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National Overview

CDC provides access to critical breast and cervical cancer screening services for underserved women in the United States, the District of Columbia, 4 U.S. territories, and 13 American Indian/Alaska Native organizations. Prior to 1990, CDC’s Division of Cancer Prevention and Control laid the groundwork for building early detection programs by funding a few states to work on the design and implementation of breast and cervical cancer screening services for medically underserved women. In part through the advocacy of CDC’s national partners, Congress recognized the importance of establishing a nationwide program and passed the Breast and Cervical Cancer Mortality Prevention Act of 1990. This landmark legislation authorized CDC to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). To begin the effort, Congress appropriated $30 million in fiscal year (FY) 1991 to fund efforts by the first eight states to establish early detection programs. Early lessons showing that individual programs needed more time for capacity building led to the development of a two-stage funding process. The Capacity Building Program offered grantees the opportunity to recruit personnel and design service delivery. After they developed their infrastructure, grantees were funded through a competitive application process to begin screening women primarily from low-income, under- or uninsured, and racial or ethnic minority groups. Since then, the NBCCEDP has experienced substantial growth and a number of legislative and policy changes.

- **1991—Beginning of the NBCCEDP.** CDC funded eight states in fiscal year (FY) 91 and added four more in FY 92.
- **1992—Implementation of the Capacity Building Program.** CDC funded an additional 18 states to develop the infrastructure necessary to deliver screening programs.
- **1993—Amendment of the Breast and Cervical Mortality Prevention Act of 1990 (Public Law 103 183).** This amendment authorized NBCCEDP funding for American Indian/Alaska Native Tribes and tribal organizations and required CDC to give funding priority to those states with a high disease burden from breast or cervical cancer.
- **1996—Establishment of mammography age guidelines.** The NBCCEDP established a goal that 75% of federally funded mammograms be provided to women 50 years of age or older.
- **1997—Nationwide expansion of the NBCCEDP.** Funding was provided to 50 states, the District of Columbia, 5 territories, and 13 tribes or tribal organizations.
- **1998—Exclusion of Medicare-eligible women.** As a result of Medicare adding these cancer screening services under the Part B coverage option, women enrolled in Medicare–Part B were excluded from the NBCCEDP-eligible population.
- **1998—Passage of Women’s Health Research and Prevention Amendments of 1998 (Public Law 105-340).** Congress allowed the NBCCEDP to add case management as a program component and enabled program grantees to contract with for-profit entities.
1999—Passage of Balanced Budget Refinement Act of 1999 (Public Law 106 113). Congress allowed the NBCCEDP to raise the reimbursement rate for Pap tests from $7.15 to $14.60 and to adjust the rate annually for inflation.

2000—Implementation of Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106 354). Congress gave states the option to provide medical assistance through Medicaid to eligible women who were screened and found to need treatment for breast or cervical cancer or precancerous conditions.

2000—Cervical cancer screening policy change. NBCCEDP grantees were encouraged to focus cervical cancer screening on women who had rarely or never been screened and to decrease over-screening of women enrolled in the program.

2001—Passage of Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001 (Public Law 107 121). Congress amended Title XIX of the Social Security Act to clarify that Indian women with breast or cervical cancer who are eligible for health services provided under a medical care program of the Indian Health Service or of a tribal organization should be included in the optional Medicaid eligibility category of breast or cervical cancer patients added by the Breast and Cervical Cancer Prevention and Treatment Act of 2000. (http://www.cdc.gov/cancer/nbccedp/index.htm)

BCCCP

Since 1991, the Michigan Department of Community Health (MDCH) has implemented a comprehensive Breast and Cervical Cancer Control Program (BCCCP) through a multi-year grant from the U.S. Centers for Disease Control and Prevention (CDC). With these funds, low-income women now have access to life-saving cancer screening services and follow-up care, including cancer treatment if that should be needed.

Through this program, women who have breast and cervical cancer will be identified at earlier stages of these diseases, when treatment is less expensive and the survival rate is more favorable. Working together, participating medical providers and local health agencies can ensure that the highest quality breast and cervical cancer control services are available to all women in their communities.

Women throughout Michigan may seek these services from local health departments and over 725 contracted BCCCP providers across the state. Services are also available through tribal health clinics of federally recognized Indian tribes.

BCCCP services are coordinated through 19 local health departments across Michigan, as well as the Karmanos Cancer Institute in Detroit. These agencies have enlisted the cooperation and participation of physicians, hospitals, and other health care organizations in their communities to assure that all necessary follow-up services are provided.

Local agencies are required to provide or arrange for basic screening services, i.e., clinical breast exams, screening mammograms, pelvic exams, Pap smears, and patient education.
Some local agencies are delivering these basic services through their existing or expanded department staff. Others are providing the basic services through subcontracts with community providers. Local agencies usually contract with radiology facilities to provide mammography services to enrolled women, as well as with clinical laboratories to analyze Pap tests. (http://www.michigancancer.org/bcccp/)

**FP/BCCCP Joint Project**

Women between the ages of 18 – 39, identified with a cervical abnormality through the Family Planning (Title X) Program, can be referred to the BCCCP for cervical cancer diagnostic follow-up.

Plan First! is a program that provides limited Medicaid to women, ages 19-44, who are at 185% of the federal poverty level. It became effective July 1, 2006.

**STD/BCCCP Joint Project**

Women of any age seen in health department STD clinics in the two participating counties (Berrien and Jackson) will receive Pap tests, and if needed, follow-up according to the BCCCP Medical Protocol. Breast cancer screening services are covered according to BCCCP guidelines.
Minimum Program Requirements

There are minimum standards local health departments must have in place to run the program. The BCCCP Minimum Program Requirements (MPRs) are issued annually several months prior to the beginning of the fiscal year. They are based on requirements from CDC, as the funding agency for the program, and are part of the contract the state has with the local health departments. An electronic copy of the MPRs can be found at: http://www.michigancancer.org/bcccp/LocalAgencyInformation/MinimumProgramRequirements.pdf

Approximately one-third of all BCCCP local health departments are included in the MDCH accreditation process each year.

An Accreditation Guidance Document is provided through the Accreditation Program Website (http://www.accreditation.localhealth.net/Tools.htm) to the local health departments at least 6 months prior to the accreditation site visit. The guidance document details specific indicators to be measured and describes the specific documentation needed to meet each indicator.

During the accreditation site visit, reviewers from the state BCCCP assess the local health department’s compliance with the BCCCP MPR’s.
SECTION X:
BREAST AND CERVICAL CANCER CONTROL PROGRAM

X1. Coordinate with MDCH/Cancer Prevention and Control Section an annual review of minimum program and reporting requirements.

Reference: PL 101-354, Section 1501(a)(6); CDC Administrative Guidance; CPBC provision

1.1 Requirements to continue screening services are met as evident from the annual site evaluation.

This indicator may be met by:

a. There must be evidence that the local health department is continuously meeting the CDC program requirements.

Documentation Requested:

• None. This indicator is met as a result of scheduling the accreditation visit.

Evaluation Question:

• None
X2. Record nonfederal hard and/or soft local match at no less than 25 percent of the local health department’s MDCH/Cancer Prevention and Control Section BCCCP funding.

Reference: PL 101-354, Section 1502(a)(b)(1)(2)(3); Amended Section 402 (c); CDC Administrative Guidance; State Advisory Committee Policy (WCDC)

2.1 Documentation exists of appropriate sources and amounts of nonfederal match, excluding the difference between providers' usual and customary charges and BCCCP rates.

This indicator may be met by:

a. The local health department must submit the “Breast and Cervical Cancer Matching Funds Report” to MDCH/Cancer Prevention and Control Section, which will include appropriate sources and amounts of nonfederal matching funds.

b. Documentation should be maintained on file that provides details on the Matching Funds Report, such as a list of providers who donate services and the types of services they provide.

Documentation Required:

- A copy of the last fiscal year ended Matching Funds Report including the Discoverer Viewer report (direct service match). If the community match consists entirely of reported direct service match, no additional documentation is required. If match beyond direct service match was submitted, documentation is required to support the match calculations as reported on the last fiscal year ended Matching Funds Report. (Minimum acceptable level of documentation: 100% correlation of documentation to Matching Funds Report.)

Evaluation Questions:

- Did the local health department meet 25% community match requirement for last fiscal year?
Yes  No

Is documentation available to fully support the match calculations?

Yes  No

If yes, provide documentation for the last fiscal year Matching Funds Report.

2.2 Matching Funds Report with details of nonfederal match contributions is submitted to MDCH/Cancer Prevention and Control Section by “Final” Financial Status Report (FSR) due date (due date is specified in contract between local health department and MDCH).

This indicator may be met by:

a. MDCH/Cancer Prevention and Control Section is in receipt of the “Breast and Cervical Cancer Matching Funds Report” by “Final” FSR due date.

Documentation Required:

• Breast and Cervical Matching Funds Report and date mailed to MDCH/Cancer Prevention and Control Section on file at local health department.

Evaluation Question:

• Was last fiscal year ended Matching Funds Report received by MDCH/Cancer Prevention and Control Section on or before the FSR due date?

Yes  No
X3. There is a system in place to monitor and take corrective action, as appropriate, to assure that the reimbursement amount paid to providers for each BCCCP-approved service is accepted as payment in full.

Reference: PL 101-354, amended Section 402(a)(1)(3); CDC Administrative Guidance

3.1 Documentation exists in the contracts and/or letters of agreement that providers receiving any BCCCP funds agree to accept up to the BCCCP reimbursement rate as payment in full for each BCCCP client.

This indicator may be met by:

a. The local health department maintains on file a contract or letter of agreement with each BCCCP clinical service provider stating that the provider agrees to accept up to the BCCCP reimbursement rate as payment in full for each BCCCP service.

Documentation Requested:

- All signed last fiscal year ended BCCCP clinical service provider contracts or letters of agreement should be pulled from files and made available to reviewers. On-site reviewers will select a sample for review.

Evaluation Question:

- Does each subcontracted physician/hospital/laboratory arrangement, in the sample selected by the on-site reviewers, reflect the providers’ agreement to accept the BCCCP reimbursement rate as payment in full for each BCCCP-authorized procedure?

  □ Yes □ No

3.2 There exists a written policy that clients are not billed for BCCCP-reimbursed services AND that outlines corrective measures when inappropriate billing occurs.
This indicator may be met by:

a. The local health department maintains on file written evidence of a policy:

- That providers have agreed, to the best of their ability, not to bill clients for any services that have been reimbursed by the BCCCP in part or in full; **AND**

- That documents the corrective measures that are taken when inappropriate billing occurs.

**Documentation Requested:**

- All signed last fiscal year clinical service provider contracts or letters of agreement stating providers should be pulled from files and made available to reviewers. Contracts and/or agreements should state providers “will not bill any BCCCP client for any service that is partially or fully covered by the BCCCP reimbursement amount for that service” or similar language.

- Written policy and/or procedure outlining procedure for identifying cases of inappropriate billing and corrective measures instituted to rectify inappropriate billing.

**Evaluation Question:**

- Has the local health department provided the specified documentation required for evaluation?

☐ Yes ☐ No

3.3 Fully-executed, current, written arrangements, consistent with BCCC Program requirements, exist for all providers reimbursed by state or federal funds.

This indicator may be met by:

a. The local health department maintains on file copies of contracts and/or letters of agreement for all providers reimbursed by state or federal funds.
Documentation Requested:

- All signed last fiscal year ended BCCCP clinical service provider contracts or letters of agreement should be pulled from the files and made available to reviewers.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

  □ Yes  □ No
X4. Assure compliance with the “funds of last resort” requirement in the federal law.

Reference: PL 101-354, Section 1504(d)(1)(2)

4.1 Each client’s insurance information is accurately recorded at the time of enrollment and at each rescreening visit. A front and back copy of each insured client’s insurance card is made at the time of enrollment and at each rescreening visit or documentation stating reason why copy of insurance card could not be obtained. Whenever possible, coverage for BCCCP services is verified with the insurance carrier to ensure that the client’s plan is not a prepaid managed care plan or other arrangement under which the client could receive coverage for BCCCP services by seeing a plan provider.

This indicator may be met by:

a. The local health department maintains on file:

   • A front and back copy of each insured client’s insurance card that is made at the time of enrollment and each rescreening visit or documentation stating reason why copy of insurance card could not be obtained; **AND**

   • Written evidence of the local health department’s process/procedure for determining BCCCP eligibility for insured women. This process/procedure should include a statement of the health department’s practice regarding verification of clients’ self-reported insurance coverage.

**Documentation Requested:**

   • Client chart records, and copy of front and back of the insurance cards (or record of why insurance card could not be obtained) for all insured clients documenting insurance information for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).

   • Written policy outlining steps/procedures for determining BCCCP eligibility for insured women. Policy should also include a
statement of the local health department’s procedure for verifying self-reported insurance coverage, and should also include what steps are taken to assure that women insured through a prepaid managed care plan or comprehensive PPO are excluded from the program.

Evaluation Questions:

- Has the local health department provided written policy for evaluation with all specified documentation required?
  
  □ Yes □ No

- Do May chart records/insurance records of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) show evidence that each client’s insurance information is accurately recorded at the time of enrollment and at each rescreening visit (e.g., copy of insurance card, accurately documented on the client enrollment form, etc)?

  □ Yes □ No

4.2 FOR HEALTH DEPARTMENTS PROVIDING CLINICAL SERVICES.
There is maximum recovery of all available insurance revenues for local health department-provided services through effective third party billing mechanisms, as evidenced by claims data/forms, Explanation of Benefits (EOB), or other auditor-approved documentation.

This indicator may be met by:

a. The local health department maintains on file billing records documenting that all available insurances have been billed appropriately and that each claim has been settled, as evidenced by EOBs or other auditor-approved documentation.

Documentation Requested:

- Copies of submitted claim data/forms for all insured clients with services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).
• Explanation of Benefits (EOB) forms or other local auditor approved documentation indicating resolution of insurance claims.

Evaluation Questions:

• Does the local health department maintain billing records on file that document the local health department’s insurance billing activities, including EOB forms or other local auditor approved documentation?

☐ Yes ☐ No

If no, explain how the local health department assures that insurance is being billed in accordance with BCCCP requirements.

• Do the billing records indicate that all available insurances have been billed appropriately for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) and that each claim has been settled, as evidenced by EOB forms or other local auditor approved documentation?

☐ Yes ☐ No

4.3 FOR HEALTH DEPARTMENTS PROVIDING CLINICAL SERVICES.

Documentation exists that there is follow-up with third party carriers on all unresolved insurance claims until the claims are fully adjudicated.

This indicator may be met by:

a. The local health department maintains on file billing records documenting that there is follow-up with third party carriers on all unresolved insurance claims until the claims are fully adjudicated.

Documentation Requested:

• Copies of submitted claim forms for all insured clients with services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).
• Explanation of Benefits (EOB) forms or local auditor approved documentation indicating resolution of insurance claims.

• Third party billing records for in-house services (if applicable) provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).

Evaluation Question:

• Does the local health department maintain billing records on file documenting that all insurance claims for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) were resolved with the carrier (e.g., either paid or rejected)?

☐ Yes ☐ No
X5. Assure that an accurate and integrated system of fiscal management is maintained on-site for health departments providing clinical services; assure that a system of communication is maintained across all other sites of clinical service delivery.

Reference: PL 101-354, Section 1504(d)(1)(2)

5.1 A system of communication exists between local health department staff and BCCCP providers to enable accurate and timely processing of clinical service data, and to assure adequate provider training and support in resolving clinical and billing issues.

This indicator may be met by:

a. The local health department maintains on file, clinical data forms, letters with test results, and insurance billing documentation (if clinical services provided at health department); AND

b. The BCCCP Coordinator maintains on file a description of the required communications between BCCCP staff at the local health department and subcontracted provider staff; AND

c. Written evidence of the local health department’s process/procedure for gathering clinical service data from each BCCCP provider/clinic and verifying the accuracy of the data.

Documentation Requested:

- Description of the system the local health department uses to maintain on file, clinical data forms, letters with test results, and insurance billing documentation (if clinical services provided at health department).

- Description of the required communications between BCCCP staff at the local health department and subcontracted provider staff.
• Written policy outlining the procedure for gathering clinical service data from each BCCCP provider/clinic and verifying the accuracy of the data.

Evaluation Questions:

• Is there evidence of a system (e.g., flow chart, regular staff minutes, etc.) for routing information from MBCIS Data Forms and/or test results or copies of exam results to all appropriate individuals?
  ☐ Yes ☐ No

• Is there a description of the required communications (e.g., data form requirements, scheduled visits by the Coordinator, specific individual contacts, etc.) between BCCCP staff at the local health department and subcontracted provider staff maintained on file at the local health department?
  ☐ Yes ☐ No

• Is there a written policy outlining the procedure for gathering clinical service data?
  ☐ Yes ☐ No

5.2 FOR HEALTH DEPARTMENTS PROVIDING CLINICAL SERVICES. Financial documentation exists for all clinical services provided to each BCCCP client—by date of service—for local health department-provided BCCCP services. Records indicate the following information: 1) the amount billed to and paid by insurance (for insured clients as evidenced by an EOB or other auditor-approved documentation); and 2) the amount billed to the Third Party Administrator (TPA) contracted by MDCH to provide BCCCP reimbursement.

This indicator may be met by:

a. The local health department maintains on file financial records that show:
  • The amount billed to the insurance company; AND
- The amount paid by the insurance company (if any), as evidenced by an EOB or other auditor-approved documentation; **AND**

- The amount billed to TPA.

**Documentation Requested:**

- Financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) as indicated in “This indicator may be met by” above.

**Evaluation Questions:**

- Have financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) been provided for evaluation, including at least one example of each item included in “This indicator may be met by” above?

  □ Yes  □ No

- Do the financial records indicate:

  a. The amount billed to the insurance company (if applicable)?

     □ Yes  □ No

  b. The amount paid by the insurance company (if any), as evidenced by an EOB or other auditor-approved documentation?

     □ Yes  □ No

  c. The amount billed to the TPA?

     □ Yes  □ No

**5.3 FOR DIRECT CLINICAL SERVICES PROVIDED THROUGH THE LOCAL HEALTH DEPARTMENT.** Billing to the TPA for local health
department-provided BCCCP services is based on accurate financial records, after insurance billings have been resolved.

This indicator may be met by:

a. There is evidence that the local health department has a financial record-keeping system that tracks billing information for in-house clinical services, and that this system is used to calculate the amounts billed to the TPA.

Documentation Requested:

- Financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served)

Evaluation Question:

- Do financial records from the local health department’s financial record-keeping system related to all services provided during May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) correspond with claim payment?

☐ Yes    ☐ No
X6. **Assure that there is community involvement with issues related to relationships with the medical community, resources for follow-up care, and recruitment of target populations.**

Reference PL 101-354, Section 1504(e); CDC Administrative Guidance

6.1 Evidence exists of processes for routine communications with providers who are part of the BCCCP delivery network, e.g., advisory committee proceedings, regular meetings with key providers, individually or in groups; key contact people identified throughout the BCCCP delivery network; and activities designed to increase general provider awareness of the BCCCP, for example distribution of packets and newsletters.

This indicator may be met by:

a. The local health department maintains on file evidence of routine communications through minutes from meetings, agendas, letters, email, correspondence, and faxes; **AND**

b. There is evidence of activities designed to increase general provider awareness, e.g., as described in the semi-annual report.

Documentation Requested (Combination of the following should demonstrate routine communications such that all providers are contacted with program updates, opportunities to address provider concerns, and access to at least annual training for new staff):

- Agenda/minutes/membership of most recent provider/advisory meetings
- Provider mailing list for BCCCP Newsletter
- Correspondence/memos/phone calls to providers within the last 6 months
- Most recent semi-annual report or other correspondence that lists activities to increase general provider awareness
Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

☐ Yes  ☐ No

6.2 Evidence exists that recruitment and promotion efforts are planned and implemented with involvement from the local ACS and community groups representing target populations.

This indicator may be met by:

a. The local health department maintains on file evidence that recruitment and promotion efforts are planned and implemented through PSAs, public awareness flyers, semi-annual newsletters, and information packets and as described in the semi-annual report.

Documentation Requested (Combinations of the following should demonstrate active partnerships with representatives of community groups that represent and advocate for target populations):

- Most recent steering committee minutes/agenda/membership
- Most recent semi-annual report – with activities listed that demonstrate partnerships with ACS or other community groups
- Other documentation of ACS or other community organization collaboration

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

☐ Yes  ☐ No

6.3 Evidence exists that efforts to maintain and expand the BCCCP delivery network are planned and implemented with involvement from the local ACS and community groups representing priority populations, i.e.,
advisory committee proceedings, phone calls, written correspondence, etc.

This indicator may be met by:

a. The local health department maintains on file evidence that efforts to maintain and expand the BCCCP delivery network are planned and implemented through meeting minutes; increasing the number of providers and/or the number of providers is maintained.

Documentation Requested (Describing efforts to address provider concerns, increase provider awareness, and assure the satisfaction of providers with the program):

- Steering committee/advisory meeting minutes from the last 12 months
- Semi-annual report from the last 12 months that lists efforts to recruit providers

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

  □ Yes   □ No
X7. Recruit women eligible for the BCCC Program, giving priority to minorities and women aged 50 to 64 and women who have previously been screened through the BCCCP.

Reference: PL101-354, Sections 1501 (a)(3) and 1504 (a); CDC Administrative Guidance

7.1 A plan exists to recruit eligible women into the local BCCCP, including specific strategies for locally significant and target populations.

This indicator may be met by:

a. The local health department maintains on file a plan to recruit eligible women from the target populations into the local BCCCP.

Documentation Requested:

- The local health department’s written plan to recruit eligible women from the target populations into the local BCCCP

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

  □ Yes   □ No

7.2 Data from the MDCH/Cancer Prevention and Control Section BCCCP database and the current demographic information available indicate that the percent of individual minority populations served by the local health department is equal to or higher than the percent in residence in the local health department’s jurisdiction (for minority populations of significant representation in those areas).

This indicator may be met by:

a. The local health department consults current demographic information (e.g., census data) to determine the percentage of individual minority populations within its jurisdiction; AND
b. The local health department uses and compares data from the MDCH/Cancer Prevention and Control Section BCCCP database with the current demographic information to ensure that it serves individual minority populations at a percentage equal to or higher than the percentage of individual minority populations represented in the local health department’s jurisdiction.

**Documentation Requested:**

- Current demographic information (e.g., census data) indicating the percentage of individual minority populations in the local health department’s jurisdiction
- Data from the BCCCP database indicating the percentage of BCCCP clients from the individual minority populations
- Evidence that the agency has used and compared data from the BCCCP database with the current demographic information to ensure that it serves individual minority populations at a percentage equal to or higher than the percentage of individual minority populations represented in the local health department’s jurisdiction

**Evaluation Questions:**

- Has the local health department provided the specified documentation required for the evaluation?
  
  □ Yes    □ No

- Does the documentation provided indicate that the local health department serves individual minority populations at a percentage equal to or higher than the percentage of individual minority populations represented in the local health department’s jurisdiction?
  
  □ Yes    □ No

7.3 Strategies are implemented regarding the retention in the program of eligible previously-screened women from the target populations. Documentation exists as evidence of ongoing efforts to retain previously screened women from the target populations, e.g., client records, tracking logs (computerized or paper).
This indicator may be met by:

a. There is a mechanism in place that documents that patients are contacted for follow-up re-screenings (i.e., tracking logs, either/or client records).

Documentation Requested:

- Documentation exists (e.g., tracking logs, either/or client records) that a patient was called for follow-up re-screenings.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

☐ Yes  ☐ No
X8. Obtain each woman’s informed consent at the beginning of each annual screening cycle.

Reference: State Advisory Committee Policy (WCDC)

8.1 Evidence is available from CHART REVIEWS that annual signed Informed Consent and Release of Information forms are present.

This indicator may be met by:

a. The local health department provides documentation of a written process in obtaining and verifying, on an annual basis, BCCCP clients’ informed consent (signed/initialed and dated during the current screening year).

b. The local health department is able to show evidence of signed/initialed and dated informed consents of clients receiving services during a specified time period.

Documentation Requested:

- Written process describing how the local health department obtains and re-verifies on an annual basis a BCCCP client’s informed consent

- Client charts will be reviewed for evidence of signed/initialed and dated informed consents covering the time period screening and diagnostic services were rendered (1 year from date signed on form).

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

  □ Yes  □ No
X9. **Assure that screening and follow-up services meet minimum state/federal requirements as specified for:** a) **Mammography facilities,** b) **Michigan licensed: Physicians, Certified Nurse Practitioners, Certified Nurse Midwives or Physician Assistants,** c) **Adherence to the BCCCP Medical Protocol.**

Reference: PL101-354, Sections 1501(a)(5) and 1503(c)(d)(e); Amended Section 402 (c). State Advisory Committee Policies (WCDC, MCC)

9.1 Verification exists that all mammography facilities used have passed the state inspection.

**This indicator may be met by:**

a. The local health department provides documentation or maintains on file certificates showing mammography facilities have passed the state inspection.

**Documentation Required:**

- Copies of mammography facilities’ certificates or documentation that mammography facilities have passed the state inspection (i.e., copies of Mammography Facility Status reports sent from MDCH to local health department)

**Evaluation Question:**

- Is the local health department able to produce a sample of at least 10% of contracted mammography facilities’ certificates upon request if they DO NOT receive copies of Mammography Facility Status reports sent from the Radiation Safety Section at the Michigan Department of Community Health?

☐ Yes  ☐ No
9.2 Evidence exists through signed clinical charts that SCREENING services are provided by Certified Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, or Physicians. Clinical breast exams, Pap and pelvic exams may be provided by nurses with documented special training related to that service who are supervised on site by a Certified Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, or Physician.

This indicator may be met by:

a. Written policy/procedure/process is in place for nurses who are trained to perform clinical breast exams, pap exams and pelvic exams and are supervised on site by a Certified Nurse Practitioner, Physician Assistant, or Physician.

Documentation Requested:

- During site visit, the local health department will provide:
  a. Evidence of written policy/procedure/process for nurses who are trained to perform clinical breast exams, pap exams and pelvic exams and are supervised on site by a certified Nurse Practitioner, Physician Assistant, or Physician is in place.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

☐ Yes ☐ No

9.3 The local health department has a policy that requires the review of provider licenses at the time of initial hire or contract; in the event of transfers or promotions upon individual attainment of a new level of provider license; and routinely at specified intervals for all local health department and subcontracted providers.

This indicator may be met by:

a. The local health department has a written policy on file that requires review of provider licenses: at the time of initial hire or contract; upon transfers or promotions upon individual attainment of a new level of
provider license; and routinely at specified intervals for all local health department and subcontracted providers.

**Documentation Requested:**

- Written policy stating that provider licenses are reviewed at specified intervals – as stated in “This indicator may be met by.”

**Evaluation Question:**

- Does the local health department have a written policy stating the procedure for review of provider licenses?

  □ Yes  □ No

**9.4** Evidence exists that DIAGNOSTIC services are provided by qualified health care providers.

**This indicator may be met by:**

a. Signed contracts or letters of agreement of BCCCP providers providing diagnostic services during the current screening year is maintained by the local health department.

**Documentation Required:**

- During site visit, the local health department will provide:
  
a. Evidence of signed diagnostic provider contracts during current fiscal year.

**Evaluation Question:**

- Has the local health department provided the specified documentation required for the evaluation?

  □ Yes  □ No

**9.5** Where consultation reports are not yet in the chart, CHART REVIEWS should show documentation of referrals and efforts to obtain consultation reports.
This indicator may be met by:

a. In the cases of women who have abnormalities, and are referred for a consultation, a consultation note from the provider or efforts to obtain the consultation report will be verified by a chart review.

Documentation Required:

- None. Included as part of MPRO chart audit.

Evaluation Question:

- None at site visit

9.6 Evidence exists through CHART REVIEWS that the BCCCP Medical Protocol is being followed or a rationale for alternate clinical pathway is documented.

This indicator may be met by:

a. A review of patient charts demonstrates that the BCCCP Medical Protocol is being followed or a rationale for alternate clinical pathway is documented, e.g., for clients with:

- CBE result - abnormality- r/o breast cancer; AND/OR

- Mammogram result – suspicious abnormality, highly suggestive of malignancy, assessment is incomplete; AND/OR

- Pap result - ASC-H, HSIL, AGC, AND/OR Squamous cell carcinoma at least ONE diagnostic follow-up procedure is documented in the client’s medical record.

Documentation Required:

- None – Evaluated as part of the MPRO chart review

Evaluation Question:

- None
9.7 The local health department has a policy/procedure in place that describes the process implemented to ensure all contracted providers have received and reviewed the current BCCCP medical protocol.

This indicator may be met by:

a. The local health department producing a copy of the current BCCCP Medical Protocol upon request.

b. A review of the policy/procedure describing the process implemented by the local health department in ensuring all contracted providers receive and review the current BCCCP medical protocol.

Documentation required:

- Copy of the BCCCP Medical Protocol
- Copy of policy/procedure describing the process for distributing and reviewing the BCCCP Medical Protocol with contracted providers

Evaluation Question:

- Has the local health department provided the specified documents required for the evaluation?
  - Yes
  - No
X10. There is a system in place to monitor and to take corrective action as appropriate to assure that each enrolled woman is provided screening, diagnostic and treatment services as needed, regardless of her ability to pay.

Reference: PL 101-354, Sections 1501(a)(1)(2) and 1503(a)(1)(2)(a)(b); CDC Administrative Guidance; CDC Performance Indicators

10.1 A protocol is available indicating that all women requiring breast and/or cervical diagnostic and/or treatment services are receiving information, assistance or advocacy from the local health departments to reduce barriers to the receipt of diagnostic and follow-up services. Women in the BCCCP should be informed of the local health department’s availability to assist with seeking follow-up services at the time of initial screening and again, at the time that a woman is informed that she has abnormal results requiring follow-up.

This indicator may be met by:

a. Evidence of a written protocol stating that BCCCP women requiring breast and/or cervical diagnostic and treatment services are informed of the local health department’s availability to assist with seeking follow-up services at the time of initial screening and again, at the time that a woman is informed that she has abnormal results requiring follow-up.

Documentation Requested:

- Documentation of written protocol in place at time of site visit.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

☐ Yes ☐ No
10.2 A tracking system is used to monitor and guide the care-coordination (and case management) provided to every enrolled woman.

This indicator may be met by:

a. Data from patient charts and the MBCIS are used to monitor and guide the care-coordination provided to every enrolled woman appropriately; AND

b. Written process/procedure is in place that describes:

• How women requiring immediate follow-up are identified for case management services; AND

• How women requiring short-term follow-up are tracked and notified when they need follow-up; AND

• How women requiring annual screening services are notified.

Documentation Requested:

• Documentation of written process/procedure at time of site visit

Evaluation Question:

• Has the local health department provided the specified documentation required for the evaluation?

☐ Yes ☐ No

10.3 Evidence is available from ANNUAL CHART REVIEWS that all women requiring IMMEDIATE follow-up based on abnormal breast and cervical screening results are receiving appropriate diagnostic services and/or treatment on a timely basis as defined in the CDC TIMELINESS Performance Indicators: 1) 75% of cases in which there is an abnormal screening result (requiring immediate follow-up) should have a final diagnosis within 60 days of that result; AND 2) 80% of clients with cancer diagnoses begin treatment within 60 days of the final diagnosis.
This indicator may be met by:

a. Charts of identified women requiring breast and/or cervical diagnostic and treatment services based on an abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received timely care according to the CDC Performance Indicators; OR

- Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year’s chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department’s quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

- None at site, part of MPRO chart review.

- If (1) not achieved, (2) will be evaluated by MDCH/Cancer Prevention and Control Section prior to site visit.

Evaluation Question:

- None at site visit

10.4 Evidence is available from ANNUAL CHART REVIEWS that all women requiring IMMEDIATE follow-up based on abnormal breast and cervical screening results are receiving: Appropriate diagnostic follow-up services with a documented final diagnosis and treatment disposition as defined in the CDC COMPLETENESS Performance Indicators:

1) 90% of abnormal screenings (requiring immediate follow-up) must have diagnostic work-up, final diagnosis, and treatment disposition documented; AND

2) 100% of clients with a cancer diagnosis need to have a treatment disposition within 100 days of diagnosis
This indicator may be met by:

a. Charts of identified women requiring breast and/or cervical diagnostic and treatment services based on an abnormal breast/cervical screening results requiring immediate follow-up indicate that women:
   
   • Have received appropriate and complete care according to the CDC Performance Indicators; OR
   
   • Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year’s chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department’s quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

• None at site, part of MPRO chart review.

• If (1) not achieved, (2) will be evaluated by MDCH/Cancer Prevention and Control Section prior to site visit.

Evaluation Question:

• None at site visit

10.5 For BCCCP women diagnosed with breast or cervical cancer who DO qualify for the Medicaid Treatment Act, documentation exists of a woman’s cancer diagnosis or precancerous condition and qualification for Medicaid.

This indicator may be met by:

a. The local health department maintains on file:

   • Documentation indicating a woman’s cancer diagnosis or precancerous condition; AND
• A copy of the Medicaid application along with supporting documentation for women who are not US citizens; **AND**

• A copy of the Medicaid approval letter.

**Documentation Required:**

• For all women enrolled under the Medicaid Treatment Act, documentation of the woman's cancer diagnosis or precancerous condition, a copy of the Medicaid application along with supporting documentation for women who are not US citizens, and a copy of the Medicaid approval letter

**Evaluation Question:**

• Has the local health department provided the specified documentation required for the evaluation?

☐ Yes ☐ No

10.6 For BCCCP women diagnosed with breast or cervical cancer who **DO NOT** qualify for the Medicaid Treatment Act, a policy/procedure is in place describing the local health department’s role in assisting women to obtain needed cancer treatment services.

**This indicator may be met by:**

a. The local health department:

• Is able to produce a policy/procedure describing their role in assisting women to obtain needed cancer treatment services **AND**

• Maintains on file a list of providers willing to assist women with low cost cancer treatment services and/or provide women with cancer treatment services regardless of ability to pay.

**Documentation Requested:**

• A written policy/procedure that states how the local health department will assist women who **DO NOT** qualify for Medicaid in obtaining needed treatment services **AND**
• A list of providers willing to assist women with low cost cancer treatment services and/or provide women with cancer treatment services regardless of ability to pay.

Evaluation Question:

• Has the local health department provided the specified documentation required for the evaluation?

☐ Yes ☐ No

10.7 Evidence is available from CHART REVIEWS of communications with women with abnormalities who refuse follow-up care and of attempts to facilitate informed decision-making regarding clinical necessity for follow-up and/or treatment

This indicator may be met by:

a. Documentation of communications with women with abnormalities who refuse follow-up care and of attempts to facilitate informed decision-making regarding clinical necessity for follow-up and/or treatment would be verified via annual chart review.

Documentation Required:

• MPRO will review chart documentation of with women that refuse follow-up care or treatment during the annual review.

Evaluation Question:

• None at site visit
X11. Maintain and utilize a computerized system (i.e., MBCIS) for tracking and monitoring clients.

Reference: PL 101-354, Section 1501(a)(6); CDC Administrative Guidance; CDC Performance Indicators

11.1 Evidence is available that program data are promptly collected and entered into the MCBIS within 60 days of client enrollment.

This indicator may be met by:

a. The local health department needs to have 75% of breast screening (CBE/Mammogram) data and cervical screening data (Pap/Pelvic exam) entered within 60 days of the breast screening result date and 60 days of the cervical result date.

Documentation Required:

- None. MDCH/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

- None at site visit

11.2 Evidence is available through matching data in both the clinical charts and the MBCIS that demonstrates congruency between the data and charts.

This indicator may be met by:

a. Data from patient charts must be entered accurately into the MBCIS as documented by comparisons during case record reviews. Evidence is available that:

- 100% congruency between the computer data and charts for all cancer diagnoses; AND

- 90% congruency between the computer data and charts for all other data
11.3 Evidence is available through analysis of MBCIS DATA that demonstrates timeliness of clinical services as defined by the CDC TIMELINES Indicators;

1) 75% of cases in which there is an abnormal screening result (requiring immediate follow-up) should have a final diagnosis within 60 days of that result; **AND**

2) 80% of clients with cancer diagnoses begin treatment within 60 days of the final diagnosis.

**This indicator may be met by:**

a. Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

   - Have received appropriate care according to the CDC Performance Indicators; **OR**

   - Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year’s chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department’s quality improvement plan/process to address plan for achieving CDC Performance Indicators.

**Documentation Required:**

- None. MDCH/Cancer Prevention and Control Section reviews off-site.
Evaluation Question:

- None at site visit

11.4 Evidence is available through analysis of MBCIS DATA that demonstrates COMPLETENESS of clinical service information as defined by CDC:

1) 90% of abnormal screenings (requiring immediate follow-up) must have diagnostic work-up, final diagnosis, and treatment disposition documented; **AND**

2) 100% of clients with a cancer diagnosis need to have a treatment disposition recorded in MBCIS within 100 days of diagnosis.

This indicator may be met by:

a. Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

   - Have received timely care according to the CDC Performance Indicators; **OR**
   - Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year’s chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department’s quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

- None. MDCH/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

- None at site visit
11.5 All individuals that access MBCIS have a completed, signed User Information/Usage Agreement form on file at MDCH/Cancer Prevention and Control Section.

This indicator may be met by:

a. The local health department must provide a list of MBCIS users. The list of users must match the MBCIS User Agreements on file at MDCH/Cancer Prevention and Control Section.

Documentation Required:

- A list of all MBCIS users with specific notation of those with “clinical” access

Evaluation Question:

- Do all individuals with “clinical” access have a MBCIS User Information/Usage Agreement form on file at MDCH?
Documentation Required for Accreditation

This section can be used to organize all the documents required for accreditation in order that they appear on the guidance document. Insert your document after the description page for each.
2.1 and 2.2

A copy of the last fiscal year ended Matching Funds Report including the Discoverer Viewer report (direct service match). If the community match consists entirely of reported direct service match, no additional documentation is required. If match beyond direct service match was submitted, documentation is required to support the match calculations as reported on the last fiscal year ended Matching Funds Report. (Minimum acceptable level of documentation: 100% correlation of documentation to Matching Funds Report.)

Breast and Cervical Matching Funds Report and date mailed to MDCH/Cancer Prevention and Control Section on file at local health department.
3.1, 3.2, and 3.3

All signed last fiscal year ended BCCCP clinical service provider contracts or letters of agreement should be pulled from files and made available to reviewers. On-site reviewers will select a sample for review.

Contracts and/or agreements should state providers “will not bill any BCCCP client for any service that is partially or fully covered by the BCCCP reimbursement amount for that service” or similar language.

Written policy and/or procedure outlining procedure for identifying cases of inappropriate billing and corrective measures instituted to rectify inappropriate billing.
4.1

Client chart records, and copy of front and back of the insurance cards (or record of why insurance card could not be obtained) for **all** insured clients documenting insurance information for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).

Written policy outlining the steps/procedures used to determine BCCCP eligibility for insured women. Policy should also include a statement of the local health department’s procedure for verifying self-reported insurance coverage, and should also include what steps are taken to assure that women insured through a prepaid managed care plan or comprehensive PPO are excluded from the program.
**4.2 and 4.3**

Copies of submitted claim data/forms for all insured clients with services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).

Explanation of Benefits (EOB) forms or other local auditor approved documentation indicating resolution of insurance claims.

Third party billing records for in-house services (if applicable) provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).
5.1

Description of the system the local health department uses to maintain on file, clinical data forms, letters with test results, and insurance billing documentation (if clinical services provided at health department).

Description of required communications between: BCCCP staff at the local health department and subcontracted provider staff.

Written policy outlining the procedure for: gathering clinical service data from each BCCCP provider/clinic and verifying the accuracy of the data.
5.1 and 5.3

Financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) as indicated in “This indicator may be met by” above.
6.1, 6.2, and 6.3

Combination of the following should demonstrate routine communications such that all providers are contacted with program updates, opportunities to address provider concerns, and access to at least annual training for new staff, active partnerships with representatives of community groups that represent and advocate for target populations, and describing efforts to address provider concerns, increase provider awareness, and assure the satisfaction of providers with the program:

- Agenda/minutes/membership of most recent provider/advisory meetings
- Provider mailing list for BCCCP Newsletter
- Correspondence/memos/phone calls to providers within the last 6 months
- Most recent semi-annual report or other correspondence that lists activities to increase general provider awareness demonstrate partnerships with ACS and other community groups
- Other documentation of ACS or other community organization collaboration
7.1

The local health department’s written plan, to recruit eligible women from the target populations into the local BCCCP
7.2

Current demographic information (e.g., census data) indicating the percentage of individual minority populations in the local health department’s jurisdiction.

Data from the BCCCP database indicating the percentage of BCCCP clients from the individual minority populations.

Evidence that the agency has used and compared data from the BCCCP database with the current demographic information to ensure that it serves individual minority populations at a percentage equal to or higher than the percentage of individual minority populations represented in the local health department’s jurisdiction.
7.3

Documentation exists (e.g., tracking logs, either/or client records) that a patient was called for follow-up re-screenings.
8.1

Written process describing how the local health department obtains and re-verifies on an annual basis a BCCCP client’s informed consent

Client charts will be reviewed for evidence of signed/initialed and dated informed consents covering the time period screening and diagnostic services were rendered (1 year from date signed on form).
9.1

Copies of mammography facilities’ certificates or documentation that mammography facilities have passed the state inspection (i.e., copies of Mammography Facility Status reports sent from MDCH to local health department).
9.2

Written policy/procedure/process is in place for nurses who are trained to perform clinical breast exams, pap exams and pelvic exams and are supervised on site by a Certified Nurse Practitioner, Physician Assistant, or Physician.
9.3

Written policy stating that provider licenses are reviewed at specified intervals
9.4

Evidence of signed diagnostic provider contracts during current fiscal year
9.7

A copy of the BCCCP Medical Protocol

Copy of policy/procedures describing the process for distributing and reviewing the BCCCP Medical Protocol with contracted providers
A written protocol is available indicating that all women requiring breast and/or cervical diagnostic and/or treatment services are receiving information, assistance or advocacy from the local health departments to reduce barriers to the receipt of diagnostic and follow-up services.
10.2

Documentation of written process/procedure used to track to monitor and guide the care-coordination (and case management) provided to every enrolled woman.
10.5

For all women enrolled under the Medicaid Treatment Act, documentation of the woman’s cancer diagnosis or precancerous condition, a copy of the Medicaid application along with supporting documentation for women who are not US citizens, and a copy of the Medicaid approval letter.

A written policy/procedure that states how the local health department will assist women who DO NOT qualify for Medicaid in obtaining needed treatment services.

And

A list of providers willing to assist women with low cost cancer treatment services and/or provide women with cancer treatment services regardless of ability to pay.
A list of all MBCIS users, with specific notation of those with “clinical” access.
**Eligibility Requirements**

To be enrolled in the BCCC Program and to receive services, a woman must:

- Have an **income less than or equal to 250%** of the Federal Poverty Level (FPL)
- Be **uninsured or underinsured**
- Be **between the ages of 40 -64** (over 64 only if enrolled in Medicare Part A only) for breast/cervical cancer screening and/or for diagnostic follow-up of breast/cervical abnormalities

**OR**

- Be **between the ages of 18 -39**, identified with a cervical abnormality through the **Title X Program, and referred to BCCCP** for cervical cancer diagnostic follow-up

Women enrolled in the following are not eligible for the program:

- Managed care program
- Health Maintenance Organization (HMO)
- Medicare Part B
**Financial Eligibility Determination**

BCCCP dollars must be used as “funds of last resort”, can be utilized only for screening and specific follow-up services, and are available to Michigan women whose household income, minus allowable deductions, places them at or below 250% of poverty.

**Family Income**

A client’s own assertion will serve as sufficient verification for family income. Women should be asked: 1) What is your income? 2) How many people are in your family?

If a woman asks for clarification, the following can be provided as guidance: a “family” consists of married persons or a single individual with or without dependent children.

In determining the income of the family, include the total income of a married couple or single person but not the income of dependents. Do not include income of other adults living in the same household.

**Additions to Income**

If the wage earner(s) receives additional income other than wages, this income is to included in family income. Examples of other income sources are: Social Security, SSI, alimony received, child support received, unemployment compensation, workmen’s compensation, disability benefits, pension/retirement, military allotments, veteran’s benefits, and interest from assets.

**Allowable Deductions**

Allowable deductions from family income include: work related expenses, alimony/child support paid, child care for working parents, health/hospital insurance premiums, and family medical expenses paid out-of-pocket.

Example 1: A husband and wife are both wage earners. They support a fifteen year old son who works part-time at a local restaurant. While the income of both husband and wife are counted, the income of the some is not included in family income in determining eligibility for Title XV funded services.

Example 2: An older woman on Social Security lives with her son who provides a major part of her support. In assessing the woman’s income for the Title XV program eligibility purposes, the income of the son is not included.
MEMORANDUM

DATE: January 24, 2007

TO: BCCCP Coordinators

FROM: Paulette M. Valliere, Ph.D.
Manager, Breast and Cervical Cancer Control Unit
Cancer Prevention and Control Section

SUBJECT: 2007 Poverty Guidelines

The new Federal Health and Human Services poverty guidelines were released in the Federal Register today. The 2007 poverty guidelines and calculation of 250% of poverty levels used for the Breast and Cervical Cancer Control Program (BCCCP) can be found in the table below. Effective immediately, these guidelines are to be used to determine BCCCP income eligibility.

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<th>250% of Poverty</th>
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BCCCP Eligibility Guidelines for Insured Women
Revised 8/2006

Following is a brief summary of Michigan’s current BCCCP eligibility guidelines for women with different types of fee-for-service and managed care insurance. As managed care continues to evolve and new variations of traditional managed care arrangements emerge, determining eligibility for the BCCCP has become more difficult. These guidelines will provide local BCCCP agencies with a basic reference tool for evaluating an insured woman’s eligibility for the BCCCP.

Traditional Indemnity Insurance (Fee-for-Service)

Up to almost 30 years ago, most people who had insurance had this type. This insurance resembles car insurance; a certain amount is paid up front, usually in monthly premiums, and then the insurance companies pays the medical bills. Usually a high deductible must first be met before the insurance company will begin paying. Once that deductible has been met, the insurance company will kick in about 80% of the medical bills.

In order to be in compliance with the federal Funds of Last Resort requirement, all insurance companies reported by these women must be first billed by the providers who performed the services and an explanation of benefits (EOB) must be obtained. The provider then bills the Third Party Administrator, sending in a claim accompanied with the EOB. If the amount of payment exceeds the amount that is allowed by the BCCCP, then the service is considered paid in full. If the amount in which the insurance paid is less that the BCCCP approved amount, the provider is entitled to the difference.

Managed Care

Due to federal statutory restrictions on screening women with certain types of managed care coverage, it is very important to determine the type of coverage a woman has prior to enrolling her in the BCCCP. The most common types of managed care arrangements are described below.

Health Maintenance Organizations (HMOs) and Other Prepaid Managed Care Plans

As the most restrictive form of managed care, HMOs and other prepaid managed care plans typically do not allow plan members to obtain health care outside of their own provider network. Members that choose to do so must pay for the entire cost of care out of their own pockets. This is because the insurer (employer) pays the HMO/plan a capitated rate each month for each enrolled member (employee). This arrangement allows members to receive health care services from the plan’s own physicians/clinicians and facilities. Member cost-sharing is limited; deductibles usually do not apply but members make modest co-payments for office visits and prescriptions.

Preventive services, such as regular breast and cervical cancer screening services, are generally covered under the prepaid capitated rate that the insurer pays the plan for each member. It is for this reason that the federal law authorizing the BCCCP
prohibits women enrolled in an HMO or other prepaid managed care plan from receiving federally funded BCCCP services. Therefore, **women who are insured by an HMO or any other type of prepaid managed care plan are not eligible to be screened in the BCCCP.** If local agencies choose to serve women enrolled in a prepaid managed care plan, then they must use **other funds** to pay for those women. That is, **BCCCP funds must not be used to pay for any clinical services and the women cannot be counted in the local BCCCP caseload for coordination.**

**Preferred Provider Organizations (PPOs)**

PPO networks are formed when an insurer (employer) enters into contractual agreements with various physicians/clinicians and facilities in a geographical area to provide health care services at a reduced rate. Participating providers normally keep their independent practices and often participate in preferred provider programs with other employers as well. PPOs are a less restrictive form of managed care than HMOs. However, coverage may not be as comprehensive as in an HMO, and deductibles often must be met before benefits can be paid. PPOs allow members to obtain care from providers who are not members of the PPO network, but there is a financial penalty to do so. Usually, services are reimbursed at 100% when rendered by a PPO provider, and at a lower percentage (e.g., 50-80%) when received outside of the PPO network.

**The decision as to whether or not to screen women insured by a PPO is left up to the local coordinating agencies.** Determining BCCCP eligibility for women who have insurance through a PPO is not always straightforward. This is because every PPO will have its own unique arrangements with its provider network. In order to screen PPO-insured women in the BCCCP, local coordinating agencies must ensure that the federal Funds of Last Resort requirement is met. This can be accomplished by contacting the PPO plan to determine the in- and out-of-network provider rules, what services are covered, the co-payment amount required, and the deductible amount and how much of that has been met. Since these coverage features can differ widely between PPO plans, this assessment needs to be performed for each PPO client. Coverage information needs to be verified and documented in the woman’s billing record prior to enrollment.

In general, a woman can be screened in the BCCCP consistent with the Funds of Last Resort requirement if one or more of the following criteria are met. Documentation as to which criteria were used to determine eligibility for the BCCCP must be kept in the client’s billing record.

- The PPO plan will issue a referral for the client to see an out-of-network BCCCP provider, thus allowing that provider to bill for his/her services at the full PPO-allowed rate; OR the BCCCP provider is a member of the PPO network;
- The PPO plan does not cover or has only limited coverage for breast and cervical cancer screening/preventive services;
- Based on the local coordinating agency’s assessment, the required co-payment creates a financial barrier to the client’s obtaining breast and cervical cancer care.
screening services;

• Based on the local coordinating agency’s assessment, the unmet deductible amount creates a financial barrier to the client’s obtaining breast and cervical cancer screening services.

The following are examples of criteria that would not be consistent with the Funds of Last Resort requirement. **Women should not be screened in the BCCCP under either of the following conditions without prior approval from the state Reimbursement Analyst.**

• The client can receive full coverage for breast and cervical cancer screening services, but only if the services are rendered by an in-network provider; out-of-network providers get reimbursed at a lower rate than the PPO-allowed rate;

• The client can receive full coverage of breast and cervical cancer screening services rendered by a PPO network provider with only a modest co-payment (e.g., $10 - $25), and/or a deductible that has been met, is low, or is not required.

**Verification of Insurance Coverage:**

Verification of insurance coverage for BCCCP services is *optional* for women who are insured through traditional fee-for-service insurance plans. The benefit of doing so is that the insurance company does not have to be billed if there is documentation on file that breast and cervical cancer screening services are not covered by the plan. Without such documentation, an insurance claim must be submitted for each clinical service and reimbursement using BCCCP funds must be withheld until the claim has been settled.

Coverage verification is *mandatory* for women insured by a known or suspected managed care plan to determine BCCCP eligibility based on:

• **Prepaid Coverage:** if the plan is a private HMO and/or a Medicaid Qualified Health Plan, then the woman is **not eligible** for the BCCCP. (Local agencies may still serve women with this type of coverage, but not as part of the BCCCP. Local or other non-BCCCP funds must be used to pay for the services - OR - the woman may choose to pay for the services herself.)

• **In-Network Services (PPOs):** if the woman has full coverage for breast and cervical cancer screening services when they are received from in-network providers (e.g., physician, radiology center, laboratory, etc.), then she is **not eligible** for the BCCCP. (Local agencies may still serve women with this type of coverage, but not as part of the BCCCP. Local or other non-BCCCP funds must be used to pay for the services - OR - the woman may choose to pay for the services herself.)

• There are three possible **exceptions** to this rule that may allow women to be screened in the BCCCP. One is if the local agency determines there is financial hardship, as described below. The second is when the woman’s primary care
provider writes a referral for her to receive breast and cervical cancer screening services out-of-network, thus allowing BCCCP providers to bill the PPO for their services and be reimbursed at the full PPO-authorized rate. Finally, if the BCCCP provider is a member of the PPO network then s/he will be paid the PPO contracted amount. In the second and third scenarios, providers would bill the BCCCP only if the PPO payment plus any co-payment/deductible owed by the woman was less than the BCCCP rate.

Financial Hardship: if the woman must pay a deductible and/or co-pay before breast and cervical cancer screening services will be covered by her plan, and the local agency determines these amounts pose a financial hardship that would prevent her from receiving services, then the woman is eligible for the BCCCP.

Nurse Practitioner Services

Insured women whose traditional fee-for-service insurance plans will not reimburse nurse practitioner services because they are not performed under the supervision of a physician are considered “uninsured for BCCCP services.” As such, they are eligible to be screened in the BCCCP and their services may be reimbursed directly from BCCCP grant funds as long as there is documentation on file regarding noncoverage of nurse practitioner services.

NOTES:

1 The BCCCP maintains its policy of allowing local agencies/providers that enroll BCCCP clients to accept women’s self-reported insurance coverage information and co pay/deductible status when determining BCCCP eligibility. However, enrolling agencies/providers that do not verify this information with the insurance plan—especially when it is unclear whether or not the plan is a prepaid managed care arrangement—assume the financial risk if it is determined after the fact that the woman’s insurance coverage would have made her ineligible for the BCCCP. (The federal Funds of Last Resort requirements prohibit the use of BCCCP funds to reimburse for any BCCCP service that could have covered by another payer.) It is recommended that local agencies have a written policy describing the process used to determine BCCCP eligibility that specifically states whether or not insurance coverage is verified prior to screening insured women.
Medicaid and BCCCP Eligibility Criteria
Revised 8/2006

Medicaid Eligibility

The Michigan Medicaid program is health care for low income people and working families who qualify. This includes families, children, and women who are pregnant. It also offers to help people who are blind, disabled, or age 65 or older. Eligibility for Michigan’s Medicaid program is based on a combination of financial and non-financial factors, and is reviewed once per year. Please note that women who are non-U.S. citizens or non-qualified aliens are eligible only for coverage of emergency services, which according to Medicaid means a “life or death” situation and eligibility is made on a per-case basis.

Within the Medicaid population there are groups that:

- Must enroll in Medicaid Health Plan (MHP). They are called the mandatory beneficiary population.
- May enroll in MHP if they chose to do so. They are called the voluntary beneficiary population.
- Are not allowed to enroll in MHP. They are called the excluded beneficiary population.

Mandatory Beneficiary Population:
- Most people who are receiving full Medicaid benefits
- People receiving Medicaid who participate in the Children’s Waiver or the Habilitation/Supports Home and Community Based Waiver
- Supplemental Security Income (SSI) recipients who do not receive Medicare

Voluntary Beneficiary Population:
- Migrants
- Pregnant women whose is pregnancy is the basis for Medicaid eligibility and pregnant women who are in their third trimester of pregnancy
- Native Americans

Excluded Beneficiary Population:
- People without full Medicaid coverage (they receive emergency services only), or receive Adults Benefits Waiver (ABW)
- People in Plus Care
- People who are dually Medicaid/Medicare eligible
- People with Medicaid who reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or state psychiatric hospital
- People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB)
- People in the MDCH Traumatic Brain Injured residential rehabilitation program
- People receiving long term care in a licensed nursing facility
- People being served under the MIChoice Waiver
- People enrolled in the Children’s Special Health Care Services (CSHCS)
- Medicaid Deductible beneficiaries
- People with commercial health plan coverage, including MHP coverage
- People in Program of All-inclusive Care for the Elderly (PACE)
- Children in foster care or child care institutions
- People in Refugee Assistance Program
- People in the Repatriate Assistance Program
- People who have been disenrolled from a MPH due to action inconsistent with plan membership

**Medicaid Health Plans (MHP)**

Michigan Department of Community Health (MDCH) contracts with health plans in the state. The MHPs are paid monthly a capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The MPH is responsible for providing, arranging, and reimbursing most medical services.

The Michigan Department of Community Health (MDCH) has contracted with 17 health plans to arrange health care for Medicaid beneficiaries. They are comprehensive providers that are responsible for managing and arranging for a wide range of Medicaid-covered services. They receive a capitated payment for enrolled beneficiaries adjusted for age, gender, program, and county of residence.

Health care beneficiaries may be charged a co-payment for:
- **$2** for a physician office visit (CPT codes 99201-99205, 99211-99215, 99385-99387, 99395-99397; excludes visits provided in an outpatient clinic or emergency room)
- **$3** for a hospital emergency room visit for a non-emergency condition
- **$1** for an outpatient hospital visit
- **$50** for the first day of an inpatient hospital stay (applies to Diagnosis Related Group (DRG) or first day per diem payment; co-pay will not be applied to transfers between acute care hospitals, from acute care to rehab, or to readmits within 15 days for same DRG/diagnosis)

The co-payments stated above apply to Medicaid fee-for-service beneficiaries age 21 and older who do not meet one of the following exceptions:
- Medicaid/Medicare dual eligible
- CSHCS, including those also enrolled in Medicaid
- Services provided to pregnant women
- Family Planning services
- Nursing facility residents
- Mental health specialty services and support provided/paid through the Prepaid Inpatient Health Plans
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry
The MHP is a prepaid plan that provides comprehensive coverage for breast and cervical cancer screening services**, as described below:

**Routine Medical Examinations:** Yearly

**Screening Mammograms:**
- Ages 20-39: Discuss with doctor
- Ages 40-64: Yearly
- Ages 65 and above: Yearly

**Pap Smears/Pelvic Exams:** Yearly

**Clinical Breast Exam:** Yearly

** While the state has set a minimum standard for services to be covered by the MHPs, each plan contracts individually with the state and thus services may differ based on each plan’s contractual arrangement.

**BCCCP Eligibility**

Since the MHP are prepaid and comprehensive coverage is provided for breast and cervical cancer screening services, women who are enrolled in these plans are not eligible to be screened in the BCCCP. Women who are not enrolled in a MHP, either due to voluntary nonparticipation or exclusion based on above eligibility list, may be screened in the BCCCP.

To determine if a woman is eligible to participate in the BCCCP, local agencies must verify and document that a woman either does not qualify for Medicaid benefits or is not enrolled in one of the Medicaid managed care options.

**To Determine Medicaid Eligibility and/or Medicaid Coverage:**

If a woman does not know whether she is eligible for Medicaid, or states that she does not have Medicaid and cannot produce a Medicaid card, the local BCCCP agency can determine her eligibility status by contacting Eligibility Verification System (EVS) – Automated Voice Response System (AVRS) at (888) 696-3510. This is a free service.

For additional questions related to the Medicaid program, please contact MICHIGAN ENROLLS at (888) 367-6557.
Medicare and BCCCP Eligibility Criteria

Medicare Eligibility

Medicare is a health insurance program for:

- age 65 or older,
- under age 65 with certain disabilities, and
- under age 65 with End-Stage Renal Disease (ESRD).

This means that most women are automatically eligible for Medicare Part A (hospital insurance, for inpatient admissions only) health care coverage on their 65th birthday, or younger if they have one of the conditions listed above. This includes non-U.S. citizens, as long as they and/or their spouse have worked the required number of hours in Medicare-covered employment and paid into Social Security.

Some women are not eligible for Medicare Part A because they and/or their spouse have less than 30 quarters of Medicare-covered employment. For your information, these women, as well as those who are disabled and under the age of 65 who lost their disability benefits due to work and earnings, can buy Medicare Part A coverage. This can be accomplished by paying the full monthly Part A premium ($393 in 2006). NOTE: The payment of these premiums would likely be a financial burden for our target population, making this situation unlikely. The women in these categories are still considered ineligible for Medicare Part A and would qualify for the BCCCP if they choose not to enroll in Medicare due to financial hardship.

Medicare beneficiaries have the option to purchase Medicare Part B (medical insurance), which provides additional coverage for physician services, hospital outpatient care, durable medical equipment, and other services outside the hospitals. The vast majority of Medicare beneficiaries pay no premium for Medicare Part A coverage, but those who elect Medicare Part B must pay a monthly premium ($88.50 in 2006) for this coverage. In addition to the premium, a Medicare beneficiary using Part B benefits will pay a deductible. The deductible is the first $124 (2006) each year of the charges approved by Medicare. After the deductible is met, Medicare will pay 80 percent of the Medicare-approved amount for most services and the beneficiary is responsible for the remaining 20 percent.

Medicare Coverage for Preventive Services (Part B)

The new Medicare coverage guidelines for screening mammography and screening pelvic/Pap smear/clinical breast exams waive the deductible, but the beneficiary will still be responsible for paying the 20% coinsurance on these procedures. Note that the beneficiary’s coinsurance amount for outpatient services at a hospital is 20% of the hospital charges.

BCCCP Eligibility

Women who qualify for Medicare Part A but choose not to enroll are not eligible to be screened in the BCCCP, as of August 15, 1998. Women who have both Medicare Part A and B coverage are not eligible to be screened in the BCCCP, as of August 15, 1998.
Women who either do not qualify for Medicare Part A (or therefore cannot obtain Medicare Part B coverage), OR who do not have Part B coverage because they cannot afford the premiums, are still eligible to be screened in the BCCCP.

To determine if an elderly and/or disabled woman is eligible to participate in the BCCCP, local agencies must verify and document that the woman either does not qualify for Medicare benefits or does not have Medicare Part B coverage.

To Verify Medicare Eligibility:

If a woman meets one of the Medicare eligibility criteria listed in the previous section, but states that she does not have Medicare and cannot produce a Medicare health insurance card, her eligibility status can be verified in one of two ways:

1. The BCCCP agency can call the Medicare Beneficiary Inquiry line when the woman is in the office, and she can authorize release of her eligibility information to the BCCCP agency. The phone number is (313) 225-8200, or (800) 482-4045 outside of the 313 calling area. The Beneficiary Inquiry line is open from 9:00 a.m. to 4:30 p.m.

To Verify Medicare Part B Coverage:

If a woman states that she has Medicare, then she should be able to show her health insurance card that identifies the enrollee, coverage she has, and eligibility date.

Women who do not have Medicare cards, or who need information on how to enroll in Medicare, should call their local Social Security office or (800) 772-1213.
MEDICARE COVERAGE AND BCCCP ELIGIBILITY CRITERIA QUICK REFERENCE

Medicare Preventive Services Coverage (Medicare Part B)  
Revised 8/2006

- **Annual mammography** for all enrolled women 40 and older.
- Pap Test/pelvis/Clinical Breast Exam (CBE) every 24 months unless a woman is high risk, then every 12 months
- Every three years, **Pap test** (NOTE: annual Pap tests and pelvic exams are authorized for women at high risk of developing cervical cancer).
- **Medicare deductible** is waived for all mammography screening, pelvic/clinical breast exams, and Pap tests.
- **Beneficiary co-payment** (20% of the amount charged by the provider) is still required for all mammograms, office visits for pelvic/clinical breast exams, and Pap tests.

BCCCP Eligibility Determination Based on Medicare Enrollment*

- Women who **qualify** for Medicare Part A but choose not to enroll are not eligible for BCCCP. Always verify Medicare eligibility prior to providing BCCCP services.
- Women enrolled in both Medicare Part A and Medicare Part B are not eligible for the BCCCP. Always check the Medicare health insurance card to determine which type of Medicare coverage the woman has available prior to providing BCCCP services.
- Women who are members of a **Medicare HMO** are not eligible for the BCCCP. They often will have both a Medicare health insurance card and a separate insurance card issued by the health plan itself. Always check the Medicare health insurance card to determine which type of Medicare coverage the woman has available. Verify against the HMO card, if available.
- Women who **do not qualify** for Medicare Part A due to insufficient length of Medicare-covered employment (and therefore cannot obtain Medicare Part B coverage) are eligible for the BCCCP.
- Women who have Medicare Part A but **cannot afford to enroll in Medicare Part B** are eligible for the BCCCP.
- Low-income women who are eligible to receive Medicare benefits, but who are not enrolled, should be encouraged to enroll in the Medicare program. They should call their local Social Security office or (800) 772 -1213.
Informed Consent

RECORD OF INFORMED CONSENT
TITLE XV BREAST AND CERVICAL CANCER

CONTROL PROGRAM

The _____________________ Health Department is offering a Breast and Cervical Cancer Control Screening Program (BCCCP). This screening program is supported by the Federal Government as part of a national plan to reduce the number of women who die of breast or cervical cancer.

PURPOSE OF THIS PROGRAM

The purpose of the BCCCP is to find out if a woman has breast or cervical cancer and, if she has cancer, to refer her for treatment. Regular screening tests can help find a cancer that may be present when it is still very small. If cancer is found before it has spread to other parts of the body, chances of survival are better but not certain.

PURPOSE OF THIS FORM

• This form explains the BCCCP so that I can decide if I want to be in this program.
• This form is my invitation to be part of the screening program.

WHAT THE PROGRAM OFFERS

• This program offers the following screening services to eligible women:
  o Clinical breast exam every year
  o Mammogram every year
  o Pelvic exam every year
  o Pap test every one to three years, depending on history
• Cost of screening services:
  o Whether or not I have health insurance, I will not be charged for screening services provided by this program.
  o If I do not have insurance, I will receive the screening services at no cost.
  o If I do have insurance, I will receive the screening services at no cost. My insurance will be billed, but I will not have to pay any program charges as a result of the co-pay or deductible.

FOLLOW-UP OF ABNORMAL SCREENING RESULTS

• I will be informed of the results of these screening tests and of any additional follow-up that may be needed.
• It is my choice whether or not to follow the recommendations of the Health Department or my physician for follow-up of any tests that are abnormal.
• If I have a personal physician, s/he will be informed of these results if I provide written approval to release this information.
• If any screening test shows something that is abnormal, the staff of the Health Department will help make plans for further exams to decide if there is a problem.
• The Health Department cannot pay for some diagnostic tests.
• Not all follow-up services are free; if I am unable to pay, the Health Department will help me find agencies and/or providers who will work with me to see that I receive needed services.

IF BREAST OR CERVICAL CANCER IS DIAGNOSED

• If breast or cervical cancer is diagnosed, the Health Department will refer me to my physician or to physicians who work with this program, to provide treatment for my cancer. I understand that the Health Department does not provide treatment.
• The Health Department does not pay for any treatment services for breast or cervical cancer.
• If I am unable to pay for treatment, the Health Department will work with me to assure that I receive appropriate services.

THINGS TO KNOW ABOUT SCREENING TESTS

RISKS:

• The risks associated with the screening tests are low.
• I may request and receive any information the Health Department has that helps explain the screening procedures and risks.
• I may ask questions at any time.

LIMITATIONS OF SCREENING TESTS

• No screening test is 100% accurate. Screening tests can sometimes miss an abnormality or show an abnormality when one is not present.
• Normal test results never rule out the later development of cancer. Repeat and regular screening is important.
• Having an abnormality does not always mean there is cancer. Only a few women with abnormal screening results will, after more tests, be diagnosed with breast or cervical cancer.

I AGREE TO:

• Be contacted when it is time to schedule the next screening appointment.
• Repeat these screening tests every year, or as recommended by my health care provider.
• Be contacted if follow-up appointments are necessary.
I have been able to ask questions about this program and this form and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. The Health Department phone number is (____/___-_________)

__________________________
Signature of Client

Date

__________________________
Signature of Person Obtaining Informed Consent

Date

CONTENTS OF THIS FORM REMAIN IN EFFECT UNTIL NEXT ANNUAL VISIT.
**CDC Performance Indicators**

Timeliness - Amount of time (measured in number of days) from an abnormal screening result to final diagnosis. Abnormal screening result refers to the result of either a CBE or MAM for breast screenings or PAP for cervical screenings.

- 75% of all cases in which there is an abnormal breast or cervical cancer screening result should have a **final diagnosis within 60 days**
- 80% of all cancer diagnoses begin treatment within **60 days of the final diagnosis**

Completeness – refers to the proper closure of screening cycles by providing appropriate follow-up care. Abnormal screening results requiring immediate follow-up must include documentation of follow-up services, a final diagnosis, and a treatment disposition.

- 90% of abnormal CBE, Mammogram or Pap Smear screenings **marked as IMMEDIATE/PLANNED follow-up** have at least one follow-up exam and a **final diagnosis**
- 100% of cases with a cancer diagnosis must have a **treatment disposition within 100 days** of the diagnosis.
Breast Cancer Screening Policies

The priority population for NBCCEDP mammography services is women between the ages of 50 and 64 who are low-income (up to 250% of federal poverty level), who have not been screened in the past year, and who have no other source of health-care reimbursement, such as insurance. Recruitment efforts should be concentrated on this population. The broader eligible population, which includes underinsured women (whose health insurance does not fully cover screening services), and women younger than 50 years of age, is described below.

**PC.1: Mammography for Women 50 years of age or older**
A minimum of 75% percent of all NBCCEDP reimbursed mammograms should be provided to program-eligible women who are 50 years of age and older and **not enrolled in** Medicare-Part B.

- If a woman is eligible to receive Medicare benefits, but is not enrolled, she should be encouraged to enroll. Women enrolled in Medicare-Part B are not eligible for the NBCCEDP clinical services.
- Women aged 50 years or older who are not eligible to receive Medicare-Part A and B are eligible to receive mammograms through the NBCCEDP. Mammograms provided to these women will be counted in the 75%.
- Medicare-enrolled women with low incomes (250% poverty or less) who cannot pay the premium to enroll in Medicare-Part B are eligible to receive mammograms through the NBCCEDP. Mammograms provided to these women will be counted in the 75%.

**PC.2: Mammography for women under 50 years of age**
Mammograms provided to program-eligible women less than 50 years of age should not exceed 25% of all mammograms provided by the NBCCEDP.

- **Asymptomatic women ages 40-49** – may be screened in the program, subject to the restriction noted above.
- **Symptomatic women under the age of 40** — NBCCEDP funds can be used to reimburse for clinical breast exams (CBE) for women under the age of 40. If the findings of the CBE are considered to be abnormal, including a discrete mass, nipple discharge, and skin or nipple changes, a woman can be provided a diagnostic mammogram by the program and/or referred for a surgical consult.
- **Asymptomatic women under the age of 40 at increased risk for breast cancer** — NBCCEDP funds cannot be used to screen asymptomatic women under the age of 40, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer or first degree relative with pre-menopausal breast cancer) for breast cancer.

**PC.3: Screening Males**
Men are not eligible to receive NBCCEDP screening and/or diagnostic services.
**PC.4: Digital Mammography**
Reimbursement for digital mammography is capped at the conventional film mammography reimbursement rate.

**PC.5: Computer-Aided Detection (CAD)**
Reimbursement of CAD is not permitted.

**PC.6: Managing Women with Abnormal Breast Cancer Screening Results**
The management of women whose mammogram and/or clinical breast exam yield abnormal results relies on a body of scientific literature which is constantly growing and changing. Clinical management strategies may also vary by geographic region and by provider. Grantees are urged to develop their clinical policies in close consultation with their Medical Advisory Committees, and in consideration of standards established by organizations such as the National Comprehensive Cancer Network (http://www.nccn.org/) and the American College of Radiology (http://www.acr.org/).
Cervical Cancer Screening Policies

The priority population for NBCCEDP cervical cancer screening services is women between the ages of 40 and 64 who have low-incomes (up to 250% of federal poverty level), who have never been screened or not been screened in the past five years, and who have no other source of health-care reimbursement, such as insurance. Recruitment efforts should be concentrated on this population. The broader eligible population, which includes underinsured women (whose health insurance does not fully cover screening services), and women younger than 40 years of age, is described below.

PC.7: Increasing Screening for NBCCEDP Eligible Women Never or Rarely Screened
20% of all clients newly enrolled for cervical cancer screening should be women who have not had a Pap test in the last 5 years.

PC.8: Cervical Cancer Screening for Women 18 - 64 Years of Age
NBCCEDP funds may be used to reimburse for Pap tests on an annual basis for Medicare Part B un-enrolled women 18 to 64 years of age, who have an intact cervix. When a woman has had three consecutive, normal Pap tests documented within a 60-month period, the screening interval shall increase to once every three years (to calculate the time period for the three normal screening tests, the first test date should be considered “month 0;” the second test would occur around month 12, and the third around month 36). If a woman receives an abnormal screening test result, policies for follow-up of abnormal cervical cancer screening tests and reimbursement of diagnostic procedures should be followed.

PC.9: Cervical Cancer Screening for Women over 64 Years of Age
- If a woman is eligible to receive Medicare benefits, but is not enrolled, she should be encouraged to enroll. Women enrolled in Medicare-Part B are not eligible for the NBCCEDP clinical services.
- Medicare-enrolled women who have low incomes (250% poverty or less) and cannot pay the premium to enroll in Medicare-Part B are eligible to receive services through the NBCCEDP.

PC.10: Pap Testing Following Hysterectomy
- NBCCEDP-funds CANNOT be used to pay for cervical cancer screening in women with complete hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer.
- The presence of a cervix can be determined on physical exam. NBCCEDP-funds CAN be used to pay for an initial examination (i.e., pelvic exam) to determine if a woman has a cervix.

Policy PC.11: Policy on Liquid-Based Technologies for Primary Cervical Cancer Screening
Programs may reimburse for liquid-based cervical cytology (such as ThinPrep® and SurePath®) for primary cervical cancer screening, up to the allowable Medicare rate. The screening interval when using liquid-based tests is every two years. Programs must
develop a means of ensuring that reimbursement for the liquid-based test is not provided more frequently than every two years.

As with conventional Pap tests, when a woman has had three consecutive, normal cervical cancer screening tests documented within a 60-month period, the screening interval shall increase to once every three years (to calculate the time period for the three normal screening tests, the first test date should be considered “month 0;” the second test would occur around month 24, and the third around month 48). If a woman receives an abnormal screening test result, policies for follow-up of abnormal cervical cancer screening tests and reimbursement of diagnostic procedures should be followed.

The specific cervical cancer screening method must be indicated in the MDEs, so that the number of liquid-based tests can be distinguished from the number of conventional Pap tests performed. This will provide a means by which the test-specific diagnostic outcomes can be compared.

**PC.12: Use of Automated Screening Technologies for Quality Assurance**
NBCCEDP funds may not be used to reimburse for automated technologies when used as a secondary assessment of Pap testing for quality assurance purposes. These quality assurance costs are built in to the pricing of tests and are paid by the cytopathology laboratories.

**PC.13: Managing Women with Abnormal Cervical Cancer Screening Results**
The management of women whose cervical cancer screening tests yield abnormal results relies on a body of scientific literature which is constantly growing and changing. Clinical management strategies may also vary by geographic region and by provider. Grantees are urged to develop their clinical policies in close consultation with their Medical Advisory Committees, and in consideration of standards established by organizations such as the American Society of Colposcopy and Cervical Pathology ([http://www.asccp.org](http://www.asccp.org)) and the American College of Obstetrics and Gynecology ([http://www.acog.org/](http://www.acog.org/)).

In order to arrive at a definitive diagnosis for a woman with an abnormal cervical cancer screening test, NBCCEDP funds may be used to reimburse for colposcopy, colposcopy-directed biopsy, endocervical curettage, and, in unusual cases, diagnostic excisional procedures (such as LEEP and cold-knife excisions), as well as associated pathology. Grantees are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

**PC.14: Reimbursement of HPV DNA Testing**
HPV DNA testing is a reimbursable procedure if used in follow-up of an ASC-US result from the screening exam, or for surveillance at one year following an LSIL Pap test without evidence of CIN on colposcopy-directed biopsy. It is not reimbursable as a screening test. Providers should specify the high-risk HPV DNA panel; reimbursement of screening for low-risk genotypes of HPV is not permitted.
**Client Data Security Policy**

The Client Data Security Policy addresses the protection of clients enrolled in the Breast and Cervical Cancer Control Program (BCCCP) and the information that is collected by the program. The Michigan Breast and Cervical Cancer Control Information System (MBCIS), Discoverer Viewer, and BCCCP Web Site contain a wealth of client sensitive data and it is the responsibility of LCA’s as administrators of the program to protect this data. With the ability now to access data from any computer that is connected to the Internet, this greatly increases the vulnerability of our client’s data. Listed below are three sub categories of this policy; program data, user name and password, and the Michigan Computer Law (MCL 752.794 – 752.797). It is the responsibility of the LCA coordinator to understand and ensure all individuals employed to work within the BCCC Program abide by these.

**Program data:**
- All information and/or documents obtained through MBCIS, Discoverer Viewer, and the BCCCP Web Site will be handled in a confidential manner.
- Use of MBCIS, Discoverer Viewer, and the BCCCP Web Site will be restricted to accessing information and generating documents which are necessary to properly conduct the administration and management of duties as they relate to breast and cervical cancer control.
- Information and/or documentation obtained through MBCIS, Discoverer Viewer, and the BCCCP Web Site will not be furnished to individuals for personal use or to any individual not directly involved with the conduct of job duties as they relate to breast and cervical cancer control.
- Alteration or falsification of any document or data obtained through MBCIS, Discoverer Viewer, and the BCCCP Web Site is strictly prohibited.
- Copying all or part of the database in any unauthorized fashion is strictly prohibited.
- Threat to or violation of MBCIS, Discoverer Viewer, and the BCCCP Web Site security will be promptly reported to MDCH.

**User names and passwords:**
- Transactions on MBCIS are logged and are subject to being audited.
- Sharing of usernames and passwords is strictly prohibited.
- The BCCCP coordinator **must** immediately notified MDCH upon the departure of any individual employed to work within the Breast and Cervical Cancer Control Program.

**Michigan Computer Law (MCL 752.794 – 752.797):**
- **Sec.752.794** A person shall not, for the purpose of devising or executing a scheme or artifice with intent to defraud or for the purpose of obtaining money, property, or service by means of a false or fraudulent pretense, representation, or promise with intent to, gain access to or cause access to be made to a computer, computer system, or computer network.
- **Sec.752.795** A person shall not intentionally and without authorization, gain access to, alter, damage, or destroy a computer, computer system, or computer network, or gain access to alter, damage, or destroy a computer software program or data contained in a computer, computer system, or computer network.

- **Sec.752.796** A person shall not utilize a computer, computer system, or computer network to commit a violation of section 174 of Act 328 of the Public Acts of 1931……being section 750.362 of the Michigan Compiled Laws. [Larceny by conversion]

- **Sec.752.797** A person, who violates this act, if the violation involves $100.00 or less, is guilty of a misdemeanor. If the violation involves more than $100.00, the person is guilty of a felony, punishable by imprisonment for not more than 10 years, or a fine of not more than $5,000.00, or both.

Questions regarding the above can be directed to Cathy Blaze at 517-324-7304.
Policy for use of Computer-Aided Detection of Abnormal Screening Mammography

Introduction
In 2001, approximately 34 million screening mammograms will be performed in the U.S. In addition, about 3.3 million diagnostic mammograms will be performed this year to follow-up on suspicious findings from those screening mammograms. It is estimated that for every 80 cancers currently detected through routine mammogram screening of healthy women, 20 additional cancers are initially missed. Of those missed, about half have cancerous features that are simply overlooked; the other half, although cancerous, look benign. Recent studies show that for every 100,000 breast cancers currently detected by screening mammography, the use of a computer-aided detection (CAD) system could result in the early detection of an additional 20,500 cancers (20.5 percent). In the real world that translates to an estimated 28,000 women a year whose cancer is missed by the human eye but could be detected by computer. Despite the concern for lead-time bias in diagnosis of breast cancer using mammography, improved detection of early stage disease would be expected to improve survival from the disease and reduce mortality over time.

Computer-aided Detection
In addition to approving the use of digital mammography equipment, the Food and Drug Administration (FDA) has recently approved a CAD system, the ImageChecker® CAD for diagnostic use in evaluating suspicious areas found on conventional film screening mammography. The FDA's approval of the ImageChecker® CAD system was based on the recommendation of its Medical Devices Advisory Committee. The panel reviewed data from clinical studies conducted by the manufacturer, R2 Technology, of Los Altos, California, in which more than 40,000 mammograms were evaluated in conjunction with the CAD technology.

CAD systems scan mammograms with a laser beam and convert the image into a digital signal. The signal is then processed by a computer to identify possible signs of cancer. Video monitors display the mammographic images, with CAD markers highlighting suspicious areas.

In clinical practice, the radiologist first reviews a mammogram in the conventional manner, then based on the mammogram assessment, activates the CAD system and looks at any suspicious areas highlighted on the monitor. The radiologist then goes back to those same areas on the original mammogram to see if any escaped notice and, if so, whether they require further evaluation.

While studies show that digital mammography is no better than conventional film mammography, but much more expensive, there is now enough evidence from independent studies to suggest that CAD is a useful adjunct to conventional film mammography when suspicious abnormalities are detected. It is particularly useful for women with dense breasts. While the equipment costs in excess of $200,000, CAD is currently available in about 200 radiology practices across the United States, and the extra cost of $15.00 approved for Medicare/Medicaid in April, 2001, a great value. It is expected that other health insurers will approve payment for the test in the near future.
Policy

NBCCEDP grantees may reimburse for CAD of screening mammography when indicated as necessary by a radiologist. Until more data are available, the decision to perform the test should be left to the best clinical judgment of the practicing radiologist. As with other new procedures, surveillance of test utilization will be essential to assure that the test is administered appropriately. For purposes of recording this procedure in the Program’s minimum data elements (MDEs), the mammography assessment code initially would be “diagnosis pending” and once a determination is made based on CAD, and re-review of existing films, a final BI-RADS® assessment category would be recorded. In most instances the assessment is incomplete (AI) category would not be appropriate as no new or additional imaging studies are being requested or performed. In those instances where additional imaging studies are considered necessary, despite the use of CAD, the use of the AI category would be appropriate. It is important to re-emphasize that this is a procedure that can enhance detection of lesions in suspicious mammography and is not intended for routine use in all screening situations. The effective date of this policy is October 1, 2001.

Reimbursement

The current 2002 CPT code for this procedure (digitization of images from radiologic film for lesion detection and further review by a physician) is 76085.

Medicare has approved a $15.00 charge for CAD. NBCCEDP grantees may choose to reimburse at or below the Medicare rate.

Summary

In summary, CAD is a new FDA approved adjunct for screening mammography which can detect as many as 20% more breast cancers than conventional reading techniques when suspicious abnormalities are present. NBCCEDP grantees may reimburse for this new test when charges for the test are billed by the attending radiologist using the CPT code noted above. The effective date of this policy is October 1, 2001.

References:


Freer T, Ulissey M. Screening mammography with computer-aided detection: Prospective study of 12,860 patients in a community breast center. Radiology 2001 220:781-6
Protocol and Reimbursement Procedure for BCCCP/FP Clients with Abnormal Cervical Results requiring a LEEP, Cold-Knife Conization or Endometrial Biopsy

July 30, 2004

This protocol addresses the following:
1. Appropriate Follow-up on Inconsistent Pap/Final Diagnoses
2. Appropriate follow-up of Pap test results of AGC (Atypical Glandular Cells) or AIS (Adenocarcinoma in Situ)
3. BCCCP Reimbursement Codes for Selected LEEP, Cold-Knife Conization, and Endometrial Biopsy Procedures
4. Appropriate Follow-up on Inconsistent Pap/Final Diagnoses in the Breast and Cervical Cancer Control Program and Family Planning/BCCCP Project

Usually Pap tests and final diagnoses obtained from biopsy or endocervical curettage (ECC) are consistent. Upon occasion, however, Pap results of High-grade Squamous Intraepithelial Lesion (HSIL) will have a Final Diagnosis result of “not cancer,” CIN1, or “atypia.” Many times, in order to assure an accurate diagnosis, the colposcopist will want to do a LEEP or cold-knife cone to assure that enough affected tissue has been sampled.

The BCCCP will reimburse for a diagnostic excisional procedure, either a LEEP or cold-knife cone, only under the following circumstances. Payment will only be done on a case-by-case basis, by a state override, and must be authorized in advance by one of the MDCH Nurse Consultants.

Procedure--When HSIL Pap results in a Final Diagnosis of CIN1 or less:

- When the colposcopy is satisfactory, a review of cytology, colposcopy and histology results should be performed
- If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines as described in the BCCCP Medical Protocol
- If Pap results of HSIL are upheld, a diagnostic excisional procedure is preferred (either cone or LEEP).
- When the colposcopy is unsatisfactory, a review of cytology, colposcopy and histology results should be performed when possible
- If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines
- If HSIL Pap is upheld, review is not possible, or biopsy-confirmed CIN1 is identified, a diagnostic excisional procedure is preferred (cone or LEEP)
- Ablation is unacceptable
- If colposcopy suggests a high-grade lesion, initial evaluation using a diagnostic excisional procedure is acceptable management (“see and treat”)
- Testing for High-risk Human Papillomavirus (HPV) is not acceptable management as triage for HSIL
Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL)

NOTE: Management options may vary if the woman is pregnant, postmenopausal, or an adolescent - refer to BCCCP Medical Protocol

Colposcopic Examination (with endocervical sampling)

- Satisfactory Colposcopy
  - CIN I, "not cancer", or atypia?
    - No change in diagnosis?
      - Obtain authorization from MDCH Nurse Consultants for LEEP/Cone Procedure
        - DO NOT ENROLL CLIENT INTO BCCCP MEDICAID TREATMENT ACT
        - Schedule client for LEEP/Cone Procedure
    - Change in diagnosis - CIN II or greater?
      - Biopsy confirmed CIN II or CIN III?
        - No change or review not possible OR only biopsy - confirmed CIN I
          - Obtain authorization from MDCH Nurse Consultants for LEEP/Cone Procedure
            - DO NOT ENROLL CLIENT INTO BCCCP MEDICAID TREATMENT ACT
            - Schedule client for LEEP/Cone Procedure
        - Enroll in BCCCP Medicaid Treatment Act
          - Assist client in obtaining treatment
          - Schedule client for LEEP/Cone Procedure

- Unsatisfactory Colposcopy
  - Biopsy confirmed CIN II or CIN III?
    - Change in diagnosis - CIN II or greater?
      - Review of cytology, colposcopy and histology results
        - No lesion identified
      - Review of cytology, colposcopy and histology results
    - No lesion identified
    - Biopsy confirmed CIN II or CIN III?
      - Enroll in BCCCP Medicaid Treatment Act
        - Assist client in obtaining treatment
        - Schedule client for LEEP/Cone Procedure
3. BCCCP Reimbursement Codes for Selected LEEP, Cold-Knife Cone and Endometrial Biopsy Procedures

The following procedures must be approved by one of the MDCH Nurse Consultants in advance of performing the procedure, unless the provider is using “see and treat.”

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Procedure Name</th>
<th>FY 07 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>57460</td>
<td>Colposcopy of the cervix with loop electrode biopsy(s) of the cervix</td>
<td>$302.81</td>
</tr>
<tr>
<td>57461</td>
<td>Colposcopy with loop electrode conization of the cervix</td>
<td>$331.51</td>
</tr>
<tr>
<td>57520</td>
<td>Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife of laser</td>
<td>$314.51</td>
</tr>
<tr>
<td>57522</td>
<td>Loop electrode excision</td>
<td>$258.18</td>
</tr>
<tr>
<td>58100</td>
<td>Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)</td>
<td>$103.33</td>
</tr>
</tbody>
</table>
Fiscal Year 2007 Office Visit Changes
Revised 8/2006

Effective October 1, 2006, two changes will take place concerning office visits. They are as follows: 1. data entry of office visits, and 2. procedure for billing office visits in conjunction with certain CPT (procedure) codes.

1. Data Entry of Office Visits
Office visits approved for payment will need to be entered into MBCIS effective October 1, 2006. This change is being implemented to assist us in matching services in MBCIS to services paid by the TPA. This process will also allow for more accurate data reporting to the Centers for Disease Control and Prevention regarding the services that were performed through the program.

In order to clear up some confusion regarding the type of visit that should be entered in MBCIS based on the service provided we have included the descriptions and CPT codes that should be associated with the appropriate service (see attached chart for full description of visits and CPT codes).

There will be four different office visits:
- **Full Office Visit** – 99203, 99204, 99386, 99387, 99213, 99214, 99396, and 99397
- **Partial Office Visit** – 99201, 99202, 99211, and 99212
- **Cervical Consult (formerly gynecological consult)** – 99241, 99242, 99243, 99244
- **Breast Consult (formerly surgical consult)** - 99241, 99242, 99243, 99244

New screening, breast and cervical follow forms will need to be in place by October 1, 2006 with the changes. We have provided you with the state version of the forms; you may use these or make changes to your existing forms. Please remember if you use your forms that you incorporate everything that is on the state forms into yours.

*Please remember that only one office visit can be billed per provider per date of service. Multiple office visit charges for the same date of service will not be paid.*

2. Procedure for Billing Office Visits in conjunction with Specified CPT codes

Effective October 1 2006, the following office visits **CANNOT** be paid with the following procedure codes unless a procedure requiring an office visit also occurred at the time.
- 88305 – Surgical Pathology, Breast or Cervical Biopsy – Level IV
- 88307 - Surgical Pathology, Breast or Cervical Biopsy – Level V
- 19102 – Breast Biopsy, Excisional, Needle Core, Using Imaging Guidance
- 19103 - Breast Biopsy, Excisional, Automated Vacuum Assisted or Rotating Biopsy Device, Using Imaging Guidance
- 19120 – Breast Biopsy, Excisional
• 19125 – Breast Biopsy, Excision of Single Lesion Identified by Radiological Marker
• 19102 – Breast Biopsy, Excisional, Needle Core, Using Imaging Guidance
• 19103 - Breast Biopsy, Excisional, Automated Vacuum Assisted or Rotating Biopsy Device, Using Imaging Guidance
• 19126 – Breast Biopsy, Excision of Each Additional Lesion
• 88172 – Cytopathology, Evaluation of Fine Needle Aspirate to determine Specimen Adequacy
• 88173 – Cytopathology, Interpretation and Report
• 57520 – Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser (approved by Ann Garvin)
• 57522 - Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser; loop electrode excision (approved by Ann Garvin)
• 99499 – Case Management (approved by Ann Garvin)
• 76090 – Diagnostic Mammogram (Unilateral)
• 76091 - Diagnostic Mammogram (Bilateral)
• 76092 – Screening Mammogram (Bilateral)
• G0202 – Digital Screening Mammogram (Bilateral)
• G0204 – Digital Diagnostic Mammogram (Unilateral)
• G0206 – Digital Diagnostic Mammogram (Bilateral)
• 00400 – Anesthesia
• 88212 – Cytopathology, Selective Cellular Enhancement Technique with Interpretation

If you have any questions, please contact Cathy Blaze at 1-517-324-7304 or cblaze@mphi.org.
### Office Visit Procedure Code Reference Chart (Abbreviated)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Office Visit</td>
<td>99203</td>
<td>Full annual clinical exam (30 minute face to face exam) ; includes both CBE and Pap test/pelvic exam ; symptomatic or diagnosed new patient evaluation</td>
</tr>
<tr>
<td></td>
<td>99204</td>
<td>Same as 99203 – (45 minute face to face exam)</td>
</tr>
<tr>
<td></td>
<td>99386</td>
<td>Full annual clinical exam includes both CBE and Pap test/pelvic exam; Asymptomatic new patient between the ages of 40-64;</td>
</tr>
<tr>
<td></td>
<td>99387</td>
<td>Same as 99386 - Asymptomatic new patient age 65 and older</td>
</tr>
<tr>
<td></td>
<td>99213</td>
<td>Full annual clinical exam; (15 minutes face to face) includes both CBE and Pap test/pelvic exam Symptomatic or diagnosed established patient new patient</td>
</tr>
<tr>
<td></td>
<td>99214</td>
<td>Same as 99213 - 25 minutes face to face</td>
</tr>
<tr>
<td></td>
<td>99396</td>
<td>Full annual clinical exam includes both CBE and Pap test/pelvic exam; Asymptomatic established patient between the ages of 40-64;</td>
</tr>
<tr>
<td></td>
<td>99397</td>
<td>Same as 396 - Asymptomatic established patient over age 65</td>
</tr>
<tr>
<td>Partial Office Visit</td>
<td>99201</td>
<td>Partial annual clinical exam (10 minutes face to face) – either CBE only OR Pap test/Pelvic only- Symptomatic or diagnosed new patient</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>Partial annual clinical exam (20 minutes face to face) – either CBE only OR Pap test/Pelvic only- Symptomatic or diagnosed new patient OR colposcopy office visit</td>
</tr>
<tr>
<td></td>
<td>99211</td>
<td>Partial annual clinical exam (5 minutes face to face or supervising) – either CBE only OR Pap test/Pelvic only</td>
</tr>
<tr>
<td></td>
<td>99212</td>
<td>Partial annual clinical exam (10 minutes face to face) – either CBE only OR Pap test/Pelvic only (includes repeat Paps)</td>
</tr>
<tr>
<td>Cervical Consult*</td>
<td>99241</td>
<td>Gyn Consultation (15 minutes face to face)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral for follow-up problem (minor) identified during screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• New or established patient</td>
</tr>
<tr>
<td></td>
<td>99242</td>
<td>Same as 99241 (30 minutes face to face) – problem is low severity</td>
</tr>
<tr>
<td></td>
<td>99243</td>
<td>Same as 99241 (40 minutes face to face)- problem is moderate severity</td>
</tr>
<tr>
<td></td>
<td>99244</td>
<td>Same as 99241 (60 minutes face to face)- problem is moderate to high severity</td>
</tr>
</tbody>
</table>

*Cervical Consult - Formerly Gynecological Consultation – Enter Cervical Consult in MBCIS for any client referred for a gynecological consult as follow-up for a cervical abnormality

*Breast Consult - Formerly Surgical Consultation – Enter Breast Consult in MBCIS for any client referred for a surgical consult as follow-up for a breast abnormality
Change in MTA coverage for BCCCP Women Diagnosed with CIN II or CIN III/CIS

Effective **July 1, 2006** the following change will occur regarding Medicaid coverage for both Family Planning BCCCP and BCCCP women diagnosed with CIN II or CIN III/CIS. Currently, these women are enrolled in Medicaid and receive coverage for at least a year (through one or two follow-up Pap tests.)

Beginning July 1, all women diagnosed with CIN II or CIN III/CIS will receive BCCCP Medicaid (MTA) coverage for **TWO** months instead of one year. (NOTE: This time limit change is effective for women diagnosed after July 1, 2006. The time limit does not affect women diagnosed prior to July 1).

The effective date of Medicaid coverage will begin the first day of the month the treatment is scheduled and end the last day of the month **one month post treatment**.

For example, a BCCCP woman diagnosed with CIN II receives a LEEP on June 20, 2006. Her Medicaid coverage will begin on June 1, 2006 and end on July 31, 2006. Follow-up Pap tests will be covered through the BCCCP, through Family Planning or the Plan First! Program.

**NOTE:** If a woman fails to show for her scheduled appointment her Medicaid coverage will be terminated immediately.

This change **ONLY** affects women diagnosed with CIN II or CIN III/CIS. They need to be informed at the time they sign their Medicaid application that they will receive Medicaid only for this two-month period. They also need to be informed where they can receive future follow-up Pap tests.

Women diagnosed with invasive cervical cancer will remain on Medicaid until their provider determines they have completed treatment and can return to annual screening.

The rationale for this change is that women diagnosed with CIN II or CIN III/CIS who receive LEEPs, Conizations, or Cryotherapy have completed treatment at that time. A review of MBCIS treatment data confirms this. Of 2075 currently enrolled BCCCP women in the MTA, 1085 have been diagnosed with CIN II (627) or CIN III/CIS (458). Almost all of these women received either a LEEP, Conization, or Cryotherapy for treatment. Follow-up Pap tests are not considered treatment. In the event a follow-up Pap test is abnormal and the woman will require additional treatment she can re-enroll in the BCCCP Medicaid program at that time.

**NOTE:** In completing the BCCCP MTA Application for women diagnosed with CIN II or CIN III/CIS, a Treatment Start Date AND Treatment End Date must be entered in the Date Treatment Began box. Michele Barton will automatically enter the end date in her system for this client. A letter will be sent to the client notifying her of when coverage begins and ends.
In assisting women to complete this application they must be informed that they will receive Medicaid ONLY for this two month period. All follow-up Pap

This policy change has been added to the BCCCP Medicaid Treatment Act Policy. Please distribute this policy to all BCCCP staff. Questions regarding this change in policy can be directed to E.J. Siegl at 517-335-8814 or sieglej@michigan.gov. Thank you.
Clinical Laboratory Improvement Amendments (CLIA)

- Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed.
- A laboratory is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health.
- CLIA is user fee funded; therefore, all costs of administering the program must be covered by the regulated facilities.
- Centers for Medicare & Medicaid Services (CMS) assume primary responsibility for financial management operations of the CLIA program.

Laboratory licensing laws of Michigan were superseded as of September 1, 1992, by the amendments to federal CLIA which brought more stringent criteria than the state law.

http://www.fda.gov/cdrh/clia/index.html

Mammography Quality Standards Act (MQSA)

Congress enacted MQSA to ensure that all women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages. In the fall of 2004, Congress reauthorized MQSA, extending the program to 2007. The Act refers to the MQSA as amended by the Mammography Quality Standards Reauthorization Acts of 1998 and 2004 (MQSRA).

Congress charged FDA with developing and implementing MQSA regulations. Interim regulations, issued in December 1993, became effective in February 1994. In 1995, FDA began enforcing MQSA when it initiated an inspection program. On October 28, 1997, FDA issued more comprehensive final regulations, which became effective on April 28, 1999. Three amendments to the regulations have been published since they were first issued.

http://www.fda.gov/cdrh/mammography/index.html

Breast and Cervical Cancer Mortality Prevention Act of 1990

Congress established the National Breast and Cervical Cancer Early Detection Program in 1991 by enacting the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354). This act authorizes CDC to provide critical breast and cervical cancer screening services to underserved women, including older women, women with low incomes, and women of racial and ethnic minority groups.

http://www.cdc.gov/cancer/nbcedp/law.htm
Breast and Cervical Cancer Prevention and Treatment Act of 2000

On October 24th, 2000, President William Clinton signed into law the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354). This Act gives states the option to provide medical assistance through Medicaid to eligible women who were screened for and found to have breast or cervical cancer, including precancerous conditions, through the National Breast and Cervical Cancer Early Detection Program.


Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001

On January 15, 2002, President Bush signed the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001 (Public Law No. 107-121). This bill amends title XIX of the Social Security Act to clarify that Indian women with breast or cervical cancer who are eligible for health services provided under a medical care program of the Indian Health Service or of a tribal organization are included in the optional Medicaid eligibility category of breast or cervical cancer patients added by the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

FP/BCCCP Joint Project

Process to Serve Title X Program Clients
Revised 05/17/06

Family Planning Agencies (FPA):

- Complete all required information on the Title X Program Cervical Screening Form for clients to be referred to Breast and Cervical Cancer Control Program (BCCCP).

- Client eligibility criteria:
  - Uninsured or underinsured women who are clients of Title X
  - Income levels <250% of poverty
  - Abnormal Pap Test results REQUIRING IMMEDIATE FOLLOW-UP WITHIN 60 DAYS of performance of the Pap Test
  - Medicaid Waiver “Plan First!” women must be clients of Title X agencies

- Forward the form to the BCCCP agency that will coordinate follow-up care. (Client procedures need to be developed between each agency to assure timely communication of referrals)

BCCCP Agencies:

- After receiving the screening form, contact the client to collect necessary BCCCP enrollment information (e.g. address, race, income, etc.) and to schedule follow-up services. All red fields in the Client Information Tab in the MBCIS data system will need to be completed.

- Data Entry Procedure - In order to enter a Title X client into the MBCIS, a BCCCP agency needs to:
  1. Enter a Family Planning ID number in the Client ID field on the MBCIS = Clients Tab. **NOTE:** The Client ID Number must begin with FP followed by 3-8 characters or letters. **NO MORE than 10 characters or letters must be used including the prefix FP** e.g. FP12345678. Use of these numbers will assist MDCH staff in data collection and analysis for Family Planning women receiving follow-up services through the BCCCP.
  2. Enter enrollment information, screening results and final diagnosis into MBCIS.
  3. Select “Family Planning” as the enrollment site on MBCIS= Enrollment tab.
  4. Enter the Pap result from the screening form as a screening Pap on the MBCIS= Service Summary tab and check the Funding field as “Non BCCCP Provider”. Check Immediate Follow-up recommended under “Work Up Plan”.

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5. For all follow-up services provided by the BCCCP, check the Funding field as BCCCP on MBCIS= Service Summary tab.

6. Once a final diagnosis is obtained, all other fields under the Diagnosis and Treatment Tab should be entered as if the client were a BCCCP client.

Plan First!

Eligibility:
- Ages 19-44 years
- Us citizens or qualified immigrants
- Michigan residents
- Have a social security number or have applied for one
- Are not receiving Medicaid

If a Plan First! client has an abnormal Pap test indicating a possible cervical cancer diagnosis, in order to receive a Colposcopy services, she will need to be a Title X client before she is referred to the Family Planning/BCCCP Joint Project. If she has cervical cancer (or CIN II), she will be eligible to apply for the BCCCP Medicaid Treatment Act (MTA) to pay for treatment. Once she has received treatment, she will be returned to Plan First! for follow-up Pap testing, as indicated.
STD/BCCCP Joint Project
June 2005

Sexually Transmitted Disease Agency Responsibilities:

1. Identify women in the STD clinic who meet the eligibility criteria
   - Uninsured or underinsured women under age 65. Women age 40 and over may be referred to BCCCP for breast screening services.
   - Income level at or below 250% of federal poverty level (same as Family Planning income guidelines)
   - Has not had a documented Pap test in the past 10 months or more.


3. Complete Pap test on client and submit requisition with Pap sample to BCCCP approved lab. Indicate BCCCP as payment source. Attach copy of insurance card to lab requisition form if client has insurance.

4. Once received, inform client of Pap test result. If the Pap test result is ASC-US (Atypical Cells – Uncertain Significance), perform a HR-HPV test as triage. If positive (+) for HR-HPV, patient should be referred for colposcopy.

5. Complete all required information on the STD/BCCCP Enrollment/Cervical Screening Form (attachment 1) and fax to BCCCP within one week of receiving Pap test results. If information is missing, BCCCP staff will call and request it.

6. If short-term follow-up is recommended, STD Agency is responsible for providing or arranging for follow-up.

7. If immediate follow-up is recommended, STD Agency should fax copy of STD/BCCCP Enrollment/Cervical Screening Form with copy of Pap test results to colposcopy/gynecology office.
   - An STD client referred to BCCCP for immediate follow-up must have an abnormal Pap test that indicates possible cervical cancer, and requires colposcopy for diagnosis. A client with a negative Pap test, Pap test showing inflammation, and Pap test that is “unsatisfactory” or “inadequate” for evaluation is not an appropriate candidate for immediate follow-up.
   - The STD Agency should advise the client to return to the STD Agency for repeat Pap tests after recommended procedure(s) at GYN office. Otherwise, she will be financially responsible for the office visits associated with the Pap test.
Colposcopy Office/Gynecologist Responsibilities:

1. Provide follow-up services, as indicated.

2. Complete case management of clients referred for immediate follow-up
   - Clients who receive Case Management services are those who have Pap test results of either AGUS, ASC-H, HSIL, invasive cancer, or adenocarcinoma
   - Appropriate documentation in the medical record of case-management services must occur. This includes assessment, plan of care, coordination of care, follow-up, patient support and education, and monitoring of care provided.
   - Follow-up information will need to be collected on all clients referred for immediate follow-up
     - Use Cervical Follow-up Form provided by the BCCCP
     - After each visit, a Cervical Follow-up Form must be completed accurately and sent to BCCCP in a timely fashion, before services will be authorized for payment
     - Send copy of follow-up results to STD Agency
   - GYN office will be responsible for communicating with the client for the following reasons
     - Reminding her of appointment date(s)
     - Rescheduling missed appointments(s)
     - Reminding her to contact STD Agency to schedule first repeat Pap test
   - GYN office will be responsible for communicating to BCCCP and STD Agency if client is “lost to follow-up” or “refuses follow-up.” Evidence must exist in the chart of communications with the client who refuses follow-up care, and of attempts to facilitate informed decision-making regarding clinical necessity for follow-up and/or treatment
   - Case Management services conclude when treatment and follow-up is completed

Special Case Management Reimbursement:

1. Upon completion of diagnostic testing and determination of a final diagnosis, the GYN office will receive a special case management reimbursement for each eligible client with one of the following abnormalities on Pap smear: HSIL, AGUS, ASC-H, Adenocarcinoma, Squamous Cell Carcinoma; or with a final diagnosis of CINII, CINIII/CIS, Invasive Cervical Cancer, or Adenocarcinoma, gained from biopsy.

2. The following diagnostic information must be completed on the Cervical Follow-up Form and sent to the BCCCP before cases eligible for Case Management reimbursement will be paid
   - Date of all follow-up tests provided
   - Final diagnosis status
   - Final diagnosis date
Stage of diagnosis and tumor size (if applicable)
➢ Treatment disposition
➢ Treatment date (for cancer diagnosis, use the date treatment was started)

County Health Department Responsibilities:

1. Provide necessary forms to STD Agency and GYN office
3. Collect follow-up information from GYN office once client has been referred for immediate follow-up
4. Provide on-going consultation when needed
5. Remind client when Pap tests are recommended by sending one notification, and if necessary, a certified letter

Michigan Department of Community Health (MDCH) Responsibilities:

1. MDCH will reimburse $50/client for coordination
2. The MDCH reimburses providers $95 for each client who receives Case Management services and is approved by the BCCCP for such reimbursement

Reimbursement Rate Schedule:

1. Procedures identified on Rate Schedule are considered covered services (Note: The same rate schedule is used for both the Family Planning/BCCCP Joint Demonstration Project and the STI/BCCCP Demonstration Project.)
2. Case management reimbursement will be negotiated with the GYN office
3. Rate schedule is subject to change
4. After client has a colposcopy, ECC, cervical conization or LEEP, follow-up Pap tests are indicated. The BCCCP will pay for up to three (3) Pap tests if done at the STD Agency or GYN office and at the GYN’s recommendation. The program will not pay for the office visit(s) associated with the Pap test(s). The Client may need to make payment arrangements with the provider for the office visit.
5. Payment arrangements may need to be made with the provider for any services not reimbursed by the BCCCP.
Billing and Collection:

1. Extensive data is required by the Centers for Disease Control and Prevention (CDCP) for each woman served with federal funds. Data of services and results of procedures are required prior to authorizing reimbursement to providers.

2. The federal law requires that any funds used to pay for direct clinical services delivered to STD/BCCCP Joint Demonstration Project clients be “funds of last resort.” This means that there must be significant attempts to collect from every available insurance plan before BCCCP funds can be used to reimburse providers for covered services.

3. For an underinsured client, providers bill any and all insurance plans prior to billing BCCCP via the Third-Party Administrator. If the client’s insurance pays below the BCCCP rate, providers may bill BCCCP for the difference between the insurance payment and the BCCCP rate. When balance billing, providers need to submit documentation of all efforts to collect payment from insurance carriers. A copy of the insurance Explanation of Benefits (EOB) Form should accompany the claim that is submitted to BCCCP. Payment of the balance will constitute payment in full and providers should not bill the client.

4. For an uninsured client, the provider bills BCCCP, accepting the reimbursement rate as payment in full. Providers agree not to bill the client for services reimbursed by BCCCP.

Medicaid Treatment Act:

1. As of October 1, 2001, women diagnosed with cancer or precancerous conditions through the BCCCP are eligible to apply for Medicaid to pay for treatment. This applies to women seen through the STD/BCCCP Project who have final cervical diagnosis of CINII, CINIII/CIS, invasive cervical cancer or adenocarcinoma.

Billing Reporting Requirements:

1. Upon completion of the services listed in the attached rate schedule, and submission of the following required information, BCCCP will pay providers an amount not to exceed the reimbursement rate. The information required is as follows:
   - Completed Client Enrollment/Cervical Screening Form
   - Explanation of benefits (EOB) for any patient with 3rd Party Insurance—required when balance billing BCCCP
   - Invoice/claim form. Statements will be rejected.
   - Follow-up information—for follow-up procedures
CPBC Amendment Instructions:

Funding for the STI/BCCCP Joint Project should be included in your Coordination column established for the Family Planning/BCCCP Joint Demonstration Project in your Comprehensive Planning, Budgeting and Contracting (CPBC) budget agreement. Your CPBC budget should be amended to include funding for this project. The column established as “FP/BCCCP” should be amended to include a funding line entitled “STI/BCCCP Coordination,” for Coordination costs of this project, allocated at $50 per woman in the approved caseload. There will be no performance requirement for this project.

The STI/BCCCP Joint Project funding is subject to the match requirement (hard or in-kind) of $1 to every $4 of MDCH agreement funding. This is the same requirement for BCCCP and for the FP/BCCCP Joint Project. Your agency is required to report community match for the BCCCP, the FP/BCCCP Joint Project, and the STI/BCCCP Joint Project all on one Matching Funds Report.
I  INTRODUCTION

This protocol has been developed for use in the Title XV Michigan Breast and Cervical Cancer Control Program and addresses the provision of services related to breast and cervical cancer screening and follow-up care only. It is recognized that a BCCCP coordinating agency or its sub-contractor for clinical screening/follow-up services may or may not have the ability and willingness to screen for and manage health problems unrelated to breast or cervical cancer.

BCCCP coordinating agencies or its subcontractors, which have the ability and willingness to screen for and manage other health problems (STD testing, blood glucose testing, hemocult, etc.), may, at their own discretion, do so at the time of the woman's visit to the BCCCP.

However, Title XV funds cannot be used for the time and materials needed to assess and manage problems unrelated to breast or cervical cancer. The protocol for assessment and management of other health problems should be developed by the BCCCP coordinating agency and added to this core protocol.

The Michigan Cancer Consortium (MCC) Breast Cancer Advisory Committee (BCAC) and the Cervical Cancer Advisory Committee (CCAC) have developed guidelines for both breast and cervical cancer screening and follow-up care. These guidelines are incorporated as part of this BCCCP medical protocol.


The Cervical Cancer Advisory Committee recognizes and promotes the use of the American Society for Colposcopy and Cervical Pathology’s (ASCCP) 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests and 2006 Consensus Guidelines for the Management of Women with Cervical Intraepithelial Neoplasia or Adenocarcinoma in Situ. Guidelines are referenced in this document and may be found at http://www.asccp.org/
II PROVISION OF BREAST AND CERVICAL CANCER SCREENING, FOLLOW-UP, AND TREATMENT SERVICES THROUGH THE BCCCP

The BCCCP provides the following breast and cervical cancer screening services: clinical breast exams, mammograms, Pap tests and pelvic exams. Screening is the attempt to detect unsuspected disease in average risk, asymptomatic women. Women identified with abnormal breast and/or cervical screening results are referred for appropriate diagnostic procedures to confirm or rule out a cancer diagnosis. In the event a breast or cervical cancer is diagnosed, the woman is assisted in obtaining necessary breast or cervical cancer-related services in a timely manner. A crucial component of the Michigan BCCCP is to ensure that women enrolled in the program receive timely and appropriate screening, diagnostic and treatment services.

III BREAST AND CERVICAL CANCER SCREENING RECOMMENDATIONS

A. Breast Cancer Screening Recommendations

1. Screening Tests
   A clinical breast exam and mammogram should be used for routine breast cancer screening.

2. Recommendations for Breast Cancer Screening

<table>
<thead>
<tr>
<th>Screening Exam</th>
<th>Interval</th>
<th>Age to Begin</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Self Exam (BSE) *</td>
<td>Monthly</td>
<td>Age 20 and older</td>
<td>Women should report any breast change promptly to their health care providers</td>
</tr>
<tr>
<td>Clinical Breast Exam (CBE)</td>
<td>Every three (3) years</td>
<td>Asymptomatic women in their 20’s and 30’s</td>
<td>CBE should be part of a periodic health exam</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>Women age 40 and older</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Annually</td>
<td>Average risk women starting at age 40</td>
<td>The American College of Physicians Practice Guidelines (2007) advises clinicians to tailor the decision to screen women on the basis of women’s concerns about breast cancer, as well as their risk for breast cancer. Based on this review, the MCC recommends no change to the current recommendation of annual mammography for average risk women beginning at age 40.</td>
</tr>
</tbody>
</table>

* No firm evidence has been identified that performing breast self-exam reduces the risk of breast cancer mortality. (Level of Evidence: The United States Preventative Services Task Force (USPSTF) found poor evidence to determine whether BSE reduces breast cancer mortality. The American Cancer Society concurs with this finding. The USPSTF found fair evidence that BSE is associated with an increased risk for false-positive results and biopsies. Due to design limitations of published and ongoing studies of BSE, the USPSTF could not determine the balance of benefits and potential harms of BSE.)
3. Upper Age Limit for Screening
   - Annual mammography screening should continue regardless of age, as long as a woman does not have serious chronic health problems.
   - For women with serious health problems or short life expectancy, evaluate ongoing early detection testing.

NOTE: BCCCP women are eligible for breast cancer screening until age 64 unless they are ineligible for Medicare or have not purchased Medicare Part B
In the absence of endocervical cells, if a Pap smear is satisfactory and negative, then regular screening should be continued.

4. Recommendations for Cervical Cancer Screening:

<table>
<thead>
<tr>
<th>Age to Begin</th>
<th>Screening Exam</th>
<th>Screening Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21 or 3 years after the onset of sexual activity until age 29</td>
<td>Conventional Pap Test OR Liquid Based Cytology (LBC)</td>
<td>Annual</td>
</tr>
<tr>
<td>Age ≥ 30* with three consecutive, negative cytology results</td>
<td>Conventional Pap Test OR Liquid Based Cytology</td>
<td>Every two to three years</td>
</tr>
</tbody>
</table>

* HR-HPV (High-Risk Human Papillomavirus testing) as an adjunct to cervical cytology testing may be used for cervical cancer screening in women 30 years of age or older. If both tests are negative, testing occurs every three years. For abnormal results, follow-up guidelines may be found on www.asccp.org.

NOTE: HR-HPV as an adjunct to cervical cytology testing cannot be reimbursed by the BCCCP.

5. Special Considerations:
   a. Women with a histologically-confirmed HSIL, whether or not they receive treatment - continue cervical cancer screening on a regular basis, for 20 years.
   b. Women who are HIV+, immunocompromised, or had in utero DES exposure – continue ANNUAL cervical cancer screening regardless of the testing method.
   c. For women whose cytology exam is satisfactory but obscured or partially obscured by inflammation – repeat the exam in 6 months. Refer for colposcopy if subsequent cytology is still interpreted as obscured, partially obscured or otherwise abnormal.
   d. Women whose cytology exam is unsatisfactory need a repeat cytology exam within the next 2 to 4 months.
   e. Per the ASCCP guidelines, adolescents and pregnant women are also given special consideration. See guidelines for details at http://www.asccp.org.
   f. Treatment of pregnant women:
      - Endocervical curettage is unacceptable in pregnant women
      - Colposcopy may be deferred until the postpartum examination
      - Invasive cancer is the only indication for treatment during pregnancy

6. For Women Who Have Had a Hysterectomy:
   a. If the hysterectomy was for cervical cancer or cervical dysplasia - continue
BREAST AND CERVICAL CANCER CONTROL PROGRAM
MEDICAL PROTOCOL

ANNUAL Pap testing.
b. For women who still have a cervix, continue testing as indicated by age, type of cytology test and Pap history.
c. Total hysterectomy for benign gynecological disease (no cervix present) - screening with vaginal cytology is NOT indicated; this does not preclude a pelvic exam.

7. Upper Age Limit for Screening:
a. Consider not screening after age 70 if the woman has had 3 documented negative Pap tests and no abnormal Pap tests in the last 10 years.
b. Consider continuing to screen if the woman is sexually active.
c. Women with comorbid illnesses may forego cervical cancer screening.
d. Continue screening if there is a history of cervical cancer, in utero DES exposure, or the woman is HIV + or immunocompromised.

NOTE: BCCCP women are eligible for cervical cancer screening until age 64 unless they are ineligible for Medicare or have not purchased Medicare Part B.

8. Indications for Referral to a Qualified Colposcopist:
a. Women age 20 and under requiring treatment for CIN2/3
b. Pregnant women with HSIL cytology.
c. Women with a significant cervical lesion in which “see and treat” may be indicated
d. Women desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia.
e. Women who have had two “unsatisfactory for evaluation” tests 2-4 months apart
f. Women with AGC (Abnormal Glandular Cells) or AIS (Adenocarcinoma in situ) on cytology. Management follows the algorithm found at www.asccp.org
g. Women with any gynecologic cancer should be referred to a Gynecologic Oncologist.
C. Provision of Screening and Diagnostic Services to Special Populations in the BCCCP.

**NOTE:** The following special populations are eligible to participate in the BCCCP as long as they meet the income requirements

1. Women < 40 identified in specified Sexually Transmitted Disease (STD) clinics who have not had a documented Pap test > 10 months are eligible for both cervical screening and diagnostic services if needed for follow-up of Pap test abnormalities.

2. Women < 40 seen in any Family Planning/Title X clinics who have an abnormal Pap test result requiring immediate follow-up for the abnormality can be referred to BCCCP for diagnostic services only to confirm or rule out a cancer diagnosis.

**NOTE:** HPV testing should be discussed and recommended to the client; however, BCCCP funds cannot pay for HR-HPV testing for Family Planning clients with screening Pap test results of ASC-US

3. Women age 40-64 seen in either STD or Family Planning/Title X Clinics for cervical services may be referred to BCCCP for breast screening and diagnostic services (if needed).

III. CLINICAL HISTORY/EXAMINATION

A. Clinical history should consist of the following:
   1. Description of current breast and GYN (gynecological) symptoms
   2. Past history of breast problems (abnormal clinical breast exams, abnormal mammograms).
   3. Past history of abnormal Pap tests. (Hysterectomy history, if applicable, and reason for hysterectomy).
   4. Personal history of breast, cervical, ovarian, colorectal cancer
   5. Family history of breast/ovarian/colorectal cancer (both maternal and paternal, age at diagnosis).
   6. Smoking history: past, current, packs per day, and duration.
   7. Last mammogram date and result.
   8. Last Pap test date and result.

B. Physical exam
BREAST AND CERVICAL CANCER CONTROL PROGRAM

MEDICAL PROTOCOL

a. Clinical Breast Examination
   • Sitting - inspection, palpation of axillary and supraclavicular nodes
   • Supine - inspection, palpation
b. External Genitalia examination
   • Inspection
   • Palpation
c. Internal examination
   • Inspection of cervix and vagina
d. Bimanual examination
   • Palpation of vaginal wall, cervix
   • Palpation of uterus and adnexae
e. Recto-vaginal exam

C. Obtain Pap Smear (if indicated)

NOTE: BCCCP funds can only reimburse for SCREENING Pap tests according to the following guidelines. These guidelines DO NOT apply to women requiring Pap tests as follow-up for an ABNORMALITY.

Screening Pap test Guidelines

Conventional Cytology (Screening Pap tests) may be performed:
   • Annually until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5-year period).
   • Then, once every (3) three years, for women with (3) three, consecutive normal/negative screening Pap tests performed within a 60-month (5 year period).

Liquid Based Cytology (LBC) may be performed:
   • Every TWO years until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5 year period).
   • Then, once every (3) three years, for women with (3) three, consecutive normal/negative Pap tests performed within a 60-month (5 year period).

D. Mammography Screening
1. Order the appropriate mammogram based on clinical breast exam findings:
   - **Screening mammogram** - performed on an **asymptomatic** woman to detect early, clinically unsuspected breast cancer.
   - **Diagnostic Mammogram** - performed on a woman with **clinical signs or symptoms** that suggest breast cancer or past history of a breast cancer or abnormality that requires ongoing monitoring.

2. Request films (if available) from last mammogram to be sent to referral mammography facility.

3. Forward results of CBE to mammography facility (if able).

4. Request copy of mammogram report. Review report to determine appropriate follow-up (if recommended by radiologist).

5. Send report of all clinical findings and follow-up recommendations (if any) to

**E. Patient Education**

1. Review physical exam components
   a. Clinical Breast Exam
      - Discuss normal findings and variances.
      - **Emphasize that any time a woman detects a breast change or a palpable mass she should seek evaluation from a qualified health care provider (breast specialist).**
   
   b. Pelvic Exam
      - Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV.

   c. Discuss indications for notifying the provider about abnormal breast and/or cervical signs/symptoms that need evaluation.

2. Discuss the importance of breast and cervical cancer screening which includes:
   - Frequency of breast and cervical cancer screening is based on the woman’s risk factors and past medical history.
   - Breast cancer screening tests include both a clinical breast exam and mammogram.
   - Cervical cancer screening tests include a Pap test. **(Frequency of Pap testing is dependent on previous Pap test results).**

   - Pelvic exams should be received **yearly**, whether or not a Pap test is needed based on risk factors and history.
• Possible testing for STDs including HPV.

3. Discuss limitations of screening procedures
   • Normal results on a screening exam do not necessarily indicate absence of disease.
   • No screening test is 100% accurate; therefore, some cases of the disease may be unavoidably missed.
   • Normal results never rule out the later development of the disease, which is why annual screening is so strongly recommended.
   • The detection of an abnormality does not mean the abnormality is cancerous. Only some of the women with abnormal screening results will, after further evaluation, be diagnosed with breast or cervical cancer.

IV FOLLOW-UP OF NORMAL AND ABNORMAL BREAST AND CERVICAL CANCER SCREENING RESULTS

A. Reminder and tracking systems
   Clinicians and agencies should develop and implement tracking systems which will:
   • Remind women to schedule cancer screening testing AND
   • Notify women of abnormal mammogram results or cervical cancer screening tests (which include positive HPV – High Risk test results) and follow-up diagnostic testing that is required.

B. Inability to contact a woman regarding abnormal results
   Each local coordinating agency should establish its own protocol for women who cannot be contacted regarding abnormal results. The protocol should include:
   • Contacting the woman by telephone and/or sending a certified letter
   • Documentation of the above in the medical record

C. Follow-up of Clinical Breast Exam Screening Results
<table>
<thead>
<tr>
<th>CBE Result</th>
<th>Type of Follow-up</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| **1. No Breast Abnormality**  
(normal glandular tissue felt upon palpation) | No Follow-up | Refer for Screening Mammogram |
| **2. Benign Breast Condition**  
(symmetrical thickening or area of thickened tissue palpated in the same location in both breasts; nodularity, irregularity or lumpiness that is not clinically suspicious): | No or Short-term Follow-up (3-7 months) | Refer for Screening* Mammogram  
*Based on the type of mammogram ordered and client’s history, a diagnostic mammogram may be ordered. This mammogram is considered screening. |
| **3. Abnormal CBE Results** that include any of the following:  
- New onset UNILATERAL breast pain, soreness or sensitivity not related to menstrual cycle changes  
- Clinically suspicious mass or asymmetrical thickening (including an area of density, a lump, or another area that stands out or is discrete from the surrounding tissue or an irregular, hard, fixed mass)  
- Nipple discharge (nonspontaneous multiduct discharge, or persistent, spontaneous, unilateral, single duct, serous, or sanguineous nipple discharge)  
- Observed skin or nipple changes (Peau d’orange, erythema, nipple excoriation, scaling, eczema) | **Immediate Follow-up** (within 1-2 months) to confirm or rule/out cancer | Refer for Diagnostic Mammogram AND additional follow-up procedures as indicated.  
See Michigan Cancer Consortium Recommendations for Follow-up of Abnormal Breast Cancer Screening Results |

**D. Follow-up of Mammogram Breast Cancer Screening Results**

<table>
<thead>
<tr>
<th>Mammogram Result</th>
<th>Type of Follow-up</th>
<th>Recommendation</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>ACR Code</th>
<th>Description</th>
<th>Follow-up Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACR 1 - Negative</td>
<td>Up to 1 year</td>
<td>No Follow-up</td>
</tr>
<tr>
<td>ACR 2 – Benign Breast Condition</td>
<td>No or Short-term Follow-up (3-7 months)</td>
<td>Based on type of mammogram ordered and client’s history, radiologist may recommend diagnostic mammogram or ultrasound.</td>
</tr>
<tr>
<td>ACR 3 – Probably Benign</td>
<td>Short-term Follow-up (3-7 months)</td>
<td>Refer for diagnostic mammogram and/or ultrasound based on radiologist recommendations. See MCC Recommendations for Follow-up of Abnormal Breast Cancer Screening Results</td>
</tr>
<tr>
<td>ACR 0 – Assessment is Incomplete</td>
<td>Immediate Follow-up (within 1-2 months) to confirm or rule/out cancer</td>
<td>Refer for diagnostic mammogram and/or ultrasound based on radiologist’s recommendation. Based on result, additional referral to a breast surgeon/specialist for evaluation may or may not be indicated. NOTE: If comparison films are requested, films should be obtained within 30 days. After review, radiologist will determine if no or additional follow-up is required.</td>
</tr>
<tr>
<td>ACR 4 – Highly Suggestive of Malignancy</td>
<td>Immediate Follow-up (within 1-2 months) to confirm or rule/out cancer</td>
<td>See MCC Recommendations for Follow-up of Abnormal Breast Cancer Screening Results</td>
</tr>
<tr>
<td>ACR 5 – Suspicious Abnormality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Special Considerations

**ABNORMAL** clinical breast examination, **NORMAL** mammogram results OR **ABNORMAL** mammogram, **NORMAL** clinical breast exam
1. Notify the patient of the results of her CBE and/or mammogram result and its implication. This information should include:
   - Explanation of the type of abnormality suspected/identified (on clinical breast exam and/or mammogram).
   - Additional diagnostic follow-up required based on the abnormality (i.e. ultrasound, surgical consultation, biopsy etc) as recommended by the radiologist/breast specialist/surgeon.
   - Implications for coverage by the BCCCP

2. Refer for additional diagnostic follow-up as indicated.

   **NOTE:** Radiologically confirmed breast cysts do not always require referral to breast surgeon/specialist. Additional follow-up is determined by size of cyst, patient history, and recommendation by the radiologist.

3. Notify the patient's primary provider (if any).
   - The physical exam findings and mammogram/ultrasound test results
   - BCCCP role/action taken
**Michigan Cancer Consortium**

**Recommendations for Follow-up of Abnormal Breast Cancer Screening Results**

**March 21, 2001**

<table>
<thead>
<tr>
<th>Abnormal Result</th>
<th>Primary Care Management</th>
<th>Indication for Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Clinical Breast Exam:</strong> Nipple Discharge, no palpable mass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Bilateral Milky Discharge</td>
<td>Conduct Pregnancy Test</td>
<td>None</td>
</tr>
<tr>
<td>2. Nonspontaneous Multiduct discharge</td>
<td>Under age 40 - Educate and Observe</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Over age 40 – Refer for Mammogram</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after mammogram</td>
</tr>
<tr>
<td>3. Persistent, spontaneous, unilateral, single duct, serous, or sanguineous nipple discharge</td>
<td>Refer for diagnostic mammogram with guaiac or cytology (optional)</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after mammogram</td>
</tr>
<tr>
<td><strong>B. Clinical Breast Exam:</strong> Lump/Mass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 30</td>
<td>Refer for Ultrasound (preferred), needle biopsy, or if low risk, observe for 1-2 menstrual cycles to see if the mass resolves;</td>
<td></td>
</tr>
<tr>
<td>Over age 30</td>
<td>Refer for mammogram and/or ultrasound</td>
<td>If lump/mass persists, refer to Breast Specialist/Surgeon for additional evaluation</td>
</tr>
<tr>
<td><strong>C. Clinical Breast Exam:</strong> Thickening/nodularity/ asymmetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 30</td>
<td>Refer for ultrasound plus mammogram if indicated</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td>Over age 30</td>
<td>Refer for bilateral diagnostic mammogram with or without ultrasound</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td><strong>D. Clinical Breast Exam:</strong> Skin changes (Peau d'orange, Erythema, Nipple excoriation, Scaling, eczema)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer for bilateral diagnostic mammogram with or without an ultrasound</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td><strong>E. Mammogram:</strong> BiRADS Category 3- ACR 3 Probably Benign</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer for bilateral diagnostic mammogram at 6 months, then every 6-12 months for 2-4 years; may include biopsy if patient noncompliant or highly anxious</td>
<td>May need to refer to Breast Specialist/Surgeon for additional evaluation after imaging (if indicated)</td>
</tr>
<tr>
<td><strong>F. Mammogram:</strong> BiRADS Category 4 – ACR 4 Suspicious Abnormality Category 5 – ACR 5 Highly Suggestive of Malignancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refer to breast specialist/surgeon for FNA or Core biopsy with post-specimen radiography if microcalcifications or Needle localization excisional biopsy</td>
<td></td>
</tr>
</tbody>
</table>
F. Follow-up of Abnormal Cervical Cancer Screening Results

1. **ABNORMAL** pelvic examination (abnormal gross appearance of cervix), **NORMAL** Pap test
   a. Notify the patient of the results of her pelvic examination and its implication. This information should include:
      - The nature of the suspected disease and differentiation between a cervical lesion or other pelvic abnormality (ovarian mass) and implications for coverage by BCCCP, etc.
      - Refer immediately for colposcopy with biopsy as indicated.
      **Do not rely on cervical cytology results alone.**
   b. Notify the patient's primary provider (if any).
      - The physical exam findings and screening test results
      - BCCCP role/action taken

2. **UNSATISFACTORY** cervical cytology specimen
   - Repeat Pap smear in 2-4 months.
   - If second Pap test is unsatisfactory, refer for colposcopy.

3. **ABNORMAL** cervical cytology report
   a. Notify the patient of the results of the Pap test and its implications within 4 days of receipt of abnormal findings, including:
      - The nature of the suspected disease
      - What a precancerous lesion is and that it is 100% curable
      - The need for further testing for definitive diagnosis before treatment
      - Treatment options available, benefits and risks of each
   b. Refer/arrange for repeat Pap test and/or diagnostic work-up and treatment based on Pap test results.

4. **Follow-up of ABNORMAL CYTOLOGY RESULTS:**
   a. The website [www.asccp.org](http://www.asccp.org) contains algorithms on the:
      - Follow-up of ASC-US cytology results for all women

   **NOTE:** BCCCP funds CAN REIMBURSE for HR-HPV testing for BCCCP clients (age 40-64) only as follow-up for screening Pap test results of ASC-US.
   - Management of adolescent women with HSIL results, ASC-US or LSIL cytology
   - Management of pregnant women with LSIL results
   - Management of HSIL, ASC-H and LSIL cytology for all women
   - Management and follow-up of AGC cytology.
   b. A diagnostic excisional procedure is recommended for women with HSIL
and an unsatisfactory colposcopy, except when pregnant.

c. A diagnostic excisional procedure is recommended for adolescents and young women with HSIL when CIN of any grade is identified on ECC.

d. Ablation is unacceptable for HSIL cytology if:
   - No colposcopy was done
   - CIN 2/3 is not identified colposcopically
   - ECC identifies CIN of any grade

e. In women less than 35 years of age with an AGC cytology result, an endometrial biopsy should be performed in the presence of, but is not limited to, the following conditions:
   - Dysfunctional uterine bleeding
   - At risk for chronic anovulation
   - A change in menstrual flow

5. **Management of Women and Adolescents with Histologically-confirmed Cervical Intraepithelial Neoplasm:**
The website [www.asccp.org](http://www.asccp.org) contains algorithms on the management of:
   - Women with histological results of CIN1, preceded by ASC-US, ASC-H or LSIL cytology
   - Women with histological results of CIN1, preceded by HSIL or AGC-NOS cytology
   - Adolescents, with a histological result of CIN1
   - Women with a histological result of CIN2/3
   - Women with AIS (Adenocarcinoma in situ) diagnosed from diagnostic excisional procedure.

6. **Appropriate follow-up for BCCCP Clients with Pap test results of HSIL with colposcopy results of CIN I, “not cancer”, or atypia**
   - When the colposcopy is satisfactory, a review of cytology, colposcopy and histology results should be performed
   - If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines as described in the BCCCP Medical Protocol
   - If Pap results of HSIL are upheld, a diagnostic excisional procedure is preferred (either cone or LEEP).
   - When the colposcopy is unsatisfactory, a review of cytology, colposcopy and histology results should be performed when possible.
   - If there is a revised interpretation of either the Pap or the histology results, the clinical management should follow the appropriate guidelines.
   - If HSIL Pap is upheld, review is not possible, or biopsy-confirmed CIN1
is identified, a diagnostic excisional procedure is preferred (cone or LEEP)

NOTE: BCCCP can reimburse for either cold knife cone or LEEP procedure. Authorization MUST be obtained prior to the procedure being performed.

- Ablation is unacceptable
- If colposcopy suggests a high-grade lesion, initial evaluation using a diagnostic excisional procedure is acceptable management ("see and treat")
- Testing for High-risk Human Papillomavirus (HPV) is not acceptable management as triage for HSIL

6. Management of Atypical Glandular Cells (AGC) or Adenocarcinoma In Situ (AIS)
   a. Initial Evaluation:
      - Colposcopy with endocervical sampling is recommended for women with all subcategories of atypical glandular cells (AGC) (AGC “not otherwise specified [NOS],” AGC “favor neoplasia”) and adenocarcinoma in situ (AIS).
      - Performance of endometrial biopsy (EMB) should be considered as part of the initial evaluation for women age 35 or older.

NOTE: BCCCP can reimburse for endometrial biopsies in this situation only. Pre-authorization MUST be obtained prior to the procedure being performed.

- Management of women with initial AGC or AIS using a program of repeat cervical cytological testing is unacceptable.

b. Subsequent Evaluation or Follow-up:
   - If biopsy-confirmed CIN is identified during the initial workup of a woman with AGC (NOS), the woman should be referred to a qualified colposcopist for treatment.
   - If invasive disease is not identified during the initial colposcopic workup, it is recommended that women with AGC “favor neoplasia” or endocervical AIS undergo a cold-knife conization or LEEP.

NOTE: BCCCP can reimburse only for a cold knife conization/LEEP. Pre-authorization MUST be obtained prior to the procedure being performed.

- If no neoplasia is identified during the initial workup of a woman with
AGC (NOS), it is recommended that the woman be followed up using a program of repeat cervical cytological testing at 4- to 6-month intervals until 4 “negative for intraepithelial lesion or malignancy” results are obtained, after which the woman may return to routine screening.

QUESTIONS REGARDING THIS PROTOCOL MAY BE DIRECTED TO:

E.J. Siegl, MA, OCN, RN,  BCCCP Nurse Consultant  517/335-8814
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Washington Square Building
Cancer Prevention and Control Section,
109 Michigan Ave, 5th Floor, Lansing, MI 48913
RESCREENING POLICY

Introduction
The Michigan Breast and Cervical Cancer Control Program and the Michigan Department of Community Health recommend annual breast and cervical cancer screening for all women 40 years of age and older. Priority for screening is given to eligible women previously screened through the BCCCP. The inclusion of 40-49 year olds in the annual rescreening policy is supported by the members of the Michigan Cancer Consortium’s Breast Cancer Advisory Committee, comprised of key representatives from the four Michigan Medical Schools and two NCI-designated Comprehensive Cancer Centers. This policy is also supported by the American Cancer Society, with whom the Michigan BCCCP has a formal partnership and close working relationship in recruiting eligible women for breast and cervical cancer screening.

Definition of Rescreening
The rescreening policy developed by the Michigan BCCCP defines rescreening as a Pap test, clinical breast exam, and/or mammogram received between 10 and 18 months of the initial or previous screening. The rescreening rate is calculated as the number of rescreening events received divided by the total number of eligible rescreenings over the duration of the program. The targeted rescreening rate for each local coordinating agency should meet or exceed either the state average or the agency’s past performance, whichever is higher.

Monitoring
The Outreach and Recruitment Consultant for the Michigan BCCCP is responsible for monitoring each local contracting agency’s adherence to the rescreening protocol. Under the protocol, local agencies implement a rescreening strategy or combination of strategies that they find to be most effective in working with their own unique populations. The local BCCCP coordinators change or modify these strategies as needed to accomplish their rescreening goals.

Assessment/Assurance
The Outreach and Recruitment Consultant at the state level monitors the success of each agency’s rescreening efforts thru the semi-annual data reports obtained from the data staff as well as thru the BCCCP Semi-Annual Recruitment/Coalition Reports submitted by all local contracting agencies. Each agency is assessed based on its ability to reach a rescreening rate that meets or exceeds either the state average or the agency’s previous performance, whichever is higher. Agencies with the rescreening rates that do not at least meet the state average are expected to show continued movement toward meeting this goal. The Outreach and Recruitment Consultant will work individually with any agency having difficulty meeting the rescreening requirements and assist them in the development of the new strategies that lead to improved rescreening rates and adherence to the rescreening protocol.
Rescreening Protocol

Introduction
This protocol has been developed for the use in the Breast and Cervical Cancer Control Program. It is based on the premise that the priority for mammograms and Pap smears should be given to eligible women previously screened thru the BCCCP. The protocol was established through a survey of local coordinating agencies and reflects their current practices. A rescreening methodology is outlined which can be used to facilitate the return of previously screened women. Four different strategies are proposed, keeping in mind that each local coordinating agency needs to decide which strategy will work best for their population and staffing situation.

The targeted rescreening rate for each local coordinating agency should meet or exceed either the state average or the agency’s past performance, whichever is higher. The rescreening rate is based on rescreening events that take place between 10 and 18 months of an initial or previous screening. Based on this calculation, Michigan’s current average rescreening rate is estimated to be 47.8%. Historically, the Michigan BCCCP calculated its rescreening rate to 56.5% and takes into account all women who return for rescreening, even those who return beyond the recommended time frame. **However, the specific rescreening formula will likely be developed by the CDC, causing Michigan’s estimated rate to change.** Agencies that do not at least meet the state average need to show continued movement toward meeting this goal.

Method
A. Patient Education
1. At each visit the screening/primary care provider should assess the woman’s understanding of the following and should educate the woman when gaps in understanding are detected:
   a. Knowledge about breast and cervical health
   b. Understanding of the significance of risk factors for breast and cervical cancer
   c. Personal practices of screening for breast and cervical cancer
   d. Knowledge of signs and symptoms of breast and cervical disease
   e. Explanation of the screening procedures for breast and cervical cancer (clinical breast examination, mammography, BSE and Pap and pelvic examination) and the importance of routine screening
   f. Her own responsibility in scheduling and obtaining breast and cervical cancer screening at the recommended ages and intervals (annually for women ages 40 and older)
   g. How and where to obtain appropriate services
   h. Knowledge and practice of BSE, normal findings and variances
   i. What actions to take if she notices a change in breast or a symptom of cervical disease **between** the annual screening examinations
   j. How and when she will be notified of the results of her screening examinations
   k. What actions will follow the detection of breast or cervical cancer abnormality, including what the various diagnostic procedures might be
2. Before a woman is referred for her first mammogram, the mammography procedure should be explained including why compression is needed, the potential for experiencing some discomfort, and ways to reduce such discomfort, including (for premenopausal women) scheduling the exam in the first half of the menstrual period.

3. At each screening visit (initial visit and subsequent annual re-screening visits) the woman will sign and date an informed consent form indicating her understanding of and willingness to participate in the BCCCP.

B. Automated Reminder System

1. At the time of initial screening, each woman’s name should be entered into the database used by all local coordinating agencies.

2. Every month, the local coordinating agency should use the database to generate a list of all women due for rescreening, within one month of their one year anniversary.

3. After a woman is rescreened, her name should remain in the database to be recontacted annually, within one month of her anniversary date.

C. Contact

1. The local coordinating agency should attempt to contact all women due for rescreening using at least one of the following for strategies. These strategies may be modified to accommodate each agency’s own unique population. Any strategy should include processes for contacting women who are due for rescreening, documenting their decision in a systematic manner (e.g. medical record, log, data system) and assessing barriers to screening for those that decline. Some models currently in use by local coordinating agencies include collaboration with ACS and other partners to assist in contacting women due for rescreening (see attachment). Consultation on rescreening strategies is available for state staff and other local coordinating agencies.
   a. Postcard system – A postcard is sent to each woman, reminding her that she is due for rescreening. A phone number should be provided for her to call to schedule an appointment.
   b. Postcard system plus phone contact – A postcard system is used as outlined above. If the woman does not respond within one month of receiving the postcard, the local coordinating agency attempts to contact her by phone.
   c. Postcard system plus phone contact plus final letter – A postcard and phone contact system is used as outline above. If after three months and multiple phone attempts the woman cannot be reached, she will be sent a certified letter. The certified letter should reemphasize the need for her to be rescreened and should urge her to contact the local coordinating agency or screening site, as appropriate, to either schedule an appointment or to discuss why she is not interested.
   d. Automatic appointment – Local coordinating agency staff schedules rescreening appointments for all women who are due for rescreening. Each of these women should then be sent an appointment letter with an appointment date and time. Each woman is asked to call the local agency to confirm her...
appointment, reschedule, or decline screening. If she fails to contact the agency, the appointment time may still be held for her according to the agency’s policy.

D. No Shows
1. All women who fail to show for a scheduled rescreening appointment should be contacted and given the opportunity to reschedule. Attempts should be made to determine the reason for the missed appointment and re-education regarding the importance of rescreening will be given when applicable.

E. Rescreening Rate
1. The targeted rescreening rate for each local coordinating agency should meet or exceed either the current state average or the agency’s past performance, whichever is higher.
2. Any agency whose rescreening rate is less than the state average must develop a plan that results in continued movement toward meeting or exceeding the state average.
Michigan Cancer Consortium Guidelines for Early Detection of Breast Cancer
November 17, 2004

Based on Guidelines of the American Cancer Society (2004), American College of Radiology (2003), and the U.S. Preventive Services Task Force (2002)

- A clinical breast exam and mammogram should be used for routine breast cancer screening.
- Annual mammography screening should continue regardless of age, as long as a woman does not have serious chronic health problems. For women with serious health problems or short life expectancy, evaluate ongoing early detection testing.

Table 1 - Recommendations for Breast Cancer Screening – Average Risk Women

<table>
<thead>
<tr>
<th>Screening Exam</th>
<th>Interval</th>
<th>Age to Begin</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Self Exam (BSE) *</td>
<td>Monthly</td>
<td>Age 20 and older</td>
<td>Women should report any breast change promptly to their health care providers</td>
</tr>
<tr>
<td>Clinical Breast Exam (CBE)</td>
<td>Every three (3) years</td>
<td>Asymptomatic women in their 20’s and 30’s</td>
<td>CBE should be part of a periodic health exam</td>
</tr>
<tr>
<td></td>
<td>Annually</td>
<td>Women age 40 and older</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td>Annually</td>
<td>Average risk women starting at age 40</td>
<td></td>
</tr>
</tbody>
</table>

- No firm evidence has been identified that performing breast self-exam reduces the risk of breast cancer mortality. (Level of Evidence: The United States Preventative Services Task Force (USPSTF) found poor evidence to determine whether BSE reduces breast cancer mortality. The American Cancer Society concurs with this finding. The USPSTF found fair evidence that BSE is associated with an increased risk for false-positive results and biopsies. Due to design limitations of published and ongoing studies of BSE, the USPSTF could not determine the balance of benefits and potential harms of BSE.)
<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Screening Exam</th>
<th>Interval</th>
<th>Age to Begin</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of prior thoracic Radiation Therapy</td>
<td>CBE</td>
<td>6-12 months</td>
<td>Begin 8-10 years after Radiation Therapy or age 40 whichever first, but not under age 25</td>
</tr>
<tr>
<td></td>
<td>Mammogram</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>2. Strong family history of breast cancer or genetic predisposition</td>
<td>CBE</td>
<td>6-12 months</td>
<td>Begin 5-10 years prior to earliest index case but not under age 25</td>
</tr>
<tr>
<td></td>
<td>Mammogram</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>3. Personal history of atypical hyperplasia or LCIS</td>
<td>CBE</td>
<td>6-12 months</td>
<td>Begin at the age of diagnosis but not under age 25</td>
</tr>
<tr>
<td></td>
<td>Mammogram</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>4. Personal History of Breast Cancer</td>
<td>CBE</td>
<td>6-12 months</td>
<td>Perform or refer for risk assessment counseling and management</td>
</tr>
<tr>
<td></td>
<td>Mammography</td>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>
Table 3 - Recommendations for Follow-up of Abnormal Breast Cancer Screening Results

<table>
<thead>
<tr>
<th>Abnormal Result</th>
<th>Primary Care Management</th>
<th>Indication for Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Breast Exam:</strong> Nipple Discharge, <em>no palpable mass</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Bilateral Milky Discharge</td>
<td>Conduct Pregnancy Test</td>
<td>None</td>
</tr>
<tr>
<td>2. Nonspontaneous Multiduct discharge</td>
<td><strong>Under age 40</strong> Educate and observe</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Over age 40</strong> Refer for mammogram</td>
<td>to Breast Specialist/ Surgeon for additional evaluation after mammogram</td>
</tr>
<tr>
<td>3. Persistent, spontaneous, unilateral, single duct, serous sanguineous nipple discharge</td>
<td>Refer for diagnostic mammogram with guaiac or cytology (optional)</td>
<td>Refer to Breast Specialist/ Surgeon for additional evaluation after mammogram</td>
</tr>
<tr>
<td><strong>Clinical Breast Exam:</strong> Lump/Mass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 30</td>
<td>Refer for ultrasound (preferred), needle biopsy, or if low risk, observe for 1-2 menstrual cycles to see if the mass resolves</td>
<td>If lump/mass persists, refer to Breast Specialist/ Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td>Over age 30</td>
<td>Refer for mammogram and/or ultrasound</td>
<td>Refer to Breast Specialist/ Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td><strong>Clinical Breast Exam:</strong> Thickening/nodularity/ asymmetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 30</td>
<td>Refer for ultrasound and mammogram if indicated</td>
<td>Refer to Breast Specialist/ Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td>Over age 30</td>
<td>Refer for bilateral diagnostic mammogram with or without ultrasound</td>
<td>Refer to Breast Specialist/ Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td><strong>Clinical Breast Exam:</strong> Skin changes - Peau d’orange, Erythema, Nipple excoriation, Scaling, Eczema</td>
<td>Refer for bilateral diagnostic mammogram with or without ultrasound</td>
<td>Refer to Breast Specialist/ Surgeon for additional evaluation after imaging</td>
</tr>
<tr>
<td>Mammogram: BiRads Category 0 – Assessment is Incomplete</td>
<td>Refer for additional evaluation (spot compression, magnification, special mammographic views, ultrasound, aspiration, etc.) based on radiologists recommendations</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after imaging if indicated</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Mammogram: BiRads Category 3 – Probably Benign</strong></td>
<td>• Refer for Diagnostic Mammogram at 6 months, then every 6-12 months for 2-4 years&lt;br&gt;• May include biopsy if patient noncompliant or highly anxious</td>
<td>Refer to Breast Specialist/Surgeon for additional evaluation after imaging if indicated</td>
</tr>
<tr>
<td><strong>Mammogram: BiRads Category 4 – Suspicious Abnormality</strong>&lt;br&gt;BiRads Category 5 – Highly Suggestive of Malignancy</td>
<td>Refer to breast specialist/surgeon for:&lt;br&gt;• FNA or&lt;br&gt;• Core biopsy with post-specimen radiography if microcalcifications or&lt;br&gt;• Needle localization excisional biopsy</td>
<td></td>
</tr>
</tbody>
</table>

In 1996, the Michigan Department of Public Health (now the Michigan Department of Community Health) released a 98-page document entitled Cervical Cancer Screening & Detection in Michigan: Recommendations to Reduce Mortality.

The guidelines were the result of several years of research and the collective expertise of professionals from the fields of public health, medicine, nursing, and epidemiology. They were written by members of the Cervical Cancer Advisory Committee, a subcommittee of the Department’s Michigan Cancer Consortium (MCC), to guide the practice of health care providers in conducting cervical cancer screening examinations and follow-up of abnormalities.

In December 2000, in recognition of the changed state of science, the MCC (now an independent body comprised of organizational members) reconvened Michigan clinical experts from a variety of disciplines, installing them as members of a new MCC Cervical Cancer Advisory Committee and charging them with revising the 1996 recommendations, based upon the current knowledge and best practice.

In March 2001, the MCC Board of Directors reviewed and approved these updated consensus guidelines, publishing them as MCC Recommendations for the Early Diagnosis of Cervical Cancer and disseminating a summary of them in a laminated, tri-fold document to primary care providers throughout Michigan.

In 2002, the MCC again assembled its Cervical Cancer Advisory Committee, this time to address recently released changes in the Bethesda System (a national, uniform framework of pathology classification for reporting the results of Pap tests) and the American Cancer Society guidelines for the initiation of Pap smear screening and the management of abnormal Pap smears.

Committee members met in late 2002 and again in early 2003 to review and revise the MCC recommendations to ensure that they were consistent with the changes at the national level and adhered to the best current clinical evidence and expert opinions. The group submitted its completed revisions to the MCC Board of Directors, which approved them in April 2003. The guidelines have been pilot-tested in several locations and are being disseminated to providers and health care systems throughout the state.

Notes about the 2003 MCC Guidelines:
In their revision of the MCC guidelines, members of the MCC Cervical Cancer Advisory Committee strove to meet two goals: 1) to maximize the delivery of cervical cancer screening techniques and 2) to minimize over-treatment of low-grade disease that often resolves spontaneously, while at the same time identifying and treating significant cervical disease.
The 2003 MCC Recommendations for the Early Diagnosis of Cervical Cancer speak to several points of concern expressed by Cervical Cancer Advisory Committee members during the guideline revision process.

The first concern was to ensure the appropriate follow-up of abnormal Pap smears by seeking to minimize, as much as possible, both the over-management and the over-treatment of less serious cervical abnormalities, especially among young women who wish to retain fertility.

A second concern was to ensure, as much as possible, that women who were, for whatever reason, not able to easily access either cervical cancer screening and/or follow-up diagnostic services would not, as a result, be placed at undue risk of developing invasive cervical cancer.

A third concern involved the possibility of promoting liquid-based cytology as the standard of care. Although this technology can potentially be used to screen women less frequently, it is more costly than a conventional Pap test. As such, it currently is much more likely to be available to providers in larger health systems than to providers working in public health and family planning agencies.

Lastly, the Advisory Committee members were concerned about the fact that the test for Human Papillomavirus is becoming more widely available and, therefore, that the appropriate use of this test should lead to more targeted follow-up.

As part of the Advisory Committee’s discussions, a cytopathologist member shared this statement from the College of American Pathologists’ Policy on Frequency of Cervical Cancer Screening, 2003:

“The College of American Pathologists encourages annual pelvic exams and regular cervical cancer screening for all women. Regular cervical cancer screening should begin three years after women become sexually active or by the age of 21. Current data indicate that most women under the age of 30 will benefit from annual cervical cancer screening. Lengthened intervals of cervical cancer screening may be appropriate for some women depending upon specific clinical circumstances.”

“Regardless of age, the appropriate screening interval should be determined by each patient in consultation with her physician taking into account detailed patient history and risk factors. A woman’s Human Papillomavirus status may be a contributing factor in determining cervical cancer screening frequency. When accuracy or completeness of the historical record is in doubt, annual screening should be the default screening interval.”

In light of the Committee’s desire to reconcile these issues, the 2003 MCC Recommendations for the Early Diagnosis of Cervical Cancer promote annual screening for cervical cancer. The recommendations also encourage providers to develop office-based systems that will notify women of abnormal Pap tests, encourage them to schedule follow-up diagnostic testing, and remind them to schedule a Pap test on a regular basis.
The Michigan Cancer Consortium would like to thank all those involved for their significant contributions of time and effort to ensure that Michigan’s guidelines continue to reflect the best of scientific evidence and expert opinions regarding the early detection of cervical cancer.

April 17, 2003
Bibliography


Section A

Michigan Cancer Consortium
Cervical Cancer Early Detection Guidelines for Primary Care Providers
Spring 2003

Screening Tests
A Pap test and speculum exam should be used for routine cervical cancer screening.

Age to Initiate Screening
Screening for cervical cancer should begin at age 21 or three years after the onset of sexual activity, whichever occurs first.

Screening Frequency
- Women should be encouraged to have annual gynecologic exams and not be discouraged from seeking Pap tests or annual screening unless they have none of the following risk factors:
  - History of sexual intercourse
  - No previous routine Pap smear (never been screened or have not been screened in 5+ years)
  - Women who are infected with high-risk HPV
  - Women with a history of cervical or vaginal dysplasia or cervical, endometrial, vaginal, or vulvar cancer
  - Women who were exposed to DES in utero
  - Women who currently have, or have had, more than one sexual partner
  - Women whose sexual partners have had more than one partner.
  - Women whose sexual partners have had other sexual partners with cervical cancer or with high-risk HPV
  - Women and women whose sexual partners have a history of substance abuse or HIV/AIDS
  - Women who began sexual intercourse at ≤ 15 years of age
  - Women with a history of sexually transmitted diseases, other than HPV
  - Women who are immunosuppressed
  - Smokers and abusers of other substances, including alcohol
- Women without risk factors: After 3 consecutive annual negative Pap tests, the screening interval may be increased to every 2 years.
- Women without a cervix, and without a prior history of gynecologic malignancy, are at low risk of cervical cancer.
**Upper Age Limit for Screening**
There is no upper age limit at which cervical cancer screening should be discontinued. A woman should be screened as long as she is at risk for HPV exposure/infection. Therefore, age should not be the sole factor in determining when screening is no longer appropriate. Provider discretion should be used with consideration of: 1) whether the woman is sexually active and therefore at risk for HPV exposure; 2) existence of other co-morbid conditions which are likely to decrease life expectancy; and 3) if she is HIV+. Women over age 70 may consider not being screened if they have had three (3) documented negative Pap tests and no abnormal Pap tests in the last 10 years.

**Reminder and Tracking Systems**
Clinicians should be encouraged to develop a system which will notify women of abnormal Pap tests, ask them to schedule follow-up diagnostic testing, and remind them to schedule a Pap test.

**Patient Education**
Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV.
**Section B**

**SPECULUM EXAM**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal gross appearance</td>
<td>Immediate referral for colposcopy with biopsy, as indicated</td>
</tr>
<tr>
<td></td>
<td>(Do not rely on cervical cytology results alone)</td>
</tr>
<tr>
<td>Perform Pap test</td>
<td></td>
</tr>
</tbody>
</table>

**Indications for Referral to Qualified Healthcare Provider**

- Women who are pregnant and have an abnormal Pap test and/or abnormal cervix, including a planned referral for postpartum management
- Women with recurrent or persistent dysplasia who have a desire for fertility
- Pap test results of AGC or AIS
- Women who are immunocompromised with abnormal Pap test ≥ ASC-US
- HSIL Pap test not confirmed by biopsy or ECC
- ASC-H with negative work-up
- Women whose Pap smear specimen is “unsatisfactory for evaluation due to Atrophy with Inflammation” and in whom the use of estrogen is contraindicated (Page B-5)
- Pap test result of “LSIL for low-risk, postmenopausal women with a history of negative Pap tests” and in whom the use of estrogen is contraindicated (Page B-6)
- **It is recommended that women with any gynecologic cancer should be referred to a GYN oncologist**

**HPV Management**

| Perform HPV (high-risk) testing 1 year after colposcopy | If results of high risk HPV test +, repeat colposcopy |

**Pap Testing on Women Who Have Had Complete Hysterectomies**

- Perform yearly speculum and bimanual exam
- There is no indication for Pap testing in most instances
- History of CIN/CIS where this was the reason for hysterectomy, DES exposure in utero, or immunocompromised status: Continue vaginal sampling
- Woman with a history of abnormal cervical biopsies (CIN2/CIN3): Pap test of vagina until 3 negative tests are achieved within 10 years, then Pap testing may be discontinued
- Women with a cervix (supra-cervical hysterectomy) should continue Pap tests based on screening guidelines
Glossary
HPV: Human Papillomavirus
ASC-US: Atypical Squamous Cells — Uncertain Significance
ASC-H: Atypical Squamous Cells — Cannot Exclude High-grade Lesion
LSIL: Low-grade Squamous Intraepithelial Lesion (mild dysplasia)
HSIL: High-grade Squamous Intraepithelial Lesion (moderate/severe dysplasia)
AGC: Atypical Glandular Cells
AIS: Adenocarcinoma in Situ
ECC: Endocervical curettage
CIN: Cervical Intraepithelial Neoplasia
HIV: Human Immunodeficiency Virus
Management Overview of Pap Test Results

Pap Test

Specimen Adequacy

Specimen Adequate for Evaluation

Satisfactory

Unsatisfactory for Evaluation

Specimen Processed, but Unsatisfactory for Evaluation due to:

Yes

No

Atrophy / Inflammation

Yes

No

Page 4

Evaluation of Results

Negative

Yes

No

LSIL

Yes

No

HSIL

Yes

No

ASC-H

Yes

No

ASC-US

Yes

No

AGC/AIS

Yes

No

Page 3

Page 3

Page 5

Follow-up of Pap Test

Return to Routine Screening

Colposcopy with ECC (unless pregnant) and biopsy, as indicated

Colposcopy with ECC (unless pregnant) and biopsy, as indicated

Refer to qualified health care provider for treatment as indicated

Manage as appropriate until a satisfactory reading obtained
PAP TEST RESULTS
ASC-US (Atypical Squamous Cells-Uncertain Significance)
or LSIL (Special Circumstance: Adolescents)

Three acceptable management strategies

ASC-US
(LSIL: Adolescents)
(ASC-US: Post-menopausal)

Colposcopy with ECC (unless pregnant) and biopsy, as indicated

Or

Repeat Pap Test in 4-6 months

Or

Perform High-Risk HPV Test
(See Page 6)

If post-menopausal, consider Intravaginal Estrogen Therapy
(See Page 6)

For LSIL Adolescents, Perform High-Risk HPV Test at 12 months

Results of Pap Test

> ASC-US

Colposcopy with ECC (unless pregnant) and biopsy, as indicated

CIN/ Cancer

Yes

Refer to qualified health care provider for treatment as indicated

No

Pap test 6 and 12 months after colposcopy
(Return to Results of Pap Test above) OR
HPV test 12 months after colp
(See Page 6)

Negative

Repeat Pap Test in 4-6 months

> ASC-US

Results

Negative

Repeat Pap Test at 12 months
PAP TEST RESULTS
UNSATISFACTORY for Evaluation, due to INFLAMMATION*
(Causes: infection, atrophy/estrogen deficiency)

Unsatisfactory for Evaluation

Type of Inflammation

Atrophy with Inflammation

Inflammation

Physical Exam Shows

Clinically Evident Inflammation or Infection Present
- Perform wet mount
- Obtain appropriate cultures
- Diagnose and treat infection

No overt infection present

Repeat Pap Test within 3 months

Specimen Adequate for Evaluation

Yes

Satisfactory Smear, Non-Obscuring Inflammation Pap Test Negative

Satisfactory Smear, Infectious Agent Identified Pap Test Negative

Treat as appropriate

No

Repeat Pap Test 1 week after treatment completed

Intravaginal Estrogen Therapy (See Page 6)

Results

Negative

≥ ASC-US

Return to Routine Screening

Colposcopy with ECC (unless pregnant) and biopsy, as indicated

CIN/Cancer

Yes

Return to Routine Screening

No

Refer to qualified health care provider for treatment as indicated

*Inflammation is not indicative of a potential cancer per se, but inflammation may obscure the result
PAP TEST RESULTS
LSIL
(Special Circumstance: low-risk, postmenopausal women, with a history of negative Pap Tests)

LSIL (low-risk, postmenopausal woman, with a history of negative Pap Tests)

Intravaginal Estrogen Therapy (See Page 8)

Repeat Pap Test 1 week after treatment completed

Repeat Pap Test in 4-6 months

Perform High-Risk HPV Test 12 months after Pap (See Page 8)

Results

Negative

Repeat Pap Test 4-6 months

≥ ASC-US

≥ ASC-US

Colposcopy with ECC and biopsy, as indicated

CIN/ Cancer

Yes

Refer to qualified health care provider for treatment as indicated

No

Return to Routine Screening

Negative

≥ ASC-US

Colposcopy with ECC and biopsy, as indicated

CIN/ Cancer

Yes

Refer to qualified health care provider for treatment as indicated

No

Return to Routine Screening
Intravaginal Estrogen Therapy, for postmenopausal women

- Intravaginal Estrogen Therapy
  - Estrogen Contraindicated?
    - Yes: Consult/refer to qualified health care provider for evaluation and treatment.
    - No: Treat with topical estrogen intravaginally for 4-6 weeks.
      - Repeat Pap Test 1 week after treatment completed.

High Risk HPV Testing

- Perform High-Risk HPV Test
  - Results
    - Positive for High-Risk HPV: Coioposcopy with ECC and biopsy, as indicated
      - CIN/Cancer: Refer to qualified health care provider for treatment as indicated
      - No: Repeat Pap Test at 12 months
    - Negative for High-Risk HPV
POSITION PAPER FOR HEALTH CARE PROVIDERS

DIGITAL MAMMOGRAPHY:
COMPARISON WITH SCREEN-FILM MAMMOGRAPHY

Mammography remains the best method of early breast cancer detection. Studies have shown that screening mammography reduces the rate of death from breast cancer among women who are 40 years of age or older. Among women age 50-69, the reduction in the mortality rate was between 16-35 percent; women age 40-49 had a reduction of 15-20 percent. However, traditional screen-film mammography is limited in its ability to detect some cancers, especially those occurring in women with radiographically "dense" breasts. For this reason, extensive research efforts to improve mammography have occurred.

Digital mammography was developed in part to address some of the limitations of screen film mammography for cancer detection. The results of the Digital Mammographic Imaging Screening Trial (DMIST), conducted from 2001-2005, by the American College of Radiology Imaging Network, adds important information that health care providers can use to assess the value of full field digital mammography (FFDM) as compared to screen film mammography (SFM).

Currently, only 8 percent of all US mammography machines are digital. As of this report, there are 23 facilities in Michigan with digital mammography equipment, mostly located in southeast Michigan. Although current access to this type of technology is limited, during the next few years, the number of facilities purchasing FFDM systems is expected to increase.

Has the DMIST study shown that FFDM is superior to SFM in terms of detecting breast cancer?

The Food and Drug Administration (FDA) regulates performance standards for all mammography equipment. The FDA approval process for digital mammography equipment requires manufacturers to show that their equipment performs at least at the level of screen film mammography. There is no requirement that the digital systems be superior. Several manufacturers have now met the FDA requirements and offer full field digital systems, which should perform at least as well as screen film mammography.

Although there have been scientific reasons to expect superior performance of digital systems, the DMIST study, which evaluated 42,760 asymptomatic women undergoing screening mammograms with both screen film and digital systems, suggest advantages of digital over film mammography.
mammography in some subgroups of women. However, the data for the entire population show no advantage of one technique over the other.

In subgroup analyses, screening with digital mammography had a significant advantage among women who were younger than 50 years of age, were pre-menopausal or peri-menopausal, and/or had radiographically dense breast tissue on film mammography.

However, a review of the data from DMIST, suggests that, in women 50 years of age or older, postmenopausal women, and women with less dense breasts, film mammography found more cancers than digital mammography, although the difference was not significant. This result is in concordance with those of other published studies (Lewin, Oslo I, and Oslo II). The higher specificity of digital mammography reported in DMIST is also supported by other data (Skaane P, Balleyguier C, and Diekmann F). Further analysis will determine if this benefit persists beyond the first digital mammogram since the screenings in this trial were a combination of first screenings and subsequent screenings.

Five types of digital mammography systems were used in DMIST. The study does not report whether certain brands of digital systems were superior to others. Overall, there was no significant difference. Therefore, mammographic facilities cannot determine from DMIST whether the advantages of digital imaging identified in some subgroups apply to equipment from all manufacturers.

The advantage offered by digital mammography appears to be limited to a minority of the women who undergo screening. Since routine screening is recommended for women 40 years of age or older, most women who undergo screening are postmenopausal and at least 50 years old, excluding them from at least two of the three subgroups that benefited from digital mammography in DMIST. Future data may determine if significant benefit is found for recommending FFDM in other subgroups of women as suggested from previous studies for film mammography.

**What are the advantages of FFDM compared to SFM?**

FFDM offers potential and practical advantages over SFM. These include:

- Improved contrast and signal to noise ratios – may allow better cancer detection
- Real time interpretation of mammograms at distant sites with the use of teleradiology and computer-aided detection equipment
- Ability to place images in a window, level them, and electronically magnify them
- Elimination of film processing, storage, copying, and retrieval
• In women who were younger than 50 years of age, women who were premenopausal or perimenopausal, and those with radiographically dense breast tissue on film mammography, the accuracy of digital mammography was significantly higher than that of screen-film mammography.

• Lower radiation dose. The DMIST data showed a 24% overall reduction in dose compared to film.

What are the potential disadvantages of FFDM?

• Spatial resolution, the ability to visualize fine detail, is somewhat better on SFM

• Difficult to compare digital images with older film studies

• The costs of FFDM systems are often one and one half to four times as expensive as film mammography systems. Additional on-going costs of maintenance and image storage compound the price differential.

• Reimbursement rate for digital mammography by payers varies. The Center for Medicaid and Medicare Services reimbursement rate is not the same for other third party payers. The potential cost of digital mammography to the patient can vary significantly but is higher than that of SFM.

• Manipulation of FFDM images (window and level settings and magnification) could require more expertise and time from the radiologist for optimal interpretation

• There was no demonstrated benefit in using digital mammography over screen film mammography in women 50 years of age or older.

Conclusion

The most important message providers can give their patients is that good quality screening mammography saves lives, by diagnosing cancer early. The availability of high-quality images and skilled interpretation and the screening of all women who are eligible for it will yield optimal benefits regardless of the type of mammogram performed. Although digital mammography can detect cancers that might be missed by film mammography, the opposite will be true for some women. All women of the appropriate age should be regularly screened. When both types of equipment are available, the decision to use digital or film equipment should be tailored to the individual woman. If only one type of equipment is available, women should recognize that most of the benefit of mammographic screening is derived from the test itself and not from the way the image is stored.
REFERENCES


Information for Consumers

Frequently Asked Questions about

Digital Mammography

What is digital mammography? Is it different from screen film mammography?

Conventional screen film mammography uses low energy x-rays that pass through a compressed breast during a mammographic examination. The exiting x-rays are absorbed by x-ray film, which is then developed into a mammographic image that can be held and looked at by the radiologist. This traditional process is similar to personal photographic cameras and photographic film where light is focused on the film and developed to produce a negative, which can be printed as a picture.

With digital mammography, low energy x-rays pass through the breast exactly like conventional mammograms but are recorded by means of an electronic digital detector instead of the film. This electronic image can be displayed on a video monitor like a TV or printed onto film. Again, this is similar to digital cameras that produce a digital picture that can be displayed on a computer screen or printed on paper. The radiologist can manipulate the digital mammogram electronically to magnify an area, change contrast, or change the brightness.

Is the mammogram procedure any different?

No. Women will not notice any difference. In digital mammography, the breast tissue is still compressed the same way as screen film mammography. The technologist can review the image and check to determine whether the image or picture is good on the computer screen. There may be a shorter wait time after the image is taken because there is no film to develop.

Is digital mammography “better” than screen film mammography?

It is often assumed that a “newer” product is an improved or better product. That is not always the case. Screen film mammography has been used for years as part of breast cancer
Several studies have been done on digital mammography and screen film mammography. One major study, the Digital Mammographic Imaging Screening Trial, has shown that there may be benefit in using digital mammography instead of screen film mammography for some women under age 50 and for women who have dense breasts but no other abnormal breast symptoms such as a lump or discharge. More studies are needed to further evaluate the two types of mammograms.

The important message here is that mammograms have been shown to save lives by detecting breast cancer early when it is the most treatable. Women over age forty who participate in regular breast cancer screening gain the most benefit.

**Is there a difference in cost between digital mammograms compared to screen film mammograms?**

Digital mammograms are more expensive than screen film mammograms. Because of this, it is important for women to check with their health insurer to see if they will pay for the digital mammogram. However, in women over 50 years of age, the results of the Digital Mammographic Imaging Screening Trial demonstrated no benefit in using digital mammography over screen film mammography.

**Important Points for Women to Consider**

- Studies have shown that mammography saves lives. **It is important for women to be screened no matter what type of mammogram they receive.**
- All women age 40 and older should receive a mammogram as part of their annual breast cancer screening along with a clinical breast exam.
- **Women should not delay getting a screen film mammogram for a digital mammogram**
- **Women should NOT have a digital mammogram if they have just recently had a screen film mammogram.**

An important point to keep in mind is that breast density may change over time. A radiologist evaluates the density of a woman’s breast during the interpretation of the mammogram. A description of breast density is usually included in the mammogram report sent to your provider.
|---------------|---------------------------------------------------------------|---------------------------------------------------------------|
| 77057-TC-26   | Screening mammography, bilateral (two view film study of each breast) Technical/Facility Component Professional Component | Screening mammogram  
- Two views of each breast  
- Performed on an asymptomatic woman |
| 77055-TC-26   | Mammography; unilateral Technical/Facility Component Professional Component | Diagnostic mammogram  
- Two or more views of one breast  
- Performed on a symptomatic woman |
| 77056-TC-26   | Mammography; bilateral Technical/Facility Component Professional Component | Diagnostic mammogram  
- Two or more views of each breast  
- Performed on a symptomatic woman |
| G0202-TC-26   | Screening mammography producing direct digital image, bilateral, all views Technical/Facility Component Professional Component | Digital screening mammogram  
- Two views of each breast  
- Performed on an asymptomatic woman |
| G0206-TC-26   | Diagnostic mammography, producing direct digital image, unilateral, all views Technical/Facility Component Professional Component | Digital diagnostic mammogram  
- Two or more views of one breast  
- Performed on a symptomatic woman |
| G0204-TC-26   | Diagnostic mammography, producing direct digital image, bilateral, all views Technical/Facility Component Professional Component | Digital diagnostic mammogram  
- Two or more views of each breast  
- Performed on a symptomatic woman |
| 88164         | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision | Conventional Pap test  
- Laboratory technical services  
- Professional component indicated by 88141 when physician interpretation required |
| 88165         | Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision | Conventional Pap test – Rescreening  
- Laboratory technical services  
- Professional component indicated by 88141 when physician interpretation required |
| 88141         | Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service) | Pap test  
- Laboratory professional services  
- Use in conjunction with codes 88142, 88143, 88164, 88165 when physician interpretation of Pap test is required |
## FY08 BCCCP Procedure Code Reference Chart

|------------------|------------------------------------------------------------|---------------------------------------------------------------|
| 88142            | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision | Thin Prep Pap test  
  • Laboratory technical services  
  • Manual screening  
  • Professional component indicated by 88141 when physician interpretation required |
| 88143            | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision | Thin Prep Pap test - Rescreening  
  • Laboratory technical services  
  • Manual screening  
  • Professional component indicted by 88141 when physician interpretation required |
| 88174            | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision | Thin Prep Pap test  
  • Laboratory technical services  
  • Automated screening |
| 88175            | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision | Thin Prep Pap test - Rescreening  
  • Laboratory technical services  
  • Automated screening with manual rescreening |
| 99203            | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
  • a detailed history;  
  • a detailed examination; and  
  • medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | Full annual clinical exam  
  • CBE AND pelvic/Pap  
  • Symptomatic or diagnosed new patient |
|------------------|---------------------------------------------------------------|-------------------------------------------------------------|
| 99204            | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
• a comprehensive history;  
• a comprehensive examination; and  
• medical decision making of moderate complexity.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family. | Full annual clinical exam  
• CBE AND pelvic/Pap  
• *Symptomatic or diagnosed* new patient |
| 99386            | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures, new patient; 40-64 years | Full annual clinical exam  
• CBE AND pelvic/Pap  
• *Asymptomatic* new patient between the ages of 40 and 64 |
| 99387            | Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures, new patient; 65 years and over | Full annual clinical exam  
• CBE AND pelvic/Pap  
• *Asymptomatic* new patient age 65 and older |
| 99201            | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
• a problem focused history;  
• a problem focused examination; and  
• straight forward medical decision making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | Partial annual clinical exam  
• Either CBE only OR pelvic/Pap only  
• *Symptomatic or diagnosed* new patient |
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<tr>
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<tbody>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family. Partial annual clinical exam • Either CBE only OR pelvic/Pap only • Symptomatic or diagnosed new patient OR colposcopy office visit</td>
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<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused history; • an expanded problem focused examination; • medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. Full annual clinical exam • CBE AND pelvic/Pap • Symptomatic or diagnosed established patient</td>
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<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • a detailed history; • a detailed examination; • medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. Full annual clinical exam • CBE AND pelvic/Pap • Symptomatic or diagnosed established patient</td>
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</tbody>
</table>
| 99396            | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years | Full annual clinical exam  
• CBE AND pelvic/Pap  
• *Asymptomatic* established patient between the ages of 40 and 64 |
| 99397            | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 65 years and over | Full annual clinical exam  
• CBE AND pelvic/Pap  
• *Asymptomatic* established patient age 65 and older |
| 99211            | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | Partial annual clinical exam  
• Either CBE only OR pelvic/Pap only (including repeat Paps) |
| 99212            | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:  
• a problem focused history;  
• a problem focused examination;  
• straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. | Partial annual clinical exam  
• Either CBE only OR pelvic/pap only (includes repeat Paps) |
|------------------|-------------------------------------------------------------|---------------------------------------------------------------|
| 99241            | Office consultation for a new or established patient, which requires these three key components:  
• a problem focused history;  
• a problem focused examination; and  
• straight forward medical decision making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family. | Breast or cervical consultation  
• Referral for follow-up problem(s) identified during screening  
• New or established patient |
| 99242            | Office consultation for a new or established patient, which requires these three key components:  
• an expanded problem focused history;  
• an expanded problem focused examination; and  
• straight forward medical decision making.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. | Breast or cervical consultation  
• Referral for follow-up of problem(s) identified during screening  
• New or established patient |
| 99243            | Office consultation for a new or established patient, which requires these three key components:  
• a detailed history;  
• a detailed examination; and  
• medical decision making of low complexity.  
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. | Breast or cervical consultation  
• Referral for follow-up of problem(s) identified during screening  
• New or established patient |
|------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| 99244            | Office consultation for a new or established patient, which requires these three key component:  
|                  | • a comprehensive history;  
|                  | • a comprehensive examination; and  
|                  | • medical decision making of moderate complexity.  
|                  | Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.  
|                  | Usually, the presenting problem(s) are of moderate to high severity.  
|                  | Physicians typically spend 60 minutes face-to-face with the patient and/or family. | Breast or cervical consultation  
|                  | • Referral for follow-up of problem(s) identified during screening  
|                  | • New or established patient |
| 57452            | Colposcopy of the cervix including upper/adjacent vagina; Service includes surgical procedure only | Colposcopy  
|                  | • Surgical procedure only  
|                  | • Office visit billed separately |
| 57454            | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage; Service includes surgical procedure only | Colposcopy with biopsy of the cervix and endocervical curettage  
|                  | • Surgical procedure only  
|                  | • Office visit billed separately |
| 57455            | Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix | Colposcopy with biopsy of the cervix  
|                  | • Office visit billed separately |
| 57456            | Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage | Colposcopy with endocervical curettage  
|                  | • Office visit billed separately |
| 87621            | Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique | HPV typing of high-risk strain |
| 88305            | Level IV – Surgical pathology, gross and microscopic examination; Breast, biopsy, not requiring microscopic evaluation of surgical margins; Cervix, biopsy  
| -TC -26          | Technical/Facility Component  
|                  | Professional Component | Breast or cervical biopsy, laboratory evaluation of tissue sample  
|                  | • Level IV |
|------------------|-------------------------------------------------------------|---------------------------------------------------------------|
| 88307-TC-26      | Level V – Surgical pathology; gross and microscopic examination; Breast, excision of lesion, requiring microscopic evaluation of surgical margins; Cervix, conization Technical/Facility Component Professional Component | Breast or cervical biopsy, laboratory evaluation of tissue sample  
• Level V |
| 10021            | Fine needle aspiration; without imaging guidance            | Fine needle aspiration of superficial breast tissue  
• Not using imaging guidance |
| 10022            | Fine needle aspiration; with imaging guidance               | Fine needle aspiration of superficial breast tissue  
• Using imaging guidance |
| 19000            | Puncture aspiration of cyst of breast; Service includes surgical procedure only | Puncture aspiration, breast cyst  
• Surgical procedure only |
| 19001            | Puncture aspiration of cyst of breast; each additional cyst (List separately in addition to code for primary procedure); (Use 19001 in conjunction with code 19000) | Puncture aspiration, breast cyst  
• Each additional cyst |
| 19100            | Biopsy of breast; percutaneous, needle core, not using imaging guidance separate procedure); Service includes surgical procedure only | Breast biopsy, needle core  
• Not using imaging guidance  
• Surgical procedure only |
| 19101            | Biopsy of breast; open, incisional                          | Breast biopsy, incisional |
| 19102            | Biopsy of breast; percutaneous, needle core, using imaging guidance | Breast biopsy, excisional  
• Needle core  
• Using imaging guidance |
| 19103            | Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance | Breast biopsy, excisional  
• Automated vacuum assisted or rotating biopsy device  
• Using imaging guidance |
<table>
<thead>
<tr>
<th>19120</th>
<th>Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions</th>
<th>Breast biopsy, excisional</th>
</tr>
</thead>
<tbody>
<tr>
<td>00400</td>
<td>Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified</td>
<td>Anesthesia CPT code used when billing for Breast biopsy, excisional (19120)</td>
</tr>
<tr>
<td>-AA</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
</tr>
<tr>
<td>-AD</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
</tr>
<tr>
<td>-QK</td>
<td>Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
<td>Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>-QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>CRNA service: with medical direction by a physician</td>
</tr>
<tr>
<td>-QY</td>
<td>Anesthesiologist medically directs one CRNA</td>
<td>Anesthesiologist medically directs one CRNA</td>
</tr>
<tr>
<td>-QZ</td>
<td>CRNA service: (supervised) without medical direction by a physician</td>
<td>CRNA service: (supervised) without medical direction by a physician</td>
</tr>
<tr>
<td>19125</td>
<td>Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion</td>
<td>Breast biopsy, excision of single lesion identified by radiological marker</td>
</tr>
<tr>
<td>19126</td>
<td>Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure); (Use in conjunction with code 19125)</td>
<td>Breast biopsy, excision of lesion identified by radiological marker</td>
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<td>-</td>
<td>• Each additional lesion</td>
<td></td>
</tr>
<tr>
<td>19290</td>
<td>Preoperative placement of needle localization wire, breast</td>
<td>Preoperative placement of needle localization wire</td>
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</tbody>
</table>
| 19291            | Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure); (Use 19291 in conjunction with code 19290) | Preoperative placement of needle localization wire  
• Each additional lesion |
| 19295            | Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure); (Use in conjunction with codes 19102, 19103) | Image guided placement of metallic localization clip during breast biopsy |
| 57500            | Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure); Service includes surgical procedure only | Cervical biopsy  
• Surgical procedure only |
| 57505            | Endocervical curettage (not done as part of a dilation and curettage) | ECC – Endocervical curettage  
• Not part of D & C |
| 77031 - TC -26   | Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation  
Technical/Facility Component  
Professional Component | Stereotactic localization guidance for breast biopsy or needle placement  
• Radiological supervision/interpretation |
| 76032 - TC -26   | Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation  
Technical/Facility Component  
Professional Component | Mammographic guidance for needle placement, breast  
• Each lesion  
• Radiological supervision/interpretation |
| 76098 - TC -26   | Radiological examination, surgical specimen  
Technical/Facility Component  
Professional Component | Radiological examination, surgical specimen |
| 77021 - TC -26   | Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation  
Technical/Facility Component  
Professional Component | Magnetic resonance guidance for needle placement  
• Radiological supervision/interpretation |
|------------------|---------------------------------------------------------------|---------------------------------------------------------------|
| 76645 TC-26      | Ultrasound, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation Technical Component Professional Component | Breast ultrasound  
• Radiological supervision/interpretation |
| 76942 TC-26      | Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation Technical/Facility Component Professional Component | Ultrasonic guidance of breast needle placement  
• Imaging supervision and interpretation |
| 88172 TC-26      | Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s) Technical/Facility Component Professional Component | Cytopathology, evaluation of fine needle aspirate to determine specimen adequacy |
| 88173 TC-26      | Cytopathology, evaluation of fine needle aspirate; interpretation and report Technical/Facility Component Professional Component | Cytopathology, evaluation of fine needle aspirate  
• Interpretation and report |
| 88325            | Consultation, comprehensive, with review of records and specimens, with report on referred material | Surgical pathology, consultation and report |
| 88329            | Pathology consultation during surgery | Pathology consultation during surgery |
| 88331 TC-26      | Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen Technical/Facility Component Professional Component | Pathology consultation during surgery  
• First tissue block  
• With frozen section(s)  
• Single specimen |
| 88332 TC-26      | Pathology consultation during surgery; each additional tissue block with frozen sections Technical/Facility Component Professional Component | Pathology consultation during surgery  
• Each additional tissue  
• With frozen section(s) |
| 88112            | Cytopathology, Selective Cellular Enhancement Technique with Interpretation (e.g., Liquid Based Slide Preparation Method), except Cervical or Vaginal **Cannot bill in conjunction with 88173** | Cytopathology, Selective Cellular Enhancement Technique with Interpretation  
• Interpretation and reports |
| 99499            | Unlisted evaluation and management | Case Management |
CASE MANAGEMENT/CARE COORDINATION PLAN
May 4, 2000; Revised 8/2002

BACKGROUND AND RATIONALE

The Michigan Breast and Cervical Cancer Control Program (BCCCP) provides screening for breast and cervical cancer and, for women with abnormal screening results, includes referral for definitive diagnostic procedures and treatment. Because of the potential diagnosis of cancer, women with abnormal screening results can be confused and overwhelmed by the diagnostic procedures and related cost/reimbursement issues. In addition, the potential or actual diagnosis of breast or cervical cancer can be devastating to a woman not only because of the cancer diagnosis per se, but also because of the emotional impact of body image concerns associated with mastectomy and hysterectomy. The clientele of the BCCCP includes many women who have not received regular health care, have had bad experiences within the health care system, and may have numerous other stresses in their lives. Without personalized assistance and support, these factors often result in non-compliance with follow-up recommendations. A crucial component of the Michigan BCCCP is to ensure that women enrolled in the program receive timely and appropriate screening, diagnostic and treatment services.

Overview of Michigan BCCCP Case Management Program

The Michigan BCCCP medical protocol requires that each BCCCP Local Coordinating Agency ensures that enrolled women with breast or cervical abnormalities receive timely and appropriate clinical services, including treatment, regardless of their ability to pay for such services. Programs are evaluated using the CDC performance indicators as a measure of adherence to the protocol. The six functions of case management (assessment, planning, resource development, coordination, monitoring, and evaluation) are implemented to accomplish this task.

Case Management services are provided to eligible women in each of the 21 BCCCP agencies throughout Michigan. Some agencies deliver clinical services on site and employ a nurse who provides hands on care as well as case management services. Other agencies subcontract all screening and follow-up services with community providers. The agency is responsible for overseeing the coordination of case management services provided to eligible women in the subcontracted community clinics.

Definition of Case Management/Care Coordination

The Michigan BCCCP defines case management/care coordination as a process of organizing, planning and evaluating patient care. It involves the rational selection and use of resources through clinical decision-making and is a collaborative process in which an individual woman’s specific health needs, following detection of a breast or cervical abnormality are met through communication, resource application, and service mobilization. Decisions made about patient care, interventions, and care activities are outlined in a written plan. The written plan...
guides implementation and progress of these interventions. The care plan is evaluated; aggregated results are analyzed to determine if individual and program patient care outcomes were achieved.

GOAL OF MICHIGAN'S CASE MANAGEMENT/CARE COORDINATION PROGRAM

The Michigan BCCC Case Management Program ensures that women identified with a breast and/or cervical abnormality receive appropriate follow-up care, including diagnostic and treatment services. Case management/care coordination facilitates appropriate use of community resources, provides patients with the care they need when they need it, and coordinates a specified group of resources for a specified group of people to assure timely delivery of services.

Case Management/Care Coordination Objectives

The Michigan BCCCP has identified the following objectives for the case management program:

1. To assess the actual or potential barriers to care, which might prevent a woman from obtaining necessary diagnostic and treatment, services following detection of a breast or cervical abnormality.

2. To assist women to overcome barriers to receipt of care through education, counseling and/or acquisition of additional resources.

3. To facilitate efficient and cost-effective use of services/resources

4. To facilitate timely progress through the follow-up cycle.

5. To facilitate patient adherence to follow-up recommendations

6. To increase patient satisfaction/retention in BCCCP

7. To establish and cultivate collaborative relationships with community providers to enhance timely and appropriate use of services.

8. To clarify and strengthen BCCCP accountability within the local community, the state, and the national.

Case Management Interventions

The model used for developing the Michigan BCCC Case Management Program has been adapted from the Case Management Society of America’s “Practice Model.” The Michigan BCCC Program has categorized case management interventions into the following categories:
Assessment, Planning, Implementation, Coordination, Monitoring and Evaluation. Case Management/Care coordination is initiated whenever women are identified with abnormal screening test results and, therefore, need definitive diagnostic procedures and possible treatment. The role of the case manager in each of these categories is as follows:

1. **Assessment**
   - Gathers information (screening history, client risk factors, physical/psychosocial/ financial needs, and screening results) to determine client needs in order to establish a plan of care.

2. **Planning**
   - Develops a plan for immediate or short-term follow-up of abnormality based on client needs assessment and abnormality identified.
   - Discusses the plan with the client and obtains input from the client on feasibility of the plan.

3. **Implementation – Patient Education, Providing Support**
   - Implements the plan of care based on client needs and follow-up services required.
   - Provides information, knowledge and skills about health or screening/diagnostic services or coordinates with subcontracted agencies to assure that the client receives this information.
   - Implements psychosocial interventions with client or family members (such as counseling, active listening and empathy) to assist in problem solving.

4. **Coordination**
   - Coordinates/initiates the brokering and referral of services to meet the needs of the client.
   - Communicates with subcontracted providers regarding provision of follow-up services.
   - Provides assistance to ensure that the client receives the follow-up services identified in the client's plan.

5. **Monitoring**
   - Coordinates/initiates ongoing or periodic reassessment of the client’s needs.
   - Coordinates/provides reassessment of the quality of care and services provided to the clients to determine if new and continuing needs are being met.

6. **Evaluation**
   - Assesses client satisfaction with services received.
   - Assesses provider satisfaction with services delivered.
   - Assesses client access to follow-up services and timeliness of services rendered.
Case management occurs at the local agency level with consultation provided by state staff as necessary. The role of the local BCCCP care manager is to:

- Obtain information from clinicians regarding interpretation of results and follow-up action needed.
- Coordinate with providers communication of test results and needed follow-up care (diagnostic procedures) to the woman.
- Educate/counsel woman regarding the meaning and implications of test results and follow-up procedures.
- Assess the woman’s preferences for and perceptions of the process of additional diagnostic evaluation and potential treatment; mutually identify actual or potential barriers to care and problem-solve to remove barriers.
- Make appointments for follow-up procedures based upon personal and health care needs of the woman.
- Obtain results from providers regarding outcomes of diagnostic procedures, recommendations for further follow-up, final diagnosis, etc. and evaluate the woman’s understanding of the outcomes as well as her ability to follow the recommendations.
- Assure timely and accurate data entry regarding final diagnosis, etc.
- Facilitate resource acquisition and other activities to defray costs for women needing treatment (Medicaid eligibility, etc).
- Facilitate informed decision-making by the woman.
- Track and monitor progress through the follow-up cycle; problem-solve and facilitate action as needed.
- Educate/counsel women (or refer as appropriate) regarding psychosocial issues pertaining to potential or actual diagnoses of cancer.
- Monitor appropriateness and timeliness of documentation
- Evaluate quality and effectiveness of case management/care coordination strategies.

* For agencies that do not provide services on site, these interventions may be delegated to subcontracted providers who are responsible for providing case management for the client at their clinic.
TARGET POPULATION FOR CASE MANAGEMENT

A. All Michigan BCCCP enrolled women, age 40-64, with an abnormal* screening result or with the diagnosis of cancer will be assessed for their need of case management services and provided such services accordingly.

*For the purpose of receiving case management services, abnormal screening results are defined as follows:

- Clinical Breast Exam - Abnormality, rule out breast cancer. This includes any of the following clinical categories: discrete palpable mass, bloody or serous nipple discharge, nipple or areola scaliness and skin dimpling or retraction.

- Mammography abnormal results include ACR categories of : suspicious abnormality (ACR 4) and highly suggestive of malignancy, biopsy should be considered (ACR 5).

- Pap test abnormal results include: High-Grade Squamous intraepithelial lesion (HGSIL), Squamous cell carcinoma, Atypical glandular cell of undetermined significance (AGUS), and adenocarcinoma.

B. Case management services may be provided to women under the following circumstances, depending on staffing and fiscal resources:

- Lack of response to rescreening reminder with a previous history of abnormal screening results
- Results requiring close monitoring to assure short-term follow-up is completed at indicated time frames for results of ASCUS, LGSIL, probably benign CBE or mammogram finding.
- Request by the client or provider.

C. Case management services conclude when a client initiates treatment or is no longer eligible to receive BCCCP services. A plan of care for ongoing treatment and follow-up needs to be in place for the client prior to termination of case management services.

Clients who have received prior case management services in the BCCCP are re-assessed for possible initiation of case management services upon receipt of rescreening results. These clients are tracked according to established policies and procedures used as reminder systems for all women requiring re-screening at each BCCCP agency.
BCCCP State Override Procedure for LCAs and State Staff
3-20-02; Revised 8/2006

There are occasions when a provider will ask the BCCCP to pay for a procedure code that is not on the approved list of codes. The requests are addressed on case-by-case basis. The procedure for addressing an override request is as follows:

1. The LCA calls either E.J. Siegl (517-335-8814) or Cathy Blaze (517-324-7304) with the request. The request is discussed and either:
   a. The request is denied. The LCA will inform the provider of the denial. **OR**
   b. The request is approved. The LCA will inform the provider of the approval.
2. The State designated person(s) will add the procedure code to the list of approved CPT codes using the Maintain Clinical Procedure Screen.
3. The State designated person(s) will add the procedure code and the approved rate to the Maintain Exam Type Screen for the state override exam type code for either a breast or cervical procedure.
4. The State will export updated rate table to TPA with the daily export information.
5. The State designated person(s) will add the service to the client’s service summary screen and set the OK to Pay.
6. The State designated person(s) will place a description of the service in comment field at the bottom of the service.
7. The OK to Pay will be exported to the TPA with the daily export information.
8. The TPA will pay the claim.
BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)
MEDICAID TREATMENT ACT
ELIGIBILITY AND ENROLLMENT

Revised March 28, 2007

I BCCCP Client Eligibility for the Medicaid Treatment Act (MTA)

A. A woman is eligible to apply for Medicaid coverage for breast/cervical cancer treatment services through the BCCCP if she

1. Is a US citizen or provides proof of residency status as defined by the Michigan Department of Human Services (see attached checklist) AND

2. Meets a, b, and c below:

a. Currently enrolled in the BCCCP. To be enrolled in the BCCCP the woman must:
   • Have an income < 250% of the federal poverty level
   • Be uninsured or underinsured
   • Be age 40 - 64 for breast/cervical cancer screening and for diagnostic follow-up of breast/cervical abnormalities OR
   • Be age 18 – 39, have been identified with a cervical abnormality through the Title X Program, and referred to the BCCCP for cervical cancer diagnostic follow-up.

AND

b. Has received a breast and/or cervical cancer SCREENING AND/OR DIAGNOSTIC service from a BCCCP provider.

AND

c. Has been NEWLY diagnosed with breast or cervical cancer or a pre-cancerous cervical condition (CIN II) through the program.

EXCEPTION for Non-Citizens

• Women who are non-citizens are only eligible for Emergency Services coverage through Medicaid if they have been in the country less than 5 years.
• Women who fall into the above category, but have been in the country more than 5 years and have valid documentation (Alien Residence Card, I-94, Visa etc.) may be eligible for full Medicaid coverage.
• Medicaid Emergency Services coverage does not include cancer treatment.
B. BCCCP Medicaid Treatment Act – Coverage Begin Date
   1. For Medicaid coverage, the begin date is the first day of the month in which eligibility is determined, beginning with the month of application (e.g., if the client is diagnosed with cancer on 11/15/05, Medicaid coverage will begin 11/1/05).

   2. Depending on the individual client’s circumstance, Medicaid coverage may begin up to 3 months prior to the application date.

II BCCCP Client Enrollment in MTA

A. Procedure for Medicaid Enrollment in the Medicaid Breast and Cervical Cancer Treatment Program (BCCPTP)
   1. BCCCP Coordinator/Case Manager/Designated Program Staff confirms breast or cervical cancer or cervical pre-cancerous condition (CIN II) from client pathology report.

   **NOTE:** The BCCCP woman is eligible to apply for Medicaid coverage only AFTER the diagnosis of breast or cervical cancer or a pre-cancerous condition (CIN II) is diagnosed.

   2. Inform the client that the following information verifying citizenship and identity must be provided at the time she signs the Medicaid application.

   a. Citizenship Verification – *any of the following is acceptable*
      - US Passport
      - Certificate of Naturalization
      - Certificate of US citizenship
      - Birth certificate
      - Report or certification of birth abroad of a US citizen
      - US Citizen ID card
      - Adoption papers
      - Military record if it shows where you were born
      - Voter ID Card* - not listed on the Michigan Department of Human Services Verification Checklist but is acceptable in verifying citizenship

   b. Identity Verification- *any of the following is acceptable*
      - Drivers License/ID Card
      - School ID
      - Federal, state, or local government ID
      - U.S. military ID card
NOTE: A Verification Checklist from the Michigan Department of Human Services is attached to assist in identifying needed documentation. IT IS NOT MANDATORY FOR THIS LIST TO BE COMPLETED.

3. BCCCP client completes the one-page Michigan Department of Community Health Medicaid Breast and Cervical Cancer Prevention and Treatment Program application. (DCH-1088).
   • All clients need a date entered in the Treatment Start Date Box so the State of Michigan Medicaid Quality Analyst can determine when to begin Medicaid Coverage
   • In completing the BCCCP MTA Application for women diagnosed with CIN II or CIN III/CIS, a Treatment Start Date AND Treatment End Date must be entered in the Date Treatment Began box. The Medicaid Quality Analyst will automatically enter the end date in her system for this client. A letter will be sent to the client notifying her when coverage begins and ends.

4. Attach a copy of the documents verifying citizenship and identity. If the client does not have the supporting documentation at the time when they are signing the application then:
   • Inform the client that they have 15 calendar days to produce the missing citizenship or identity documentation.
   • Inform Michele Barton (in writing) that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.

NOTE: If unable to obtain documentation during that time period or if the client requires assistance in obtaining a copy of her birth certificate, notify E.J. Siegl at 517-335-8814.

5. BCCCP Medicaid BCCCP Coordinator/Case Manager/Designated Program Staff will coordinate processing of application through the State of Michigan Medicaid agency by performing the following duties:
   • Signing the one-page Michigan Department of Community Health Medicaid Breast and Cervical Cancer Prevention and Treatment Program application (DCH-1088) verifying that the client meets all eligibility for the BCCTP.
   • Faxing the Medicaid application (along with copies of appropriate citizenship/residency paperwork if appropriate) to the Medicaid Quality Analyst. Hard copy is mailed.
• Filing a copy of the application along with a copy of the pathology report confirming breast/cervical cancer or CIN II in the client’s program file.

B. Case Management of BCCCP clients enrolled in MTA

The BCCCP Coordinator/Case Manager will:

1. Identify the appropriate Medicaid enrolled provider(s) (surgeons, medical oncologists and/or radiation oncologists) willing to accept client as a new patient for breast or cervical cancer treatment.

2. Arrange for client’s cancer treatment with the appropriate provider(s). This includes any or all of the following:
   • Contacting providers to refer client for cancer treatment
   • Arranging for transportation to treatment (if needed)
   • Providing patient information on types of treatment
   • Providing patient information on financial resources for treatment, providers willing to accept uninsured patients for treatment, and payment for cancer drugs if client not eligible for Medicaid coverage
   • Providing information on continuing care post cancer treatment (E.g., screenings needed, frequency, survivorship issues, etc.)

3. Notify the provider IMMEDIATELY of client’s Medicaid ID number to be used for all FUTURE claims for provided services.

NOTE: If the client is DENIED Medicaid coverage:

The BCCCP Coordinator/Case Manager/Designated Program Staff will assist clients in obtaining cancer treatment through appropriate providers.

III. Procedure for Medicaid REDETERMINATION of BCCCP Clients Diagnosed with Cancer - Continued BCCCP Client Eligibility for Medicaid

A. Prior to the anniversary date when the client was initially enrolled in the BCCPTP, the Medicaid Quality Analyst will contact each BCCCP coordinator/case manager with a list of women for that coordinator’s agency requiring re-determination for continued Medicaid coverage.

B. The BCCCP Coordinator/Case Manager will:

1. Contact the woman to determine if she continues to meet BCCCP eligibility criteria (age, income, and lack of creditable insurance eligibility)

NOTE: The coordinator/case manager should attempt to contact the woman at least three times. If unable to contact the woman to complete the application the Medicaid Quality Analyst should be contacted.
2. Contact the woman’s health provider to determine if the woman is still receiving breast or cervical cancer treatment. Documentation stating that the woman is still undergoing breast or cervical cancer treatment is required. This can be accomplished one of three ways:
   • Written note from provider stating that the woman still requires breast or cervical cancer treatment OR
   • Documentation of a verbal conversation in the client’s medical record between the BCCCP Coordinator/Case Manager and the client’s health care provider that breast or cervical cancer treatment is still required OR
   • Completion of the attached Medicaid Redetermination form by the provider. (See attached form)

3. A copy of the one-page Medicaid renewal application should be attached to the original Medicaid application along with supporting documentation of continued cancer treatment.

D. For BCCCP Women Determined to Be NOT - ELIGIBLE to continue receiving Medicaid, (i.e. the woman DOES NOT meet BCCCP eligibility criteria or her cancer treatment has ended – see IV B)

1. Termination of cancer treatment is DETERMINED BY THE WOMAN’S HEALTH CARE PROVIDER. Information on termination of cancer treatment can be obtained from the health care provider as described under III, B, 2.

2. If cancer therapy has concluded, the woman will be informed by the BCCCP Coordinator/Case Manager that she can be re-enrolled in the BCCCP to receive breast and cervical cancer screening services as long as she meets BCCCP eligibility requirements.

IV Duration of Medicaid Coverage For BCCCP Women
A. It is the responsibility of the BCCCP Coordinator/Case Manager/Designated Program Staff to contact the woman’s health care provider to determine if the woman is still receiving treatment and/or associated follow-up cancer care for breast or cervical cancer.
B. A woman remains eligible for the BCCCP Medicaid Treatment Program as long as she is still receiving breast or cervical cancer treatment and/or associated follow-up cancer care according to her health care provider. Breast or cervical cancer treatment is defined as the following:

- Breast or cervical cancer surgical procedures
- Provision of chemotherapy to treat the breast or cervical cancer
- Provision of radiation therapy to treat the breast or cervical cancer
- Monitoring of side effects relating to the type of breast or cervical cancer therapy received by the woman
- Monitoring of follow-up of breast or cervical cancer treatment provided to determine if therapy was successful in treating the cancer

C. Policy Exception (Effective July 1, 2006)

- BCCCP women diagnosed with CIN II or CIN III/CIS will receive Medicaid coverage for **TWO** months instead of one year.
- The effective date of Medicaid coverage will begin the first day of the month the treatment is scheduled and end the last day of the month **one month post treatment**.

E.g. a BCCCP woman diagnosed with CIN II is scheduled for a LEEP on June 20, 2006. Her Medicaid coverage will begin on June 1, 2006 and end on July 31, 2006.

- Follow-up Pap tests may be covered through the BCCCP if the client returns to the program.
MICHIGAN BREAST AND CERVICAL CANCER CONTROL
MEDICAID TREATMENT ACT PROGRAM
DETERMINATION OF CONTINUED TREATMENT

LCA Name_________________________ Date sent to Provider____________

BCCCP Client Name___________________Date of Birth __________________

In order to determine continued eligibility for Medicaid services, please indicate below the status of the above named BCCCP client.

☐ The client is still receiving treatment for (check one)
   _______ breast cancer
   _______ cervical cancer
   _______ CIN II
   _______ CIN III/CIS

☐ The client has completed treatment. She received _____________(procedure) on  
   ___________ (date). She can return to Family Planning or BCCCP for follow-up Pap     
   tests post treatment.

☐ The client has completed treatment and can return to routine screening.

________________________________  _______________________
Signature       Date

Additional Information:
Medicaid Citizenship Requirement for BCCCP MTA Program Enrollment

March 23, 2007

Effective April 1, 2007 persons requesting Medicaid coverage through the BCCCP must provide documentation of both identity and citizenship at initial application.

Those individuals receiving Medicaid prior to April 1, 2007 must provide these documents at their yearly re-determination date if they are continuing to receive Medicaid coverage for cancer treatment.

Documents used to verify citizenship and identity provided by the BCCCP client may be originals or copies of the original document.

Procedure for Enrolling BCCCP Clients in Medicaid for Cancer Treatment

1. Once the cancer diagnosis (or pre-cancerous condition) is confirmed, the client is eligible to apply for the BCCCP MTA. Inform the client that the following information verifying citizenship and identity must be provided at the time they sign the application and they should bring this with them.

   a. Citizenship Verification – any of the following is acceptable
      - US Passport
      - Certificate of Naturalization
      - Certificate of US citizenship
      - Birth certificate
      - Report or certification of birth abroad of a US citizen
      - US Citizen ID card
      - Adoption papers
      - Military record if it shows where you were born
      - Voter ID Card* - not listed on the Michigan Department of Human Services Verification Checklist but is acceptable in verifying citizenship

   b. Identity Verification- any of the following is acceptable
      - Drivers License/ID Card
      - School ID
      - Federal, state, or local government ID
      - U.S. military ID card

NOTE: A Verification Checklist from the Michigan Department of Human Services is attached. This is FYI only. You do not need to use the checklist – it is provided to assist you in obtaining needed documentation.

2. Assist the client in completing the one-page MDCH Medicaid Breast and Cervical Cancer Prevention and Treatment Program application. (DCH-1088) as before.
3. Attach a copy of the documents verifying citizenship and identity. If the client does not have the supporting documentation at the time when they are signing the application then:

- Inform the client that they have **15 calendar days** to produce the missing citizenship or identity documentation.
- Inform Michele Barton (in writing) that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.

**NOTE:** If unable to obtain documentation during that time period or if the client requires assistance in obtaining a copy of her birth certificate, notify E.J. Siegl at 517-335-8814.

4. Fax a copy of the Medicaid application along with copies of appropriate citizenship/identity supporting documentation to Michele Barton as in the past.

5. This policy does not affect non-citizens. Non-citizens are still eligible to receive Emergency Services Only (ESO) coverage as in the past.
You must verify your identity and U.S. citizenship status before we can determine your eligibility for Medical Assistance.

To help us, please provide a copy of the item(s) checked below. Do not send original documents.

[ ]

[ ]

**WHO MUST YOU PROVIDE PROOF FOR?**

**CITIZENSHIP**

Proof of [ ] identity or [ ] citizenship or [ ] both for the following persons:

- The best way to prove you are a citizen is with one of the following:
  - U.S. Passport
  - Certificate of naturalization (DHS N-550 or N-570)
  - Certificate of U.S. citizenship (DHS N-560 or N-561)

If you do not have any of the items listed above, you will need two documents, one document to show you are a citizen and one to prove who you are.

Document you are a citizen with:

- Your birth certificate
- A report or certification of birth abroad of a U.S. citizen (form FS-240 or FS-545)
- U.S. citizen ID card (DHS Form I-97)

[ ]

[ ]

**IDENTITY RECORDS**

Show who you are with one of the following:

- Drivers license/ID card
- School ID card
- Federal, state or local government ID card
- U.S. military ID card

[ ]

[ ]

[ ]

[ ]

**WHY MUST YOU PROVIDE PROOF OF CITIZENSHIP FOR MEDICAID?**

Congress passed a law beginning July 1, 2006 that requires all people who get Medicaid or people who apply for Medicaid to document that they are U.S. citizens or nationals. If you are enrolled in Medicare, receive Supplemental Security Income (SSI), or are a "qualified alien," you will not be affected by this new law.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Important Information

Call me right away if you have any questions or problems getting the proofs. I will help you get the proofs if you ask for help.

You must get the proofs to me or call me by the due date below. If you do not, your benefits may be denied or cancelled.

[ ]

[ ]

**DUE DATE** 

**SPECIALIST NAME**

**TELEPHONE**

**FAX #**
Michigan Medicaid Breast and Cervical Cancer Prevention and Treatment Program Policy

Revised September 19, 2007

I Introduction

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 granted states the option to provide full Medicaid coverage to women, who otherwise would not have health care coverage for breast and/or cervical cancer and cervical precancerous conditions (CIN II), for the duration of their cancer treatment.

To qualify for Medicaid coverage under this program, a woman must meet certain criteria; 1) be under age 65, 2) without creditable health care insurance coverage, 3) screened through the state's Breast and Cervical Cancer Early Detection Program, which is administered by the Centers for Disease Control and Prevention, and 4) require treatment for breast and/or cervical cancer or cervical pre-cancerous conditions (CIN II).

In 2001, Michigan approved state funding to implement the BCCPTA. The Michigan Medicaid Treatment Act (MTA) became effective October 1, 2001 and affords full Medicaid benefits to certain women who meet the Michigan Breast and Cervical Cancer Control Program (BCCCP) Medicaid eligibility criteria as described in II.

II BCCCP MTA Eligibility Criteria

In order to be eligible for the Michigan BCCCP Medicaid Treatment Act, a woman must meet the following requirements outlined in A - E:

A. Be a Michigan resident

B. Be a US citizen or registered alien, AND provide citizen and identify verification documentation, as requested below by the Michigan Department of Human Services
   1. Citizenship Verification – any of the following is acceptable
      • US Passport
      • Certificate of Naturalization
      • Certificate of US citizenship
      • Birth certificate
      • Report or certification of birth abroad of a US citizen
      • US Citizen ID card
      • Adoption papers
      • Military record if it shows state born
      • Voter ID Card
2. Identity Verification\textsuperscript{3} - (Photo ID) - \textit{any of the following is acceptable}

- US Passport
- Drivers License/ID Card
- School ID
- Federal, state, or local government ID
- U.S. military ID card

C. Meet BCCCP\textsuperscript{5,6} age, income, and insurance status eligibility criteria. To be eligible for the BCCCP the woman must:

1. Meet the \textbf{age\textsuperscript{5,6}} requirements of:
   - \textbf{40 - 64} to receive breast/cervical cancer screening and/or diagnostic follow-up of breast/cervical abnormalities \textsuperscript{2,9,10}
   - \textbf{18 – 39} and referred to BCCCP for diagnostic follow-up\textsuperscript{2,9,10} of a cervical abnormality from the Title X Program.

\textbf{Note: Special Considerations\textsuperscript{6} –} Title X Program women age 18 – 39 referred to the BCCCP for diagnostic follow-up\textsuperscript{2} of a Pap test abnormality are eligible to apply for the BCCCP MTA if diagnosed with cervical cancer or a cervical precancerous condition (CIN II).

2. Meet the \textbf{income requirements} of \(\leq 250\%\) of the current year’s federal poverty level\textsuperscript{5,6}

3. Be \textbf{uninsured or underinsured\textsuperscript{5,6}}
   - Women enrolled in Managed Care Programs, Health Maintenance Organizations, or Medicare Part B are \textit{ineligible} for the MI BCCCP

D. Have no \textbf{creditable insurance coverage\textsuperscript{5,6}} for cancer treatment (as defined in §2701(c) of the Public Health Services Act, 42 U.S.C. §300gg(c)).

   - A woman is considered to have no creditable insurance if her health insurance contains a pre-existing condition exclusion, which either excludes for treatment of breast or cervical cancer, or covers limited services, but not treatment for breast or cervical cancer.

E. Has been \textbf{NEWLY diagnosed within 1-2 months} with either breast or cervical cancer or cervical pre-cancerous lesions (CIN II) and needs to \textbf{begin treatment} for such conditions\textsuperscript{1,2}
F. Special Considerations:

1. Agencies who are close to achieving their caseload for the year may choose to perform 1 or more of the following:
   a. Purchase additional caseload slots AND/OR
   b. Procure additional funds to provide breast/cervical screening and diagnostic services AND/OR
   c. Contract with county health plans or similar health care providers to provide BCCCP women screening and diagnostic services.

2. BCCCP eligible women who are screened and diagnosed with breast or cervical cancer or a cervical precancerous condition (CIN II) through a, b, or c above may be eligible for the BCCCP MTA if they meet the following criteria:
   - BCCCP age (40-64) and income requirements (< 250% FPL)
   - Lack of creditable insurance coverage for cancer treatment
   - NEWLY diagnosed with breast or cervical cancer within the past 1-2 months and HAS NOT started treatment

3. If meeting the criteria as stated in # 2, the woman will be enrolled in the BCCCP MTA following the procedure outlined under III.

III Enrollment in BCCCP MTA

A. Verifying Cancer Diagnosis and Completion of MTA Application

BCCCP Coordinator or Designated Program Staff will:

1. Confirm the woman’s cancer diagnosis (breast or cervical cancer or cervical pre-cancerous condition – CIN II) from her pathology report.

   NOTE: The woman is eligible to apply for BCCCP MTA coverage only AFTER the diagnosis of breast or cervical cancer or a cervical pre-cancerous condition (CIN II) is diagnosed.

2. Assist the woman in completing the one-page Michigan Department of Community Health Medicaid Breast and Cervical Cancer Prevention and Treatment Program application. (DCH-1088).

3. Coordinate the processing of the MTA application through the State of Michigan Medicaid agency by performing the following:
   - Signing the one-page Michigan Department of Community Health Medicaid Breast and Cervical Cancer Prevention and Treatment Program application (DCH-1088) verifying that the woman meets all eligibility for the BCCCP MTA.
• Faxing the Medicaid application (along with copies of appropriate citizenship/residency paperwork, if appropriate) to the Medicaid Quality Analyst. The original application must be mailed to the Medicaid Quality Analyst.

• Filing a copy of the application, citizenship/residency paperwork and a copy of the pathology report confirming breast/cervical cancer or cervical precancerous condition in the woman’s MTA program file.

B. BCCCP MTA - Coverage Begin Date
1. The BCCCP MTA begin date for Medicaid coverage is the first day of the month in which eligibility is determined, beginning with the month of application. (E.g. A woman diagnosed with cancer on 11/10/06 begins treatment on 11/25/06, Medicaid coverage will begin 11/1/06.)

• Medicaid coverage may begin up to 3 months prior to the application date depending on the date the woman was diagnosed with cancer.
• Coverage is effective for 1 year from the month of the start date.

2. Policy Exception (Effective July 1, 2006)
a. All women diagnosed with cervical precancerous conditions (CIN II or CIN III/CIS) through the BCCCP will receive Medicaid coverage for TWO months instead of one year

NOTE:
• Women diagnosed with invasive cervical cancer or CIN III/CIS requiring extensive treatment beyond the initial surgical procedure will have BCCCP MTA coverage extended for up to one year or until the treatment is complete (if less than 1 year).
• Women receiving treatment beyond the one year anniversary date will be reviewed for continued eligibility as described in V.)

b. The effective date of Medicaid coverage will begin the first day of the month the treatment is scheduled and end the last day of the month one-month post treatment. (E.g. BCCCP woman diagnosed with CIN II is scheduled for a LEEP on June 20, 2006. Her Medicaid coverage will begin on June 1, 2006 and end on July 31, 2006.)

c. Follow up Pap tests may be covered through the BCCCP if the woman returns to the program.
C. Arranging for Cancer Treatment of MTA Enrolled Women

BCCCP Coordinator or Designated Program Staff will:

1. Identify the appropriate Medicaid enrolled provider(s) (surgeons, medical oncologists and/or radiation oncologists) willing to accept the woman as a new patient for breast or cervical cancer treatment.

2. Inform the provider of the following:
   - The woman is enrolled in the BCCCP MTA and will receive full Medicaid coverage for any service she requires in addition to her cancer treatment.
   - Medicaid is to be billed using the woman’s Medicaid ID number for all FUTURE claims for any provided clinical services.
   - Medicaid coverage is effective while the woman is undergoing active cancer treatment. Once cancer treatment is completed, Medicaid coverage will end.²

3. Arrange for the woman’s cancer treatment with the appropriate provider(s). This includes any or all of the following:
   - Contacting providers to refer the woman for cancer treatment
   - Arranging for transportation to treatment (if needed)
   - Providing information on continuing care post cancer treatment (E.g.. screenings needed, frequency, survivorship issues, etc.)

IV Duration of Medicaid Coverage For MTA Women

A. MTA enrolled women are eligible to receive full Medicaid benefits as long as they are in need of treatment for breast or cervical cancer or pre-cancerous lesions.¹²

B. A woman remains eligible⁷,⁸ for the BCCCP MTA as long as she is still receiving breast or cervical cancer treatment and/or associated follow-up cancer care (beyond routine care, i.e. surveillance monitoring) according to her health care provider. Breast or cervical cancer treatment⁹,¹⁰ is defined as the following:
   - Breast or cervical cancer surgical procedures
   - Provision of chemotherapy to treat the breast or cervical cancer
   - Provision of radiation therapy to treat the breast or cervical cancer
   - Monitoring of side effects relating to the type of breast or cervical cancer therapy received by the woman
   - Monitoring of follow-up of breast or cervical cancer treatment provided to determine if therapy was successful in treating the cancer
V. Ongoing Review of BCCCP MTA Eligibility

A. BCCCP MTA review date is one year from month of start date.\textsuperscript{2}
   • The State of Michigan Medicaid Quality Analyst will notify BCCCP Coordinators of the names and dates of women in their program due for annual review.

B. The BCCCP Coordinator or Designated Program Staff will:
   1. Contact the woman to determine if she continues to meet the following eligibility criteria to continue on the BCCCP MTA:
      • Age and income requirements
        \textbf{NOTE:} If a woman turns 65 years before her review date, her coverage under the BCCCP MTA will end when she turns 65.
      • Lack of Creditable Insurance.
   2. Contact the woman’s healthcare provider determine if she is still receiving treatment (as defined in IV B) for breast or cervical cancer or cervical precancerous lesions (CIN II).
      a. Women meeting all the criteria in V B will re-sign the one-page Medicaid application. BCCCP MTA coverage will continue for one year from the date signed or until her cancer treatment is completed (if less than one year).
      b. If a woman fails to meet any of the eligibility criteria as stated in V B she will be notified in writing the reason why her coverage is ending (over age, over income, obtained creditable insurance, completion of cancer treatment or failed to renew application) and the date her MTA coverage will end.

VI. BCCCP MTA Hearing/Appeal Rights\textsuperscript{11}

A. If a woman disagrees with or is dissatisfied with MTA program eligibility, covered service determination or decision, she has the right to request an administrative fair hearing to before the State Office of Administrative Hearings and Rules for the Department of Community Health.

B. The woman needs to submit a written request for the hearing to the State Office of Administrative Hearings and Rules. The woman may select, at her discretion, legal counsel to represent her during the administrative appeal.

C. The State Office of Administrative Hearings and Rules will review the request and contact the woman regarding the date and time of her hearing by the Administrative Law judge.
References

**BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)**
**MEDICAID TREATMENT ACT (MTA)**
**ELIGIBILITY AND ENROLLMENT PROCEDURE MANUAL**

*(For use by BCCCP Agency Staff)*

Revised September 19, 2007

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I  BCCCP Medicaid Treatment Act (MTA) Eligibility Criteria

In order to be eligible for the Michigan BCCCP Medicaid Treatment Act, a woman must meet the following requirements outlined in A - E:

A. Be a Michigan resident

B. Be a US citizen or registered alien, AND provide citizen and identify verification documentation as requested below by the Michigan Department of Human Services
   1. Citizenship Verification – *any of the following is acceptable*
      • US Passport
      • Certificate of Naturalization
      • Certificate of US citizenship
      • Birth certificate
      • Report or certification of birth abroad of a US citizen
      • US Citizen ID card
      • Adoption papers
      • Military record if it shows state born
      • Voter ID Card
   2. Identity Verification- (Photo ID)- *any of the following is acceptable*
      • US Passport
      • Drivers License/ID Card
      • School ID
      • Federal, state, or local government ID
      • U.S. military ID card

C. Meet BCCCP age, income, and insurance status eligibility criteria of the BCCCP. To be eligible for the BCCCP the woman must:
   1. Meet the *age* requirements of:
      • 40 – 64 to receive breast/cervical cancer screening and/or diagnostic follow-up of breast/cervical abnormalities
      • 18 – 39 and referred to BCCCP for diagnostic follow-up of a cervical abnormality from the Title X Program.

   **Note: Special Considerations** – Title X Program women age 18 – 39 referred to the BCCCP for diagnostic follow-up of a Pap test abnormality are eligible to apply for the BCCCP MTA if diagnosed with cervical cancer or a cervical precancerous condition (CIN II).

   2. Meet the *income requirements* of \( \leq 250\% \) of the current year’s federal poverty level
3. Be **uninsured or underinsured**
   - Women enrolled in Managed Care Programs, Health Maintenance Organizations, or Medicare Part B are **ineligible** for the MI BCCCP

D. Have no **creditable insurance coverage** for cancer treatment (as defined in §2701(c) of the Public Health Services Act, 42 U.S.C. §300gg(c)).
   - A woman is considered to have no creditable insurance if her health insurance contains a pre-existing condition exclusion, which either excludes for treatment of breast or cervical cancer, or covers limited services, but not treatment for breast or cervical cancer.

E. Has been **NEWLY diagnosed within 1-2 months** with either breast or cervical cancer or cervical pre-cancerous lesions (CIN II) and needs to **begin treatment** for such conditions.

F. **Special Considerations:**

1. For Agencies who who perform 1 or more of the following:
   a. Purchase additonal caseload slots **AND/OR**
   b. Procure additional funds to provide breast/cervical screening and diagnostic services **AND/OR**
   c. Contract with county health plans or similar helath care providers to provide BCCCP women screening and diagnostic services.

2. **BCCCP eligible women** who are screened and diagnosed with breast or cervical cancer or a cervical precancerous condition (CIN II) through 1, 2, or 3 above may be eligible for the BCCCP MTA if they meet the following criteria:
   - BCCCP age (40-64) and income requirements (≤ 250% FPL)
   - Lack of creditable insurance coverage for cancer treatment
   - **NEWLY** diagnosed with breast or cervical cancer within the **past 1-2 months** and **HAS NOT** started treatment

3. The woman will be enrolled in the BCCCP MTA following the procedure under II.

**NOTE :**
   a. Women screened through the **purchase of additional caseload slots** (as stated in 1a) **WILL** count in the total caseload for the year.
      - All client data MUST be documented in MBCIS
b. Women screened through 1 b or c as stated above WILL NOT count in the total caseload for the year.

- **NO demographic, screening, or diagnostic data** should be entered in MBCIS.

- The Michigan BCCCP MTA Release of Information form **must** be completed by the woman (see attached) in order to contact her provider to obtain any health history information. This includes a copy of the pathologist’s report confirming the cancer diagnosis.

- **NOTIFY E.J. Siegl PRIOR** to enrolling these women in Medicaid with the following information:
  - Name of woman
  - Birthdate
  - Cancer Diagnoses
  - Date of Diagnoses
  - Date Treatment Began
II Enrollment in BCCCP MTA

A. Verifying Cancer Diagnosis and Completion of MTA Application

BCCCP Coordinator or Designated Program Staff will:

1. Confirm the woman’s cancer diagnosis (breast or cervical cancer or cervical pre-cancerous condition- CIN II) from her pathology report.

   NOTE: The woman is eligible to apply for BCCCP MTA coverage only AFTER the diagnosis of breast or cervical cancer or a cervical pre-cancerous condition (CIN II) is diagnosed.

2. Assist the woman in completing the one-page Michigan Department of Community Health Medicaid Breast and Cervical Cancer Prevention and Treatment Program application. (DCH-1088).
   a. DCH-1088 may only be obtained from Michele Barton.
   b. Prior to signing the application, a copy of the required documents proving citizenship and identity as described in I B must be obtained from the woman.
   c. If the woman does not have the supporting documentation at the time when they are signing the application then:
      • Inform the woman that she has 15 calendar days to produce the missing citizenship or identity documentation.
      • Inform Michele Barton (in writing) that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.

   NOTE: If unable to obtain documentation during that time period or if the woman requires assistance in obtaining supporting documents (e.g. a copy of her birth certificate), notify E.J. Siegl.

3. Coordinate the processing of the application through the State of Michigan Medicaid agency by performing the following:
   a. Signing (see NOTE below) the Medicaid Breast and Cervical Cancer Prevention and Treatment Program application verifying that the woman meets all eligibility for the BCCCP MTA.

      • A date must be entered in the Treatment Start Date Box on the application so the State of Michigan Medicaid Quality Analyst (Michele Barton) can determine when to begin BCCCP MTA Coverage.
      • For women diagnosed with CIN II or CIN III/CIS, a Treatment Start Date AND Treatment End Date must be entered in the Date Treatment Began box.
• Michele Barton will automatically enter the end date in the State of Michigan database for this client.
• A letter will be sent to the client notifying her when coverage begins and ends (if applicable).

b. **Faxing** the Medicaid application (along with copies of appropriate citizenship/residency paperwork, if appropriate) to Michele Barton at 517-373-9305.

c. **Mailing** the original Medicaid application to Michele Barton
   Michele Barton, Quality Assurance Analyst
   Eligibility Quality Assurance Section
   Michigan Department of Community Health
   PO Box 30479
   400 South Pine
   Lansing, MI 48909-7979

   **NOTE:** Applications should ONLY be sent to Michele and not be forwarded through the county Family Independence Agency (FIA).

d. For women who are unable to produce citizenship and/or identify documentation:
   • Inform the woman that she has **15 calendar days** to produce the missing citizenship or identity documentation.
   • Inform Michele Barton (in writing) that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.

   **NOTE:** If unable to obtain documentation during that time period or if the client requires assistance in obtaining a copy of her birth certificate, notify E.J. Siegl at 517-335-8814.

e. **Filing** a copy of the application, citizenship/residency paperwork and a copy of the pathology report confirming breast/cervical cancer or cervical precancerous condition in the woman’s MTA program file.

   **NOTE:**
   • For BCCCP MTA clients applying for Medicaid: **ONLY** the BCCCP Coordinator or an identified health department BCCCP staff person can sign the application. (Medicaid policy states that only state or county employees are authorized to witness and sign Medicaid applications)
   • E.J. Siegl needs to be informed of the authorized signers for each BCCCP agency.
   • Signing the BCCCP MTA application by someone other than the BCCCP Coordinator or identified health department
BCCCP Staff person will invalidate the application and delay the processing for Medicaid.

Exception:
- Karmanos Cancer Institute (KCI) BCCCP staff are unable to sign the MTA applications (non state or county employees).
- KCI staff will obtain the following information (Pathology report confirming the cancer diagnosis, copy of citizenship and identify information, and original signed MTA application by the woman).
- Information will be sent to E.J. Siegl at MDCH via overnight mail.
- E.J. will verify the information received, notify KCI of receipt of the information, sign the application, fax required information to Michele Barton, and mail hard copies to Michele Barton.

B. BCCCP MTA - Coverage Begin Date
1. The BCCCP MTA begin date for Medicaid coverage is the first day of the month in which eligibility is determined, beginning with the month of application. (e.g. A woman diagnosed with cancer on 11/10/06 begins treatment on 11/25/06, Medicaid coverage will begin 11/1/06.)

   • Medicaid coverage may begin up to 3 months prior to the application date depending on the date the woman was diagnosed with cancer.
   • Coverage is effective for 1 year from the month of the start date.

2. Policy Exception (Effective July 1, 2006)
   a. ALL women diagnosed with with cervical precancerous conditions (CIN II or CIN III/CIS) through the BCCCP will receive Medicaid coverage for TWO months instead of one year.

   b. The effective date of Medicaid coverage will begin the first day of the month the treatment is scheduled and end the last day of the month one-month post treatment.

      (e.g. BCCCP woman diagnosed with CIN II is scheduled for a LEEP on June 20, 2006. Her Medicaid coverage will begin on June 1, 2006 and end on July 31, 2006.)

   c. Follow up Pap tests may be covered through the BCCCP if the woman returns to the program.

   d. NOTE:
      • Women diagnosed with invasive cervical cancer or CIN III/CIS requiring extensive treatment beyond the initial
surgical procedure will have BCCCP MTA coverage extended for up to one year or until the treatment is complete (if less than 1 year).

- For these women DO NOT ENTER a Treatment End Date on the Medicaid Application.
- Women receiving treatment beyond the one year anniversary date will be reviewed for continued eligibility as described in IV.)

C  Arranging for Cancer Treatment of MTA Enrolled Women

BCCCP Coordinator or Designated Program Staff will:

1. Identify the appropriate Medicaid enrolled provider(s) (surgeons, medical oncologists and/or radiation oncologists) willing to accept the woman as a new patient for breast or cervical cancer treatment.

2. Inform the provider of the following:
   - The woman is enrolled in the BCCCP MTA and will receive full Medicaid coverage for any service she requires in addition to her cancer treatment.
   - Medicaid is to be billed using the woman’s Medicaid ID number for all FUTURE claims for any provided clinical services.
   - Medicaid coverage is effective while the woman is undergoing active cancer treatment. Once cancer treatment is completed, Medicaid coverage will end.

3. Arrange for the woman’s cancer treatment with the appropriate provider(s). This includes any or all of the following:
   - Contacting providers to refer the woman for cancer treatment
   - Arranging for transportation to treatment (if needed)
   - Providing information on continuing care post cancer treatment (e.g., screenings needed, frequency, survivorship issues, etc.)

4. NOTE: Some women may require additional support beyond what is stated in # 2 for cancer treatment. Contact E.J. Siegl to assist in coordinating care if additional resources are needed.

5. For women who are granted Emergency Service Coverage Only (Non-citizens) or are DENIED Medicaid coverage for other reasons: The BCCCP Coordinator/Case Manager/Designated Program Staff will assist clients in obtaining cancer treatment through appropriate providers.
III. Duration of Medicaid Coverage For MTA Women

A. MTA enrolled women are eligible to receive full Medicaid benefits as long as they are in need of treatment for breast or cervical cancer or pre-cancerous lesions.

B. It is the responsibility of the BCCCP Coordinator or Designated Program Staff to contact the woman’s health care provider to determine if the woman is still receiving treatment and/or associated follow-up cancer care for breast or cervical cancer.

C. A woman remains eligible for the BCCCP MTA as long as she is still receiving breast or cervical cancer treatment and/or associated follow-up cancer care (beyond routine care, i.e. surveillance monitoring) according to her health care provider. Breast or cervical cancer treatment is defined as the following:
   • Breast or cervical cancer surgical procedures
   • Provision of chemotherapy to treat the breast or cervical cancer
   • Provision of radiation therapy to treat the breast or cervical cancer
   • Monitoring of side effects relating to the type of breast or cervical cancer therapy received by the woman
   • Monitoring of follow-up of breast or cervical cancer treatment provided to determine if therapy was successful in treating the cancer
IV. Ongoing Review of BCCCP MTA Eligibility

A. Prior to the anniversary date when the client was initially enrolled in the BCCCP MTA Michele Barton will contact each BCCCP coordinator with a list of women for that coordinator’s agency requiring annual re-determination for continued Medicaid coverage.

1. Review date is one year from month of start date.

2. Policy Exception (as described in B 2). - BCCCP women diagnosed with cervical precancerous conditions (CIN II or CIN III/CIS) will receive Medicaid coverage for TWO months instead of one year except for women requiring extensive treatment beyond the initial surgical procedure. For these women MTA coverage can be extended until the treatment is completed.

B. The BCCCP Coordinator/Designated Program Staff will:

1. Contact the woman to determine if the woman continues to meet the BCCCP eligibility criteria which include:
   - Age and income requirements
     NOTE: If a woman turns 65 years before her review date, her coverage under the Treatment Act will end when she turns 65.
   - Lack of Creditable Insurance.

   NOTE: The coordinator/designated Program Staff should attempt to contact the woman at least three times. If unable to contact the woman to complete the application notify Michele Barton. Medicaid coverage will be terminated for failure to renew.

2. Contact the woman’s health provider to determine if the woman is still receiving breast or cervical cancer treatment or has completed treatment.

3. Obtain documentation from the provider stating that the woman is still undergoing breast or cervical cancer treatment. This can be accomplished one of three ways:
   - Written note from provider stating that the woman still requires breast or cervical cancer treatment OR
   - Documentation of a verbal conversation in the client’s medical record between the BCCCP Coordinator/Case Manager and the client’s health care provider that breast or cervical cancer treatment is still required OR
   - Completion of the attached Medicaid Redetermination form by the provider. (See attached form)
c. Assist the woman to complete the one-page Medicaid application and send to Michele Barton as described in II B OR
d. Inform the woman that she is no longer eligible for the program for the following reason (over age, over income, obtained creditable insurance, or completion of cancer treatment) and the date her MTA coverage will end.
V. BCCCP MTA Hearing/Appeal Rights

A. If a woman disagrees with or is dissatisfied with MTA program eligibility, covered service determination or decision, she has the right to request an administrative fair hearing to before the State Office of Administrative Hearings and Rules for the Department of Community Health.

B. The woman needs to submit a written request for the hearing to the State Office of Administrative Hearings and Rules. The woman may select, at her discretion, legal counsel to represent her during the administrative appeal.

C. The State Office of Administrative Hearings and Rules will review the request and contact the woman regarding the date and time of her hearing by the Administrative Law judge.

D. E.J. Siegl will be notified of the date and time of the woman’s hearing. She will notify the BCCCP Coordinator and request specific information on the woman that determined her ineligibility for the program.

- A written summary of the reason(s) the BCCCP MTA coverage was discontinued for the woman will be submitted to the Administrative Tribunal, the woman requesting the hearing, and the BCCCP Coordinator.

- E.J. Siegl will present the case before the judge and the woman in a telephone hearing on the assigned date. Final determination of the woman’s request for reinstatement of BCCCP MTA will be determined by the judge.
MDCH BCCCP MTA Contact Staff

1. Michele Barton, Quality Assurance Analyst  
   Phone: 517-241-8164, Fax: 517-373-9305

2. E.J. Siegl, BCCCP Nurse Consultant,  
   Phone: 517-335-8814, Fax: 517-335-9397

3. Ann Garvin, BCCCP Nurse Consultant  
   Phone: 517-335-9087, Fax: 517-335-9397
MICHIGAN BREAST AND CERVICAL CANCER CONTROL

MEDICAID TREATMENT ACT PROGRAM

DETERMINATION OF CONTINUED TREATMENT

LCA Name_________________________ Date sent to Provider____________

BCCCP Client Name___________________Date of Birth __________________

In order to determine continued eligibility for Medicaid services, please indicate below the status of the above named BCCCP client.

☐ The client is still receiving treatment for (check one)
    _______ breast cancer
    _______ cervical cancer
    _______ CIN II
    _______ CIN III/CIS

☐ The client has completed treatment. She received _____________(procedure) on ______________(date). She can return to Family Planning or BCCCP for follow-up Pap tests post treatment.

☐ The client has completed treatment and can return to routine screening.

________________________________  _______________________
Signature       Date

Additional Information:
MICHIGAN BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)
MEDICAID TREATMENT ACT
RELEASE OF INFORMATION

CONFIDENTIALITY

I UNDERSTAND THAT:

- Any personal information obtained about me will be kept confidential
- This information will not be given to anyone outside of this program without my written permission
- Only information about me that does not identify me will be used in grouped reports or for other scientific purposes concerned with controlling breast and cervical cancer.
- I may be asked some time in the next several years to answer questions about my breast or cervical health, or my experiences with this screening program. I understand I am not required to answer such questions. If I do, I do not have to identify myself.
- AIDS-related information about me will not be released unless I provide written consent on a separate document.

I GIVE PERMISSION AND AGREE TO:

- Provide the BCCCP Agency with information about me, including my health history and reports of screening and diagnostic tests and procedures relating to breast or cervical cancer.
- Allow the BCCCP Agency to give information regarding my case to:
  - My physician
  - Any consulting physician
  - Any clinic or hospital to which I may be referred
  - My health insurance company
  - Any other individual designated by me
  - The Michigan Department of Community Health, which is running this program for the State of Michigan.

I have been able to ask questions about this program and this form, and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. BCCCP Agency Phone number is (____/___-___________)

_________________________
Signature of client       date

_________________________
Signature of person obtaining informed consent   date

THIS FORM IS IN EFFECT FOR ONE YEAR FROM THE DATE OF SIGNATURE

Implemented October 2001
Policy Statement

The Michigan Breast and Cervical Cancer Control Program (BCCCP) provides Pap testing for cervical cancer to income eligible women age 40 to 64. The purpose of the Pap test is to detect pre-cancerous or cancerous lesions at their earliest stage to reduce morbidity and mortality from cervical cancer.

Current BCCCP policy is to reimburse for Pap tests (conventional or liquid based cytology [Thin-Prep™, Sure-Path™]) on an annual basis. Effective November 1, 2006 the following policy change regarding the interval for Pap testing in the BCCCP will occur:

1. Conventional Cytology (Screening Pap tests) may be performed:
   - **Annually** until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5-year period).
   - **Then, once every (3) three years, for** women with (3) three, consecutive normal/negative screening Pap tests performed within a 60-month (5 year period).

2. Liquid Based Cytology (LBC) may be performed:
   - Every **TWO** years until three (3), consecutive normal/negative Pap tests are obtained within a 60-month (5 year period).
   - **Then, once every (3) three years, for** women with (3) three, consecutive normal/negative Pap tests performed within a 60-month (5 year period).
Procedure

1. For a new BCCCP client receiving CONVENTIONAL (slide) Pap testing:
   - The follow-up to a Negative screening Pap test is a screening Pap test performed annually (once/year), until three (3) consecutive Negative Pap Test results are achieved within a 60 month (5 year) time period.
   - After (3), three consecutive normal Pap tests are obtained within this time period; the Pap test interval will increase to ONCE every (3) three years.

<table>
<thead>
<tr>
<th>Date of Pap test</th>
<th>Initial Pap</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
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<td>April 1, 2008</td>
<td>April 1, 2011</td>
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</table>

   | Type of Pap test | Conventional | Conventional | Conventional | Conventional |
   | Time interval    | Month 0      | Month 12     | Month 24     |              |

   | Result           | Negative     | Negative     | Negative     |              |

   3 Negative Paps within 60 months

   One Pap every 3 years

2. New BCCCP client receiving LIQUID-BASED CYTOLOGY (LBC) (Thin-Prep™, Sure-Path™)
   - The follow-up to a Negative/normal screening Pap test result is a screening Pap test every TWO (2) years
   - After (3), three consecutive normal Pap tests are obtained within this time period; the Pap test interval will increase to ONCE every (3) three years.

<table>
<thead>
<tr>
<th>Date of Pap test</th>
<th>Initial Pap</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2006</td>
<td>April 1, 2008</td>
<td>April 1, 2010</td>
<td>April 1, 2013</td>
<td></td>
</tr>
</tbody>
</table>

   | Type of Pap test | LBC         | LBC          | LBC          | LBC          |
   | Time interval    | Month 0     | Month 24     | Month 48     |              |

   | Result           | Negative    | Negative     | Negative     |              |

   3 Negative Paps within 60 months

   One Pap every 3 years
3. For a BCCCP returning client, who has received a combination of CONVENTIONAL AND LBC Pap tests

<table>
<thead>
<tr>
<th>Type of Pap test</th>
<th>Initial Pap</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>LBC</td>
<td>LBC</td>
<td>LBC</td>
<td></td>
</tr>
<tr>
<td>Date of Pap test</td>
<td>April 1, 2006a</td>
<td>April 1, 2007b</td>
<td>April 1, 2009c</td>
<td>April 1, 2012c</td>
</tr>
<tr>
<td>Time interval</td>
<td>Month 0</td>
<td>Month 12</td>
<td>Month 36</td>
<td>Month 72</td>
</tr>
<tr>
<td>Result</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td></td>
</tr>
</tbody>
</table>

- **a** – Client first received conventional Pap test- recommended screening interval is **yearly**
- **b** – Next Pap test was LBC. Result was negative. Screening interval increases to every **two years**
- **c** - For women who have had three (3) consecutive Negative screening Pap Tests (within the previous (5) five years, paid for by BCCCP), they are to have screening Pap tests (either conventional or liquid-based) only once every three (3) years (>35 months from the previous screening Pap test)

**Policy Exceptions**

1. Abnormal Pelvic Exam
   - If the cervix appears **abnormal** or the client has symptoms that indicate a diagnosis of “r/o cervical cancer” (bleeding, foul-smelling discharge), the provider may perform a Pap test. Documentation in MBCIS of the abnormal pelvic exam must occur in order for the Pap test to be paid by BCCCP.

2. Abnormal Pap test
   - The above policy does not apply to women who have had any abnormal Pap test result (>ASC-US or greater, including ASC-US w/ Negative HR HPV) during the previous three years, or who are receiving follow-up Pap testing.
Example: BCCCP Client with ASC-US Pap test result from LBC

<table>
<thead>
<tr>
<th>Date of Pap test</th>
<th>Initial Pap</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
<th>Next Pap Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April 1, 2005</td>
<td>April 1, 2007</td>
<td>April 1, 2008</td>
<td>April 1, 2010</td>
</tr>
<tr>
<td>Time interval</td>
<td>Month 0</td>
<td>Month 24</td>
<td>Month 0</td>
<td>Month 24</td>
</tr>
<tr>
<td>Result</td>
<td>Negative</td>
<td>ASC-US</td>
<td>Negative</td>
<td>Negative*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HR HPV +</td>
<td></td>
<td>continue until 3 consecutive negative Paps then schedule ONCE/3 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colp with Bx/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ECC done –</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up –</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repeat Pap in</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 year as per</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BCCCP Protocol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information**

- Women will still need to receive a pelvic exam annually, along with a CBE and screening mammogram.
- Women who have had a hysterectomy, including removal of the cervix, for benign indications are not to receive Pap testing.
- Women who have had a hysterectomy but still have a cervix will need to receive Pap testing per protocol.
- This policy does not apply to women in the Family Planning/BCCCP Joint Project, as they are women who have had abnormal Pap tests requiring follow-up diagnostic testing to rule out a cancer diagnosis.
CDC Recommendations for Cervical Cancer Screening

Conventional and Liquid Base Cytology

In 2005, a panel of cervical cancer experts was convened by CDC in order to examine and weigh the scientific and programmatic evidence related to cervical cancer screening practices in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The panel recommended the following for conventional Pap testing and liquid base cytology.

Conventional Pap Testing

Recommendation
Continue reimbursement for annual screening using conventional cytology (Pap).
–Annually and
–Every three years for women with three consecutive normal Pap tests within a five-year period

Rationale
• No new evidence has emerged to warrant a change in existing policy.
• Morbidity and mortality from cervical cancer have declined substantially since the introduction of conventional cytology.
• Conventional cytology is well integrated into existing clinical practice.
• Conventional cytology is well accepted among patients

The rationale for this policy is that 50-60% of deaths from invasive cervical cancer occur in women who have either never been screened or have rarely been screened (the last Pap test performed was five or more years ago). In addition, studies have shown that, after three (3) or more prior normal Pap tests, the cost-effectiveness of annual testing declines and the cost per life-year saved increases substantially.¹ False-positive Pap tests (tests which are reported as ABNORMAL but that are normal) are more likely with annual Pap testing, and will result in unnecessary follow-up diagnostic testing.

Liquid Base Cytology

Recommendation:
Allow reimbursement for biennial screening with LBC as opposed to annual screening with conventional cytology

**Biennial screening interval:** Biennial screening is an important component to LBC tests. Because LBC has a higher sensitivity and lower specificity than conventional Pap tests, more false positives will result when using LBC. Women with these test results must receive a full diagnostic workup to distinguish the true positives from the false positives. Diagnostic procedures such as colposcopy have their own set of risk to patients, both physical and emotional. On the other hand, a negative test result with LBC is so reliable that there is no need to rescreen for two years. Thus the every-other year interval is an important mechanism both for protecting women from false positives and all that they entail, and for ensuring that the greatest number of women can be screened with limited program resources.

**Rationale:**

- **Patient acceptability** - Test administration similarities between LBC and conventional cytology; make patient acceptability of LBC high.

- **Clinical efficiency** - No additional provider time or training is required for administering LBC, making clinical efficiency for LBC high. While some additional supplies might be required, these should be covered under Medicare reimbursement rates. Ease of HPV triage enhances both clinical efficiency and patient adherence and acceptability because requirements for repeat patient visits are reduced.

- **Weighed against patient/program costs** - These advantages are weighed against patient and program costs associated with increased false positive rates. Higher false positive rates are in part an artifact of interpreter experience with the new technology and trends suggest the levels of false positive findings are declining with experience. Further HPV testing can assist in distinguishing between false positive and potentially true positive findings. Despite these trends, however, increased rates of false positive findings result in down stream program costs for follow-up tests and case management as well as patient burdens associated with unnecessary follow-up.
DATE: January 17, 2008

TO: BCCCP Coordinators

FROM: E.J. Siegl, Nurse Consultant
Cancer Prevention and Control Section

SUBJECT: Documenting Post Biopsy Mammograms in MBCIS

Depending on the type of biopsy performed and the lesion that is identified, a mammogram may be performed along with the biopsy or immediately afterwards. In this case, the mammogram is used to evaluate the biopsy procedure and no BI-Rads recommendation will be made by the radiologist. In order for the biopsy to be reimbursed by BCCCP the following needs to be documented in MBCIS.

1. Choose “Other Breast Diagnostic Procedure” as the Exam Type in the Service Summary.
2. Under “Other Exam Description” document “Post Biopsy Mammogram.”
3. No results are entered under Service Results.
4. NOTIFY E.J. SIEGL, TORY PHELPS OR SAM BURKE of this procedure to assure reimbursement.
MI Breast and Cervical Cancer Control Quality Improvement Program
2006

BCCCP Overview

The Michigan Department of Community Health’s (MDCH) Cancer Prevention and Control Section have been involved with implementing the Breast and Cervical Cancer Control Program (BCCCP) since 1991. Women throughout Michigan receive services from over 700 contracted BCCCP providers across the state. Services are also available through tribal health clinics of seven federally recognized Indian tribes.

BCCCP services are coordinated through 19 local health departments across Michigan as well as the Karmanos Cancer Institute in Detroit. These agencies have enlisted the cooperation and participation of physicians, hospitals, and other health care organizations in their communities to assure that all necessary follow-up services are provided.

Local agencies are required to provide or arrange for basic screening services, i.e., clinical breast exams, screening mammograms, pelvic exams, Pap Smears, and patient education. Some local agencies are delivering these basic services through their existing or expanded department staff. Others are providing the basic services through subcontracts with community providers. Local agencies contract with radiology facilities to provide mammography services to enrolled women, as well as with clinical laboratories to analyze Pap smears. An extensive patient data and tracking system is used to ensure appropriate follow-up of abnormalities and encouragement of routine screening. Coordination of this tracking system is the responsibility of the local agency.

Implementing the MI BCCC QI Plan

Since 1995, the MDCH Cancer Prevention and Control Section have conducted comprehensive on-site evaluations. These staff had visited each health department to review relevant clinical records and interview key staff involved with the MI Breast and Cervical Cancer Control Program. Beginning in 1999, the Cancer Prevention and Control Section collaborated with the Michigan Peer Review Organization (MPRO) in developing a comprehensive program that primarily will focus on process improvements in the MI BCCC Program.

MPRO is an independent organization, who uses clinical expertise and professionally recognized standards to evaluate the appropriateness of medical care in Michigan and nationwide. MPRO’s focus is to ensure that health care services are delivered in the most appropriate and cost effective setting that services are medically necessary, and that high quality care is rendered.

Since 1999, MPRO has conducted the BCCCP chart audits within the framework of a collaborative quality improvement project (QIP). This QIP is the basis that was used to assist coordinating agencies in recognizing areas for potential improvement and to develop and implement improvement plans.
Medical Record Audit Goals and Objectives

The goals of the annual chart reviews are to validate the information contained in the BCCCP database, assess adherence to the CDC standards of timeliness and completeness and provide a framework for improved patient care through a collaborative improvement process.

The chart reviews assists the MDCH Cancer Prevention and Control Section in accomplishing the following objectives:

- Developing collaborative relationships with coordinating agencies to provide an environment for continuous quality improvement.
- Addressing the assessed learning needs of agency staff regarding CQI methods and skills needed to develop improvement plans.
- Validating information in the BCCCP database and participant adherence to the CDC standards of timeliness and completeness through medical record abstraction.
- Presenting an analysis and summary of aggregate validation data and specific results for each coordinating agency.
- Assisting agencies to develop and implement improvement plans through consultation and feedback.
- Summarizing and report the final improvement plans and outcomes of agency efforts to improve the quality of care through ongoing cycles of improvement and measurement.
- Measuring adherence to the CDC documentation guidelines and medical protocol through medical record abstraction and database validation.

Collection of data regarding the indicators is the way in which performance is measured and progress towards improvement identified within the BCCC Program. There are two components to data collection in the QIP.

1. **BCCCP Annual Chart Review**
   The annual chart reviews include validation of the program database and assessment of adherence to the CDC standards of timeliness and completeness. The tools include the BCCCP Record Abstraction Tool adapted from the BCCCP Screening and Follow-up Forms, and the BCCCP Quality Indicators developed from the CDC Medical Protocol. Local agency staff collaborates with MPRO in conducting the annual reviews.

2. **Analyzing Statewide and Agency Specific Program Data**
   The second component of data collection for this project relates to the overall goal of improving the care of clients receiving breast and cervical cancer screening. This involves monitoring program processes through the use of data collection tools and graphs. The Michigan Breast and Cervical Information System (MBCIS) is a statewide database system that assists the BCCCP Coordinator in analyzing program data, identifying problem areas and developing a plan for process improvement. Information retrieved from the MBCIS data system provides for timely and accurate analysis of data to determine program effectiveness in providing breast and cervical screening and follow-up services.
Methodology

MPRO conducts the data quality and protocol adherence validation study based on a sample of medical records from the coordinating agencies. Clinical care provided to BCCCP clients and recorded in the medical record is reviewed according to the BCCCP medical protocol.

The medical record audit encompassed six steps:
- Sample Selection
- Creation of an abstraction tool
- Reliability testing of the tool
- Data abstraction
- Data analysis
- Report generation

Sample Selection

The sample for medical abstraction is drawn from a sub-population of women with abnormal results from breast or cervical cancer screenings. A randomized sampling strategy, stratified by each agency is used to determine the final sample. The proposed chart sample requested from each agency is 30 breast cases and up to 20 cervical cases. The total number of cases selected from each agency equals 50. If the client were randomly selected for breast and cervical abnormalities, both records are reviewed. If the client is selected for a cervical abnormality only, the breast record is not reviewed.

Creation of the BCCCP Data Abstraction Tool

MPRO uses an electronic abstraction tool they developed by adapting the BCCCP Screening and Follow-up Forms, and the CDC Performance Indicators. The performance indicators are used to assess each agency’s progress and to assist the Cancer Section in identifying program areas, which may require additional technical assistance. In addition, the indicators are also used as part of the Cancer Section’s decision-making process regarding award levels for each fiscal year. Although funding is not assigned solely on the basis of an agency’s scores on these indicators, the indicators are used as an important part of the information considered by the Cancer Section in determining appropriate funding levels.

The proposed performance indicators are organized based on the type of follow-up the client requires: Immediate or Short-term.

1. Immediate Follow-up (follow-up diagnostic testing must be completed within 30-60 days)
   Clients requiring immediate follow-up are reviewed according to the CDC standards of timeliness and completeness. These indicators are from the CDC’s Program Progress Review and will be used by the CDC in making funding decisions for Michigan’s BCCCP Program.
• **Timeliness** refers to the amount of time (measured in number of days) from an abnormal screening result to final diagnosis. Abnormal screening result refers to the result of either a CBE or MAM for breast screenings (whichever is the earliest abnormal result), or a PAP smear for cervical screenings.

• **Completeness** refers to the proper closure of all screening cycles. In the event of an abnormal screening result or cases in which diagnostic work-up is planned regardless of the result, a client’s record must include follow-up services, a final diagnosis and a treatment disposition.

2. Short-term follow-up (follow-up diagnostic testing that is completed within 3-7 months)

Clients requiring short-term follow-up are reviewed according to those standards identified in the BCCCP Medical protocol. This would include the following:

- CBE results of Probably Benign
- Mammogram results of ACR 3- Probably Benign
- Pap test results of ASC-US

**Reliability Testing of the MI BCCCP Data Abstraction Tool**

Data is abstracted from selected medical records by trained registered nurses using the BCCCP Data Abstraction Tool. MPRO performs reliability testing of the abstraction tool to ensure that data abstraction instructions are clear and understandable, allowing abstractors to obtain consistent answers. Reliability testing is done using the medical records obtained from the random sample of cases drawn from the study. MPRO strives to obtain an industry standard of an overall 90% reliability score for the abstraction tool.

**Data Abstraction**

The study evaluates data collected during a specified time frame from the previous fiscal year. The MDCH Cancer Section provides MPRO with a list of cases from the BCCCP database that identifies all patients screened in the past fiscal year who meet the following criteria:

- The screening occurred during the identified time frame of the previous fiscal year.
- An abnormal finding was identified on initial breast or cervical screening
- The coordinating agency responsible for this patient’s care is currently involved in the MI BCCCP.

MPRO randomly selects the specified number of cases based on the indicators developed for the data abstraction for each coordinating agency’s population of women with abnormal breast screening findings. Agencies are notified of the charts they need to review for this evaluation. The agency staff conducts the medical record abstraction on a password protected laptop once they have completed training from MPRO and successfully passed the reliability and validity testing by a score of greater than 90%.
Data Analysis

After the medical record data abstraction is completed, the data is sent to MPRO and uploaded into an Access file. MPRO performs a rate-based analysis of each coordinating agency’s adherence to selected CDC performance indicators. Each agency’s rate of adherence is compared to the statewide aggregate rate and the CDC standard. These analyses may be indicators of process problems and will assist agencies in identifying areas for quality improvement. MPRO will then develop these analyzes for each agency and the statewide aggregate.

Report Generation

Reports are generated to serve the following functions:
- Provide MDCH Cancer Section with aggregated findings for the entire State of Michigan.
- Provide MDCH Cancer Section with findings for individual coordinating agencies.
- Provide agencies specific measurements as feedback and a tool in the CQI effort.

MPRO forwards reports to MDCH Cancer Section for review and approval. Upon approval, copies will then be mailed to coordinating agencies with instructions on how to interpret the report and use reported findings for development of improvement plans.

Ongoing Quality Improvement Monitoring

Education Sessions

Since 1999, MPRO and MDCH staff jointly provided several education sessions to all local BCCCP agencies throughout MI. These sessions emphasized development of improvement plans using a rapid-cycle improvement method. This approach focused on small incremental improvement cycles that provided opportunities for rapid feedback and created building blocks for continuous improvement cycles. Frequent small improvements allow for ongoing evaluation of the process to determine whether the most appropriate issues are being addressed and if the effects of the improvements are measurable. This method allows for lessons learned in the first improvement cycle to be applied to subsequent cycles.

MPRO also provided an educational toolkit to each coordinating agency to assist in the process of self-evaluation and performance improvement using CQI methods. The toolkit provided materials on the following:
- An overview of the CQI process
- Successful techniques for building effective CQI teams
- Flow chart tools and models to guide participants in their analysis of processes involved in areas of poor performance
- A variety of CQI tools (e.g. sample cause and effect diagrams, force field analysis, and control charts) for thorough discussion in the educational sessions
- CQI process reporting formats.
**Technical Assistance**

MPRO provides technical assistance to MDCH as requested and to assist in the ongoing development of CQI goals to guide departmental and LCA CQI efforts. Through consultation, MPRO assists MDCH in further development and refinement of performance indicators and a BCCCP quality improvement strategic plan. MPRO is also available to provide telephone consultation to LCAs upon request.

At the end of the contract year, MPRO summarizes each coordinating agency’s outcomes and analyzes lessons learned. The statewide annual report includes a description of the project, goals and objectives, and a comprehensive record of achievement.

The continuing success of the QIP is due to the close collaborative working relationship between the MDCH Cancer Section and MPRO. The medical record chart audit was presented positively as part of an ongoing CQI process. Because of this, local agencies are very receptive in participating in chart reviews and in working with MPRO and the MDCH Cancer Section in developing and implementing individual agency quality improvement plans.

**MDCH Data Quality Reports**

On a monthly basis, MDCH staff review the MBCIS data for missing clinical information on screening and follow-up services delivered to BCCCP clients. This information needs to be sent to CDC twice yearly and determines funding levels for the next year. Program Data and Nurse Consultants develop specific reports to assist agencies in identifying the missing information. These reports vary depending on agency and data requirements and are followed by telephone consultation whenever possible to trouble shoot process issues with retrieving missing data.
How Caseload is Determined for the Michigan BCCCP

When Does a Client Count Toward Caseload?

A client counts toward annual caseload if the data entered in MBCIS indicate she has one or more screening services (i.e. Mammogram, CBE, Pap smear, Pelvic exam) paid for with Federal funds. Or, for the current fiscal year, a client will also count toward caseload if she is between 40 and 49 and has a screening mammogram paid for with State funds.

The fiscal year (FY) for which caseload counts is the one in which the earliest screening service (in the current screening cycle on MBCIS) took place. Cycles frequently stretch over two FY’s due to scheduling and the need for follow-up services. In such cases, the client counts toward caseload only in the earlier year. (Occasionally, for clinical reasons one woman may have 2 cycles in the same FY, both of which contribute to the caseload total.)

In addition to when the initial screening service took place and how it was funded, the remaining determinants of caseload are the program’s eligibility requirements. Specifically, the client receiving services must be between 40 and 64 years old, her enrollment status must be “active”, and her household income level must be at or below 250% poverty to count toward caseload. Please note that Family Planning clients do not count toward BCCCP caseload.

Reasons Why a Client “Screened This Year” May Not Count Toward Caseload

1. **Client Inactive**—the client has a designated status of “inactive” in MBCIS for the current FY.

2. **Over 250% poverty**—the client’s income exceeds program eligibility based on total household income and the number of household members.

3. **Caseload Prior FY**—even though a client has had one or more clinical services for the current FY, she has already been counted toward last year’s caseload because an eligible, earlier service in her screening cycle exists.

4. **Client under 40**—the client was not 40 years old at the start of her screening cycle.

5. **Funding Discrepancy**—if funding for clinical services is not recorded correctly in MBCIS, the client may not count toward caseload until all problems are fixed. Ensure that the client’s most recent screening cycle has at least one federally-funded, eligible, screening service. A State funded mammogram will complete this requirement if the client is aged 40 to 49 at the time of service.

6. **Client data entered after deadline**—the “date created” system variable in MBCIS for a client indicates that her data were entered into MBCIS after the deadline for data entry for the current FY. It is critical to note that the MBCIS data entry deadline is independent from billing deadlines for the Third Party Administrator (TPA).
August 13, 2007

Subject: FY 2007/2008 Local Funds Use for Additional Michigan Breast and Cervical Cancer Control Program Caseload

Dear Health Officer,

Several local coordinating agencies (LCAs) have expressed interest in ‘purchasing’ extra caseload above the caseload allocated to them by the Michigan Breast and Cervical Cancer Control Program (BCCCP). The BCCCP staff has determined that the third party administrator (TPA) for the program, Health Advantage, is able to accept funds directly from the LCAs only. Health Advantage will allocate a portion of the funds for administrative costs and a portion will fund reimbursement for screening and diagnostic services. Only procedure codes listed on the FY2008 BCCCP Unit Cost reimbursement rate schedule will be reimbursed. Additional services will not be reimbursed (e.g., facility fees). What this opportunity means is that any participating LCA can ‘purchase’ additional caseload for FY08 if the LCA has local funds and anticipates the need for additional caseload for the fiscal year.

Please note: No Coordination Funding will be paid from additional caseload purchased. Coordination Funding will remain based on your current FY08 caseload without any local funds included.

For a fee of $300 per woman, an LCA may purchase caseload slots for additional women above FY08 current caseload. This amount is based on a projected average cost per woman and includes administrative fees that will pay for all BCCCP-approved services a woman screened might need. So, for example, $30,000 will pay for up to 100 additional women over the LCA’s original caseload.

The $300 per woman fee is non-negotiable. Forecasting is not an exact science. We have projected the cost per woman at a level that we feel will ensure that sufficient funds are available to cover all additional women funded with local funds. This amount is based on past experience and inflated at a reasonable rate with fairness to the LCAs in mind. We will not be put in a position where the additional women will cost more than the local funds support, as we do not have any available funds to cover the balance.

There will be NO opportunity to receive funds back at the end of the fiscal year. There will be no exceptions. Therefore, in purchasing additional caseload, an agency is cautioned to be sure that the caseload is feasible to be screened by September 30, 2008. Please be sure to take into consideration the FY08 proposed BCCCP caseload offered in the mailing dated
August 3, 2007. Because of restrictions in the mechanisms for tracking women through MBCIS and the fact that many providers have contracts with multiple health departments, it is not possible to track spending by agency. Providers do not bill Health Advantage by agency, just by services rendered to BCCCP women.

If your LCA wishes to participate in this funding opportunity, please contact me by email or letter by Friday, September 14, 2007. This is a one-time offer for FY08. You will need to provide the following information:

- Additional caseload number
- Total funding amount ($300 times additional caseload number)

Do not send any local funds to Health Advantage at this time. Once we have heard back from interested LCAs, we will contact you with the proper procedures to transfer funds to Health Advantage.

As always, BCCCP state staff will continue to assist local staff in the tracking of caseload including any additional caseload purchased with local funds. Thank you for your continued support of the program.

Sincerely,

Paulette M. Valliere, Ph.D.
Manager, Breast and Cervical Cancer Control Unit
Cancer Prevention and Control Section

cc: BCCCP Coordinator
## FY2008 BCCCP Unit Cost Reimbursement Rate Schedule

<table>
<thead>
<tr>
<th>Screening Services</th>
<th>FY2008 BCCCP Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Screening Mammogram (Bilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>77057</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>77057-TC</td>
</tr>
<tr>
<td>c. Professional Only</td>
<td>77057-26</td>
</tr>
<tr>
<td><strong>2. Diagnostic Mammogram (Unilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>77055</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>77055-TC</td>
</tr>
<tr>
<td>c. Professional Only</td>
<td>77055-26</td>
</tr>
<tr>
<td><strong>3. Diagnostic Mammogram (Bilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>77056</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>77056-TC</td>
</tr>
<tr>
<td>c. Professional Only</td>
<td>77056-26</td>
</tr>
<tr>
<td><strong>4. Digital Screening Mammogram (Bilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>G0202</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>G0202-TC</td>
</tr>
<tr>
<td>c. Professional Only</td>
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</tr>
<tr>
<td><strong>5. Digital Diagnostic Mammogram (Unilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>G0206</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>G0206-TC</td>
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<tr>
<td>c. Professional Only</td>
<td>G0206-26</td>
</tr>
<tr>
<td><strong>6. Digital Diagnostic Mammogram (Bilateral)</strong></td>
<td></td>
</tr>
<tr>
<td>a. Global</td>
<td>G0204</td>
</tr>
<tr>
<td>b. Technical/Facility Only</td>
<td>G0204-TC</td>
</tr>
<tr>
<td>c. Professional Only</td>
<td>G0204-26</td>
</tr>
<tr>
<td><strong>7. Pap Test, Lab Component (in Bethesda System) - Read by Technician</strong></td>
<td>88164</td>
</tr>
<tr>
<td><strong>8. Pap Test – Rescreening, Lab Component (in Bethesda System) - Read by Technician</strong></td>
<td>88165</td>
</tr>
<tr>
<td><strong>9. Pap Test, Lab Component - Read by Pathologist</strong></td>
<td>88141</td>
</tr>
<tr>
<td><strong>12. Pap Test, Automated Thin Layer Preparation (Thin Prep) – Automated Screening</strong></td>
<td>88174</td>
</tr>
<tr>
<td>Screening Services</td>
<td>FY2008 BCCCP Rate</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>15. Office Visit - New Patient Partial Exam</td>
<td>39.20</td>
</tr>
<tr>
<td>16. Office Visit, Established Patient Full Exam</td>
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<td>17. Office Visit, Established Patient Partial Exam</td>
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<td>18. Breast or Cervical Consultation</td>
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<td>19. Colposcopy (Surgical Procedure Only)</td>
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<td>20. Colposcopy with Biopsy of the Cervix and Endocervical Curettage (Surgical Procedure Only)</td>
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<td>22. Colposcopy with Endocervical Curettage (Surgical Procedure Only)</td>
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<td>23. HPV Typing</td>
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## FY2008 BCCCP Unit Cost Reimbursement Rate Schedule

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<thead>
<tr>
<th>Diagnostic Services</th>
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<td>24. Surgical Pathology, Breast or Cervical Biopsy - Level IV</td>
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<tr>
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<td>37.59</td>
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<td>27. Fine Needle Aspiration of Superficial Breast Tissue, Using Imaging Guidance</td>
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<td>28. Fine Needle Aspiration, Breast Cyst (Surgical Procedure Only)</td>
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<td>32. Breast Biopsy, Excisional, Needle Core, Using Imaging Guidance</td>
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<td>33. Breast Biopsy, Excisional, Automated Vacuum Assisted or Rotating Biopsy Device, Using Imaging Guidance</td>
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## FY2008 BCCCP Unit Cost Reimbursement Rate Schedule

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<thead>
<tr>
<th>Diagnostic Services</th>
<th>FY2008 BCCCP Rate</th>
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<tr>
<td>34. Breast Biopsy, Excisional</td>
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<tr>
<td>a. Anesthesia services performed personally by anesthesiologist</td>
<td>00400-AA 82.75</td>
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<td>b. Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
<td>00400-AD 49.65</td>
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<tr>
<td>c. Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
<td>00400-QK 41.38</td>
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<tr>
<td>d. CRNA service: with medical direction by a physician</td>
<td>00400-QX 41.38</td>
</tr>
<tr>
<td>e. Anesthesiologist medically directs one CRNA</td>
<td>00400-QY 41.38</td>
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<tr>
<td>f. CRNA service: (supervised) without medical direction by a physician</td>
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<td>35. Breast Biopsy, Excision of Single Lesion Identified by Radiological Marker</td>
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<td>d. CRNA service: with medical direction by a physician</td>
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<td>e. Anesthesiologist medically directs one CRNA</td>
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<td>f. CRNA service: (supervised) without medical direction by a physician</td>
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<td>36. Breast Biopsy, Excision of Each Additional Lesion</td>
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<td>37. Pre-op Placement, Needle Localization Wire</td>
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<td>38. Pre-op Placement, Needle Localization Wire, Each Additional Lesion</td>
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<td>39. Image Guided Placement of Metallic Localization Clip, During Breast Biopsy</td>
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<tr>
<td>41. Endocervical Curettage (not part of D&amp;C)</td>
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<td>42. Stereotactic Localization of Breast Biopsy</td>
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<td>44. Radiological Examination, Surgical Specimen</td>
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<td>48. Cytopathology, Evaluation of Fine Needle Aspirate to determine Specimen Adequacy</td>
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<td>Diagnostic Services</td>
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<td><strong>49. Cytopathology, Interpretation and Report</strong></td>
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<td><strong>50. Surgical Pathology, Consultation and Report</strong></td>
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<td><strong>51. Pathology Consultation During Surgery</strong></td>
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<td><strong>52. Pathology Consultation During Surgery, First Tissue Block, with Frozen Section(s), Single Specimen</strong></td>
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<td><strong>54. Cytopathology, Selective Cellular Enhancement Technique with Interpretation (e.g., Liquid Based Slide Preparation Method), except Cervical or Vaginal</strong></td>
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<td>53.64</td>
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<tr>
<td><strong>55. Case Management</strong></td>
<td>99499</td>
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Anesthesia Required Modifiers and Payment Calculation  
(Each claim line billing for anesthesia services must include one of the following modifiers. The modifier used will generate a calculated fee screen as described under “Payment Rate”)

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<tr>
<th>Modifier</th>
<th>Description</th>
<th>Payment Rate</th>
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<td>(3 ABUs + 2 Time Units) X $16.55</td>
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<tr>
<td>AD</td>
<td>(3 ABUs) X $16.55</td>
<td>Flat rate of 3 ABUs, no time units</td>
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<tr>
<td>QK</td>
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<td>QX</td>
<td>(3 ABUs + 2 Time Units) X $16.55</td>
<td>50%</td>
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<tr>
<td>QY</td>
<td>(3 ABUs + 2 Time Units) X $16.55</td>
<td>50%</td>
</tr>
<tr>
<td>QZ</td>
<td>(3 ABUs + 2 Time Units) X $16.55</td>
<td>100%</td>
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</tbody>
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*2007 Medicare Conversion Factor = $16.55
<table>
<thead>
<tr>
<th>Abnormal Cervical Screening Follow-up Services</th>
<th>FY2008 BCCCP Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pap Test, Lab Component (in Bethesda System) - Read by Technician</td>
<td>88164</td>
</tr>
<tr>
<td>2. Pap Test – Rescreening, Lab Component (in Bethesda System) – Read by Technician</td>
<td>88165</td>
</tr>
<tr>
<td>3. Pap Test, Lab Component - Read by Pathologist</td>
<td>88141</td>
</tr>
<tr>
<td>6. Pap Test, Automated Thin Layer Preparation (Thin Prep) – Automated Screening</td>
<td>88174</td>
</tr>
<tr>
<td>8. Office Visit, New Patient Partial Exam (Pelvic/Pap Exam Only)</td>
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<td>99202</td>
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<td>10. Cervical Consultation (Cervical Only)</td>
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<td>99243</td>
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<td>99244</td>
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<td>11. Colposcopy (Surgical Procedure Only)</td>
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<tr>
<td>12. Colposcopy with Biopsy of Cervix and Endocervical Curettage (Surgical Procedure Only)</td>
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<tr>
<td>13. Colposcopy with Biopsy of Cervix (Surgical Procedure Only)</td>
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<tr>
<td>14. Colposcopy with Endocervical Curettage (Surgical Procedure Only)</td>
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## Abnormal Cervical Screening Follow-up Services

<table>
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<th>Service Description</th>
<th>Code</th>
<th>FY2008 BCCCP Rate</th>
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</thead>
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<tr>
<td>Eligible</td>
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<td></td>
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<tr>
<td>a. Global</td>
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<tr>
<td>b. Technical/Facility Only</td>
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<td>52.14</td>
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<td>c. Professional Only</td>
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<td>37.59</td>
</tr>
<tr>
<td><strong>16. Surgical Pathology - Level V, Cervical Biopsy Only</strong></td>
<td></td>
<td></td>
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<tr>
<td>Eligible</td>
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<td></td>
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<td><strong>17. Biopsy, Cervix Uteri, Single or Multiple, or Local Excision of Lesion, with or without Fulguration (Surgical Procedure Only)</strong></td>
<td>57500</td>
<td>122.67</td>
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<tr>
<td><strong>18. Endocervical Curettage (not part of D&amp;C)</strong></td>
<td>57505</td>
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<tr>
<td><strong>19. Surgical Pathology, Consultation and Report (Cervical Only)</strong></td>
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<td>173.22</td>
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<td><strong>20. HPV Typing</strong></td>
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<td><strong>Only approved for follow-up</strong></td>
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<td><strong>21. Case Management</strong></td>
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<td>Abnormal Cervical Screening Follow-up Services</td>
<td>FY2008 BCCCP Rate</td>
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<tr>
<td>1. Pap Test, Lab Component (in Bethesda System) - Read by Technician</td>
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<td>2. Pap Test – Rescreening, Lab Component (in Bethesda System) – Read by Technician</td>
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<tr>
<td>3. Pap Test, Lab Component - Read by Pathologist</td>
<td>88141</td>
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<td>6. Pap Test, Automated Thin Layer Preparation (Thin Prep) – Automated Screening</td>
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<td>8. Office Visit, New Patient Partial Exam (Pelvic/Pap Exam Only)</td>
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<td>9. Office Visit, Established Patient Partial Exam (Pelvic/Pap Exam Only)</td>
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<td>11. Colposcopy (Surgical Procedure Only)</td>
<td>57452</td>
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<tr>
<td>12. Colposcopy with Biopsy of Cervix and Endocervical Curettage (Surgical Procedure Only)</td>
<td>57454</td>
<td>145.94</td>
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<td>13. Colposcopy with Biopsy of Cervix (Surgical Procedure Only)</td>
<td>57455</td>
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<td>14. Colposcopy with Endocervical Curettage (Surgical Procedure Only)</td>
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<td>126.77</td>
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<td>Abnormal Cervical Screening Follow-up Services</td>
<td>FY2008 BCCCP Rate</td>
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<td>15. Surgical Pathology - Level IV, Cervical Biopsy Only</td>
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<tr>
<td>Eligible</td>
<td>89.73</td>
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<tr>
<td>a. Global</td>
<td>52.14</td>
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<tr>
<td>b. Technical/Facility Only</td>
<td>37.59</td>
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<td>16. Surgical Pathology - Level V, Cervical Biopsy Only</td>
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<tr>
<td>a. Global</td>
<td>78.88</td>
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<td>17. Biopsy, Cervix Uteri, Single or Multiple, or Local Excision of Lesion, with or without Fulguration (Surgical Procedure Only)</td>
<td>122.67</td>
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<td>18. Endocervical Currettage (not part of D&amp;C)</td>
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<td>19. Surgical Pathology, Consultation and Report (Cervical Only)</td>
<td>173.22</td>
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<td>20. HPV Typing</td>
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<td>** Only approved for follow-up **</td>
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<td>21. Case Management</td>
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<td>CPT</td>
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<tr>
<td>57460</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix</td>
<td>$302.81</td>
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<td>57461</td>
<td>Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix</td>
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<td>57520</td>
<td>Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser</td>
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<td>57522</td>
<td>Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser; loop electrode excision</td>
<td>$253.33</td>
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<td>Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method</td>
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<td>58110</td>
<td>Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)</td>
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<td>174.0</td>
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<td>174.1</td>
<td>Malignant neoplasm of female breast; Central portion</td>
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<td>Malignant neoplasm of female breast; Lower-inner quadrant</td>
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<td>Malignant neoplasm of female breast; Upper-outer quadrant</td>
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<td>Malignant neoplasm of female breast; Lower-outer quadrant</td>
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<td>Malignant neoplasm of female breast; Axillary tail</td>
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<td>Malignant neoplasm of cervix uteri; Cervix uteri, unspecified</td>
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<td>182.0</td>
<td>Malignant neoplasm of body of uterus; Corpus uteri, except isthmus</td>
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<td>Malignant neoplasm without specification of site; Other</td>
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<td>216.5</td>
<td>Benign neoplasm of skin; skin of trunk, (includes breast and chest wall)</td>
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<td>217</td>
<td>Benign neoplasm of breast</td>
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<td>221.8</td>
<td>Benign neoplasm of other female genital organs; Other specified sites of female genital organs</td>
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<td>Neoplasm of uncertain behavior of genitourinary organs; Other and unspecified female genital organs</td>
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<td>Neoplasm of uncertain behavior of other and unspecified sites and tissues; Breast</td>
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<td>Other disorders of breast; Hypertrophy of breast</td>
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<td>Other disorders of breast; Fat necrosis of breast</td>
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<td>Other disorders of breast; Signs and symptoms in breast; Other</td>
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<td>611.9</td>
<td>Other disorders of breast; Unspecified breast disorder</td>
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<td>616.89</td>
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<td>622.0</td>
<td>Noninflammatory disorders of cervix; Erosion and ectropion of cervix</td>
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<td>Noninflammatory disorders of cervix; Leukoplakia of cervix (uteri)</td>
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<td>Noninflammatory disorders of cervix; Hypertrophic elongation of cervix</td>
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<td>Noninflammatory disorders of cervix; Mucous polyp of cervix</td>
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<td>Noninflammatory disorders of cervix; Other specified noninflammatory disorders of cervix</td>
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<td>Noninflammatory disorders of cervix; Unspecified noninflammatory disorder of cervix</td>
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<td>625.8</td>
<td>Pain and other symptoms associated with female genital organs; Other specified symptoms associated with female genital organs</td>
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<td>625.9</td>
<td>Pain and other symptoms associated with female genital organs; Unspecified symptom associated with female genital organs</td>
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<td>Disorders of menstruation and other abnormal bleeding from female genital tract; Excessive or frequent menstruation</td>
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<td>626.6</td>
<td>Disorders of menstruation and other abnormal bleeding from female genital tract; Metrorrhagia</td>
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<td>Disorders of menstruation and other abnormal bleeding from female genital tract; Postcoital</td>
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<td>793.80</td>
<td>Nonspecific abnormal findings on radiological and other examination of body structure; Breast; Abnormal mammogram, unspecified</td>
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<td>Other and nonspecific abnormal cytological, histological, immunological and DNA test findings; Abnormal Papanicolaou smear of cervix and cervical HPV; Abnormal glandular Papanicolaou smear of cervix</td>
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<td>795.01</td>
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<td>795.02</td>
<td>Other and nonspecific abnormal cytological, histological, immunological and DNA test findings; Abnormal Papanicolaou smear of cervix and cervical HPV; Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (HSIL)</td>
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<td>Other and nonspecific abnormal cytological, histological, immunological and DNA test findings; Abnormal Papanicolaou smear of cervix and cervical HPV; Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LSIL)</td>
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<td>795.05</td>
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<td>922.0</td>
<td>Contusion of trunk; Breast</td>
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<td>V10.3</td>
<td>Personal history of malignant neoplasm; Breast</td>
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<td>V10.41</td>
<td>Personal history of malignant neoplasm; Genital organs; Cervix uteri</td>
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<td>V10.42</td>
<td>Personal history of malignant neoplasm; Genital organs; Other parts of uterus</td>
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<td>V10.43</td>
<td>Personal history of malignant neoplasm; Genital organs; Ovary</td>
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<td>V10.44</td>
<td>Personal history of malignant neoplasm; Genital organs; Other female genital organs</td>
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<td>V15.89</td>
<td>Other personal history presenting hazards to health; Other specified personal history presenting hazards to health; Other</td>
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<td>V16.3</td>
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<td>V45.71</td>
<td>Acquired absence of organ; Acquired absence of breast</td>
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<td>Follow-up examination; Following surgery; Following surgery, unspecified</td>
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<td>Follow-up examination; Following surgery; Following other surgery</td>
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<td>V69.2</td>
<td>Problems related to lifestyle; High-risk sexual behavior</td>
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<td>V71.1</td>
<td>Observation and evaluation for suspected conditions not found; Observation for suspected malignant neoplasm</td>
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<td>V72.31</td>
<td>Special investigations and examinations; Gynecological examination; Routine gynecological examination</td>
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<td>V72.32</td>
<td>Special investigations and examinations; Gynecological examination; Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial</td>
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<td>V72.5</td>
<td>Special investigations and examinations; Radiological examination, not elsewhere classified</td>
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<td>V72.6</td>
<td>Special investigations and examinations; Laboratory examination</td>
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<td>V72.84</td>
<td>Special investigations and examinations; Pre-operative examination, unspecified</td>
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<td>V76.10</td>
<td>Special screening for malignant neoplasms; Breast; Breast screening, unspecified</td>
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<td>V76.11</td>
<td>Special screening for malignant neoplasms; Breast; Screening mammogram for high-risk</td>
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<td>V76.12</td>
<td>Special screening for malignant neoplasms; Breast; Other screening mammogram</td>
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<td>V76.19</td>
<td>Special screening for malignant neoplasms; Breast; Other screening breast examination</td>
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<td>Other laboratory</td>
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<td>Biopsy pathology</td>
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<td>Other pathology</td>
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<td>0320</td>
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<td>Anesthesia incident to other diagnostic services</td>
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<tr>
<td>0520</td>
<td>General classification free-standing clinic</td>
<td></td>
</tr>
<tr>
<td>0521</td>
<td>Rural health clinic</td>
<td></td>
</tr>
<tr>
<td>0523</td>
<td>Family practice clinic</td>
<td></td>
</tr>
<tr>
<td>0529</td>
<td>Other free-standing clinic</td>
<td></td>
</tr>
<tr>
<td>0920</td>
<td>General classification - other diagnostic services</td>
<td></td>
</tr>
<tr>
<td>0923</td>
<td>Pap smear</td>
<td></td>
</tr>
</tbody>
</table>
### FY 08 Approved Place of Service Codes for the BCCCP and WISEWOMAN Programs

<table>
<thead>
<tr>
<th>Place of Service Codes</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Indian Health Service Free Standing Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider Based Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free Standing Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider Based Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to tribal members admitted as inpatients or outpatients.</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
<td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>A facility/unit that moves from place-to-place equipped to provide preventative, screening, diagnostic, and/or treatment services.</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility, other than a psychiatric, which primarily provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services by, or under the supervision of a physician to patients admitted for a variety of medical conditions.</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
<td>A portion of the hospital which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
</tr>
</tbody>
</table>
## FY 08 Approved Place of Service Codes for the BCCCP and WISEWOMAN Programs

<table>
<thead>
<tr>
<th>Place of Service Codes</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>A freestanding facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td>A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventative, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
<td>A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary care under the general direction of a physician.</td>
</tr>
<tr>
<td>71</td>
<td>Public Health Clinic</td>
<td>A facility maintained by either State of local health departments that provides ambulatory primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
<td>A certified clinic which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
<td>A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician’s office.</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
<td>Other Place of Service not identified above.</td>
</tr>
<tr>
<td>Hold Code</td>
<td>Hold Code Descriptor As It Appears on the Explanation of Payments (EOP)</td>
<td>BCCCP Hold Code Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>AB</td>
<td>Benefit not covered for age</td>
<td>BCCCP services inappropriate for age of client</td>
</tr>
<tr>
<td>AR</td>
<td>Claims not authorized by LCA</td>
<td>Claim requires authorization by LCA</td>
</tr>
<tr>
<td>CH</td>
<td>Charge less than zero</td>
<td>Amount charged for service is less than zero</td>
</tr>
<tr>
<td>E2</td>
<td>Requesting Primary Carrier's EOB</td>
<td>Primary insurance EOB missing</td>
</tr>
<tr>
<td>HC</td>
<td>Historical Claim Line</td>
<td>Claim line to be reviewed by state staff</td>
</tr>
<tr>
<td>I9</td>
<td>ICD-9 code</td>
<td>Non-Program ICD-9 code</td>
</tr>
<tr>
<td>IC</td>
<td>Insurance Payment</td>
<td>Primary insurance paid more than the BCCCP rate - claim paid in full</td>
</tr>
<tr>
<td>IP</td>
<td>Insurance Partial Payment</td>
<td>Primary insurance is less than the BCCCP rate</td>
</tr>
<tr>
<td>IV</td>
<td>Code No longer valid</td>
<td>No longer a valid CPT/HCPCS or ICD-9 code</td>
</tr>
<tr>
<td>JL</td>
<td>Revenue Code Not In Contract</td>
<td>Non-Program Revenue Code</td>
</tr>
<tr>
<td>JM</td>
<td>CPT/HCPCS Code not in Contract - OR - billing with an invalid program ICD-9 code</td>
<td>Non-Program CPT/HCPCS code or a BCCCP service billed with a WISEWOMAN ICD-9 code and vice versa</td>
</tr>
<tr>
<td>JT</td>
<td>No Related Service On File</td>
<td>Claim line pending related service</td>
</tr>
<tr>
<td>JU</td>
<td>No Related Service On File</td>
<td>Claim line rejected for no related service (e.g. anesthesia billed, with no related surgery) then rejected</td>
</tr>
<tr>
<td>N5</td>
<td>Prior FY date</td>
<td>Service date for prior fiscal year</td>
</tr>
<tr>
<td>N6</td>
<td>State Override</td>
<td>State BCCCP approved payment</td>
</tr>
<tr>
<td>N8</td>
<td>Provider not enrolled</td>
<td>Provider/Billing Agency not enrolled in MBCIS</td>
</tr>
<tr>
<td>N9</td>
<td>Service Partially / Fully Done By Another Provider</td>
<td>Service performed by another provider</td>
</tr>
<tr>
<td>ND</td>
<td>Duplicate Claim</td>
<td>Duplicate claim</td>
</tr>
<tr>
<td>NE</td>
<td>Place of Service not covered</td>
<td>Inappropriate site for care given</td>
</tr>
<tr>
<td>NP</td>
<td>Non-participating Provider</td>
<td>Provider/Billing Agency not enrolled in MBCIS</td>
</tr>
<tr>
<td>PB</td>
<td>Authorization Required</td>
<td>Claim requires authorization by LCA</td>
</tr>
<tr>
<td>PS</td>
<td>Program Service Mis-match</td>
<td>Claim information not matching MBCIS information or service not in MBCIS</td>
</tr>
<tr>
<td>WC</td>
<td>Client is not a WISEWOMAN client</td>
<td>Not a WISEWOMAN Client</td>
</tr>
<tr>
<td>XA</td>
<td>Denied Claim Paid</td>
<td>Claim denied in error. Denied claim now paid</td>
</tr>
<tr>
<td>XB</td>
<td>Payment Error</td>
<td>Claim paid in error. TPA reversed payment made in error</td>
</tr>
<tr>
<td>VR</td>
<td>Void and Replace</td>
<td>New claim number issued</td>
</tr>
<tr>
<td>RE</td>
<td>Refund</td>
<td>Vendor sent in a refund check to Health Advantage</td>
</tr>
<tr>
<td>TK</td>
<td>Take backs</td>
<td>MDCH has requested money back from a provider</td>
</tr>
</tbody>
</table>
MEMORANDUM

DATE: March 28, 2007

TO: BCCCP Coordinators

FROM: Cathy Blaze
Data Quality/Reimbursement Analyst
Cancer Control Services Project

SUBJECT: Blue Cross Blue Shield (BCBS) and certain UAW Health Care Policies

It has recently come to our attention that individuals covered under certain BCBS UAW health care policies can receive services from health departments but these services will not be paid for by their insurance. This means that these women should receive their screening services from a provider other than the health department so that services are paid by insurance and BCCCP is the payer of last resort.

Below are the health plan policy and group numbers that are affected:

- General Motors – group numbers 83100 – 83540
- Delphi – group numbers 72100 - 72524
- Ford – group numbers 87240 – 87297 & 89750 – 87973
- DaimlerChrysler - group numbers 82100 - 82900
- Visteon – group numbers 73111 – 73200

What does this mean?

Any woman that has BCBS insurance with one of the above group numbers needs to be referred to a subcontracted provider for her services.

What happens if the only facility for screening services in the county is a health department?

Provide the screening services for these women at the health department as usual. Billing will follow the same procedure that is used for resubmission/corrections for end of fiscal year billing. The claim must be faxed to Cathy Blaze (517/324-7324) with the following information written at the top of each claim:

- MBCIS #
- Authorization Date
- “BCBS UAW health plan”
- Group plan number
Failure to follow the above procedure could result in claims not being paid. If you have questions or need assistance, please contact Cathy Blaze at 517-324-7304 or cblaze@mphi.org.
April 25, 2008

Dear Provider:

Thank you for your continued excellence and dedication to providing high quality services to our members. We strive to provide high quality services as well, through the timely and accurate processing of claims.

There have been some concerns brought to our attention recently involving payments being routed to members rather than providers. The following information is being provided to you in an effort to alleviate the above concern and enhance the turnaround time on all claims that are submitted.

Please be sure that each claim that is submitted for services received by a BCCCP member includes the following:

- On the CMS 1500 please check “YES” in box 27
- On the UB04 please ensure that box 2 contains the information for the person/group who should receive payment if it differs from the person/group indicated in box 1
- On electronic claims please verify that loop 2300, CLM 08 (Claim Information Section), “Assignment of Benefits Indicator” is set to “YES”

In addition to the above steps, please note that all services covered by BCCCP and provided to current members of BCCCP do not require a co-pay. These services include:

- Family Planning/BCCCP Joint Project services
- Breast health services
- Cervical health services
- WISEWOMAN services (if applicable)

If you have any questions regarding the information above please contact the Michigan Breast and Cervical Cancer Control Program’s claim line at 866-930-6324.

Sincerely,

BCCCP/Health Advantage, Inc.
Breast and Cervical Cancer Control Program
Reimbursement Policy for Scheduling BCCCP Clients
Annual Exam and Screening Services

Policy for Reimbursement of BCCCP Clients Screening and Diagnostic Services

REVISED*

Effective Date - August 15, 2007

*This policy replaces the following two policies:
1. Policy for Reimbursement of Screening and Diagnostic Services – Effective February 1, 2007

Rationale for Policy Revision
1. Provide a mechanism for BCCCP coordinators to schedule annual office visits for screening services that would coincide with processes in place at provider offices and clinics.
2. Clarify BCCCP reimbursement of specific screening and diagnostic services according to program and CDC guidelines.
3. Identify specific screening and diagnostic services that require approval from BCCCP Nurse Consultants for reimbursement.

Policy Statement
The purpose of this policy is to assure:
1. Adherence to program guidelines in providing and reimbursing for both screening and diagnostic services provided to BCCCP Clients.
2. Accurate reimbursement of program services.

Policy Summary:
The following is a summary of key changes in this policy:
1. MBCIS will automatically populate the Breast/Cervical Anniversary Dates AND Reminder Dates fields 1 year (365 days) from the FIRST OFFICE VISIT EXAM DATE the client was seen from the previous year.
2. Screening mammograms will NOT be reimbursed if performed prior to 365 days from the date of the previous SCREENING Mammogram date entered in MBCIS.
3. Agency staff can physically change the system’s anniversary and reminder dates to coincide with the needs of the woman or the Pap test due date. The date must be greater than 365 days from the FIRST office visit exam date of the previous year for the office visit to be reimbursed.
4. Clarification of services reimbursed by the program has been separated into Screening Services and Diagnostic Services to assist the coordinator and provider in determining reimbursement.
5. Reimbursement of Pap tests for clients who have received a hysterectomy has been added.
Procedure
A. Reimbursement of SCREENING Services Provided to BCCCP Clients
   1. OFFICE VISITS -
      a. Description – SCREENING Office Visit Exam may include any or all of the following: CBE, Pelvic Exam, Pap test – if eligible see # 3- Pap Tests on page 4)
      
      b. Reimbursement - ONE (1) Annual Screening Office Visit Exam will be reimbursed per fiscal year.
         • Office Visit Exam MUST BE > 365 days from FIRST office visit exam date of the previous year that was entered in the Michigan Breast and Cervical Information System (MBCIS)

Example 1 –Office Visits

<table>
<thead>
<tr>
<th>Service</th>
<th>Date Received</th>
<th>Breast/Cervical Anniversary/Reminder Due Date</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST Annual Screening Office Visit Exam</td>
<td>12/13/2006</td>
<td>12/13/2007&lt;br&gt;Breast AND Cervical Anniversary Date and Reminder Dates will be 12/13/2007 (See Table 1 and Table 2)</td>
<td>Annual Screening Office Visit Exams performed prior to 12/13/2007 will be DENIED payment.</td>
</tr>
</tbody>
</table>

   c. MBCIS Anniversary/Reminder Date Calculation

   Anniversary Date
   • The anniversary date will automatically be set to 365 days for BOTH breast and cervical from the FIRST office visit exam date of the previous year that was entered in MBCIS)
   • MBCIS will automatically populate the Breast/Cervical Anniversary Dates AND Reminder Dates fields 1 year (365 days) from the FIRST OFFICE VISIT EXAM Date entered in the Service Summary (see examples below).

   NOTE: Subsequent Office Visit Exams/Consults WILL NOT change the anniversary/reminder dates.

   • Anniversary/Reminder dates will be calculated on a nightly basis allowing us to account for any changes to screening services.
   • The generic reminder exam type will now be office visit codes. (See Table 2)
d. **NOTE:**

- It is the LCA’s responsibility to monitor adherence to annual exam dates especially for those clients who may or may not be due for Pap tests.

- Pap test due dates are determined ONLY by the date found in “Client Eligible for Pap Test” Field in MBCIS NOT BY THE CERVICAL ANNIVERSARY DATE

- Agency staff can physically change the system’s anniversary and reminder dates to coincide with the needs of the woman or the Pap test due date. The date must be **greater than 365 days** from the FIRST office visit exam date of the previous year for the office visit to be reimbursed.

2. **MAMMOGRAMS**
   
   a. Description – SCREENING Mammogram includes bilateral views.

   **NOTE:** Based on a woman’s history, a Diagnostic Mammogram may be ordered as a screening.

   b. Reimbursement - Screening mammogram (or if diagnostic ordered in place of screening based on woman’s history) – **ONE** within a 12 month (365 day) time period
• Screening mammograms will **NOT** be reimbursed if performed prior to **365 days** from the date of the previous SCREENING Mammogram date entered in MBCIS. (See Example 2)
• Mammograms that are unsatisfactory will need to be repeated. BCCCP will reimburse for the repeated test.

c. **MBCIS Date Calculation**
• No mammogram reminder date will be populated in MBCIS.

**NOTE:**
• Agencies need to inform Clients, Providers, and Mammography Facilities that BCCCP will **NOT** reimburse for Screening Mammograms < **365 days** from previous exam.

Example 2 - Mammograms

<table>
<thead>
<tr>
<th>Service</th>
<th>Date Received</th>
<th>Reminder Due Date</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Mammogram</td>
<td>8/4/2006</td>
<td>No mammogram reminder date will be populated in MBCIS</td>
<td></td>
</tr>
<tr>
<td>(As part of annual screening – DOES NOT include Diagnostic Mammograms as follow-up for abnormal Screening Mammograms or post biopsy)</td>
<td></td>
<td>Client should be scheduled to receive next mammogram AFTER <strong>8/4/2007</strong>.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening Mammograms performed, (&lt; 365 days from previous SCREENING mammogram date) will be <strong>DENIED</strong> payment</td>
<td></td>
</tr>
</tbody>
</table>

3. **PAP TESTS** - Refer to the BCCCP “Pap Test Screening Interval and Reimbursement Policy - October 2006” for guidelines on Pap test reimbursement
   a. **Description** – Frequency of test is based on type and result of Pap test
      • Conventional Pap test – annual Pap test (one year- 365 days after previous exam date) until 3 consecutive negative Pap tests obtained in 5 year time-period
      • Liquid Based Pap test – every two years (two years after previous exam date) until 3 consecutive negative Pap tests obtained in 5 year time-period
      • After 3 consecutive, normal Pap tests within 5 years are obtained – Pap test every three years (three years after previous exam date) for Conventional or Liquid Based
EXCEPTION - Pap Testing for Abnormal Appearing Cervix
Pap tests performed for abnormal pelvic exam (due to abnormal appearing cervix or a part of a rule/out cervical cancer diagnosis) NEED TO BE AUTHORIZED from a MDCH Nurse Consultant who will enter the Pap into MBCIS and approve reimbursement.

b. Reimbursement - Refer to the BCCCP “Pap Test Screening Interval and Reimbursement Policy - October 2006” for guidelines on Pap test reimbursement
   • SCREENING Pap tests performed prior to Client Eligible for Pap Test Date will be DENIED payment
   • Pap tests that are unsatisfactory will need to be repeated. BCCCP will reimburse for the repeated test.

c. MBCIS Date Calculation
   • MBCIS will automatically populate the Client Eligible for Pap Test Date Field.
   • Pap Testing on Hysterectomy Clients
     Clients that have had a hysterectomy and do not have a cervix as recorded in the Medical History tab on MBCIS will show a Pap test eligibility date of 12-31-9999. These clients are NOT ELIGIBLE for Pap tests in our program. (See Table 3)

EXCEPTION: Clients with History of Hysterectomy Performed for CERVICAL CANCER
Pap tests NEED TO BE AUTHORIZED from a MDCH Nurse Consultant who will enter the Pap into MBCIS and approve reimbursement.

Table 3

<table>
<thead>
<tr>
<th>Anniversary Dates</th>
<th>12-31-9999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast 03-21-2008</td>
<td></td>
</tr>
<tr>
<td>Cervical 03-21-2008</td>
<td></td>
</tr>
<tr>
<td>Client Eligible for Pap Test</td>
<td>12-31-9999</td>
</tr>
</tbody>
</table>

All fields marked with * are required

B. Reimbursement of DIAGNOSTIC Services Provided to BCCCP Clients
1. OFFICE VISITS/BREAST CONSULTS/CERVICAL CONSULTS
   a. Description – Office visit or consult billed as part of follow-up for an abnormal breast screening test result (either CBE or Mammogram) OR abnormal Cervical screening test result
   b. Reimbursement
• **ONE** (1) office visit/consult as **follow-up** for an abnormal breast/cervical screening test result.

**NOTE:** **NO MORE THAN TWO** office visits and/or consults will be reimbursed per fiscal year unless prior authorization is obtained from BCCCP Nurse Consultants.

**EXCEPTION:** No prior authorization is needed for consult/office visit exam post breast biopsy.

2. **DIAGNOSTIC MAMMOGRAMS**
   a. Description – Follow-up mammogram as per radiologist’s recommendation
   b. Reimbursement - **ONE** within a 12-month time period (<365 days) for initial follow-up of screening mammogram results as per radiologist recommendation

**NOTE:** No prior authorization is needed for the first diagnostic mammogram as follow-up to an abnormal CBE or Screening Mammogram result of ACR 0.

3. **ULTRASOUNDS**
   a. Reimbursement - **ONE** Ultrasound exam performed within a 12 month time-period as part of the INITIAL DIAGNOSTIC follow-up to rule out or confirm a cyst vs. solid lesion.
   b. Prior authorization from MDCH Nurse Consultants required for additional ultrasound testing

4. **PAP TESTS RESULTS OF:**
   a. Atypical Glandular Cells (AGC)
      • Colposcopy and Endometrial Curettage (ECC) need to be performed on women Pap test results of AGC
      • **For women >age 34,** an endometrial biopsy (EMB), in addition to ECC and colposcopy needs to be performed
      • Once the date for the EMB has been determined, the EMB will need to be approved from a MDCH Nurse Consultant who will enter it into MBCIS
      • EMB’s will **ONLY** be reimbursed for Pap test results of AGC
   b. High -Grade Squamous Intraepithelial Lesion (HSIL) or AGC Pap with Colp/Biopsy result < CIN II.
      • Diagnostic LEEP’s or Cone’s may **ONLY** be performed on women with Pap test results of HSIL or AGC Pap and a colposcopy/biopsy result of not cancer/atypia/CIN I.
      • Once the pathologist has confirmed both Pap and histology results, and the clinician has determined the procedure/date, the
MDCH Nurse-Consultant needs to be contacted to approve reimbursement of the procedure(s) and enter the information into MBCIS.

5. FOLLOW-UP PAP TESTS
   a. Reimbursement – Only Pap tests performed according to the medical protocol for follow-up of screening Pap test abnormalities will be reimbursed.
   b. High Risk HPV Tests
      • **ONE** High Risk (HR) HPV test within a 12 month time-period may be performed as follow-up for an ASC-US Pap test only

      **NOTE:** More than one HR - HPV test/year or HR-HPV tests performed for Pap test results other than ASC-US will be denied.

C. Monitoring Reports
   1. MDCH Responsibilities - Submit weekly reports to agencies identifying clients whose payments will be reversed if they:
      • Present for annual office visit < 365 days from previous office visit
      • Receive Screening Mammogram < 365 days from previous screening mammogram date
   2. LCA Responsibilities - Implement processes that monitor the following
      • Accurate annual exam notification of clients and what will be performed during the exam (combination of CBE, Pap test, and Pelvic exam based on client due dates)
      • **ALL** breast and cervical biopsies, including fine needle aspirations for cysts.
      • **ALL** imaging procedures (mammograms, ultrasounds) for short-term follow-up beyond the initial screening – this includes 6-month follow-up mammogram and/or ultrasound.
      • **ALL** Pap tests for short-term follow-up beyond the initial screening Pap test – including 6-month follow-up Pap tests after colposcopy.
### BCCCP Reimbursement Review Summary

**SCREENING SERVICES**  
*Effective August 15, 2007*

<table>
<thead>
<tr>
<th>SCREENING Services</th>
<th>Time Frame</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Office Visit</td>
<td>≥ 365 days from previous FIRST annual screening office visit</td>
<td>Will reimburse <strong>ONE/year</strong> (365 days)</td>
</tr>
<tr>
<td>Screening Mammogram</td>
<td>≥ 365 days from previous <strong>SCREENING</strong> Mammogram</td>
<td>Will reimburse <strong>ONE/year</strong> (365 days)</td>
</tr>
<tr>
<td>Screening Pap tests</td>
<td>Frequency depends on type and result of Pap test - Refer to the BCCCP “Pap Test Screening Interval and Reimbursement Policy”</td>
<td>Reimbursement denied if prior to “Client Eligible for Pap Test” Date unless prior authorization obtained.</td>
</tr>
<tr>
<td>Screening Pap Tests – Hysterectomy Clients – Performed for CERVICAL CANCER</td>
<td>Frequency depends on type and result of Pap test - Refer to the BCCCP “Pap Test Screening Interval and Reimbursement Policy”</td>
<td>Prior authorization required prior to Pap test being preformed</td>
</tr>
<tr>
<td>Screening Pap Tests – Hysterectomy Clients – Performed for NON-Cervical Cancer</td>
<td><strong>Not-Eligible</strong> to Receive Pap tests</td>
<td>Reimbursement will be <strong>denied</strong></td>
</tr>
</tbody>
</table>
**BCCCP Reimbursement Review Summary**

**DIAGNOSTIC SERVICES**

**Effective August 15, 2007**

**NOTE:** Time Frame for each of the following Diagnostic Services is variable and depends on the type of follow-up required.

<table>
<thead>
<tr>
<th>DIAGNOSTIC Services</th>
<th>Reimbursement</th>
</tr>
</thead>
</table>
| Office Visits/Breast Consults/Cervical Consults | • ONE (1) office visit/consult as follow-up for an abnormal breast/cervical screening test result.  

**NOTE:** NO MORE THAN TWO office visits and/or consults will be reimbursed per fiscal year unless prior authorization is obtained  

**Exception:** NO prior authorization is needed for consult/office visit exam post breast biopsy. |
| Diagnostic Mammograms | • ONE within a 12-month time period (<365 days) for initial follow-up of screening mammogram results as per radiologist recommendation  

**NOTE:** NO prior authorization is needed for the first diagnostic mammogram as follow-up to an abnormal CBE or Screening Mammogram result of ACR 0. |
| Ultrasounds | • ONE Ultrasound exam performed within a 12-month time-period as part of the INITIAL DIAGNOSTIC follow-up to rule out or confirm a cyst vs. solid lesion.  

• Prior authorization required for additional ultrasound testing |
| AGC Pap Test Result | • For women < age 35, ECC and colposcopy/biopsy  

• For women ≥ age 35, Endometrial biopsy (EMB), IN ADDITION to ECC and colposcopy/biopsy  

• Prior authorization required from a MDCH nurse consultant  

• EMB’s will ONLY be reimbursed for Pap test results of AGC. |
| HSIL Pap Test with Colp/bx result not cancer/atypia/CIN I | • Diagnostic LEEP or Cone  

• Prior authorization required from a MDCH nurse consultant  

• Diagnostic LEEP or Cone will ONLY be reimbursed for HSIL Pap test with colp/bx result of not cancer/atypia/CIN I |
| Follow-up Pap tests | • Only Pap tests performed according to the medical protocol for follow-up of screening Pap test abnormalities will be reimbursed. |
| High Risk HPV Tests Performed as immediate follow-up for ASC-US Pap in order to determine triage | • ONE High Risk (HR) HPV test within a 12 month time-period may be performed as follow-up for an ASC-US Pap test only  

**NOTE:** More than one HR - HPV test/year or HR-HPV tests performed for Pap test results other than ASC-US will be denied. |
**Rarely and Never Screened for Cervical Cancer Outreach Plan**

**Goal:** Increase appropriate cervical cancer screening rates; increase rate of follow-up diagnostic testing for abnormal Pap tests; reduce incidence of and mortality from cervical cancer.

**Target Group:** Women who have been rarely or never screened for cervical cancer.

**Objective # 1:** Provide education on the importance of receiving cervical cancer screening and follow-up.

**Strategy:** Local Coordinating Agencies will promote cervical cancer screening and, in partnership with the agencies/organizations such as those noted below, disseminate existing cervical cancer prevention educational material and resources to the outreach locations such as those identified in the table.

<table>
<thead>
<tr>
<th>Specific Target Groups</th>
<th>Outreach Location</th>
<th>Partner Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victims of Domestic Violence</td>
<td>Domestic Violence Shelters</td>
<td>County-based councils on alcoholism and substance abuse</td>
</tr>
<tr>
<td>Women in recovery from Substance Abuse</td>
<td>Drug Treatment Facilities</td>
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<tr>
<td>50+ years of age</td>
<td>Senior Citizen Centers</td>
<td>AARP, Area Agencies on Aging</td>
</tr>
<tr>
<td>Homeless</td>
<td>Homeless Shelters, Food Banks</td>
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</tr>
<tr>
<td>Low Income</td>
<td>Thrift Stores, Laundromats, Food Banks</td>
<td>WIC, Focus: Hope, Community Action Agencies</td>
</tr>
<tr>
<td>STD/HIV patients</td>
<td>Free Health Clinics, FQHC, HIV Treatment facilities</td>
<td>MDCH STD/HIV</td>
</tr>
<tr>
<td>Mentally Disabled</td>
<td>Mental Health Facilities</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>Physically Disabled</td>
<td>Centers for Independent Living</td>
<td>Goodwill Industries, Salvation Army,</td>
</tr>
</tbody>
</table>

**Ethnic/Minority Groups:**

<table>
<thead>
<tr>
<th>Hispanic (esp. Migrant populations)</th>
<th>Migrant Clinics</th>
<th>CHASS, MSU Extension, Office of Migrant Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American (esp. Low Income communities)</td>
<td>Free Clinics, FQHC, Beauty Salons</td>
<td>FACED, NAACP, Sister’s Network, Urban League</td>
</tr>
<tr>
<td>Asian (esp. Vietnamese, elderly and recent immigrants)</td>
<td>Community businesses and places of worship</td>
<td>HAAP, Lacks Cancer Center, Vietnamese Radio &amp; Asian Grocers</td>
</tr>
<tr>
<td>Arabic (esp. recent immigrants and elderly)</td>
<td>Community businesses and places of worship</td>
<td>ACCESS, Arab American and Chaldean Council</td>
</tr>
<tr>
<td>Native American</td>
<td>Tribal Clinics</td>
<td>Inter-Tribal Council</td>
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<tr>
<td>Amish</td>
<td>Community businesses and places of worship</td>
<td></td>
</tr>
<tr>
<td>Rural residents</td>
<td>Community stores and places of worship</td>
<td>Rural Health Association</td>
</tr>
</tbody>
</table>
Objective # 2: Provide education and support in obtaining screening and follow-up services to target population

**Strategy:** Develop network of volunteers who currently function as or have the potential to be trained as Community Health Workers, Community Health Advocates, Patient Care Aides, or Patient Navigators to provide education, and assistance with obtaining screening and follow-up services.

- Identify local organizations that provide CHW related services, e.g.
  1. Health Asian American Project (Lay Health Workers)
  2. Madres y Mujeres del Mañana (Mothers and Women of Tomorrow)
     also known as Tres Ms (Lay Health Advisors)
  3. Improving Cancer Outcomes in African Americans (Community Cancer Advocates)
  4. Parish Nurses
  5. Members of church Health Ministries
  6. American Cancer Society volunteers

- Develop or obtain a Cervical Cancer, patient navigator training module
- Develop and implement process

Objective # 3: Partner with American Cancer Society to develop a modified “Tell A Friend” program focusing on cervical cancer that addresses the target population.

**Strategy:** Recruit and train women from ACS, Gilda’s Club, Sister’s Network and other survivor groups to serve as “Tell A Friend” volunteers.

Objective # 4: Review current outreach and recruitment strategies implemented by BCCCP Local Coordinating Agencies. Identify and share the specific strategies used to successfully recruit women rarely and/or never screened for cervical cancer.

**Strategy:** Based on data provided by the BCCCP Data Team, BCCCP Outreach and Recruitment Consultant will identify the BCCCP LCAs that have met the MPR. The O & R Consultant will assess the most recent Semi-Annual Reports of these agencies and determine the specific strategies used to attract women in the target population. BCCCP Upper Peninsula and Upper Lower Peninsula Liaisons will be contacted for input on agency performance and success.

Objective # 5: Review data from BCCCP Data Team providing MDE information for Never/Rarely Screened for Cervical Cancer.

**Strategy:** Draft and send letters to all LCAs to either:
- Acknowledge success in accomplishing 20% MDE
- Acknowledge near success in accomplishing 20% MDE
- Identify need for improvement in accomplishing 20% MDE and provide guidance
Objective # 6: Review BCCCP outreach and recruitment data collected from women newly enrolled in the program or returning for re-screening after 5 years.

Strategy: Participants will be asked questions regarding how they heard of program services and why they made the appointment to receive services. Obtain this information from the BCCCP Data and Evaluation Team to assess information on strategies that were effective in recruiting the targeted population.

Objective # 7: Foster collaborative relationships with Tribal Clinics.

Strategy: Identify BCCCP agencies that have collaborative agreements with Tribal Clinics. Identify successful strategies that result in the recruitment of “rarely and never screened women” and encourage implementation of these strategies. Provide consultation and available resources, as needed.

Objective # 8: Foster collaborative relationships with coordinators of the Healthy Asian American Project (HAAP).

Strategy: Continue to encourage and support project’s objective to recruit medically underserved Asian American women in seven Asian sub-populations including Asian Indian, Chinese, Hmong, Filipino, Japanese, Korean, and Vietnamese to participate in cancer screening services including cervical cancer. Encourage greater emphasis on strategies that successfully recruit women who have never or rarely been screened. Provide information on resources developed by Centers for Prevention and Disease Control developed for Asian women.

Objective # 9: Continue to foster collaborative relationships with Community Liaisons of the Improving Cancer Outcomes in African Americans (ICOAA) project. The project focuses on providing education to encourage cancer screening and participation in clinical trials.

Strategy: Provide cervical cancer literature to Community Cancer Advocates in Detroit for distribution during community cancer education sessions, also to faith-based initiatives in Flint and Pontiac, survivors’ dinner in Lansing and school-based initiatives in Saginaw.

Objective # 10: Develop partnerships with organizations that provide services to Hispanic women e.g. MDHS - Migrant Services and Michigan State University – Extension.

Strategy: Provide cervical cancer literature that is culturally and linguistically appropriate to partners that can be distributed to women in the target population.
<table>
<thead>
<tr>
<th>HEALTH DEPT &amp; COORDINATORS</th>
<th>PHONE NUMBERS</th>
<th>HEALTH OFFICERS &amp; OTHER STAFF</th>
<th>BILLING/FINANCE STAFF</th>
<th>FAX NUMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barry-Eaton District Health Department</strong>&lt;br&gt;Jackie Anderson, RN  &lt;br&gt;BCCCP Coordinator  &lt;br&gt;1033 Health Care Dr.  &lt;br&gt;Charlotte, MI 48813  &lt;br&gt;<a href="mailto:janderson@bedhd.org">janderson@bedhd.org</a>  &lt;br&gt;<strong>Hours</strong>: 8:00 – 5:00</td>
<td>517/541-2625 (Jackie)  &lt;br&gt;517/541-2630 or 517/485-7110 ext 630 (Eaton)  &lt;br&gt;269/945-9516 (Barry)</td>
<td>Steve Tackitt  &lt;br&gt;Health Officer  &lt;br&gt;517/541-2607 x 607 <a href="mailto:stackitt@bedhd.org">stackitt@bedhd.org</a>  &lt;br&gt;Robert Schirmer, MD, MS  &lt;br&gt;Medical Director</td>
<td>Ron Wingate,  &lt;br&gt;Billing/Staff  &lt;br&gt;517/541-2673  &lt;br&gt;<strong>BCCCP Claims:</strong>  &lt;br&gt;Susan Landon  &lt;br&gt;269/945-9516 x131 <a href="mailto:slandon@bedhd.org">slandon@bedhd.org</a></td>
<td>517/543-0451 (Eaton)  &lt;br&gt;269/945-4304 (Barry)  &lt;br&gt;517/543-7737 (Admin)</td>
</tr>
<tr>
<td><strong>Central Michigan District Health Department</strong>&lt;br&gt;Michele Wolfe  &lt;br&gt;BCCCP Coordinator  &lt;br&gt;2012 E. Preston Ave.  &lt;br&gt;Mt. Pleasant, MI 48858  &lt;br&gt;<a href="mailto:mwolfe@cmdhd.org">mwolfe@cmdhd.org</a>  &lt;br&gt;<strong>Hours</strong>: 8:30 – 4:30</td>
<td>989/773-5921 Ext. 127 (Michele)</td>
<td>Mary Kushion  &lt;br&gt;Health Officer  &lt;br&gt;989/773-5921 Ext. 121 <a href="mailto:mkushion@cmdhd.org">mkushion@cmdhd.org</a>  &lt;br&gt;Robert Graham, DO  &lt;br&gt;Medical Director  &lt;br&gt;Pam Goudreau  &lt;br&gt;Case Manager  &lt;br&gt;989/773-5921 Ext. 150 <a href="mailto:pgoudreau@cmdhd.org">pgoudreau@cmdhd.org</a>  &lt;br&gt;Rhonda Greaves  &lt;br&gt;Case Manager  &lt;br&gt;989/426-9431 Ext. 19 <a href="mailto:rgreaves@cmdhd.org">rgreaves@cmdhd.org</a></td>
<td>Carolyn Cardon  &lt;br&gt;Dir. of Admin. Services  &lt;br&gt;989/773-5921 Ext 122 <a href="mailto:ccardon@cmdhd.org">ccardon@cmdhd.org</a></td>
<td>Isabella Co.  &lt;br&gt;989/773-4319  &lt;br&gt;Gladwin Co.  &lt;br&gt;989/426-6952</td>
</tr>
<tr>
<td><strong>Chippewa County Health Department</strong>[Vacant]  &lt;br&gt;BCCCP Coordinator  &lt;br&gt;508 Ashmun St., Ste. 120  &lt;br&gt;Sault Ste. Marie, MI 49783  &lt;br&gt;<strong>Hours</strong>: 8:00 – 4:30</td>
<td>906/635-3572 or 906/635-3591  &lt;br&gt;906/635-3606</td>
<td>David Martin, RS, MPA  &lt;br&gt;Health Officer  &lt;br&gt;906/635-3621 <a href="mailto:dmartin@chippewahd.com">dmartin@chippewahd.com</a>  &lt;br&gt;Dr. Elsi Baccari, D.O.  &lt;br&gt;Medical Director  &lt;br&gt;Nancy Heyns  &lt;br&gt;Personal and Family Health Supervisor  &lt;br&gt;Catherine Worden, FNP  &lt;br&gt;Teri Kowlaski, FNP</td>
<td>Christine Lundquist,  &lt;br&gt;Finance Director  &lt;br&gt;906/635-3603 <a href="mailto:clundquist@hline.org">clundquist@hline.org</a></td>
<td>906/635-1701 (Sault Ste. Marie)</td>
</tr>
<tr>
<td><strong>Public Health Delta-Menominee Counties</strong>&lt;br&gt;Evigela Lindquist  &lt;br&gt;BCCCP Coordinator  &lt;br&gt;2920 College Avenue  &lt;br&gt;Escanaba, MI 49829-9592  &lt;br&gt;<a href="mailto:elindquist@phdm.org">elindquist@phdm.org</a>  &lt;br&gt;<strong>Hours</strong>: 8:00 – 4:00</td>
<td>906/789-8112</td>
<td>Barbara Chenier, MA  &lt;br&gt;Health Officer <a href="mailto:bchenier@phdm.org">bchenier@phdm.org</a>  &lt;br&gt;M. Gail Shebuski, MD, MPH  &lt;br&gt;Medical Director</td>
<td><strong>Data:</strong>  &lt;br&gt;Sharon Heitman  &lt;br&gt;(Delta)  &lt;br&gt;906/786-4111x166 <a href="mailto:SHHeitman@phdm.org">SHHeitman@phdm.org</a>  &lt;br&gt;<strong>Data:</strong>  &lt;br&gt;Kay Nelson  &lt;br&gt;(Menominee)  &lt;br&gt;906/863-4451x322 <a href="mailto:KNelson@phdm.org">KNelson@phdm.org</a></td>
<td>906/786 8148 (Sharon)  &lt;br&gt;906/863-7142 (Menominee)</td>
</tr>
<tr>
<td>HEALTH DEPT &amp; COORDINATORS</td>
<td>PHONE NUMBERS</td>
<td>HEALTH OFFICERS &amp; OTHER STAFF</td>
<td>BILLING/FINANCE STAFF</td>
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<td><strong>Dickinson-Iron</strong></td>
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<td><strong>District Health</strong></td>
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<td>Department</td>
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<tr>
<td>Beverly Olson, LPN</td>
<td>906/779-7247</td>
<td>Linda Piper, RN, MPH Health Officer</td>
<td>Stephen Markham Finance Administrator</td>
<td>906/774-9910 (Beverly)</td>
</tr>
<tr>
<td>BCCCP Coordinator</td>
<td>906/265-4187</td>
<td>818 Pyle Drive Kingsford, MI 49802</td>
<td>601 Washington Ave. Iron River, MI 49935</td>
<td>906/265-4198</td>
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<tr>
<td>818 Pyle Drive</td>
<td>906/779-7201</td>
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<tr>
<td>Kingsford, MI 49802</td>
<td><a href="mailto:bbigelow@hline.org">bbigelow@hline.org</a></td>
<td>Randall M. Johnson, MD Medical Director</td>
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<tr>
<td><a href="mailto:bbigelow@hline.org">bbigelow@hline.org</a></td>
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<tr>
<td><strong>Heights: 8:00 – 4:00</strong></td>
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<tr>
<td><strong>Mailings:</strong> Barb Peterson, RNC, OGNP</td>
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<tr>
<td>601 Washington Ave</td>
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<td>Iron River, MI 49935</td>
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<td><a href="mailto:bpeterson@hline.org">bpeterson@hline.org</a></td>
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<tr>
<td><strong>Dickinson &amp; Iron counties</strong></td>
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<tr>
<td><strong>District Health</strong></td>
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<tr>
<td>Department #2</td>
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</tr>
<tr>
<td>Deb Baumann</td>
<td>800/822-0264</td>
<td>Debra Pelton &lt;Acting&gt; Health Officer</td>
<td>Debra Pelton Finance Director</td>
<td>989/343-1899 (Deb)</td>
</tr>
<tr>
<td>BCCCP &amp; WW Coordinator</td>
<td>(Toll-free)</td>
<td><a href="mailto:dpelton@dhd2.org">dpelton@dhd2.org</a></td>
<td>630 Progress St. West Branch, MI 48661</td>
<td></td>
</tr>
<tr>
<td>Health Services Manager</td>
<td>989/345-5020</td>
<td></td>
<td></td>
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<tr>
<td>630 Progress Street</td>
<td>(Main Office)</td>
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<tr>
<td>West Branch, MI 48661</td>
<td>989/343-1801</td>
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<tr>
<td><a href="mailto:dbaumann@dhd2.org">dbaumann@dhd2.org</a></td>
<td>(Deb)</td>
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<tr>
<td><strong>Hours: 8:00 – 4:30</strong></td>
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<tr>
<td><strong>Alcona, Arenac, Iosco, Midland, Ogemaw &amp; Oscoda counties</strong></td>
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<tr>
<td><strong>District Health</strong></td>
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<tr>
<td>Department #4</td>
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<tr>
<td>Rosanne Schultz, RN, BSN</td>
<td>800/221-0294</td>
<td>John Bruning, RS, MBA Health Officer</td>
<td>Judy Greer, BS Finance Director &amp; Administrative Services Director</td>
<td>989/356-3529</td>
</tr>
<tr>
<td>BCCCP &amp; WW Coordinator</td>
<td>(Toll-free)</td>
<td>989/356-4507 <a href="mailto:jbruning@hline.org">jbruning@hline.org</a></td>
<td>989/356-4507 <a href="mailto:jgreer@hline.org">jgreer@hline.org</a></td>
<td></td>
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<tr>
<td>Pers. Hlth / Nursing Director</td>
<td>989/356-4507</td>
<td>Joshua Meyerson, MD, MPH Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100 Woods Circle, Suite 200 Alpena, MI 49707-1492 <a href="mailto:rschultz@hline.org">rschultz@hline.org</a></td>
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<tr>
<td><strong>Hours: 8:00 – 4:00</strong></td>
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<tr>
<td><strong>Alpena, Cheboygan, Montmorency &amp; Presque Isle counties</strong></td>
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</tbody>
</table>

*Note: Dickinson Iron HD is in the Central Time Zone (1 hour behind)*

BCCCP Billing:
Bev Richards
906/265-4151
bevr Richards@hline.org

BCCCP Claims & Billing:
Connie Stasiak
989/343-1817
cstasiak@dhd2.org

BCCCP Billing:
Judy Greer, BS
989/356-4507
jgreer@hline.org
# BCCCP Local Coordinating Agency Contact Information

**Updated: 04/03/2008**

<table>
<thead>
<tr>
<th><strong>HEALTH DEPT &amp; COORDINATORS</strong></th>
<th><strong>PHONE NUMBERS</strong></th>
<th><strong>HEALTH OFFICERS &amp; OTHER STAFF</strong></th>
<th><strong>BILLING/FINANCE STAFF</strong></th>
<th><strong>FAX NUMBERS</strong></th>
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<tbody>
<tr>
<td><strong>District Health Department #10</strong></td>
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<tr>
<td>Joni Sholtey</td>
<td>231/355-7530 (Joni - White Cloud)</td>
<td>Linda VanGills, MA Health Officer 3986 N. Oceana Dr. Hart, MI 49420 231/873-2193 <a href="mailto:lvangills@dhd10.org">lvangills@dhd10.org</a></td>
<td>Christine Lopez, Billing/Finance 1049 Newell St. PO Box 850 White Cloud, MI 49349 231/689-7300 <a href="mailto:clopez@dhd10.org">clopez@dhd10.org</a></td>
<td>231/845-0438 Ludington (Joni &amp; Sarah)</td>
</tr>
<tr>
<td></td>
<td>231/845-7381 (Joni - Ludington)</td>
<td>James Wilson, DO Medical Director Joni Erlewein, Nurse Practitioner District Health Department #10 PO Box 850 White Cloud, MI 49349 231/355-7527 <a href="mailto:jerlewein@dhd10.org">jerlewein@dhd10.org</a></td>
<td></td>
<td>231/873-4248 Hart (Linda VanGills)</td>
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<tr>
<td></td>
<td>231/902-8543 (Joni – Hart)</td>
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<td></td>
<td>231/845-7381 (Sarah)</td>
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<tr>
<td><strong>Genesee County Health Department</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dianna LaBonte RN, BSN</td>
<td>810/237-4545 (main line)</td>
<td>Robert Pestronk, MPH Health Officer 630 S. Saginaw St. Flint, MI 48502 810/257-3588 <a href="mailto:bpestronk@ghchd.us">bpestronk@ghchd.us</a></td>
<td>Carolyn Ratza, Accounting Supervisor 630 S. Saginaw St. Flint, MI 48502</td>
<td>810/257-3147 (Admin)</td>
</tr>
<tr>
<td>BCCCP &amp; WW Coordinator Burton Branch</td>
<td>810/237-4571 (Dianna)</td>
<td>Gary Johnson, MD, MPH, FAAP Medical Director 810/257-3155</td>
<td></td>
<td>810/742-2561 (Dianna)</td>
</tr>
<tr>
<td></td>
<td>810/237-4544 (Toni)</td>
<td>Mary Bluteau, RN 810/237-4570 <a href="mailto:mbluteau@ghchd.us">mbluteau@ghchd.us</a></td>
<td></td>
<td>810/742-2561 (Toni)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loretta Nimo, NP Jackie Smiley, NP</td>
<td></td>
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<tr>
<td><strong>Huron County Health Department</strong></td>
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</tr>
<tr>
<td>Mitzi Koroleski</td>
<td>877/269-0822 (Toll-free)</td>
<td>Gretchen Tenbusch, RN, MSA Health Officer <a href="mailto:gtenbusch@chd.us">gtenbusch@chd.us</a></td>
<td>Delilah Sheldon, Finance Director 989/269-9721 x 128</td>
<td>989/269-5155 (BCCCP)</td>
</tr>
<tr>
<td>BCCCP &amp; WW Coordinator Bad Axe</td>
<td>989/269-9721 x 122 (Mitzi)</td>
<td>Dr. Russell Bush, MD Medical Director</td>
<td>Karen Iseler, Secretary <a href="mailto:kiseler@chd.us">kiseler@chd.us</a></td>
<td>989/269-4181 (Admin)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nancy Miller, NP Jeanine Pfundt, Nurse Midwife</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mailings:** Sarah Olencizak 916 Diana Ludington, MI 49431 soleniczak@dhd10.org

*Crawford, Kalkaska, Lake, Mason, Manistee, Mecosta, Missaukee, Newaygo, Oceana, and Wexford counties

**Mailings:** Toni McCrum, MS, RN tmccrum@ghchd.us

*Genesees and Lapeer counties

**Mailings:** Sarah Olencizak 916 Diana Ludington, MI 49431 soleniczak@dhd10.org

*Genesees and Lapeer counties

**Mailings:** Toni McCrum, MS, RN tmccrum@ghchd.us

*Genesees and Lapeer counties

**Mailings:** Sarah Olencizak 916 Diana Ludington, MI 49431 soleniczak@dhd10.org

*Genesees and Lapeer counties
<table>
<thead>
<tr>
<th>Local Coordinating Agency</th>
<th>Contact Information</th>
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<td><strong>BCCCP</strong></td>
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<tr>
<th>HEALTH DEPT &amp; COORDINATORS</th>
<th>PHONE NUMBERS</th>
<th>HEALTH OFFICERS &amp; OTHER STAFF</th>
<th>BILLING/FINANCE STAFF</th>
<th>FAX NUMBERS</th>
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</thead>
<tbody>
<tr>
<td><strong>Ingham County Health Department</strong></td>
<td>877/221-6505 (Toll-free)</td>
<td>Dean Sienko, MD, MS Health Officer / Medical Director 517/887-4311 <a href="mailto:dsienko@ingham.org">dsienko@ingham.org</a></td>
<td>John Jacobs, Chief Financial Officer 517/887-4430 <a href="mailto:hjjacobs@ingham.org">hjjacobs@ingham.org</a></td>
<td>517/394-4674 Karen &amp; Laura 517/887-4310 Dean</td>
</tr>
<tr>
<td>Karen Jennings BCCCP Coordinator 5303 S Cedar PO Box 30161 Lansing, MI 48909 <a href="mailto:kjennings@ingham.org">kjennings@ingham.org</a></td>
<td>517/887-4364 (Main number)</td>
<td>Laura Peterson <strong>Mailings</strong> Deputy Health Officer 517/887-4455 <a href="mailto:lpetersen@ingham.org">lpetersen@ingham.org</a></td>
<td>**Eric Thelen, Sr. Acct. 517/887-4345 fax: 517/887/4490 <a href="mailto:hfhelen@ingham.org">hfhelen@ingham.org</a></td>
<td></td>
</tr>
<tr>
<td>Hours: 8:00 – 5:00</td>
<td>517/887-4421 (Karen)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy Diawara WISEWOMAN Coordinator <a href="mailto:ndiawara@ingham.org">ndiawara@ingham.org</a></td>
<td>517/887-4600 (Nancy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Ingham, Clinton, Gratiot, Ionia, Jackson, Livingston, Oakland, and Washtenaw counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Southwest Michigan BCCCP** | 888-AGE-40up or 888/243-4087 (Toll free) | Linda Vail Buzas, MPA Health Officer 269/ 373-5160 lvbuza@kalcounty.com | Tammy Lahman Deputy Director Finance 269/373-5257 | 269/373-5362 |
| (a.k.a.: Kalamazoo County Health and Community Services Department) | 269/373-5383 (Lynn) | Richard Tooker, MD, MPH Medical Director 269/373-5261 | | |
| Lynn Ann Jones BCCCP & WW Coordinator 3299 Gull Road P.O. Box 42 Nazareth, MI 49074-0042 ljone@kalcounty.com | 269/373-5213 (BCCCP) | Bonnie Dykehouse Program Manager 269/373-5028 Fax: 269/373-5168 bldyke@kalcounty.com | BCCCP Admin Assistant: Tammy Vander Horst 269/373-5277 tkvand@kalcounty.com | |
| Hours: 8:00 – 5:00 | | | BCCCP Claims: Kathy Izenbaard 269/373-5243 ksizen@kalcounty.com | |
| Local Web site: www.kalcounty.com/hcs/bcccp | | | | |
| * Allegan, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph & Van Buren counties | | | | |
**HEALTH DEPT & COORDINATORS**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Karmanos Cancer Institute** | Dorothy Tillmon  
BCCCP Coordinator  
Manager, Clinical Services  
tillmond@karmanos.org  
Karmanos Cancer Institute  
24601 Northwestern Highway  
Southfield, MI 48075-2473 |
| **Denise Hill**           | Denise Hill  
BCCCP Coordinator  
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Karmanos Cancer Institute  
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Southfield, MI 48075-2473 |

**Kent County Health Department**  
Sally Cory  
BCCCP Coordinator  
700 Fuller Ave. NE  
Grand Rapids, MI 49503  
sally.cory@kentcountyMI.gov  
**Hours:** 8:00 – 5:00

**Lenawee County Health Department**  
Mary Vallad, RN, MS  
BCCCP & WW Coordinator  
1040 S. Winter, Suite 2328  
Adrian, MI 49221  
mkvallad@hline.org  
**Hours:** 8:00 – 4:30  
**Kent, Montcalm, and Ottawa counties**

**HEALTH OFFICERS & OTHER STAFF**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Robert Burack, MD, MPH** | Principal Investigator  
University Health Center-5C  
4201 St. Antoine  
Detroit, MI 48201  
313/577-5519  
pager-313/745-0203 #1795  
rburack@med.wayne.edu  
(Dorothy & Denise)  
248/351-0784 |
| **Gloria Slade**          | Case Manager  
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sladeg@karmanos.org  
Kimberley H  
248/351-0752 |
| **Catherine Raevsky, BS** | Health Officer  
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Bill Anstey  
Deputy Officer  
616/632-7278 |
| **Mark Hall, MD, MPH**    | Medical Director  
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Teresa Branson  
Health Education Supervisor  
616/632-7121  
Teresa.Branson@kentcountyMI.gov  
Sandra Wolff  
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sandra.wolff@kentcountyMI.gov  
R. Michael Kight, RS, MS  
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mkight@hline.org  
Dennis Chernin, MD, MPH  
Medical Director  
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mikee@hline.org  
Mike Ernst, BBS  
Business Office Coordinator  
517/264-5206  
mikee@hline.org  
517/264-0790 |

**BILLING/FINANCE STAFF**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Admin Assistant**       | Shelia Summers  
248/351-1220 x 7701  
summerss@karmanos.org  
Dr. Burack  
313/745-4710 |
| **BCCCP Billing:**        | Diane Baroky  
248/351-1220  
barokyd@karmanos.or  
Kimberley Hannaford  
248/351-1220 x 7716  
hannafok@karmanos.org  
**BCCCP Claims:**        | Kimberly H  
248/351-0752 |

**Fax Numbers**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| **Robert Burack**         | (Dorothy & Denise)  
248/351-0784 |
| **Shelia Summers**        | (Dr. Burack)  
313/745-4710 |

**FOR MORE INFORMATION CALL**  
**888/242-2702 or 800/KARMANOS (800/527-6266) (Toll-free)**
## HEALTH DEPT & COORDINATORS

### LMAS District Health Department
- **Melissa Copenhaver**
  - BCCCP Coordinator
  - 14150 Hamilton Lake Road
  - Newberry, MI 49868
  - mcopenhaver@lmasdhd.org
  - **Hours**: 8:30 – 4:00
  - 906/420-1869 - Cell

**Mailings**: Debbie Hoder
- BCCCP Business Manager
dhoder@lmasdhd.org

*Luce, Mackinac, Alger, & Schoolcraft counties*

### Marquette County Health Department
- **Jill Fries**
  - BCCCP Coordinator
  - 184 US 41 Hwy
  - Negaunee, MI 49866
  - jfries@mqtcty.org
  - **Hours**: 8:00 – 5:00

### Muskegon County Health Department
- **Joyce Rademacher**
  - BCCCP Coordinator
  - 209 E. Apple Ave., Ste. D155
  - Muskegon, MI 49442
  - rademacherto@co.muskegon.mi.us
  - **Hours**: 8:00 – 5:00

**Mailings**: Pat Krehn
- krehmpa@co.muskegon.mi.us

### PHONE NUMBERS

<table>
<thead>
<tr>
<th>Area</th>
<th>Numbers</th>
<th>Health Officers &amp; Other Staff</th>
<th>Billing/Finance Staff</th>
<th>Fax Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LMAS District Health Department</strong></td>
<td>906/293-1324 (Luce Co.)</td>
<td>Marv Henderson, Health Officer <a href="mailto:mhenderson@lmasdhd.org">mhenderson@lmasdhd.org</a></td>
<td>Lisa Kleeman, Finance Manager 906/293-1343 <a href="mailto:lkleeman@lmasdhd.org">lkleeman@lmasdhd.org</a></td>
<td>906/293-5453</td>
</tr>
<tr>
<td></td>
<td>906/387-2297 (Alger Co.)</td>
<td>James Terrian, MD Medical Director 906/293-1310 <a href="mailto:jterrian@lmasdhd.org">jterrian@lmasdhd.org</a></td>
<td>BCCCP Claims &amp; Billing: Kim Gould – Luce Co. 906/293-5107 ext 318 <a href="mailto:kgould@lmasdhd.org">kgould@lmasdhd.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>906/643-1100 (Mackinac Co.)</td>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>906/341-4102 (Schoolcraft Co.)</td>
<td></td>
<td>Debbie Hoder 906/293-5107 ext 322 <a href="mailto:dhoder@lmasdhd.org">dhoder@lmasdhd.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>906/293-1322 (Debbie)</td>
<td></td>
<td>Marv Henderson <a href="mailto:mhenderson@lmasdhd.org">mhenderson@lmasdhd.org</a></td>
<td></td>
</tr>
<tr>
<td><strong>Marquette County Health Department</strong></td>
<td>906/475-7844 or 906/315-2627</td>
<td>Randall M. Johnson, MD,MPh Health Officer &amp; Medical Director <a href="mailto:rjohnson@mqtcty.org">rjohnson@mqtcty.org</a></td>
<td>Jim Rahoi Finance Officer 906/315-2609 <a href="mailto:jrahoi@mqtcty.org">jrahoi@mqtcty.org</a></td>
<td>906/475-4435</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corrine Brownell, Supervisor Personal Health</td>
<td>BCCCP Billing: Wendy Perry 906/315-2602 <a href="mailto:wperry@mqtcty.org">wperry@mqtcty.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Denise Koehn, NP, RN <a href="mailto:dkoehn@mqtcty.org">dkoehn@mqtcty.org</a> 906/475-7844</td>
<td><strong>BCCCP Claims</strong>:</td>
<td></td>
</tr>
<tr>
<td><strong>Muskegon County Health Department</strong></td>
<td>231/724-4411</td>
<td>Kenneth A. Kraus, SW, MPA Health Officer 231/724-1212 <a href="mailto:krauske@co.muskegon.mi.us">krauske@co.muskegon.mi.us</a></td>
<td>Nancy Bramer Finance Supervisor 231/724-1201 <a href="mailto:bramema@co.muskegon.mi.us">bramema@co.muskegon.mi.us</a></td>
<td>231/724-3596</td>
</tr>
<tr>
<td></td>
<td>231/724-1244</td>
<td>Douglas Hoch, MD, MPH Medical Director 231/724-6309</td>
<td>Kathy Swihart, Finance Analyst 231/724-1233</td>
<td>231/724-6674</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>BCCCP Billing</strong>: Mary Young 231/724-1297 <a href="mailto:youngma@co.muskegon.mi.us">youngma@co.muskegon.mi.us</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Case Management ONLY</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><strong>BCCCP Claims</strong>: Deb Wilson 231/724-1286 <a href="mailto:wilsonde@co.muskegon.mi.us">wilsonde@co.muskegon.mi.us</a></td>
<td></td>
</tr>
</tbody>
</table>
### HEALTH DEPT & COORDINATORS

#### Health Department of Northwest Michigan
- **Teresa Sington**
  - BCCCP Coordinator
  - 209 Portage Drive
  - Bellaire, MI 49615
  - tsington@nwhealth.org

  **Hours:** 8:30 – 5:00

  *Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Leelanau & Otsego counties

- **Gerald Chase, MPH**
  - Health Officer
  - 220 West Garfield Charlevoix, MI 49720
  - 231/547-6523
  - g.chase@nwhealth.org

- **Linda Yaroch RN, MPH**
  - Deputy Health Officer
  - 231/547-7621
  - l.yaroch@nwhealth.org

- **Joshua Meyerson, MD, MPH**
  - Medical Director

- **Patricia Fralick, RN, MBA**
  - Dir of Family & Comm Health
  - 3434 Harbor Petoskey Rd Suite A
  - Harbor Springs, MI 49740
  - 231/347-5628
  - p.fralick@nwhealth.org

- **Christie Vogelhiem**
  - Administrative Services Director

- **BCCCP Billing:**
  - Teresa Sington
  - 231/533-1012
  - t.sington@nwhealth.org

- **BCCCP Claims:**
  - Valeri Ramage
  - 231/547-7665
  - v.ramage@nwhealth.org

#### Shiawassee County Health Department
- **Lisa Paganini, RN**
  - BCCCP Coordinator
  - 110 E. Mack Street
  - Corunna, MI 48817
  - lpaganini@shiawassee.net

  **Hours:** 8:00 – 5:00

- **George J. Pichette, JD**
  - Director/Health Officer
  - 310 N. Shiawassee
  - Corunna, MI 48817
  - 989/743-2318
  - gpichette@shiawassee.net

- **Dennis Chernin, MD, MPH**
  - Medical Director

- **Lisa Smith, BBA**
  - Director Finance

- **BCCCP Claims:**
  - Serena Smelser
  - 989/743-2335
  - ssmelser@shiawassee.net

#### Western UP District Health Department
- **JoAnn Stark**
  - BCCCP Coordinator
  - 540 Depot Street
  - Hancock, MI 49930
  - jstark@hline.org

  **Hours:** 8:00 – 4:00

- **Guy St.Germain, MPA**
  - Health Officer
  - gstgermain@hline.org

- **M. Gail Shebuski, MD, MPH**
  - Medical Director

- **Maureen Salo, RN**
  - BCCCP Nurse

- **Cathryn A. Beer**
  - Financial Reporting Analyst

- **BCCCP Claims:**
  - Brenda Pertile - Gogebic
  - 906/667-0200
  - bpertile@hline.org

  - Chris Frazer – Ontonagon
  - 906/884-4485
  - cfrazer@hline.org

  - Carol Marinich – Baraga
  - 906/524-6120
  - cmarinich@hline.org

  - Monica Koehn – KBIC
  - 906/353-4580
## HEALTH DEPT & COORDINATORS

<table>
<thead>
<tr>
<th>HEALTH DEPT &amp; COORDINATORS</th>
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<th>FAX NUMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upper Peninsula Consultant</strong></td>
<td>906/249-4368</td>
<td>* 2-LMAS, 9-Chippewa, 6-Western UP, 10-Delta-Menominee, 11-Dickinson-Iron, 19-Marquette</td>
<td>906/249-4368 (Same as house #)</td>
<td></td>
</tr>
<tr>
<td>Denise Koehn</td>
<td>(Denise)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>275 Flodin Road</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gwinn, MI 49841</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:denisewhnp@aol.com">denisewhnp@aol.com</a></td>
<td></td>
<td></td>
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</tr>
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**Updated: 04/03/2008**
# Michigan Department of Community Health BCCCP Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone #</th>
<th>Fax #</th>
<th>Email Address</th>
<th>Position</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blaze, Cathy</td>
<td>517-324-7304</td>
<td>517-324-7324</td>
<td><a href="mailto:cblaze@mphi.org">cblaze@mphi.org</a></td>
<td>Reimbursement Project Coordinator</td>
<td>Non-clinical education, MBCIS and DCH File Transfer user security, Billing, Program manuals</td>
</tr>
<tr>
<td>Burke, Sam</td>
<td>517-241-6913</td>
<td>517-335-8752</td>
<td><a href="mailto:Burkes5@michigan.gov">Burkes5@michigan.gov</a></td>
<td>Program Technical Analyst</td>
<td>Billing and reimbursement</td>
</tr>
<tr>
<td>Carr, Mike</td>
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<td>517-335-9397</td>
<td><a href="mailto:carrmi@michigan.gov">carrmi@michigan.gov</a></td>
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<td>Report requests, GIS mapping, Data Quality and Discoverer Viewer reports and caseload</td>
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<tr>
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<td>517-335-9397</td>
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<td>Lead analyst Contractual and financial management</td>
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<td><a href="mailto:sharris@mphi.org">sharris@mphi.org</a></td>
<td>Data Manager</td>
<td>MBCIS Manager and Business Analyst, CDC reporting, Monthly data profile, Special data and report requests</td>
</tr>
<tr>
<td>Lorraine, Viki</td>
<td>517-335-9966</td>
<td>517-335-9397</td>
<td><a href="mailto:lorrainev@michigan.gov">lorrainev@michigan.gov</a></td>
<td>WISEWOMAN Intervention Specialist</td>
<td>WISEWOMAN Lifestyle Intervention, Behavior Change related to Nutrition, Physical Activity, and Smoking Cessation</td>
</tr>
<tr>
<td>Nestell, Carrie</td>
<td>517-335-8517</td>
<td>517-335-9397</td>
<td><a href="mailto:nestellc@michigan.gov">nestellc@michigan.gov</a></td>
<td>Public Health Consultant</td>
<td>Communications Coordinator for Cancer section</td>
</tr>
<tr>
<td>Phelps, Tory</td>
<td>517-335-8854</td>
<td>517-335-8752</td>
<td><a href="mailto:Phelpst2@michigan.gov">Phelpst2@michigan.gov</a></td>
<td>Program Technical Analyst</td>
<td>Billing and reimbursement</td>
</tr>
<tr>
<td>Roberts, Robin</td>
<td>517-335-1178</td>
<td>517-335-9397</td>
<td><a href="mailto:robertsrobi@michigan.gov">robertsrobi@michigan.gov</a></td>
<td>WISEWOMAN Program Coordinator / Data Manager</td>
<td>WISEWOMAN - Program Administration, Data System, CDC Reporting, Special Data Requests</td>
</tr>
<tr>
<td>Sandra Kimball</td>
<td>517-335-9301</td>
<td>517-335-9397</td>
<td><a href="mailto:kimballs@michigan.gov">kimballs@michigan.gov</a></td>
<td>Secretary</td>
<td>BCCCP Secretary</td>
</tr>
<tr>
<td>Siegl, EJ</td>
<td>517-335-8814</td>
<td>517-335-9397</td>
<td><a href="mailto:sieglej@michigan.gov">sieglej@michigan.gov</a></td>
<td>Nurse Consultant</td>
<td>Quality improvement, Professional education, Cancer treatment, Clinical Consultation, Breast Cancer</td>
</tr>
<tr>
<td>Valliere, Paulette</td>
<td>517-335-8049</td>
<td>517-335-9397</td>
<td><a href="mailto:vallierrep@michigan.gov">vallierrep@michigan.gov</a></td>
<td>Unit Manager</td>
<td>Program Director – BCCCP and WISEWOMAN Programs</td>
</tr>
<tr>
<td>Name</td>
<td>Phone 1</td>
<td>Phone 2</td>
<td>Email</td>
<td>Position</td>
<td>Responsibilities</td>
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</tr>
<tr>
<td>Koehn, Denise</td>
<td>906-249-4368</td>
<td>906-249-4368</td>
<td><a href="mailto:denisewhnp@aol.com">denisewhnp@aol.com</a></td>
<td>Upper Peninsula Consultant</td>
<td>Program support</td>
</tr>
<tr>
<td>Waldron, Gwen</td>
<td>517-335-9619</td>
<td>517-335-9397</td>
<td><a href="mailto:WaldronG@michigan.gov">WaldronG@michigan.gov</a></td>
<td>Data Entry/Department Analyst</td>
<td>WISEWOMAN/COLORECTAL Data Entry &amp; assist with Department Analyst duties</td>
</tr>
</tbody>
</table>