STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Office of Maternal, Child and Family Health

Bill J. Crouch
Cabinet Secretary

Ayne Amjad, MD, MPH
Commissioner & State Health Officer

INFORMATION UPDATE

TO: WV Breast and Cervical Cancer Screening Providers

FROM: Charlene Hickman, Director
WV Breast and Cervical Cancer Screening Program

DATE: July 2, 2021

RE: Policy, Guidelines, Changes, Fillable Forms

EFFECTIVE: June 30, 2021

This update covers a plethora of topics related to the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) policy, guidelines, and changes, including allocations, BCC#s, forms, contracts, financial issues etc.

As stated in the previous Information Update dated June 16, 2021, BCC numbers will not be assigned each year as in the past. Your BCC number will change with the Program Year. For example, if your BCC# is currently BC201033, your BCC number for this program year will be 10332022. If your number is BC181018, your new number will be 10182022. You will also no longer receive allocations as there are no limits to the quantity of services you can provide to program participants within the guidelines.

All the forms have been updated and made fillable and are available on the WVBCCSP website at http://www.wvdhhr.org/bccsp/pi_forms.asp Please complete them electronically rather than by hand. This will make it more convenient for you and minimize errors or incomplete data as well as improve legibility. Samples are attached for your convenience. The batch invoice form is fillable and automatically calculates – please complete it accordingly.

Letters of Agreement remain in effect until cancelled by either party upon thirty (30) days' notice in writing and delivered by mail or in person as stated in the Agreement. If you are "suspending" services, please provide a reason for suspension and a projected timeline for resuming services in your notification of suspension. If you need a copy of your Letter of Agreement, please contact our office.

Other important changes to note are outlined in the updated BCCSP Eligibility Overview, also attached. These changes include enrollment at age 21 for cervical screening and transgender male and female as indicated within the document.

Telehealth is not an acceptable practice in WVBCCSP; and therefore, will not be reimbursed. Additionally, telehealth may not be utilized to refer a patient for a mammogram.

Information Update
July 2021

It is imperative that your invoices are submitted within 60 days of the date of service as stated in your Letter of Agreement. Noncompliance may result in you not being reimbursed. Timely submission of invoices allows us to be able to report accurate and timely data to our funders at the US Centers for Disease Control and Prevention (CDC). Inaccurate reporting could result in a loss of funding for the program. Invoices must be submitted using the exact name and address that is listed on your W-9 to be processed. The state auditor's office will not honor an invoice that is submitted otherwise. Guidance related to this is also attached.

Please contact me at 1-800-642-8522 or 304-558-5388 or via email at Charlene.m.hickman@wv.gov. should you have any questions or concerns.

Attachments

cc: James Jeffries, Director, OMCFH
Tara Buckner, Chief Financial Officer, DHHR
Linda Shaffer, Director, SPOE

West Virginia Department of Health and Human Resources
Office of Maternal, Child & Family Health

WV Breast and Cervical Cancer Screening Program
Client Enrollment Form

WVBCCSP Enrollment Facility: _____

WVBCCSP #: _____ **Enrollment Date (mm/dd/yyyy):** _____ /_____ / _____

Social Security #: _____ -_____ -_____ **Date of Birth**: _____ /_____ / _____

Client Name (Last, First, MI): _____

Client Address: _____

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

Day Phone: (____) _____ **Night/Alternate Phone:** (____) _____

Income Eligible? ☐ Yes ☐ No ☐ Unknown

Has Medicare? ☐ Yes ☐ No ☐ Unknown

Has Medicaid? ☐ Yes ☐ No ☐ Unknown

Insurance Status: ☐ Uninsured ☐ Underinsured ☐ Insured ☐ Unknown

Ref. to Insurance? ☐ Yes ☐ No

Address Update ☐

WISEWOMAN Enrollment ☐ **Patient Navigation ONLY Enrollment** ☐

Ethnicity: Are you of Spanish or Hispanic origin, such as Mexican American, Latin American, Puerto Rican, or Cuban?

☐ Yes (Hispanic) ☐ No (Non-Hispanic)

Race(s): What race do you consider yourself? Choose up to 5.

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Unknown

Education:

☐ Less than HS ☐ Some HS ☐ HS Graduate ☐ GED ☐ Technical School ☐ Some College
☐ College Graduate

Marital Status:

☐ Never Married ☐ Married ☐ Divorced/Separated ☐ Partnered ☐ Widowed

How did you hear about our Program?

☐ DHHR ☐ Newspaper ☐ Presentation ☐ TV
☐ At Work ☐ Friend/Relative ☐ Patient in WVBCCSP ☐ Radio

Consent for Release of Information and Statement of Confidentiality

I consent to the gathering, use, and disclosure of my information by the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP)/WISEWOMAN. This information is needed for the purpose of providing benefits or services (including patient navigation), obtaining payment for my benefits or services, and to conduct normal business operations. By agreeing to take part in the WVBCCSP/WISEWOMAN, I give permission to any and all of my healthcare providers, clinics and/or hospitals to provide all information concerning Pap tests, breast exams, mammograms, lab work, and any other related care to the WVBCCSP/WISEWOMAN.

Information given to WVBCCSP/WISEWOMAN will be confidential, which means information will be used to meet the purpose of the WVBCCSP/WISEWOMAN and any published reports will not identify me by name. I understand that notifying me of test results is a very important part of the WVBCCSP/WISEWOMAN, and that all available resources may be used to notify me if I have an abnormal test result.

I agree to have a Pap test, breast exam, mammogram, patient navigation services, and lab work as recommended and I will participate in diagnostic tests (Program funded) and lifestyle interventions determined necessary. I give my consent for the WVBCCSP/WISEWOMAN and the West Virginia Medicaid program to coordinate my care and provide case management services as needed.

I understand that knowingly providing false information may result in criminal, civil, or administrative action.

I, _____, swear that the information given on this form is true and correct.

Signature: _____ Date Signed (mm/dd/yyyy): _____/_____/_____

Witness: _____ Date Signed (mm/dd/yyyy): _____/_____/_____

I understand that my participation in the WVBCCSP/WISEWOMAN is voluntary and that I may drop out and withdraw my consent to release information at any time. I have received a copy of the privacy policy.

West Virginia Department of Health and Human Resources
Office of Maternal, Child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Radiology Report

Screening Facility: _____ WVBCCSP #: _____

Client Name (Last, First, MI): _____

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

Mammography/Ultrasound Facility: _____

Comparison with previous exam: □ No □ Yes Date of Previous Exam (mm/dd/yyy): _____/_____/_____

MAMMOGRAPHY PROCEDURES

□ Additional Mam Views
□ Mammogram

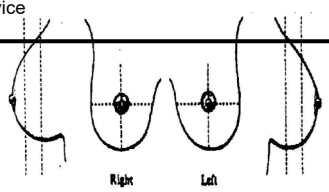
Date of Breast Procedure (mm/dd/yyyy): _____/_____/_____

VIEWS TAKEN

□ Additional View in CC
□ Additional View in ML
□ Bilateral
□ Magnification Spot
□ Unilateral-Lt
□ Unilateral-Rt
□ Spot Compression

INDICATION FOR MAMMOGRAPHY

□ Screening
□ Dignostic
□ Non-program mammogram, referred in for dx evaluation
□ No mammogram
□ No Breast Service



MAMMOGRAPHY RESULTS

□ Negative (BI-RADS 1)
□ Benign Findings (BI-RADS 2)
□ Probably Benign (BI-RADS 3)
□ Suspicious Abnormality (Consider Bx) (BI-RADS 4)
□ Highly Suggestive of Malignancy (BI-RADS 5)
□ Unsatisfactory
□ Need Evaluation or Film Comparison (BI-RADS 0)
□ Result pending
□ Result unknown, presumed abnormal, mammogram from non-program funded

Date of Mammogram (mm/dd/yyyy): _____/_____/_____

Paid for by WVBCCSP? □Yes □ No

ULTRASOUND RESULTS

□ Assessment is Incomplete, Need Additional Imaging
□ Benign Finding
□ Highly Suggestive of Malignancy
□ Known Biopsy - Proven Malignancy
□ Negative
□ Not Done - Other/Unknown Reason
□ Probably Benign
□ Refused
□ Suspicious Abnormality (Consider Bx)

Date of Ultrasound (mm/dd/yyyy): _____/_____/_____
Paid for by WVBCCSP? □ Yes □No

RADIOLOGIST'S RECOMMENDATIONS

□ Additional Mam Views*
□ Biopsy*
□ CBE by Consult*
□ Fine Needle Aspirate (FNA)*

Shaded boxes with an * indicate that work-up is necessary.

□ Follow Routine Screening

□ MRI: high-risk ONLY; requires preauthorization*
□ Obtain Definitive Rx*
□ Repeat Mammogram Immediately*

□ Short term follow-up Mam (return in six (6) months)

□ Surgical Consult*

REQUIRED SIGNATURE

Interpreting Physician's Signature:_____ Date (mm/dd/yyyy): _____/_____/_____

Please Provide a copy of the mammography/ultrasound narrative to your WVBCCSP Tracking and Follow-up Nurse .

Original: WVBCCSP Two (2) copies: Screening Clinic OMCFH/WVBCCSP Form #Y204 Rev. 06/21
Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714

West Virginia Department of Health and Human Resources

Office of Maternal, Child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Referral Form

All results plus the Radiology or Cervical Diagnostic Reports must be mailed to the screening provider and a copy must be forwarded with the invoice to the WVBCCSP. See bottom of form for the WVBCCSP address.

Screening Facility: _____ **BCCSP#:** _____

Screening Clinician: _____ **Date referred:** _____/_____/_____

Telephone: (_____) _____

Client Name (Last, First, MI): _____ **DOB:** _____/_____/_____

Social Security #: _____- ____- _____

Provider To whom Referred.

Referral Provider: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____**Phone: (____)** _____

Date Appointment: _____/_____ /_____ **Time:** _____

Breast Referral for:

- ☐ **Screening mammogram**
- ☐ **Screening mammogram unilateral**
- ☐ **Diagnostic mammogram bilateral**
- ☐ **Diagnostic mammogram unilateral**
- ☐ **Breast biopsy**
- ☐ **Fine needle aspiration**
- ☐ **Puncture aspiration of cyst**
- ☐ **Surgical consultation**
- ☐ **Ultrasound:** ***reimbursement when performed one month of Mam***

Date of Mammogram: _____ /_____ /_____

Reimbursement rendered for approved CPT codes ONLY.

CBE result

Date Performed: ____/____ /_____

- ☐ Benign finding
- ☐ Bloody/Serous Nipple Discharge
- ☐ Discrete Palp mass (Dx benign)
- ☐ Discrete Palp mass (susp for cancer)
- ☐ Nipple/Areolar Scaliness
- ☐ Normal Exam
- ☐ Not done/Normal CBE in past 12 months
- ☐ Not done – other/Unknown reason
- ☐ Skin dimpling or retraction

Paid for by WVBCCSP ☐ **Yes** ☐ **NO**

Most Recent Pap Test

Date Performed: _____ /_____ /_____

Facility that performed test: _____

_____

Paid for by WVBCCSP? ☐ **Yes** ☐ **NO**

Reminder: ***a copy of the test report must be attached to this form***

Indication for Colposcopy

- ☐ Visualized cervical lesion.

Pap test result of:

- ☐ Adenocarcinoma
- ☐ AIS
- ☐ AGC
- ☐ ASC-H
- ☐ *ASC-US (with a +, high-risk HPV test)*
- ☐ HSIL
- ☐ LSIL
- ☐ Squamous cell carcinoma.

I understand that I have met the eligibility guidelines for the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP). I may have health insurance and still be eligible for this referral to be paid for fully or partially by the WVBCCSP. My insurance will be billed first. I also understand that the program will not cover pre-operative testing and certain other procedures that may be ordered. I will take this referral form to the physician or facility named above when I go to my appointment.

Patient Signature: _____ **Date:** _____/_____/_____

Original: Physician Copy: WVBCCSP Copy: Screening Provider Copy: Patient WVBCCSP Form # Y202 Rev. 06/2021

Send to WVBCCSP 350 capitol street, Room 427, Charleston VW 25301 Tel: (304) 558-5388 or 1-800-642-8522

West Virginia Department of Health and Human Resources
Office of Maternal, Child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Breast Diagnostic Report

Referral Facility: _____ Phone: (___) _____ _____

CBE Date (mm/dd/yyyy): ____/____/____ Mammogram Date(mm/dd/yyyy): ____/____/____

Client Name (Last, First, MI):

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

BREAST PROCEDURES & RESULTS (Dates in mm/dd/yyyy)

☐ Surgical Consultation

Date Performed: ____/____/____

☐ Biopsy/FNA Recommended
☐ No Intervention—Routine FU
☐ Not Done-Other/Unk Reason
☐ Refused
☐ Short Term FU in Six (6) Months
☐ Surgery or Tx Recommended
☐ Ultrasound Recommended
☐ Unknown

Paid by WVBCCSP? ☐ Yes ☐ No

☐ Consultant Repeat CBE

Date Performed: ____/____/____

☐ Benign Finding
☐ Bloody/Serious Nipple Discharge
☐ Discrete Palpable Mass (Dx Benign)
☐ Discrete Palpable Mass-Susp for Cancer
☐ Nipple/Areolar Scaliness
☐ Normal Exam
☐ Not Done-Other/Unk Reason
☐ Refused
☐ Skin Dimpling/Retraction
☐ Unknown

Paid by WVBCCSP? ☐ Yes ☐ No

☐ Biopsy

Date Performed: ____/____/____

☐ Atypical Ductal Hyperplasia (ADH)
☐ Ductal Carcinoma In Situ (DCIS)
☐ Hyperplasia
☐ Invasive Breast Cancer
☐ Lobular Carcinoma In Situ
☐ Normal Breast Tissue
☐ Not Done-Other/Unk Reason
☐ Other Benign Changes
☐ Refused
☐ Unknown

Paid by WVBCCSP? ☐ Yes ☐ No

☐ Fine Needle Aspirate (FNA)

Date Performed: ____/____/____

☐ No Fluid/Tissue Obtained
☐ Not Done—Other/Unk Reason
☐ Not Suspicious for Cancer
☐ Refused
☐ Suspicious for Cancer
☐ Unknown

Paid by WVBCCSP? ☐ Yes ☐ No

BREAST RECOMMENDATION

Date Patient Notified(mm/dd/yyyy): ____/____/____

☐ Additional Mam Views
☐ Biopsy
☐ CBE by Consult
☐ Fine Needle Aspirate (FNA)
☐ Follow Routine Screening
☐ MRI: *WVBCCSP does NOT reimburse for MRI*
☐ Obtain Definitive Rx
☐ Repeat Mammogram Immediately
☐ Short Term Follow-up Mam in Six (6) Months
☐ Surgical Consult
☐ Ultrasound: *Reimbursement only when performed within one month of mammogram.*

CYCLE DISPOSITION FOR DIAGNOSTIC PROCEDURES / STATUS OF FINAL DIAGNOSIS

Date(mm/dd/yyyy): ____/____/____

☐ Complete ☐ Deceased ☐ Lost to Follow-up ☐ Refused

FINAL DIAGNOSIS

Date(mm/dd/yyyy): ____/____/____

☐ Breast Cancer Not Diagnosed

☐ Ductal Carcinoma In Situ (DCIS) - Stage 0
☐ Invasive Breast Cancer*
☐ Lobular Carcinoma In Situ (LCIS) - Stage 0*

*Treatment status and treatment date required for these diagnoses.

TREATMENT STATUS

Date(mm/dd/yyyy): ____/____/____

☐ Client Deceased
☐ Not Indicated/Not Needed
☐ Transportation Problems
☐ Financial Problems
☐ Pending/Unknown
☐ Treatment Started
☐ Lost to Follow-up
☐ Refused by Client
☐ Other Problems: _____

NOTES/GENERAL COMMENTS

BREAST AND CERVICAL CANCER SCREENING PROGRAM

West Virginia Department of Health and Human Resources

Office of Maternal, Child and Family Health

Case Management / Medicaid referral

Section I: To be completed by BCCSP Provider.

Client Name: _____ Today's Date: _____

Client SSN: ____- ___ - _____ DOB: _____ Phone Number: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Clinic Name: _____Referring Physician Name: _____ Phone: (____) _____

Diagnosis: _____ Diagnosis Date: _____

Diagnosis Services Required:

Medicaid Referred: ☐ Yes ☐ No Medicaid Referral Date: _____

BCCSP Provider Signature: _____ Title: _____

Important --- Please fax form to BCCSP @ 304-558-7164

Section II: To be completed by the treating physician's office.

Date of visit with physician: _____ Treatment Planned: ☐ Yes ☐ No

Physician Name: _____ Phone: (___) _____

Diagnosis Services and /or Course of Treatment Planned: _____

_____

_____

_____

Treatment Started Date: _____ Treatment Termination Date: _____

Authorized Provider Signature: _____ Title: _____

Important --- Please fax form to BCCSP @ 304-558-7164

CASE MANAGEMENT USE ONLY: Date assigned to Case Manager: _____

Date of Initial Patient Contact: _____ Appt. Date with Patient (if applicable): _____

Remarks: _____

_____

_____

_____

_____

_____

_____

_____

West Virginia

Breast and Cervical Cancer Screening Program

Certificate of Diagnosis for Medicaid Coverage/Eligibility

Client Name: _____ SSN#: _____

BCCSP Screening Clinic: _____

Diagnosis Date: _____

Breast or Cervical Diagnosis that is being treated: **Please Check one**

- ☐ **Atypical ductal hyperplasia** (Diagnosis made by excisional biopsy)
- ☐ **Invasive ductal breast cancer**
- ☐ **Invasive lobular breast cancer**
- ☐ **Ductal carcinoma in situ (DCIS)**
- ☐ **Lobular carcinoma in situ (LCIS)**
- ☐ **Metastatic breast cancer**
- ☐ **Adenocarcinoma**
- ☐ **CIN I/mild dysplasia**
- ☐ **CIN II/moderate dysplasia**
- ☐ **CIN III/severe dysplasia**
- ☐ **Carcinoma in situ (CIS)**
- ☐ **Squamous cell carcinoma**
- ☐ **Adenocarcinoma**
- ☐ **Atypical glandular cells/AGUS** (cervical only, endometrial/uterine not eligible)

By signing, I certify that this patient is in treatment for the condition indicated above.
(Repeat Pap tests, mammogram, etc. are not considered active treatment)

Physician's signature: _____Please print and sign here_____ **Date:** _____

Physician Name: _____

Physician Phone: _____ **Fax**: _____

Y600 Rev: 06/2021

CDC Centers for Disease Control and Prevention

U.S. Department of Health and Human Services HRSA Health Resources and Services Administration

West Virginia Department of Health & Human Resources Bureau for Public Health

West Virginia Breast & Cervical Cancer Screening Program You're Worth It

West Virginia Department of Health and Human Resources
Office of Maternal, child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Cervical Diagnostic Report

Referral Facility: _____ **Phone: (_____)**_____
Pap Test Date (mm/dd/yyyy): _____/_____/_____ **Pap Test result:** _____
Client Name (Last, First, MI): _____
Social Security #: _____ _____ _____ **Date Of Birth:** _____/_____/_____

Cervical Procedure(s) Performed

Procedures Paid by WVBCCSP

Date Performed (mm/dd/yyyy): _____/_____/_____

Procedure A

- ☐ *Colposcopy with Biopsy*
- ☐ *Colposcopy with ECC*
- ☐ *Colposcopy without Biopsy*
- ☐ *Endocervical curettage*
- ☐ *Endometrial Biopsy with Colposcopy*: **Only reimbursed with a Pap test result of AGC or Adenocarcinoma.**

Procedures Paid by D&T Fund or MTA

Date Performed (mm/dd/yyyy):____/_____/_____

Procedure B

- ☐ *Cervical Polyp Removal*
- ☐ *Cold knife Conization*
- ☐ *Cryotherapy*
- ☐ *Endocervical Curettage*
- ☐ *Hysterectomy*
- ☐ *Laser*

These procedures require prior approval in order to be reimbursed.

Cervical Procedures A Result:

- ☐ *Adenocarcinoma*
- ☐ *CIN I*
- ☐ *CIN II*
- ☐ *CIN III/CI*
- ☐ *Invasive (WNL)*
- ☐ *No Tissue Present*
- ☐ *Not Done, Other Unknown Reason*
- ☐ *Other, Non-Malignant Abnormality (HPV, Condylomata)*
- ☐ *Refused*
- ☐ *Unknown*

Date of Findings (mm/dd/yyyy): _____/_____/_____

Cervical Procedure B Result:

- ☐ *Adenocarcinoma*
- ☐ *CIN I*
- ☐ *CIN II*
- ☐ *CIN III/ CIS*
- ☐ *Invasive (WNL)*
- ☐ *No Tissue Present*
- ☐ *Not Done, Other Unknown Reason*
- ☐ *Other, Non-Malignant Abnormality (HPV, Condylomata)*
- ☐ *Refused*
- ☐ *Unknown*

Date of Findings (mm/dd/yyyy): _____/_____/_____

Cervical Recommendation A

Date Patient Notified (mm/dd/yyyy): _____/_____/_____

- ☐ *Colposcopy with Biopsy*
- ☐ *Colposcopy without Biopsy*
- ☐ *Cold knife Conization*
- ☐ *Definitive treatment*
- ☐ *Follow routine Screening*
- ☐ *Hysterectomy*
- ☐ *LEEP*
- ☐ *Other:* _____
- ☐ *Short Term follow-Up in Six (6) Months*

Cervical Recommendation B

Date Patient Notified (mm/dd/yyyy): _____/_____/_____

- ☐ *Hysterectomy*
- ☐ *Short Term follow-Up in Six (6) Months*

Status of Final Diagnosis

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *Complete*
- ☐ *Deceased*
- ☐ *Lost to Follow-Up*
- ☐ *Refused*

Final Diagnosis

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *CIN I/Mid Dysplasia*
- ☐ *CIN II/Moderate Dysplasia**
- ☐ *CIN III/Sever Dysplasia/CIS (Stage0)**
- ☐ *HSIL**
- ☐ *HPV/Condylomata/Atypia*
- ☐ *Invasive Cervical Cancer**
- ☐ *LSIL*
- ☐ *Normal/Benign Reaction /Inflammation*
- ☐ *Other:* _____

* Treatment status and treatment date required for these diagnoses

Treatment Status

Date (mm/dd/yyyy): _____/_____/_____

- ☐ *Client Refused*
- ☐ *Not Indicated/Not Needed*
- ☐ *Financial Problems*
- ☐ *Treatment Started*
- ☐ *Lost to Follow-Up*
- ☐ *Refused by Client*
- ☐ *Other Problems*: _____

West Virginia Department of Health and Human Resources
West Virginia Bureau for Public Health
Office of Maternal, Child and Family Health

West Virginia Diagnostic and Treatment Fund Application

Patients who have Insurance, Medicare, Medicaid, HMO or Out-of State residents are not eligible.

Patient Information Last Name: _____ **First Name:** _____ **Middle Initial:** __

Street Address: _____ **City/Town:** _____ **State:** _____ **Zip:** _____

SSN: _____ **DOB:** _____ **Telephone Number:** _____ **Sex:** ☐ **M** ☐ **F**

WV Resident? ____ Yes ____ No (If no, stop, the patient is not eligible)

Family Income and Insurance Information: (Must be completed)

Total number of family members: _____ Total gross annual income: _____
Is the patient covered by Medicaid? Yes ____ No ____ (If yes, stop, the patient is not eligible)
Is the patient covered by health insurance or an enrollee of an HMO? ____ Yes ____ No (If yes, stop, the patient is not eligible)

ONLY THE PROCEDURES LISTED BELOW ARE COVERED. TELEPHONE APPROVALS CAN NOT BE ACCEPTED.

BREAST REQUEST

_____ (00400) General anesthesia Dx breast procedure

CERVICAL REQUEST (Please attach pathology report)

Must have a positive cervical biopsy indicating need for further treatment.

_____(57460 OR 57461) Loop electrode excision procedure (LEEP)
_____(57500) Biopsy of excision of lesion
_____(57505) Endocervical curettage
_____(57511) Cryocautery of cervix
_____(57513) Laser surgery of cervix
_____(57520) Conization of cervix with or without repair
_____(57522) Conization with LEEP
_____(58120) Dilation & curettage-diagnostic and/or therapeutic
_____(00940) General anesthesia Dx cervical procedure
_____(64435) Paracervical Nerve Block

Physician submitting application: (fax number required)

Name:_____

FEIN:_____

Address:

Phone:_____ Fax:_____

Date submitted:

Date procedure scheduled:

Person submitting application:

Approval/denial to be faxed to:_____

THIS APPLICATION FOR SERVICES HAS BEEN:

☐ Approved * ☐ Denied (see comments)

***SUBJECT TO AVAILABILITY OF FUNDS**

By Financial Office:

Signature Title Date

Comments:

Return to: Diagnostic and Treatment Fund
Breast & Cervical Cancer Screening Program
350 Capitol Street, Room 427
Charleston, WV 25301-3714
Phone: 1-800-642-8522 or (304) 558-5388
Fax: (304) 558-7164

Information contained in this application is confidential.

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES MEDICAID APPLICATION FOR WVBCCSP PARTICIPANTS

Please answer all questions as completely and accurately as possible. If you do not understand a question, please call a WVBCCSP Case Manager at (304) 558-5388 or 1-800-642-8522.

Last First Middle Initial

Address: _____ Home Phone: ( ) _____
Box / Route / Street Apt. #

Address: _____ Work Phone: ( ) _____
City / Town State Zip (If you may receive calls at work.)

Age: _____ Date of Birth: _____

In case of emergency, please contact: _____ Phone Number: _____

Contact person with whom a message may be left: _____Phone Number: _____

ADDITIONAL INFORMATION

Do you have medical insurance? __Yes __No
If yes, what type? __Medical __Hospital __Cancer Other: _____

Company Name: _____Policy Number: _____

Address: _____

* Do you have children under age 19? ☐ Yes ☐ No * What is your monthly gross income? _____

* Do you have asset (excluding your home) that total more than $2.000? ☐ Yes ☐ No

*** These questions are being asked to evaluate your potential eligibility for other Medicaid coverage, but your answers will not affect your eligibility under the Breast and Cervical Cancer Prevention and Treatment Act.**

Provider is required to read this to patient

1. I certify that all statements on this form have been read to me and I understand the questions. I certify that all the information I have given is true and correct.
2. I give my permission for any financial institution, government agency or department, doctor, hospital, business concern, or person to give any information to an employee of the Department which would have to do with my receiving medical benefits.
3. I know that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
4. I understand, if I give incorrect of false information or if I fail to report changes, then I may be required to repay any benefits I receive. I may also be prosecuted for fraud and I understand that any information given is subject to verification by an authorized representative of the Department.
5. I understand by accepting medical assistance under the BCCSP option I agree to give back to the State any and all money that is received from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has made or will make payment.

Applicant Signature: _____ Date: _____

Witness, if signed by mark: _____ Signature of the person helping to complete the form: _____

West Virginia Department of Health and Human Resources
Office of Maternal, Child & Family Health

West Virginia Breast and Cervical Cancer Screening Program
Patient Data Form

WVBCCSP Screening Facility:_____

WVBCCSP #: _____ **Visit Date:** _____ /_____ /_____

Patient Name (Last, First, MI): _____

Social Security #: _____-_____-_____ **Date of Birth**: _____ /_____ /_____

VISIT TYPE

☐ Initial ☐ Annual Cervical ☐ Ref. Prev. Enroll
☐ Annual Routine ☐ Repeat Pap/CBE ☐ Ref. MTA
☐ Annual Breast ☐ Ref. for Enrollment

CERVICAL SERVICES DATA

Prior Pap test? ☐ Yes, Date: _____ /_____ /_____ ☐ No
(estimated or partial dates accepted)

Does patient have a cervix? ☐ Yes ☐ No
Has patient had a hysterectomy? ☐ Yes ☐ No
Was hysterectomy due to cervical cancer? ☐ Yes ☐ No

HIGH RISK FOR CERVICAL CANCER?

☐ Yes ☐ No ☐ Not Assessed ☐ Unknown

PELVIC EXAM

☐ Yes ☐ No **Date Performed:** _____ /_____/_____

PAP TEST

Date Performed: _____ /_____ /_____

Check ONLY one (1) result:

☐ Adenocarcinoma*
☐ Adenocarcinoma In Situ (AIS)*
☐ Atypical glandular cells (AGC)*
☐ Atypical squamous cells, cannot exclude HSIL (ASC-H)*
☐ Atypical squamous cells of undetermined significance (ASC-US)
☐ High-grade SIL (HSIL)*
☐ Low-grade SIL (LSIL)/including HPV changes
☐ Negative for intraepithelial lesion or malignancy
☐ Other-specify: _____
☐ Result Pending
☐ Result unknown, presumed abnormal, non-program*
☐ Squamous cell carcinoma*
☐ Unsatisfactory

Indication for Pap test:
☐ Screening (routine Pap test)
☐ Surveillance for positive, abnormal test
☐ Non-program Pap, referred in for dx evaluation
☐ Pap after primary HPV+
☐ No Pap
☐ No cervical services , Breast record only
☐ Unknown

HPV

Date Performed: _____ /_____ /_____

Check ONLY one (1) result:

☐ Positive (genotyping done, types 16 or 18)
☐ Positive (genotyping done, NOT types 16 or 18)
☐ Positive (genotyping NOT done)
☐ Negative

Indication for HPV test:
☐ Co-test/ or Screening
☐ Reflex
☐ Test not done
☐ Unknown

CERVICAL SERVICES PAYMENT

Cervical Services Paid for by WVBCCSP? ☐ Yes ☐ No

CLINICIAN TIME

Clinician Time: _____ Minutes (***ONLY** report time spent with patient)

SMOKING STATUS/TOBACCO REFERRALS

Smoking History? ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked
Referred to a tobacco QuitLine: ☐ Yes ☐ No
Referred to other tobacco cessation service: ☐ Yes ☐ No

BREAST SERVICES DATA

Prior Mammogram? ☐ Yes, Date: _____ /_____ /_____ ☐ No
Previous History of Breast Cancer? ☐ Yes ☐ No
Age 40-49? ☐ Yes ☐ No

HIGH RISK FOR BREAST CANCER?

☐ Yes ☐ No ☐ Not Assessed ☐ Unknown

CLINICAL BREAST EXAM

Date Performed: _____ /_____ /_____

Check ONLY one (1) result:

☐ Normal/Benign findings-schedule CBE in one year
☐ Abnormality suspicious for cancer-dx evaluation needed*
☐ Bloody/serous nipple dish
☐ Discrete palp mass - (Dx Benign)
☐ Focal pain or tenderness
☐ Skin dimpling /retraction
☐ Nipple/areolar scaliness
☐ Not done normal CBE for past 12 months
☐ Not done other/unknown reason
☐ Refused

BREAST SERVICES PAYMENT

Breast Services Paid for by WVBCCSP? ☐ Yes ☐ No

GENERAL COMMENTS—Breast and cervical Services

Diagnostic workup Planned?

Breast ☐ Yes ☐ No **Cervical** ☐ Yes ☐ No

Comments:

REQUIRED SIGNATURES

Exam performed by:

Clinician's Signature

Date: _____ /_____ /_____

*** Indicates Diagnostic Work-up Required**

Original: WVBCCSP Two (2) copies: Provider OMCFH/WVBCCSP Form #Y106 Rev. 06/21

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714

West Virginia Department of Health and Human Resources
Office of Maternal, Child & Family Health

West Virginia Breast & Cervical Cancer Screening Program
You're Worth It

WV Breast and Cervical Cancer Screening Program
Patient Navigation Form

WVBCCSP Screening Facility: _____

WVBCCSP #: _____ **Initial Contact Date** (mm/dd/yyyy): _____ /_____ / _____

Social Security #: _____ -_____ -_____ **Date of Birth** (mm/dd/yyyy): _____ /_____ / _____

Client Name (Last, First, MI): _____

Reason for Navigation (check only one for which Patient Navigation was initiated**)**

□ Breast and Cervical Cancer Screening
□ Breast Cancer Screening only
□ Cervical Cancer Screening only
□ Breast Diagnostic Services
□ Cervical Diagnostic Services
□ WISEWOMAN Services (for WISEWOMAN providers only)
□ Breast Cancer Treatment
□ Cervical Cancer Treatment

Medical Insurance

□ Insured: Medicaid
□ Insured: Medicare
□ Insured: Private
□ Uninsured: WVBCCSP
□ Uninsured: Self Pay

Resources/Referrals Provided

□ Transportation Assistance/Referral
□ Translator/Language Services
□ Provided Education
□ Financial Assistance Referral
□ Social Work Referral
□ Community Resources Referral
□ Flexible Appointment Time
□ Child/Elder Care Resource Referral
□ Pregnancy Resource Referral
□ Referral to Female Healthcare Provider
□ Referral to County WVDHHR Office
□ Other: _____

Barriers	Resolved?
□ Language: Interpreter Needed	□ Yes □ No
□ Cultural Beliefs/Myths About Cancer	□ Yes □ No
□ Financial Issues to pay for dx and/or Treatment	□ Yes □ No
□ Lack of Transportation	□ Yes □ No
□ Caring for Child or Elder: Needing flexible time appointment	□ Yes □ No
□ Fear of Test/Cancer/CVD	□ Yes □ No
□ Gender of Provider: Prefer same gender care provider	□ Yes □ No
□ Work (difficulty requesting time off to receive medical care)	□ Yes □ No
□ Disability: Needing accommodation for appointment	□ Yes □ No
□ Insurance Issues (only when it is a barrier for completing diagnosis services and or Treatment)	□ Yes □ No
□ Family Problems (Explain): _____	□ Yes □ No
□ Other: _____	□ Yes □ No

Documentation of Contacts

Date of Contact	Type of Contact	Result of Each Contact	Contact Notes
	□ Face-to-Face □ Phone □ Mail	□ Spoke with Client □ Did Not Speak with Client	
	□ Face-to-Face □ Phone □ Mail	□ Spoke with Client □ Did Not Speak with Client	

Patient Navigation Outcomes

□ Completed
□ Lost to Follow-up (Make several attempts before checking this box)

*Please feel free to provide additional outcome comments in the notes section.

Notes: _____

Navigator Signature: _____ **Date** (mm/dd/yyyy): _____ /_____/ _____

Original: WVBCCSP Two (2) copies: Provider OMCFH/WVBCCSP Form #Y104 Rev. 06/21

Send to: WVBCCSP 350 Capitol Street, Room 427, Charleston, WV 25301-3714

West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP)

ELIGIBILITY OVERVIEW

WVBCCSP FEDERAL FUNDS	DIAGNOSTIC & TREATMENT FUND WV STATE FUNDS	MEDICAID TREATMENT ACT CENTERS FOR MEDICAID AND MEDICARE (BMS)
Purpose: Provide early detection, screening and referral services for breast and cervical cancers with special emphasis on women of low income, minorities, women with disabilities, women who partner with women and older women.	**Purpose:** Assist medically indigent patients in securing diagnostic services necessary to determine whether they have breast or cervical cancer.	**Purpose:** Provide Medicaid benefits to uninsured women diagnosed with breast and cervical cancer and certain pre-cancerous conditions.
Covered Breast Screening: • Clinical Breast Exam (CBE) • Mammography • Ultrasound fine needle aspiration (FNA) • Surgical consultation • Breast biopsy **Covered Cervical Screening:** • Pelvic examination • Pap test • HPV test • Some treatment medications • Colposcopy with/without cervical biopsy	**What is Covered:** • General Anesthesia for diagnostic breast or cervical procedure • LEEP or Conization with LEEP • Biopsy of excision of cervical lesion • Endocervical curettage • Cryocautery of cervix • Laser surgery of cervix • Conization of cervix with or without repair • Dilation and curettage • Paracervical nerve block • Colposcopy with/without cervical biopsy	**What is Covered:** The Medicaid card covers all needed medical services specified as a covered benefit or service by WV Medicaid.
Enrollment Eligibility: • WV resident • Female or **Transgender*** • Uninsured or underinsured • Income at or below 250% of federal poverty level (FPL) • Breast and cervical Age 25-64 • **Cervical only Age 21-24**	**Eligibility:** • WV resident • Female • Uninsured • Income at or below 250% of federal poverty level • 21-64 years of age • **WVBCCSP enrollment not required**	**Eligibility:** • WVBCCSP enrollee - may be enrolled before or after diagnosis • Female WV resident • Under age 65 • Diagnosed with breast or cervical cancer and/or certain precancerous conditions and in need of medical treatment • Uninsured or otherwise lacking credible coverage

Updated May 2021

WVBCCSP Screening & Diagnostic Services at-a-Glance

Eligibility Services

- West Virginia resident
- Female or **Transgender***
- Age 25-64 (breast and cervical)
- **Age 21-24 (cervical only)**
- Income at or below 250% of the current Federal Poverty Level (FPL)
- Uninsured or underinsured
- Not a participant in a program that provides these services

Screening Services

- Patient Education on breast and cervical cancer and tobacco cessation
- Pelvic examination – **Age 21-64**
- Pap test (every 3 years) – **Age 21-64**
- Co-testing (combination of Pap testing and HPV testing) or primary HPV **(**every 5 years) – **Age 30-64**
- Clinical breast exam (CBE) – Age 25-64
- Screening mammogram – **Age 40-64**

Diagnostic Services

- Diagnostic mammogram (short-term follow-up mammogram reimbursed at six -month intervals only)
- Breast surgical consult – required for abnormal CBE or abnormal mammogram.
- Fine needle aspiration (FNA)
- Ultrasound of breast – must be done within 30 days after mammogram (reimbursement for ultrasound only if used in conjunction with mammogram)
- Breast biopsy
- Colposcopy with or without biopsy
- Endocervical curettage
- Loop electrosurgical excision procedure (LEEP) and associated pathology (in unusual cases)

***Transgender men (female-to-male) who have not undergone a total hysterectomy or who have not undergone a bilateral mastectomy.**

***Transgender women (male-to-female) who have taken or are taking hormones.**

Please note this information is intended to provide an overview of the screening and diagnostic services and eligibility guidelines for the program. For more specific guidance, please refer to the latest WVBCCSP Policies and Procedures Manual update, consult your CCI, or call (304) 558-5388 or 1 (800) 642-8522.

West Virginia Breast and Cervical Cancer Screening Program

FY 2021-2022 Diagnostic & Treatment Fund Rates

Effective Date June 30, 2021

Procedure	CPT Code	Rate
General anesthesia Dx Breast Procedure	00400	$21.34
Loop electrode excision procedure (LEEP)	57460	$303.18
Loop electrode excision procedure (LEEP)	57461	$339.25
Biopsy of excision of lesion	57500	$144.54
Endocervical curettage	57505	$137.78
Cryocautery of cervix	57511	$182.79
Laser surgery of cervix	57513	$187.28
Conization of cervix with or without repair	57520	$336.02
Conization with LEEP	57522	$290.14
Dilation & curettage-diagnostic and/or therapeutic	58120	$284.53
General anesthesia Dx Cervical Procedure	00940	$21.34
Paracervical Nerve Block	6445	$75.61

Vendor Name Inconsistency Options

As of April 2019, all State agencies have been working with the West Virginia State Auditor's Office to improve internal processes; promote transparency; ensure proper, prompt payment; and mitigate fraud risk. One aspect of this effort is to consistently require invoices from vendors to identify the complete legal name on the invoices. This effort applies to all vendors doing business with the State. In order for DHHR/BPH to process payment, the legal vendor's name must be used and match the following:

1) The contractor purchase order, where applicable;
2) The vendor registration in WV OASIS (State of WV accounting system);
   and
3) The business registration with the WV Secretary of State.

DHHR started sending vendors letters back in June 2019 and then sent some vendors second letters on March 2020. We still have about 20 vendors who have not complied with the request. I've attached how this vendor is registered with the Secretary of State and WV OASIS. They are billing under Radiological Physician Associates.

DHHR has sent us the following options for vendors having an issue fitting their name in the box provided on the medical forms. Please note that two different medical forms are submitted to us for processing. The reference Boxes 1 and 32 are used for the service location and Boxes 2 and 33 are used for the provider billing address.

For UB04/OMB1500 medical claim forms, the following options are available:

1. Decrease the font size.
2. Continue the name on the 2nd line in Box 1/32.
3. Continue the name on the 2nd line in Box 1/32 in front of the address information.
4. Leave Box 1 as currently completed and utilize Box 2/33 for the full legal name as it appears in OASIS.
5. If none of these is feasible, the vendor may attach the claim form to an invoice that shows the entire name in the remit to address, matching OASIS exactly.

Please note: If you utilize third party billing, it is your responsibility to pass this information along to them.