

Arkansas BreastCare Provider Manual



Arkansas Department of Health

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1. Program overview

Introduction

In 1995, the Arkansas Department of Health (ADH) entered into a five-year agreement with the Centers for Disease Control and Prevention in accordance with the Breast and Cervical Cancer Mortality Prevention Act, Public Law 101-354, to provide screening and diagnostic breast and cervical cancer control services. The mission of the Breast and Cervical Cancer Control Program (BCCCP) is to increase the rate of early detection of breast and cervical cancer and reduce morbidity from these diseases. The target population is low-income women age 50 and older who are uninsured or underinsured. Enrollment and screening was initiated at Local Health Units (LHU), Community Health Centers (CHC), and Area Health Education Centers (AHEC). From September 1995 to March 1999, there were 125 Breast cancers and 9 cervical cancers diagnosed through the BCCCP; however, federal funds were not available for treatment.

State legislation was initiated in 1995 to extend coverage to include breast cancer treatment services for eligible women. The Breast Cancer Act of 1997 was signed into law by Governor Mike Huckabee on March 11, 1997 which established the Breast Cancer Control Program now called BreastCare. \$3.2 million for screening, diagnosis, treatment, and education is funded by Arkansas tobacco tax. BreastCare is administered by ADH with guidance from the eight-member Breast Cancer Advisory Board appointed by the governor. BreastCare was implemented on February 16, 1999. Still there was no funding for cervical cancer treatment.

BreastCare and BCCCP, now called BreastCare, were integrated to insure timely diagnosis and treatment for all eligible women. For the purposes of this manual, BreastCare will be referred to as “the Program”. The Program utilizes the existing health care delivery system to include CHC, AHEC, hospitals, outpatient radiology centers, surgeons, family physicians, radiologists, pathologists, medical oncologists, radiation oncologists, laboratories, ambulatory surgery centers, and radiation therapy facilities. Providers must have a contractual agreement with ADH before providing services for ADH clients. Providers are bound by all policies and regulations in this Provider Manual, in addition to the policies and regulations in the Public Health Service Agreement. Not all sections of this manual will be relevant to every provider, but each provider is encouraged to become familiar with the entire manual to better serve ADH patients.

Updates

This manual will be updated as changes in policy and procedures occur. Initial notification of such changes may be in the form of Official Notices, remittance advice (RA) messages, e-mails, or messages on the ADH web site (www.healthy.arkansas.gov). All changes made to the BreastCare policy will be incorporated into the BreastCare Provider Manual. A [BreastCare Update Log](#) is provided for your convenience to record program updates.

Client eligibility

A client must meet the basic eligibility requirements as follows:

- Arkansas resident
- Age 40 or older
- Income \leq 200% of the Federal Poverty Level (FPL). View or print the [Income Guidelines](#)
- Non-credible insurance

A participating Primary Care Provider (PCP) or county health department determines patient eligibility and enrolls the patient online. The computer auto-assigns the patient to either Plan A, Plan C, or Plan M. A woman assigned to Plan A receives services covered by State funds only. A woman assigned to Plan C receives services covered by Federal funds first. If she needs services not covered by Federal funds, her care is covered by State funds. A woman assigned to Plan M has not been screened or diagnosed through the BreastCare program. She enters the program for treatment only after a cancer or precancerous cervical diagnosis and all claims are billed to Medicaid. Medicare Part B and Medicaid recipients are not eligible for services. For the purposes of the Program, the Family Planning Medicaid Waiver is not considered to be Medicaid coverage for breast services. Males, females age 65 and older, and non U.S. citizens are not eligible for Medicaid category 07 and are not eligible for treatment.

Plan A State	Plan C Federal	Plan M BreastCare Medicaid
Females Age 40-49, and	Females Age 50 and older, and	
		Females, under age 65, U.S. citizens or permanent residents, with a current diagnosis of breast cancer requiring treatment, or
		Biopsy diagnosis of cervical cancer, carcinoma-in-situ, or CIN II or III requiring treatment, and
Income at or below 200% FPL, and	Income at or below 200% FPL, and	Income at or below 200% FPL, and
Uninsured, or non-credible insurance, and	Uninsured, or non-credible insurance, and	Uninsured, or non-credible insurance, and
Arkansas resident	Arkansas resident	Arkansas resident

Income Calculation

The income for every person in the household must be counted. Multiple families living under one roof are considered to be one household. Alimony, child support, foster care, retirement and disability incomes are counted. Verification of income is not required.

Exception: High school and college students' incomes are not counted, but they are counted as a person in the household number.

Non-credible Insurance

A patient is considered to have non-credible insurance and is eligible for BreastCare when at least one of these criteria is absent:

- Coverage for inpatient care
- Coverage for outpatient care
- Coverage for physician services

Ineligible Women

Underinsured women are not covered for BreastCare services. Underinsured includes women with high deductibles and co-payments. Medicare Part B and Medicaid recipients are not eligible for services. This does not apply to the Family Planning Medicaid Waiver. Family Planning Medicaid Waiver recipients may be eligible for services if they meet the criteria listed on the previous pages.

If a woman is ineligible for BreastCare, a referral is made to a community provider, Encore for Women's Health, and /or Komen grantee. See Referrals for Indigent Care in this Volume. The PCP gives the woman a list of available resources by clicking on the "Additional Resources" link on the Patient Enrollment page online.

BreastCare identification card

When determined eligible, a BreastCare participant receives a computer-generated identification (ID) card for eligibility verification. Eligibility cannot be verified through the AEVCS System in the same manner as are Medicaid eligibility transactions.

The BreastCare Identification Card is printed and issued to the patient at the time of enrollment or at the first visit. The card guarantees an individual's eligibility until the expiration date on the card unless her circumstances change. The client is notified if her eligibility is ended or updated for any reason. Eligibility must be verified at each annual and follow-up visit. To withhold information or to give false information to the Arkansas Department of Health in order to receive services from BreastCare may constitute fraud, which is against the law. Fraud may be punished by imprisonment, a fine, or both.

Jane Doe
Client ID Number: 7777000000
Plan: A
Begin Date: 7/1/2011
Expiration Date: 6/30/201
PCP: Community Health Center
PCP Phone: (501) 123-4567

A program of the Arkansas Department of Health

Loss of ID card

When BreastCare participants report loss of an identification (ID) card or she doesn't have one with her on any particular visit, the PCP can reprint another card. If a patient does not present her ID card at the time of her visit, the provider may call her PCP to verify eligibility. Providers will not receive a paper referral.

Enrollment process

A woman must be enrolled in the Program through a participating PCP or county health department to be eligible for ADH services. A woman may enroll over the phone or in person for screening, diagnostic, or treatment services. All women enrolled are issued the list of Covered and Non-covered Services and Welcome to BreastCare pamphlet. She may be referred to the PCP by anyone including a nonparticipating PCP, mammography facility, or she may self-refer. A PCP is not required to enroll a woman who wants to receive her exam by another PCP or is she has been referred by a participating PCP. They are not required to enroll non-English speaking women without an adult interpreter. If services are rendered before a woman has been enrolled, ADH cannot reimburse for these services.

Self-referral

A woman may call a participating PCP herself to see if she is eligible and enroll in the program. If a woman is eligible and there is an available slot, the PCP enrolls the patient and enters the enrollment information into the online database. An appointment is scheduled with the enrolling PCP for a clinical breast exam (CBE) and/or Pap test. View or print the [Pap test policy](#). The patient is issued a computer-generated ID card that must be taken to all appointments. After the exam is completed, the provider enters the client data online. The provider schedules the mammogram appointment based on the CBE result.

Non-Participating Primary Care Provider referral

A non-participating PCP's office may refer a patient to a PCP who is able to enroll patients in the program. If the office puts the patient on the phone, she should be prepared to give the her age, gross monthly income, household size, and insurance status. If the patient is eligible and there is an available slot, she is enrolled in the program. An appointment is made with the participating PCP for a CBE and/or Pap test and mammogram referral. However, if the patient has already received her CBE or Pap test, she may be enrolled for mammogram only. The referring PCP is invited to participate in BreastCare. **PCPs should refer all potentially eligible women to a participating PCP or county health department for eligibility determination and enrollment.**

Mammography facility referral

A mammography facility may call a participating PCP or county health department when a woman has come in for a mammogram or diagnostic procedure and is identified as being potentially eligible for the program. Because coverage for the same date of service is dependent on the patient's and provider's eligibility, the procedure for that date of service is not covered if the patient is not enrolled before the procedure is performed. If eligible, the woman is enrolled in the appropriate plan and the mammogram is performed. The mammography provider must always verify eligibility through either the patient's ID card or by calling the PCP who enrolled her.

Mammography facility responsibilities

The Mammography facility receives orders for all initial, annual and follow-up mammograms from local providers for BreastCare patients. When the mammogram is scheduled, personnel should record the PCP's name, the plan, and client ID number given by the referring PCP or county health department. If the woman does not have her card, eligibility and the client ID number may be verified by calling the referring PCP. The mammography facility sends the mammogram report to the appropriate PCP and a letter to the patient. Annual reminders sent by the mammography facility instructs the patient to call her PCP to schedule their appointment and to bring their BreastCare ID card to their mammogram appointment. The facility should perform all necessary reimbursable procedures during the same appointment. A referral or preauthorization is not required for any covered radiology procedure. The mammogram/ procedure code, result code, and the client ID number must be entered on the Claim form. Go to the BreastCare website for [Billing Instructions](#).

Primary Care Provider (PCP) participation

For the purposes of this program, the following specialties enrolled as ADH providers will be considered PCPs:

- Family Practice
- General Practice (including osteopath)
- Gynecologist
- Internal Medicine
- Advanced Practice Nurses
- Community Health Centers
- Area Health Education Centers (Texarkana and Eldorado)

PCP role and responsibilities

Role of PCP

- Determines eligibility
- Enrolls clients
- Schedules mammograms
- Schedules other breast or cervical appointments
- Follows-up on all abnormal test results appropriately
- Offers community resources to ineligible clients
- Provides program materials for the patient
- Enters clinic visit data online within five days.
- Updates all online data until final diagnosis is reached on each patient

Responsibilities

As an ADH primary care provider, the PCP authorizes their name to be listed as a primary care provider and consents to release their name to women who require enrollment and screening through the program. A PCP agrees to enroll all eligible women and perform a CBE and Pap test if appropriate. After the exam is done, the PCP orders the appropriate mammogram and enters the client data online. Missed appointments must be documented online by updating the appointment status on the Patient Management page. The physician receives the mammogram and Pap test reports and follows up on any abnormal test result. A woman with an abnormal mammogram or Pap test is referred to the [Regional Care Coordinator](#). The PCP may refer patients only to ADH providers. ADH providers can be found at www.healthy.arkansas.gov under programs and services, BreastCare, Find a Doctor. However, if the patient chooses to go to a non-ADH provider, she is responsible for the charges incurred. The PCP may follow their follow-up policy and procedures or they may use the ADH follow-up policy and procedures. View or print [Notification of Pap test/mammogram results](#).

The PCP must have access to the BreastCare Online Data System. After the provider agreement is approved, go to <https://health.arkansas.gov/adhinternetapps> to request access. An e-mail will be sent with a link to set up the provider's password. Click on that link and enter a password of your choice. Then click on login. A BreastCare button will

display on the left menu. When you are ready to enroll a patient, login and click on the BreastCare button.

Policies:

Each PCP or LHU determines eligibility, enrolls the patients, and schedules the mammogram appointment. Eligibility must be verified on the each time the patient is seen in the clinic.

Procedures:

1. A patient contacts the PCP directly to enroll in the BreastCare program.
2. Logon to <https://health.arkansas.gov/adhinternetapps>
3. Search for the patient's name.
4. Click on the BreastCare button, then click on Patient Management. The BreastCare Patient Information screen displays. Enter all missing information. Click on "continue with Patient".
5. For existing patients, the Open Plan Options screen displays. Choose the option of "Assess Eligibility".
6. Go through all the questions to determine eligibility. If eligible, the system enrolls the patient and gives her a BreastCare Identification (ID) number. Verification of income is not required.
7. Enter an appointment date for a Clinical Breast Exam (CBE) and/or Pap test in the clinic.
8. Enter the appointment status as "Scheduled". If the patient reschedules the appointment or did not keep the appointment, change the appointment status appropriately.
9. Click on "BreastCare Card" at the top right of the Patient Management Screen to print the ID number, begin and ending dates, and PCP name to give to the patient at the time of enrollment or at her first visit.
10. Issue a copy of the pamphlet "Welcome to BreastCare and "Covered and Non-covered Services.
11. If the patient is not eligible, click on "additional resources" and a list displays that can be printed and given to the patient.

Procedures:

The PCP or LHU enters all screening and diagnostic services received by BreastCare patients into the ADH's online Patient Management System according to the following procedure:

1. Enter the visit for CBE and Pap test online within five days in Patient's Medical History.
2. Enter the mammogram appointment on the Mammogram page.
3. Check on mammogram results within 10 working days and enter results online on the Procedure page.
4. Enter Pap test/HPV results online. The HPV test is entered as a separate procedure with date performed the same date as the liquid-based Pap test.

5. Enter all follow-up information including name, date, location, and results of any diagnostic procedures performed within five days of receiving the results.
6. Enter procedure results online as soon as results are received.

Provider participation requirements

Physician and non-physician providers must be ADH providers to utilize the BreastCare billing and reimbursement system. To become a participating provider, a [Public Health Service Agreement](#) must be completed online at <https://health.arkansas.gov/breastCare>. BreastCare will e-mail all of the completed documents to the provider for them to print, sign, and mail to ADH, 4815 W. Markham, Slot H-11, Little Rock, AR 72205. Physicians, Nurse Practitioners, and CRNAs must complete the Provider Name and Specialty Form. Group practices must submit their name, billing information if different from the group's address, and a Provider Name and Specialty Form with each physician /nurse in the group. Medical license, DEA license, and the Medicare number must be submitted for each clinician initially and upon each renewal. When a signed agreement is received, the provider will be issued a BreastCare provider number for the group, each individual physician, and one number for a facility.

To assure quality services, the physician will obtain one (1) CME each annually, as appropriate, related to breast cancer diagnosis/treatment and/or cervical cancer diagnosis/management. Anesthesiologists will obtain CME as required by their specialty. Documentation of CME must be submitted with the Provider Agreement biannually. Providers may visit www.healthy.arkansas.gov for CME opportunities. Participation in scheduled BreastCare web conferences is also required.

Mammography facilities must provide proof of Food and Drug Administration Mammography Quality Standards Act Certification or provisional certification. Mammogram results must be reported using the MQSA final assessment categories. Facilities must accept BreastCare orders for mammogram and ultrasound procedures that have original signatures by ADH clinicians. View or print the [Adapted MQSA Regulations](#). Laboratories must provide proof of CLIA Certification. Pap test results must be reported in the Bethesda System. View or print the [Bethesda System 2001 Recommendations](#).

The provider may perform covered procedures subsequent to, and as indicated by, initial evaluation, without need for prior approval unless prior approval is required. Appropriate treatment will be given according to sound medical judgment and the informed consent of the patient. All treatment options will be discussed with the patient. The provider may not provide any non-covered services without full disclosure to the patient that said service will not be paid by ADH and the patient will be responsible. It is the responsibility of the provider who renders service to document that BreastCare requirements are met.

2. Coverage

Scope

The Arkansas Department of Health covers breast and cervical cancer screening, diagnosis, and treatment for women age 40 and older who are enrolled in the Program within restrictions set in federal and state guidelines. Coverage for breast and cervical cancer treatment is limited to females of any age who are eligible for Medicaid category 07. Detailed coverage, limitations, prior authorization, reference information and other requirements may be found in those specific sections within this manual. The patient's eligibility for services should be determined before services are rendered. BreastCare is not a Medicaid program, and participants are not subject to Medicaid benefits. However, when a woman is diagnosed with breast or cervical cancer or certain precancerous conditions, she may be eligible for a special breast and cervical cancer Medicaid category 07. When determined eligible for this special category, the patient is entitled to the full range of Medicaid benefits while she is receiving cancer treatment. Go to the [Client eligibility](#) section of this manual.

Medical benefits

The following is a table summarizing the coverage for each plan. Refer to the ADH website for a complete listing of covered BreastCare procedure codes and rates. View or print the reimbursement rates for [Breast](#) and [Cervical](#) procedures.

Eligible medical conditions for referral

- A need for screening or diagnostic mammogram
- A mammogram requiring further diagnosis
- An abnormal CBE requiring further diagnosis
- A Pap test requiring further diagnosis
- A breast or cervical biopsy which indicates need for treatment
- A breast or cervical cancer patient who is receiving treatment and needs financial assistance

Plan A State	Plan C State and Federal	Plan M BreastCare Medicaid
Clinical Breast Exam	Clinical Breast Exam	
Screening mammogram	Screening mammogram	
All diagnostic services required for follow-up after an abnormal clinical breast exam or mammogram	All diagnostic services required for follow-up after an abnormal clinical breast exam or mammogram	
<i>Breast Cancer treatment</i>		
Surgical treatment Chemotherapy Radiation therapy	Surgical treatment Chemotherapy Radiation therapy	Infiltrating Ductal Carcinoma Infiltrating Lobular Carcinoma Ductal Carcinoma-in-situ (DCIS) Lobular Carcinoma-in-situ Paget's Disease Malignant Phyllodes Tumor Recurrent Breast Cancer Breast Cancer with Metastatic Disease
<i>Cervical Cytology</i>		<i>Cervical Cancer Treatment</i>
Pap test Colposcopy Cervical biopsy All diagnostic services for follow-up after an abnormal Pap test	Pap test Colposcopy Cervical biopsy All diagnostic services for follow-up after an abnormal Pap test	Squamous Cell Carcinoma Adenocarcinoma Recurrent Cervical Cancer Cervical Cancer with Metastatic Disease Precancerous Treatment Cervical Intraepithelial Neoplasia CIN II/III/CIS

Covered services by plan

View or print the list of [covered and non-covered services](#) that is given to every client upon enrollment. Refer to plan A or C for services that are covered by each plan. All BreastCare enrollees are informed of their coverage and are responsible for non-covered services.

Benefit limits

Benefit limitations apply to all procedures/treatment. View [Billing Instructions](#) at the ADH website for an explanation of specific benefit limitations for each procedure code.

Screening benefit limits

Mammograms

One screening mammogram per Federal Fiscal Year (July 1 through June 30) is covered and must be performed in the same month as the previous year. Procedure code 77057 and G0202 is subject to the benefit limit. Procedure codes 77055, 77056, G0204, and G0206 must be used for all other mammograms in the same fiscal year and are limited to three per fiscal year.

A mammogram result of unsatisfactory is not payable. An unsatisfactory mammogram must be repeated until a satisfactory result is achieved.

Pap tests

Effective July 1, 2007, the following liquid-based cytopathology procedures with normal results are reimbursable every 24 months.

- 88142 (cytopathology, liquid-based Pap test, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision)
- 88175 (cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision)

After three consecutive negative Pap tests, procedure codes 88141, 88142, 88150, 88148, 88164 and 88175 are only payable every three years. Exception: Patients who have had hysterectomies for cervical cancer or CIN II/III, DES exposure, are HIV positive, or have any other immunocompromised condition continue to receive annual Pap tests.

A patient who has had a hysterectomy for a benign condition and who does not have a cervix is not eligible to receive a Pap test. 88141, 88142, 88150, 88148, 88164, and 88175 (Pap tests) are not payable if this condition is present. Pap tests are reimbursable only if the patient has a cervix or she has had a hysterectomy due to cervical CIN II/III or cancer or she is symptomatic.

The specimen adequacy must be reported with the Pap test result. **If the specimen adequacy is unsatisfactory, the Pap test result must be unsatisfactory, and the Pap test must be repeated in three months.**

Office visits

99203, 99212, 99213 can be billed by family physicians, internal medicine, gynecologists, nurse practitioners, surgeons, Community Health Centers, and Area Health Education Centers. These codes cannot be billed for post-treatment follow-up visits.

Diagnostic benefit limits

A PCP referral is required for surgical consultation.

Procedure code 99203 can be billed two times per FFY and two times per date of service. Procedure codes 99212 and 99213 can be billed three times per FFY and one time per date of service. These codes cannot be billed for post-treatment follow-up visits.

Procedure code 76095 (stereotactic breast biopsy) is not payable for a palpable mass.

Each procedure code 80076 (hepatic function panel), 80053 (comprehensive metabolic panel), 71020 (chest x-ray) can be billed preoperatively only up to two times per FFY and four times per lifetime. Result and recommendation codes are not required for these procedures.

Procedure code 85025 (complete blood count) and 85027 (Hemogram and platelet count, automated) can be billed preoperatively only.

Effective July 1, 2007, HPV DNA high risk testing (87621) is reimbursable when used in the follow-up of an ASC-US result from the screening Pap test. The HPV test is not reimbursable as a screening test. Providers must specify the high-risk HPV DNA panel; reimbursement of screening for low-risk genotypes of HPV is not covered by BreastCare.

Procedure codes 57421 (endoscopy with biopsy of vagina/cervix), 57420 (Colposcopy for entire vagina and cervix), 57452 (colposcopy without biopsy), 57454 (colposcopy with biopsy and endocervical curettage), 57455 (colposcopy with biopsy), 57456 (colposcopy with endocervical curettage), 57505 (endocervical curettage), 57460 (colposcopy with loop electrode biopsy), 57461 (colposcopy with conization), 57520 (conization of cervix), and 57522 (conization of cervix), 58100 (endometrial biopsy), and 58110 (endometrial sampling, biopsy performed in conjunction with colposcopy) cannot be billed on the same date of service as 99203, 99212 and 99213 (office visits).

Procedure codes 57460, 57461, 57520, 57522 are payable only for diagnostic purposes with prior approval and according to the policy for Reimbursement of LEEP and Cone. Go to the [Case Management](#) section of this manual for more information.

Treatment Referrals

Treatment covered by BreastCare is limited to uninsured patients who are eligible for Breast and Cervical Cancer Medicaid category 07. State funds do not cover treatment services for breast or cervical cancer or precancerous cervical conditions. Physicians must call the Provider line at 501-661-2513 to refer all uninsured patients diagnosed with breast or cervical cancer. This phone number must not be given to patients. All claims for a BreastCare enrollee diagnosed with breast or cervical cancer and who is also a Medicaid recipient are billed to Medicaid and covered according to Medicaid's guidelines.

If a patient is instructed to apply for regular Medicaid but refuses to apply within 30 days from the date of the breast or cervical cancer diagnosis, the treatment provider may bill the patient. The patient has been informed of this requirement.

BreastCare provider specialties

Certain provider types and specialties may perform BreastCare services. See the following table and codes, BreastCare Provider Types and Specialties. Each procedure code can only be performed by certain provider types and specialties and billed with certain diagnosis codes. View or print the [Procedure Codes to Provider Types/ Specialties/Diagnosis Codes](#).

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Physician, M.D.	02	Surgery: General/Oncology/
02	Physician, M.D., Group	08	Family/General Practice
03	Physician, D.O.	11	Internal Medicine
04	Physician, D.O., Group	16	OB/GYN
68	Managed Care - Group AHEC (Provider specialty 08)	22	Pathology
		30	Radiology
		05	Anesthesia
		C3	CRNA
05	Hospital	W6	Inpatient
		W7	Outpatient
09	Independent Laboratory	69	Independent Laboratory
10	Independent Radiology	63	Mammography
28	Ambulatory Surgical Center	A4	Ambulatory Surgical Center
49	Federally Qualified Health Center/Rural Health Center	F2	Federally Qualified Health Center/Rural Health Independent Free Standing
58	Nurse Practitioner	N3	Nurse Practitioner

Prior Authorization

Colposcopy with loop electrode biopsy of cervix (57460), colposcopy with loop electrode conization of cervix (57461), conization of cervix (57520), and loop electrode excision (57522) are covered for diagnostic purposes only and require Prior Authorization (PA). The PA procedure is performed according to state guidelines to insure that all women receive a high standard of care. All requests for PA should be submitted by the attending physician/facility that will perform the procedure/treatment on the Authorization for Prior Approval. View or print the [Authorization for Prior Approval form](#). Each provider must obtain a prior authorization number. A procedure that requires PA must be approved by the BreastCare Nursing Coordinator before the procedure is performed.

NOTE: Prior authorization of a service does not guarantee reimbursement for the service unless:

1. The participant is enrolled in BreastCare on the dates of service.
2. The service is provided by an ADH participating provider.
3. All other program requirements are met.

Prior Authorization request procedure

The following procedure must be followed for PA.

1. Complete and forward the Request for Prior Authorization to

Arkansas Department of Health
4815 W. Markham, Slot H-11
Little Rock, AR 72205
Attn: BreastCare Nurse
Fax: 1-501-280-4049
2. The BreastCare nurse reviews the Authorization for PA. BreastCare notifies the provider of the approval or denial of the PA within 30 working days following receipt of the PA request.
3. If the treatment plan is denied, the Authorization for PA form is returned to the provider with an explanation of the denial on the BreastCare Disposition. The BreastCare Medical Director reviews and makes the final determination regarding denials of PA requests.
4. If additional information is needed, the Authorization for PA will be returned with the BreastCare Disposition form explaining reason for return. The Request for PA may be resubmitted with the required information.
5. If the request is approved, the Authorization for PA will be returned to the provider with the assigned prior authorization number. Service may then be provided. The PA number must be entered on the claim form. All claims for procedure codes requiring PA that do not have a PA number will be denied.

Scope, frequency, and duration of authorization

The beginning date of service authorized by ADH is the prior authorization (PA) effective date. The beginning date of service is usually the beginning date requested by the provider.

Prior authorization is valid for the procedure codes and dates of service that ADH authorizes. The procedure codes and dates of service are linked electronically to a PA Control Number and the participant's files. When billing using the PES software, enter the PA Number at the "PA Number" prompt on the electronic claim form.

PA control numbers may be used only by the providers to whom they are issued. ADH issues PA numbers to "clinic" or "group" providers by request when appropriate. Clinic and group providers are sole-proprietor individual practices, or practice associations or partnerships of providers of the same provider type, and has one revenue and tax liability of which is identified by a Federal Employer Identification Number. A PA number issued to a group practice is linked to the group provider number to bill for the authorized services.

Prior authorizations are valid until the end of the patient's eligibility period. The BreastCare Identification card indicates the eligibility expiration date. If the patient's eligibility expires during treatment, the eligibility must be renewed through the PCP before it expires. Prior authorization does not guarantee payment unless the patient is eligible on the date of service.

3. Reimbursement

The methods used by the ADH to determine reimbursement rates for BreastCare services are fee-for-service and capitation based on the current Medicare allowable reimbursement rates. The participating provider agrees to accept the ADH fee-for-service and/or capitated reimbursement rates. The rates are revised annually to reflect the current Medicare rates. The provider agrees to not bill the patient for covered services. ADH is the payer of last resort. All invoices for patient services must be submitted within 30 days after the date of service. ADH does not have access to claims information. For billing questions, please call Hewlett Packard (HP) Enterprises toll free at 1-855-661-7830.

The provider may not bill under this Program for:

1. Completion of a form.
2. A broken or missed appointment.
3. A professional service rendered by phone or mail.

Reimbursement for screening and diagnostic procedures

ADH provides fee-for-service reimbursement for all screening and diagnostic procedure codes with modifiers 26, TC, or complete component. Professional and technical components may be billed separately. When procedure codes 19000, 19001, 19100, 19101, 19290, or 19291 are performed by a physician in a facility rather than an office, use facility as place of service. The reimbursement amount will be the Medicare allowable for being performed in a facility. Independent radiology facilities should use office as place of service.

Procedure codes 19120, 19125, and 19101 with outpatient as place of service are reimbursed at a capitated rate. Anesthesia, pathology, radiology, and lab may be billed separately. Providers must bill actual charges or up to the capitated limit. These codes should be used for excisional or incisional biopsies for diagnosis only.

HPV High Risk Testing (87621) is payable only as follow-up to ASC-US result on screening Pap test.

Effective July 1, 2007, cytopathology laboratories are required to enter the referring provider when submitting a claim for a Pap test of any type.

Procedure codes 57460, 57461, 57520, 57522 are payable only for diagnostic purposes with prior approval and according to the policy for Reimbursement of LEEP and Cone. Go to the [Case Management](#) section of this manual for more information.

Reimbursement for treatment procedures

Reimbursement for treatment is limited to uninsured women who are eligible for Breast and Cervical Cancer Medicaid (Category 07) and meet all other program eligibility criteria. If a BreastCare enrollee is diagnosed with breast or cervical cancer and is also a Medicaid recipient, treatment procedures are covered and billed according to Medicaid's guidelines.

Automatic deposit

BreastCare reimbursement by automatic deposit or Electronic Funds Transfer (EFT) is required. EFT allows the payments to be directly deposited into the provider's bank account. EFT increases cash flow because money is made available sooner than the actual clearance date of paper checks. A Remittance Advice (RA) is mailed to the billing address on the provider's agreement weekly with the status of all transactions.

The provider must complete the Authorization for Automatic Deposit online and return a **voided check** to ADH with the signed agreement. Go to healthy.arkansas.gov. Click on Programs and Services, BreastCare, Just for Providers, forms and manuals, for the [Authorization for Automatic Deposit form](#). Complete this form to make any updates to your banking information and mail to BreastCare, attention: Shiela Couch.

Timely filing limit

Claims must be filed within 60 days from the date of service. After 120 days from the date of service, claims will be suspended for failure to submit the claim by the filing deadline. These claims will be reviewed manually and will delay reimbursement.

Claims for services provided from July 1 – June 30 must be billed by August 15 of each year to receive reimbursement. Exceptions to this policy cannot be made.

Appeal process

A provider or patient who receives a denial from BreastCare either for payment of a claim or for the coverage of a procedure may request a review of the denial by Arkansas Department of Health. All requests for review must be submitted in writing to the Director of BreastCare, Arkansas Department of Health, 4815 W. Markham, Slot H-11, Little Rock, AR 72205.

Fraud and abuse

Any provider who engages in fraudulent billing practices will be immediately suspended from participation until these practices are evaluated and resolved. Also, any provider discovered to be involved in fraudulent billing practices or found to be accepting or soliciting unearned rebates, refunds or other unearned considerations, whether in the form of money or otherwise, will be referred to the appropriate legal agency for prosecution under applicable federal or state laws. Any provider who engages in abuse or over-utilization of services provided to BreastCare clients, when such abuse or over-utilization has been determined by ADH professional staff, medical consultants, contractors or designees, may be terminated from participation in the BreastCare program, required to repay monies paid by the BreastCare program for such services or have other appropriate action taken upon recommendation of the above-referenced parties.

Except where participation has been terminated, each provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs will include, at a minimum, the following:

1. Instruction on admissions and authorization for payments

2. Instruction on the use and format of required program forms
3. Instruction on key provisions of the BreastCare program
4. Instruction on covered procedures and reimbursement rates
5. Instruction on how to inquire about program requirements, payment or billing problems and the overall operation of the program

4. Case management

Outcomes

Follow-up for patients that have been examined and/or referred for screening or diagnostic services is an integral part of patient care. Primary care providers document screening and diagnostic services and final outcomes in the Online Data System. State and Federal guidelines require specialists to provide outcome information on the Claim form with each procedure billed. View [Billing Instructions](#) at healthy.arkansas.gov. Click on Programs and Services, BreastCare, Just for Providers, forms and manuals.

CHCs and AHECs report final outcomes for patients using the Breast or Cervical diagnostic forms. View or print the [Breast Diagnostic Form](#) or the [Cervical Diagnostic Form](#). Go to the [Community Health Centers and Area Health Education Centers](#) section of this manual for the enrollment, screening, referral, case management process.

Performance standards

- Performance feedback and outcome data are given to providers on a regular basis. The following performance standards are used for overall program evaluation, quality assurance, and outcome indicators:
- For normal screening results, closure for 90% of cases is achieved in one month from the date of Pap test and/or mammogram report. Closure means Pap test and/or mammogram results are in the chart. The patient record is kept open for annual re-screening.
- For abnormal screening results, follow-up for 90% of cases is completed within two months.
- The interval from screening to final diagnosis is no longer than 60 days. Completed follow-up means all definitive diagnostic procedures are performed and treatment is started if indicated. The result is documented in the chart and the woman and BreastCare are notified. Exception: Patient refused or is lost to follow-up.
- The interval for Pap test screening for women age 50 and older depends on past results and risk factors. With a history of three negative Pap tests and asymptomatic, women are screened every 3 years. Otherwise women will be screened every 24 months. Women who have had hysterectomies for a benign condition are not screened for cervical cancer.

Core Performance Indicators

Indicator Type	Program Performance Indicator	Program Standard
Screening	Initial Pap test; Rarely or Never Screened	≥ 20%
	Screening Mammograms Provided to Women ≥ Age 50	≥ 75%
Cervical Cancer Diagnostic Indicators	Abnormal Screening Results with Complete Follow-up	≥ 90%
	Abnormal Screening Results; Time Screening to Diagnosis > 60 days	≤ 25%
	Treatment started for HSIL, CIN II, CIN III, CIS, Invasive	≥ 90%
	HSIL, CIN II, CIN III, CIS; Diagnosis to Treatment > 90 days	≤ 20%
	Invasive Carcinoma; Diagnosis to Treatment > 60 days	≤ 20%
Breast Cancer Diagnostic Indicators	Abnormal Screening Results with Complete Follow-up	≥ 90%
	Abnormal Screening Results; Screening to Diagnosis > 60 days	≤ 25%
	Treatment started for Breast Cancer	≥ 90%
	Breast Cancer; Diagnosis to Treatment > 60 days	≤ 20%

Follow-up/reporting

Follow-up

Providers are responsible for assuring that women with abnormal or inadequate screening tests receive appropriate follow-up. Ten to fifteen percent of participants are expected to require further diagnostic testing, and a very small percentage will ultimately need treatment. BreastCare requires that abnormal follow-up is completed in 60 days. Each provider must have an established breast and/or cervical follow-up policy, procedures, and tracking system in place. Providers may use their own follow-up policy and procedures or they may use the ADH policies and procedures for follow-up. View or print the [Notification of Pap Test and Mammogram Results](#) and [Pap test/Mammogram Management Protocol](#) documents, or go to the [Missed Appointments](#) section of this manual. There is a Care Coordinator in each region of the state to assist with abnormal follow-up. View or print the [Regional Care Coordinator's Contact Information](#).

Reporting

After a PCP sees a patient for a CBE and/or Pap test, a claim is submitted for an office visit. The PCP entering the Pap and mammogram result online is a condition of payment. However, the PCP is responsible for updates to the online Patient Management System each time there is an appointment made or result received and when the patient is Lost to follow-up or refuses services until the final diagnosis status is complete. After a

procedure/visit is performed by any other provider, the result and recommendation is submitted on the BreastCare Claim form. To determine which result and recommendation codes are required for each type of service and procedure code being billed, or for more information on submitting the claim form, refer to the [Billing Manual](#).

Follow-up and closure of all abnormal screening tests are necessary unless a patient refuses or is lost to follow-up. When a provider is aware that a patient refuses diagnostic work-up or is lost to follow-up, the provider refers this patient to the regional care coordinator. View or print [Care Coordinator Referral Form](#).

Manual or computerized tracking systems are acceptable. Mammogram/Pap test logs must be maintained and kept updated to track test results. The provider may contact the BreastCare Nursing Coordinator for assistance in implementing an office reminder/tracking system. View or print the [Pap test Log](#) or the [Mammogram Log](#).

Referrals for case management

The role of the BreastCare Care Coordinators is to coordinate client care to provide timely and appropriate follow-up for women with abnormal test results. This is accomplished through identifying needs and barriers to adequate care, establishing a plan of care with the client's input and coordinating activities to obtain appropriate care. The Care Coordinator:

- reassesses the plan and its effectiveness as well as the client's compliance with the plan of care and, finally, evaluates each individual case.
- develops resources and works to improve the utilization of existing resources in the counties he/she serves.
- manages the delivery of services to meet the multiple needs of program participants with abnormal breast and/or cervical screening results or a diagnosis of cancer.
- initiates the transition to BreastCare Medicaid for eligible women.
- provides professional education and outreach to providers.

Case management services begin when the provider refers a client for assistance in obtaining care and ends when the client no longer needs Case Management services. The BreastCare Medicaid clients are case managed until treatment is started and tracked until treatment ends. The Care Coordinator must consult with the Program Nursing Consultant on any unresolved provider or patient issues.

Abnormal screening results that must be referred to a Care Coordinator for follow-up and tracking include:

- Mammography - Suspicious abnormality (category 4) and highly suggestive of malignancy (category 5).
- Ultrasound - Solid mass suspicious for cancer.

- Pap – ASC-US with HPV Positive, ASC-H, AGC, AGC-EM, AEC, LGSIL, HGSIL, Carcinoma-in-Situ (CIS), and squamous cell carcinoma.
- Abnormal clinical breast exam requiring a breast biopsy.
- Enrollees who are consistently non-compliant with follow-up and for any diagnostic treatment procedures.
- Enrollees that refuse follow-up or are lost to follow-up.

All patients with a breast or cervical cancer diagnosis or cervical biopsy diagnosis of CIN II/ III, or CIS must be referred to the Care Coordinator for possible transition to Medicaid Category 07.

Providers contact their assigned Care Coordinator by phone to notify him/her of a patient who is eligible for case management services. A copy of the patient's applicable reports (mammogram, ultrasound or Pap/HPV) and the [Care Coordinator Referral Form](#) is completed and sent to the Care Coordinator, who then becomes responsible for entering the patient data online. The patient's record should be placed in a pending file until the Care Coordinator notifies the provider that the record may be closed.

The Care Coordinator returns any pertinent documentation regarding services the woman received to the provider to be included in the patient record when case management activities are completed.

Referrals for Breast and Cervical Cancer Medicaid

The Breast and Cervical Cancer Treatment Act (BCCCPTA) gives the option of providing Medicaid benefits to uninsured women under age 65 who are in need of treatment for breast and cervical cancer and women with cervical biopsy diagnoses of CIN II/ III or CIS. The woman must meet the eligibility requirements for BreastCare. Arkansas implemented this program December 1, 2001 by expanding the BreastCare program currently administered by the Arkansas Department of Health. The application process is as follows:

When a woman who is currently enrolled in BreastCare is diagnosed with breast or cervical cancer or cervical biopsy diagnosis of CIN II/ III or CIS, providers notify the Regional Care Coordinator. The provider completes [The Care Coordinator Referral Form](#) and [Diagnosis Verification and Treatment Plan](#) and faxes them to the appropriate Care Coordinator within five days of a biopsy with a result of cancer. The Care Coordinator and the Program Nursing Coordinators initiate and complete the application process for the woman. The provider completes the [Annual Verification of Treatment](#) at the end of each year to report if the patient is still in treatment.

To refer any age woman who is not enrolled in BreastCare and is diagnosed with breast or cervical cancer or a specific precancerous cervical condition, the treatment provider calls the provider line at 501-661-2513. During the period of Medicaid coverage, a woman is entitled to the full range of Medicaid benefits. This coverage ends when the breast or cervical cancer treatment ends.

Referrals for indigent care

Uninsured patients needing diagnostic or treatment services that are not covered by the program are referred to an institution or provider in their community who offers free/reduced cost care, Arkansas Health Care Access Foundation (AHCAF) or UAMS. See Providers Offering Free/Reduced Cost Care and Community Health Centers/Area Health Education Centers of Arkansas in the Appendices of this Volume. Women may contact Encore for Women's Health at 501-663-8111 or 888-663-3914 for additional resources. Refer patient to call 1-888-4ppa-now for prescription assistance.

Available community resources must be accessed before referring to AHCAF and UAMS. A woman who is unable to enroll in BreastCare or is ineligible may be referred to a Komen grantee according to where she lives in the state. A woman who is unable to enroll in BreastCare and lives in the following counties may be referred to the UAMS Mobile Mammography Program for a screening mammogram. The provider is not responsible for follow-up or case management for these women.

- Grant
- Lee
- Miller
- Dallas
- Franklin
- Lincoln
- Logan
- Marion
- Monroe
- Calhoun
- Lafayette
- Nevada
- Newton
- Pike
- Prairie
- Perry
- Poinsett
- Woodruff
- Cleveland
- Fulton
- Lonoke
- Montgomery

Referral to AHCAF

1. Complete an Arkansas Health Care Access Foundation, Inc. application, with a notation at the top right corner of the application that this is a "B&C Screening" application. (Also write "B&C Screening" on the outside of the envelope.) The PHN and the patient must sign the application.
2. Mail the original to the Foundation.
3. Give a copy to the patient and keep a copy in the Arkansas Health Care Access Foundation binder in the LHU.
4. Make the appointment and notify the patient of the arrangements.
5. If any problem occurs, contact the Foundation for clarification.

Referral to UAMS Mobile Mammography

1. Instruct the patient to call 1-800-259-8794.
2. UAMS assesses her eligibility based on $\leq 200\%$ Federal Poverty Level.
3. UAMS instructs the patient on the date, time, and location the Mobile van will be in her area performing mammograms.
4. UAMS refers women who need a Pap test to a participating PCP.
5. The PCP enrolls eligible women who need a Pap test and schedules an appointment.
6. UAMS covers cost of breast screening, diagnostic and ultrasound. BreastCare is not billed for mammograms.
7. BreastCare covers cost of office visit for Pap test and laboratory charge for Pap.
8. BreastCare covers cost of diagnostic follow-up for abnormal Pap test results.

Note: BreastCare clients receiving a mammogram on any other mobile mammography unit must be enrolled on or before the date of service.

Referral to Komen Grantees

Visit www.Komenarkansas.org to obtain mammogram assistance for women who live in the Arkansas Affiliate counties. Click on “Grants.”

Visit www.Komenozark.org to obtain mammogram assistance for women who live in the Ozark Affiliate counties. Click on “Grants.”

Visit www.Komentexarkana.org to obtain mammogram assistance for women who live in the Texarkana Affiliate counties. Click on “where your money goes.”

ADH responsibilities

The BreastCare Nursing Coordinators and the Regional Care Coordinators assist with tracking and follow-up, case management, quality assurance, and professional development. ADH is responsible for management of the overall data quality and integrity. The Minimum data element (MDE) report is submitted to Centers for Disease Control and Prevention every six months. An analysis of this report determines if Arkansas' BreastCare program meets the 11 required core indicators. ADH will share the outcome of the MDE report with all providers. Epidemiological reports are also generated to study trends in the BreastCare population.

The [Adequacy of Follow-up for Breast Cancer Screening](#) algorithm and the [Bethesda 2001 Recommendations](#) are used to monitor and evaluate abnormal breast and cervical follow-up. When a diagnostic work-up is required, a final diagnosis must be documented for follow-up to be considered adequate. Refused or lost to follow-up are exceptions. When a diagnostic work-up is required, the time from the CBE, mammogram, and/or Pap test to the final diagnosis must be no more than 60 days. The BreastCare Nursing Coordinators and Regional Care Coordinators are responsible for obtaining follow-up data that has not been submitted on a claim or reporting form.

Clinical guidelines

The physical assessment may include a pelvic exam and Pap test. A woman may request breast exam/mammography alone or Pap and pelvic alone. However, the complete package of services (CBE, Pap test, pelvic exam, and annual mammography referral) is encouraged for eligible women. See Clinical Breast Exam and Pap test procedures below.

The Arkansas Department of Health recommends the following publication for management guidelines for breast abnormalities: *The Management 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 at www.utmb.edu/surgery/clerks/primer.htm.

Mammogram management

The provider uses the MQSA final assessment categories and the Patient Management Protocol to manage all patient mammogram results. View or print the [Adapted MQSA Regulations](#), [Pap test/Mammogram Management Protocol](#), and [Breast Management Flow Chart](#).

Management of negative/positive CBE

Follow-up procedures are based on the clinical breast examination results.

Negative Clinical Breast Examination

The following procedure is followed for a patient with a negative CBE.

1. Refer for a screening mammogram. Also order breast ultrasound in the presence of a palpable mass.
2. If the screening mammogram is abnormal, schedule additional studies as recommended by the radiologist.
3. If the screening mammogram result is probably benign, schedule a repeat diagnostic mammogram at the interval recommended by the radiologist (3-6 months).
4. Document receipt of reports and further follow-up plans.
5. Call the Regional Care Coordinator or the BreastCare Nursing Coordinator with questions concerning results or recommendations.

Positive Clinical Breast Examination

The following procedure must be followed for a patient with a positive CBE.

1. Refer for diagnostic mammogram.
2. Schedule additional studies as recommended by the radiologist. If a biopsy is recommended, refer to a trained radiologist to perform the biopsy when appropriate. If the radiologist performs a biopsy that results in a benign diagnosis or if ultrasound demonstrates a **simple** cyst or benign abnormality, a surgical consultation is not required. If an ultrasound results in a diagnosis other than a simple cyst, **and** the radiologist has not performed a biopsy, refer the patient for surgical consultation even in the presence of a normal diagnostic mammogram and/or **normal** ultrasound.
3. Document receipt of reports and further follow-up plans.
4. Call the Regional Care Coordinator or the BreastCare Nursing Coordinator if the radiologist's or surgeon's recommendations differ from the Patient Management Protocol.

NOTE: The mammogram results must always be compared to the CBE result. A palpable solid mass must result in a surgical consultation and/or biopsy.

A breast ultrasound is an additional study that helps determine whether a mass is cystic or solid. If an ultrasound result is cystic, no further follow-up is required. All other ultrasound results with a positive CBE require a surgical consultation and/or biopsy.

Clinical Breast Examination procedure

1. With the patient sitting:
 - a. Inspect for asymmetry, abnormal superficial vascular patterns, dimpling, nipple retraction, peau d'orange.
 - b. Palpate axillary, supraclavicular, and infraclavicular nodes. Note size, location, mobility and consistency of nodes palpated.
2. With the patient lying down:
 - a. Palpate the breast with the pads of the three middle fingers. The palpation motion should consist of small circles, about the size of a dime.
 - b. Examine the breast tissue in the armpit and chest area from collarbone to below the breast using the vertical strip method. Use the following three distinct pressure levels:
 - the first circle with very light pressure.
 - the second circle with medium pressure.
 - the third circle with deep pressure.
 - c. Observe for spontaneous nipple discharge.
 - d. Repeat procedure on other breast. Never examine just one breast.

NOTE: The vertical strip is more effective in lump detection and is now the recommended pattern.

Surgical scarring and skin lesions, such as moles or birthmarks, are not considered abnormal/suspicious for cancer. These exam findings are documented as normal/benign. A CBE of the chest wall is performed on a post-mastectomy site.

Breast biopsies

Breast biopsies are considered reimbursable procedures only when performed by participating surgical/ radiology providers, after preliminary image evaluation, on an outpatient basis, and in accordance with approved guidelines. Refer to a trained radiologist to allow for the least invasive and least costly approach when appropriate. View or print the [Biopsy Guidelines](#) approved by the CDC and the BreastCare Medical Advisory Committee.

Cervical cytology

Women are eligible for Pap tests according to ADH policy. BreastCare patients receive ThinPrep liquid-based Pap tests with normal results every 24 months. If a woman has had cervical cancer, CIN II/III, DES exposure, is HIV positive, or has other immunocompromised condition; she receives a Pap test every 12 months. A woman who has had a total hysterectomy for a benign condition does not receive a pelvic exam and Pap test. ADH will not cover pelvic exams and Pap tests on women who do not have a cervix; however, if a woman does not know if her cervix was removed, a pelvic exam may be done to determine anatomy. The office visit for a pelvic exam alone is not a reimbursable visit. If a woman has had a hysterectomy due to cervical cancer or dysplasia, or if the cervical stump remains, the Pap test is reimbursable. HPV DNA reflex testing is performed only for ASC-US Pap results. See [Algorithm for ThinPrep/HPV Tests](#).

All screening sites performing Pap tests must use participating cervical cytology laboratories. Claims submitted from other laboratories will be denied. The BreastCare client Identification number must be entered on the Pap Requisition form before being sent to the laboratory.

Pap test management protocol

Pap test results are reported according to the [Bethesda 2001 Recommendations](#) and must be managed according to the American Society of Colposcopy and Cervical Pathology (ASCCP). Go to the ASCCP website at <http://www.asccp.org/consensus/cytological.shtml>. The Nursing Coordinators and Regional Care Coordinators use these guidelines to evaluate follow-up.

A diagnostic work-up must be scheduled when there is a Pap test result requiring colposcopy/MD consult per ADH policy. The time from an abnormal Pap test to the final diagnosis must be no more than 60 days. Cervical polyps are not neoplasia and do not require follow-up.

Note: If the Pap test is negative but patient is symptomatic for cervical cancer, refer patient for further evaluation. BreastCare reimburses for a GYN consult for symptomatic patient.

Conventional Pap test collection and packaging

1. Assemble the following supplies:

- Pap-Pak kit
- Cotton swabs
- OB/GYN swabs
- Speculums
- Spray fixative or solution
- Mailing containers/envelopes
- Cytology Request
- Normal saline
- Gloves/appropriate personal protective equipment

2. Wash hands. Remove an individual Pap-Pak kit from the dispenser box, if applicable.

3. Open the Pap-Pak and remove the plastic mailer. Open the plastic mailer and remove the glass slide. Print the patient's name and date of birth on the frosted end of the glass slide using a pencil. Put on gloves.

4. Insert warm speculum using a small amount of warm water as lubricant.

NOTE: Do not use lubricating jelly.

5. Before obtaining Pap test, gently remove excess exudate or blood with OB/GYN swab. (See the [diagram](#) located in this manual.)

NOTE: Abnormal cells may be in the exudate or blood.

6. Use an endocervical brush to take the endocervical smear.

NOTE: The endocervical brush is contraindicated in known or suspected pregnant patients. Use a cotton-tipped applicator moistened with normal saline.

When endocervical brush is used, insert tip gently into the cervical canal and rotate only 180°. Do not place material on the slide until specimen is obtained with Ayres spatula. When cotton-tipped applicator is used, insert tip of the applicator gently inside the endocervical canal and rotate it 360°. Roll material in an arch across one-half of the slide.

7. Place flared end of Ayres spatula at the external os (ectocervix). Rotate the spatula 360 degrees about the cervical os with firm but gentle pressure, making certain to scrape the entire squamo-columnar junction.

8. Apply the spatula material in an arch across one-half of the slide in a broad swirl motion. Then roll the brush across the slide beside the first specimen. Avoid making the smear too thick.

9. Obtain gonorrhea specimen after obtaining Pap test from the endocervix with appropriate applicator.
10. Holding the slide level, immediately fix by using spray fixative in the pump bottle **provided by cytology lab**. One to two full depressions should fix the slide.

NOTE: Fix within 15 seconds or air drying may occur and cause unsatisfactory results.

11. Place the slide in the white plastic mailer with the patient's name visible through the mailer window. Close the plastic mailer.

NOTE: A snap sound is heard when the mailer is securely closed.

12. Clearly print the patient's name on the space provided on the outside of the Pap-Pak.
13. Fold the corresponding Cytology Request form in half and secure the form and the Pap-Pak using a rubber band. **Do not use tape** to secure the request form to the Pap-Pak.
14. Place Pap-Pak in designated area for mailing.

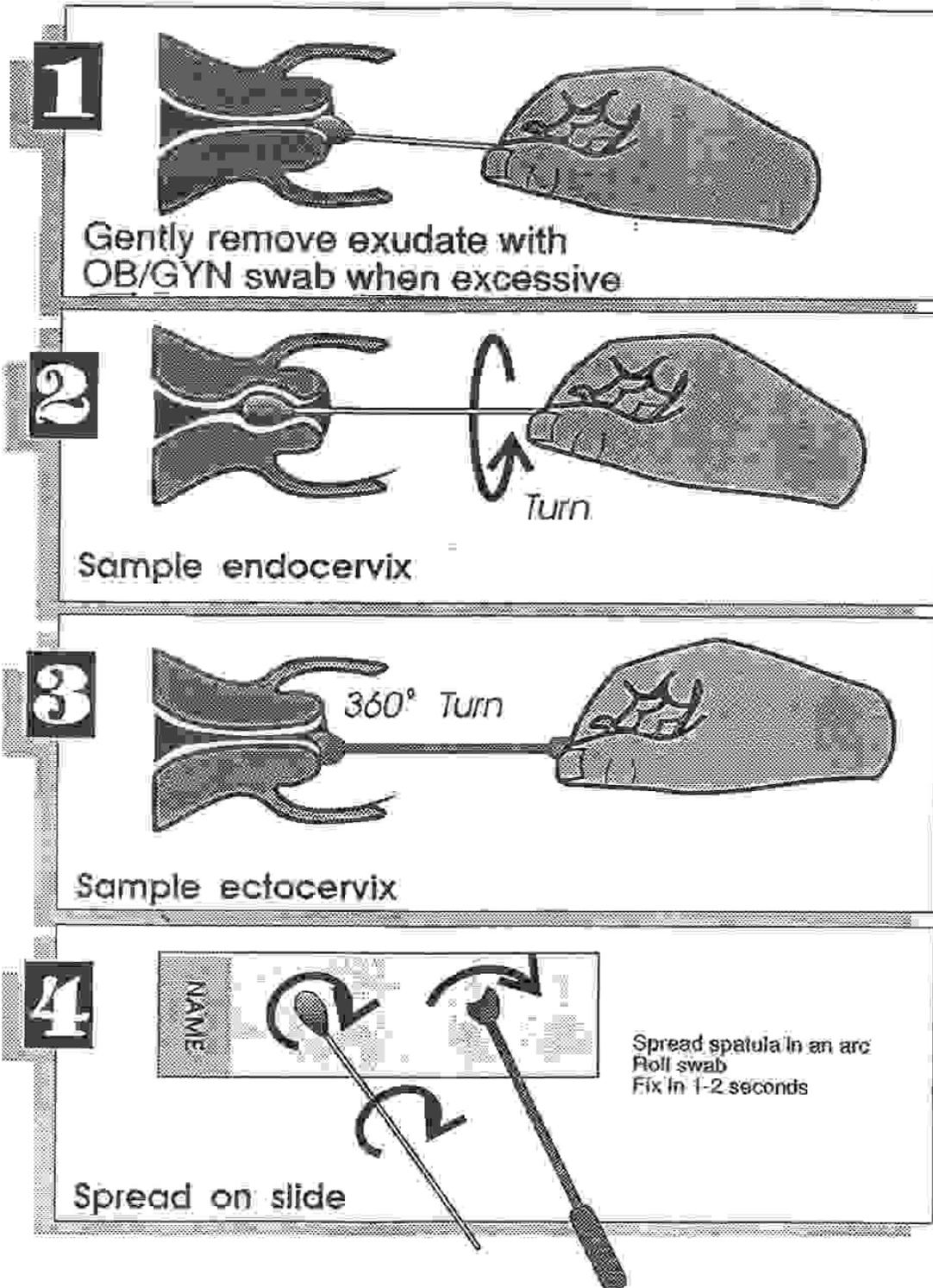
1 Gently remove exudate with OB/GYN swab when excessive

2 Sample endocervix
Turn

3 Sample ectocervix
360° Turn

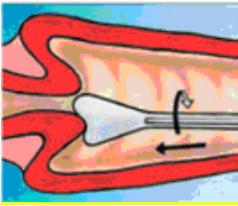
4 Spread on slide
NAME
Spread spatula in an arc
Roll brush
Fix in 1-2 seconds

Taking a Pap Smear with Endocervical Brush for a Non Pregnant Patient



Taking a Pap Smear with a Cotton Tipped Applicator for a Pregnant patient

Liquid-based cytology collection technique



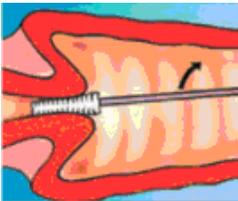
Obtain an adequate sampling from the ectocervix using a plastic spatula.

Note: Protective eyewear is not required.



Rinse the spatula as quickly as possible into the PreservCyt® Solution vial by swirling the spatula vigorously in the vial 10 times.

Discard the spatula.



Obtain an adequate sampling from the endocervix using an endocervical brush device. Insert the brush into the cervix until only the bottommost fibers are exposed. Slowly rotate 1/4 or 1/2 turn in one direction. DO NOT OVER-ROTATE.



Rinse the brush as quickly as possible in the PreservCyt Solution by rotating the device in the solution 10 times while pushing against the PreservCyt vial wall. Swirl the brush vigorously to further release material. Discard the brush.



Tighten the cap so that the torque line on the cap passes the torque line on the vial.

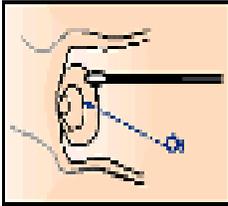


Record the patient's name and ID number on the vial the patient information and medical history on the cytology requisition form.



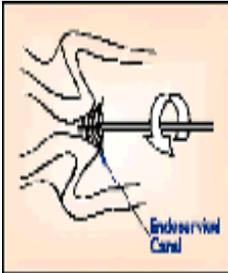
Place the vial and requisition in a specimen bag for transport to the laboratory.

HPV DNA collection technique



Preparation: Remove excess mucus from the cervical os and surrounding ectocervix using a cotton or Dacron® swab. Discard the swab.

Note: Protective eyewear is not required.

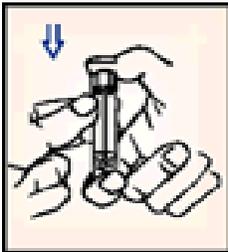


Step 1. Insert brush 1–1.5 centimeters into the cervical os until the largest outer bristles of the brush touch the ectocervix. Rotate three (3) full turns in a counterclockwise direction. Do not insert brush completely into the cervical canal.

Step 2. Remove brush from the canal. Avoid touching the bristles to the outside of the tube or any other object. (Not pictured.)



Step 3. Insert brush to bottom of transport tube. Then, snap off sampler shaft at score line, leaving brush–end inside tube.



Step 4. Re–cap tube securely by snapping it in place. Store at room temperature with other laboratory supplies.

Colposcopy

Colposcopy services are covered for BreastCare clients but may only be performed by ADH participating providers. ADH does not cover colposcopy services for Reproductive Health or Perinatal Health patients. BreastCare patients cannot be charged for colposcopy.

The patient must be given a copy of her Pap test when she is notified of her abnormal Pap test. Give the patient a list of participating providers to choose from. Assist her with making an appointment for colposcopy. She will present her BreastCare ID card at the time of her visit that will identify her as a BreastCare patient.

The colposcopy provider should send the colposcopy/biopsy result and recommendation to the referring provider; however, the primary care provider is responsible for obtaining the colposcopy/biopsy result and entering results online. Final pathology may include conization, LEEP/LLETZ, or hysterectomy. The final diagnosis is the tissue diagnosis with the most severe result. Follow-up is based on the American Society of Colposcopy and Cytopathology (ASCCP) recommendations. View or print [Management of Histological Diagnosis of Cervical Intraepithelial Neoplasia](#).

LEEP and Cone

Effective June 1, 2004, a Loop Electrode Excision Procedure (LEEP) 57460 or 57522 and conization of the cervix (Cone) 57461 or 57520, may be reimbursed for the management of women with high grade squamous intraepithelial lesions (HSIL) and atypical glandular cells (AGC) based on the ASCCP recommendations. View or print the [Management of HSIL](#) or [Management of AGC](#) reference sheets. The laboratory will bill procedure code 88307.

The following procedure must be followed:

1. The cytology laboratory notifies BreastCare immediately of all Pap test results of HSIL and AGC. The report is faxed to Dianne Crippen, RN at 501-280-4049 and to the primary care provider.
2. Reimbursement for LEEP or Cone as follow-up for HGSIL and AGC Pap tests is approved when the following conditions are present:
 - a. no lesion on satisfactory colposcopy
 - b. only biopsy-confirmed CIN I is identified
 - c. unsatisfactory colposcopy
3. A second review of the cytology and histology is performed as required by The Centers for Disease Control and Prevention (CDC) when the above conditions are present. If the review yields a revised interpretation, management follows guidelines for the revised interpretation.
4. The performing provider (primary care provider or gynecologist) must obtain preauthorization from the BreastCare Nursing Coordinator on an individual basis to ensure that LEEP or Cone is performed consistent with the recommendations of the ASCCP Consensus Conference on Management of Abnormal Cervical Cytology Report 2001.
5. The performing provider (primary care provider or gynecologist) must report the final pathology result of the LEEP or Cone to the BreastCare Nursing Coordinator to obtain a prior authorization number for billing purposes. The laboratory is not required to obtain this number.

6. Forms

This section contains a convenient list of links for the most often requested BreastCare forms.

[Care Coordinator Referral Form \(BC-2\)](#) and instructions

[Mammogram Log \(BC-4\)](#)

[Pap test and HPV Log \(BC-7\)](#)

[Breast](#) and [Cervical](#) TNM Classification and Staging forms

[Diagnosis Verification and Treatment Plan \(BCM-8\)](#)

[Annual Verification of Treatment \(BCM-13\)](#)

Appendix

This appendix contains links to other documentation referenced in this manual.

[Adapted MQSA regulations](#)

[Adequacy of Follow-up, Breast Cancer Screening](#)

[Bethesda 2001 Recommendation overview](#)

[Breast biopsy guidelines](#)

[Breast management flow chart](#)

[BreastCare Income Guidelines](#)

[Clinical trial resources](#)

[Covered and non-covered services](#)

[Management of AGC](#)

[Management of HSIL](#)

[Notification of Pap test/mammogram results](#)

[Pap test/mammogram management protocol](#)

[Patient assistance drug programs](#)

[Procedure codes to provider types/specialties/diagnosis codes](#)

[Regional Care Coordinator Contact Numbers](#)

[Management of Histological Diagnosis of Cervical Intraepithelial Neoplasia](#)

[Algorithm for ThinPrep/HPV Tests](#)

Update Log

Update No.	Release Date						
1.		34.		67.		100.	
2.		35.		68.		101.	
3.		36.		69.		102.	
4.		37.		70.		103.	
5.		38.		71.		104.	
6.		39.		72.		105.	
7.		40.		73.		106.	
8.		41.		74.		107.	
9.		42.		75.		108.	
10.		43.		76.		109.	
11.		44.		77.		110.	
12.		45.		78.		111.	
13.		46.		79.		112.	
14.		47.		80.		113.	
15.		48.		81.		114.	
16.		49.		82.		115.	
17.		50.		83.		116.	
18.		51.		84.		117.	
19.		52.		85.		118.	
20.		53.		86.		119.	
21.		54.		87.		120.	
22.		55.		88.		121.	
23.		56.		89.		122.	
24.		57.		90.		123.	
25.		58.		91.		124.	
26.		59.		92.		125.	
27.		60.		93.		126.	
28.		61.		94.		127.	
29.		62.		95.		128.	
30.		63.		96.		129.	
31.		64.		97.		130.	
32.		65.		98.		131.	
33.		66.		99.		132.	