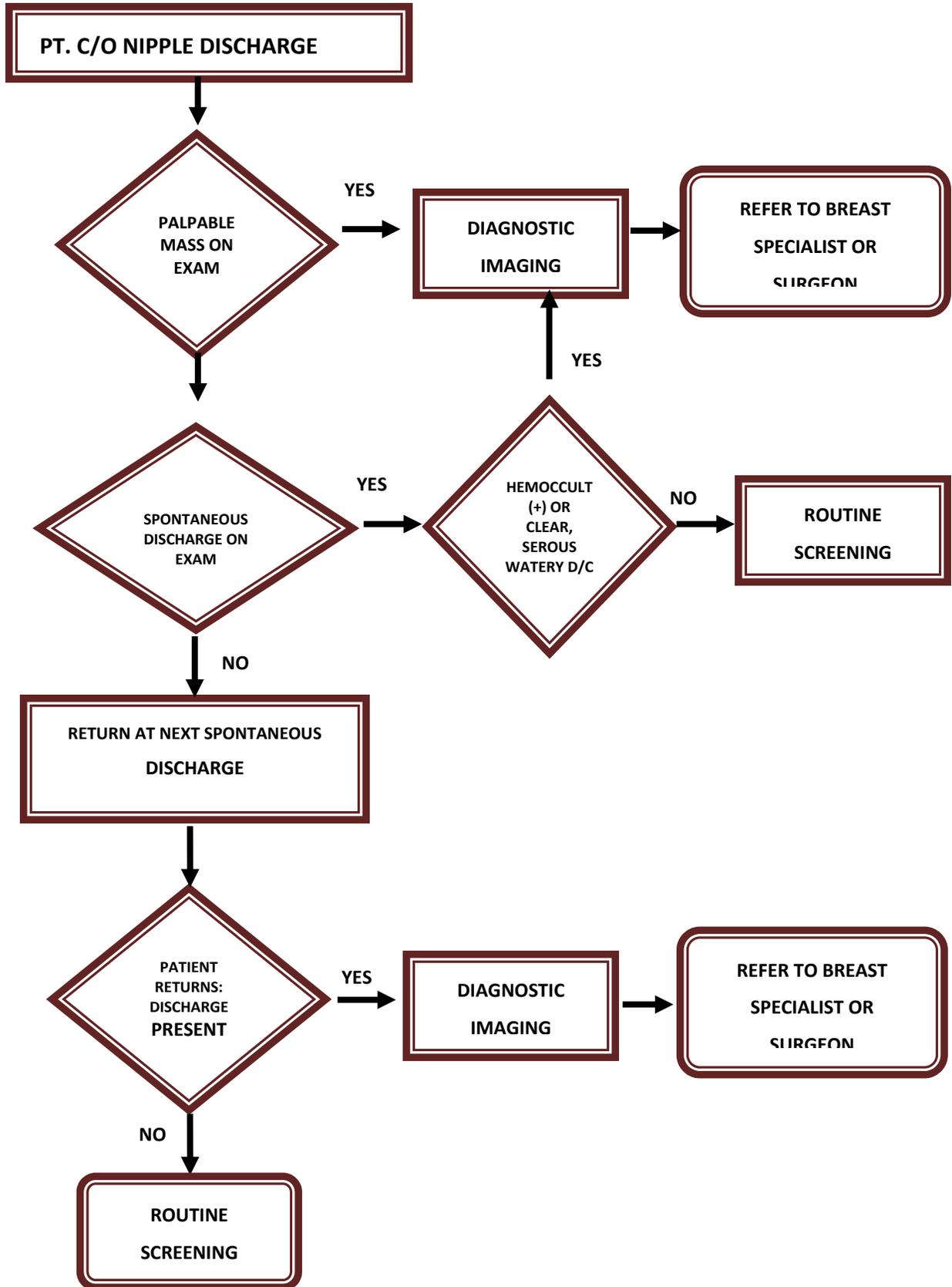
ALGORITHM #2 - MANAGEMENT OF WOMEN WITH ABNORMAL MAMMOGRAMS AND NORMAL CLINICAL BREAST EXAM

Note: Modified from California Department of Health Services CBE ALGORITHMS, 2005.
(See Attachment)



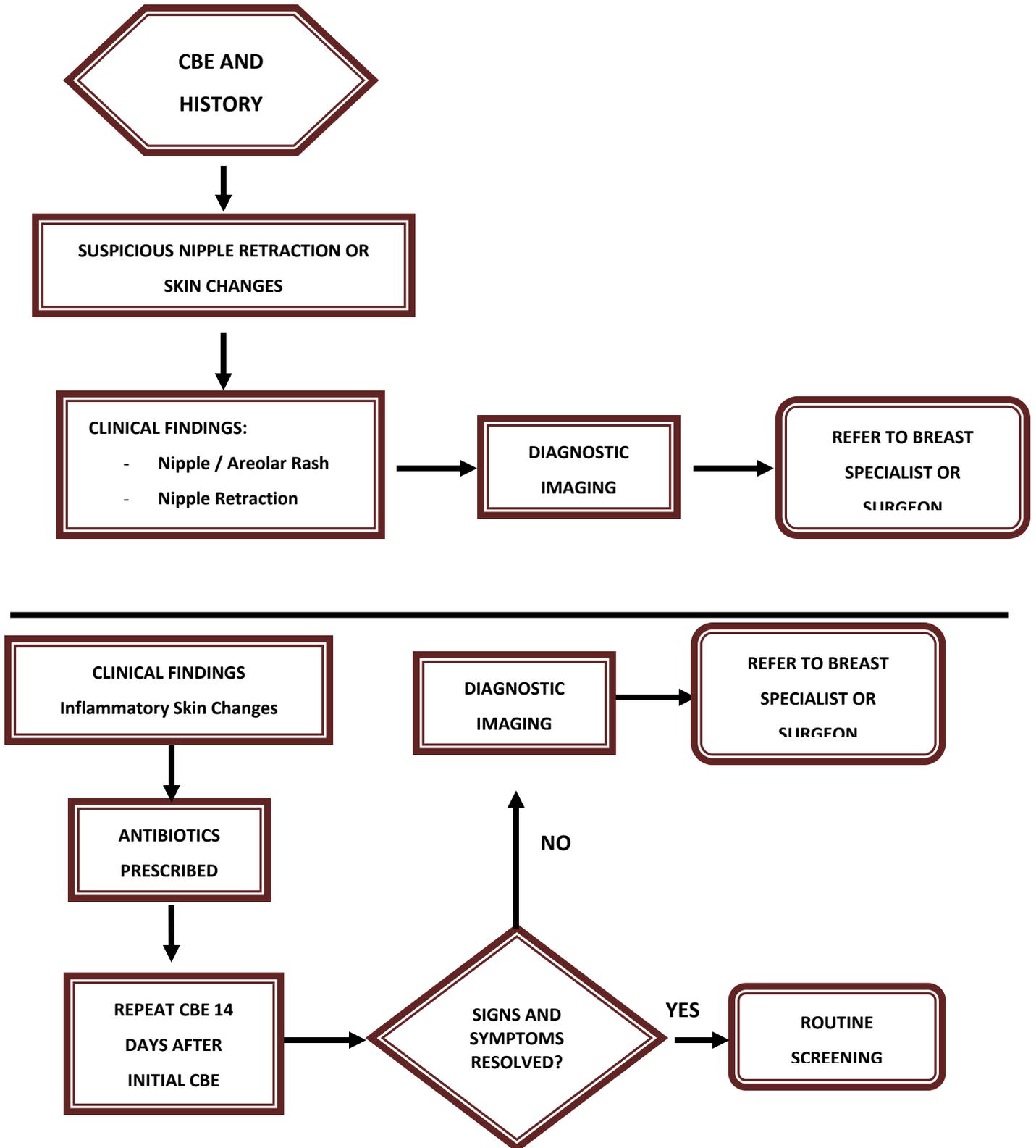
July 2008

ALGORITHM #3 - SPONTANEOUS UNILATERAL NIPPLE DISCHARGE

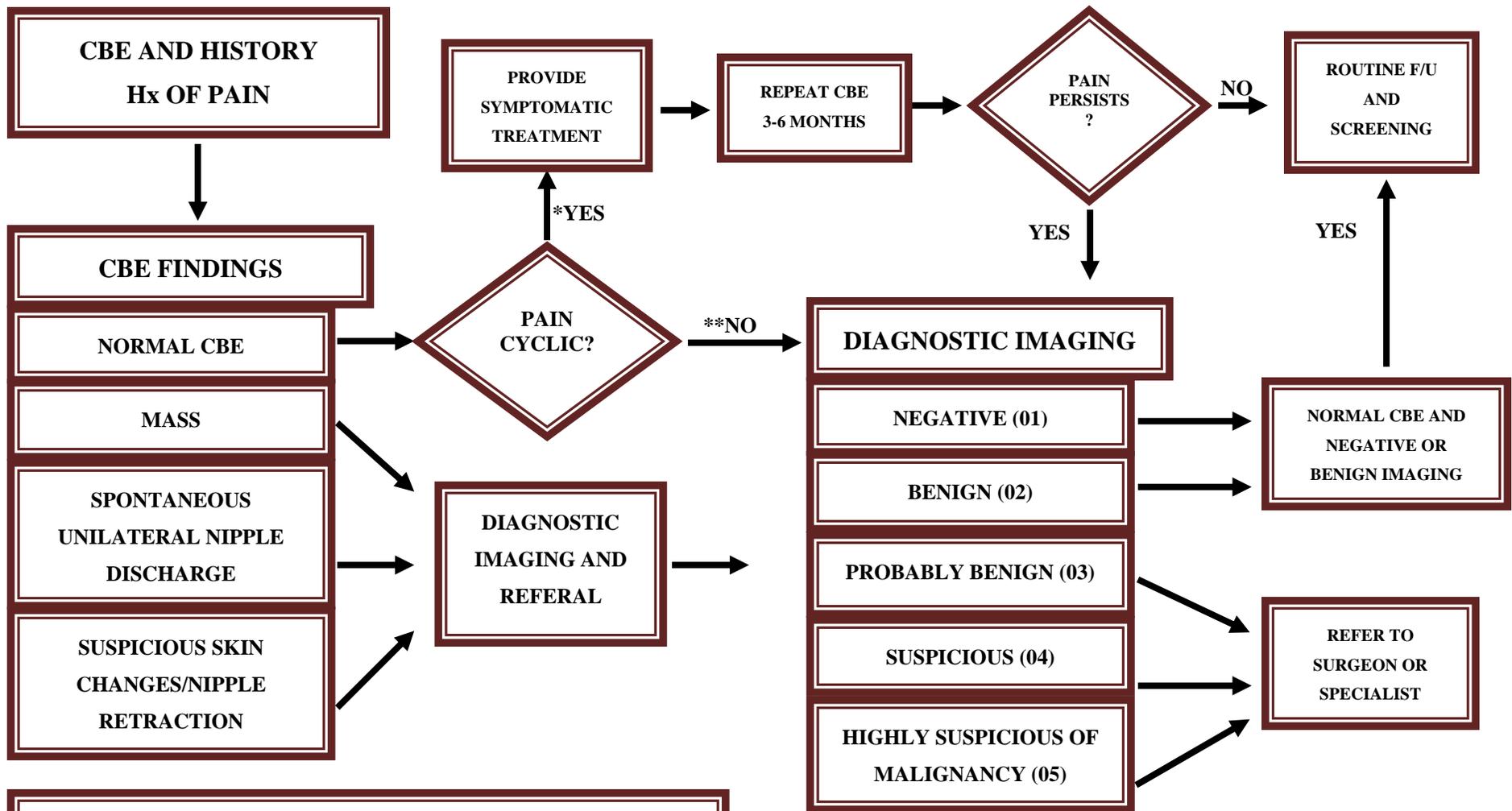


ALGORITHM #4 - NIPPLE RETRACTION / BREAST SKIN CHANGES

Note: Modified from California Department of Health Services CBE ALGORITHMS, 2005.



ALGORITHM #5 - BREAST PAIN (NON – LACTATING WOMAN)



***Cyclic Pain:** Typically bilateral and patient describes as diffuse, full, dull, achy and/or heavy.

****Non-Cyclic Pain:** Typically unilateral and patient describes as sharp, localized, throbbing, burning, and/or stabbing.

Note: Modified from California Department of Health Services
CBE ALGORITHMS, 2005.

July 2008

Public Health Use Only

ACS Reach to Recovery Program Can

Contact Me: Yes

Signed : _____

Date : _____

State Office Use Only

Case #: _____

Program Code: _____

**PRESUMPTIVE ELIGIBILITY SCREENING GUIDE
(Breast or Cervical Cancer)**

Diagnosis: _____ Verified: Yes

Date of Diagnosis: _____

Name: _____

Address: _____

City: _____ County: _____ Zip: _____

Phone Number: _____

Date of Birth: / / Social Security Number: - -

Estimated Income: _____

Medicaid Category: _____ MCO: _____

Eligibility Begin Date: / / Eligibility End Date: / /

TBCSP Provider Signature: _____ Date: _____

This individual has been screened and found to be in need of treatment for breast/cervical cancer by a contracted provider of the Tennessee Breast/Cervical Cancer Early Detection Program (TBCSP)

The 2010 Poverty Guidelines for Tennessee

250% FPL

MONTHLY	ANNUAL
2,256	27,075
3,035	36,425
3,815	45,775
4,594	55,125
5,373	64,475
6,152	73,825
6,931	83,175
7,710	92,525

For families with more than 8 persons, add \$779/month or \$9350/year for each additional person.



AUTHORIZATION TO VENDOR

State Agency:	HEALTH	Program: TN Breast & Cervical Screening Program (TBCSP)	
Delegation # DP-11-31348-00	Edison Requisition # 21		Edison PO #
CFDA # 93.283	Account Code:		Speed Code: HL00000352

VENDOR INFORMATION

Vendor:	
Address:	
FEIN/SSN: <input type="checkbox"/> C – or <input type="checkbox"/> V –	Phone:
Edison Vendor #	

AUTHORIZATION

Service Authorized	Units Authorized	Unit Cost	Amount Authorized
TOTAL AMOUNT AUTHORIZED :			

Authorization Begin Date: July 1, 2010	Authorization End Date: June 30, 2012
State Authorization: (signature with printed name & title)	Vendor Acceptance: (signature with printed name & title)
NAME AND TITLE – Mary Jane Dewey, Program Director	NAME AND TITLE -

TERMS OF AUTHORIZATION

1. The Vendor agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of the authorized service or in the employment practices of the Vendor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.
2. The Vendor warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Vendor in connection with any work contemplated or performed relative to this Authorization.
3. The Vendor understands and agrees that this Authorization shall be null and void if the Vendor is, or within the past six months has been, a state employee or if the Vendor is an entity in which a controlling interest is held by an individual who is, or within the past six months has been, a state employee. For purposes of this provision, an individual shall be deemed a state employee until such time as all compensation for salary, termination pay, and annual leave has been paid. The Vendor further understands and agrees that this Authorization shall be null and void if the Vendor is a former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.
4. The State may terminate this purchase without cause for any reason, and such termination shall not be deemed a breach of contract by the State.
5. The Vendor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Vendor, its employees, or any person acting for or on its or their behalf relating to this purchase. The Vendor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this purchase or otherwise enforce the obligations of the Vendor to the State.

6. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Authorization, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Authorization.
 - a. The Vendor hereby attests, certifies, warrants, and assures that the Vendor shall not knowingly utilize the services of an illegal immigrant in the performance of this Authorization and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Authorization.
 - b. The Vendor shall maintain records for all personnel used in the performance of this Authorization. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.
 - c. The Vendor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a vendor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a vendor is discovered to have knowingly used the services of illegal immigrants during the performance of this Authorization.
 - d. For purposes of this Authorization, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Authorization.
7. Activities and records pursuant to this Authorization shall be subject to monitoring and evaluation by the State or duly appointed representatives.
8. The State is not responsible for the payment of services rendered without specific, written authorization.
9. The Vendor will submit an invoice in form and substance acceptable to the State to effect payment.

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number								

or

Employer identification number								

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.socialsecurity.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or single-owner LLC	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner ³
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

⁴ List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Tennessee Breast and Cervical Screening Program (TBCSP)

LETTER OF AGREEMENT (2009)

I, _____, representing
(Print Full Name)

(Print Name of Business)

have read and would like to serve as Primary Screening Provider (PSP) / Referral Provider / Both. (**circle the appropriate choice**). The following services will be provided for eligible participants as applicable for provider type (check all that apply):

- Breast Cancer Screenings – Data submitted within 30 days of service
- Cervical Cancer Screenings – Data submitted within 30 days of service
- Diagnostic Services – Data submitted timely to ensure Final Diagnosis determined within 60 days of initial abnormal screening.
- Fax data within 5 business days of Date of Service for patient's determined to have abnormal findings.
- Send diagnostic reports to the designated Primary Screening Provider. I understand that most primary screening providers are local health departments, primary care clinics or other non-profit clinics. Diagnostic reports will be sent in 60 days or less.
- Submit invoices in 60 days or less using HCFA 1500 and/or UB92 forms. I understand that any invoices not sent on these forms will be returned to my office for re-submission.
- Accept the payments as listed on the TBCSP fee schedule (attached) and write-off the balance. In accordance with Medicare rules, you cannot bill any participants in the program for the balance on any procedures or for CPT code services not on our fee schedule. TBCSP enrollees will not be turned over to collection agencies for outstanding claims.**
- I agree to accept reimbursement rates for CPT codes used by the program, which are set by the federal government and are reimbursed at 100% of the Medicare rate. However, I understand that the Medicare rate is adjusted annually, thus the reimbursement rate (although still 100% of the Medicare rate) is subject to change.
- Participate in quality assurance monitoring as scheduled by TBCSP, if requested.
- Maintain quality assurance/improvement activities in my facility to ensure that Program guidelines are being met.
- Follow TBCSP Program Guidelines on all enrollees who have abnormal screenings and case manage as needed to ensure the health and safety of each patient enrolled in the program.
- Ensure all employees involved with the program are in-serviced on the program to assure knowledge of patient eligibility for enrollment and program requirements.

_____ Provide written notification to the TBCSP Central Office of a change of physical or billing address within 30 days. In addition, any changes in Tax ID will be submitted to the Central Office within 30 days.

_____ Provide or accept a 60-day notice when a decision to terminate is made by either party.

_____ **Current copy of the State License for Facility and/or Doctor is attached.**

I fully understand and agree with all conditions evidenced by the information provided below:

PROVIDER (TAXPAYER NAME): _____

TAX ID#: _____

BUSINESS NAME (IF DIFFERENT): _____

PHYSICAL ADDRESS: _____

ADDRESS TO SEND PAYMENT IF DIFFERENT FROM ADDRESS LISTED ABOVE:

PAYMENT CODE (Please Check Appropriate Box):

GLOBAL TC 26

PHONE: (____) _____

FAX: (____) _____

SIGNATURE: _____

NAME (printed) _____

TITLE: _____

DATE: _____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37247

CHANGE OF PERSONAL/COMPANY INFORMATION FORM

SSAN#: _____ Or FEIN#: _____

Important- Please check one to specify whether you are:

a new vendor changing information adding another location, same tax ID

Name: _____

(list only the name associated with the tax id number)

Mailing Address: _____

Mailing Address: _____

City, State and Zip Code: _____

Phone Number: _____

Effective Date for this change: _____

Name: _____

(printed name of authorized representative)

Title: _____

(if applicable)

Prior information that is or may be on our current files. *

Name: _____

(list only the name associated with the tax id number)

Mailing Address: _____

Mailing Address: _____

City, State and Zip Code: _____

Phone Number: _____

Are you a TN state employee? Yes No If no, are you a former TN state employee?

Yes No If yes, please indicate separation

date _____

I, _____, verify the above information is complete and true.

(Signature of Vendor)

This information has been verified by Department Staff of _____

(Signature of Staff)

(Position)

(Date)

*Old information is not needed if this is to add an additional location. Only lines that are to be changed need to be filled out.
Example: To change PO Box at same office, completely fill out new address and list old PO Box number on Mailing address line. Please contact Ruma Purkayastha at (615) 253-3987, if you have any questions.

REIMBURSEMENT SCHEDULE – 2010

SPECIAL NOTES:

1. Medicare has discontinued the use of consultation CPT codes (CPT 99241-99244). Providers are to bill for consultation services using patient consultation office visit codes 99201-99205.
2. **CPT codes 99386 and 99387 should be used for New Patient Preventive Office Visit – breast and cervical component only.**
3. **CPT 99396 should be used for Established Patient preventive Office Visit – breast and cervical component only.**
4. Direct digital imaging screening and diagnostic mammograms (G0202, G0204 and G0206) will be reimbursed at the conventional screening mammogram rate.
5. The program will NOT reimburse for CAD according to national policy.
6. The program will NOT reimburse for MRI according to national policy.
7. The program is forbidden by federal law from paying for treatment.
8. The program does NOT reimburse for HER 2 or ER/PR lab tests since these tests are used to decide the treatment options for women with breast cancer.
9. The program does NOT provide or cover the payment of Pap tests for women under the age of 40.
10. The Program does NOT provide or pay for HPV screening for women under the age of 40.
11. TBCSP reimburses for HPV testing ONLY when the Pap test is ASCUS for women age 40 and older and for one year follow up when the original Pap test was LSIL.
12. Reimbursement for enrollment in the program (99080A) can only be charged once for the first year of enrollment by the screening provider. If the woman comes back for rescreening the next year and still meets eligibility requirements, you cannot charge 99080A again.
13. Case management consists of those activities that are over and above the usual and customary activities involved in assuring that a patient receives the necessary diagnostic services to reach a final diagnosis. Reimbursement for case management (99080B) can only be charged by the screening provider.
 - a. A maximum of three (3) case management charges can be billed for a cycle.

Case management can only be charged for cases with abnormal screening results that need follow up diagnostics.

CPT Codes

Based on Cahaba Government Benefit Administrators, LLC - Tennessee, 2010

CPT Codes	BREAST SCREENING PROCEDURES	REVISED CY 2010
	DESCRIPTION	
77057	Bilateral Screening mammogram	71.45
77057 26	Professional Component	33.38
77057 TC	Technical Component	38.07
G 0202	Bilateral Digital Screening Mammogram	71.45
G 0202 26	Professional Component	33.38
G 0202 TC	Technical component	38.07
	BREAST DIAGNOSTIC PROCEDURES	
76645	Unilateral or bilateral Ultrasound	81.21
76645 26	Professional	25.81
76645 TC	Technical Component	55.40
77055	Diagnostic Unilateral Mammogram (global)	75.30
77055 26	Professional fee	33.38
77055 TC	Technical Component	41.92
77056	Diagnostic Bilateral Mammogram (global)	95.96
77056 26	Professional Component	41.53
77056 TC	Technical Component	54.43
G 0204	Diagnostic Digital Bilateral mammogram	95.96
G 0204 26	Professional Component	41.53
G 0204 TC	Technical component	54.43
G 0206	Diagnostic Digital Unilateral Mammogram	75.30
G 0206 26	Professional Component	33.38
G 0206 TC	Technical Component	41.92

CPT Codes	BREAST DIAGNOSTIC PROCEDURES	REVISED CY 2010
10021	FNA without Imaging guidance	119.65
10021 F	Facility Fee	55.18
10022	FNA with Imaging guidance	119.09
10022 F	Facility Fee	167.93
19000	Puncture aspiration of cyst	93.31
19000 F	Facility Fee	63.47
19001	Puncture aspiration each addt'l used with 19000	24.04
19001 F	Facility Fee	8.55
19100	Needle core breast biopsy no imaging guidance	118.92
19100 F	Facility Fee	178.26
19101	Open, incisional breast biopsy	272.83
19101 F	Facility Fee	400.00
19102	Needle core breast biopsy with imaging guidance	187.11
19102 F	Facility Fee	266.32
19103	Automated vacuum assisted biopsy	469.38
19103 F	Facility Fee	400.00
19120	Excision of cyst, fibroadenoma, duct or nipple lesion, etc.	400.07
19120 F	Facility Fee	400.00
19125	Excision of breast lesion identified by pre operative placement of radiological marker, open, single lesion	444.41
19125 F	Facility Fee	400.00
19290	Pre operative placement of needle localization wire, breast	138.54
19291	Pre Operative placement of needle localization wire, breast, each additional lesion	59.90
19295	placement metallic clip during breast biopsy	74.64
76098	Radiological Examination of surgical specimen	17.31
76098 26	Professional Component	7.79
76098 TC	Technical Component	9.52

	76942	Ultrasonic guidance for needle biopsy	163.43
	CPT Codes	BREAST DIAGNOSTIC PROCEDURES	REVISED CY 2010
	76942 26	Professional Component	32.00
	76942 TC	Technical Component	131.42
	77031	Stereotactic Localization for Breast Biopsy	154.12
	77031 26	Professional Component	76.27
	77031 TC	Technical Component	77.85
	77032	Preoperative Placement of Needle Wire	51.12
	77032 26	Professional Component	26.84
	77032 TC	Technical component	24.28
	88172	Evaluation of Fine Needle Aspiration	47.92
	88172 26	Professional Component	28.13
	88172 TC	Technical Component	19.79
	88173	Interpretation of Fine Needle Aspiration	120.83
	88173 26	Professional Component	64.79
	88173 TC	Technical Component	56.04
	88305	Breast Biopsy interpretation	92.67
	88305 26	Professional Component	35.03
	88305 TC	Technical Component	57.64
	88307	Breast excision of lesion requiring microscopic evaluation of surgical margins	190.12
	88307 26	Professional	74.73
	88307 TC	Technical component	115.38
	CPT Codes	MISCELLANEOUS CODE ASSOCIATED WITH DIAGNOSTICS PERFORMED IN A HOSPITAL UNDER GENERAL ANESTHESIA	REVISED CY 2010
	00400	Anesthesia up to 3 units at \$70.00 / unit	\$210.00 Max Allow

CPT Codes	CERVICAL SCREENING	REVISED CY 2010
87621	Hybrid capture II from Digene-HPV test (high risk typing only) used only for management of ASCUS pap tests and one year follow up for LSIL pap test	50.27
88141	Pap smear, requiring interpretation by Physician (conventional)	25.53
88142	Liquid based Thin Prep	29.02
88143	Liquid based Thin Prep with manual screening and rescreening under physician supervision	29.02
88164	Pap Smear, reported in Bethesda System under physician supervision	15.13
88174	Liquid based Thin Prep, automated screen method under physician supervision	30.60
88175	With screening by automated system and manual rescreen or review under physician supervision	37.22
CERVICAL DIAGNOSTICS		
57452	Colposcopy without Biopsy	96.44
57452 F	Facility Fee	41.00
57454	Colposcopy & Biopsy and endocervical curettage	137.45
57454 F	Facility Fee	50.50
57455	Colposcopy with biopsy only	126.82
57455 F	Facility Fee	53.00
57456	Colposcopy with endocervical curettage only	119.84
57456 F	Facility Fee	51.00
57505	Endocervical curettage - not done as part of a dilation and curettage	89.34
57505 F	Facility Fee	46.00
58100	Endometrial Sampling (biopsy) with or without endocervical sampling without cervical dilation	97.40
58100 F	Facility Fee	41.00
58110	Endometrial Sampling with colpo	42.58
58110 F	Facility Fee	37.81
88305	Biopsy Level IV	92.67
88305 26	Professional	35.03
88305 TC	Technical Component	57.64
88331	Pathology consultation during surgery single specimen	81.79
88331 26	Professional	56.55
88331 TC	Technical Component	25.24
88332	Pathology consultation during surgery each additional specimen	36.66
88332 26	Professional Component	27.78
88332 TC	Technical Component	8.88

CPT Codes	OTHER CODES	REVISED 2010
99080 A	New Enrollee Fee (one time only charge - Primary Screening Providers only)	10.00
99080 B	Case management and follow up of diagnostic referral and recommendations (Primary Screening Providers only)	20.00
OFFICE VISITS		
99201	Patient Office Visit for consultation (10 min)	35.88
99202	Patient Office Visit for consultation (20 min)	62.37
99203	Patient Office Visit for consultation (30 min)	90.48
99204	Patient Office Visit for consultation (40 min)	140.91
99205	Patient Office Visit for consultation (50 min)	177.53
99211	Established Patient Office Visit (5 min)	17.48
99212	Established Patient Office Visit (10 min)	35.88
99213	Established Patient Office Visit (15 min)	60.99
99214	Established Patient Office Visit (30 min)	91.58
99386	New Patient Preventive Office Visit; breast and cervical screening component only	32.38
99387	New Patient Preventive Office Visit; 46-60 minute breast and cervical component only	32.38
99396	Established Patient Preventive Office Visit: breast and cervical screening component only	32.38

SPECIAL NOTE:

Occasionally, a provider will bill for an office visit that is a higher code (longer time) than listed above. If this happens, pay at the highest rate available based on the type of office visit.

**ALL OF THE FOLLOWING CODES MUST BE PRIOR
APPROVED BY CENTRAL OFFICE**

	CPT Codes	ADDITIONAL CERVICAL DIAGNOSTICS	REVISED CY 2010
	57460	Endoscopy with LEEP	255.22
	57460 F	Facility Fee	153.00
	57461	Endoscopy with CKC	287.87
	57461 F	Facility Fee	164.00
	57500	Biopsy with fulguration no colpo	113.43
	57500 F	Facility Fee	70.00
	57520	Conization	271.28
	57520 F	Facility Fee	400.00
	57522	LEEP - diagnostic	233.80
	57522 F	Facility Fee	400.00
	88305 G	Biopsy interpretation	92.67
	88305 26	Professional	35.03
	88305 TC	Technical Component	57.64
	88307 G	Surgical Pathology	190.12
	88307 TC	Technical Component	115.38
	88307 26	Professional	74.73
	85025	Complete CBC	11.14
	81001	Urinalysis	4.54
	84703	Quantitative HCG	10.76
	36415	Venipuncture	3.00

TENNESSEE BREAST CANCER SCREENING TRANSMITTAL SHEET

(Sheet No. 2 - Revised January 29, 2009)

Diagnostic Workup Information:			
Additional Mammogram:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Results: 01 Negative (BI-RADS 1) 02 Benign finding (BI-RADS 2) 03 Probably benign – short term follow-up (BI-RADS 3) 04 Suspicious abnormality – biopsy (BI-RADS 4) 05 Highly suggestive of malignancy (BI-RADS 5) 06 Assessment incomplete/need additional imaging (BI-RADS 0) 07 Unsat – technically unsat/repeat 10 Results pending 11 Results unknown/presumed abnormal/mam from other source 13 Film Comparison required (BI-RADS 0)
Ultrasound:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	
Additional Ultrasound:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	
Film Comparison: Y Yes N No			
Film Imaging Outcome:	Result Date: _____ (MM/DD/CCYY)	1. Negative (BI-RADS 1) 2. Benign Finding (BI-RADS 2) 3. Probably Benign – Short interval follow up indicated (BI-RADS 3) 4. Suspicious Abnormality – Biopsy should be considered (BI-RADS 4) 5 Highly Suggestive of Malignancy – Take Appropriate action (BI-RADS 5) 7 Unsatisfactory – This applies if the additional imaging results was technically Unsatisfactory and final assessment could not be made. 8 Additional imaging pending.	
Additional Procedures	Procedure Date:	Result Date:	Results:
Repeat Breast Exam	_____ (MM/DD/CCYY)	_____ (MM/DD/CCYY)	1 Normal 2 Benign/no follow-up required 3 Discrete palpable mass – suspicious 4 Discrete palpable mass – benign 5 Bloody or serous nipple discharge 6 Skin dimpling or retraction 7 Needed but not performed 8 Not needed/not done – other reason
Biopsy	_____ (MM/DD/CCYY)	_____ (MM/DD/CCYY)	
Fine Needle Aspiration	_____ (MM/DD/CCYY)	_____ (MM/DD/CCYY)	
Physician Consultation	_____ (MM/DD/CCYY)	_____ (MM/DD/CCYY)	
Additional Physician Consultation	_____ (MM/DD/CCYY)	_____ (MM/DD/CCYY)	
Other Procedure code: 007 Stereotactic Localization 008 MRI 009 Metastatic Workup			
Diagnosis Disp:	1. Workup Complete 2. Workup Pending 3. Lost To Follow Up 4. Workup Refused 9. Irreconcilable	Diagnosis Date: _____ (MM/DD/CCYY)	<u>Final Diagnosis :</u> 2. Invasive Breast Cancer 3. Breast Ca not diagnosed 4. Lobular carcinoma in situ 5. Ductal carcinoma in situ
Treatment Disposition:	1 Treatment started 2 Treatment pending 3 Lost to follow-up (need date of l last contact) 4 Treatment refused 5 Treatment not needed	Treatment Date: _____ (MM/DD/CCYY)	

TENNESSEE CERVICAL CANCER SCREENING TRANSMITTAL SHEET

(Sheet No. 1 Screening - Revised FEBRUARY 5, 2009)

Patient's Information:

Enrollment Site: _____ Enrollment Date: _____ Date Sent: _____

Name: _____ DOB: _____ SS#: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Race: [W] [B] [O] Ethnicity: H – Hispanic Origin N – Not Hispanic Origin U – Unknown

Previous Pap? Y Yes N No U Unknown		Date of Previous Pap: This is very important for us to find women who have never had a Pap or if last Pap more than 5 years ago _____ (MM/CCYY)			
Reason for Pap Test: 5. Routine Pap Test 6. Patient under Surveillance. 7. Pap test done by referral doctor (Provide Date) 8. Not done. 9. Unknown.		REFERRAL/FIRST APPT DATE: If patient was referred in for diagnosis only, provide date of appt: _____ (MM/DD/CCYY)			
Pelvic/Rectal Exam:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Results: 1 Normal 2 Abnormal 8 Not indicated 9 Indicated/not provided		
Pap Smear:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Results: 1 Negative for lesion or malign 2 Atypical squamous cells 3 LSIL 4 Atypical squamous not excluding HSIL 5 HSIL 6 Squamous cell carcinoma 7 Abnormal glandular cells 8 Other * (Requires note) 11 Result pending 12 Result unknown, presumed abnormal	Spec Type: 1 Conventional 2 Liquid Based 3 Other 4 Unknown	Spec Adeq: 1 Sat 2 Unsat 3 Unknown
* Pap Result Other: (20 character of text) MUST PROVIDE A NOTE					
HPV Test:	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Results: 1 Positive 2 Negative 3 Test Not Done. 9 Unknown		
Workup Planned: Y Yes N No P Pending, not yet determined		Short Term Follow-Up: Y Yes N No		Next Screening Pap: 02 months 06 months 03 months 12 months 06 months 24 months	

**Note: Pap results of (4, 5, 6, 7, and 12) requires workup plan of (Y or P). If Workup Plan is (Yes), you have to fill out sheet number two for Diagnostics.
 Pap test result of "8" requires a note in the note field**

TENNESSEE CERVICAL CANCER SCREENING TRANSMITTAL SHEET
 (Sheet No. 2 Diagnostics - Revised FEBRUARY 5, 2009)

Patient Name: _____

Date: _____

Diagnostic Workup Information:			
Colpo with Biopsy and/or ECC: <p style="text-align: center; font-size: 1.5em;">(Y / N)</p> If Colpo with biopsy or ECC select Y If Colpo without biopsy or ECC select N If no Colpo is done leave blank	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Results: 1. Normal/benign reaction/inflammation 2. HPV/Condylomata/Atypia 3. CIN I/ Mild dysplasia 4. CIN II/ /Moderate dysplasia 5. CIN III/ Severe dysplasia 6. Invasive Cervical Carcinoma 7. Other * (Requires note) 8. Low Grade SIL 9. High Grade SIL
Loop Electrosurgical Excision (LEEP)	Procedure Date: _____ (MM/DD/CCYY)		
Cold Knife Cone:	Procedure Date: _____ (MM/DD/CCYY)		
Endocervical Curettage Alone (ECC): provide date if only an ECC was done but no colpo was done	Procedure Date: _____ (MM/DD/CCYY)		
Other Procedure: 012 Endometrial Biopsy 008 Excision of Endocervical Polyps 007 Gynecologic Consultation	Procedure Date: _____ (MM/DD/CCYY)	Result Date: _____ (MM/DD/CCYY)	Enter Result from above list:
Diagnosis Disp: 1. Workup Complete 2. Workup Pending 3. Lost To Follow Up 4. Workup Refused 5. Irreconcilable (9 can ONLY be used for cases where there is no sufficient way to translate the clinical scenario. Eg. Clinician schedules for short term F/U instead of immediate diagnostic work up.)	Diagnosis Date: _____ (MM/DD/CCYY)	<u>Final Diagnosis</u> 1. Normal/benign reaction/inflammation 2. HPV/Condylomata/Atypia 3. CIN I/ Mild dysplasia 4. CIN II/ /Moderate dysplasia 5. CIN III/ Severe dysplasia 6. Invasive Cervical Carcinoma 7. Other * (Requires note) 8. Low Grade SIL 9. High Grade SIL	
Final Diagnosis Other: (20 character of text):			
Treatment Disposition: 1 Treatment started 2 Treatment pending 3 Lost to follow-up (need date of last contact) 4 Treatment refused * 5 Treatment not needed	Treatment Date: _____ (MM/DD/CCYY)		

***Use only when MD decided that treatment was not needed at this time (doctor discretion, pregnancy, late stage diagnosis and no treatment due to quality of life, etc.)**