



TENNESSEE BREAST AND CERVICAL SCREENING PROGRAM

PROGRAM MANUAL

Revised

APRIL 2014

TABLE OF CONTENTS

Section 1	INTRODUCTION	
	Overview.....	1 – 1
	TBCSP Roles and Responsibilities.....	1 – 3
	The Medical Advisory Committee.....	1 – 4
Section 2	ELIGIBILITY GUIDELINES	
	General Eligibility Guidelines.....	2 – 1
	Determining Income Status.....	2 – 1
	Breast Screening Eligibility.....	2 – 2
	Cervical Screening Eligibility.....	2 – 2
	Special Cervical Screening Circumstances	2 – 3
	Women Who are Not Eligible	2 – 4
	Special Target Groups.....	2 – 4
Section 3	PRESUMPTIVE ELIGIBILITY GUIDELINES FOR TREATMENT TDH	
	Presumptive Eligibility Guidelines.....	3 – 1
	Enrollment of Women Diagnosed by TBCSP.....	3 – 2
	Enrollment of Women NOT Diagnosed by TBCSP.....	3 – 2
	Presumptive Eligibility.....	3 – 3
	Presumptive Eligibility for Inconclusive Diagnosis.....	3 – 3
	Medical Record and Case Management	3 – 3
	TennCare Eligibility.....	3 – 4
	Annual Verification of Treatment.....	3 – 5
	TennCare Bureau Statement on Coverage.....	3 – 6
	PE Process Flow Chart – Breast	3 – 7
	PE Flow Chart – Cervical.....	3 – 9
	Yearly Anniversary Approval Process.....	3 - 10
	TennCare Appeal Process.....	3 - 11
	DHS Presumptive Eligibility Guidelines and Form.....	3 –17
	PE Form.....	3 – 18
Section 3 a	Interim Guideline Exceptions to PE Process	
Section 4	SCREENING PROVIDER ROLE AND RESPONSIBILITIES	
	Provider Requirements.....	4 – 1
	Program Enrollment.....	4 – 2
	Client Education.....	4 – 2
	Visit Types – Initial Visit.....	4 – 3
	Annual Established Patient Visit.....	4 – 3
	Outside Referral by TBCSP for Special Services.....	4 – 3
	Referral to TBCSP after an Abnormal Screening.....	4 – 3
	Recordkeeping.....	4 – 3
	Tracking and Follow Up.....	4 – 4
	Women who are not following thru with referrals.....	4 – 5

TABLE OF CONTENTS

Breast Cancer Screening

Normal Results.....	4 – 5
Abnormal Results (CBE or Mammogram).....	4 – 5

Cervical Cancer Screening

Normal Results.....	4 – 6
Abnormal Results.....	4 – 6
Special Notes.....	4 – 6

Section 5

REFERRAL PROVIDER NETWORK

Program Requirements.....	5 – 1
Enrolling a Provider.....	5 – 1
Central Office Processing of a New or Renewing Provider.....	5 – 2
Mammography Providers	5 – 2
Laboratories.....	5 – 3
Referral for Additional Diagnostics.....	5 – 3
Reporting/Documentation Requirement.....	5 – 3
Communication and Consultation.....	5 – 3

Section 6

CONFIDENTIALITY & PATIENT INFORMATION

Standard Release Form.....	6 – 1
Informed Consent Form.....	6 – 1
Referral Form	6 – 1
Other Required Program Forms – Transmittal Sheets.....	6 – 1
Informed Consent Form – English.....	6 – 2
Informed Consent Form – Spanish	6 – 3
TBCSP PE Screening Guide (internal use)	6 - 4

Section 7

DATA COLLECTION

Screening Providers who are Local Health Departments.....	7 – 1
Screening Providers who are 330 sites.....	7 – 1
Required Submittal of Data to CDC.....	7 – 1
Data Entry Into PTBMIS.....	7 – 1
PTBMIS Commands.....	7 – 3
PTBMIS Cheat Sheets.....	7 – 4
PTBMIS Registration Screen.....	7 – 5
BCF Screens.....	7 – 9
CCF Screens.....	7 – 11

Section 8

CASE MANAGEMENT

Women with Abnormal Results of Cancer Diagnosis.....	8 – 1
Additional Circumstances for Case Management	8 – 1
Definition of Case Management	8 – 2
Minimum Required Follow Up – Cervical	8 – 3
Minimum Required Follow Up – Breast	8 – 4

TABLE OF CONTENTS

Section 9 QUALITY ASSURANCE

Methods for Conducting Quality Assurance..... 9 – 1

Standards of Care..... 9 – 2

Responsibility for Quality Assurance..... 9 – 2

Minimum Data Element Reports..... 9 – 2

Section 10 REIMBURSEMENT GUIDELINES

Reimbursable Services 10 – 1

Services Not Covered 10 – 1

General Reimbursement Guidelines..... 10 – 2

Covered Breast Services..... 10 – 2

Covered Cervical Services..... 10 - 3

Other Reimbursement Related Guidelines..... 10 – 3

PTBMIS Managed Care System for Processing Claims..... 10 – 4

Esupplier, Steps to Create Online Account 10 - 5

Instructions For Managed Care Authorization 10 – 8

Section 11 OTHER REQUIRED PROGRAM COMPONENTS

Professional Education..... 11 – 1

Public Education and Outreach..... 11 – 1

Coalitions and Partnerships..... 11 – 2

TN Cancer Coalition (TC2)..... 11 – 2

Susan G. Komen for the Cure Affiliates 11 – 2

Reach to Recovery Program of ACS 11 – 3

APPENDICES

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.

Chapter 1 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 to 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.

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 receive the 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

March 2014

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 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
 14. identify counties that will provide the service

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 participating women 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; they serve on a voluntary basis. These members 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 Medical 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 Services Director 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, based on funding availability, 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. The annual FPL is normally received by March each year. The FPL chart is sent electronically to the regional coordinators when Central Office receives 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 at or below 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 21 – 39** who meet general eligibility guidelines may be enrolled in TBCSP if they need further diagnostic services **after the initial Pap results are received.*** TBCSP does not pay for initial Pap but may pay for 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

TBSCP will only cover Pap tests following ASCCP guidelines.

Routine screening is defined as - "Cotesting every five (5) years (Pap test with HPV High Risk panel) or Pap testing alone every three (3) years."

Women are considered high risk and in need of screening who have had a hysterectomy due to cervical neoplasia or cervical cancer, exposed to DES in-utero, are immunocompromised due to HIV infection, organ transplantation or any immunocompromising disease.

The exact screening methodology and screening intervals are not clearly outlined. The science on screening for these women is limited. Most recommendations only state that high-risk women should be screened more often. Because evaluations of women who have had cervical cancer is really more of a surveillance than a screening, CDC has a separate policy stating that these women should be followed indefinitely. The type of follow-up will often be determined by the provider according to the extent of the cancer.

If the reason for the hysterectomy cannot be documented, routine screening with Pap testing every 3 years or cotesting every 5 years is appropriate.

Following spontaneous regression or appropriate management of CIN2, CIN3 or adenocarcinoma in situ, routine screening should continue for at least 20 years even if this extends screening past age 65 years. Routine screening is defined as - "Cotesting every five (5) years (Pap test with HPV High Risk panel) or Pap testing alone every three (3) years."

- Women 30 – 64 years with a normal Pap result but an abnormal HPV result should have either 1) repeat cotesting in 12 months or 2) immediate HPV genotyping for HPV 16 and 18. At this time, CDC policy does not allow reimbursement for HPV genotyping. The women should NOT be referred directly to colposcopy. If the 12 month repeat cotesting is positive, the women should be referred to colposcopy.
- If the 12 month repeat cotesting is negative, the women should be screened again with cotesting in 5 years.

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 it has been 2 or more years since last mammogram.
 - For cervical cancer = never or it has been 5 or more years since last Pap test.

SECTION 3 PRESUMPTIVE ELIGIBILITY (PE) 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. The Presumptive Eligibility Screening Guide Form (PE Form), (page 3-17) is faxed to TN Health Connection at 1-855-315-0669.

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 need of treatment.**

“Needs Treatment” is defined as a woman in “need of cancer treatment services. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Woman who are determined to require only routine monitoring services for a precancerous breast or cervical condition are not considered to need treatment.” (CMS Guidance)

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 PE Form and fax to TN Health Connection at 1-855-315-0669.
3. Give the woman one copy and keep original form for the medical record.
4. Provide TennCare advocacy and case management until TennCare enrollment is completed and treatment is started.
5. Educate the woman to go Online at www.healthcare.gov, or If the woman needs to use a computer to apply for TennCare Medicaid through the Health Insurance Marketplace, her local DHS office will have one she can use (See Page 3-5), or
 - a). By phone at 1-800-318-2596 – DHS also has phones for enrollment or
 - b). Assistance from one of the following *Navigator* agencies:
 - Get Covered TN Consumer Assistance (Seedco): 1-866-720-1711
 - Tennessee Primary Care Association: 1-800-343-3136
6. Educate the woman that if she needs to make changes to her address, name, income, or the number of people in her household or have questions about the TennCare program, call the Tennessee Health Connection at 1-855-259-0701.
7. For non-TennCare related services (e.g. food stamps, families first, childcare, etc) inform woman that she must contact her local Department of Human Services.
8. Educate client on the American Cancer Society Reach 2 Recovery Support, complete the area on the form “Yes” or “No” and fax to Central Office at 615-741-3806.
9. **(Temporary Process)** - Scan and send secure PE Form electronically to Frances Neal at TennCare (IT Approval) or fax to 615-532-5236.

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 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 PE Form and fax to TN Health Connection at 1-855-315-0669.
5. Provide the woman one copy and keep the original form for the medical record.
6. See 5-9 in above section (Page 3-2).
7. Provide TennCare advocacy and case management until TennCare enrollment is completed and treatment is started.
8. **(Temporary Process)** - Scan and send secure PE Form electronically to Frances Neal at TennCare (IT Approval) or fax to 615-532-5236.

Presumptive eligibility

Presumptive eligibility starts the day the regional or local coordinator completes the Presumptive Eligibility Form and faxes it to TN Health Connection; coverage lasts 45 days from that date. The woman MUST go to the Healthcare.gov site or call 1-800-318-2596 for assistance to enroll.

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.

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.

TennCare Eligibility:

After completing presumptive enrollment, advise the woman that she must go to the Healthcare.gov website or call 1-800-318-2596 as soon as possible.

The PE information will be input by Health Connections and a letter will be sent out by TennCare advising the patient to have Treatment Plan completed and returned to TennCare within 30 days from the date of the letter. (See Page 3-??? For Letters)

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

******Review per TENNCARE- IN PROCESS******

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

1. Advise her of her appeal 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 enroll 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

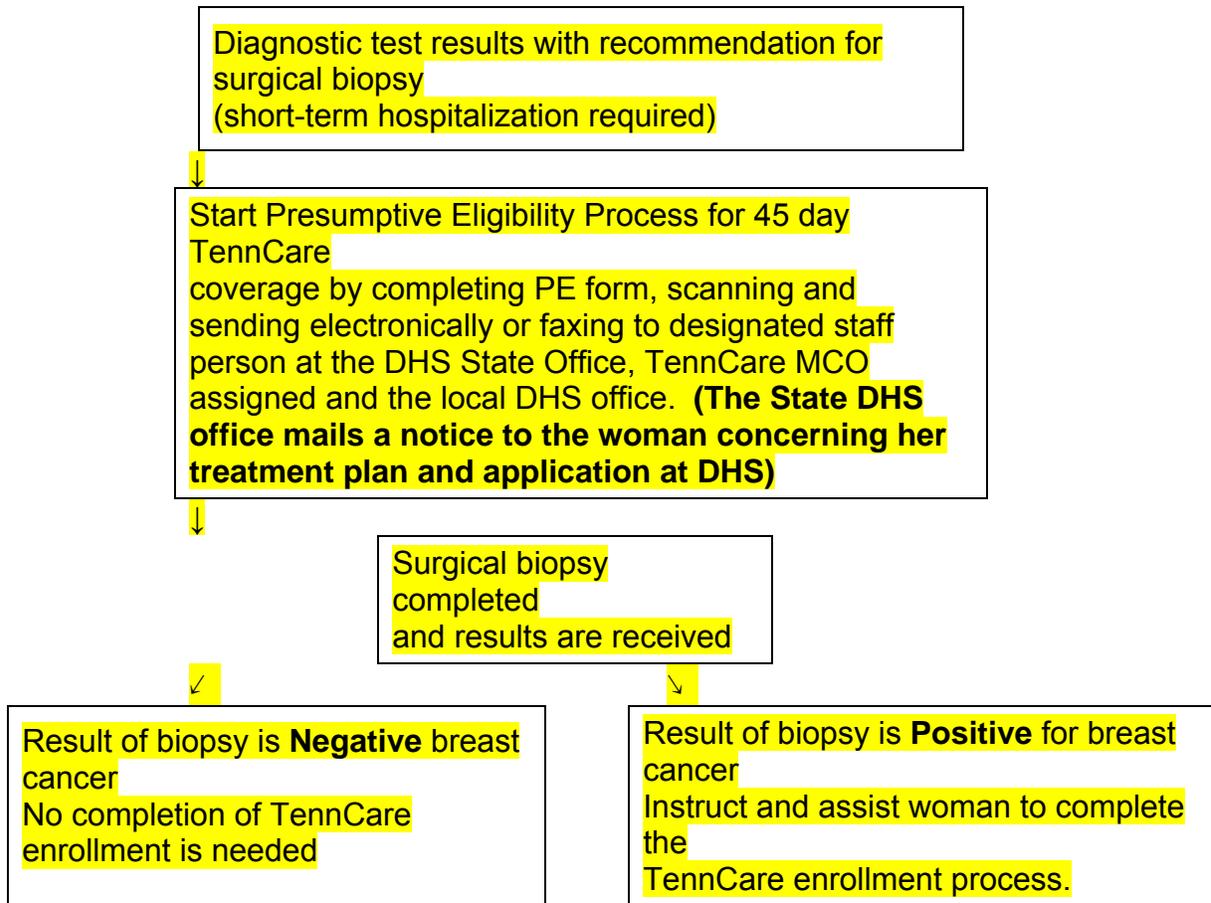
None

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) 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 needed will be covered by that category of TennCare.

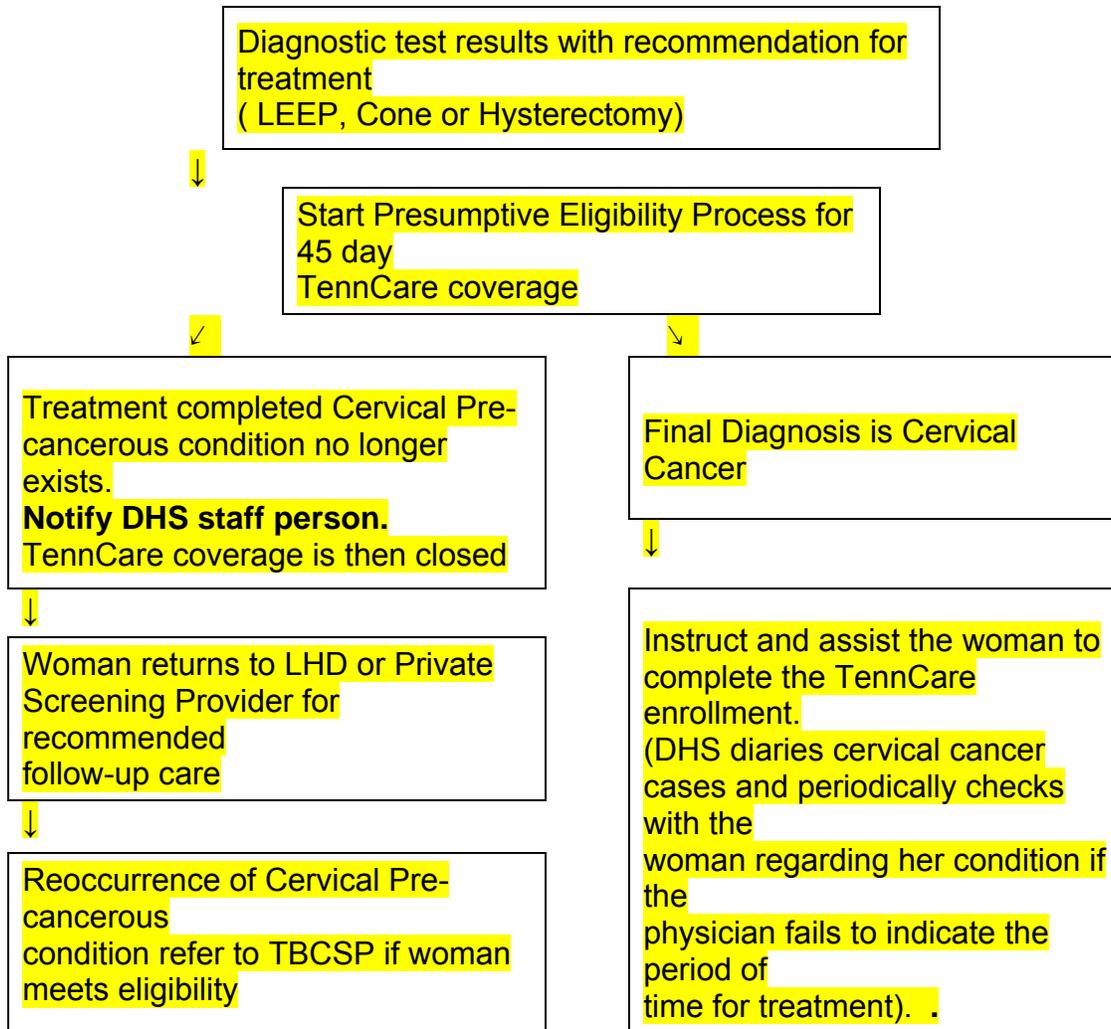
3) When the biopsy result is **negative**, you will notify the woman not to complete enrollment. No further treatment is indicated.

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 April , 2014



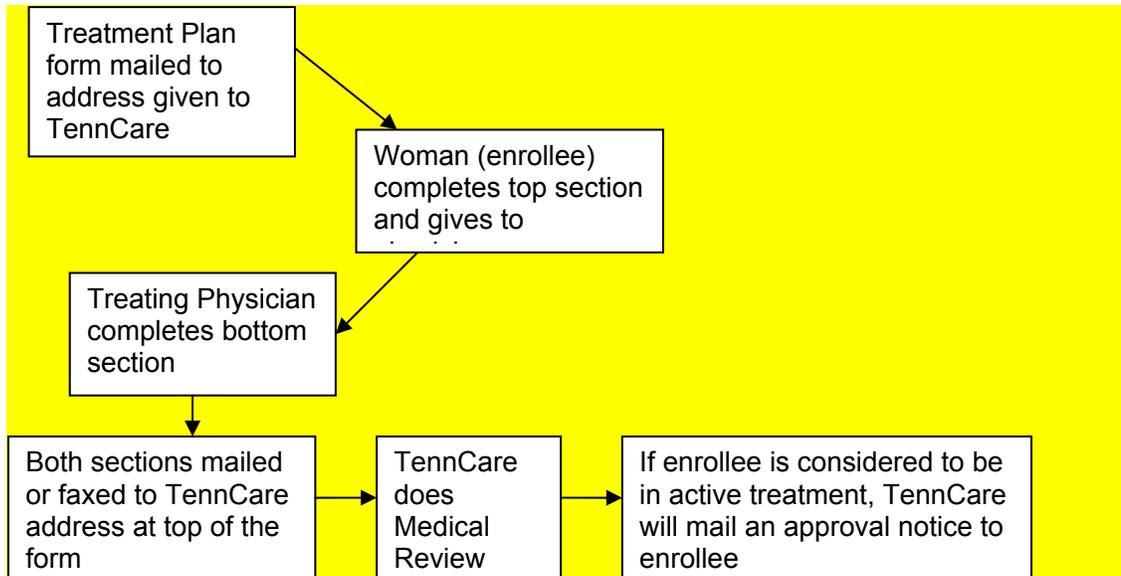
Instructions

- 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

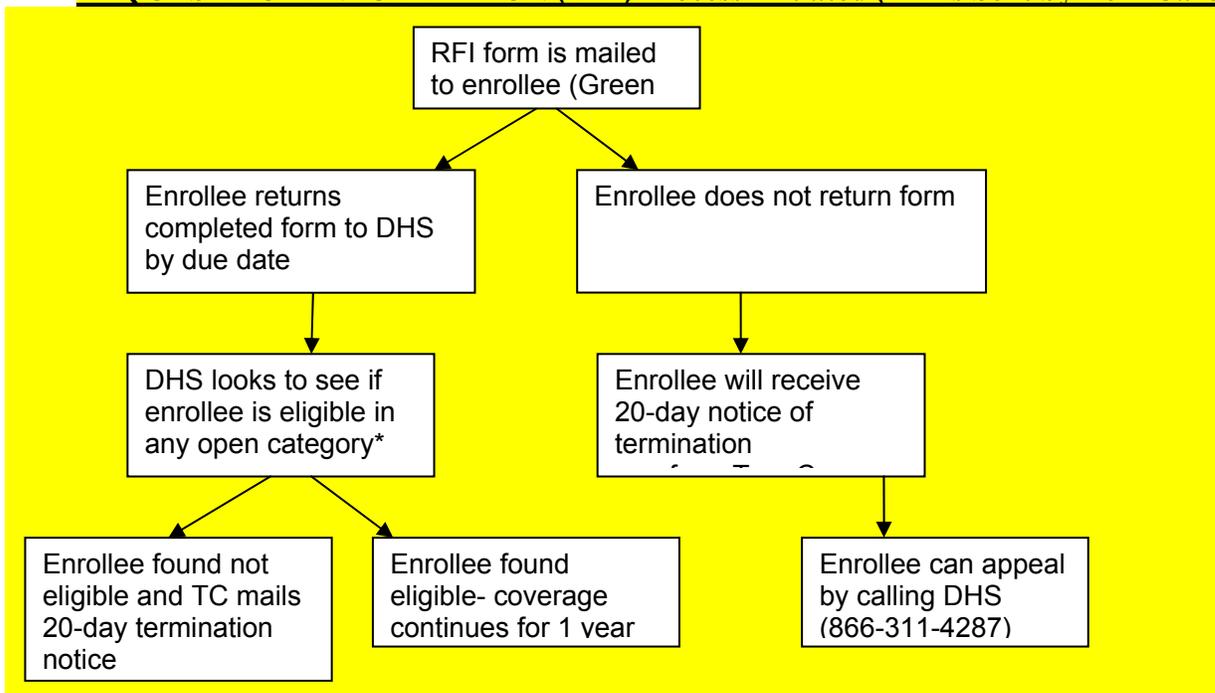
YEARLY ANNIVERSARY APPROVAL PROCESS

A Treatment Plan form will be mailed prior to the woman's one year anniversary date with TennCare to the address she (enrollee) gave to TennCare. **Treatment plan forms and questions about TennCare Coverage are sent to Frances Neal or current contact.**



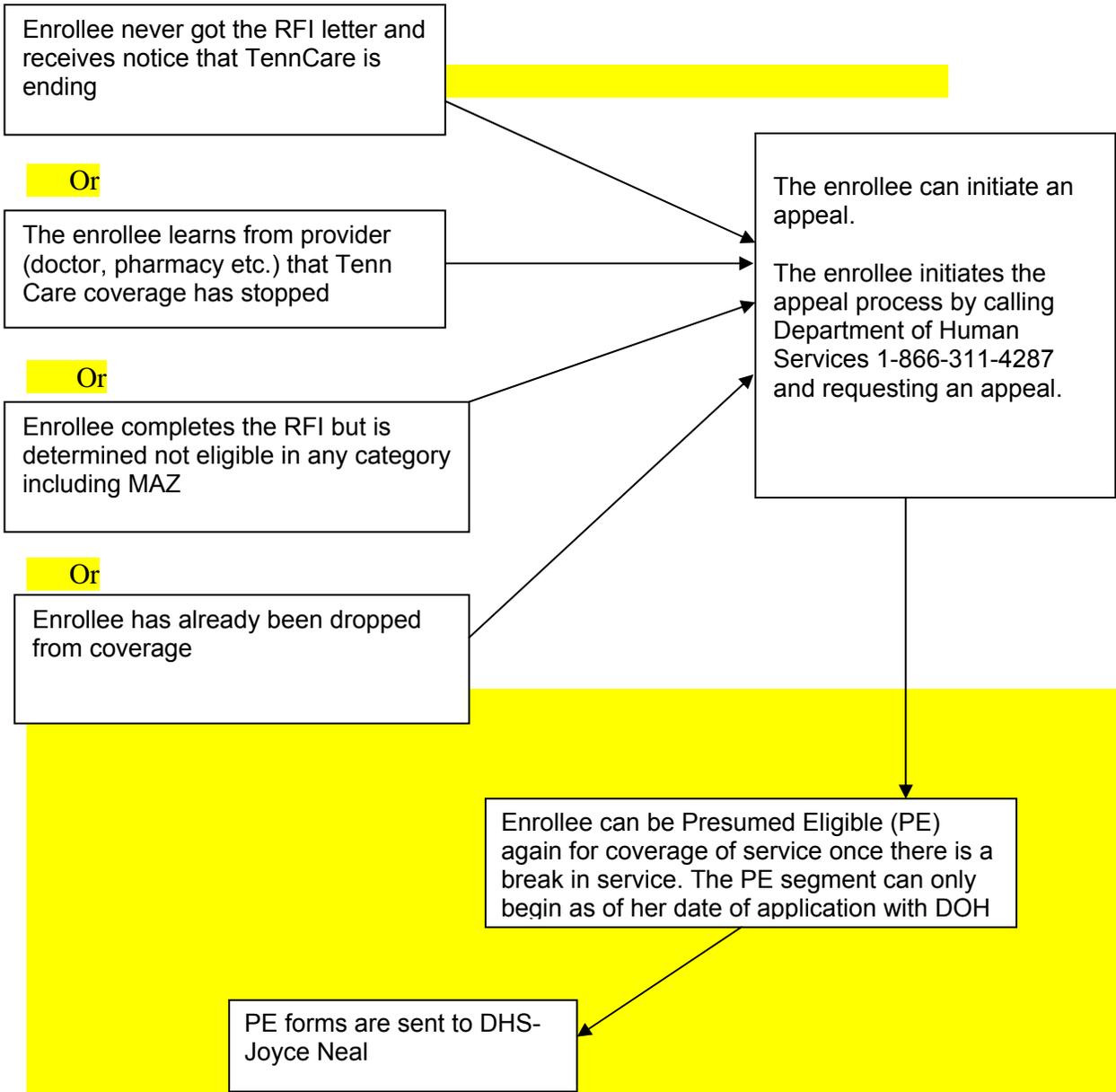
If form is not returned or the enrollee is no longer undergoing treatment for breast or cervical cancer, the RFI (Request for Information) Process is initiated Green Form.

REQUEST FOR INFORMATION (RFI) Process Initiated (RFI's Sent by TennCare Only)



* If the woman is still undergoing treatment for Breast or Cervical Cancer and is not 65 and does not have other insurance or Medicare and cannot be found eligible in any other Medicaid category, then the caseworker should advise that she submit her treatment plan form to TennCare as soon as possible. If the referral is sent to Joyce Neal at DHS, Joyce will research the case and send the form to Frances Neal at TennCare for a medical review.

APPEAL PROCESS



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

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.

Bulletin No. 20
06/07/2002

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 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 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).

Bulletin No. 20
06/07/2002

- (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.

Bulletin No- 20
06/07/2002

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.

Bulletin No. 20
06/07/2002

(**Insert Region**) REGION

Public Health Use Only
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: _____ **Treatment Plan Submitted** Yes NO

Name: _____

Address: _____

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

Phone Number: _____

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

Estimated Income: _____

Medicaid Category: **MAZ** **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)

1st Copy – State Office (FAX: 855-315-0669)

2nd Copy – Client

3rd Copy – County Office

Revised – March 2014

PATIENT INFORMATION
PRESUMPTIVE ELIGIBILITY TENNCARE

You Have Been Approved for
Breast and Cervical Cancer Presumptive Eligibility

Your Presumptive TennCare benefits should begin **today**. **Please do not schedule any procedures or surgery until your health care provider has verified your eligibility in the TennCare system.**

Your Presumptive TennCare benefits will end _____.
(insert date)

To ensure that you have TennCare Medicaid coverage beyond 45 days, you must apply for TennCare Medicaid as soon as possible.

Here are **three (3)** ways to apply for TennCare Medicaid:

1. Online at www.healthcare.gov, **or** If you need to use a computer to apply for TennCare Medicaid through the Health Insurance Marketplace, your local DHS office will have one you can use, **or**
2. By phone at 1-800-318-2596 and DHS can provide phone if needed, **or**
3. Assistance from one of the following *Navigator* agencies:
 - a. Get Covered TN Consumer Assistance (Seedco): 1-866-720-1711
 - b. Tennessee Primary Care Association:1-800-343-3136

If you need to make changes to your address, name, income, or the number of people in your household or have questions about the TennCare program, call the **Tennessee Health Connection** at **1-855-259-0701**.

For non-TennCare related services (e.g. food stamps, families first, childcare, etc) you must contact your local Department of Human Services



STATE OF TENNESSEE
HEALTH CARE FINANCE AND ADMINISTRATION
P.O. Box 305240
NASHVILLE, TENNESSEE 37230-5240

Do you need special help?
Call 1-855-259-0701 for free

RID
NAME
ADDRESS
CITY, ST, ZIP
Chapter 2

February 28, 2014

Chapter 3 We need information from you.

You've been approved for presumptive TennCare Medicaid because you said that you need treatment for breast and/or cervical cancer. Remember, you must file an application for TennCare very soon. The Department of Health gave you the due date for filing your application. If you don't file it by that date, it could be too late.

You can complete your application online at www.healthcare.gov. Or call the Health Insurance Marketplace at **1-800-318-2596** and ask them to send you one. You can also apply by phone at **1-800-318-2596**.

You're getting this letter because we need proof that shows you are in active treatment.
[Tenn.Comp.R&Regs. 1200-13-13-.02]

You can use the treatment plan that is included with this letter. It must be completed by your doctor who is treating you for breast or cervical cancer.

You have **until <30 DAYS>** to get it to us.

There are 2 ways to get this to us:

1. Mail it to: Tennessee Health Connection
Eligibility Operations
P.O. Box 305240
Nashville, TN 37230-5240
2. Fax it to: 1-855-315-0669
Be sure to keep the page that says your fax went through.

What if we don't get this from you by <30 DAYS>?

We won't be able to approve you for TennCare Medicaid in the Breast or Cervical Cancer Program. You can only get TennCare Medicaid this way if we have proof you are being treated for breast or cervical cancer.

Do you need help with this letter?

Is it because you have a health, mental health, or learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help, and we can help you. Call the Tennessee Health Connection for free at **1-855-259-0701**.

- **Do you have a mental illness and need help with this letter?**

The TennCare Advocacy Program can help you.

Call them for free at **1-800-758-1638**.

People who lie on purpose to get TennCare may be fined or sent to jail.

We do not allow unfair treatment.

No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you have been treated unfairly? Do you have more questions? Do you need more help? Call the Tennessee Health Connection for free at **1-855-259-0701**.



**Chapter 4 State of Tennessee
HealthCare Finance and Administration**

Breast or Cervical Cancer Treatment Plan Form

Please print the following information and mail or fax a signed copy to:

TennCare, Eligibility Operations, P.O. Box 305240, Nashville, TN 37230-5240, Fax: 1-855-315-0669

Patient's Full Name		Date of Birth		Social Security Number	
Street		City		State	Zip

Do you have health insurance? Yes No If yes, company name: _____
 Policy #: _____ Effective Date: _____ Type of coverage: _____
 Do you receive SSI and or Medicare? Yes No

Please have your treating physician fill out the portion below:

Is this patient currently under your treatment for the following condition or conditions?

Breast Cancer - Date of Diagnosis _____ AND/OR Cervical Cancer - Date of Diagnosis _____

If so, please answer the following regarding the current plan of treatment.

- Radiation Treatment.** If your patient is currently undergoing radiation treatment, please provide the information below:
 Number of treatments: _____ and the duration date expected is: _____.
- Chemotherapy Treatment.** If your patient is currently undergoing chemotherapy treatment, please provide the following: Number of treatments: _____ and the duration date expected is: _____.
- Planned Surgery.** If your patient is currently planned for surgery, please provide the information below:
 Type of surgery is _____ and planned date is _____.
- Completed Surgery.** If your patient has received surgery for Breast and/or Cervical Cancer, please provide the information below:
 Type of surgery was _____ and date completed was _____.
- Reconstruction Surgery.** If your patient is currently undergoing reconstructive surgery or has planned reconstruction surgery, please, provide the information below:

- **Hormonal Therapy.** If your patient is currently undergoing hormonal therapy, please provide the information below:
Type is _____, dose is _____, begin date is/was _____, and the expected completion date is/was _____.

**This information is required to determine if eligibility can continue.
Failure to return this form could result in loss of eligibility.**

Physician's Name: _____ Physician's TN License # _____
Office Phone Number: _____ Office Fax Number: _____
Office Address: _____

I certify that the above-named patient has been diagnosed with the medical condition listed. I understand that this information will be used to determine this patient's medical eligibility for Medicaid. I understand any intentional act on my part to provide false information that will potentially result in a person obtaining benefits or coverage to which she is not entitled is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act.

Physician's Signature: _____ Date: _____

Tennessee Breast and Cervical Cancer Screening Program

Coordinators:

Section 3 Presumptive Eligibility (PE) Guidelines for Treatment April 14, 2014

Please note that on Pages 6-22, the yellow highlighted areas indicate that TennCare staff is in the process of reviewing the material and changes will be provided upon their release to the TBCSP.

The blue highlights on Pages 2 and 3 are related to TennCare Advocacy and Case Management until the patient is verified in the TennCare system. Although the TBCSP staff had been informed that additional case management would not be required after enrollment in TennCare, reported numbers by TennCare indicate that women are not following-up as required to ensure enrollment in TennCare MAZ. Provision of case management after enrollment in PE TennCare is being re-evaluated and will be updated in the Manual at a later date.

This also, applies to Section 8, Page2, 4th bullet.

The bolded areas on Pages 2 (#9) and 3 (#8) indicate that scanning and/or faxing the PE Form to Frances Neal is a temporary measure.

There is no information related to start date of the Tennessee Eligibility Determination System (TEDS) at this time. The manual will be updated upon implementation of the system.

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. Screening Providers are considered the Medical Home for clients referred to TBCSP.

Providers Must:

1. Maintain current and applicable federal and/or state licenses
2. Agree to accept the program approved reimbursement rate 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 completed Transmittal Sheet with results to Central Office or affiliated Regional Coordinator if a 330 site
5. Provide appropriate and timely follow-up for all TBCSP participants according to TBCSP guidelines established by CDC.
6. Provide client education
7. Expand public education and community outreach to minority groups and the never or rarely screened woman by working with county partners.
8. Assess tobacco use for all women screened into the program and make appropriate referral (Quit Line) to smoking cessation services. (01/01/2011)
9. Comply with referral requirements regarding Affordable Care Act.

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)
- Screen returning clients to ensure eligibility criteria are met.
- Local health departments enter client 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 or affiliated Regional Coordinator 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.

Client 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 clients with the information necessary:

- To understand the screening procedures used in the detection of breast and cervical cancer
- To motivate the client 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)
- To understand the availability of preventative therapies as relates to Breast and Cervical Cancer. (HPV vaccine)
- Educate regarding Affordable Care Act (ACA)

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 Client Visit

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

Annual screening services include:

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

Outside Referral:

Refer Client 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
- Surgical Consult

Record Keeping

The TBCSP requires that a copy of all TBCSP reimbursed screening and diagnostic reports are placed in the client'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/medical home 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 clients with abnormal results.

The screening provider/medical home 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.
- 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 referral date.
- 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 or affiliated Regional Coordinator. **Women Who Do Not Follow Through with Referral Appointments**

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

- Make three attempts to contact client, 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 for two 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 or abnormal CBE 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 and comply with FDA/MQSA guidelines.
- 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. It must be stressed that the provider **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
- The TBCSP Letter of Agreement form
- The W -9 Tax Payer Identification Number form
- The Automatic Deposit form – also called the ACH form
- Authorization to Vendor Form

These forms and a “Change of Personal/Company Information Form” are included at the end of this section 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. Contracts are renewed every three (3) years.

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**
AND WORKSHEETS

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.

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.

Please note: All Forms with a PH # are obtained and ordered from Property, Planning and Assessment.

Other Required Program documents -Transmittal Sheets

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

Informed Consent

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.

Presumptive Eligibility (PE) Screening Guide

This form is used to enroll woman as a TennCare (Medicaid) presumptive eligibility case who meets the program general eligibility requirements, is diagnosed with breast or cervical cancer or precancerous conditions for these diseases, and is a documented resident of Tennessee.

**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 related to breast or cervical, 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 _____

Date of Birth _____

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 usted tiene un resultado anormal en el examen de mama o del cuello uterino, la clínica/médico trabajará con el programa para ayudarle a obtener más pruebas de diagnóstico y tratamiento. El programa puede pagar por servicios diagnósticos limitados, pero no puede pagar por el tratamiento. Si usted necesita tratamiento, usted podría ser elegible para Medicaid y le ayudaremos con esto
- ♦ 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 de nacimiento _____

Fecha _____

(**Insert Region**) REGION

Public Health Use Only

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: _____ Treatment Plan Submitted Yes NO

Name: _____

Address: _____

City: _____ County: _____ Zip: _____

Phone Number: _____

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

Estimated Income: _____

Medicaid Category: **MAZ** 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)

1st Copy – State Office (FAX: 855-315-0669)

2nd Copy – Client

3rd Copy – County Office

Revised – March 2014

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 under **Section 13 Annually Updated Material**.

Screening providers who are local health departments

- Enter information in the PTBMIS screens
- Central Office provides Incomplete/Missing Data Reports to the Regional Coordinators about cases with missing data elements
- Incomplete/Missing Data 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 related to screening and diagnostic services
- Screening sites in Shelby and Davidson counties enter transmittal sheets for designated providers and coordinate data entry with the regional office and/or Central 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 Incomplete/Missing Data Reports at least monthly to collect missing data

Required Submittal of Data to CDC

- Submitted to CDC twice each year in April (data entered June-Dec of prior year) and October (data entered Jan-June of prior year).
- Reflect the enrollment and screening/diagnostic status of all enrollees for the most recent 6-month period, and all historic patient files.
- 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
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 curser 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 curser 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 Date	Age
Alias			
Addr			
City	State	Zipcode	County
Hphone	Wphone	Contact	
SSN	Race	Sex	Migrant
Occupation	Educ	School	Mar. Stat
Is Patient Confidential Contact?	Patient Status	Census	Hispanic
Primary Language			
Addr			
City	State	Zipcode	
Emergency Contact		Phone	
Responsible Party	Relationship to Resp Party	Phone	
Name		SSN	
Addr			
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.

New Addition to Screen 2.

As of April 2014, changes to the PTBMIS system may require the insertion of "0" (Zero) to the Client Status for screen to advance.

REGISTRATION SCREEN 2

U			
Patient No.	Date Updated	Birth Date	USA Born? Y
Name			
Date of Entry into Country		HSIS Entry/Update Date	
Country of Origin		HSIS Sent Date	
Proficient in English (Y/N)	Preferred Language	Client Status	0
Ethnicity	SSI (Y/N)		
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:            Residency NP roof Id 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                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:	
Payor:	Priority:	Last Updated:	Effective :
Notes:	User ID	Through :	Sent Date :
Total Income:	Adjustments:	Net Income:	Family Size:
Eligibility	Case No:	Claim Filing Ind:	
Plan Code:	BCS000	Copay:	
Policy Number:	Chapter 1 Leading 0 + Social	Policu Type:	Name: B
Group Number:	Assign Benefits:	Signature Source:	Supplemental Ins:
PPO/HMO:	BC/BS Coordinated Home Care:	Insurance Co. Type:	I
Insur. Name:	Address:		Relat. to Ins:
City:	St:	Zip:	Sex: DOB:
Insured Employer/School:	Insured ID#:		Phone:
Insured SSN:	Deductible Code:	Benefits Exhausted:	
Copay Percentage:	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.		Enc Dt		Srv Dt		Entry Dt	
Name				Service Site		Date Sent	
BCF Cycle No:		330#:					
PREV MAM?		DATE OF PREV MAM:		PAP TEST THIS VISIT?			
BREAST SYMPTOMS:		BRST SELF EXAM:		BRST CANCER HIST:			
REASON FOR MAM:		BRST DX REFERRED IN DATE:					
SCREENING		PROC DATE		CHG PGM		RESULT DATE	
BREAST EXAM:							
INITIAL MAMMOGRAM:							
WORKUP PLANNED:		SHORT-TERM FOLLOW-UP:		NEXT SCREENING MAMMOGRAM:			

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"/>	
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"/>				

Regarding the film comparison fields on the second screen of the breast cycle-

1. **ONLY** when you have abnormal breast result (needs diagnostic) and you go to the second screen, will you fill in the film comparison/Film Imaging Outcome field.
2. **ONLY** when Initial Mammogram result is **(06) or (13)**, will the **Film Comparison** be (Y) Yes. ALL other results are (N) No.
3. When you have Dates in either Additional Mammogram or Ultrasound you must provide the **Film Imaging Outcome** date and result.
If you don't have additional mamm or ultrasound you can leave final imaging outcome date and result blank.
4. Date of Film Imaging Outcome must equal the date of Final Diagnosis Date.

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.	<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"/>
CCF Cycle No:	<input type="text"/>	330#:	<input type="text"/>				
PREVIOUS PAP?	<input type="text"/>	DATE OF PREVIOUS PAP:	<input type="text"/>				
REASON FOR PAP:	<input type="text"/>	CERVICAL DX-REFERRED IN DATE:	<input type="text"/>				
SCREENING		PROC DATE	CHG PGM	RSLT DATE	RSLT	SPEC TYPE	SPEC ADQCY
PELVIC/RECTAL EXAM:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
PAP SMEAR:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PAP RESULT OTHER:	<input type="text"/>						
HPV:		<input type="text"/>		<input type="text"/>	<input type="text"/>		
WORKUP PLANNED:	<input type="text"/>	SHORT-TERM FOLLOW-UP:	<input type="text"/>	NEXT SCREENING PAPSMEAR:	<input type="text"/>		

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

SECTION 8 CASE MANAGEMENT/ PATIENT NAVIGATION

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 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 (ASCUS, LSIL, HSIL).
- **Pelvic Exam** – abnormal results only apply to women with visible cervical /endocervical abnormalities or abnormal 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 of case management/patient navigation

- 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)

Pelvic Exam Result:	These are options a clinician may choose based on individual cases
Normal/Benign Finding	Routine
Abnormal – cervical/endocervical or bleeding site undeterminable	Gyn consult
Pap Test Results:	These are options a clinician may choose based on individual cases
Negative – for Intraepithelial Lesion/Malignancy	Routine Screening- Pap testing every 3 years or cotesting with HPV every 5 years
Cytology negative - HPV positive	12 month follow-up with cotesting
Atypical Squamous Cells Undetermined Significance (ASC-US) HPV Negative	Repeat contesting in 3 years
Atypical Squamous Cells Undetermined Significance (ASC-US) HPV Positive	Colposcopy Treatment if indicated
Atypical Squamous Cells Cannot Exclude High Grade SIL (ASC-H)	Colposcopy Treatment if indicated
Low Grade SIL (LSIL) HPV negative	Repeat contesting in 12 months or Colposcopy Treatment if indicated
Low Grade SIL (LSIL) HPV unknown or positive	Colposcopy Treatment if indicated
High Grade SIL (HSIL)	LEEP or Colposcopy Treatment if indicated
Atypical Glandular Cells (AGC)	Colposcopy Endocervical sampling Endometrial sampling Treatment if indicated Short term follow-up Refer to ASCCP Guidelines for full details
Adenocarcinoma In Situ (AIS)	GYN referral for hysterectomy or conservative management if future fertility is desired

**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. A medical record review consists of review of the electronic medical record (EMR) and hard copy comparison of relevant documents. 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.
- Incomplete/Missing Data 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

Prior to a site visit, the following reports will be provided by the data manager to the nurse liaison for review with the regional coordinator and site manager during the site

- Most recent "Incomplete/Missing Data Report"
- Annual Comparison Report
- Most recent Cap Report
- CDC Minimum Data Report

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; method of tracking and follow up of women enrolled, 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 requesting the corrective action plan within 30 days of receipt.

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: $\geq 90\%$)
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). Additional procedure related codes can be considered for reimbursement, but must first be reviewed and approved 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 (ONE TIME ONLY)
 2. CPT code #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.

Services Not Covered

- No CPT codes other than the ones listed will be reimbursed.
- 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).
- Vendors cannot bill patients for the balance of charges associated with breast and cervical evaluation in accordance with national policy and the letter of agreement they signed when they enrolled as a provider.

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 the age of 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 of 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. abnormal ultrasound

Covered Cervical Services

Pap Test Visit – ONLY covered for women 40 - 64. TBCSP will only cover Pap tests following ASCCP guidelines. Routine screening is defined as - “Cotesting every five (5) years (Pap test with HPV High Risk panel) or Pap testing alone every three (3) years.”

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)

Endocervical curettage

Endometrial Biopsy – when Pap test result is AGC

Cervical biopsies - as part of a colposcopy

Biopsy of cervical polyps

Pelvic Exam - to determine if a woman has a cervix if this is in question.

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 up to two weeks until the data is received; after this time period, it will be returned to the vendor.

PTBMIS Managed Care System for Processing Claims

The following pages are abbreviated instructions for authorizing payment through the PTBMIS system called "Managed Care". All vendors have been assigned an Edison number as of FY 2012. The number consists of three fields – the vendor identification number (10 characters), the Location ID (10 characters) and the address number (5 characters). Any discrepancy in the vendor number will result in the claims being held until the correction is made. For more detailed instruction, contact the regional office PTBMIS staff or Central Office.

A sample Approved Payments (AP) Report is also included. This report is provided by the Bureau of Administrative Services after claims that have been authorized for payment transferred electronically and reviewed and approved for payment by the Bureau of Administrative Services (BAS) and F and A. The AP Report is used to cross check with the claims authorization reports; duplicate claims will be dropped before the AP report is issued and any vendor numbers flagged as invalid will be withheld from the batch until the correct payment identifier is assigned. Any questions regarding AP reports should be referred to Central Office.

Remit Advises for Vendors

As of March 2012, the Department of Finance and Administration no longer sends remit advises to vendors. Vendors should sign up for and use the electronic information system called eSupplier to identify payments they have received. <https://supplier.edison.tn.gov>

STEPS TO CREATE ONLINE ACCOUNT WITH Esupplier

- 1) Type In <https://supplier.edison.tn.gov>**
- 2) Under the heading of "Login ", click on "Register as a Supplier"**
- 3) Code: type In all caps- "ABCDEFGH"**
- 4) User ID: type In caps- type In "TN @ _____" (your choice to fill In the blank)**
- 5) Description: (this could be the name of the company)**
- 6) Email ID: (person who is handling the account)**
- 7) Password: (minimum of eight characters, including one letter, one number and one special character)**
- 8) Confirm password**
- 9) Currency: type In all caps "USD"**
- 10) Federal ID: tax ID number - no spaces or dashes**
- 11) Vendor ID number – note: this field could automatically fill In once you have supplied federal tax Id number) If not, click on magnifying glass.**
- 12) Click "CREATE"**

Payback

 Want to know when the State of TN is paying you?

 Want to know what your TN State deposit is for?

 Want to be the first to know when TN State contracts are open for bids?

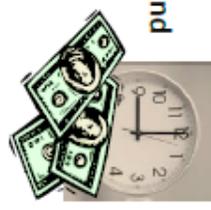
 Want to help save the planet and eliminate trash?

 Are you tired of waiting for someone to call you back?

Be an eSupplier

Results

Savings in Time and Money



Department of Finance and Administration, Authorization No. 317382, 20,000 copies, February 2012. This public document was promulgated at a cost of \$.05 per copy



Saving Our World
One Paper ACH Remit at a Time

Vendors who are registered as an eSupplier do not receive paper ACH remittances.

Deposit information and so much more can be found on your eSupplier account by logging into

<https://supplier.edison.tn.gov>

Thank you for caring enough to be a part of this initiative and helping keep our world green!

CONTACT INFORMATION
General Questions: 615-532-5150
Log In Assistance: 615-741-4357 or toll free 866-376-0104

Be a
State of Tennessee

eSupplier



<https://supplier.edison.tn.gov>

Starting at <https://supplier.edison.tn.gov>

Training

Click here for links to the Bidder and eSupplier tool kit and user instructions. Please read the instructions on the main page and click on the links at the bottom to navigate to the appropriate training.

[Bidder and Supplier Training Tool](#)

Training is easy!

Signing up is easy!

Supplier Registration

Fill in the following information and click on the Create button to create a Supplier account. In order to self register you must have received a predefined code and know your corresponding vendor ID.

Code:

User ID: Description:

Email ID:

Password:

Confirm:

Language: Currency:

Tax ID: Customer [Find View All] [Filter] [Close]

Vendor ID:

Create

Viewing payments is easy!

Review Payments

State Of Tennessee

Supplier Actions

Reference	Invoice Number	Payment Date	Amount
0000000592	0000098886	12/06/2011	\$27,600.00 USD
0000000593	0000098318	12/06/2011	\$19,540.00 USD
0000000594	0000098319	12/06/2011	\$8,000.00 USD
0000000595	0000098350	12/06/2011	\$21,672.50 USD
0000000596	0000098361	12/06/2011	\$18,567.50 USD

Learning about State contracts is easy!

View Events and Place Bids

Search Results

Event ID	Event Name	Event	Type	End Date
31701-0000002092	RSTVC 362 F5 Network Security and Support	RFI	RFx	02/06/2012 01:00 PM CST
31701-0000002870	RSTVC #3054 SWS Distributed Software	Sell	RFx	02/10/2012 02:00 PM CST
31701-0000004609	RSTVC 304 Wireless LAN Auda	Sell	RFx	02/10/2012 02:00 PM CST
32101-0000004342	Jarriental Service-SWC 948 Middle TN Region	Sell	RFx	02/17/2012 02:00 PM CST
32101-0000004384	Fire Alarm Monitoring & Altra, DLS, Memphis, TN	Sell	RFx	02/06/2012 02:00 PM CST
32101-0000004457	Generator Maintenance, Citizens Plaza Nashville	Sell	RFx	02/14/2012 02:00 PM CST

INSTRUCTIONS FOR MANAGED CARE AUTHORIZATION

** Each patient has both a CCF/BCF screen but ONE managed care eligibility #.

PROCEDURE FOR AUTHORIZING A CLAIM

- **PLF, PS, PB** or **A** (last/first name, social, birthdate or patient number <enter>
- Select the correct patient from the list that appears
- Enter DBTR on the command line to display all prior patient authorizations. This step reduces duplication of claims payment.
- Tab down to the authorization to see the detail if one is listed for the same date of service. If no claims listed then
- Type **BTR** in command line. This will generate a new screen.
-
- Enter provider number or tab once and enter provider name <enter>
- Tab down to correct vendor and put a "V" to see vendor detail including address<enter>
- F3 to exit this screen<enter>
- Tab to the correct vendor you want and put an "X" next to the vendor number <enter> The patient's authorization screen appears with the vendor number added.
- Enter the CPT number to be authorized and the number of units or select from the CPT codes listed and enter the units. <enter>
- Authorization number is assigned by the system and you will use this number when you key in the claim.

PROCEDURE FOR ENTERING A CLAIM

- Enter CLA at the blinking cursor at the top of the screen + space + authorization number <enter> Example: CLA 065339<enter>
- 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)
 - 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 Rec'd** 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**
- 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.

PAYING THE CLAIM

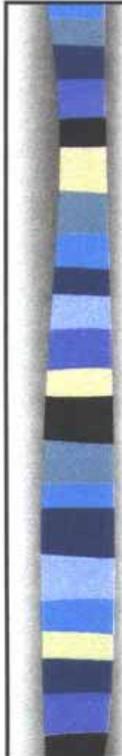
- Each week, your System Admin will run a job that sends all the claim information to the Business Administration Services (BAS) in Nashville.
- BAS will upload the data, review for errors and send to F and A for payment.
- F and A will cut check or transfer money electronically to vendor.
- The AP Report will be sent electronically to all regions. It should be matched against the **Claims Authorized for Payment (CLAUTH)** Report to verify that all claims have been processed.

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

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, presumptive eligibility for Medicaid/TennCare coverage of those diagnosed, and data collection forms with the office manager.
- Educate the referral providers regarding the availability of program resources for use in their office, including 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.
- Partner with a participating Certified Application Counselor (CAC).

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, resulting 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 –

1. Educate all women of the importance of annual screening throughout their lives
2. Provide outreach to 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 phone 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

Participation in Coalitions and Partnerships

Participation in coalitions and partnerships 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.

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 TC2 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 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.

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, 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.

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.
- 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 others efforts for prevention and early intervention.

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

APPENDICES:

Appendix
Evaluation of Common Breast Problems- PDF
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
Program Materials:
Breast Algorithms
Abnormal Clinical Breast Exam Guidance
Presumptive Eligibility Form
2014 Poverty Guidelines For Tennessee
Authorization To Vender
W – 9 Form
Letter of Agreement
Change of Personal / Company Information Form
Reimbursement Schedule 2014
Breast Transmittal Sheets
Cervical Transmittal Sheets
ASCCP 2013 Management Algorithms
Central Office Approval LEEP diagnostic
Central Office Approval Breast

Note: The following article is in the PDF version of the Manual.

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

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.

Estrogen Receptor (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 peri-menopausal 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. Women under the age of 35 generally are advised that 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.

2013 TBCSP Guidelines on MRI

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

Policy: The Tennessee Breast & Cervical Cancer Screening Program (TBCSP) does not reimburse for breast MRI. The program will enroll women in presumptive eligibility (PE) for TennCare who have suspicious symptoms or signs of reoccurrence of breast cancer.

Background

Magnetic Resonance Imaging (MRI) uses a magnetic field and pulses of radio waves to make pictures of the breast. This procedure is not approved for use with CDC funding for grantees of the National Breast & Cervical Early Detection Program (NBCCEDP). According to the revised NBCCEDP Program Guidance Manual 10/2012 “the role of MRI in the diagnosis of breast cancer is still being defined.” The TBCSP fee schedule does not contain the CPT code for MRI.

MRI is often used to evaluate of the stage of breast cancer, choose the best treatment, determine an implant rupture, look at tissue changes during treatment for breast cancer and check women with dense breasts. MRI often has a high rate of false positive results and is more costly than other methods.

There are frequent requests from surgeons and oncologists to perform a breast MRI as part of the diagnostic process for detecting breast cancer as well as using it as an adjunct screening tool for women with breast cancer who have frequent follow-up visits with their surgeon or oncologist. TBCSP cannot be responsible for payment of MRI in these situations and cannot provide PE without other suspicious symptoms for breast cancer.

Program Procedures:

In summary, TBCSP does not pay providers for MRI and does not routinely enroll women in PE as a routine follow-up from breast cancer treatment. If a woman has suspicious symptoms and exhibits signs of a reoccurrence of breast cancer, she may be given presumptive eligibility in order to proceed with a thorough evaluation. The MRI may then be performed when enrollment is verified in TennCare.

02/13/2013

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.

ABNORMAL CLINICAL BREAST EXAMS

When a clinical breast exam (CBE) is abnormal or a woman has symptoms suspicious for cancer, a diagnostic mammogram and an ultrasound is obtained.

Further diagnostic work-up must occur, even if these diagnostic tests, i.e. mammogram and ultrasound are normal. On the transmittal sheet, the CBE would be coded Results- 3, 4, 5, or 6.

A complete diagnostic work up must also include one of the following:

- Consultation by a surgeon or breast specialist
- Fine needle aspiration or biopsy
- Return visit to the screening site for a repeat breast exam within 60 days so as to occur in the same cycle.

An ultrasound or additional mammogram with routine or short-term follow-up alone is not acceptable. At this time, all regions have referral providers that include surgeons who are breast specialists.

A final diagnosis must be made within 60 days of the abnormal CBE.

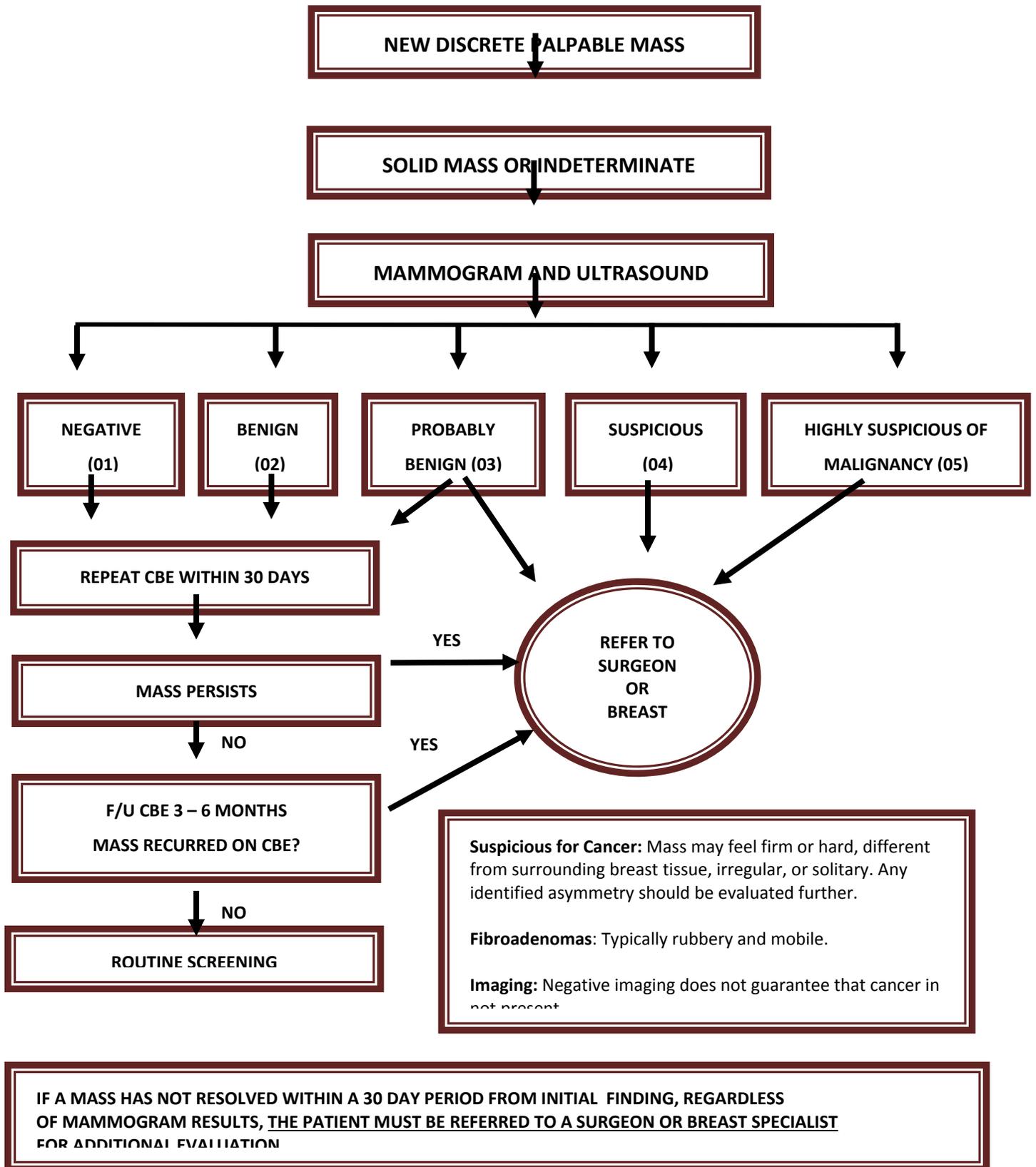
The only time a complete workup does not need to be done is when the CBE is coded:

- Result 1- Normal
- Result 2- Benign/No Follow-up Required.

PROGRAM MATERIALS

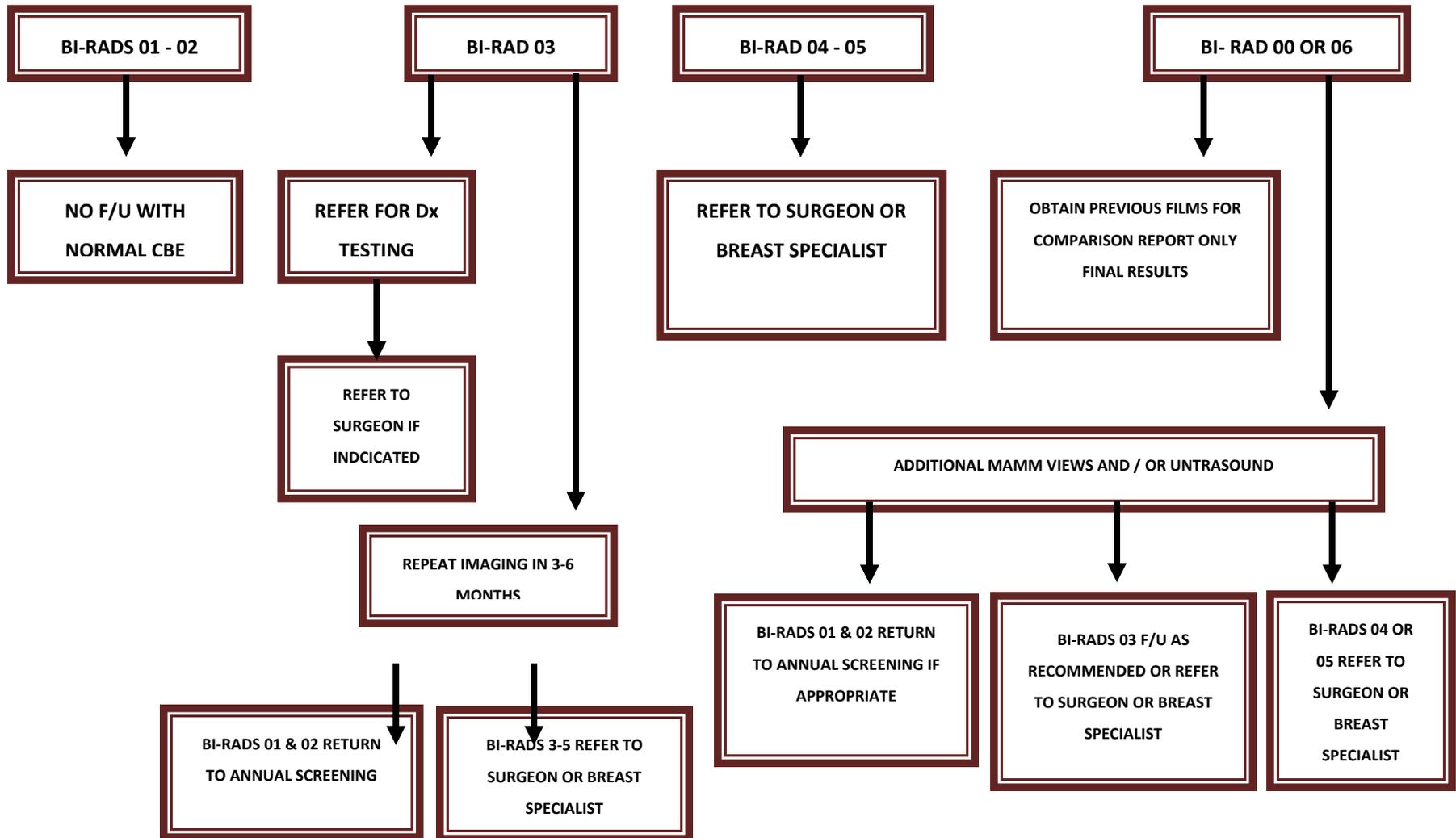
BREAST ALGORITHMS

ALGORITHM #1 - PALPABLE MASS - SOLID OR INDETERMINATE

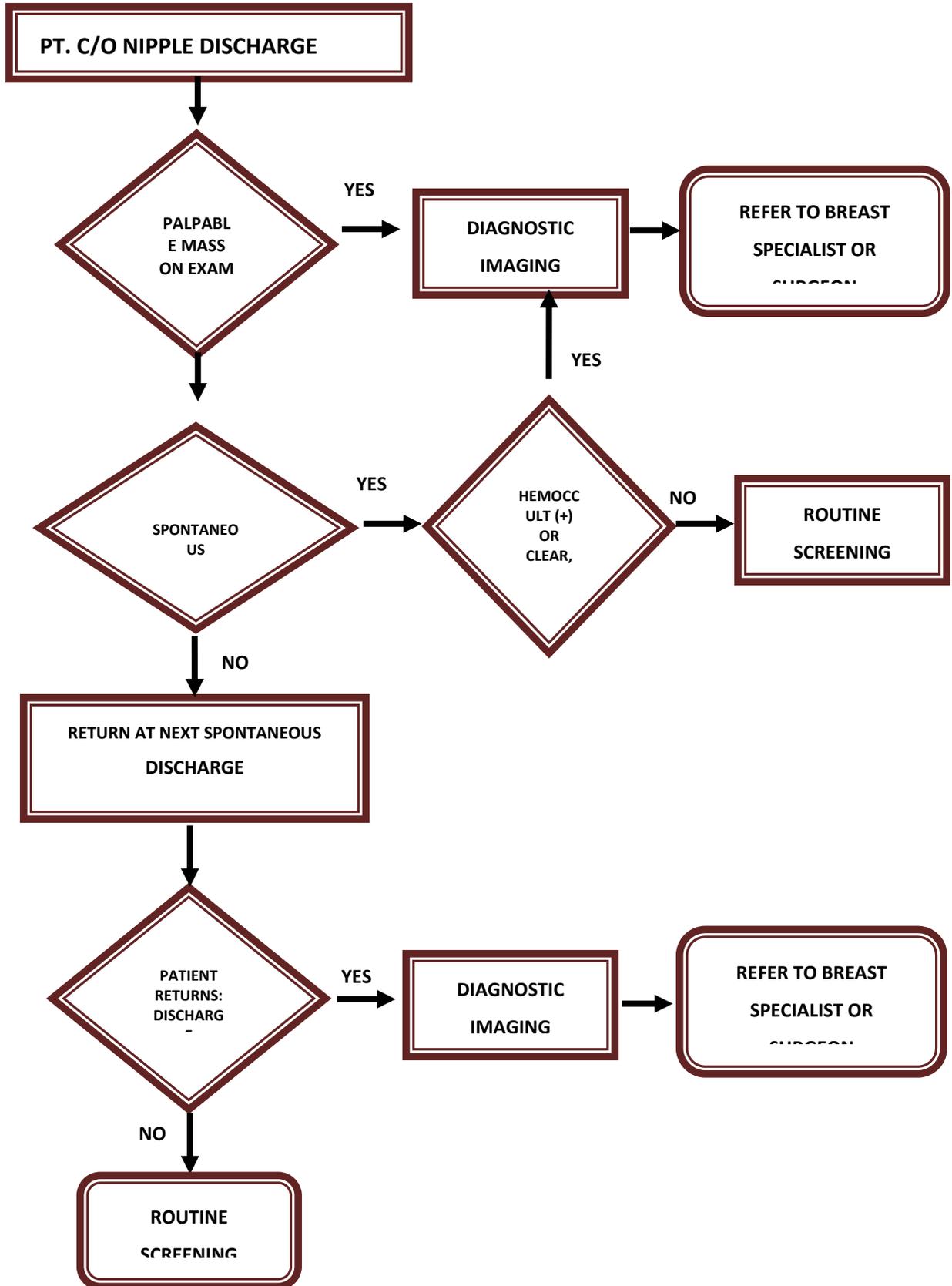


ALGORITHM #2 - MANAGEMENT OF WOMEN WITH ABNORMAL MAMMOGRAMS AND NORMAL CLINICAL BREAST EXAM

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

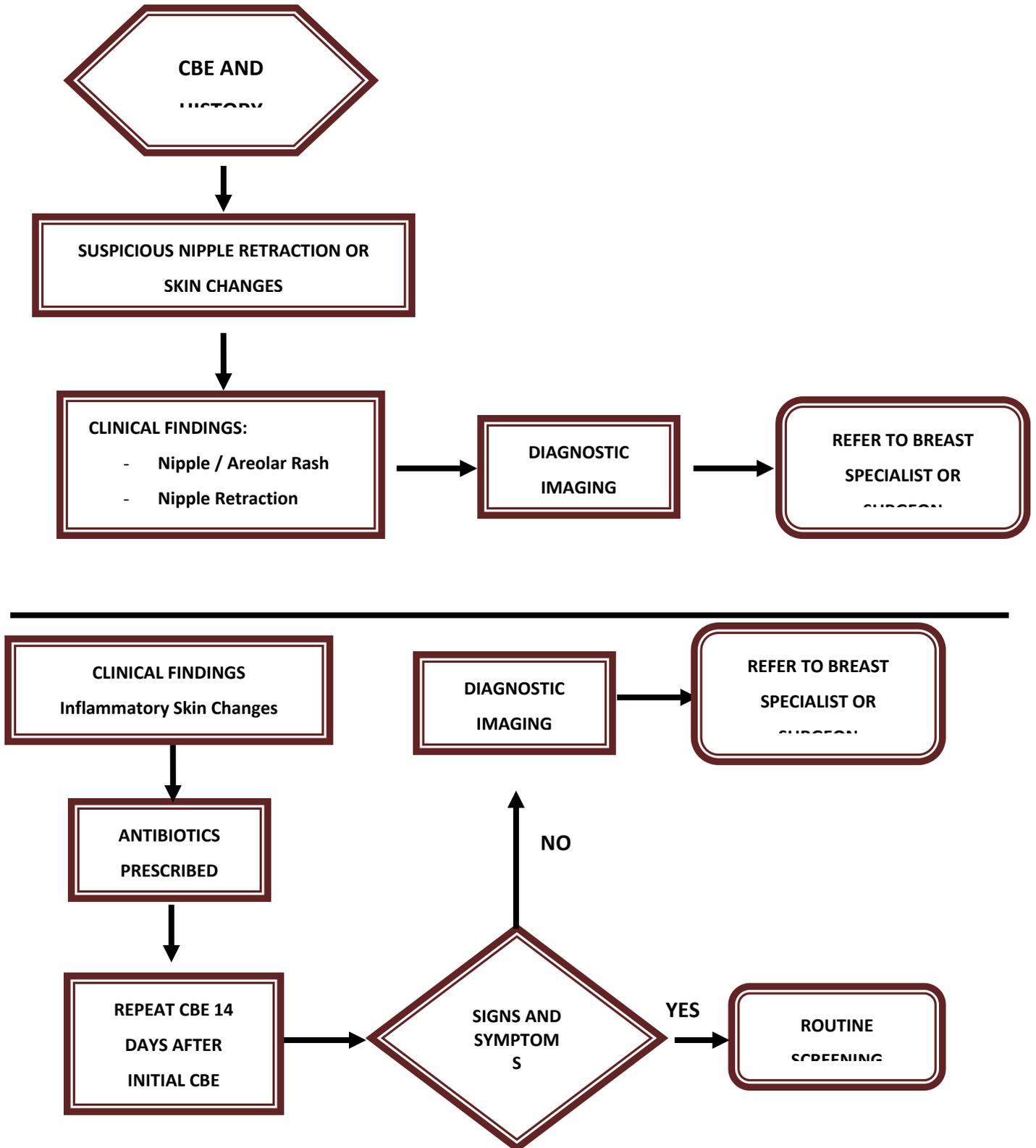


ALGORITHM #3 - SPONTANEOUS UNILATERAL NIPPLE DISCHARGE

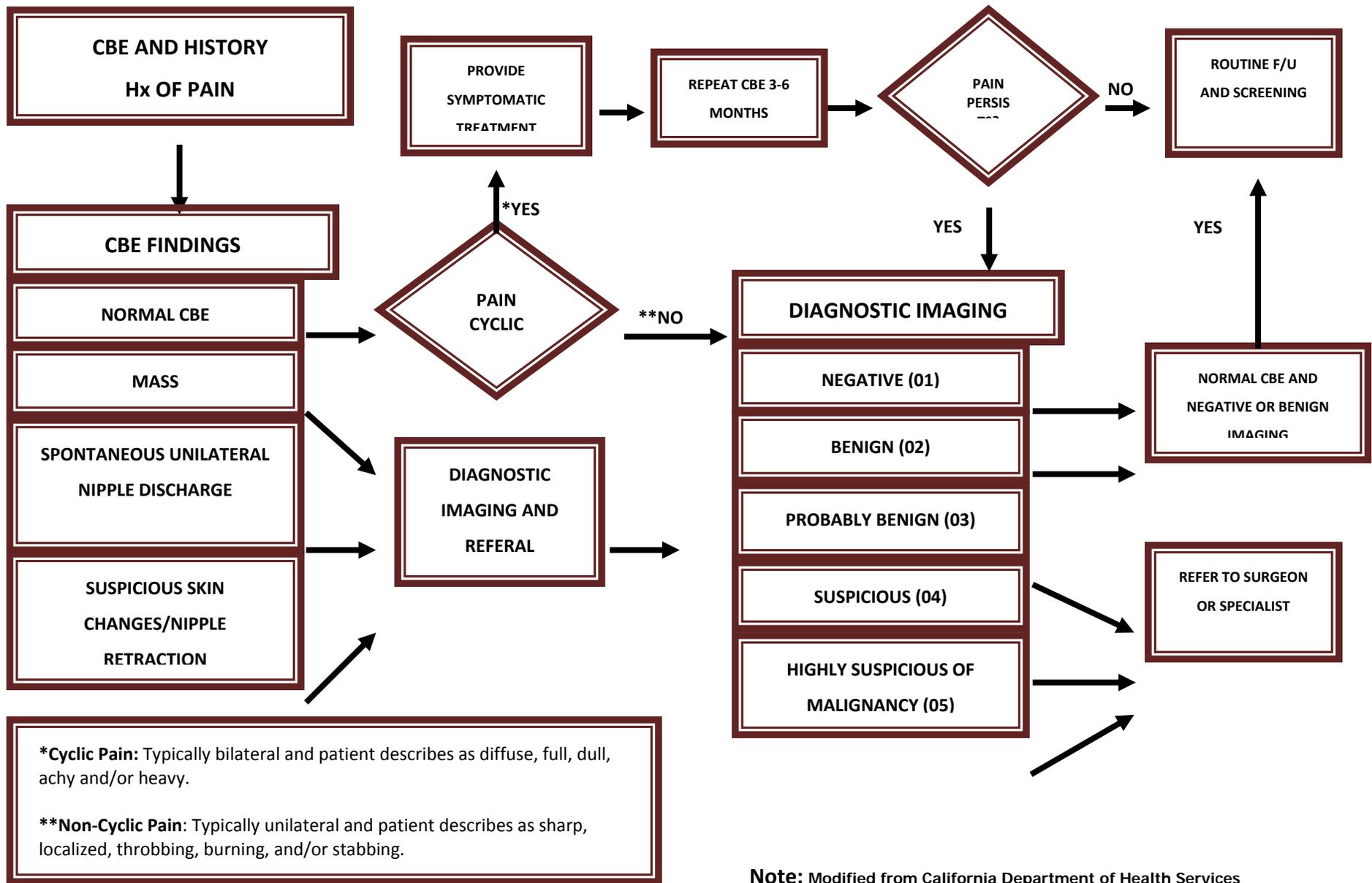


ALGORITHM #4 - NIPPLE RETRACTION / BREAST SKIN CHANGES

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

2014 Federal Poverty Level Guidelines – 48 Border States & D.C.

Household (Tax Filing Unit) Size	2014 FPL	138% ¹ (Medicaid)	150%	200%	250%	400%
1	\$11,670	\$16,105	\$17,505	\$23,340	\$29,175	\$46,680
2	\$15,730	\$21,707	\$23,595	\$31,460	\$39,325	\$62,920
3	\$19,790	\$27,310	\$29,685	\$39,580	\$49,475	\$79,160
4	\$23,850	\$32,913	\$35,775	\$47,700	\$59,625	\$95,400
5	\$27,910	\$38,516	\$41,865	\$55,820	\$69,775	\$111,640
6	\$31,970	\$44,119	\$47,955	\$63,940	\$79,925	\$127,880
7	\$36,030	\$49,721	\$54,045	\$72,060	\$90,075	\$144,120
8	\$40,090	\$55,324	\$60,135	\$80,180	\$100,225	\$160,360

For families/households with more than 8 persons, add \$4,060 for each additional person.

¹As of Jan. 1, 2014, MAGI represents the income limit for TennCare's AFDC-MO, PLIS, CoverKids, and Standard categories.



AUTHORIZATION TO VENDOR

AUTHORIZATION PERIOD

Begin: July 1, 2013

End: June 30, 2016

STATE INFORMATION

State Agency: Department of Health

Program: Tennessee Breast and Cervical Cancer
Early Detection (TBCCEDP)

State Contact:

Delegation #

Edison Record #

Edison PO #

CFDA #

93.994

Account Code:

70804000

Speed Code:

HL00000778

VENDOR INFORMATION

Vendor:

Address:

Phone:

FEIN/SSN:

Edison Vendor #

Ownership/Control: (required information)

African American

Asian

Hispanic

Native American

Female

Person w/Disability

Small Business

Government

NOT Minority/Disadvantaged

Other:

AUTHORIZATION DETAIL

Service Authorized

Payment Amount

TOTAL AMOUNT AUTHORIZED :

— NOTICE: AUTHORIZATION TO VENDOR TERMS AND CONDITIONS ATTACHED —

AUTHORIZATION & ACCEPTANCE

State Authorization: (signature with printed name & title)

Vendor Acceptance: (signature with printed name & title)

Name and Title – Grace K. Luskin, Program Director

AUTHORIZATION TO VENDOR TERMS AND CONDITIONS ATTACHMENT

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. **[THIS SECTION SHALL NOT BE APPLICABLE IF THE VENDOR IS A TENNESSEE GOVERNMENTAL ENTITY]**
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.
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. **[THIS SECTION SHALL NOT BE APPLICABLE IF THE VENDOR IS A GOVERNMENTAL ENTITY]** 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 *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, 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 *Tennessee Code Annotated*, Section 12-4-124, *et seq.*, 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 must 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/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	
	<input type="checkbox"/> Exempt payee	
	Address (number, street, and apt. or suite no.)	Requestor'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 the "Name" line 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.

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

Social security number								
		-		-				
		-		-				
Employer identification number								
		-						
		-						

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below).

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 ▶
------------------	----------------------------	--------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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.

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:

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

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

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.

(This is page 1 of 4 pages, please contact TBCSP Central Office for additional information)

**Tennessee Breast and Cervical Screening Program
(TBCSP)**

**LETTER OF AGREEMENT
(2014)**

I fully understand and agree with all conditions listed. The following is correct contact information for my office and billing agency (if applicable):

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: _____

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

I have read the following stipulations and would like to serve as a

_____ Primary Screening Provider

_____ Referral Provider

_____ Both (**check the appropriate line**).

TENNESSEE BREAST CANCER SCREENING TRANSMITTAL SHEET

(Sheet No. 2 - Revised December 1, 2010)

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 – no way to translate result to data record.		Diagnosis Date: _____ (MM/DD/CCYY)	Final Diagnosis : 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 April 29, 2014)

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: _____ (MM/CCYY) This is very important for us to find women who have never had a Pap or if last Pap more than 5 years ago			
Reason for Pap Test: 1. Routine Pap Test 2. Patient under Surveillance. 3. Pap test done by referral doctor (Provide Date) 4. 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: 03 months 24 months 06 months 36 months 12 months 60 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 April 29, 2014)

Patient Name: _____

Date: _____

Diagnostic Workup Information:			
Colpo with Biopsy and/or ECC: <p style="text-align: center;">(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 9. 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)	Final Diagnosis 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 l 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.)**



The society for lower genital tract disorders since 1964.

Algorithms

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

American Society for Colposcopy and Cervical Pathology

Introduction

Cytology

Since the publication of the 2006 consensus guidelines, new cervical cancer screening guidelines have been published and new information has become available which includes key cervical cancer screening and follow up, and cervical precancer management data over a nine year period among more than 1 million women cared for at Kaiser Permanente Northern California. Moreover, women under age 21 are no longer receiving cervical cancer screening and cotesting with high-risk HPV type assays, and cervical cytology is being used to screen women 30 years of age and older.

Therefore, in 2012 the American Society for Colposcopy and Cervical Pathology (ASCCP), together with its 24 partner professional societies, Federal agencies, and international organizations, began the process of revising the 2006 management guidelines. This culminated in the consensus

conference held at the National Institutes of Health in September 2012. This report provides updated recommendations for managing women with cytological abnormalities. A more comprehensive discussion of these recommendations and their supporting evidence was published in the *Journal of Lower Genital Tract Disease* and *Obstetrics and Gynecology* and is made available on the ASCCP website at www.asccp.org.

Histopathology

Appropriate management of women with histo-pathologically diagnosed cervical precancer is an important component of cervical cancer prevention programs. Although the precise number of women diagnosed with cervical precancer each year in the U.S. is not known, it appears to be a relatively common occurrence. In 2001 and 2006, the American Society for Colposcopy and Cervical Pathology and 28 partner professional societies, federal agencies, and international organizations, convened processes to develop and update consensus guidelines for the management of women with

cervical precancer. Since then, considerable new information has emerged about management of young women, and the impact of treatment for precursor disease on pregnancy outcomes. Progress has also been made in our understanding of the management of women with adenocarcinoma in-situ, also a human papillomavirus (HPV)—associated precursor lesion to invasive cervical adenocarcinoma. Therefore, in 2012 the ASCCP, together with its partner organizations, reconvened the consensus process of revising the guidelines. This culminated in the September 2012 Consensus Conference held at the National Institutes of Health. This report provides the recommendations developed for managing women with cervical precancer. A summary of the guidelines themselves—including the recommendations for managing women with cervical cytological abnormalities — are published in *JLGTD* and *Obstetrics & Gynecology*.

General Comments

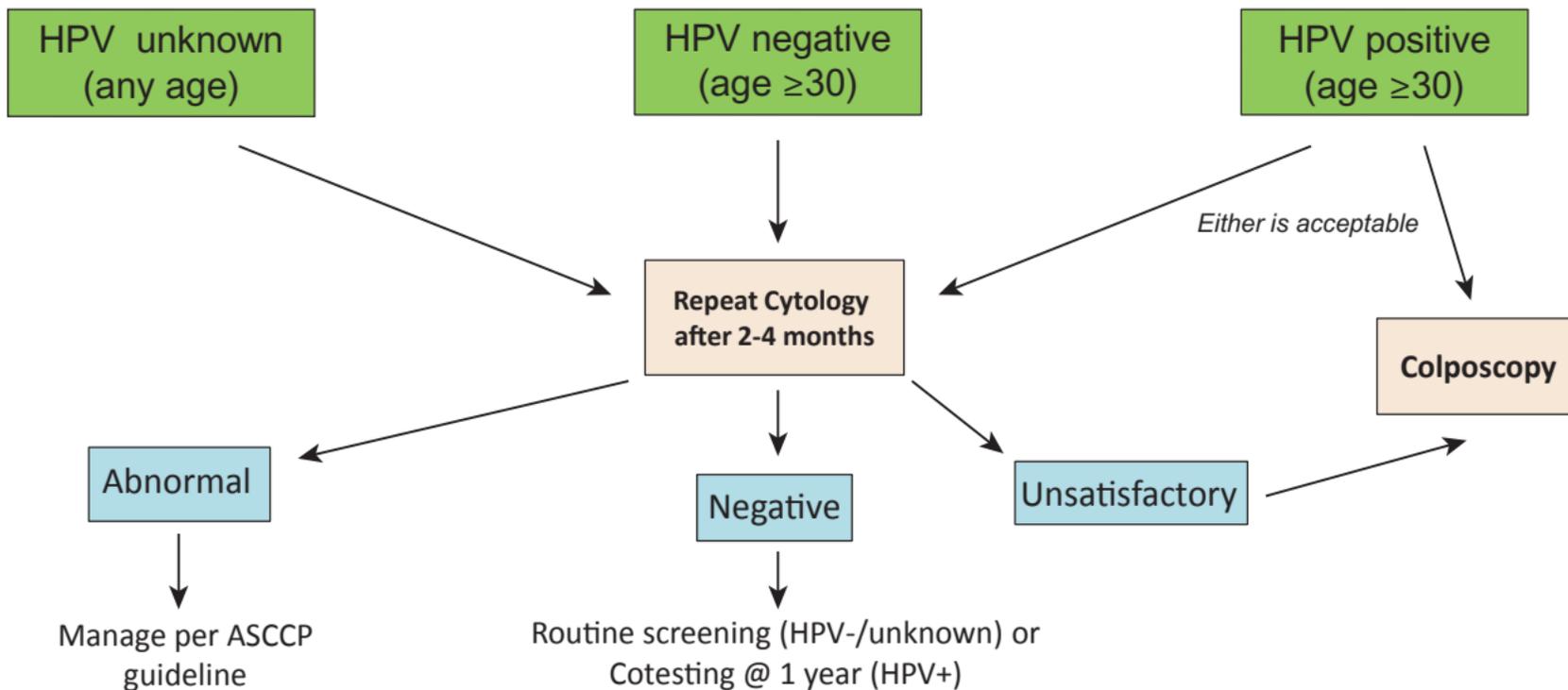
Although the guidelines are based on evidence whenever possible, for certain clinical situations limited high-quality evidence exists. In these situations the guidelines are based on consensus expert opinion. Guidelines should never be a substitute for clinical judgment. Clinical judgment should always be used when applying a guideline to an individual patient since guidelines may not apply to all patient-related situations. Finally, both clinicians and patients need to recognize that while most cases of cervical cancer can be prevented through a program of screening and management of cervical precancer, no screening or treatment modality is 100% effective and invasive cervical cancer can develop in women participating in such programs.

The 2001 Bethesda System terminology is used for cytological classification. This terminology utilizes the terms low-grade squamous intraepithelial lesion (LSIL) and high-grade squamous intraepithelial lesion (HSIL) to refer to low-grade lesions and high-grade cervical cancer precursors respectively. For managing cervical precancer, the histopathological classification is two-tiered applying the terms cervical intraepithelial neoplasia grade 1 (CIN 1) to low-grade lesions and CIN2,3 to high-grade lesions. If using the 2012 Lower Anogenital Squamous Terminology (LAST), CIN1 is equivalent to histopathological LSIL and CIN2,3 is equivalent to histopathological HSIL. Please note that cytological LSIL is not equivalent to histopathological CIN 1 and cytological HSIL

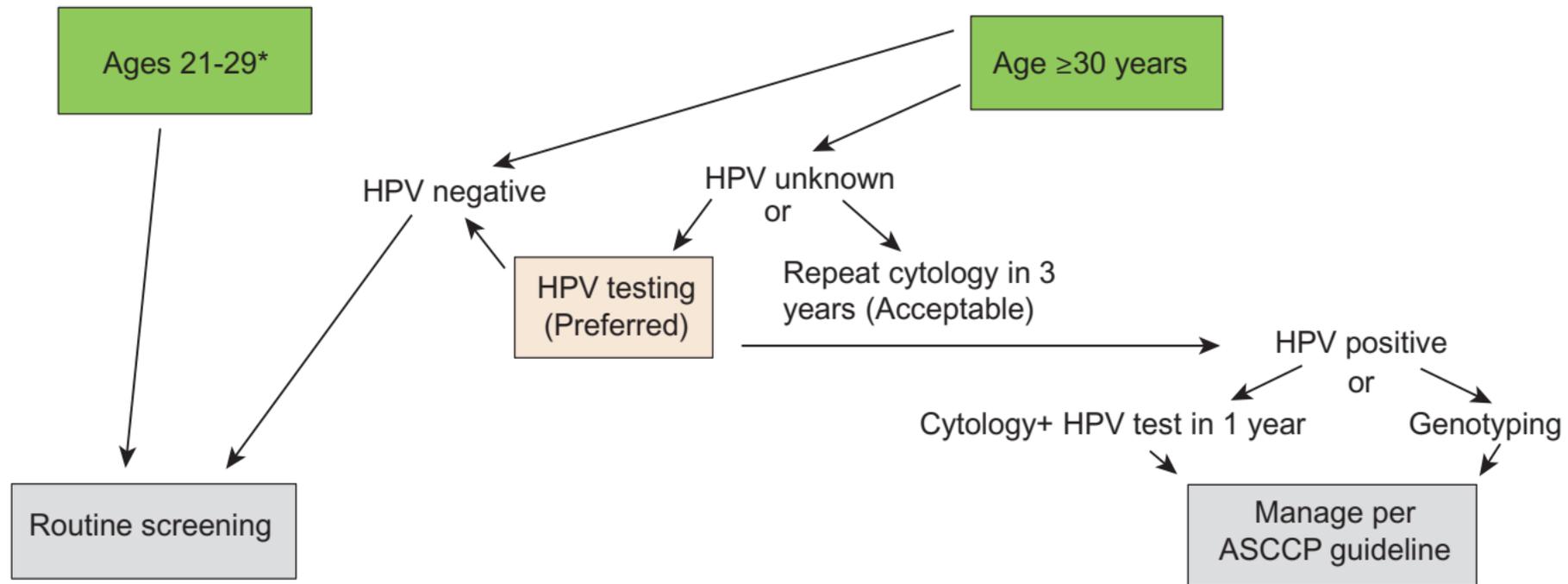
is not equivalent to histopathological CIN2,3. The current guidelines expand clinical indications for HPV testing based on studies using FDA-approved, validated HPV assays. Management decisions based on results using HPV tests not similarly validated may not result in outcomes intended by these guidelines. HPV testing should be restricted to high-risk (oncogenic) HPV types. Testing for low-risk (non-oncogenic) HPV types has no role in evaluating women with abnormal cervical cytological results. Therefore, whenever “HPV testing” is mentioned in the guidelines, it refers to testing for high-risk (oncogenic) HPV types only.

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Unsatisfactory Cytology



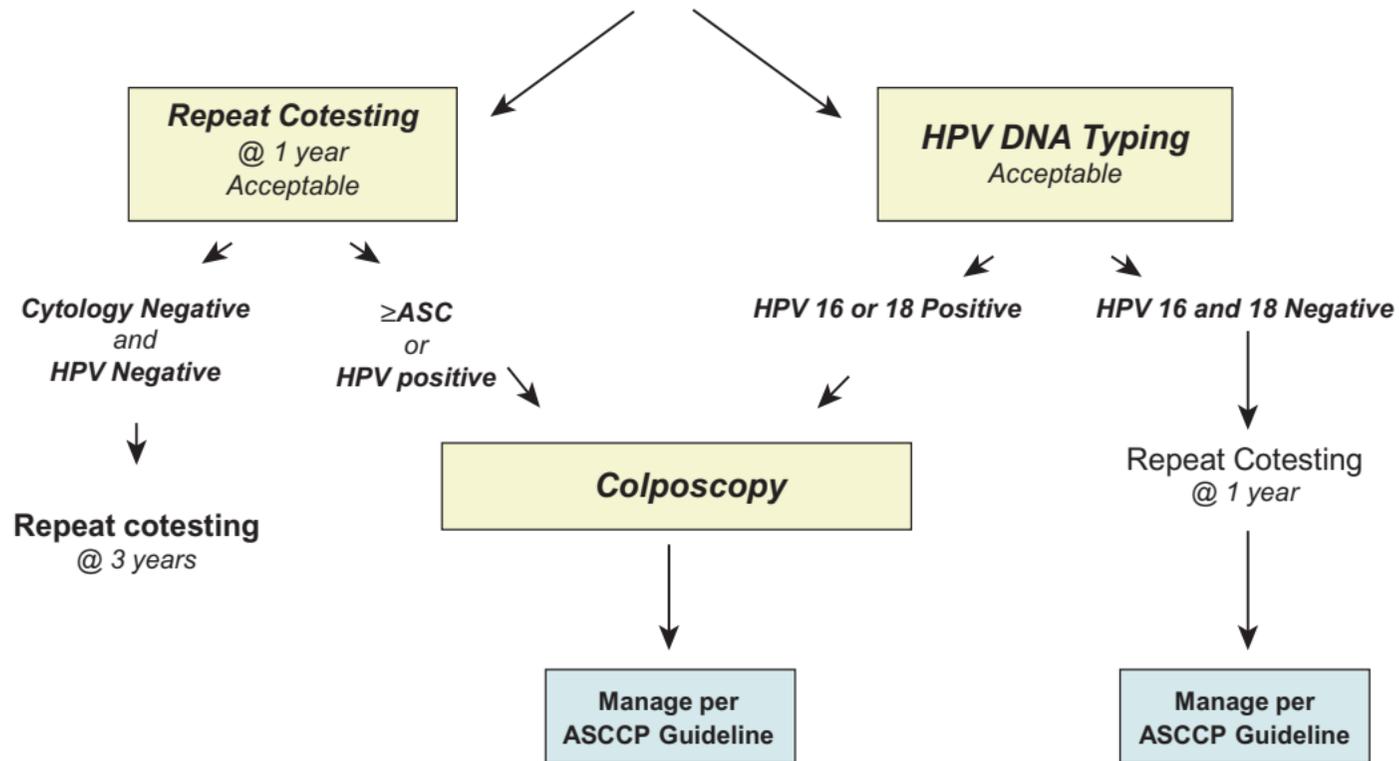
Cytology NILM but EC/TZ Absent/Insufficient



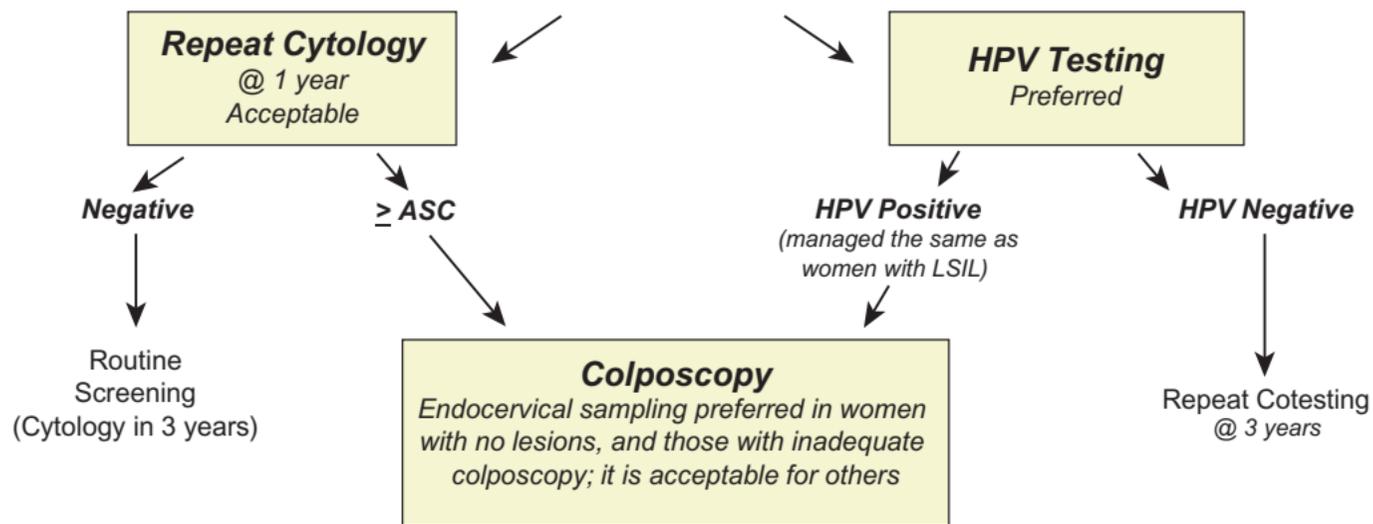
*HPV testing is unacceptable for managing women ages 21-29 years

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Management of Women \geq Age 30, who are Cytology Negative, but HPV Positive



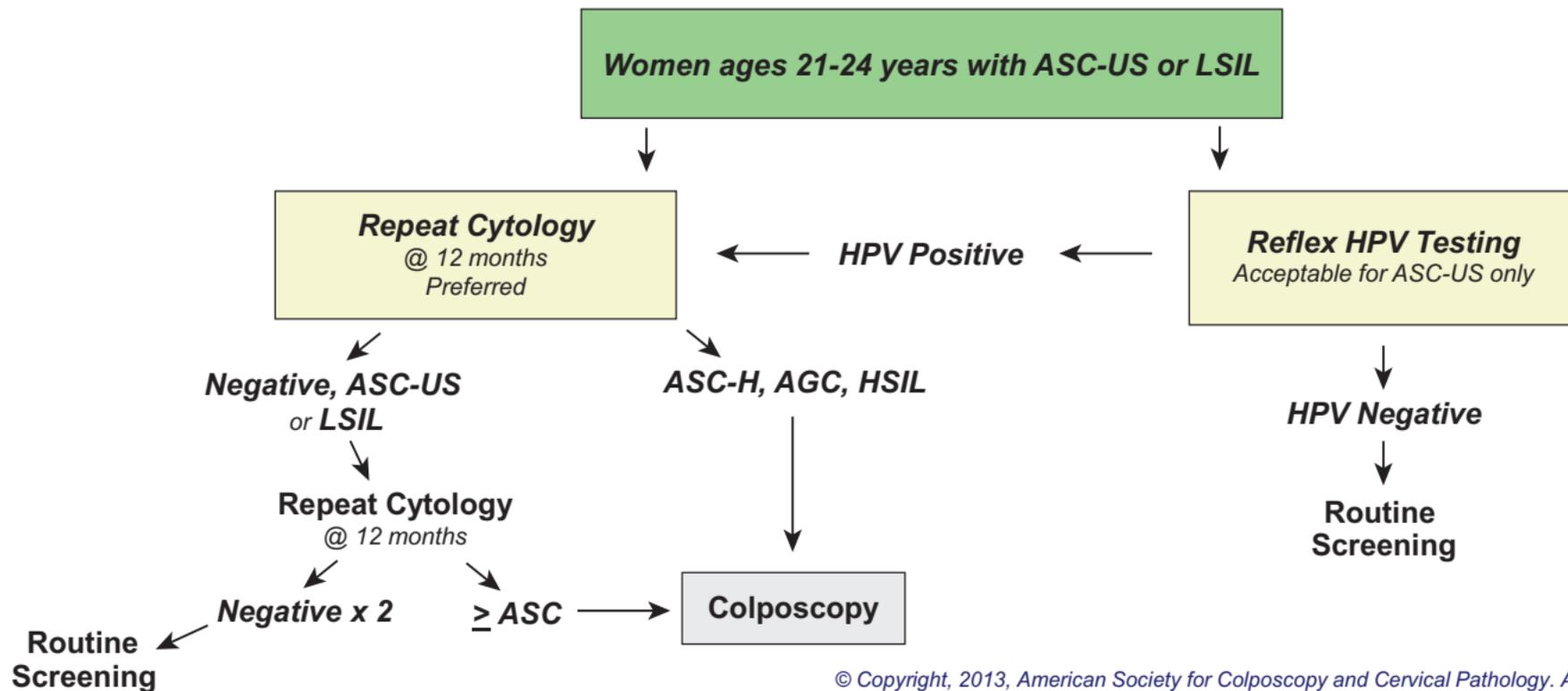
Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology*



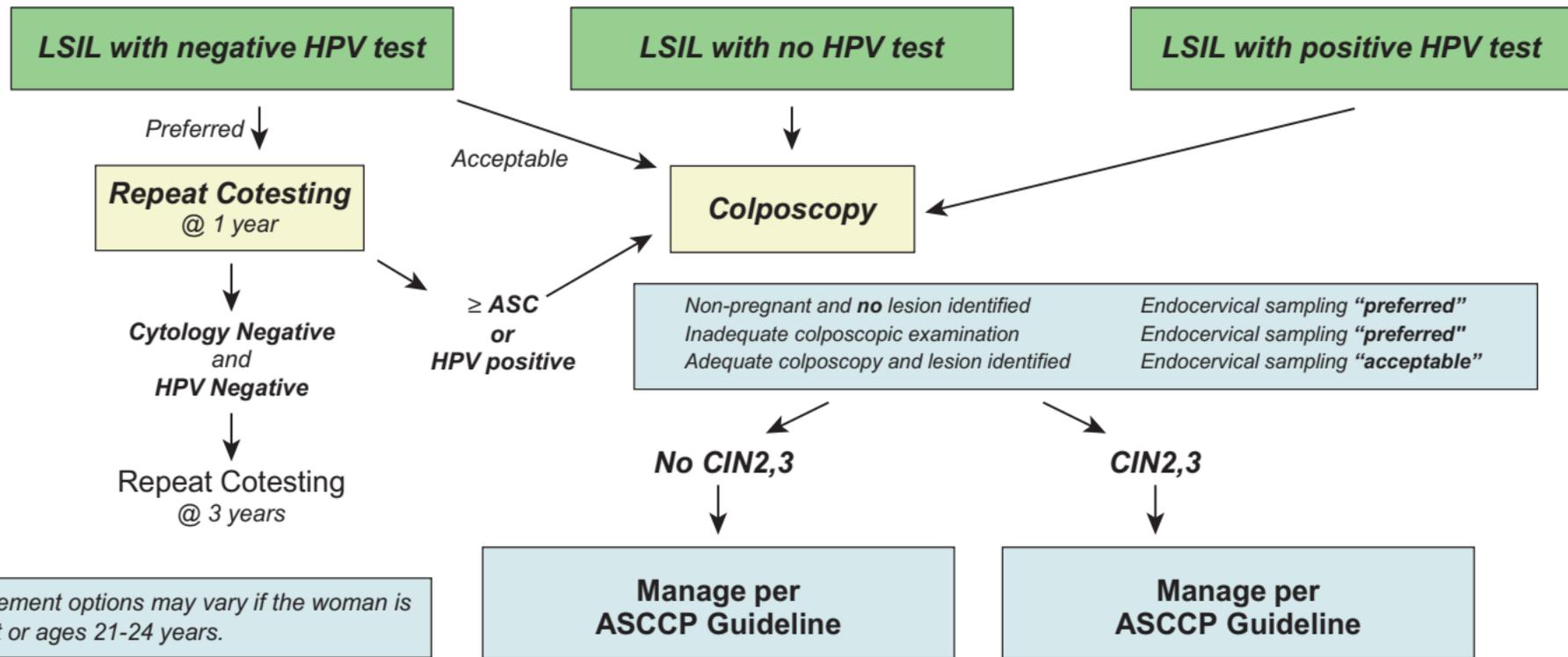
*Management options may vary if the woman is pregnant or ages 21-24.

Manage per ASCCP Guideline

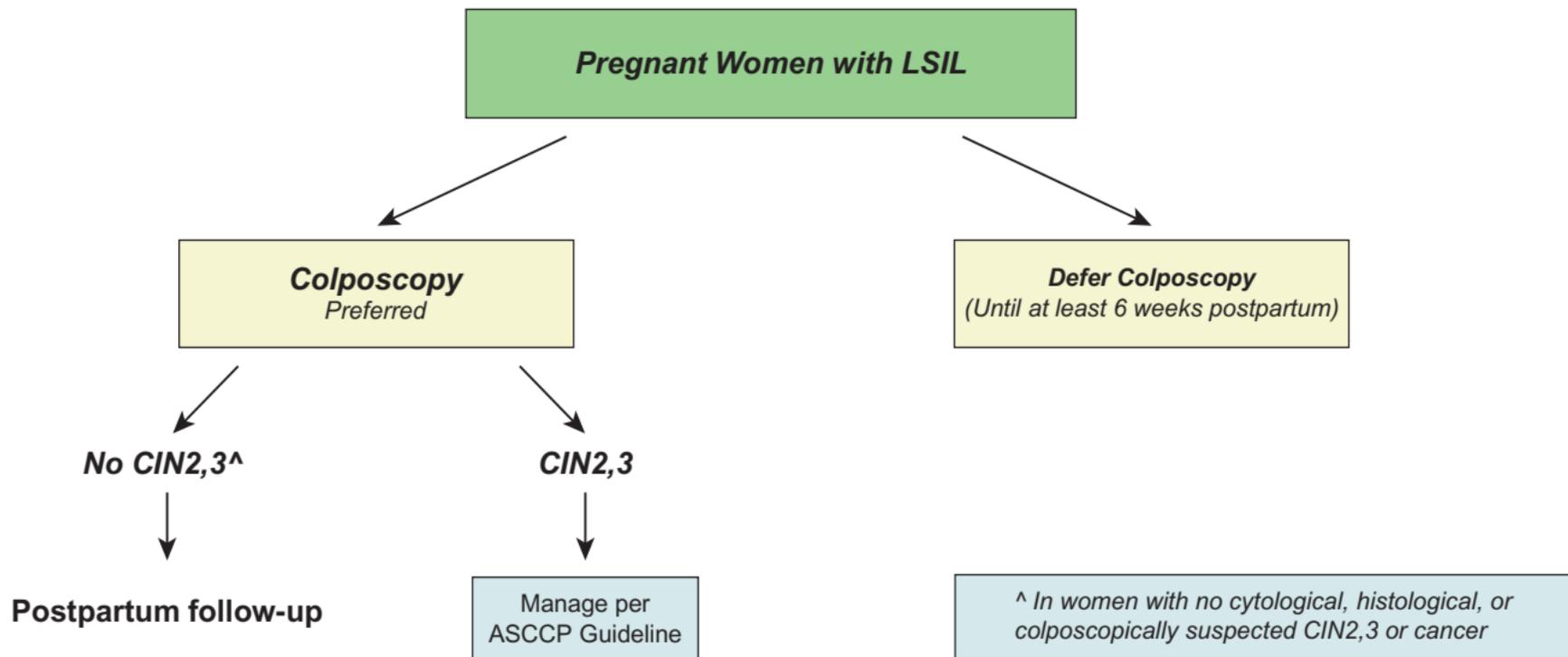
Management of Women Ages 21-24 years with either Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)



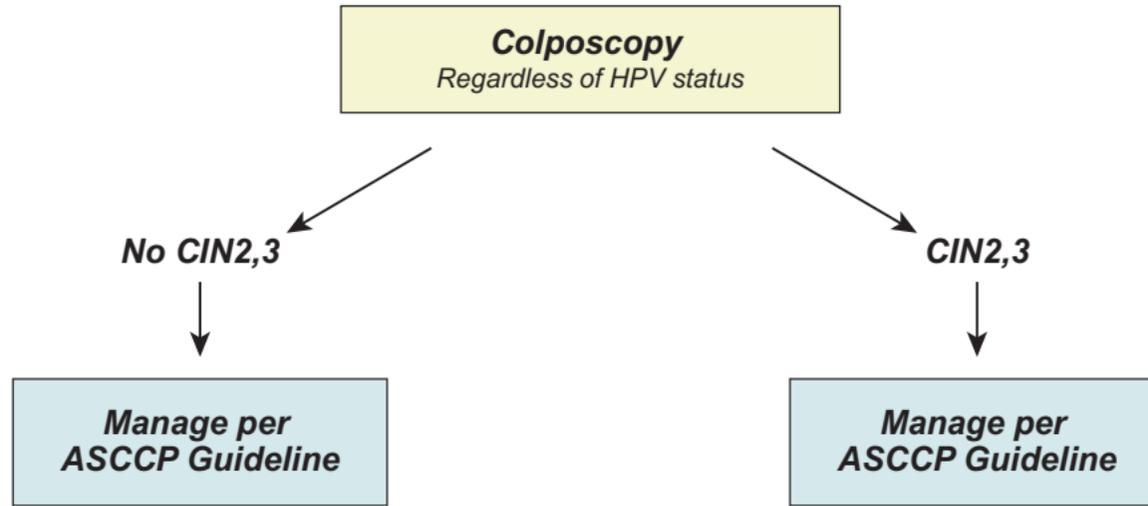
Management of Women with Low-grade Squamous Intraepithelial Lesions (LSIL)*



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

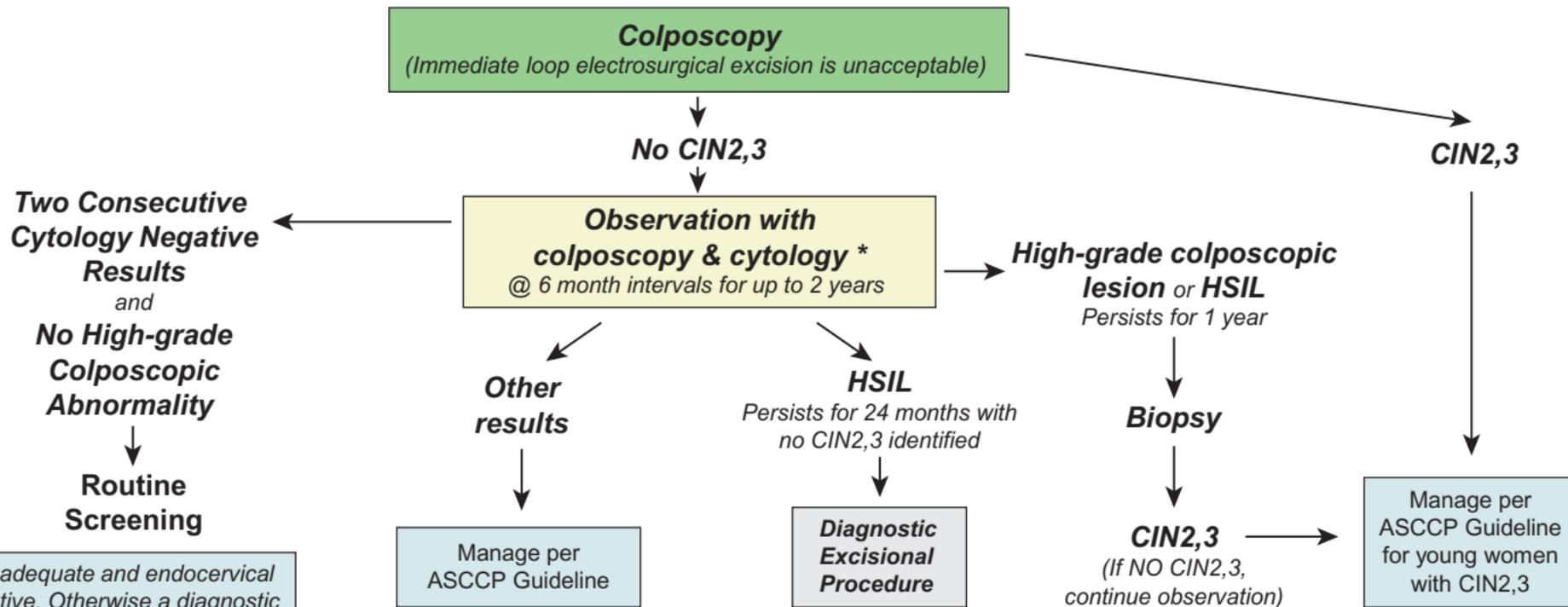


**Management of Women with Atypical Squamous Cells:
Cannot Exclude High-grade SIL (ASC-H)***



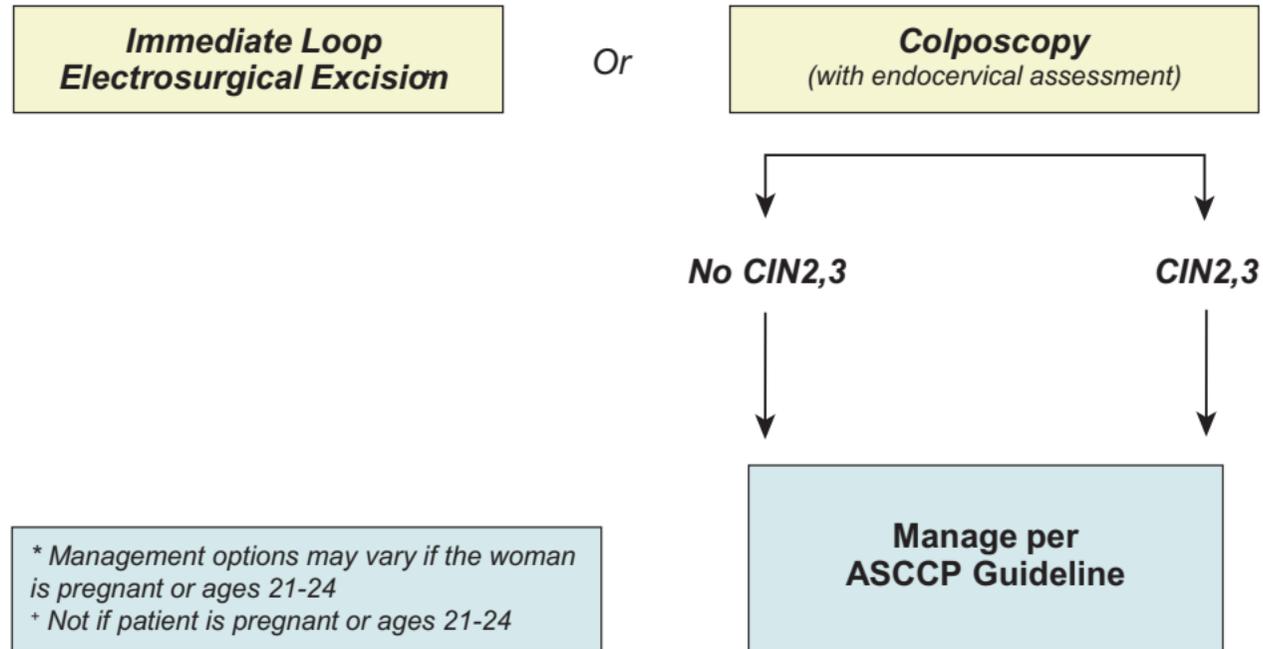
* Management options may vary if the woman is pregnant or ages 21-24 years.

Management of Women Ages 21-24 yrs with Atypical Squamous Cells, Cannot Rule Out High Grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion (HSIL)



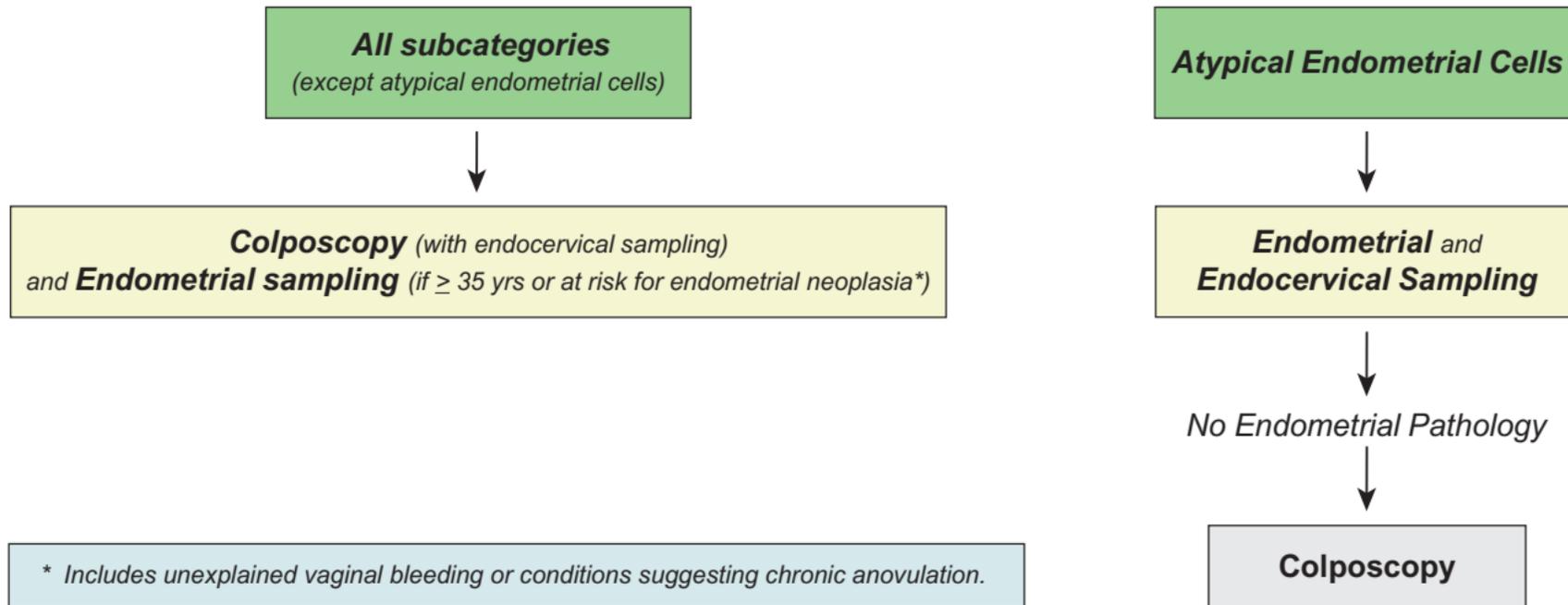
*If colposcopy is adequate and endocervical sampling is negative. Otherwise a diagnostic excisional procedure is indicated.

Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)*

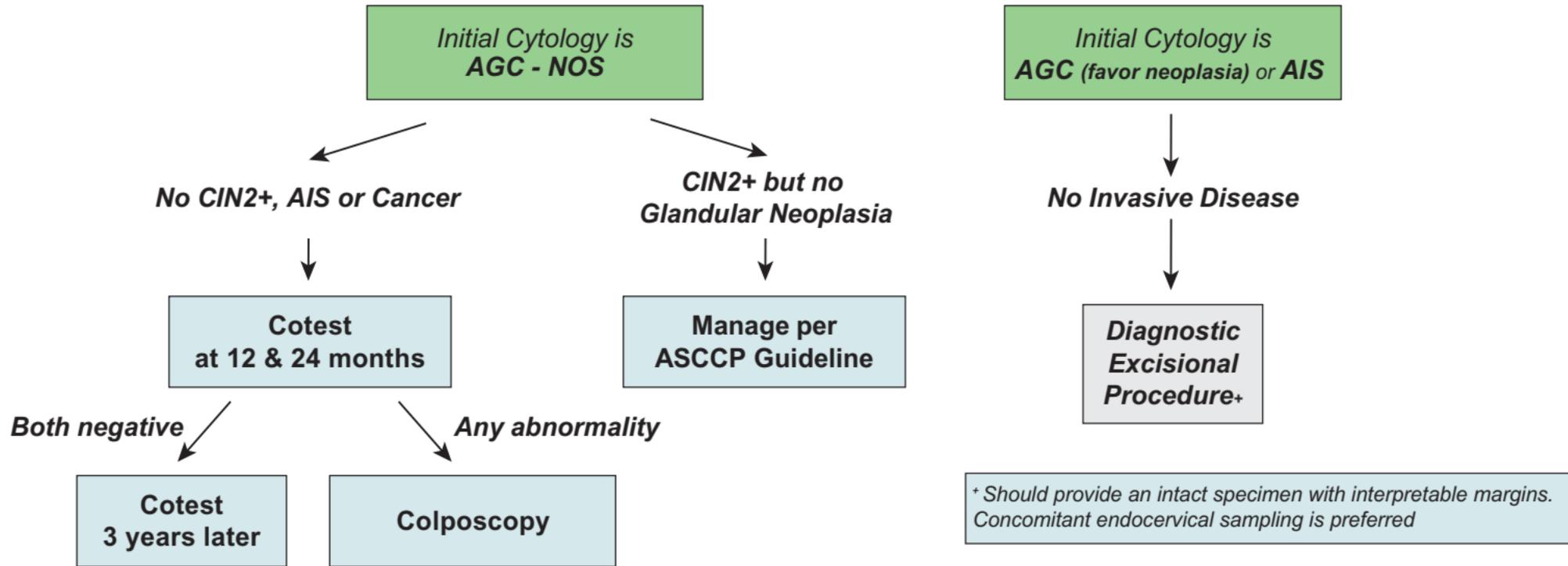


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Initial Workup of Women with Atypical Glandular Cells (AGC)

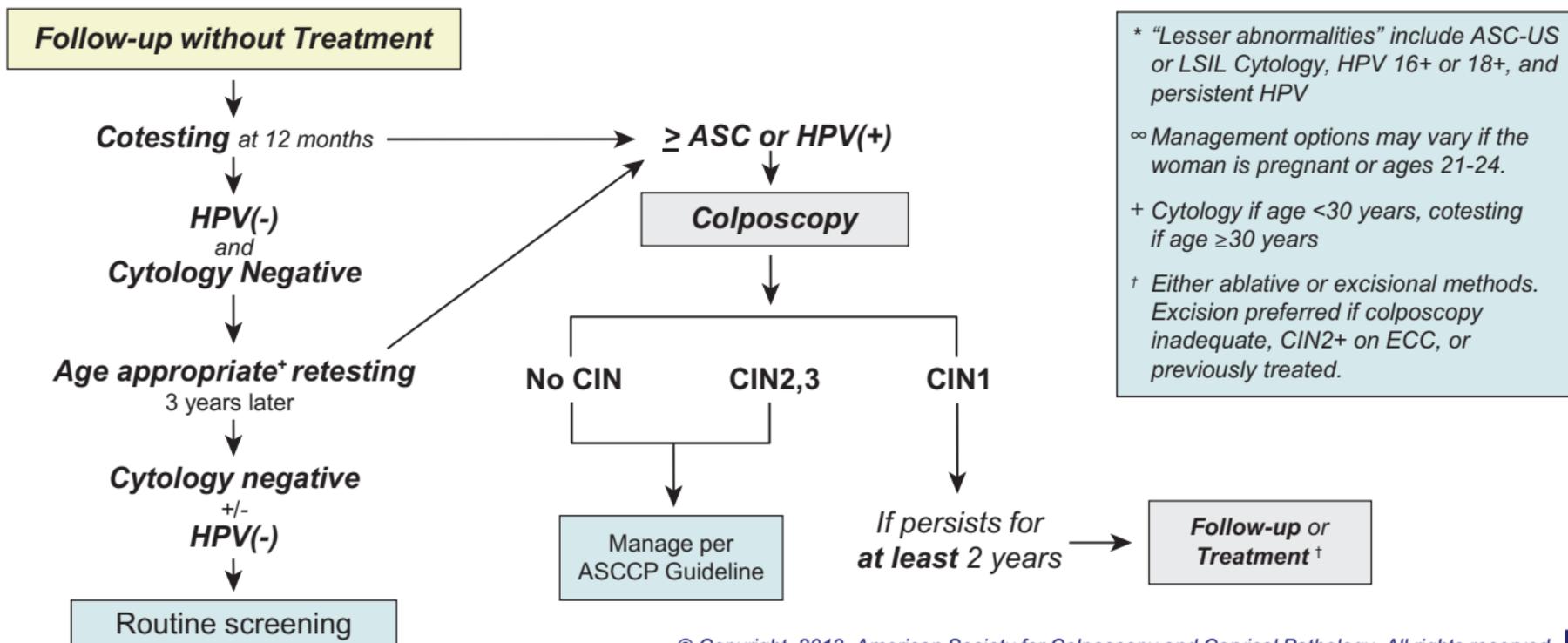


Subsequent Management of Women with Atypical Glandular Cells (AGC)

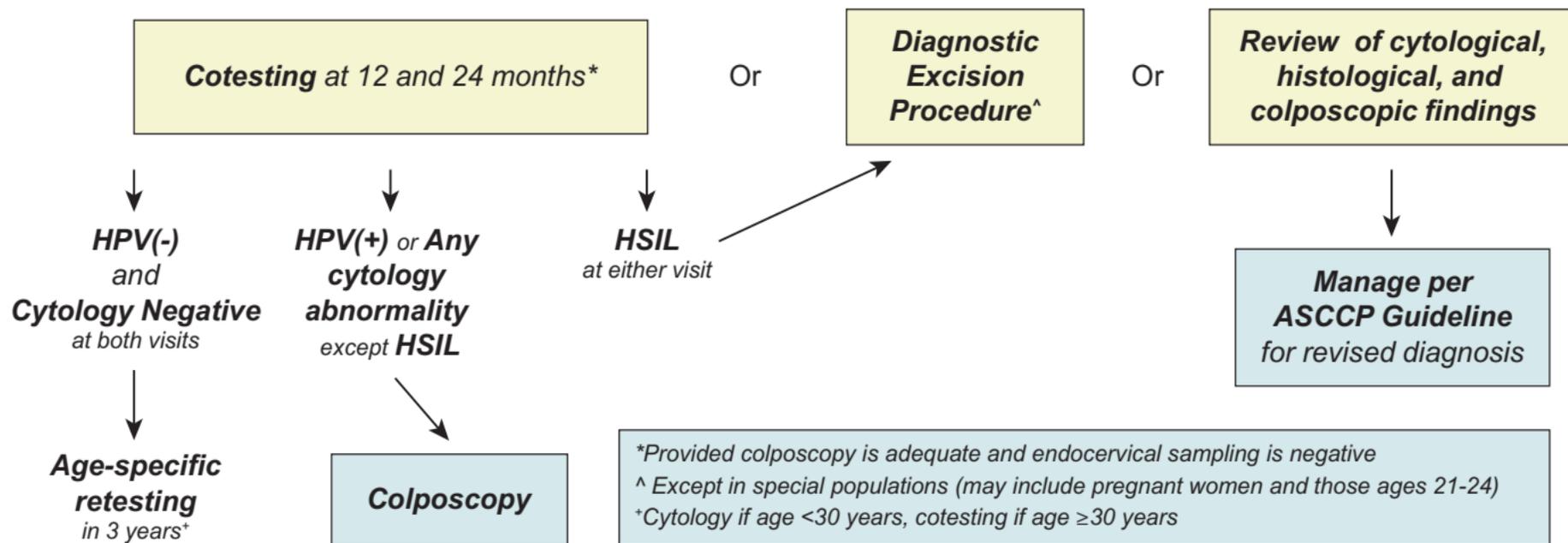


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Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 1 (CIN1) Preceded by “Lesser Abnormalities”^{*∞}

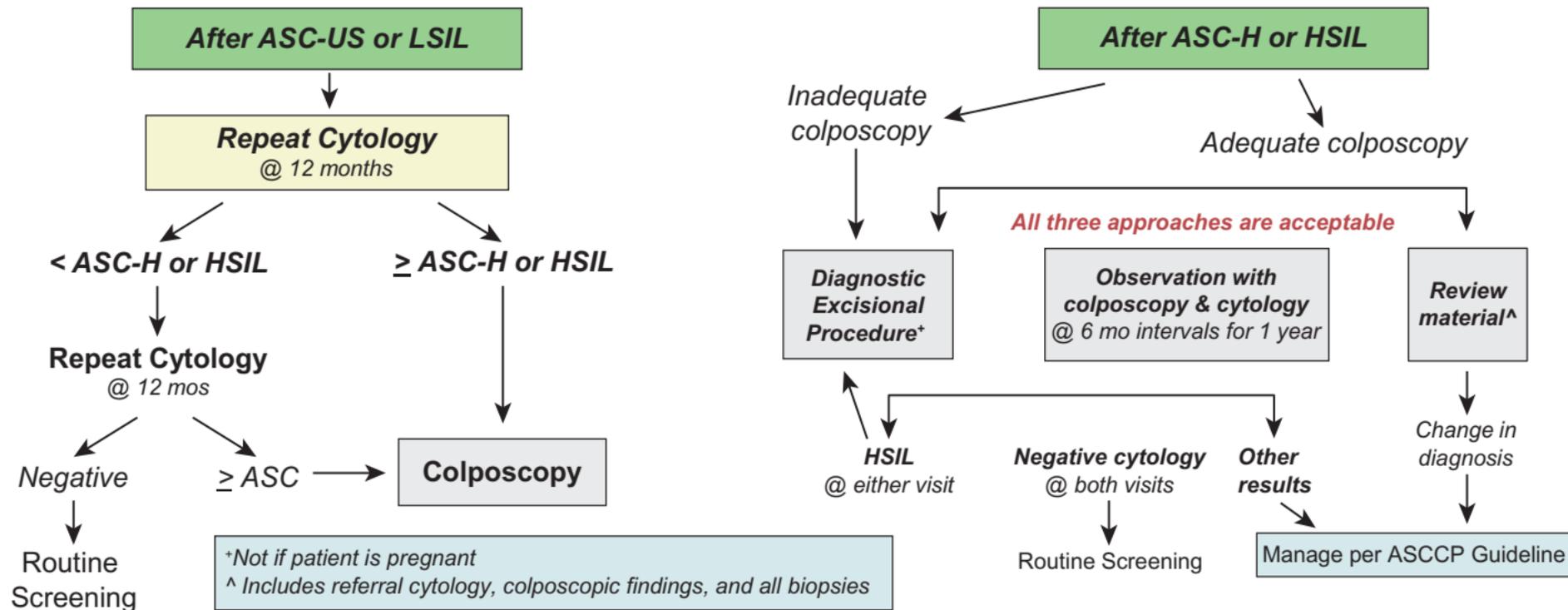


Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 1 (CIN1) Preceded by ASC-H or HSIL Cytology



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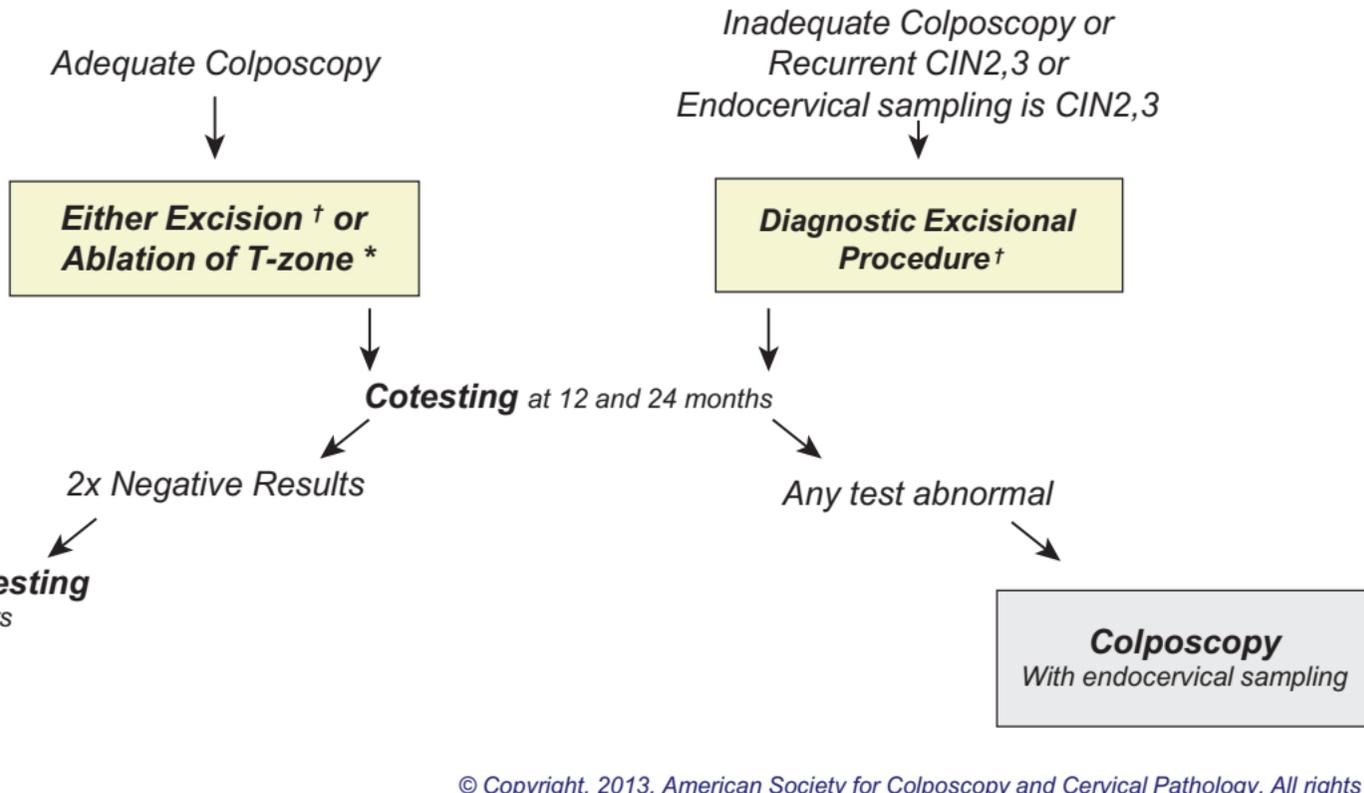
Management of Women with No lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 1 (CIN1) in Women Ages 21-24



Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 2 and 3 (CIN2,3)*

*Management options will vary in special circumstances or if the woman is pregnant or ages 21-24

†If CIN2,3 is identified at the margins of an excisional procedure or post-procedure ECC, cytology and ECC at 4-6mo is preferred, but repeat excision is acceptable and hysterectomy is acceptable if re-excision is not feasible.

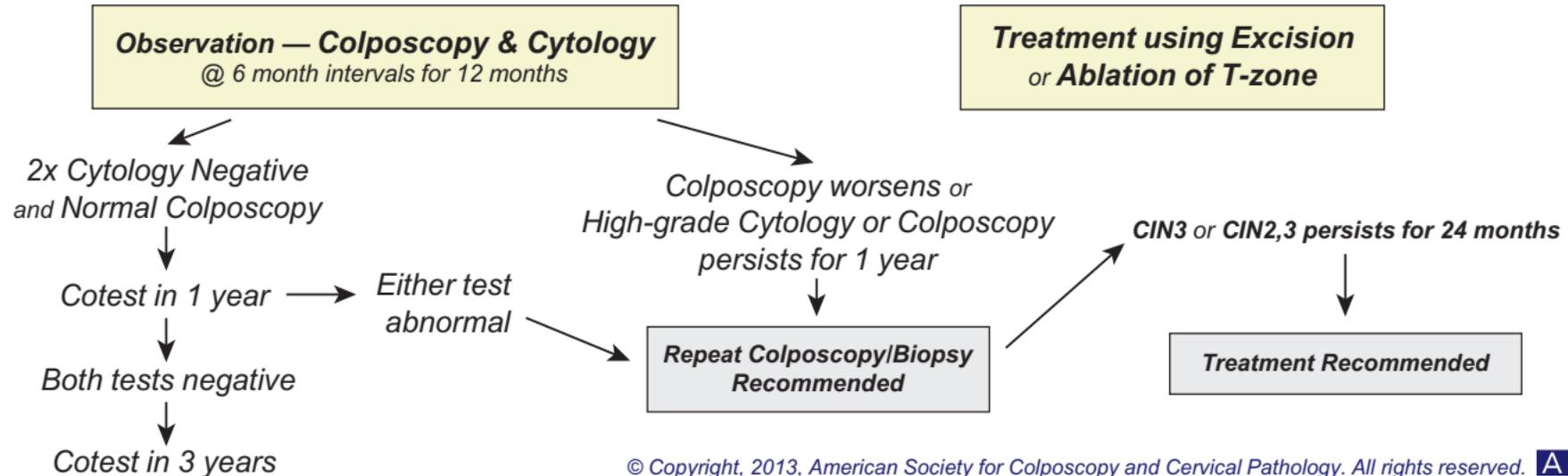


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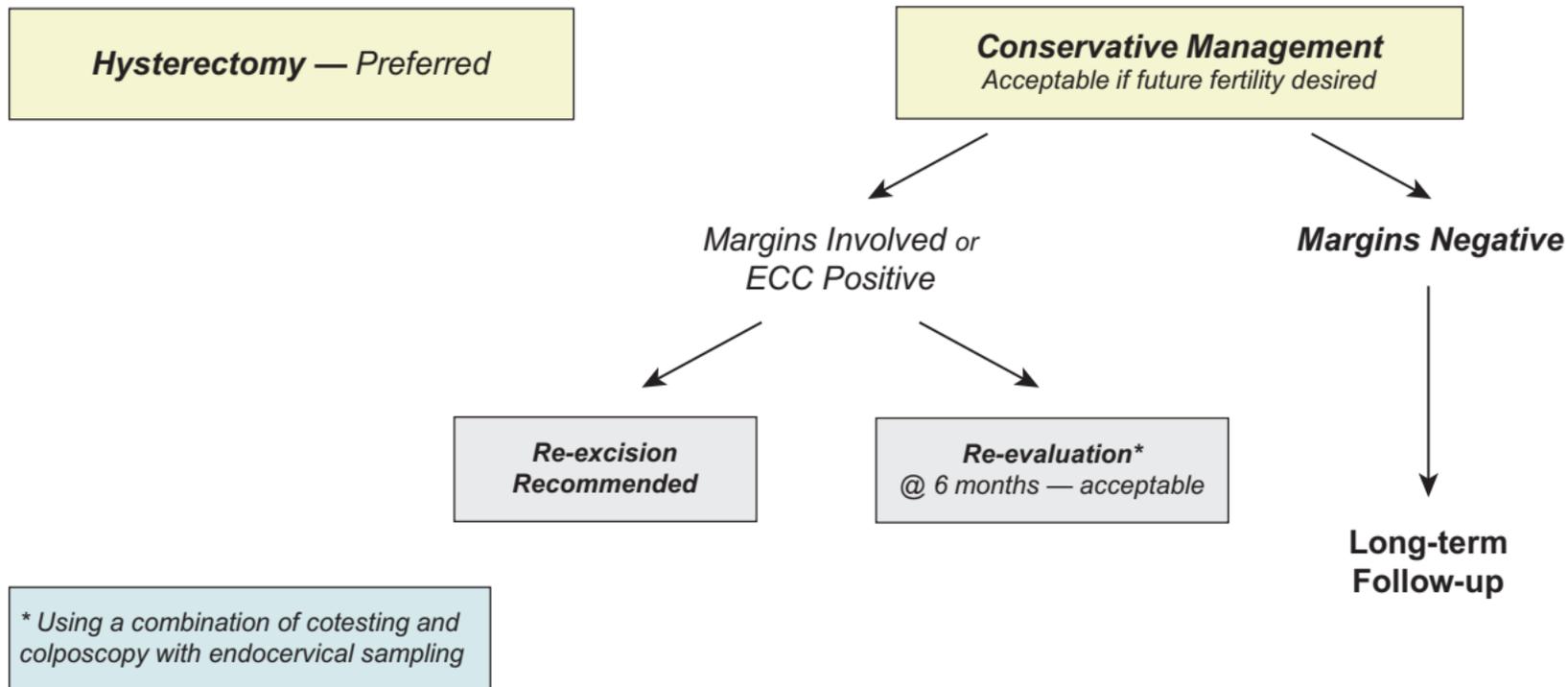
Management of Young Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia — Grade 2,3 (CIN2,3) in Special Circumstances

Young Women with CIN2,3

Either treatment or observation is acceptable, provided colposcopy is adequate. When CIN2 is specified, observation is preferred. When CIN3 is specified, or colposcopy is inadequate, treatment is preferred.



Management of Women Diagnosed with Adenocarcinoma in-situ (AIS) during a Diagnostic Excisional Procedure



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Interim Guidance for Managing Reports using the Lower Anogenital Squamous Terminology (LAST) Histopathology Diagnoses

***Low Grade Squamous
Intraepithelial Lesion
(LSIL)****



***Manage like
CIN1***

**Histopathology Results only.*

***High Grade Squamous
Intraepithelial Lesion
(HSIL)****



***Manage like
CIN2,3***

Definitions

Terms Utilized in the Consensus Guidelines

- **Colposcopy** is the examination of the cervix, vagina, and, in some instances the vulva, with the colposcope after the application of a 3-5% acetic acid solution coupled with obtaining colposcopically-directed biopsies of all lesions suspected of representing neoplasia.
- **Endocervical sampling** includes obtaining a specimen for either histopathological evaluation using an endocervical curette or a cytobrush or for cytological evaluation using a cytobrush.
- **Endocervical assessment** is the process of evaluating the endocervical canal for the presence of neoplasia using either a colposcope or endocervical sampling.
- **Diagnostic excisional procedure** is the process of obtaining a specimen from the transformation zone and endocervical canal for histopathological evaluation and includes laser conization, cold-knife conization, loop electrosurgical excision procedure (LEEP), and loop electrosurgical conization.
- **Adequate colposcopy** indicates that the entire squamocolumnar junction and the margin of any visible lesion can be visualized with the colposcope.
- **Endometrial sampling** includes obtaining a specimen for histopathological evaluation using an endometrial aspiration or biopsy device, a “dilatation and curettage” or hysteroscopy.

Acknowledgments

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CENTRAL OFFICE APPROVAL FOR LEEP PROCEDURE

Plases Fax to - (615) 741-3806 Supporting Documentation, Data Transmittal Sheet, and Contact Information

Date: _____ **Screening Site:** _____

Contact Person: _____ **Email:** _____

Fax Number: _____ **Phone :** _____

Patient Name: _____ **DOB:** _____

Description of Services Requested:

Signature of Staff Requesting LEEP:

_____ **Date:** _____

Signature of Central Office Person Authorizing Approval:

_____ **Date:** _____

Procedure is considered approved when screening site receives this document back with Authorizing Approval signed as confirmation. Please Print information except where requested signature.

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FOR WOMEN UNDER 40

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Sheet, and Contact Information

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Contact Person: _____ **Email:** _____

Fax Number: _____ **Phone:** _____

Patient Name: _____ **DOB:** _____

Description of Suspicious Findings and Diagnostic Services Requested:

Signature of Staff Person Requesting Diagnostic Services:

_____ **Date:** _____

Signature of Central Office Person Authorizing Approval:

_____ **Date:** _____

Procedure is considered approved when screening site receives this document back with Authorizing Approval signed as confirmation. Please Print information except where requested signature.