

I. Requirements for Providers:

For the purpose of this agreement, Providers include physicians, registered nurse practitioners, advanced practice nurses, hospitals, mammography facilities, ambulatory surgery centers, and cytology laboratories.

The *BreastCare* Provider Manual is considered an extension of this contract and providers must comply with it in order to provide services for the program. The Provider Manual can be accessed on the ADH website for BreastCare at ARBreastCare.com under the “Just for Providers” section. Though not all parts of the manual, or this agreement, are relevant to all providers, each provider is encouraged to become familiar with both the entire agreement and the manual to better serve *BreastCare* patients.

Women enrolled in *BreastCare* will present an identification card at each visit. The provider will verify a patient’s eligibility and coverage before providing services. The Provider should refer any potentially eligible woman not enrolled to a participating BreastCare Primary Care Provider (PCP) before providing services.

The PCP will determine eligibility using the BreastCare Online System, which uses income at or below 250% as the income limit. The patient will be given an appointment for a clinical breast exam, Pap test, mammogram or diagnostic/treatment services as appropriate. The referring Provider or PCP will maintain responsibility for patient follow-up.

The Provider will perform appropriate examinations/procedures/treatment for which the patient was referred. The Provider reserves the discretion to determine which breast or cervical cancer screening, diagnostic or treatment service is medically indicated for the patient. The Provider will provide appropriate examinations/procedures/treatment, based on sound medical judgment and the patient’s informed consent.

In most cases, the Provider may perform reimbursable covered procedures subsequent to and as indicated by initial evaluation, without prior approval. CPT codes 57460, 57461, 57520 and 57522 require prior authorization (See the Provider Manual for Authorization for Prior Approval). The Provider may **not** provide non-covered services to the patient **without full disclosure to the patient** that the services will **not** be paid by *BreastCare* (See the Provider Manual for specific exclusions. See breast and cervical reimbursement tables for covered services). The patient must be informed that she will be responsible for payment of these services. Only *BreastCare* Providers, with signed Public Health Service Agreements, may perform reimbursable services.

BreastCare recommends the following publications for the management of breast or cervical problems:

- ◆ U.S. Preventive Services Task Force Recommendations for Breast Screening, Cervical Cancer Screening, BRCA-Related Cancer Risk Assessment, Genetic Counseling, and Genetic Testing. Breast Cancer: Medications for Risk Reduction:
<http://www.uspreventiveservicestaskforce.org/page/name/recommendations>
- ◆ NCCN GUIDELINES FOR DETECTION PREVENTION & RISK REDUCTION, Breast Cancer Risk Reduction, Breast Cancer Screening and Diagnosis, Genetic/Familial High-Risk Assessment: Breast and Ovarian, Cervical Cancer Screening.
- ◆ Evaluation of Common Breast Problems: A Primer for Primary Care Providers, prepared by The Society of Surgical Oncology and The Commission on Cancer of The American College of Surgeons for the Centers for Disease Control and Prevention (CDC)

- ◆ American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology Screening Guidelines for the Prevention and Early Detection of Cervical Cancer. ASCCP, 2012.
- ◆ American Society for Colposcopy and Cervical Pathology Algorithms: <http://www.asccp.org/guidelines-2/management-guidelines-2>
- ◆ Practice Bulletin Number 131, Clinical Management Guidelines, Screening for Cervical Cancer, American College of Obstetricians and Gynecologists, November, 2012.

Breast biopsies are considered reimbursable procedures only when performed by participating providers after preliminary image evaluation on an outpatient basis and in accordance with approved guidelines. The least invasive and least costly approach should be used when appropriate.

Breast and cervical cancer and certain cervical tissue diagnosis of CIN II/III and carcinoma in situ are possibly covered, by the BreastCare program, for uninsured patients. Contact the BreastCare program for qualifying information.

Mammography facilities must have proof of Food and Drug Administration Mammography Quality Standards Act certification or provisional certification. Mammography facilities must also accept orders for mammograms from any qualified health professional. Laboratories must have proof of CLIA certification.

HIPAA requires all medical providers to **have a National Provider Identifier (NPI)**. The provider must enter their assigned group or facility number on the first page of the *BreastCare* agreement and the individual providers' NPI numbers must be entered on the Provider Name and Specialty Form.

II. Requirements for Physicians, Registered Nurse Practitioners, Advanced Practice Nurses and Certified Registered Nurse Anesthetists Providers:

The Provider must have a valid, unencumbered Arkansas license. A copy of the license and DEA number, if relevant, must be submitted with the initial contract. CRNAs must submit their RN and CRNA license annually. Each Provider in a group practice must provide this information before a BreastCare agreement can be executed. Thirty (30) Days prior to your providers' medical license and DEA registration expiring, you will receive an email notification, informing you of expiration. Fax updated copies of each individual provider's Arkansas Medical or Nursing Licenses, and DEA Registrations (if applicable) prior to expiration to 501-661-2189, Attention BreastCare Provider Management.

The Provider agrees to obtain one (1) CME/CEU annually, as appropriate, related to breast cancer diagnosis/treatment and/or cervical cancer diagnosis/management. Documentation of CME must be submitted with each initial and renewal contract. CRNAs and anesthesiologists are exempt from the CME requirement.

III. Requirements for Primary Care Provider (PCP): Providers who enroll BreastCare Patients

The PCP agrees to:

- ◆ Authorize his/her name to be listed and consents to the release of his/her name to women who do not have a participating PCP.
- ◆ Perform a clinical breast exam (CBE) and Pap test, if needed (reimbursable visit). (See the Provider Manual for cervical cancer screening guidelines)
- ◆ Enroll and maintain patient information in the BreastCare Online System. Provider understands claims will not pay until results are entered into the BreastCare Online System.
- ◆ Provide enrolled patients with a **Welcome to BreastCare pamphlet at initial visit.**
- ◆ Receive the mammogram and Pap test reports and enter results into BreastCare Online System.
- ◆ Follow up on abnormal mammograms and Pap tests according to accepted standard of care.

- ◆ Assess the smoking status of every woman and refer smokers to the Arkansas Tobacco Quitline per CDC requirement.
- ◆ Refer patients or lab work only to participating providers..
- ◆ A performance evaluation/chart review annually on a random basis or as needed.

Note: Any claim that is submitted for an office visit will be rejected if the office visit and results of the CBE, Pap and mammogram are not entered in the BreastCare Online System. When the results are entered, the provider can resubmit the claim.

IV. Requirements for Reporting and Billing:

Providers must use a unique *BreastCare* claim form. Paper claims are accepted; however, electronic billing is preferred. Special software, installation and training are provided free to Providers (See Billing Instructions and printable version of the claim form at ARBreastCare.com.)

After the appropriate procedures have been performed, the provider will notify the patient and/or the ordering physician of the test results/diagnosis and submit the test result codes on the Claim Form to HP Enterprise Services. Contact HP Enterprise Services at 1-855-661-7830 for reporting/billing questions.

- **Within ten (10) working days**, the patient will be notified of her mammogram results in easily understandable “layman’s” terms.
- **Within ten (10) working days**, the mammography facility, cytology laboratory or specialist will send the mammogram/Pap test results/diagnosis to the referring Provider. Mammography results will be reported using the MQSA assessment categories. Pap test/cervical cytology results will be reported using Bethesda System.
- **Within 24 hours**, the mammography facility and cytology laboratory will notify the *BreastCare* Nurse Coordinator by phone (501) 661-2942 or fax (501) 280-4049 for cases needing immediate follow up.
- **Within sixty (60) days**, the Provider must submit the claim to HP Enterprise Services. The Provider understands that providing specified test results is a condition of payment. All providers are not required to submit test result codes for all CPT codes. See the *BreastCare* billing instructions at ARBreastCare.com for a detailed explanation of the provider’s responsibilities for entering test result codes with claims. Anesthesia providers are not required to submit any test result codes. Electronic billing is preferred and will be given first priority; however, paper claims may be submitted, only if necessary. Payments are disbursed electronically into the provider’s bank account. **The Provider must complete an Authorization for Automatic Funds Deposit form in order to receive the electronic funds transfers for claims. No paper checks are issued.**
- **By August 15th of the following fiscal year (July 1 – June 30)**, the Provider must have submitted all claims for services rendered to *BreastCare* patients during that fiscal year. If the Provider fails to submit the claim within this time frame and *BreastCare* cannot pay, the Provider is prohibited from billing the patient. Because of untimely filing, the claim then becomes the responsibility of the provider. There will be no exceptions to this policy.

V. Requirements for Reimbursement:

BreastCare will provide a Provider Manual, reporting and billing forms and technical assistance, as needed. HP Enterprise Services will provide special, user friendly, computer software, at no charge, for electronic reporting and billing. Fee-for-service reimbursement is provided for screening and diagnostic procedures using current Medicare reimbursement rates. The professional and technical fees may be invoiced separately for screening and diagnostic procedures. A fixed reimbursement is provided for breast biopsies when performed in an outpatient facility. The Provider will refer to the appropriate table for billing purposes

and submit claims to HP Enterprise Services as instructed in the billing instructions. Reimbursement tables are found and updated as needed at ARBreastCare.com.

The Provider is required to report their National Provider Identifier (NPI) to BreastCare for reimbursement of electronic transactions. BreastCare providers must go to <https://www.medicaid.state.ar.us> and select the Provider section to link the NPI number(s) to the BreastCare provider number(s). Enter the BreastCare Provider Number and Tax ID to access the NPI reporting tool. The current BreastCare Provider Number, NPI, Tax ID or Social Security Number, and taxonomy code are needed to link the NPI. Individual providers must have their group report their individual NPI numbers.

BreastCare Services are reimbursable services according to program guidelines for eligible women. Specimens must be submitted to *BreastCare* participating laboratories. After the patient's exam, the PCP schedules a mammogram/ultrasound appointment based on the CBE result. The PCP enters the patient visit, mammogram appointment, diagnostic procedures and all procedure results and recommendations in the BreastCare Online Data System. Referrals are made to the regional care coordinator for abnormal results.

The Provider agrees to accept the amount reimbursed by the patient's insurance and/or *BreastCare* as payment in full and **will not** bill the patient. All claims for patient services must be submitted within 60 days of the date of service.

Authorized Official Name (*Print*): _____

Authorized Official Title: _____

Authorized Official Signature: _____ Date: _____