

FISCAL YEAR 2008

**POLICIES
and
PROCEDURES
MANUAL**

for

**Breast and Cervical
Cancer Services**



Department of State Health Services
Division for Family and Community Health Services

Revised 9/2007

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Introduction

General Information

PURPOSE OF MANUAL

The Department of State Health Services (DSHS) Policy and Procedure Manual for Breast and Cervical Cancer Services (BCCS) is a guide for DSHS contractors who deliver BCCS services in Texas. The policy manual has been structured to provide contractor staff with information needed to comply with BCCS Administrative, Client Services and Community Activities, and Reimbursement, Data Collection and Reporting policies.

To provide BCCS services, contractors are required to be in compliance with specific federal and state laws outlined in the manual. The state rules that apply most specifically to BCCS services in Texas are found in the Texas Administrative Code (TAC), Title 25 Part 1, Chapter 61.

PROGRAM AUTHORIZATION AND SERVICES

The Breast and Cervical Cancer Services (BCCS) is authorized by the Public Health Service Act (PHS Act), Title XV, [42 U.S.C. 300k et. seq.] and established by Public Law 101-354, the National Breast and Cervical Cancer Early Detection Program Reauthorization Act of 2007 and amended by 105-340, the Women's Health Research and Prevention Amendments of 1998.

The Texas Department of State Health Services received funding for the period of June 29, 2007 - June 30, 2008, through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). The purpose of the cooperative agreement is to administer breast and cervical cancer early detection and screening services to low income women in Texas. The state program will be referred to in this manual as Breast and Cervical Cancer Services (BCCS).

The BCCS enables women with low incomes to have access to high quality screening and diagnostic services for breast and cervical cancer. This is accomplished through an extensive network of contractors and, private and public stakeholders. With the addition of Title V Maternal and Child Health Block Grant funds, DSHS has expanded the Texas program to include cervical dysplasia treatment for eligible women.

BCCS CONTRACTOR RESPONSIBILITIES

Contractor requirements include program management, eligibility determination; screening and diagnostic services; including case management services, client education and treatment initiation if clinically indicated; quality management; professional development; recruitment, including public education and outreach; data collection, including tracking and follow-up; and partnerships. Collectively, these components will ensure the achievement of performance measures.

Program Management – The purpose of program management is to maximize available resources to implement and maintain BCCS components according to BCCS policies and procedures. Contractors are required to coordinate and administer program activities with supportive management systems.

Eligibility - Contractors are required to determine BCCS eligibility prior to enrolling women.

Screening and Diagnostic Services - Contractors must provide a clinical breast examination (CBE) and mammogram to women receiving breast cancer screening, and a CBE, pelvic examination, and Pap test to women screened for cervical cancer. Each enrolled client will receive individualized education and screening for breast and/or cervical cancer. Clients with abnormal screening or diagnostic results will be provided with case management services except as noted in Section II Clinical Guidelines. Contractors are required to provide follow-up of clients with abnormal results, provide dysplasia treatment to eligible women and ensure initiation of treatment for clients with a diagnosis of cancer.

Quality Management – Contractors are expected to ensure the quality of services by monitoring performance and identifying opportunities for improvement.

Professional Development – Contractors are responsible for ensuring health care professionals provide BCCS services competently and with sensitivity to diverse patient cultures.

Recruitment – Contractors must establish outreach methods to recruit priority populations and provide public education.

Data Collection – Contractors are required to use the TWICES B&C Module to collect data for each client until her screening cycle closes. Comply with and utilize the DSHS integrated, web-based system to collect and process breast and cervical cancer data, reports and financial billing in accordance with the business requirements of the web-based system.

Partnerships – Contractor agencies must establish and maintain partnerships with coalitions, community-based organizations and other health and human services agencies that further the goal of providing breast and cervical cancer services in the proposed service area.

PERFORMANCE MEASURES

Contractors are required to meet BCCS performance measures. The following performance measures are used to assess, in part, the contractor's effectiveness in providing BCCS services:

Screening Indicators

- 20% of clients newly enrolled for cervical cancer screening should be women who have not had a Pap test in the past five years.
- A minimum of 75% of all NBCCEDP reimbursed mammograms should be provided to program-eligible women who are 50 years of age and older and not enrolled in Medicare-Part B.

Cervical Cancer Diagnostic Indicators

- A minimum of 90% of abnormal cervical screening results must have a complete follow-up with no more than 3% lost to follow-up, 2% refused and 5% pending.
- The interval between initial screening (pap collection date) and diagnosis of abnormal cervical cancer screenings should be 60 days or less.
- A minimum of 90% of HSIL, CIN II, CIN III, CIS and invasive cervical cancer diagnoses must have started treatment.
- The interval between diagnosis (test collection date) and initiation of treatment for HSIL, CIN II, CIN III and CIS should be 90 days or less.
- The interval between diagnosis (test collection date) and initiation of treatment for invasive cervical cancer should be 60 days or less.

Breast Cancer Diagnostic Indicators

- A minimum of 90% of abnormal breast screening results must have a complete follow-up with no more than 3% lost to follow-up, 2% refused and 5% pending.
- The interval between initial screening and diagnosis of abnormal breast cancer screenings should be 60 days or less.
- A minimum of 90% of breast cancer diagnoses must have started treatment.
- The interval between diagnosis and initiation of treatment for breast cancer should be 60 days or less.

Administrative Indicators

- A minimum of 250 unduplicated clients must be served.
- A minimum of 95% of the awarded funds must be expended.
- Expend at least one dollar of matching funds for every three dollars of BCCS/CDC funds.

BCCS CONTRACTOR CLINICAL RESPONSIBILITIES

Contractor requirements include the following:

- Accepting appropriate referrals for diagnostic services;
- Providing follow-up of clients with abnormal results;
- Assisting eligible clients in applying for the Medicaid Treatment Act;
- Ensuring clients, who are not Medicaid Treatment Act eligible, access to treatment; and
- Communicating with clinical providers regarding the benefits and requirements of the BCCS program.

STATE OFFICE RESPONSIBILITIES

In partnership with its contractors, the BCCS is responsible for attaining the goals and objectives of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The BCCS achieves program goals and objectives through implementation and monitoring of the following program components: program management, screening and diagnostic services (including case management), data management, quality assurance and quality improvement, evaluation, partnerships, and professional development.

Program Management – The purpose of program management is to maximize available resources to implement all BCCS components in accordance with established policies and procedures. The major management activities include:

- Completing annual work plan after final CDC award and submitting reports to CDC on time;
- Awarding and executing all contracts by July 1, 2007;
- Ensuring the expenditure of at least 95% of BCCS funds and meeting 100% match requirements;
- Training all designated PPCU/PMU staff on program components and core performance indicators;
- Updating and disseminating a BCCS Policy Manual; and
- Providing technical assistance to contractors to successfully implement the TWICES B&C Module.

Screening and Diagnostic Services – The purpose of screening and diagnostics is to reduce mortality from breast and cervical cancers by detecting pre-cancerous or cancerous lesions at their earliest stages. BCCS has established requirements for eligibility to ensure eligible women receive BCCS-funded services. Additionally, BCCS staff provides training and technical assistance to contractors to meet CDC standards.

Data Management – The purpose of data management is to ensure availability of high-quality data for program planning, quality assurance and evaluation.

Quality Assurance and Quality Improvement – The goal of quality assurance is to meet the national MDE benchmarks. BCCS coordinates with the DSHS Performance Management Unit to ensure timely quality assurance visits, appropriate review of findings, and implementation of plans to correct findings. Quality Management Branch policies and procedures can be found at: <http://www.dshs.state.tx.us/qmb/>

Evaluation – The purpose of evaluation is to assess the quality, effectiveness and efficiency of BCCS implementation and to gather useful information to aid in planning, decision-making and improvement.

Partnerships – The purpose of coalition and partnership building is to expand and maximize resources, coordinate BCCS activities, overcome obstacles to the recruitment of priority populations, and promote the delivery of comprehensive breast and cervical cancer screening services.

Professional Education – The purpose of professional education is to assure that BCCS healthcare and allied health professionals are trained on current breast and cervical cancer screening clinical guidelines.

DEFINITIONS

The following words and terms, when used in this manual, have the following meanings.

Case Management - Case management is an individualized approach for each BCCS enrolled woman with an abnormal screening or diagnostic result, or a diagnosis of cancer, which involves establishing, brokering, and sustaining a system of available clinical and essential support services.

Centers for Disease Control and Prevention (CDC) – The federal agency responsible for protecting the health and safety of all Americans and for providing essential human services, especially for those people who are least able to help themselves; CDC issues funds and develops policy for the National Breast and Cervical Cancer Early Detection Program.

Client – An individual who has been screened, determined to be eligible for services and has successfully completed the eligibility process.

Contractors – The entity Department of State Health Services has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

Department of State Health Services (DSHS) - The agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.

Diagnosis – The recognition of disease status determined by evaluating the history of the client and the disease process, and the signs and symptoms present. Determining the diagnosis may require microscopic (i.e. culture), chemical (i.e. blood tests), and/or radiological examinations (x-rays).

Dysplasia Treatment – The four dysplasia treatment CPT Codes, to be paid for by Title V funds, listed on the Allowable CPT Codes and Reimbursement Rates form are for dysplasia treatment not paid for by the Medicaid Treatment Act.

Federal Poverty Level (FPL) - The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid in the U.S., define eligibility income limits as some percentage of FPL.

Health and Human Services Commission (HHSC) – The state agency that has oversight responsibilities for designated Health and Human Services agencies, including DSHS, and administers certain health and human services programs including the Texas Medicaid Program, Children's Health Insurance Program (CHIP), and Medicaid waste, fraud, and abuse investigations.

Health Service Region (HSR) - For administrative purposes, DSHS has grouped counties within a specified geographic area into 11 Health Service Regions.

Medicaid – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

Medicaid Treatment Act – Reference to the federal law (Breast and Cervical Prevention and Treatment Act of 2000) that authorizes states to provide medical assistance through Medicaid for treatment to eligible women who are screened under the scope of Title XV as provided for in Senate Bill 10, 80th Texas Legislature and are found to be in need of treatment for qualifying breast or cervical diagnoses.

Minimum Data Elements (MDE) – A set of standardized data elements developed by CDC to monitor clinical services provided to BCCS-enrolled women.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP) – A federal program, administered by the CDC that helps women who are low-income, uninsured and underserved to gain access to screening programs for early detection of breast and cervical cancer.

Outreach – Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of participants.

Provider – An individual clinician or group of clinicians who provide services.

ACRONYMS

Acronym	Term
BCCS	Breast and Cervical Cancer Services
CLIA	Clinical Laboratory Improvement Amendments
CMB	DSHS Contract Management Branch
CDSB	DSHS Contract Development and Support Branch
CDC	Centers for Disease Control and Prevention
DHHS	U.S. Department of Health and Human Services
DSHS	Texas Department of State Health Services
FPL	Federal Poverty Level
HIPAA	Health Insurance and Portability Accountability Act
HHSC	Texas Health and Human Services Commission
HSR	DSHS Health Service Region
LEP	Limited English Proficiency
MDE	Minimum Data Element
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
QMB	DSHS Quality Management Branch
RFP	Request for Proposal
TAC	Texas Administrative Code
TWICES B&C MODULE	Texas Wide Integration Client Encounter System

Section I

Administrative Policies

Purpose: Section I assists the contractor in conducting administrative activities such as assuring client access to services and managing client records.

CLIENT ACCESS

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services.
- Comply with all applicable civil rights laws and regulations including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and ensure services are accessible to persons with limited English proficiency and speech or sensory impairments.
- Have a policy in place that requires qualified staff to assess and prioritize client's needs.
- Accept appropriate referrals for breast or cervical diagnostic services.
- Provide referral resources for individuals that cannot be served or cannot receive a specific service.
- Manage funds to ensure that established clients continue to receive services throughout the budget year.

Continuity of Care – Clients receiving screening, rescreening, and case management services through the BCCS must receive continuity of care. If an agency discontinues BCCS services due to termination of its contractual agreement with DSHS, clients with abnormal screening or diagnostic results must receive continued follow-up and case management services.

(See, also, Section 1, Chapter 3 – Client Rights)

ABUSE REPORTING

The Department of State Health Services expects contractors to comply with state laws governing the reporting of abuse. Contractors must have an agency policy regarding abuse. While the majority of BCCS clients are adults, it is mandatory to be familiar with and comply with adult and child abuse reporting in Texas.

To report abuse or neglect, call **1-800-252-5400** or use the secure website:
<http://www.txabusehotline.org/>

CONFIDENTIALITY

All contracting agencies must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for protection of client privacy. Information about HIPAA can be found at:

<http://www.hhs.gov/ocr/hipaa/>

Employees and volunteers must be made aware during orientation that violation of the law in regard to confidentiality may result in civil damages and criminal penalties.

The client's preferred method of follow-up (cell phone, email, work phone) must be documented in the client's record. (See Client Health Record Section II Chapter 3, page 4)

Each client must receive verbal assurance of confidentiality and an explanation of what confidentiality means (kept private and not shared without permission) and any applicable exceptions such as abuse reporting (See Section I Chapter 2).

NON-DISCRIMINATION

DSHS Contractors must comply with state and federal anti-discrimination laws, including without limitation:

- (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
- (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- (3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*);
- (4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- (5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- (6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and
- (7) HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable.

To ensure compliance with DSHS non-discrimination policies, DSHS Contractors must:

- have a written policy that states the agency does not discriminate on the basis of race, color, national origin including limited English proficiency (LEP), religion, disability, age, or sex;
- sign a written assurance as to compliance with applicable federal and state civil rights laws and regulations;
- have procedures for notifying the HHSC Civil Rights Office of any program or service-related discrimination allegation or complaint within ten (10) calendar days of the allegation or complaint;
- notify all clients and applicants of the Contractor's non-discrimination policies and complaint procedures;

- ensure that all Contractor staff is trained in the agency's non-discrimination policies and complaint procedures;
- take reasonable steps to ensure that LEP persons have meaningful access to its programs and services, and not require a client with LEP to use friends or family members as interpreters. However, a family member or friend may serve as a client's interpreter if requested, and the family member or friend does not compromise the effectiveness of the service or violate client confidentiality.

The Contractor must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office
701 W. 51st Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885

The Contractor must prominently display in client common areas, including lobbies and waiting rooms, front reception desk and locations where clients apply for services, the following two posters:

- “Know Your Rights” [\[English\]](#) [\[Spanish\]](#)

Size: 8.5” x 11” (standard size sheet of paper).

Posting Instructions: Post the English and Spanish versions of this poster next to each other.

Questions: Contact the [HHSC Civil Rights Office](#).

- “Need an Interpreter” [\[Language Translation\]](#) [\[American Sign Language\]](#)

Size: 8.5” x 11” (standard size sheet of paper).

Posting Instructions: Post the “Language Translation” version and “American Sign Language” version next to each other.

Questions: Contact the [HHSC Civil Rights Office](#).

The Contractor must have available, completed, and signed copies of the Non-Discrimination Policies and Procedures Survey, ADA/Section 504 Policies and Procedures Survey, and Limited English Proficiency (LEP) Policies and Procedures Survey prior to any scheduled on-site review by the Quality Management Branch (QMB) review team.

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- More Information about applicable laws and regulations can be found on HHSC's Civil Rights Office website at:
<http://www.hhs.state.tx.us/aboutHHS/CivilRights.shtml>
 - The Non-Discrimination Policies and Procedures Survey, ADA/Section 504 Policies and Procedures Survey, and Limited English Proficiency (LEP) Policies and Procedures Survey and their instructions can be downloaded at the QMB website at:
<http://www.dshs.state.tx.us/qmb/contractor.shtm>

TERMINATION OF SERVICES

Clients must never be denied services due to an inability to pay.

Contractors have the right to terminate services to a client if the client is disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the Contractor's ability to provide services or if the client's behavior jeopardizes his or her own safety, clinic staff, or other clients.

Any policy related to termination of services must be included in the Contractor's policy and procedures manual.

RESOLUTION OF GRIEVANCES

Contractors must ensure that clients have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors' policy and procedure manuals must explain the process clients will follow if they are not satisfied with the care received. If an aggrieved client requests a hearing, a Contractor shall not terminate services to the client until a final decision is rendered.

Any client grievance must be documented in the client's record.

DSHS contractors must have an organized and secure client record system. The contractor must ensure that the record is organized and readily accessible, available to the client upon request with a signed release of information, and confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use or inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility as well as during transfer between clinics and in between home and office visits

In addition, a confidentiality assurance statement must appear in the client's record. The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to law.

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients and subcontractors must maintain for the time period specified by DSHS all records pertaining to client services, contracts, and payments. Record retention requirements are found in 15 TAC §354.1004 (relating to Time Limits for Submitted Medicaid Claims) and 22 TAC 165 (relating to Medical Records). Contractors must follow contract provisions and the DSHS Retention Schedule for Medical Records. All records relating to services must be accessible for examination at any reasonable time to representatives of DSHS and as required by law. DSHS guidelines for medical record retention are available at: <http://www.dshs.state.tx.us/records/medicalrec.shtm>.

PERSONNEL POLICY AND PROCEDURES

Contractors must develop and maintain personnel policies and procedures to ensure that clinical staff are hired, trained, and evaluated appropriately to their job position. Personnel policies and procedures must include job descriptions, a written orientation plan for new staff and performance evaluation. Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Contractors must show evidence that employees meet all required qualifications, are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.

Contractors must provide medical care services under the supervision, direction, and responsibility of a qualified Medical Director.

Contractors must have a documented plan of organized staff development. There must be an assessment of training needs, quality assurance indicators, and changing regulations/requirements. Must also include BCCS orientation and in-service training for all personnel, including volunteers. There must be documentation of initial employee orientation and continuing education on BCCS policies standards, requirements, and recommendations to conduct breast and cervical cancer screening activities.

FACILITIES AND EQUIPMENT

DSHS contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the handling of hazardous waste, fire safety, and working medical equipment.

Hazardous Materials – Contractors must have written policies and procedures that address:

- the handling, storage and disposing of hazardous materials and waste according to applicable laws and regulations;
- the handling, storage and disposing of chemical and infectious waste including sharps; and
- an orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety – Contractors must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment – Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment. Documentation must include:

- assessments of the clinical and physical risks of equipment through inspection, testing and maintenance;
- reports of any equipment management problems, failures and use errors; and
- an orientation and education program for personnel who use medical equipment.

Smoking Ban – Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must also comply with this policy.

QUALITY MANAGEMENT

Organizations that embrace Quality Management (QM) concepts and methodologies and integrate them into the structure of the organization and day-to-day operations discover a very powerful management tool. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on the four core Quality Management principles of focusing on: the client, systems and processes, measurement and teamwork. Contractors must have a Quality Management program individualized to their organizational structure and based on the services provided. The goals of the quality program should ensure availability and accessibility of services, and quality and continuity of care.

A Quality Management program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability. Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities.

The Quality Management Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, where applicable, annually reviews and approves the quality work plan for the organization.

The Quality Management Committee must meet at least quarterly to:

- receive reports of monitoring activities
- make decisions based on the analysis of data collected
- determine quality improvement actions to be implemented
- reassess outcomes and goal achievement

Minutes of the discussion and actions taken by the committee must be maintained.

The quality work plan at a minimum must:

- include clinical and administrative standards by which services will be monitored
- include process for credentialing and peer review of clinicians
- identify individuals responsible for implementing monitoring, evaluating and reporting
- establish timelines for quality monitoring activities
- identify tools/forms to be utilized
- outline reporting to the Quality Management Committee

Although each organization's quality program is unique, the following activities must be undertaken by all agencies providing client services:

- on-going eligibility, billing, and clinical record reviews to assure compliance with program requirements and clinical standards of care
- tracking and reporting of adverse outcomes
- client satisfaction surveys
- annual review of facilities to maintain a safe environment, including an emergency safety plan
- annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current

Data from these activities must be presented to the Quality Management Committee. Plans to improve quality should result from the data analysis and reports considered by the committee and should be documented.

Information on the operating process of DSHS's Quality Management Branch as well as policies and review tools can be located at <http://www.dshs.state.tx.us/qmb/default.shtm>

CONTRACT AMENDMENTS AND REVISIONS

There are three (3) types of modifications that can be made to a contract. Each category of change will have its own modification process in order for the requested changes to be incorporated into the contract.

Modifications to the contract must be in accordance to the Fiscal Year 2008 Performance Contract General Provisions (Core/Subrecipient).

<http://www.dshs.state.tx.us/grants/docs/08ef29-12425.pdf>

The three contract modification types are:

Contract Notification

Contract Revision

Contract Amendment

Amendments must be in writing and agreed to by both parties, except as otherwise specified in the Contractor's Notification of Change to Certain Contract Provisions section or the Contractor's Request for Revision to Certain Contract Provisions section of the Fiscal Year 2008 Performance Contract General Provisions (Core/Subrecipient).

<http://www.dshs.state.tx.us/grants/docs/08ef29-12425.pdf>

The deadline for processing contract revisions and amendments is 90 days prior to the end of the contract term. Contracts will not be amended within the last 90 days of the contract period except by exception. Requests for contract revisions and/or amendments within the last 90 days of the contract period will be examined on a case-by-case basis by DSHS.

1. Contract Notification: Certain changes may be made to the contract without a written amendment or DSHS prior approval.

The contractor may make contract revisions at any time during the contract term with formal written notification to DSHS.

The changes that can be made without a contract revision or amendment are:

- Contractor's contact person and contact information.
- Contact information for key personnel, as stated in the application.
- Cumulative budget line item transfers that exceed 10% among direct cost categories, other than the equipment category, of cost reimbursement contract attachments of less than \$100,000, provided the total budget amount is unchanged.
- Minor corrections or clarifications to the contract language that in no way alter the contract Statement of Work, objectives or performance measures.
- A change in the contractor's share of the budget concerning non-DSHS funding other than program income and match, regardless of the amount of the change, provided that in changing the budget, contractor is not supplanting DSHS funds.

Procedure for a Contract Notification:

Within ten (10) calendar days of the change, the contractor notifies CDSB in writing of any change listed above. The notification may be by letter, fax or email to:

Department of State Health Services
Contract Development and Support Branch
1100 W. 49th Street, Mail code 1914
Austin, TX 78756
Fax: (512) 458-7235
cdsb@dshs.state.tx.us

CDSB forwards the notification to DSHS Contract Services Contracting Unit (CSCU) with a copy to the Contract Management Branch (CMB) and designated FCHSD program staff.

2. Contract Revision: Certain changes to the contract may be made through the Contract Revision request process rather than through the amendment process.

Contracts will not be revised within the last 90 days of the contract term except under justifiable situations that will be examined on a case by case basis by DSHS.

The changes allowed for a contract revision are:

- Change in clinic hours or location, including contractor's official change of address.
- Cumulative budget line item transfers among direct cost categories other than the equipment category that exceed 10% of cost reimbursement contract attachments of \$100,000 or more, provided that the total budget amount is unchanged.
- Line item transfer of funds for direct payment of training allowances for any cost reimbursement contract.
- Change in equipment list substituting an item of equipment equivalent to an item of equipment on the approved budget, (e.g., purchase of XYZ brand computer instead of approved ABC brand computer with essentially identical features as the XYZ computer.)
- Changes in the equipment category of a previously approved equipment budget (other than acquisition of additional equipment, which requires an amendment to the Contract).
- Changes specified in applicable cost principles as requiring prior approval, regardless of dollar threshold.

Procedure for a Contract Revision:

Contractor completes two copies of the DSHS Contract Revision Request (CRR) Form <http://www.dshs.state.tx.us/grants/forms/ef29-12414.doc> and has their authorized representative sign both copies on behalf of Contractor.

Both original, signed forms are submitted to CDSB at:

Department of State Health Services
Contract Development and Support Branch
1100 West 49th Street – Mail Code 1914
Austin, Texas 78756

After the review by CDSB and CMB, both copies of the CRR form are signed by the DSHS CSCU director.

CSCU mails one copy to the contractor and retains one copy of the CRR in the contractor file.

3. Contract Amendment

Except as noted above, modifications to the contract must be in writing, agreed to by both parties, and constitute a formal amendment to the contract.

A contractor's request to amend a contract must include a justification for the request, and, if a budget revision or amendment is requested during the last quarter (90 days) of the contract term, must include a written reason for the delay in making the request. Revision or amendment requests may be granted at the discretion of DSHS.

Procedure for a Contract Amendment:

Contractor completes a Contract Revision Request (CRR) Form <http://www.dshs.state.tx.us/grants/forms/ef29-12414.doc> and submits it electronically to CDSB at: cdsb@dshs.state.tx.us.

A signature on the CRR Form is not needed since the documentation for the formal amendment requires original signatures from both parties.

CSCU will mail or electronically forward two originals of the final amendment to contractor for signature.

The contractor must timely review, sign, and forward back the amendment to CSCU. CSCU will send the contractor the original executed amendment to the contractor.

CONTRACTS WITH SUBRECIPIENT SUBCONTRACTS

Contractors may enter into contracts with subrecipient subcontractors unless restricted or otherwise prohibited in a specific Program Attachment(s). Prior to entering into an agreement equaling \$25,000 or twenty-five percent (25%) of a Program Attachment amount, whichever is greater, Contractors shall obtain written approval from DSHS.

Contracts with subcontractors shall be in writing and include the following:

- Name and address of all parties;
- A detailed description of the services to be provided;
- Measurable method and rate of payment and total amount of contract;
- Clearly defined and executable termination clause;
- Beginning and ending dates that coincide with the dates of the applicable Program Attachment(s) or cover a term within the beginning and ending dates of the applicable Program Attachment(s);
- Access to inspect the work and the premises on which any work is performed, in accordance with the Access and Inspection Article in this Contract; and
- A copy of these General Provisions and a copy of the Statement of Work and any Special Provisions in the Program Attachment(s) applicable to the subcontract.

Contractor is responsible to DSHS for the performance of any subcontractor.

Contractor shall monitor both financial and programmatic performance and maintain pertinent records that shall be available for inspection by DSHS. Contractor shall ensure that subcontractors are fully aware of the requirements placed upon them by state/federal statutes and regulations and under this Contract. Contractor shall not contract with a subcontractor, at any tier, that is debarred or suspended or excluded from or ineligible for participation in federal assistance programs.

Status of Subcontractors – Contractor shall require that all subcontractors certify that they are in good standing with all state and federal funding and regulatory agencies; are not currently debarred, suspended, revoked, or otherwise excluded from participation in federal grant programs; are not delinquent on any repayment agreements; and have not had a contract terminated by DSHS. Contractors shall further require that subcontractors certify that they have not voluntarily surrendered within the past three (3) years any license issued by DSHS.

MAMMOGRAPHY QUALITY ASSURANCE - All mammography facilities, including subcontracted facilities, providing services to the BCCS must:

- possess a current Certification of Mammography Systems from DSHS Regulatory Licensing Unit, Mammography Certification Program (each mammography unit must be fully accredited or undergoing accreditation); and
- possess a current, mammography facility certificate from the appropriate agency certifying compliance with the U.S. Food and Drug Administration Mammography Quality Standards, Final Rules, 21 CFR Part 900.

The DSHS Regulatory Licensing Unit, Mammography Certification Program can be contacted at 512.834.6688 for certification questions. Information on inspection results, escalated enforcement, or "cease and desist" status may be directed to the Custodian of Records at 512-834-6688, extension 2202. **The BCCC will not reimburse for services provided by a mammography provider with “escalated enforcement” status or “cease and desist” status.**

CYTOLOGY QUALITY ASSURANCE – Contractors subcontracting for screening and diagnostic cytology services must have current documentation that the subcontractor for cytology meets all quality assurance standards required by the BCCC as established under state and federal laws.

All cytology laboratories providing services to BCCC contractors/subcontractors must:

- Possess a current, unrevoked and unsuspended registration certificate issued by the U.S. Department of Health and Human Services (DHHS) under the terms of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88);
- Use the 2001 Bethesda System for Reporting Cervical/Vaginal Cytological Diagnoses;
- The lab must have a mechanism for expedited notification of pap tests which are CIN III or greater such that the clinic is notified no later than the next business day after the case is signed out.

Section II

Client Services and Community Activities

Purpose: Section II provides policy requirements for providing client services and community activities.

GENERAL ELIGIBILITY

Screening and Eligibility Determination - For an individual to receive BCCS services, three (3) criteria must be met:

- Gross individual income at or below 200% of the adopted Federal Poverty Level (FPL): <http://www.dshs.state.tx.us/BCCSs/eligibility.shtm#income>
- Applicant is a Texas resident; and
- Not eligible for other programs/benefits providing the same services.

Financial Eligibility – BCCS contractors are required to determine BCCS eligibility prior to enrolling women in the BCCS.

Contractors must develop a policy to determine BCCS financial eligibility. The policy shall be available for Quality Assurance Review visits. The policy must require documentation of the following:

- the woman's family income is at or below 200% of the federal poverty level;
- the woman does not have private insurance OR that she is unable to pay her insurance deductible or co-payment;
- the woman is not eligible for Medicare Part B or is unable to pay premiums for Medicare Part B.

The policy shall require each woman's financial eligibility to be documented in the client record including special eligibility circumstances for women 65 and older that are not eligible for or cannot pay premiums for Medicare Part B.

Contractor's eligibility policies must address whether or not proof of income is a requirement for BCCS eligibility and if so, define how proof of income is documented in the client record. NOTE: Any woman who will be assisted by a BCCS contractor to apply for the Medicaid Treatment Act must have verification of income documented in her client record. This includes women who have been diagnosed with a qualifying cancer by BCCS contractors or other health care providers.

Contractors shall use the following definition of family composition in implementing cost-sharing policies and determining financial eligibility for the Medicaid Treatment Act:

Family Composition – The group consists of the applicant, her spouse, and all mutual and non-mutual children. If an unmarried applicant lives with a partner, ONLY count the partner's income and children as part of the group IF the applicant and her partner have mutual children together. No children aged 19 and older or other adults living in the household should be counted as part of the group.

In determining financial eligibility, Contractors shall use gross income from the sources identified in Appendix G. The following dependent care expenses are allowable deductions from gross total income: Actual expenses up to \$200.00 per child per month

for children under age two and \$175.00 per child per month for each dependent age two or older.

Income Calculation

- If income is received in lump sums or at longer intervals than monthly, such as seasonal employment, the income is prorated over the period of time the income is expected to cover.
- Weekly income is multiplied by 4.33.
- Income received every two weeks is multiplied by 2.17.
- Income received twice monthly is multiplied by 2.

Residency Eligibility – An individual must be physically present within the geographic boundaries of Texas and must verbally state that she:

- has the intent to remain within the state, whether permanently or for an indefinite period; and
- does not claim residency in any other state or country.

There is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purposes of BCCS eligibility.

TWICES - Before entering a woman into the TWICES database, Contractors shall determine whether the woman has ever received services funded by BCCS and has an existing CD Number (a unique number assigned to each BCCS client that is used to record BCCS-services provided to a woman).

Contractors shall apply for all other available sources of third party funding prior to submitting requests for payment to DSHS for services rendered.

Breast Cancer Screening Services Eligibility – Screening refers to procedures, such as clinical breast examination (CBE) and mammogram, for women who present without a symptom that are suspicious for breast cancer. A screening mammogram must be provided within 60 days following the CBE. The BCCS recommendations for mammography screening are:

- Ages 50 and older: Women should be screened every year.
- Ages 40-49: Asymptomatic women ages 40-49 may be screened subject to the restriction of not exceeding 25% of BCCS funded mammograms to women under the age of 50.
- Women under age 40 can receive a CBE only if they are symptomatic. If a CBE is abnormal, refer for diagnostic assessment.

Breast Cancer Diagnostic Services Eligibility – Women of any age can be enrolled in the BCCS for diagnostic assessment if they are:

- symptomatic; AND

-
- have an abnormal clinical breast examination; AND/OR
 - have an abnormal mammogram.

Cervical Cancer Screening Services Eligibility – To be eligible for cervical cancer screening services, a woman must meet financial eligibility and be age 18 to 64 years of age.

A woman who meets the financial and age criteria and has had a hysterectomy is eligible for cervical cancer screening services only if the hysterectomy was due to cervical cancer or neoplasia, or if the cervix remains. The presence of a cervix can be determined on physical examination. BCCS funds can be used to pay for an initial examination, i.e., pelvic examination to determine if a woman has a cervix.

Cervical Cancer Diagnostic Services Eligibility – Women ages 18 to 64 may be enrolled in the BCCS for diagnostic assessment provided there is:

- documentation of two abnormal Pap results of ASC-US which are 6 months apart or one abnormal Pap result of ASC-US HPV positive for high risk types; OR
- one abnormal Pap result of ASC-H; LSIL; HSIL or AGC.

(See Algorithm #1A for diagnostic procedures.)

LEGEND:

ASC-US = Atypical Squamous Cells of Undetermined Significance

ASC-H = Atypical Squamous Cells: Cannot exclude High-grade Squamous Intraepithelial Lesion

LSIL = Low-grade Squamous Intraepithelial Lesion

HSIL = High-grade Squamous Intraepithelial Lesion

AGC = Atypical Glandular Cells

HPV = Human Papillomavirus

Cervical Dysplasia Treatment Eligibility – To be eligible for cervical dysplasia treatment, a woman must:

- meet BCCS financial eligibility,
- have a non-qualifying diagnosis for the Medicaid Treatment Act (See Section II, Chapter 3, Treatment and also Appendix C Medicaid Treatment Act Qualifying Diagnoses),
- not be eligible for the Medicaid Treatment Act.

RESCREENING ELIGIBILITY

Breast Cancer Rescreening Eligibility – Rescreening is the process of returning for a breast cancer screening test at a predetermined interval, usually one year, when no symptoms are present. Contractors must verify each previously enrolled woman's eligibility for BCCS services. A woman is eligible for rescreening if she:

-
- received a BCCS-funded breast cancer screening (clinical breast examination and mammogram) during the previous 12-month budget period (the baseline year); **and**
 - still meets the BCCS eligibility requirements.

Cervical Cancer Rescreening Eligibility - Rescreening is the process of returning for a cervical cancer screening test at a predetermined interval when no symptoms are present. When a woman has had three consecutive, normal Pap tests documented within a 60-month (5 year) period, the screening interval shall increase to once every three years. Once there is documentation of three normal/benign results within a five-year period, BCCS funds may be used to reimburse for Pap tests once every three years.

The screening interval when using liquid-based tests is once every 2 years if the result is normal. As with conventional Pap test, when a woman has had three consecutive, normal cervical cancer screening tests documented within a 60-month (5 year) period, the screening interval with liquid-based testing will increase to once every three years.

Women with special circumstances, who are considered high-risk, may be rescreened more frequently as determined by the clinician (e.g. HIV, immunosuppressed, history of cervical cancer).

If a woman receives an abnormal screening test result, policies for follow-up of abnormal cervical cancer screening tests and reimbursements of diagnostic procedures should be followed.

Exceptions to Rescreening – Contractors **are not required to rescreen a woman** if the contractor has documented that she:

- cannot be located or has moved from the contractor's service area;
- no longer meets the BCCS income eligibility standard;
- has Medicare Part B or other health insurance which provides coverage for breast and/or cervical cancer screening;
- refuses (in writing or verbally) to return for BCCS services;
- received a BCCS-funded breast cancer screening within the previous 11 months;
- is age 40-49 and received a BCCS-funded breast cancer screening within the last 24 months; or
- is clinically ineligible (i.e., her screening cycle has changed due to an abnormal result; treatment for breast or cervical cancer or any other medical condition for which the clinician recommends delaying rescreening).

Assessment of Cost-Sharing (Co-pay) - Contractor may establish policies and procedures for charging, billing and collecting cost-sharing schedule of fees for client services using the following guidelines:

- any cost-sharing schedule shall include discounts for clients with income between 101% and 200% of the most current federal poverty income level.

- clients with incomes at or below 100% of federal poverty level shall not be charged a cost share amount.
- cost-sharing amounts shall not exceed 25% of the authorized reimbursement amount for BCCS authorized services.
- clients who declare an inability to pay a cost share amount shall not be denied services.
- fees may be waived for individuals with incomes between 101% and 200% of the most current federal poverty income level, who as determined by contractor, are unable, for good cause, to pay for breast and cervical cancer services.

OTHER FEES

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors who have expended their awarded funds must continue to serve their existing BCCS eligible clients per the BCCS policy, Section I Chapter 1 – Client Access. It is allowable to obtain other funding to pay for these services as well as to charge a cost-sharing fee. Cost-sharing revenue should be recorded as program income for the BCCS contract.

Contractors who have expended their BCCS funds are not required to enroll new clients as BCCS clients, however, it is allowable to offer services at full-pay or on a sliding scale basis.

GENERAL INFORMED CONSENT

Consent information must be effectively communicated to every client, including those who have language barriers (in compliance with Limited English Proficiency regulations) or who have disabilities that impair communication. If the client does not understand the language of the consent form, the form must be interpreted.

Women who are referred to a BCCS contractor with a qualified breast or cervical diagnosis who meet Medicaid Treatment Act eligibility and an application for medical assistance is completed, must sign a general informed consent that addresses case management, confidentiality and authorization to enter or view data in the statewide database (TWICES).

Contractors must obtain the client's written, informed, voluntary general consent to receive services prior to the client receiving any services. If there is a period of time of two years or more during which a client does not receive services, the general consent must be signed again prior to delivery of services.

In the general consent form contractors must include a statement whereby a client's signature authorizes the contractor to view the client's BCCS clinical services/data history that has been stored in the state-wide database (e.g. TWICES). If this statement is not included in the general consent, an additional consent must be developed for the client to sign along with the general consent.

PROCEDURE SPECIFIC INFORMED CONSENT

The Texas Medical Disclosure Panel has developed a List A (informed consent requiring full and specific disclosure) and a List B (informed consent not requiring specific disclosures) for certain procedures.

List A (informed consent requiring full and specific disclosure) can be found at: http://www.texmed.org/uploadedFiles/Global_Media/ListAProceduresRequiringFullDisc.pdf.

List B (informed consent not requiring specific disclosures) can be found at: http://www.texmed.org/uploadedFiles/Global_Media/ListBProceduresRequiringFullDisc.pdf

For all other procedures not on List A or B, the physician must disclose all risks that a reasonable patient would want to know about. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

With regard to **Conization of the Cervix, an A list procedure**, the required Disclosure and Consent Form can be found at:

<http://www.dshs.state.tx.us/HFP/PDF/TMDP%20English%20Medical%20%20Disclosure%20Consent%20Form.pdf>.

The required disclosures for conization of the cervix are:

- Hemorrhage with possible hysterectomy to control
- Sterility
- Injury to bladder
- Injury to rectum
- Failure of procedure to remove all of cervical abnormality

BCCS CONTRACTOR CLINICAL RESPONSIBILITIES

Contractor requirements include the following:

- Accepting appropriate referrals for diagnostic services;
- Providing follow-up of clients with abnormal results;
- Assisting eligible clients in applying for the Medicaid Treatment Act;
- Ensuring clients, who are not Medicaid Treatment Act eligible, access to treatment;
- Communicating with clinical providers regarding the benefits and requirements of the BCCS program.

CLIENT HEALTH RECORD (MEDICAL RECORD)

Contractors must ensure that a client health record (medical record) is established for every client who obtains clinical services. Note: A client health record does not have to be established for women referred to a BCCS contractor with a qualifying diagnosis and the BCCS contractor will only be performing presumptive eligibility determination, assistance with the medical assistance application and case management services. For these women, the BCCS contractor shall establish a Case Management Record as described in the next heading.

Client health records must be maintained according to accepted medical standards and State laws, including those governing records retention. All client health records must be:

- Complete, legible, and accurate, documenting all clinical encounters, including those by telephone, in ink, without erasures or deletions
- Signed by the provider making the entry, including name of provider, provider title and date for each entry
- Readily accessible to assure continuity of care and availability to client
- Systematically organized to allow easy documentation and prompt retrieval of information

The client's record must include:

- Client identification and personal data (including financial eligibility)
- Preferred language/method of communication
- Where and how to contact the client (to facilitate continuity of care and assure confidentiality, adhering to HIPAA* regulations)
- Medical history
- Physical examination
- Laboratory and other diagnostic tests orders, results and follow-up
- Assessment or clinical impression
- Plan of care, including education/counseling, treatment, special instructions and referrals
- Scheduled revisits
- Informed consent documentation
- Refusal of services documentation

- Allergies and untoward reactions to drugs recorded prominently in specific location
- Problem list to provide a consistent mechanism to document and track health and social problems/issues and to promote continuity of care

**Health Insurance Portability and Accountability Act of 1996*

CASE MANAGEMENT RECORD

BCCS contractors must establish a case management record for every woman with a qualifying breast or cervical diagnosis referred to a BCCS contractor who meets the Medicaid Treatment Act eligibility criteria. If a woman does not meet the Medicaid Treatment Act eligibility criteria, the BCCS contractor may decide whether or not to accept the woman for case management. If she is accepted for case management, a case management record must be established. If she is not accepted for case management, the woman should be provided with information about available local resources and referred back to the diagnosing health professional.

The case management record will be maintained according to State laws, including those governing records retention. Case management records are subject to review during Quality Assurance Review visits.

Components of the case management record are:

- Case management assessment and service plan (as needed) - Using the Comprehensive Case Management Form (sample in Appendix B) the assessment and service plan should be recorded electronically using the TWICES/B&C Module. The filled in form may be printed out for the client to sign; a copy of the signed Comprehensive Case Management Form must be maintained in the case management record.
- General informed consent that addresses case management, confidentiality and authorization to enter or view data in the statewide database (TWICES).
- Pathology report with definitive qualifying diagnosis.
- Financial eligibility documents - The BCCS contractor's internal financial eligibility policy will describe the documentation required to be kept in the file.
- Citizenship documentation - see HHSC website for citizenship verification sources <http://www.dads.state.tx.us/handbooks/TexasWorks/A/300/358.1.htm> .
- Alien status documentation - see HHSC web site for alien status verification sources <http://www.dads.state.tx.us/handbooks/TexasWorks/A/300/311.htm>.

BREAST CANCER SCREENING SERVICES

Breast cancer is the most common cancer among women in Texas. The American Cancer Society estimates that approximately 12,120 new cases of breast cancer are diagnosed annually among women in Texas and each year 2,480 women will die of breast cancer in Texas.

Goals of Breast Cancer Screening – The goal of breast cancer screening is to reduce premature mortality from breast cancer and to improve survival of breast cancer by ensuring quality breast cancer screening and diagnostic services for women.

Definition of Screening – Screening is a process to detect unsuspected disease in asymptomatic women. The methods used for early detection and screening of breast cancer are clinical breast examination (CBE) and mammography.

Components of Breast Cancer Screening

Screening – The contractor must provide a complete breast cancer screening, which includes a CBE, mammogram and client education for women who present without symptoms that are suspicious for breast cancer. A screening mammogram must be provided within 60 days following the CBE. The contractor must document the CBE and mammogram results in the client's record. The BCCS follows National Cancer Institute recommendations for mammography screening:

- Ages 50 and older: Women should be screened every year.
- Ages 40 to 49: Women are encouraged to discuss, with a health care professional, the advisability of breast cancer screening with mammography.

Clinical Breast Examination (CBE) – CBEs must be performed by a qualified clinician, such as a physician, physician's assistant, nurse practitioner, certified nurse midwives, or qualified registered nurses with specialized training. Complete documentation of the CBE must be included in the client record. A second CBE is not required for women referred to a BCCS contractor because of an abnormal CBE or screening mammogram.

A breast health history must be included as part of the CBE. The health history includes:

- date and time intervals of previous mammograms;
- date and results of the last CBE;
- date and results of any previous breast surgery;
- date of last menstrual period;
- history of medications (hormonal replacement therapy, oral contraceptives);
- risk factors for breast cancer (advancing age, personal history of breast cancer or breast biopsy results with moderate, severe, or atypical epithelial hyperplasia; or family history of first degree relatives with breast cancer); and
- description of breast symptoms.

The BCCS follows the National Cancer Institute's recommendations for CBE. The CBE should include the following components:

- **With the woman sitting:** Inspection for asymmetry, abnormal superficial vascular patterns, nipple retraction, and peau d' orange.

Palpation of axillary and supraclavicular/infraclavicular nodes. Note size, location, mobility, and consistency of nodes palpated.

- **With the woman supine:** Palpation of the breast to include the axillary tail, areola and nipples.

Mammography Reports – Facilities must prepare a written report of the results of each mammography examination. This report must include the following:

- the name of the client and an additional client identifier;
- the name of the physician who interpreted the mammogram;
- an overall final assessment of findings, classified in one of the following categories:
 - *Negative* (Category 1)
 - *Benign* (Category 2)
 - *Probably benign* (Category 3) (Finding has a high probability of being benign.)
 - *Suspicious* (Category 4) (Finding lacks all the characteristic morphology of breast cancer, but indicates a definite probability of being malignant.)
 - *Highly suggestive of malignancy* (Category 5)
 - *Assessment is incomplete: need additional imaging evaluation* (Category 0) (Finding for which additional imaging evaluation is needed. This is almost always used in a screening situation and should rarely be used after a full imaging work up. A recommendation for additional imaging evaluation includes the use of spot compression, magnification, special mammographic views, ultrasound, etc.)

Client Education – The contractor must provide and document breast cancer information to every woman who receives breast cancer screening and/or diagnostic services through BCCS. The following information must be explained verbally to each woman in her primary language and may be supplemented with printed or audio-visual materials in the woman's primary language:

- description of cancer;
- risk factors for breast and cervical cancer;
- signs and symptoms of breast and cervical cancer;
- importance of screening at regular intervals;
- medical procedures as part of her current check-up;
- steps a woman must take to complete her current check-up;
- description of possible results of the medical procedures;
- date of next appointment and a telephone number to call with questions and/or to make her next appointments;
- eligibility to receive BCCS services can change from year to year; and
- information on the limitations of breast cancer screening e.g., a normal screening result does not necessarily indicate the absence of disease; normal results never rule out the later development of disease, which is why ongoing regular screening is recommended; and that an abnormal finding does not necessarily mean that the finding is cancerous.

FOLLOW-UP FOR SCREENING RESULTS

When both CBE and screening mammogram results are normal, routine re-screening is recommended.

Abnormal CBEs and mammograms always require further diagnostic evaluation.

Follow-up of CBE results

- Normal/benign CBE results require diagnostic referral only if mammogram results are abnormal.
- Abnormal (suspicious for cancer) CBE results require referral for a diagnostic mammogram and ultrasound or consultation with a surgeon or breast specialist (**any two**).

Follow-up of screening mammography results

- Negative (Category 1) screening mammography results require diagnostic referral only if CBE results are abnormal.
- Benign (Category 2) screening mammography results require diagnostic referral only if CBE results are abnormal.
- Probably Benign (Category 3) screening mammography results (with normal/benign CBE results) require radiologist recommendation for the next screening or diagnostic examination; **AND**, diagnostic referral if CBE results are abnormal.
- Suspicious (Category 4) screening mammography results require a consultation with surgeon or breast specialist with tissue sampling (biopsy).
- Highly Suggestive of Malignancy (Category 5) screening mammography results require referral for consultation with surgeon or breast specialist with tissue sampling (biopsy).
- Incomplete (Category 0) - Additional Imaging Evaluation Needed screening mammography results require additional imaging (mammography and/or ultrasound).

Note: This is the expected minimum follow-up. More procedures or examinations may be necessary to clarify screening examination results and to obtain a final diagnosis. A normal mammogram does not rule out cancer.

Women with Implants – Screening recommendations for women with either reconstructive or cosmetic breast implants is 4-6 specified diagnostic views.

Breast tissue must be present to be able to do these mammograms.

Professional Consultations for Screening Follow-up – Referrals for follow-up of screening results must be made to physicians with expertise in managing breast problems. General surgeons, radiologists, obstetricians, and gynecologists may be considered breast specialists depending on the focus of their practice. A consultation can only be performed by a physician who did not perform the original screening examination.

Consultations must involve direct examination. (Note: Interpretation of other images and imaging reports by a radiologist as a second opinion without direct examination of the client cannot be reported as a professional consultation.) Nurses, midwives, nurse practitioners, physician assistants, and primary care physicians do NOT qualify as breast specialists.

CERVICAL CANCER SCREENING SERVICES

Approximately 1,100 women in Texas are diagnosed with cervical cancer each year. Another 390 die from the disease each year (ACS). Of all cancers, cervical cancer is among the most amenable to prevention and early detection through screening. Cervical cancers detected at the earliest stage have 10-year survival rates of 99 percent.

Goals of Cervical Cancer Screening – The goal of cervical cancer screening for the BCCS is to reduce premature mortality from cervical cancer and to improve survival of cervical cancer by ensuring quality cervical cancer screening and diagnostic services for women in Texas.

Definition of Screening – Screening is a process to detect unsuspected disease in asymptomatic women. The methods used for early detection and screening of cervical cancer are pelvic examination and Pap test.

Components of Cervical Cancer Screening

Screening – The components of cervical cancer screening are pelvic examination, Pap test, CBE and client education. However, no CBE is needed if referred in for abnormal pelvic exam or abnormal pap test. HPV DNA testing is not reimbursable as a screening test.

Clinical Cervical Examination – Cervical cancer screenings must be performed by qualified clinicians, such as physicians, physician’s assistants, nurse practitioners, certified nurse midwives, or qualified registered nurses who have had specialized training.

A comprehensive assessment should include:

- CBE (Refer to follow-up recommendations if an abnormality is detected);
- assessment of the abdomen;
- assessment of the external genitalia;
- visual assessment of the cervix and collection of cervical cells for cytological analysis (Pap test);
- visual inspection of the vaginal vault during withdrawal of the speculum and the bimanual examination; and
- recto/vaginal examination.

A complete cervical health history must be included as part of the examination. The health history includes:

- date and results of the last pelvic examination and Pap test;
- date and results of any previous pelvic surgery, chemotherapy, and/or radiation therapy;
- date of last menstrual period and history of pregnancies;
- history of medications including oral contraceptives and hormonal replacement therapy;
- risk factors for cervical cancer; and description of present pelvic symptoms.

Cervical screen of overweight women – Note the following suggestions for screening overweight women:

- Position the patient as far down on the exam table as possible. Usually, she can still be “as comfortable” with her buttocks partially off the table.
- Elevate hips with a stack of sheets/pillows and raise the end of the exam table using the bracket underneath the bed of the table.
- Ask the patient to tilt the pelvis toward provider can help to locate and visualize the cervix.
- Purchase an extra large and long speculum such as the “Clinton” and a vaginal wall retractor to keep the vaginal walls from obscuring the view.
- Place a condom over the speculum blade with the tip open to retract the vaginal walls.

CYTOLOGY REPORTS – The 2001 Bethesda System for Reporting Cervical/Vaginal Diagnoses must be used for reporting cytology results. The components of a cytology report using the Bethesda system are:

- **Specimen adequacy**
 - Satisfactory for evaluation (*describe presence or absence of endocervical/transformation zone component and any other quality indicators, e.g., partially obscuring blood, inflammation, etc*)
 - Specimen rejected/not processed (*specify reason*)
 - Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of (*specify reason*)
 - Unsatisfactory for evaluation – The woman must have a repeat pap smear no sooner than 3 months after the unsatisfactory pap smear. The underlying condition should be treated (if applicable) prior to performing the repeat pap smear.
- **General categorization**
 - Negative for Intraepithelial Lesion or Malignancy
 - Epithelial Cell Abnormality: See Interpretation/Result (*specify ‘squamous’ or ‘glandular’ as appropriate*)
 - Other: See Interpretation/Result

- **Interpretation/Results**

- Negative for intraepithelial lesion or malignancy
- Other
 - Endometrial cells (*in a woman > 40 years of age*)
- Squamous Cell
 - Atypical squamous cells
 - ♦ of undetermined significance (ASC-US)
 - ♦ cannot exclude HSIL (ASC-H)
 - Low grade squamous intraepithelial lesion (LSIL) encompassing: HPV/mild dysplasia/CIN 1
 - High grade squamous intraepithelial lesion (HSIL) encompassing: moderate and severe dysplasia, CIS/CIN 2 and CIN 3 with features suspicious for invasion (*if invasion is suspected*)
 - Squamous cell carcinoma
- Glandular Cell
 - Atypical glandular cells -NOS [state endocervical, endometrial]
 - Atypical glandular cells, favor neoplastic [state endocervical, endometrial]
 - Endocervical adenocarcinoma *in situ*
 - Adenocarcinoma [state endocervical, endometrial or NOS]

- **Other Malignant Neoplasms:** (*specify*)

CLIENT EDUCATION - The contractor must provide and document cervical cancer information to every woman who receives cervical cancer screening and/or diagnostic services through the BCCS program. The following information must be explained verbally to each woman in her primary language and may be supplemented with printed or audio-visual materials in the woman's primary language:

- description of cervical cancer;
- risk factors for cervical cancer;
- signs and symptoms of cervical cancer;
- information on HPV and safer sex practices;
- information on the HPV vaccine;
- clinical procedures (pelvic exam and Pap test);
- importance of screening at regular intervals;
- steps a woman must take to complete her current check-up;
- description of possible results of the medical procedures;
- date of next appointment and a telephone number to call with questions and/or to make her next appointments; and
- eligibility to receive BCCS services can change from year to year.

FOLLOW-UP OF SCREENING RESULTS

Normal screening examination (pelvic and Pap test) – A negative Pap test needs no further diagnostic workup. The clinician must notify a woman of findings, including the need for continued routine screening examinations.

When a woman has had three consecutive, normal Pap tests documented within a 60-month (5 year) period, the screening interval shall increase to once every three years. Once there is documentation of three normal/benign results within a five-year period, BCCS funds may be used to reimburse for Pap tests once every three years.

The screening interval when using liquid-based tests is once every 2 years if the result is normal. As with the conventional Pap test, when a woman has had three consecutive, normal cervical cancer screening tests documented within a 60-month period, the screening interval with liquid-based testing will increase to once every three years.

Women with special circumstances are at greater risk for cancer and require annual screenings. The special circumstances are not limited to, but can include those with HIV, taking immunosuppressive medications, or a total hysterectomy for cervical cancer.

If a woman receives an abnormal screening test result, BCCS contractors shall follow the protocols and algorithms for the management of abnormal cervical cancer screening tests below. Reimbursement is based upon compliance with these protocols and algorithms.

For the purpose of managing abnormal screening results and following the cervical diagnostic algorithms for an adolescent, a BCCS-enrolled adolescent is defined as a female aged 18 up to 22 years of age.

Management of Abnormal Pelvic Examinations:

- Abnormal pelvic exams and abnormal Pap tests require further diagnostic evaluations.
- A normal Pap test does not rule out cancer if a woman has a cervical lesion on pelvic examination.
- A colposcopy is allowed with an abnormal pelvic exam if determined by the clinician.

Management of Abnormal Pap Tests:

- **Atypical Squamous Cells of Undetermined Significance (ASC)** – ASC is interpreted as cellular changes that have an atypical appearance. These changes may be due to an inflammatory process, estrogen deficiency (as in a post-menopausal woman), or dysplastic changes. The 2001 Bethesda System subdivides atypical squamous cells of undetermined significance (ASC-US) and atypical squamous cells, cannot exclude HSIL (ASC-H). For ASC-US, the cytology

report should contain an opinion from the cytopathologist as to which of the above reasons are responsible for the atypical cellular changes (if possible). The underlying cause (if it can be determined) may be treated, and the Pap test repeated. The woman must be referred for colposcopy in the presence of atypical squamous cells if there is: a repeat Pap test with ASC-US; or one Pap result of ASC-US with high-risk type HPV DNA panel; or one Pap result of ASC-H. (See Algorithms 1, 2, & 3) **Note: BCCS can reimburse for a high-risk HPV DNA panel following an ASC-US pap test.**

- **Low Grade Squamous Intraepithelial Lesion (LSIL)** – The woman must be referred for colposcopy. This is mild dysplasia (CIN I) or cellular changes due to the HPV. Mild dysplasia is characterized by definite abnormalities in nuclear development, with retention of an essentially normal cytoplasm. (See Algorithms 5, 6 & 7) **Note: BCCS does not reimburse for high risk HPV DNA testing at one year following an LSIL pap test.**
- **High Grade Squamous Intraepithelial Lesion (HSIL)** – The woman must be referred for colposcopy. With moderate dysplasia, the cell nucleus shows further signs of abnormal development and some abnormalities in the cytoplasm. Severe dysplasia is characterized by severe changes in development of the cell as well as loss of normal structure of the cell's arrangement into tissue. Invasion of the basement membrane can occur at any phase of CIN, but it is more likely to occur at CIN III. A biopsy must be performed to determine if invasion has occurred. When no lesion or only biopsy-confirmed CIN I is identified after satisfactory colposcopy in women with HSIL, a review of the cytology, colposcopy, and histology results must be performed. A second colposcopy may be performed at this time. If a cytological interpretation of HSIL is upheld or if review is not possible, a diagnostic excisional procedure is preferred in non-pregnant women. (See Algorithm 8)
- **Atypical Glandular Cells Of Undetermined Significance (AGC)** – The woman must be referred for colposcopy. The atypical glandular cells category is associated with a substantially greater risk for cervical neoplasia than the ASC or LSIL categories. Colposcopy with endocervical sampling is recommended for women with a Pap result of AGC, with the exception that women with atypical endometrial cells would initially be evaluated with endometrial sampling. Endometrial sampling should be performed in conjunction with colposcopy in women older than 35 years with AGC and in younger women with AGC who have unexplained vaginal bleeding. (See Algorithm 4)
- **Squamous Cell Cancer** – Cancerous cells have probably invaded through the basement membrane and into the cervical stroma, where the cells have access to blood and lymph vessels, enabling them to metastasize throughout the body. The woman should be referred for further evaluation to determine the extent of the invasion.

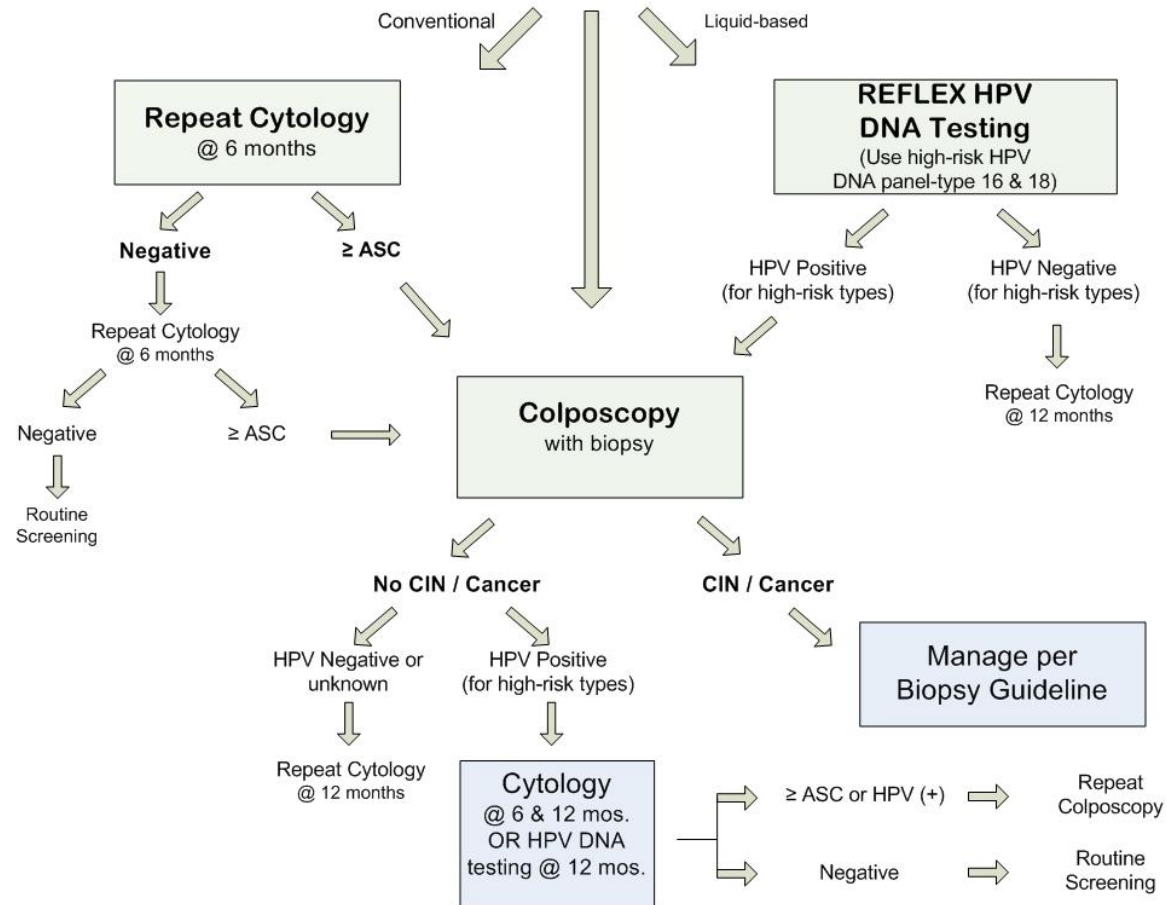
OTHER FINDINGS

Adenocarcinoma – Adenocarcinoma of the uterine cervix is a malignant neoplasm of epithelial cells in a glandular or gland like pattern. The cytology report should include the probable site of origin (endometrial, extra uterine, or endocervical). Most adenocarcinoma occur within the endocervical canal and carries a poorer prognosis than squamous carcinoma especially if lymph nodes are involved. The woman should be referred immediately for appropriate care.

Algorithms

Algorithm #1

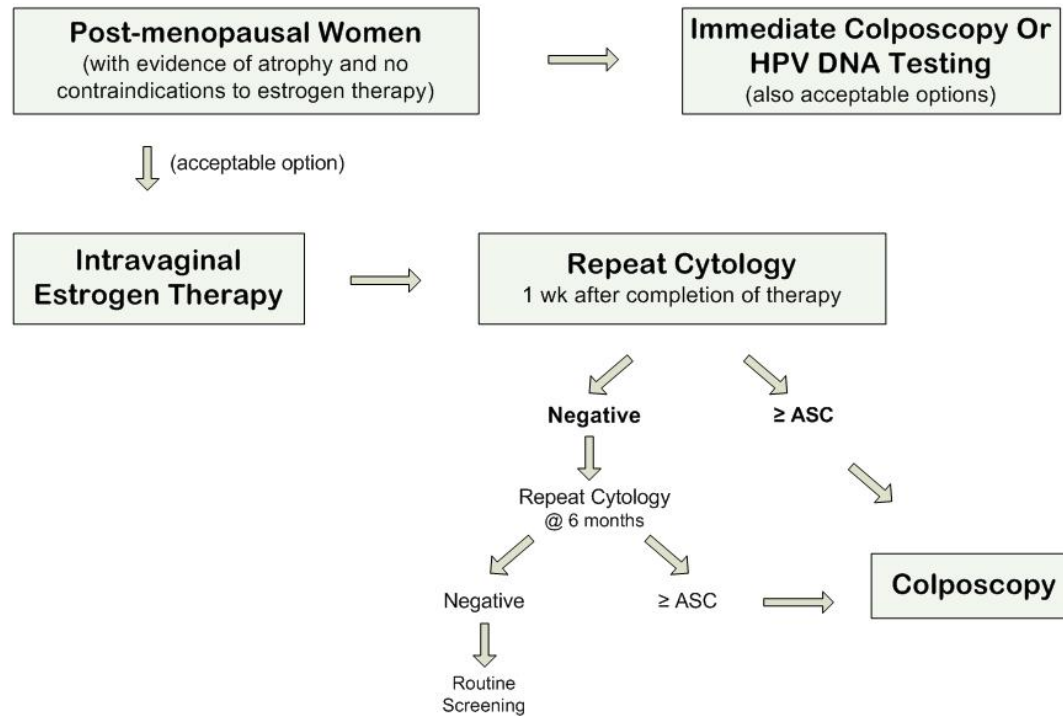
Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US)



Adapted from ASCCP 2002 Guidelines

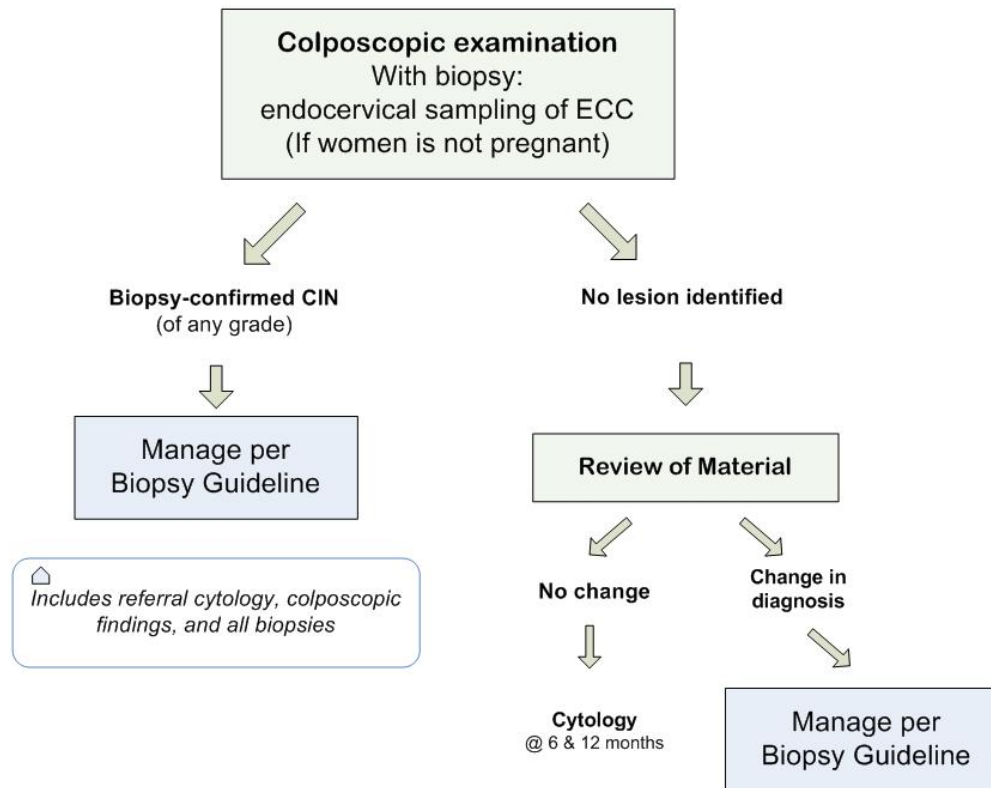
Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US) in Special Circumstances

Conventional and Liquid-Based Paps



Adapted from ASCCP
2002 Guidelines

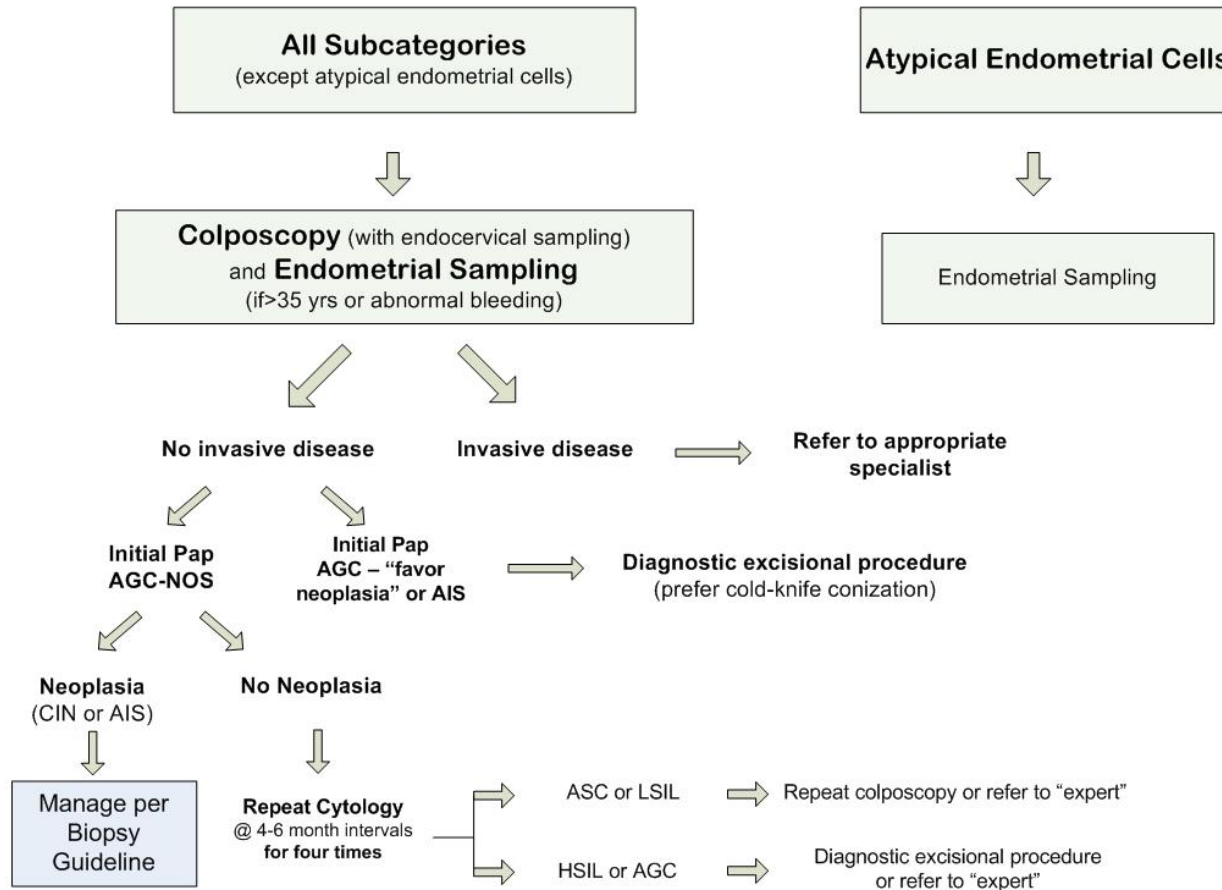
Management of Women with Atypical Squamous Cells:
High-grade SIL (ASC-H)



Adapted from ASCCP
2002 Guidelines

Algorithm #4

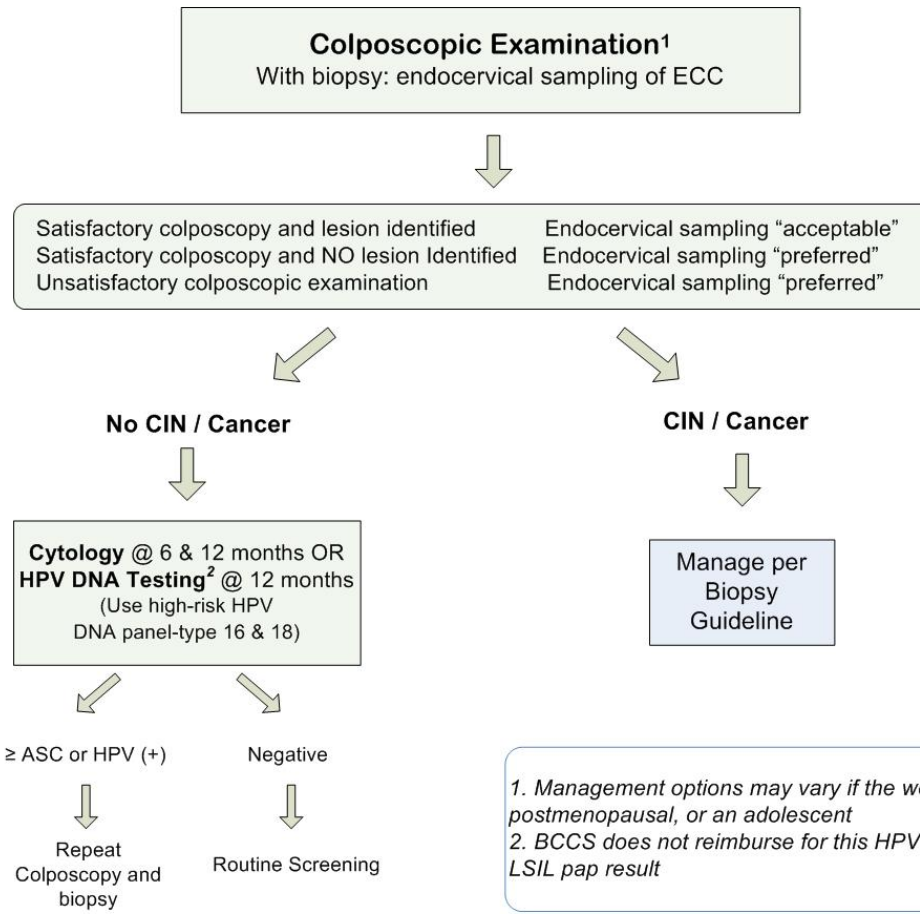
Management of Women with Atypical Glandular Cells (AGC)



Adapted from ASCCP 2002 Guidelines

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

Conventional and Liquid-Based Paps

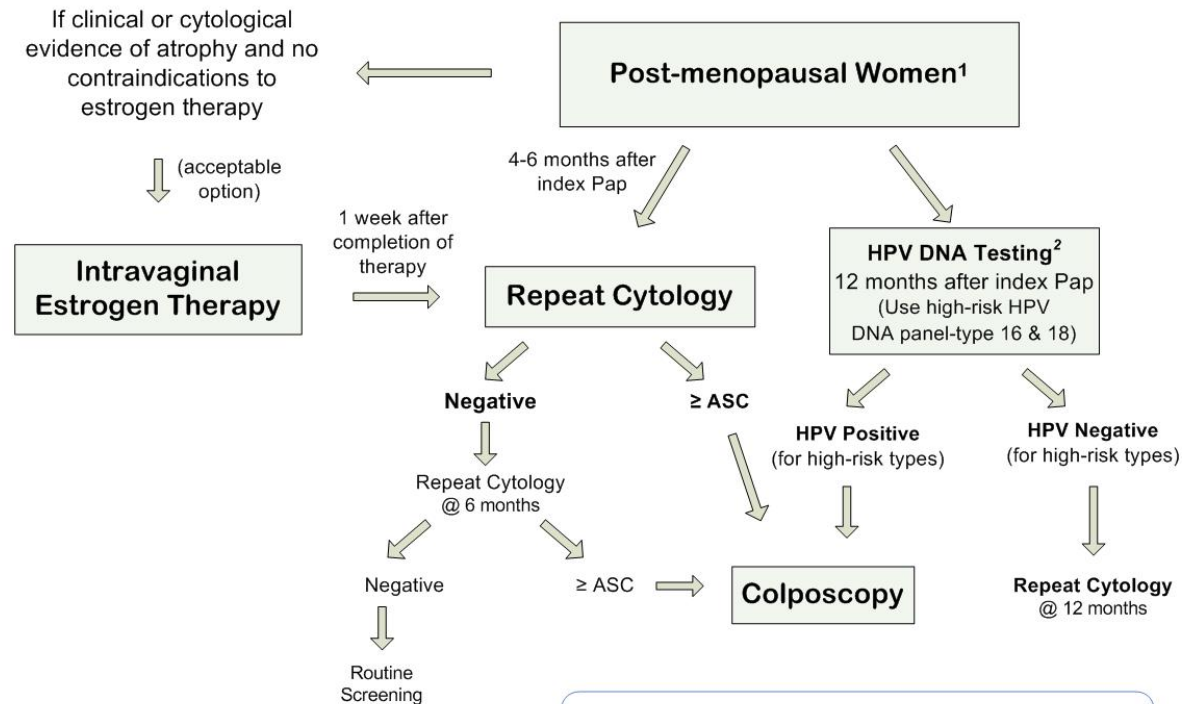


1. Management options may vary if the woman is pregnant, postmenopausal, or an adolescent
 2. BCCS does not reimburse for this HPV DNA test with a LSIL pap result

Adapted from ASCCP
2002 Guidelines

Management of Women with Low-grade Squamous Intraepithelial Lesions In Special Circumstances

Conventional and Liquid-Based Paps

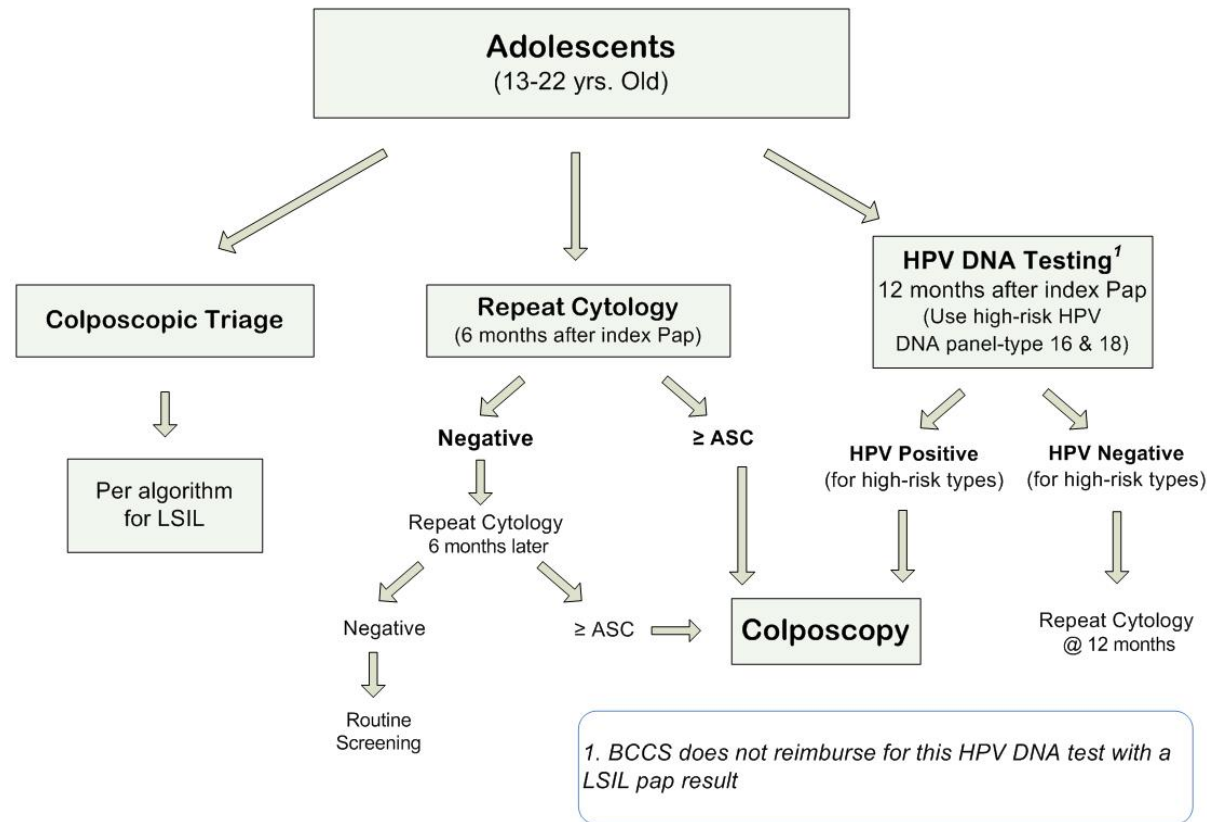


1. For low-risk, post-menopausal women with a history of negative screening
 2. BCCS does not reimburse for this HPV DNA test with a LSIL pap result

Adapted from ASCCP 2002 Guidelines

Management of Women with Low-grade Squamous Intraepithelial Lesions In Special Circumstances

Conventional Paps



Adapted from ASCCP
2002 Guidelines

RESCREENING SERVICES

In order for breast or cervical cancer screening to be most effective, the screening must be conducted at *regular intervals*. Contractors must attempt to notify each woman in writing of her regular screening due date.

Client Education for Breast and Cervical Cancer Rescreening – The contractor must provide and document screening information for every woman who is rescreened. The following information must be explained verbally to each woman in her primary language and may be supplemented with printed or audio-visual materials in the woman's primary language:

- importance of regular screening;
- possible results;
- eligibility requirements; and
- the shared responsibility of the client and the contractor in following through with regular screening.

CASE MANAGEMENT SERVICES

Case management is an individualized approach for each BCCS-enrolled woman with an abnormal screening or diagnostic result, or diagnosis of cancer, which involves establishing, brokering, and sustaining a system of available clinical and essential support services. (**Note: Case management does not include eligibility determination.**)

The goal of case management for the BCCS is to ensure that women enrolled in the BCCS program receive timely and appropriate services. Assessment of medical, education and essential support needs and the provision of related services when necessary, assist in attaining this goal. The outcome of case management and the progress toward reaching this goal is evaluated by the performance measures outlined in this manual and the DSHS contract.

In Texas, the Breast and Cervical Cancer Prevention and Treatment Act was implemented to provide Medicaid benefits to uninsured women under age 65 who have a qualifying diagnosis and require treatment for breast or cervical cancer. Women who have been diagnosed with a qualifying breast or cervical cancer, regardless of whether or not they were diagnosed by a BCCS contractor, are eligible for the BCCS program for assistance with completing the application for the Medicaid Treatment Act and case management services.

BCCS contractors shall provide case management to BCCS-enrolled clients with abnormal screening and diagnostic results AND to those referred to them with a qualifying breast or cervical diagnosis who meet Medicaid Treatment Act eligibility criteria defined under the Breast and Cervical Cancer Treatment Act heading found later in this Chapter. Case managers are responsible for identifying and accessing

resources for cancer treatment services for BCCS-enrolled women in need, regardless of their ability to pay. BCCS contractors may bill DSHS for case management services provided.

BCCS contractors **may** choose to provide case management for women referred to them with a breast or cervical cancer diagnosis, which are screened and determined to be ineligible for the Medicaid Treatment Act. If case management is initiated, BCCS contractors shall follow the woman until treatment is initiated and may bill DSHS for the case management services. If case management will not be initiated, the woman should be provided with information about available local resources and referred back to the diagnosing health professional (case management may not be billed to DSHS).

Below is a table comparing case management services for traditional BCCS-enrolled clients and for those referred to a BCCS contractor with a qualifying diagnosis.

ACTION	For Traditional BCCS-Enrolled Clients Who Have Abnormal Screening Or Diagnostic Results	For Clients with a Qualifying Diagnosis Referred to a BCCS Contractor for Assistance in Applying for the Medicaid Treatment Act
Initiation of Case Management	With an abnormal result	Upon completion of the assessment of Medicaid Treatment Act eligibility criteria and medical assistance application
Assessment of Essential Support and Social Resources	Assessment conducted within 30 days of the abnormal result or before the next diagnostic service	Assessment conducted within 30 days of the Medicaid Treatment Act eligibility determination
Case Management Plan	Notes recorded and follow-up documented within 30days of the date of the service plan activity	Notes recorded and follow-up documented within 30 days of the date of the service plan activity
Case Management and Follow-up on Diagnostic Tests	Completed in accordance with Requirements for Case Management Compliance , specified in this Chapter of the Policy Manual	Not Applicable
Completion of Case Management	Diagnosis resolved and no treatment is needed; treatment is initiated; or client is documented lost-to-follow-up or refused services	Initiation of treatment; or client is documented lost-to-follow-up or refused services

For clients enrolled with a BCCS contractor for screening or diagnostic services, case management must be initiated with receipt of an abnormal result. The client must be informed and understand the screening and follow-up process. The case manager and client must discuss how diagnostic services will be arranged. Case management services conclude when a client initiates treatment, is no longer in need of BCCS services or is documented lost-to-follow-up or refused services.

For clients who are referred to a BCCS contractor with a qualifying breast or cervical cancer diagnosis, case management must be initiated after the Medicaid Treatment Act eligibility requirements and medical assistance application are completed. Case management will include an assessment of medical, education and social support services. Case management services conclude when a client initiates treatment or is documented lost-to-follow-up or refused services.

When a woman concludes her cancer treatment, has been released by her physician to return to a schedule of routine screening, and continues to meet BCCS eligibility requirements, she may return to the BCCS program for services if she meets all eligibility requirements.

As stated earlier in this chapter, BCCS contractors must establish a case management record for every woman with a qualifying breast or cervical diagnosis referred to a BCCS contractor who meets Medicaid Treatment Act eligibility criteria. BCCS contractors **may** choose to provide case management for women referred to them with a breast or cervical cancer diagnosis, which are screened and determined to be ineligible for the Medicaid Treatment Act. If she is accepted for case management, a case management record must be established. The case management record will be maintained according to State laws, including those governing records retention. Case management records are subject to review during Quality Assurance Review visits.

Case Management Components - Key elements of the case management components include assessment, planning, coordination, monitoring, evaluation, and resource development.

Assessment – Assessment is a cooperative effort between the client and case manager to examine and document the client’s need for services (screening, diagnostic, treatment, and essential support services) through a process of gathering critical information from the client. The assessment includes consent and assurance of confidentiality between the client, the case manager, and the contractor.

All BCCS-enrolled clients with abnormal screening results must receive a BCCS needs assessment, using the TWICES B&C Module, case management screen or documenting in the client’s progress notes, unless the client refuses. Assessment components include client information, including other contact information, the need for social resources, other services the client has accessed, education and counseling issues, consent for case management and confidentiality. The assessment is to be conducted within 30 days from the date of referral for diagnostic procedures or prior to

the initiation of the first diagnostic service. The assessment should be conducted in a face-to-face interview format.

All women referred to a BCCS contractor with a qualified breast or cervical diagnosis must receive the same services described in the paragraph above except the assessment is to be conducted within 30 days from the date a BCCS contractor completes the Medicaid Treatment Act eligibility determination and medical assistance application or prior to the initiation of treatment. The assessment should be conducted in a face-to-face interview format if possible.

Planning – Planning is a cooperative effort between the client and case manager to develop an individual service plan to meet the client’s immediate, short-term and long-term needs as identified in the assessment.

The plan includes needs identified in the assessment, services planned related to those needs, timeframes for providing the services, referral, outcome and follow-up. As applicable, timeframes must be consistent with BCCS required screening and diagnostic intervals. The service plan must be documented in TWICES B&C Module case management screen or the client’s progress notes. Services must be completed no later than 30 days of the date of planned activity or prior to initiation of treatment.

Coordination – Coordination is the implementation of the service plan, including the appropriate use of available resources to meet the needs of the client.

Implementation of planned services and ongoing case manager-client consultation is documented in the TWICES B&C Module, case management screen or the client’s progress notes. Coordination of services may include scheduling appointments, making referrals, and obtaining and disseminating appropriate reports.

Monitoring – Monitoring is key to ensuring achievement of the desired goal of accurate and timely access to services. Monitoring is the ongoing assessment of the client’s service plan to ensure that the client’s needs are met. As additional needs are identified, they are recorded in TWICES B&C Module, case management screen or the client’s progress notes. The case manager must document that the planned service or initiation of treatment took place within 30 days of the planned service date.

In addition to monitoring clients who are receiving case management services, BCCS contractors must establish a system to monitor abnormal screening or diagnostic results for the purpose of identifying clients who need to have case management initiated.

Resource Development – Resource development is the establishment of formal and informal agreements to maximize availability and access to essential screening, support, diagnostic and treatment services. Documentation must be maintained in a resource directory developed specifically for detailing services that support BCCS-enrolled women with unmet needs.

Evaluation – Evaluation is the process of assessing the effectiveness of case management activities. This should be conducted at the client and agency levels; through client satisfaction surveys and with internal quality assurance reviews.

Requirements for Case Management Compliance

- Contractors must assure case management occurs with each BCCS-enrolled woman with abnormal results or diagnosis of cancer until the cycle is closed or treatment is initiated. Treatment initiated is the date a treatment plan is developed with the treating physician or team, the start of chemotherapy or radiation or the date of surgery-whichever is first.
- At a minimum, all clients with an abnormal result must receive a BCCS needs assessment within 30 days of receipt of the result or prior to the initiation of the first diagnostic service.
- All women referred to a BCCS contractor with a qualified breast or cervical diagnosis, who have completed the Medicaid Treatment Act application and have met the eligibility requirements shall receive a BCCS needs assessment within 30 days from the date the BCCS contractor determines the woman met the eligibility requirements.
- The needs assessment must include client consent for case management services.
- Contractor must have a system in place to ensure that monitoring of abnormal diagnostic results is conducted and documented at the contractor level.
- Contractor must contact the client with abnormal screening results no later than five working days following receipt of an abnormal screening result. All screening services must be documented.
- Contractor must contact the client with abnormal diagnostic results no later than two working days following the receipt of an abnormal diagnostic result. Diagnostic services and procedures specific consent, if applicable, must be documented
- All contact attempts can be made by office visit, telephone, and home visit or by mail. Attempts to contact the client must be written or presented verbally (when appropriate) in the client's primary language, if limited English proficient, including appropriate provisions for the visually and hearing impaired.
- The contractor must attempt to obtain in writing and document in the client record informed refusal from the client if the client fails to keep appointments or refuses recommended procedures. If the client cannot or will not sign an informed refusal, the contractor must document verbal refusal. Before closing the client record as a refusal, a thorough review of the client's plan, recommendations, and case manager's actions must be conducted to ensure proper closure.
- Before a contractor can consider a client "lost to follow-up," the contractor must have at least three documented separate attempts to contact the client, with the last attempt sent by certified mail.

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- Within one month after the client and case manager complete the case management plan, the case manager must follow-up and document that the service was actually implemented; and that there is written validation of final diagnosis.
 - As additional needs are identified, they are recorded on the plan and the accompanying services and time frames are indicated.
 - Contractors must notify the BCCS state office in writing when diagnostic and/or treatment needs cannot be met due to non-availability of resources.
 - Contractors must develop and maintain a resource directory containing information on services that could support women with unmet needs who are eligible for BCCS.

ACCESS TO TREATMENT

The following treatment options are available for eligible women with a qualifying diagnosis:

- The BCCS program provides funds for cervical dysplasia treatment services for women who have a qualifying diagnosis and who are not eligible for the Medicaid Treatment Act. For a description of qualifying diagnoses, see the heading in this Chapter entitled, Cervical Dysplasia Treatment.
- The Breast and Cervical Cancer Treatment Act (Medicaid Treatment Act) provides Medicaid coverage to women who have qualified breast or cervical cancer diagnoses and meet all other Medicaid Treatment Act eligibility criteria. See Appendix C for Texas Medicaid Treatment Act Qualifying Diagnosis Guidance.

CERVICAL DYSPLASIA TREATMENT

Only awarded Title V funds will be used for treatment of cervical dysplasia.

The circumstances in which dysplasia funds may be used are:

- The cervical dysplasia diagnosis is not covered by the Medicaid Treatment Act (e.g. CIN I, CIN II); and
- A BCCS-diagnosed woman or a woman referred to BCCS that is not eligible for the Medicaid Treatment Act for cervical dysplasia treatment (therefore she may receive dysplasia treatment, as appropriate for CIN I, CIN II, CIN III, CIS).

Cervical dysplasia treatment services, as indicated by history, risk assessment, physical exam and test results, **will only** include the following CPT Codes:

- Office Visit – in conjunction with treatment only CPT Code 99214
- Cryotherapy CPT Code 57511

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- | | |
|----------------------------------|----------------|
| • Laser | CPT Code 57513 |
| • Loop Electrode Excision (LEEP) | CPT Code 57522 |

TWICES B&C Module has been programmed to generate billing to the Title V cervical dysplasia awarded funds.

BREAST AND CERVICAL CANCER TREATMENT ACT

The Breast and Cervical Cancer Medicaid Treatment Act Program is a special Medicaid program authorized by federal and state laws to provide access to cancer treatment services for qualified women. In Texas, the Medicaid Treatment Act is administered by the Health and Human Services Commission (HHSC). BCCS contractors are responsible for assisting women with completion of the HHSC medical assistance application (Form 1034), determining presumptive eligibility for qualified women and assessing case management needs. HHSC is responsible for determining the final eligibility and notifying the client.

Eligibility – To qualify for the Treatment Act, the woman must meet all of the following:

- Be diagnosed under the scope of Title XV as provided for in Senate Bill 10, 80th Texas Legislature and need treatment for one of the following biopsy-confirmed definitive diagnoses for breast or cervical cancer: CIN III, severe cervical dysplasia, cervical carcinoma in-situ, invasive cervical cancer, ductal carcinoma *in situ* (DCIS) or invasive or infiltrating breast cancer (See Appendix C Texas Medicaid Treatment Act Qualifying Diagnosis Guidance);
- Be at or below 200% of the federal poverty level;
- Not be insured, that is, she must not otherwise have creditable coverage (including current enrollment in Medicaid);
- Be under age 65; and
- Be a U.S. citizen or qualified alien and a Texas resident.

Need Treatment – A woman is considered to “need treatment” if, in the opinion of the woman’s treating health professional, the screening and diagnostic evaluations indicate that the woman is in need of cancer treatment services. The treating health professional may be the individual who conducts the screen or any other health professional with whom the individual consults.

Verification of Citizenship and Identity – As part of Public Law 109-171, Deficit Reduction Act of 2005, individuals declaring to be a United States (U.S.) citizen or nationals of the U.S. must provide evidence of citizenship when applying for or receiving Medicaid benefits. Documented verification must establish both citizenship and identity.

See the following websites for more information:

Citizenship - <http://www.dads.state.tx.us/handbooks/TexasWorks/A/300/358.1.htm>;

Resident Alien – <http://www.dads.state.tx.us/handbooks/TexasWorks/A/300/311.htm>

The Medicaid rules that govern citizenship and alienage apply to the Medicaid Treatment Act. In general, to be eligible for Medicaid an individual must either be a citizen or a qualified alien. In Texas, legal permanent residents who arrived in the United States after August 21, 1996 are barred from receiving Medicaid. If the BCCS Contractor (or health provider) is uncertain if a woman meets citizenship and alienage status, the completed 1034 should be submitted for processing and determination. When citizenship and alienage is in question, the woman may not be considered presumptively eligible.

Presumptive Eligibility – Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before a full Medicaid determination is completed, based on a determination by a Medicaid provider of likely Medicaid eligibility. Presumptive eligibility facilitates the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer.

BCCS contractors or if a BCCS contractor is not a Medicaid provider, a BCCS subcontractor that is a Medicaid provider, shall be responsible for determining if a woman is presumptively eligible for the Medicaid Treatment Act. This includes collecting and reviewing documents to ensure she has a qualifying medical diagnosis and meets financial, age, citizenship and identity requirements and assisting the woman in completing the medical assistance application (Form 1034). If there is doubt as to whether a client qualifies for Medicaid services, the BCCS contractor does not make a presumptive eligibility determination, but completes the medical assistance application and forwards it to DSHS with appropriate accompanying documentation. After review, DSHS will forward the package to HHSC for a final determination.

Presumptive eligibility begins on the day after the date of the procedure that confirms a qualifying breast or cervical diagnosis if the BCCS contractor determines that the woman is likely to meet the eligibility criteria described above.

Coverage – A woman is entitled to full Medicaid coverage while in active treatment for breast or cervical cancer; coverage is not limited to coverage for treatment of breast or cervical cancer.

Eligibility for coverage ends when the woman no longer meets the criteria for this eligibility category (for example, because she has attained age 65 or has creditable coverage, or no longer needs treatment for breast or cervical cancer).

A woman is not limited to one period of eligibility. A new period of eligibility and coverage commences each time a woman is found to need treatment of breast or cervical cancer and meets all other eligibility criteria.

BCCS Contractor Responsibilities – BCCS contractor (or BCCS' subcontractor that is a Medicaid provider) will be responsible for:

- determining BCCS eligibility (financial and Texas residency);

-
- verifying the diagnosis of a qualifying condition for medical assistance;
 - assisting in completing medical assistance application;
 - determining client presumptive eligibility;
 - faxing the following medical assistance application and documents to the DSHS/BCCS Medicaid Treatment Act Coordinator (see Contact Information below) :
 - Form 1034
 - pathology report of a biopsy-confirmed qualifying condition
 - citizenship and identity verification
 - calling the DSHS/BCCS Medicaid Treatment Act Coordinator to confirm receipt of the application and required documents.

Timeframe – BCCS contractors must submit the medical assistance application (1034) and other required documents to the DSHS/BCCS Medicaid Treatment Act Coordinator no later than two (2) working days from the date the presumptive eligibility determination is made.

DSHS/BCCS Contact Information – For additional information and/or questions regarding the Breast and Cervical Cancer Treatment Act contact the Department of State Health Services Preventive and Primary Care Unit, Breast and Cervical Cancer Services program at:

Telephone Number: (512) 458-7796
Fax Number: (512) 458-7203
Email Address: ppcu@dshs.state.tx.us

DSHS/BCCS State Office Responsibilities – DSHS/BCCS program staff are responsible for reviewing the clinical documents and other required documents and submitting the package to the HHSC Medicaid Unit within two working days of receipt of the complete application package.

HHSC Medicaid Unit Responsibilities – HHSC is responsible for determining the final eligibility and notifying the client. Final eligibility will be determined by HHSC Medicaid Unit within two (2) working days of receipt of a presumptive eligibility application packet. Eligibility for applications that are not “presumed eligible” will be determined within 45 calendar days of receipt of the application packet.

For assistance with client eligibility determination questions, call HHSC at:
Centralized Benefits Services
1-800-248-1078

Reinstating Medicaid - A woman who was previously enrolled in Medicaid under the Treatment Act, and who is no longer on Medicaid, but is still in active treatment for the original cancer, may reapply for Medicaid. The BCCS contractor can help the woman to reapply by:

- Obtaining a letter from the treatment provider indicating that the woman is still in treatment for the original cancer;

- Assisting in completing a new medical assistance application (Form 1034);
- Faxing the following documents to the DSHS/BCCS Medicaid Treatment Act Coordinator:
 - The new Form 1034
 - The letter from the treatment provider
 - The original qualifying condition pathology report
 - Citizenship and identity verification
- Calling the DSHS/BCCS Medicaid Treatment Act Coordinator to confirm receipt of the fax.

COMMUNITY EDUCATION

To facilitate community awareness of and access to BCCS and Medicaid Treatment Act services, contractors must establish and implement planned activities whereby these services are made known to their partners and the community. Contractors should review a range of strategies and assess the availability of existing resources and materials. Promoting activities should be reviewed annually and be responsive to the changing needs of the BCCS program and the community.

Contractors must:

- implement strategies to enroll women in BCCS including:
 - identifying the priority populations to receive information,
 - identifying the population at highest risk for developing breast and/or cervical cancer, and
 - establishing relationships with internal and external partners to reach eligible women in the priority populations;
- implement strategies to raise community awareness of the Medicaid Treatment Act including:
 - educating partners such as subcontractors, other health care providers, community organizations, coalitions, and local advocacy groups about the Treatment Act and how to appropriately refer a non-BCCS diagnosed client for Treatment Act screening and
 - educating women diagnosed with breast or cervical cancer about Treatment Act eligibility requirements and how to apply for services;
- provide information to each eligible woman in her primary language;
- provide access to information that is culturally sensitive, linguistically appropriate and also available to the visually and hearing impaired; and
- conduct outreach activities if less than 75% of all mammograms are provided to women ages 50-64, or the projected number of women to be screened is not reached.

Section III

Reimbursement, Data Collection and Reporting

Purpose: Section III provides policy requirements for submitting reimbursement, data collection and required reports.

REQUIREMENTS FOR REIMBURSEMENT

Billing Procedures for BCCS Contractors

Requests for reimbursement will be generated weekly as one of the automated functions of the TWICES B&C Module. BCCS services and procedures that have met business rules will be marked approved to pay and submitted electronically to DSHS for processing through the State Comptroller. Paid claims will be deposited into the contractor's direct deposit account.

Case management services must be provided to a woman with abnormal results whether or not the contractor receives case management funds. Diagnostic services are required in order to bill for case management. As long as a case management needs assessment has been completed, contractors can bill for case management services provided to women with abnormal results who are lost to follow-up or have refused further services as well as treatment initiation. If billing for case management at 6-month follow-up, there must be an abnormal result and the case management needs assessment should be updated.

REPORTING

Request for Advance or Reimbursement Form 270 – Form 270 is to be submitted no later than 60 days after the completion of the contract year to the Claims Processing Unit and to the Contract Development and Support Branch (CDSB). A copy of the form may be found at the following website: <http://www.dshs.state.tx.us/grants/forms.shtm>

Report Name: Form 270 - Request for Advance or Reimbursement (TDH GC-10)				
Submission Date: No later than sixty (60) days after the end of the contract term				
Submit Copy to:				
Name of Unit/Branch	Original Required		Accepts Fax, Mail, or Email	# Copies
	Yes	No		
Contract Development and Support Branch (CDSB)		X	Mail or Fax	1
Accounting Section/Claims Processing Unit (CPU)	X		Mail only	1
Instructions: Accounting Section (CPU) requires an original signature on Form 270; CDSB will accept a copy by mail or by fax.				
Fax Numbers:	Contract Development and Support Branch		(512) 458-7235	
	Accounting Section/Claims Processing Unit		(512) 458-7442	
	Preventive and Primary Care Unit		(512) 458-7203	
Mail Codes:	In order to ensure timely and accurate delivery of Department of State Health Services mail, please use the following mail codes when submitting reports.			
	Contract Development and Support Branch		1914	
	Accounting Section/Claims Processing Unit		1940	
	Preventive and Primary Care Unit		1923	
Mailing Address:	1100 W. 49th Street, Austin, Texas 78756-3199			
Claims Process Unit Email Address	Invoices@dshs.state.tx.us			

Match Report – Matching funds refer to non-Federal resources (money and/or in-kind contributions). The CDC requires the BCCS to provide \$1 in match for every \$3 awarded. See below for examples of acceptable match items. All BCCS contractors must secure, budget, expend and report non-Federal match. Match reports are submitted to BCCS on a quarterly basis. This form can be found at: http://www.dshs.state.tx.us/chscontracts/all_forms.shtm See below for instructions on completing the report. Contractors must maintain and submit back-up documentation to support matching contributions.

Report Name: Quarterly Matching Contribution Report				
Submission Date: Quarterly, within 30 days following the end of each quarter				
Submit Copy to:				
Name of Unit/Branch	Original Required		Accepts Fax, Mail, or Email	# Copies
	Yes	No		
Contract Development and Support Branch (CDSB)		X	Email only	1
Instructions: Quarter Matching Contribution report does not require original signature and should be e-mailed to: cdsb@dshs.state.tx.us				

Instructions for completing the Quarterly Match Report

1. The contractor organization name must appear as it does on the DSHS contract.
2. Indicate the current budget period (07/01/YY – 06/30/YY)
3. Indicate the reporting quarter

<u>Match Report Quarters:</u>	<u>Due Dates</u>
1 st Jul 1 – Sep 30	30 days following end of qtr.
2 nd Oct 1 – Dec 31	30 days following end of qtr.
3 rd Jan 1 – Mar 31	30 days following end of qtr.
4 th Apr 1 – Jun 30	30 days following end of qtr.

4. Indicate the base award, all additional awards (if applicable) and total funding for reporting year.
5. Indicate the match projected for the approved base award. If your organization received additional funding, indicate the match projected for additional funds. Indicate “N/A” if no additional funds were awarded. Total match projected for both base award and additional awards and note it on the “Total Match.”

-
6. Type in the name/signature of the person authorized to verify the match information (i.e., that reported match is correct and auditable).
 7. List each item by category (program component), detailed description of service provided, funding source [e.g., another (non-federal) grant, local government, donation from individual or organization], and amount of each match item. Items must be those that would be paid by the BCCS, are directly allocable to BCCS activities, and cannot include indirect or overhead costs. Indicate total amounts for each quarter and cumulative totals.

Examples of acceptable match items by category (not all-inclusive)

Screening/Diagnostic Services:

- clinical breast and pelvic examinations;
- office visits and/or breast consultations
- clinical procedures approved for reimbursement by the program
- difference between usual and customary charges and Medicare reimbursement rates approved by the program.

Case Management Services:

- staff time conducting face-to-face and telephone contact with clients who have abnormal breast or cervical findings to provide case management activities such as assessment, planning, and monitoring; and local travel required for follow-up of individual clients.

Public Education/Information:

- staff time conducting breast and/or cervical cancer media campaigns;

Client Education:

- staff time spent providing breast and cervical cancer education to program clients
- educational materials provided to individual clients such as videotapes, and pamphlets

Outreach:

- staff time spent conducting outreach and recruitment activities to increase the number of women screened by the program
- staff's local travel necessary to conduct outreach and recruitment activities

Data Collection:

- staff time for data collection and reporting
- costs of local program data tracking software and other tools

Quality Assurance:

- staff time to review client records to assess compliance with program requirements.

Professional Development/Professional Education:

- expenses paid by contractor to attend breast/cervical cancer-related training, workshops, or conferences. (Break out travel, per diem, conference fees, and CEU fees)

Costs associated with the above activities (e.g., staff time, postage, supplies) may be reported as match if they are directly allocable to those activities. Such items that are not directly allocable to program activities and that would be defined as overhead or indirect costs are not allowable as match. Treatment costs are not allowable as match.

Supporting information must be included on the form or attached separately to document the method used to calculate match amounts. See examples on next page.

Category	Description of Services	Funding Source(s) and Amount of Each	1 st Qtr.	2 nd Qtr.	3 rd Qtr.	4 th Qtr.	Cumul. Total Qtrs. 1-4
1. Screening and Diagnostic Services	Difference between usual and customary charges and BCCC Medicare rates	N/A	\$20,000	\$30,000	\$35,000	\$40,000	\$125,000
	Facility charges for excisional breast biopsies	Memorial Hospital	\$7,000	\$5,500	\$2,000	\$4,000	\$18,500
2. Case Management Services	Case management of clients with abnormal screening and/or diagnostic results	X funding source 10 clients x \$100 each	\$500	\$800	\$700	\$1,000	\$3,000
3. Public Information and Outreach	Breast cancer pamphlets for quarterly health fair	Komen Foundation 1,000 pamphlets@ \$.50 ea.	\$500	\$500	\$500	\$500	\$2,000
4. Client Education	Staff time to conduct face-to face-interviews with clients	Y funding source Health Educator salary = \$30,000 x 10% = \$3,000 x 20% fringe = \$20+\$3,000 = \$3,020	\$1,200	\$2,400	\$2,000	\$3,020	\$8,620
5. Data Collection	Staff time to conduct data collection and reporting	Kellogg Foundation Office assistant salary = \$25,000 x 10% = \$2,500 x 20% fringe = \$500 = \$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$12,000
6. Quality Assurance	Staff time for reviewing BCCC client records	Client Fees R.N. salary = \$50,000 x 5% = \$2,500 x 20% fringe = \$500 + \$2,500 = \$3,000	\$3,000	\$2,500	\$3,000	\$3,000	\$11,500
7. Professional Education	Attendance at breast cancer conference	City Funding Source Travel expenses for 1 nurse				\$500	\$500
8. Program Management	Staff time processing billing	County Funds Accountant salary = \$40,000 x 5% = \$2,000 x 20% fringe = \$400+\$2,000 = \$2,400	\$2,400	\$2,400	\$2,400	\$2,400	\$9,600
Grand Total			\$37,600	\$47,100	\$48,600	\$57,420	\$190,720

**BREAST AND CERVICAL CANCER CONTROL
QUARTERLY MATCH REPORT**

1. Contractor Name _____
2. Budget Period _____ 3. Quarter ____1 ____2 ____3 ____4
4. Total Funding Award for Current Budget Period: Base Award _____ Additional Funding Award _____
Total Award _____
5. Total Match Projected for Current Budget Period: Base Match _____ Match for Additional Funding: _____
Total Match _____
6. Date Match Report Submitted _____ Name of Person Submitting Report _____
7. In the table below, list your actual match contributions for each quarter. Describe each service, the funding source(s) for each service, and the total match for each quarter. Indicate the cumulative totals in the appropriate spaces. Use additional pages if necessary.

SAMPLE

Category	Description of Services	Funding Source(s) and Amount of Each (Federal Funds are not approved for as a match source)	1 st Qtr.	2 nd Qtr.	3 rd Qtr.	4 th Qtr.	Cumul. Total Qtrs. 1-4
1. Screening and Diagnostic Services							
2. Case Management							
3. Public Information and Outreach							
4. Client Education							
5. Data Collection							
6. Quality Assurance							
7. Professional Education							
8. Program Management							
Grand Total							

Program Narrative Report – An annual program narrative report is required that describe successes, challenges and barriers in meeting the goal(s) and objective(s) described in the work plan for each of the BCCS program components.

A sample report format is on the next page and the final form is available on the BCCS web site, on the Forms page at:

http://www.dshs.state.tx.us/chscontracts/all_forms.shtm. There should be a separate page for each program component and the total length of the report shall not exceed ten (10) pages.

The report is due no later than 60 days after the contract attachment ends and should be e-mailed to: ppcu@dshs.state.tx.us.

BCCS components include: Program Management; Screening, Diagnosis, Case Management, and Dysplasia Treatment; Quality Management; Professional Development; Recruitment; Data Collection and Partnerships.

Breast and Cervical Cancer Services
FY08 Annual Program Narrative REPORT - SAMPLE

Legal Name of Agency:

Instructions: Using this form, write a program narrative report describing successes, challenges and barriers to meeting the goal(s) and objective(s) described in the work plan for each of the BCCS program components. The total length of the report should not exceed ten (10) pages. The report is due no later than 60 days after the contract attachment ends and should be e-mailed to: ppcu@dshs.state.tx.us

Use a separate page for each BCCS Component. BCCS Components include: Program Management; Screening, Diagnosis, Case Management, and Dysplasia Treatment; Quality Management; Professional Development; Recruitment; Data Collection and Partnerships.

<p>Component:</p> <p>Goal:</p> <p>Objective(s):</p> <p><u>Successes</u></p> <p><u>Challenges</u></p> <p><u>Barriers</u></p>
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SANCTIONS DUE TO NONCOMPLIANCE WITH REPORTING

The Performance Management Unit will apply the following procedures when reports and/or vouchers are not received by the required deadlines:

Fifteen (15) calendar days after a monthly report or voucher is due – The Contract Manager will send a written notice requesting the monthly report or voucher be immediately submitted within five (5) business days. Note: payments cannot be processed until correct and complete information is received.

Five (5) business days after the written notice is sent – The Contract Manager will discuss contractors who have not complied with the manager of the Contract Management Branch (CMB). Depending on the circumstances of the contractor, technical assistance (TA) may be provided. If the contractor has frequently been late in submitting reports and billing, contract sanctions may be imposed.

Contract sanctions – According to Article XIV of the Fiscal Year 2008 Performance Contract General Provisions (Core/Subrecipient), the list of sanctions that may be imposed is not limited to the following:

- require contractor to receive technical or managerial assistance;
- temporarily withhold cash payments;
- permanently withhold cash payments;
- disallow use of all or part of the funds allocated to the contract;
- delay execution of a new contract or renewal;
- reduce funding for the contract;
- suspend all or part of the contract;
- terminate the contract; or
- deny additional or future contracts or renewals.

Introduction:

Effective July 1, 2007, the Department of State Health Services (DSHS) Breast and Cervical Cancer Services program (BCCS) will utilize the Texas-Wide Integrated Client Encounter System (TWICES) Breast and Cervical Cancer Module for data collection, reporting and billing. TWICES B&C Module is a software application that will run in a web browser connected to a single database. This application was developed by DSHS to assist BCCS contractors in:

- Automating the required documentation and record-keeping;
- Improving data information quality and access;
- Reducing paper work and duplication of client information;
- Measuring performance and outcomes of BCCS services;
- Sharing client information between BCCS contractors; and
- Processing billing files.

If you encounter system problems with TWICES or the TWICES B&C Module, you can contact the TWICES Help Desk. Examples of problems they can assist you with are:

- Cannot log on;
- Need to change a password;
- Need to modify a security code;
- Getting system error messages.

The TWICES Help Desk is open from 8:00 a.m. to 5:00 p.m. Central Standard Time.

You can contact the TWICES Help Desk by:

Telephone: **(512) 218-1037**

Fax: **(512) 341-4452 ATTN: TWICES HELP DESK**

E-mail: On the TWICES Main Menu there are two hyperlinks. Use the “Suggestions/Comments” link to submit a suggestion or use the “Report A Bug” link to report a bug. When you click on either of these hyperlinks, you will be presented with an e-mail form addressed to key TWICES personnel. Type in your bug report or your suggestion and click “Send” (in the upper left-hand corner).

For problems related to BCCS policy and/or the TWICES B&C Module, please contact the Steve Johnson, the Data Manager for the BCCS program, at (512) 458-7111 extension 2697, or steve.johnson@dshs.state.tx.us. Examples of appropriate questions or issues include, but are not limited to:

- Cannot close out a cycle;
- How to run reports;
- How to bill; and
- Other technical assistance.

DATA COLLECTION

To demonstrate and evaluate the effectiveness of a breast and cervical cancer screening program, data collection is necessary.

Minimum Data Elements – The Minimum Data Elements (MDE's) is the set of data CDC has determined to be the basic elements necessary to effectively measure the quality of BCCS services and adherence to federal requirements. CDC uses the MDE's to measure the Texas BCCS performance and to make funding decisions.

A **screening cycle** is the time period from the first screening exam until:

- Final diagnosis is reached or treatment is initiated.
- Client is lost to follow-up.
- Client refuses needed procedures.

Data is used to assist in answering the following:

- **Outreach:** Are you reaching your priority population? Are women at higher risk for developing breast and/or cervical cancer being reached?
- **Quality assurance:** Does service delivery occur within established timelines? Are clients receiving appropriate services? Are results being received in a timely manner?
- **Case management:** Are BCCS clients getting lost in the health care system? Are too many clients refusing services?
- **Evaluation:** What trends are emerging? What contractors are successful? What methodologies are then using? Where are areas that need improvement?

Will I submit data forms?

TWICES is an Internet-based system that backs up data every five minutes so data will be automatically be submitted to the Texas Department of State Health Services;

Data entry into the system is the responsibility of the contractor;

It is recommended that your agency stay current with data entry into the TWICES system to ensure you have timely data for program management and to generate reimbursement for services provided.

Obtaining Forms and Supplies

The AG-30, Requisition for Office Supplies/Forms/Literature form is to be used for obtaining most items needed for the BCCS. The form can be found at: <http://dbs.dshs.state.tx.us/mamd/litcat/AG-30.asp>. Below are items that may be ordered using the AG-30 form.

Item	Description	Obtain Thru	Order option: Phone/Fax #	Order option: On-line address
*M-47	State Cytology laboratory form (for Pap specimens)	Women's Health Lab	ph: 210/531-4596 Fax: 210/531-4506	http://dbs.dshs.state.tx.us/mamd/litcat/default.asp
*M-47	State Cytology laboratory form (for Pap specimens)	DSHS Warehouse	ph: 512/458-7761	http://dbs.dshs.state.tx.us/mamd/litcat/default.asp
Pap Supplies	Cytobrushes, slides, etc.	Women's Health Lab	ph: 210/531-4596;or 888/440-5002 Fax: 210/531-4506	n/a
Pap Supplies	Cytobrushes, slides, etc.	DSHS Pharmacy	ph: 512/458-7500 Fax: 512/458-7489	n/a

***The M-47 State Cytology Laboratory forms used with Pap specimens are designated for contractors using the State Laboratory (Texas Center for Infectious Diseases-TCID) only.** Contractors using private labs will need to obtain laboratory forms through the Pap facility utilized. However, *all* contractors, regardless of the lab they are using, may obtain Pap supplies through the Texas Department of State Health Services (DSHS) Pharmacy or Women's Health Lab by requesting them on the AG-30 order form. Contractors using TCID may also request mailing labels for Pap specimens on the AG-30 order form. For your reference, please note the customer service telephone number for the Women's Health Laboratories: (888) 440-5002 or (210) 531-4596.

Obtaining Forms and Supplies

To order supplies from the DSHS Pharmacy complete the DSHS AG-30 form by filling out the “quantity” and “description” columns and the “ship to address” box. Sign the form in the “authorized signature” box and the mail the AG-30 form to the Texas Department of State Health Services, 1100 West 49th Street, Austin, Texas 78156, attention Pharmacy or fax to (512) 458-7489.

BCCS Data Forms – The BCCS program will not longer use the BCCS Screening forms (D-19B, D19C) and BCCS Diagnostic forms (D-23, D-24). The data elements for these forms are part of the TWICES/B&C data entry screens for screening, diagnostics and treatment.

What if the TWICES B&C Module goes down? The TWICES system has been live since 2001, and has been up 99.9% of the time. It has a redundant system that will come up in the event of a system failure. Data is backed up every 5 minutes (since it is internet-based). The most data a contractor will lose is 5 minutes and this is evident if data you just put into the system is not present. Contractors can just re-enter the data once the system returns to operation.

When the system is down for planned maintenance, a banner will appear on the TWICES Main Page. You will know the system is down when you cannot log on.

In the event TWICES or TWICES B&C Module is down due to an unforeseen event, fire, or damage to Internet lines, your agency will need to collect data for entry into the system when it is restored. A sample data collection form is available for your use. Each agency may modify this form. The form can be found on our website at: http://www.dshs.state.tx.us/chscontracts/all_forms.shtm#bccc.

You will not send the forms to the BCCS program for data entry, all data entry is to be done by the contractor.

Medical Records - A printed copy of the client’s screening cycle (in the reports function) will suffice for the client’s record but it is not required by the BCCS program. Electronic BCCS records will remain on line for the life of the system.

TWICES Basics

Navigation through TWICES

TWICES Screens

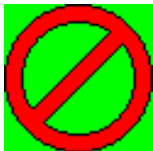
Navigate TWICES screens the same way that you navigate a standard Windows application or the Internet by "clicking" with the mouse or moving field-by-field through a screen by using your TAB key.

- To click press the left button on your mouse once.
- To double-click press the left button on your mouse twice in quick succession.

Buttons and Hot Keys

Most of the screens use command buttons for navigation. These can be found at the bottom of each screen. When you click your mouse on a button, you will go to the next screen. Each button also has a hot key (keyboard shortcut) that can be used instead of pressing the button. To access the hot key, you would press Alt + whatever letter is underlined on the button. For example, for an Exit button marked "Exit", you would press the Alt Key then "x" while still holding down the Alt Key. This will have the same effect as pressing the Exit button.

Some of the screens (such as the menu screens) use hyperlinks for navigation. Hyperlinks are usually lines of colored text that you can recognize by moving your mouse over them. When you move your mouse over a hyperlink, the color changes and your pointer icon changes to a hand icon.



WARNING: When using TWICES, do not use any of the navigation buttons in the navigation bar at the top of the page. TWICES provides Command Buttons or selections at the bottom of the screen for navigation.

The Status Bar that displays at the bottom of the screen shows the progress when loading a web page and what security zone you are in. A picture of a lock will show when you are on a secure site. For best performance, do not attempt to change screens until the status bar indicates, "Done."

Types of Fields

There are different types of fields used in TWICES. They are listed below:

- Text - free-form field to type in either letters or numbers.
- Check Boxes – allows you to select an option. Use either the mouse or the space bar to select the option.
- Radio Buttons – allows you to select an option. Use either the mouse or the space bar to select the option.
- Date - allows you to enter a date. Format for the field is mm\dd\yyyy.
- Lookup list - allows you to select from a list of options. Use the mouse to pull-down the box to select the appropriate option or use the arrow key on your keyboard to select the appropriate option. If you know the option you want, you can type the first letter and you will be brought to the first of the options that have that same first letter. This can save a little time if the list is long.

Computer Settings

If dates are not appearing the way you want on reports, you may want to change the short date and long date formats on your computer. To do this, click on the Start button in the lower left-hand corner of your computer screen. Select Settings, then Control Panel. You will be presented with a window of icons. Double-click the globe icon. In Windows 2000 or '98, this selection will be called Regional Options. In Windows NT, this selection will be called Regional Settings. When you double-click this icon, you will be presented with a screen that has tabs across the top. Select the Date tab, and you will be brought to the following window:

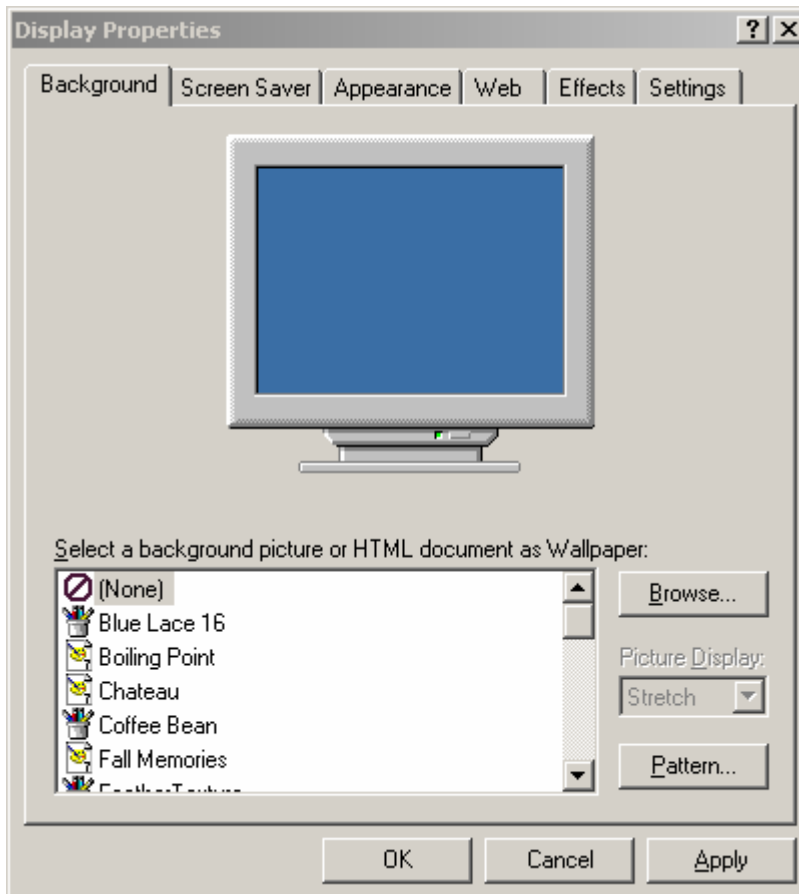
The image shows a screenshot of the Windows 'Regional Options' dialog box, specifically the 'Date' tab. The window has a title bar with a question mark and a close button. Below the title bar are several tabs: 'General', 'Numbers', 'Currency', 'Time', 'Date', and 'Input Locales'. The 'Date' tab is selected. The dialog is divided into three main sections: 'Calendar', 'Short date', and 'Long date'. The 'Calendar' section has a text box that says 'When a two-digit year is entered, interpret as a year between:' followed by two input boxes containing '1930' and '2029' with a small arrow icon between them. The 'Short date' section has a 'Short date sample' text box containing '8/22/2006', a 'Short date format' dropdown menu showing 'M/d/yyyy', and a 'Date separator' dropdown menu showing '/'. The 'Long date' section has a 'Long date sample' text box containing 'Tuesday, August 22, 2006' and a 'Long date format' dropdown menu showing 'dddd, MMMM dd, yyyy'. At the bottom of the dialog are three buttons: 'OK', 'Cancel', and 'Apply'.

For both the short date and long date formats, you can select a format option from a pull-down list. Select the format you want and press Apply. A sample of the format you selected will appear in the corresponding date sample text box. If the format displayed is the format you want, press OK to accept the change.

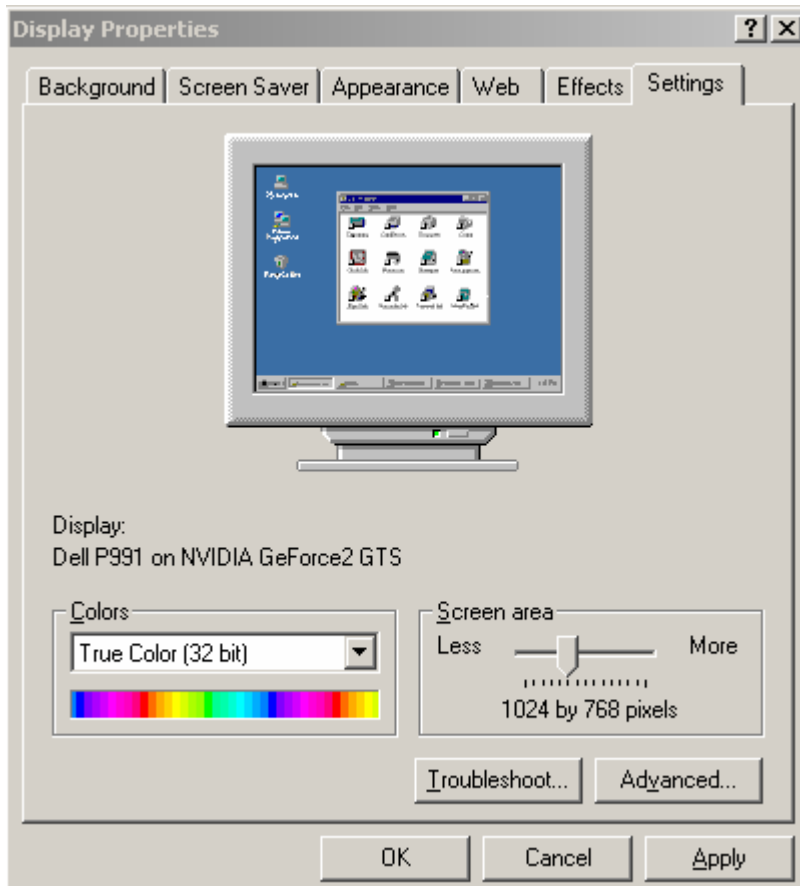
Instructions for customizing computer screen display to view all TWICES navigation buttons are as follows:

- Go to desk top and right click
- Click on “Properties”
- Click on “Settings”

Display set up on Desktop



- Then go to Settings Tab



Move arrow to the right, will see 1024 by 768 pixel

- Click on "Apply"
- Click on "OK"

Make sure the Screen Area is 1024 by 768 pixels.

Printing in TWICES

Your printer must be set up correctly in Windows and in other Windows-based programs before printing in TWICES.

All TWICES reports will have a Print button. When you press that button, you will get a Windows Print dialog box. To print to your default printer, just click OK.

TWICES Security

Logging into TWICES

When you log into TWICES, your user name and password are checked against the TWICES user table for validity. If your user name and password are valid, your security levels for each module are made available throughout your TWICES session. In this way, the system will always know what rights you have to each module.

TWICES Modules

The following modules each have their own security level. Your security level may differ for each module. The collection of module security levels makes up your user profile.

- Client
- BCCS Master
- BCCS Services
- Recall
- System Reports

TWICES Security Levels

Security Level	Rights
0	No Access to TWICES
1	View Only – User's home clinic
2	View Only – User's home clinic
3	View, Add, Edit information for user's home clinic. Also can submit system reports for home clinic.
4	View information for all sites in agency. Add or edit information for home clinic. Also can submit system reports for home clinic.
5	View, Add, or Edit information for all sites in agency. Can also submit system reports for all sites in agency.

Button and Look-up List Behaviors

The buttons and look-up lists in TWICES will behave according to your security level. Following are some examples of how security affects object behaviors.

- For a client search or a vaccine inventory search, the site look-up list will only show your home site unless you have a security level that allows you to view information for all sites in the agency.
- When submitting a system report, the default report type is “Agency Summary”. If you only have rights to run reports against your home site, the Submit button will be disabled until you change the report type to “Single Site Summary”.
- For Vaccine Inventory, if you do not have the rights to add a vaccine lot, the Add button will be disabled. If you have the rights to add a vaccine lot, but only have rights to add information for your home site, the site look-up in the Add Lot screen will only show your home site.
- For Immunizations, if you do not have the rights to add an immunization service, the Add Current button will be disabled. If you have the rights to add an immunization but only have rights to add information for your home clinic, the site look-up in the Add Current screen will only show your home site.
- For Recall, if you do not have the rights to change the recall count, the Change Count button will be disabled.

Please be aware of how your security level impacts the behavior of TWICES. If a button or look-up list does not seem to be working correctly, please check your security level for that module before calling the Help Desk.

Login to TWICES

When starting the TWICES system, you must login. A login-dialog box will appear and ask you for your User Name and Password. Follow the steps below to login to the system.

1. Follow your clinic's directions on turning on your computer and logging into your network (if needed).
2. After following the directions of your Internet provider, enter the TWICES web address into the address field of Microsoft's Internet Explorer version 5 and then click on the GO button.
3. Read the security notice and press the I Have Read the Security Notice button to go to the Login Screen.
4. At USER NAME enter in your login name.
5. At PASSWORD enter in your assigned password.
6. Click SUBMIT to continue.

Login to TWICES

When you first start TWICES, you will be presented with a Security Notice screen. After reading the security notice, press the large button in the middle of the screen to access TWICES.

Security Notice

This is not a public use Web Site.

- Access requires the explicit consent of the Texas Department of State Health Services.
- All activities on this Web site, including attempted access, are monitored and recorded.
- Anyone accessing this Web site expressly consents to such monitoring and recording. This information will be provided to United States and other law enforcement agencies to pursue criminal prosecution if monitoring reveals evidence of criminal activity.
- This Web Site uses a computer security system that is designed to prevent unauthorized access. Intentionally accessing a computer without authorization, or exceeding authorized access and thereby obtaining information from a computer which is used in interstate or foreign commerce or communication, is a criminal offense under 18 United States Code §1030(a)(2).

I HAVE READ THE SECURITY NOTICE AND HAVE CONSENT TO ACCESS THIS WEB SITE

Pressing this button takes you to the Login Screen.

Department of State Health Services

Enter your username and password for the TWICES application.

Login:

Password:

Site ID:



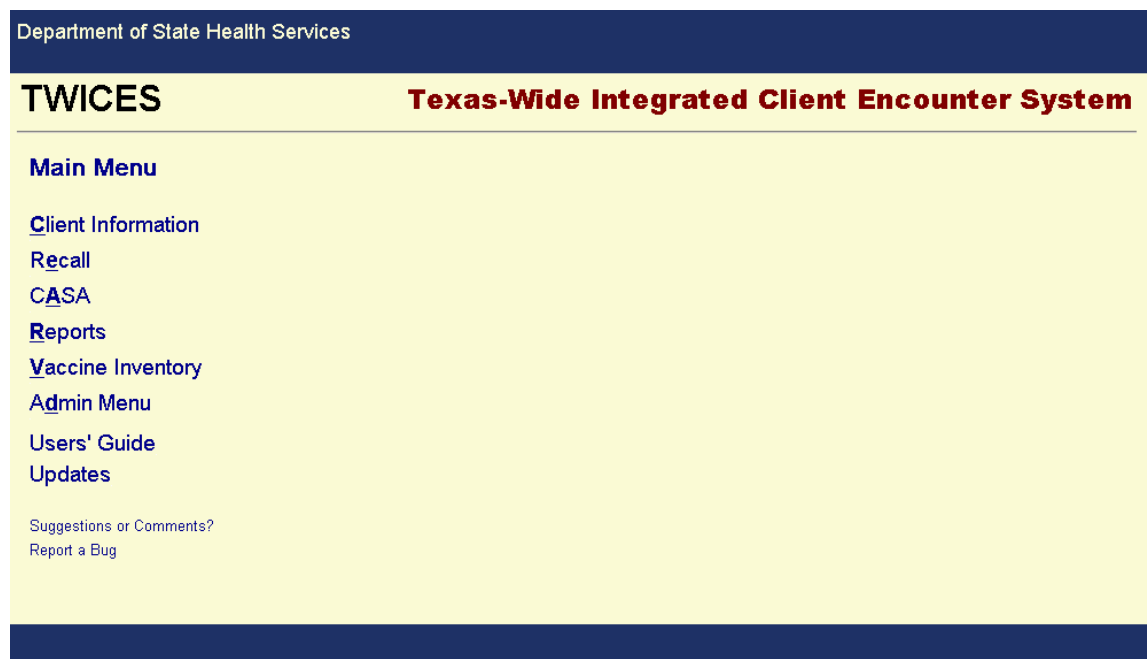
1100 West 49th Street Austin, TX 78756

Help Desk (512) 218-1037

To log into TWICES, enter your login ID and password and click the Submit button.



Note: If you have forgotten your password or you are a new user who needs to be added to the system, please call the TWICES Help Desk at **(512) 218-1037**.



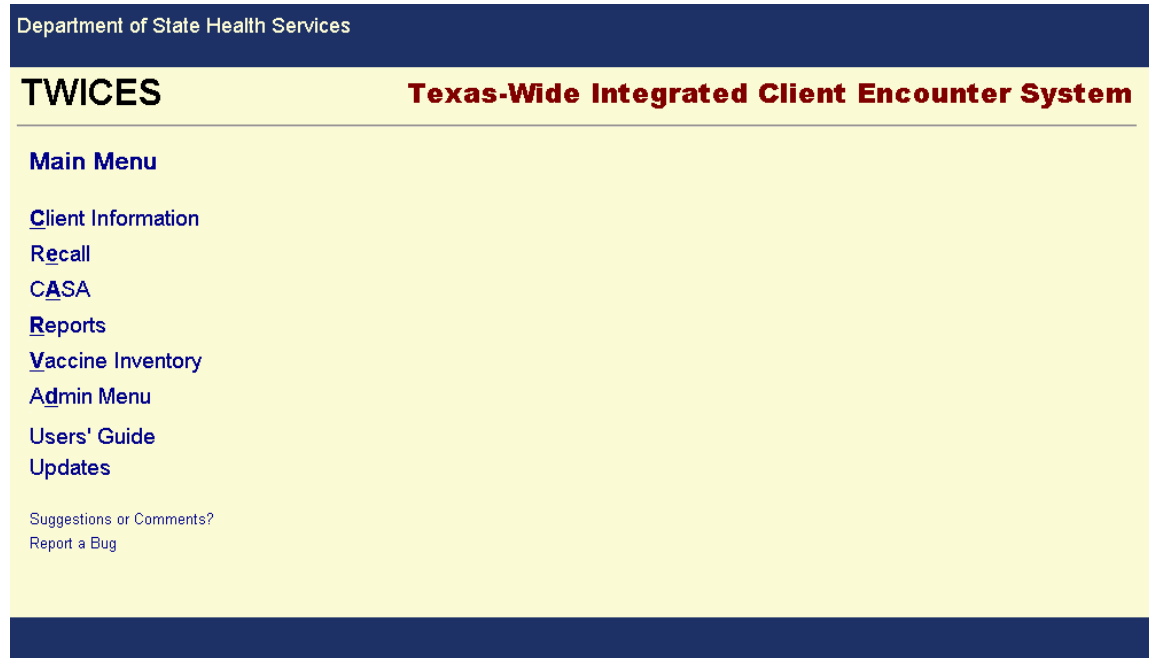
You should now be at the [Main Menu](#) screen.

TWICES Modules

The available modules in TWICES are:

- [Client Information](#) - the entry point for all client information. Enter client demographics and visits and services for all programs.
- [Recall](#) - System for recalling clients by mail or phone for needed immunizations.
- [CASA](#) - is the place to set up and execute CASA jobs. CASA is available from the Main Menu where the jobs will run at overnight.
- [Reports](#) - the place to submit and retrieve all TWICES batch reports.
- [Vaccine Inventory](#) - the place to enter and retrieve a clinic's/agency's vaccine inventory records.
- TWICES Users' Guide - A guide to all the screens and data fields in TWICES.
- TWICES Updates - A screen listing all new TWICES changes.
- Admin Menu – If your security settings permit, this is where agencies, facilities, providers, and users are added and revised.

Main Menu



This section provides an overview of how to use the Main Menu. After logging in to TWICES, you will arrive at the Main Menu. From this screen, you will have access to your specific client information, administrative reports, vaccine inventory, and recall.

Main Menu Overview

From the Main Menu, you are able to select:

- [Client Information](#) - Takes you to the Client Search screen.
- [Recall](#) – Takes you to the Recall module.
- [CASA](#) – Takes you to the CASA module.
- [Reports](#) – Takes you to the Reports module.
- [Vaccine Inventory](#) - Takes you to the Vaccine Inventory module.
- [TWICES Users' Guide](#) – Opens up the Users' Guide in a new window.
- [TWICES Updates](#) – Takes you to a page where you can find the latest information about changes in TWICES.
- Admin Menu – If your security settings allow, this takes you to a module where agencies, facilities, providers, and users can be added or modified.
- [Code Lookup](#) (Hidden link) – Alt+q takes you to a lookup screen where you can search for CPT and diagnosis codes.

E-Mail Links

There are two e-mail links on the Main Menu. One is “Suggestions/Comments?” for making suggestions, and the other is “Report A Bug” for reporting problems with TWICES. Both e-mail links deliver your message to TWICES personnel who will address your problem or suggestion. If you do not receive a timely response to your e-mail, it could be that either the e-mail system is down or the addressees are not in the office. Please call the Help Desk if you do not receive a response to your e-mail within an hour of the time you sent it.

TWICES Updates Screen

Department of State Health Services

TEXAS
Department of
State Health Services

TWICES UPDATES

February 20, 2006 **NEW**

Client	The percent poverty field has been corrected to return the correct percentage based on the client's income.
Reports	<p>Wording has been updated for both the English and Spanish versions of the following reports: Declaration of Residency, Statement of Applicant's Rights and Responsibilities, Eligibility Determination Form, Presumptive Eligibility Form</p> <p>The Immunizations by VFC Category report now has a column for Hurricane Relief.</p> <p>The PHC 200 and PHC 300 reports have been updated to comply with program requirements.</p> <p>The C33 (Monthly Biological) report has been modified to show activity for each lot number. All of the VFC vaccine types are listed, and the lot number activity is totaled for each vaccine type. Also, there is now a section where you must fill in your clinic's hours of operation. The hurricane relief codes of the C33</p>

Menu

From this page you are able to access the following button:

- **Menu** (Hot Key = Alt + M)

Takes you back to the Main Menu.

CPT/Diagnosis Code Lookup Screen

Screen Before Performing a Search

Code Search

CPT Code Search
 Enter Search Text:

Diagnosis Code Search
 Enter Search Text:

Results from Searching for “Edema” in CPT Codes

Code Search

CPT Code Search
 Enter Search Text:

Diagnosis Code Search
 Enter Search Text:

<u>CPT CODE</u>	<u>CPT DESCRIPTION</u>
67208	Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; cryotherapy, diathermy
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation
67218	Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)

CPT/Diagnosis Code Lookup Screen

Results from Searching for “Leprosy” in Diagnosis Codes

Code Search

CPT Code Search
 Enter Search Text:

Diagnosis Code Search
 Enter Search Text:

<u>DIAGNOSIS CODE</u>	<u>DIAGNOSIS DESCRIPTION</u>
030	LEPROSY
0300	LEPROMATOUS LEPROSY (TYPE L)
0301	TUBERCULOID LEPROSY (TYPE T)
0302	INDETERMINATE LEPROSY (GROUP I)
0303	BORDERLINE LEPROSY (GROUP B)
0308	OTHER SPECIFIED LEPROSY
0309	LEPROSY UNSPECIFIED
V742	SCREENING EXAMINATION FOR LEPROSY (HANSEN'S DISEASE)

You can access the Code Lookup screen by pressing Alt+q from either the Main Menu or from the Services Menu. This will bring up the screen in an independent window that you can leave active while you continue working in TWICES. Enter a string to search for in either CPT codes or diagnosis codes. When you press the corresponding Search button, the list of codes containing the string will appear.

Clients

The Client module allows you to enter, change, and copy clients in TWICES. It is also the entry point for the [TWICES](#) System. You must search for and select a client before you can access TWICES B&C Module.

Client Search

Department of State Health Services

Client Search

Last Name

First Name

DOB

ClientID

Sex Male Female

SSN

Chart #

Medicaid #

Search Type

To reduce the occurrence of duplicates, the Client Search screen forces you to search for clients based on one or more of the following information points before allowing you to enter in a new client's information. Search for specific clients by using the search criteria below.

You must complete at least two of the fields to perform a client search unless you are searching by Client ID. However, the more information you provide will tighten the search criteria and will return fewer clients on the [Client Search Results Screen](#).

- Last Name
- First Name

- Date of Birth (DOB)
- Sex
- SSN
- Chart #
- Medicaid #
- Search Type [Local Agency (default) or Other Agencies]

To complete a Client Search, you must:

1. Enter in the search criteria as mentioned above.
2. Select Search - Search will take you to the [Client Search Results](#) screen.

Things to Know Before Searching for A Client

If your search returns more than 100 records, you will receive an error message asking you to refine your search criteria. This will prevent the web server's performance from being compromised by returning too large a record set.



Hint: The Last Name, First Name, and DOB fields allow for partial searches. For example, if the last name is Aguilar and you are not sure how to spell it, you can type in "Ag", and the system will return all clients whose last names begin with "Ag" and who meet your other search criteria.

The First Name field works the same way as the Last Name field. You can search on a full or partial first name.

For the DOB field, you can search for a birth month rather than a specific birthday by entering a date like "03/2000". This will return all clients who were born in March of 2000 and who meet your other search criteria.

You cannot search with 999999999 for Social Security Number or with

55555555 for Medicaid Number. You will get an error message.

Be careful when searching by Medicaid number or chart number. These are “exact match” search fields, which means that the record will not be retrieved unless the field in the database is identical to what you have entered in the search screen. For example, if you have a new client named Alice Bluegown with a chart number of AB1234, it’s possible that her chart number may not yet have been entered into TWICES. Therefore, when you search with “Bluegown”, “Alice”, and “AB1234”, you will not retrieve her record because the chart number field in TWICES is blank. Blank does not match “AB1234”. If you are searching with one of these fields and do not retrieve the desired client, try searching again with only last name and first name to be sure that the client is not already entered into TWICES. In this way, you will minimize the possibility of entering a duplicate client.

From the Client Search screen you can access the following buttons:

Search (Hot Key = Alt + S) – Takes you to the Client Search Results screen with the results of your search showing

Menu (Hot Key = Alt + M) – Returns you to the [Main Menu](#)

No Client Found in the Existing TWICES System

The screenshot shows a web interface for the Department of State Health Services. At the top, it says "Department of State Health Services". Below that, the title "Client Search Results" is displayed in red. A central message box states "No Records Retrieved". Below this message is a table with search criteria fields:

ClientID =	Last Name = R	First Name = R	DOB =
Gender =	SSN =	Chart # =	Medicaid # =

At the bottom of the interface is a toolbar with the following buttons: Select, Add, New Search, Menu, IB Search, and BCC Search.

Above screen indicates client is not found in the TWICES database.

Now proceed to search the BCC Data base to see if the client is there; select "BCC Search", the last button on the right in the bottom toolbar.

Department of State Health Services

BCC Search to Create Master or Link to existing TWICES Client

Last Name	APPLE	First Name	TONI	DOB	2/1/1961 12:00:00 AM
ClientID		Sex	<input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> N/A	SSN	999999999
Chart #		Medicaid #			

No Records Retrieved

[Link BCC Master](#) [New BCC Master](#) [TWICES Search](#) [BCC Search](#)

When you are in this screen you can create a link to an existing client. In this situation this is a new client so there will not be any record of services provided.

Proceed to page III - 46 to add a new client.

Client Search Results For Client in the Existing TWICES System

Department of State Health Services

Client Search Results

Client ID	Name	DOB	Agency	Phone	Address
6076059	AATEST, AATEST	01/01/1972	R999	7787789	PO BOX 54
7893601	ADAMS, AMANDA ALICE	10/10/2000	R999	3334455	234 ELM STREET
7893594	AGUIRREEE, ALLEN DAVID	10/10/1993	R999		
7893592	ALFREDO, ALBERT ALLEN	10/10/1990	R999	8887766	234 ELM STREET
7893599	ANTHONY, ANTONIO CHARLES	10/10/1990	R999		234 ELM STREET
7893606	ATLANTA, ALLEN THOMAS	10/10/1995	R999		234 ELM STREET
7893608	AVILA, ARMANDO ANTONIO	10/10/1990	R999	4445566	234 ELM STREET

Select Add New Search Menu

After the Client Search is completed, a listing of the clients that met the criteria will be displayed on the Client Search Results screen. You are able to sort the information by clicking the column headings: Client ID, Name, DOB, Agency, and Phone.



Note: If no clients meet your search requirements, you will be brought to the Client Search Results screen with no records showing. If your search retrieves more than 100 records, you will get an error message telling you to refine your search criteria.

From the Client Search Results screen, you are able to access the following buttons:

- **Select (Hot Key = Alt + S)** – Brings you to the [Selected Client](#) screen, a snapshot of information related to the selected client displays to assist you in identifying the client. This button is disabled until a client record is selected. From the Selected Client screen, you are able to access:



Hint: You can also double-click on the row of the desired client to go to the Selected Client screen.

- **Add (Hot Key = Alt + A)** – Brings you to the [Client Add](#) screen, which adds a client with complete demographic information. From this screen, you are able to access:
- **New Search (Hot Key = Alt + N)** – Returns you to [Client Search](#) screen
- **Menu (Hot Key = Alt + M)** – Returns you to TWICES [Main Menu](#).

Selected Client

The following read-only fields are displayed on the Selected Client screen.

Department of State Health Services

Selected Client

Last Name	AATEST	SSN	999999999
First Name	AATEST	Chart #	
Middle Name		Medicaid #	
Suffix	DRS	Street Address	PO BOX 54
Mother's Maiden			
Sex	FEMALE	City	AUSTIN
Race	WHITE	Zip Code	78756
	HISPANIC	Home Phone	1 512 7787789
Date Of Birth	01/01/1972		

Reports:

If the user has access to other TWICES Modules, all of the buttons at the bottom of the screen will be activated. If the user only has access to the B&C Module, the Services button will be the only button activated.

Field	Description
Last Name	Last name of the client
First Name	First name of the client
Middle Name	Middle name of the client
Suffix	A designation that should follow the client's name such as Jr., MD, or Ph.D.
Mother's Maiden	Maiden name of the client's mother
Sex	Gender of the client
Race	Race of the client
Date of Birth	Birth date of the client
SSN	Social security number of the client
Chart #	Chart number assigned to the client
Medicaid #	Medicaid number of the client, if applicable.
Street Address	Residential address of the client
City	City where client resides.
Zip Code	Zip code where client resides
Home Phone	Phone number of client's residence

From the Selected Client screen, you are able to access the following buttons:

- • [View](#)
- • [Change](#)
- • [Copy](#)
- • [Immunizations](#) or [Services](#)
- • [Financial](#)
- • [Prev List](#)
- • [New Search](#)
- • [Menu](#)
- • [Delete](#) (for certain security levels)
- • [Request](#)

View (Hot Key = Alt + V)

Brings you to a read-only version of the [Client Add](#) screen for the selected client.

Change (Hot Key = Alt + C)

Brings you to a writable version of the [Client Add](#) screen for the selected client. All fields can be modified.

Copy (Hot Key = Alt + O)

Brings you to a writable version of the [Client Add](#) screen with a copy of the selected client's information. You must provide a new Social Security number. When you save the new client, the system will issue it a new client ID. This is useful for entering family members that all have the same last name and address.

Immunizations (Hot Key = Alt + I)

This is the entry point for the [Immunizations Module](#). You will be brought to the Immunization Master page with the selected client's information showing.



Note: If you have access to only one program module, this button will show that Module (i.e., Primary Care, Tuberculosis, etc.) and will take you directly to that module. The Hot Key for each button will be Alt + the underlined letter. The example shown above is for someone who only has access to the Immunizations module.

Services (Hot Key = Alt + S)

If you have access to more than one program module, the Immunizations button (shown above) will be replaced by the Services button. This button will bring you to the [Services Menu](#) where the modules to which you have access will be displayed.

Financial (Hot Key = Alt + F)

This will bring you to the [Client Financial](#) page where you can enter Financial, Billing, and Insurance information for a client.

Prev List (Hot Key = Alt + P)

This will bring you to the [Client Search Results](#) page with the results of your last client search showing.

New Search (Hot Key = Alt + N)

This will bring you to the [Client Search](#) screen where you can perform a new search.

Menu (Hot Key = Alt + M)

This will bring you to the TWICES [Main Menu](#).

Delete (Hot Key = Alt + D)

This button only appears if you have a security level of 5. This button will delete the selected clients and all records associated with that client. Please be **very careful** with the use of this button.

Request (Hot Key = Alt + R)

In the center of the Selected Client screen is the Request button and a pull-down list labeled Reports. Select a report from the list and press Request, and the report will be brought to the screen where you can read and print it. Following are the eight reports available from this list:

Client Chart Labels

Labels are produced that include the client’s last name, first name, birth date, gender, social security number, Medicaid number, client ID, agency ID, and chart number. These labels can be printed on standard 1” x 2.75” labels.

Department of State Health Services

AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999
AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999
AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999
AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999
AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999	AATEST, AATEST 01/01/1972 F 999999999 6076059 R999

Print
Back

Client Mailing List Labels Labels are produced that show the client’s name and mailing address. If no mailing address is available, the residential address will be shown. These labels can be printed on standard 1” x 2.75” labels.

Department of State Health Services		
AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756
AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756
AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756
AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756
AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756	AATEST AATEST PO BOX 54 AUSTIN, TX 78756

Print Back



Note:

If you select either mailing labels or chart labels, you will be prompted for the number of rows you wish to print. You can print up to nine rows.

All reports have a Print and a Back button. The Print button will bring up a standard Windows Print dialog box from which you can select your printer and print the report. The Back button will take you back to the [Selected Client](#) screen.

Services Menu

Department of State Health Services

CLIENT SERVICES MENU

[Primary Health Care](#)


[Family Planning](#)

[Health](#)

[Tuberculosis](#)

[Breast and Cervical](#)

[Selected Client](#) [Search Results](#) [New Search](#) [Main Menu](#)

	Hint: You can press Alt + Q from the Services Menu in order to access the Code Lookup screen.
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- [Recall](#) - System for recalling clients by mail or phone for needed immunizations.
- [Vaccine Inventory](#) - the place to enter and retrieve a clinic's/agency's vaccine inventory records.

Client Financial Information

The Client Financial screen enables you to enter financial, billing, and insurance information for a client. Some of the fields on this screen are common with fields on the Client Add screen. Information for these fields can be added or updated from either screen.

Objectives

After completing this section, you will be able to:

- Enter financial information for a client
- Enter billing information for a client
- Enter insurance information for a client
- Identify fields that are common to both the Client Add and Client Financial screens

Client Financial Sections

- [Financial and Billing](#)
- [Insurance](#)

From this screen, you are able to access the following buttons:

- **Financial** (Hot Key = Alt + F) takes you to the [Financial and Billing Sections](#) of this screen
- **Insurance** (Hot Key = Alt + I) takes you to the [Insurance Section](#) of this screen
- **Save** (Hot Key = Alt + S) saves the record and returns you to the [Selected Client](#) screen.
- **Exit** (Hot Key = Alt + X) discards any changes made and returns you to the [Selected Client](#) screen.

Field Descriptions

Client Financial and Billing Fields

AATEST, AATEST		DOB: 01/01/1972	Age: 34 Yrs., 7 Mos., 29 Days	ID: 6076059
----------------	--	-----------------	-------------------------------	-------------

Financial			
Number in Household	<input type="text" value="3"/>	Marital Status	<input type="text" value="Common Law"/>
Monthly Income	<input type="text" value="526"/>	Employment Status	<input type="text" value="Unknown/Not Specified"/>
Percent Poverty	<input type="text" value="38%"/>	Education Level	<input type="text" value="Not Specified"/>

Billing			
Primary Coverage	<input type="text" value="Title V"/>	THSteps/EPST	<input type="checkbox"/>
Medicaid Eligible	<input type="text" value="No"/>	Medicare #	<input type="text" value="123456789101"/>
Medicaid #	<input type="text"/>	Part A or B	<input type="text" value="Part A Only"/>
Eligible Date	<input type="text"/>	WIC #	<input type="text"/>
Title V Eligible Date	<input checked="" type="checkbox"/> <input type="text" value="1/1/2007"/>	PC Screened	<input type="text"/>
Title 20 Eligible Date	<input checked="" type="checkbox"/> <input type="text" value="11/15/2000"/>	PC Screen Date	<input type="text"/>
Title 20 #	<input type="text" value="FC1234"/>	PC Screen Site	<input type="text"/>

Financial	Insurance	Save	Exit
-----------	-----------	------	------

Field	Description
Number in Household	Total number of people living together in the same household. Any unborn children are included in the total, if appropriate. Automatically filled in with 1.
Monthly Income	Monthly gross income earned by all members of the household. Default value is 0.
Percent Poverty	Read-only. Automatically filled in with the calculated poverty percentage. Calculated using the Poverty Table to match the number of people in the household and the monthly gross income of the household. If Number in Household and Income are not filled in, the Percent Poverty will default to 0%.
Primary Coverage	The primary insurance coverage for the client. Select from a pull-down list.
Medicaid Eligible	Indication of client's Medicaid eligibility status. Select from a pull-down list. Options are Yes, No, or Pending. Default is Pending. (Also on Client Add screen.)
Medicaid #	Medicaid number for the client. This field is only accessible if Medicaid Eligible is set to Yes. If there is an existing Medicaid number

	and Medicaid Eligible is set to Pending, the field will be grayed out but not cleared. If Medicaid Eligible is set to No, the field will be grayed out and cleared. (Also on Client Add screen.)
Eligible Date	(Required field if there is a Medicaid number) Date that the client becomes eligible for Medicaid. This field is only accessible if there is a Medicaid number. If there is an existing eligibility date and Medicaid Eligible is set to Pending, the field will be grayed out but not cleared. If Medicaid Eligible is set to No, the field will be disabled and cleared. (Also on Client Add screen.)
Title V	Checkbox indicating whether client is eligible for Title V.
Title V Eligible Date	Date that the client becomes eligible for Title V. This field will be grayed out until you check Title V. If you uncheck Title V and there is an existing date, this field will be grayed out but not cleared. Also, if the primary coverage is Medicaid, the Title V checkbox will be unchecked and the eligible date will be grayed out but not cleared.
Title 20	Checkbox indicating whether the client is eligible for Title 20.
Title 20 Eligible Date	Date that the client becomes eligible for Title 20. This field will be grayed out until you check Title 20. If you uncheck Title 20 and there is an existing date, this field will be grayed out but not cleared. Also, if the primary coverage is Medicaid, the Title 20 checkbox will be unchecked and the eligible date will be grayed out but not cleared.
Title 20 #	This field will be grayed out until you check Title 20. If you uncheck Title 20 and there is an existing number, this field will be grayed out but not cleared. Also, if the primary coverage is Medicaid, the Title 20 checkbox will be unchecked and the Title 20 number will be grayed out but not cleared.
Marital Status	Marital status of the client. Select from a pull-down list. Defaults to Unknown unless the client is less than 13 years old. In this case, the default is Never Married.

	Note: For a new client, the marital status default is “Unknown” in the database. Therefore, if the client is less than 13 and the pull-down defaults to Never Married, then you will be prompted to save the status when you exit the screen. (This is especially important for Primary Health Care.)
Employment Status	Employment status of the client. Select from a pull-down list. Defaults to Unknown
Education Level	Education level of the client. Select from a pull-down list. Defaults to Not Specified.
TH Steps/EPSDT	Checkbox indicating whether client is eligible for EPSDT.
Medicare #	Client’s Medicare number. Must be a nine-digit number.
Part A or B	Indication of whether Medicare covers Part A, Part B, or both. Select from a pull-down list. Not accessible until Medicare number is entered.
WIC #	Client’s WIC number
PC Screened	Client’s eligibility status for Primary Health Care. Select from a pull-down list.
PC Screen Date	Date the client was screened for Primary Health Care.
PC Screen Site	Site where the client was screened. Select from a pull-down list.
Billing	Indication for who is responsible for payment for services.

Insurance Fields

Field	Description
Insured ID #	Insurance policy number
Insured Name	Name of person holding the insurance policy
Address (Insured)	Address of person holding the insurance policy
City (Insured)	City of residence for policy holder
State (Insured)	State of residence for policy holder. Default is "TX". Select from a pull-down list.
Zip Code (Insured)	Zip code for residence of policy holder. Must be five or nine digits.
Phone (Insured)	Phone number for policy holder including prefix and area code. Prefix must be 0,1, or left blank. Area Code must be 3 digits or left blank. Phone number must be 7 digits.
Date of Birth (Insured)	Date of birth for policy holder. Must be a valid date format after 01/01/1850 and on or before the current date.

Sex (Insured)	Gender of policy holder.
Relation to Client	Relationship between policy holder and client. Select from a pull-down list.
Ins. Plan/Program	Name of insurance company or program
Policy Group/FECA #	Policy group number or FECA number
Employer/School	Employer or school through which insurance is issued.
Primary Care Provider	Name of primary care provider for the client
Provider ID #	Performing provider number
Address (Provider)	Address of provider
City (Provider)	City where provider is located
State (Provider)	State where provider is located. Default is "TX". Select from a pull-down list.
Zip Code (Provider)	Zip code for location of provider. Must be five or nine digits.

Client Add

This section provides an overview of how to use Client Add. Client Add stores detailed information that is used by all the Public Health programs and services in TWICES. This includes demographic information and contact information. Every client receiving services must be entered into Client Add.

Client Add Sections

Client Add is separated into three sections of client information. They include:

- [Client](#)
- [Contact](#)
- [Notes](#)

From this screen, you are able to access the following buttons:

Client (Hot Key = Alt + C) takes you to the [Client Section](#) of the Client Add screen.

Contact (Hot Key = Alt + O) takes you to the [Contact Section](#) of the Client Add screen.

Notes (Hot Key = Alt + N)

takes you to the [Notes Section](#) of the Client Add screen. If notes have already been added for a client, this button will display in blue.

Save (Hot Key = Alt + S)

Saves all changes and additions and returns you to [Selected Client](#) screen.

Exit (Hot Key = Alt + X)

Discards all changes and returns you to [Selected Client](#) screen.

Field Descriptions

Client Section Fields

Editing: FAMILY3, CHILD4 DOB:01/25/1986 Age: 18 Yrs., 2 Mos., 20 Days ID:44

Client

Last Name	* FAMILY3	Twin	<input type="checkbox"/>
First Name	* CHILD4	Chart #	<input type="text"/>
Middle Name	<input type="text"/>	Medicaid Eligible	No
Suffix	<input type="text"/>	Medicaid #	<input type="text"/>
Mother's Maiden	MCDONALD	Eligible Date	<input type="text"/>
SSN	* 111111122	THSteps/EPSTD	<input type="checkbox"/>
Date of Birth	* 01/25/1986	Client Status	Active
Sex	* <input checked="" type="radio"/> Male <input type="radio"/> Female	Status Date	01/25/2001
Race	* White	Date of Death	<input type="text"/>
Hispanic	<input type="radio"/> Yes <input checked="" type="radio"/> No	Responsible Person	<input type="text"/>
Hispanic Origin	<input type="text"/>	Relationship	<input type="text"/>
Country of Birth	* United States	HIPAA Consent	No Record
Preferred Language	Unknown	HIPAA Date	<input type="text"/>

Client Contact Notes Save Exit

This screen contains the client's basic demographic information.

Field	Description
Last Name	(Required) Client's last name. The first character must be

	alphabetic.
First Name	(Required) Client's first name. The first character must be alphabetic.
Middle Name	Client's middle name or initial.
Suffix	Suffix for the client's name, such as Jr., Sr., MD, etc.
Mother's Maiden	Client's mothers maiden name. The first character must be alphabetic.
SSN	(Required) Client's Social Security Number (SSN). Must be nine digits. If the SSN is not known, use 999-99-9999. TWICES will display a warning message if a duplicate SSN is used (other than 999-99-9999).
Date of Birth	(Required) Client's date of birth. Must be after 1/1/1850 and on or before the current date. When updating a client record, if the Date of Birth is increased (making the client younger), you will receive a message stating that this change could impact service records and asking you whether you want to make that change.
Sex	(Required) Client's gender. Select either Male or Female.
Race	(Required) Client's race. Select from a pull-down list. Default for the field is Not Specified.
Hispanic	(Required) Defaults to No.
Hispanic Origin	(Required if Hispanic is Yes) Client's Hispanic nationality. Select from a pull-down list.
Preferred Language	Client's preferred language. Select from a pull-down list. Default for the field is English.
Twin	Check box indicating whether client is a twin. Clients who are indicated to be twins will be subject to stricter matching criteria before being included on a client duplicate report.
Chart #	Free-form field to note the medical-chart identifier assigned by the clinic.
Medicaid Eligible	Pull-down list for Medicaid Eligibility status. Choices are Yes, No, and Pending. Default is Pending. Must be set to Yes in order to access the Medicaid number and eligibility date fields. If Medicaid Eligible is set to Pending after Medicaid number and date are filled in, those fields will be grayed but the information retained. If set to No, the fields will be grayed out and cleared. (Also on Client Financial screen)

Medicaid #	Number on the client's Medicaid card. If Medicaid number is not known, leave the field blank. (Also on Client Financial screen)
Eligible Date	(Required if MEDICAID # is filled in) Medicaid eligibility date taken from the client's Medicaid card. Date must be after 1/1/1990 and before the current date. This date should never be more than a year old, so it is a good practice to check this date at each client visit and update it, if necessary. This field is not accessible until a Medicaid number is entered. (Also on Client Financial screen)
THSteps/EPST	Checkbox is disabled if Medicaid is "No". (Also on Client Financial screen)
Status	Client's current status in the clinic. Select from a pull-down list. Default for the field is Active.
Status Date	Automatically filled in with the date when the STATUS is entered or modified. This date can be overwritten.
Date of Death	(Required if the STATUS shows Deceased) Date of client's death. Date must be on or after client's birth date and on or before current date.
Responsible Person	If the client is underage, name of the person who is legally responsible for the client.
Relationship	(Required if the RESPONSIBLE PERSON is filled in) Relationship between the client and the RESPONSIBLE PERSON. Select from a pull-down list. Default for the field is Other/Unknown.
HIPAA Consent	Designate whether client signed HIPAA consent form. Defaults to "No Record".
HIPAA Date	(Required if HIPAA Consent is "Refused" or "Signed")

Contact Section Fields

Editing: FAMILY3, CHILD4 DOB:01/25/1986 Age: 18 Yrs., 2 Mos., 20 Days ID:44

Contact

Home Phone Alternate Phone

County of Residence * Alt. Phone Location

Residence Address Mailing Address

City City

State State

Zip Code Zip Code

Census Tract

This screen contains the client's addresses and phone numbers.

Field	Description
Home Phone	Client's home phone number including prefix and area code. Prefix must be 0, 1, or left blank. Area Code must be 3 digits or left blank. Phone number must be 7 digits.
County	(Required) County where the client lives. Select from a pull-down list. Listing is from the Federal Information Processing System. Default for the field is your clinic's county.
Residence Address	Street address where the client lives. There are two text boxes available to accommodate a two-line address.
City	City where the client lives.
State	State where the client lives. Default for the field is Texas.
Zip Code	Zip Code where the client lives. Must be either 5 or 9 digits.
Census Tract	Census tract where the client lives.

Alternate Phone	Alternate phone number for client including prefix and area code. Prefix must be 0,1, or left blank. Area Code must be 3 digits or left blank. Phone number must be 7 digits.
Alternate Phone Location	Location of the alternate phone
Mailing Address	Address where the client receives mail. There are two text boxes available to accommodate a two-line address. Hint: You can enter "*" or "Same" and the residential address will be copied into the mailing address fields.
City	City where the client receives mail.
State	State where the client receives mail. Default for the field is Texas.
Zip Code	Zip Code where the client receives mail. Must be either 5 or 9 digits.

Notes Section



This large text box is available to add any additional information about the client.

Add a Client Using Complete Add

1. From the Client Search Results screen, select ADD.
2. Enter the client information. Be sure to complete the required fields or you cannot save the record.
3. Click the Save command button to save the record. You will return to the Selected Client Screen with the new client information displayed. When you first add a client, the client will not appear in the Previous Search Results list even if the client meets the search parameters. You will need to execute a new search to see the new client in the results list.



Note: If a client is entered with the same last name, first name, social security number, and birth date as another client in the database, you will receive a warning that you may be entering a duplicate client.

The screenshot shows a web interface for the Department of State Health Services. At the top is a dark blue header with the text "Department of State Health Services". Below this is a yellow banner with the title "CLIENT SERVICES MENU" in red, bold, uppercase letters. The main content area is also yellow and contains a list of menu items in blue text: "Immunizations", "Primary Health Care", "Child Health", "Family Planning", "Maternal Health", "Tuberculosis", "Lab/Exam/Other Services", and "Breast and Cervical". At the bottom of the menu area, there are four navigation links: "Selected Client", "Search Results", "New Search", and "Main Menu". The interface is framed by dark blue bars at the top and bottom.

To add or view a BCCS service for a client select the “**Breast and Cervical**” button from the menu.

BCC Client Search

Department of State Health Services

BCC Search to Create Master or Link to existing TWICES Client

Last Name	APPLE	First Name	TONI	DOB	2/1/1961 12:00:00 AM
ClientID		Sex	<input type="radio"/> Male <input checked="" type="radio"/> Female <input type="radio"/> N/A	SSN	999999999
Chart #		Medicaid #			

No Records Retrieved

Link BCC Master New BCC Master TWICES Search BCC Search

In this “BCC Client screen, a link to an existing client can be created. In this situation, this is a new client so there will not be any record of services provided. From this screen you will click on the “New BCC Master”.

BCC Client Search

Department of State Health Services

BCC Search to Create Master or Link to existing TWICES Client

Last Name First Name DOB

ClientID Sex Male Female N/A SSN

Chart # Medicaid #

BCC Id	Name	DOB	Agency	Phone	Address
89	CLAP, CLAP	01/02/1957	BCC0		
90	CLOVER, CLOVER	01/02/1957	BCC0		
90	DOE, JANE	01/02/1957	BCC0		
89	DOE, JANE	01/02/1957	BCC0		

Select New BCC Master TWICES Search BCC Search

This screen depicts what it would look like if the client is already in the system. High light and click on “Link BCC Master” or double click on the client’s name to bring up the “BCC Master” for the client.

BCC Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Master

CD Number: **BCCA70197** SSN: **999999999**

Hispanic: Yes No UnKnown

Race/Ethnicity: **Not Specified**

Multi Race: White Black Hawaii/Pacific
 Asian Am Indian/Alaskan Unknown

Alias:

Breast Screening Cycle **Cervical Screening Cycle**
No Breast Cycles No Cervical Cycles

This “BCC Master” screen contains information that was transferred from when the demographic data was entered.

In this example the client has not had any Breast or Cervical Screening Cycle services provided.

There are no defaults in this screen.

Selecting the **Hispanic or Multi Race** completes the demographic data needed. If the client is multi-raced, the additional race may be entered on this screen.

Alias - Alias may be a nickname, previous married name, of just another name.

Notes – Selection of this button has a notes section and the use of this has been explained under selected client.

Save – Select this button following any changes or updates in the “BCC Master” prior to exiting. If this step is skipped, all changes/updates will be lost.

Exit – Selection of this button will return you to the previous screen. A message box “Are you sure you want to Exit without saving” will appear. If information was saved it is safe to move to next step.

Add “Breast Cycle-” and “Add Cervical Cycle” buttons allow you to add a service for the client.

Breast Cancer Screening Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Screening Master

CD Number: BCCA70197 Cycle #: 2.00
 Clinic: Chart #:

Screening History

Is this a short-term follow-up to a previous abnormal screening? <input type="radio"/> Yes <input checked="" type="radio"/> No	Has the client ever had breast cancer? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Is this client a referral into BCC <input type="radio"/> Yes <input checked="" type="radio"/> No	Does the client have breast implants? <input type="radio"/> Yes <input checked="" type="radio"/> No
Did breast symptoms lead to this visit? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Has client had a mammogram before? <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Date of prev mammogram

CD Number

The CD Number is a **nine-digit number** used to uniquely identify all clients served by the BCCS. Please note the following:

- Clients are automatically assigned one unique CD number.
- Under no circumstances does a client’s CD number change. Clients keep their originally assigned CD number through the life of the program (even if they transfer to another contractor within the BCCS).
- CD numbers are unique to each client; therefore CD numbers may not be shared or duplicated.
- CD numbers are created according to the following rules:
 - First three digits are the site number assigned to the BCC contractor. The contractor number will always be 3 digits (include any leading zeros).
 - *For example, the first three digits of all CD numbers assigned by the provider whose site number is seven would be “007”, not “7”.*
 - Next two digits represent the calendar year in which the CD number is assigned. All clients enrolled on or after 1/1/2000 will have the letter “A” in the first position, and the number “0” in the second position. The “A” represents the new millennium and the “0” represents which year of the millennium.
 - *For example, for a client enrolled in the year 2000, their two digits for the calendar year would be “A0”. A client enrolled in the year 2001, would enter “A1” in these two digits. For the year 2003 enrollees, it would be “A3”, ext...*
 - The remaining four digits will be assigned. They range from 0001 through 9999. All four digits will be completed with numerals (letters, spaces, or dashes will not be used).
 - *For example, in the year 2002, site 007 could assign valid CD numbers such as: 007 A2 0025, 007 A2 0103 and 007 A2 8914.*

Contractor No. – This is the three-digit identification number **assigned to each BCCS contractor by the state office.**

Cycle Number - The screening cycles are represented by whole numbers (i.e., 1-5). Whole numbers represent annual screening cycles. Short-term follow-ups are designated as a decimal (i.e., 1.1 designates short-term follow up from an abnormal screening). The basis for additional short-term follow-up (i.e., 1.2, 1.3) is based upon provider clinical judgment.

Clinic Number - This is a **four-digit identification number** to distinguish between individual clinic locations. (BCCS contractors may provide services through many different clinic sites.) The BCCS contractor assigns and enters this number. If a client receives services at multiple clinic locations, this number should represent the clinic responsible for providing screening services.

Chart Number - This is the chart number or medical record number or client ID number assigned by the clinic or BCCS contractor. It may include up to ten (10) characters and contain letters, numbers, spaces, and dashes.

Clinic – Drop down menu of agency clinics.

BCC Breast Cancer Screening Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Screening Master

CD Number: BCCA70197 Cycle #: 2.00
 Clinic: Chart#:

Screening History

Is this a short-term follow-up to a previous abnormal screening? <input type="radio"/> Yes <input checked="" type="radio"/> No	Has the client ever had breast cancer? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Is this client a referral into BCC <input type="radio"/> Yes <input checked="" type="radio"/> No	Does the client have breast implants? <input type="radio"/> Yes <input checked="" type="radio"/> No
Did breast symptoms lead to this visit? <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Has client had a mammogram before? <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Date of prev mammogram <input type="text" value="06/01/2006"/>

Must answer all radio button questions. If try to save and a data element is missing, an error box will pop up and inform what field needs entry.

Is this a short-term follow-up to a previous abnormal screening?

SELECT "YES" if a client is returning for a short- term follow-up visit.

Select "No" if client is returning for an annual or biannual visit.

To determine a **short-term follow-up**, consider the purpose of the visit. It is not the amount of time that passes between tests, but rather the reason that the amount of time passed. For example –

- A planned delay, such as a clinician wanting some time to pass before re-evaluating, would begin a new cycle.
- If the clinician wanted immediate diagnostic tests, but the woman or a scheduling problem delayed the tests, then the tests are a continuation of the abnormal screening cycle.

Is this client a referral into BCCS?

Select "Yes" if client was referred to this program by a medical professional because of symptoms and/or abnormal screening/diagnostics.

Did breast symptoms lead to this visit?

Select "Yes" if client detected symptoms that resulted in seeking breast cancer screening services.

Has the client ever had breast cancer?

Select "Yes" if a client has ever had breast cancer.

Select "No" if they have never had breast cancer.

Select “Unknown” if the attending clinician is unsure whether or not a client has had breast cancer.

BCC Breast Cancer Screening Master

Does the client have breast implants?

Select “Yes” if the client has had breast reconstruction or cosmetic breast augmentation, or if they have had any other kind of breast implant that might interfere with a normal screening mammogram.

Has client had a mammogram before?

Select “Yes” if client had a mammogram any time prior to current visit. Enter the date of the most recent mammogram. (i.e. mm/dd/yy) If the exact date is unknown, provide an approximate date such as month and year or just year. (i.e. mm/yy)

Select “No” if a client has never had a mammogram before, or if a client is not sure if they have ever had a mammogram or a "breast x-ray.

Screening Tests

For an overview of BCC breast screening guidelines, click here: [OVERVIEW](#)

Is a diagnostic workup planned for this client? Yes No

Cycle Closed? Yes No Is next visit needed? Yes No Next visit date:

Services Performed

ServiceDate	BCCCode	Descript	CBE	Pelvic	OtherCode	ResultsDate	Result	BillTo	BillDate
-------------	---------	----------	-----	--------	-----------	-------------	--------	--------	----------

Add Service Edit Service Diagnosis/Treatment CM Plan Print Cycle Summary Save Exit

Screening Tests

Selecting the “Overview” button will display the BCCS Breast screening guidelines.

Is a diagnostic workup planned for this client?

This screen defaults to “**NO**” at this stage of the cycle.

Select "**Yes**" if while in the services screen, there was an abnormal result for service or test.

Situations a diagnostic workup may not be needed:

- Negative diagnostic mammogram following a Suspicious screening mammogram.
- Negative diagnostic mammogram following breast symptoms.

Cycle Closed – defaults to “**NO**” until a definitive diagnosis has been reached.

- A closed cycle is where all screening results have been recorded as well as diagnostics if needed,
- This question must be answered to close a cycle and
- Cycle has to be closed for approval for payment of last procedure.

BCC Breast Cancer Screening Master Screening Tests

Next Visit Date - Date of next screening or short term follow up. The next visit date will be the start of a new cycle. May be entered as mm/dd/yy or mm/yy.

However, prior to closing of a cycle, “Next Visit Date” may be used for future planned visits within the present cycle.

Breast Cancer Screening Cycle Services Summary

Screening Tests

For an overview of BCC breast screening guidelines, click here: [OVERVIEW](#)

Is a diagnostic workup planned for this client? Yes No

Cycle Closed? Yes No Is next visit needed? Yes No Next visit date:

Services Performed

ServiceDate	BCCCode	Descript	CBE	Pelvic	OtherCode	ResultsDate	Result	BillTo	BillDate
-------------	---------	----------	-----	--------	-----------	-------------	--------	--------	----------

[Add Service](#) [Edit Service](#) [Diagnosis/Treatment](#) [CM Plan](#) [Print Cycle Summary](#) [Save](#) [Exit](#)

Services Performed

This area lists all screening and diagnostic services and status toward achieving a final diagnosis.

Description of Navigation Buttons

Add Service - Selection of this button brings up the “BCC Service” Menu to document a service provided for breast cancer screening or diagnostics.

Edit Service – Selection of this button allows adding results or making changes. It is accomplished by highlighting the service row, which will turn it light blue and clicking on “Edit Service” or just double clicking on the line to be changed.

Diagnosis/Treatment - Selection of this button brings up the “Diagnostics/Treatment” screen for breast cancer. If there is an abnormal result the system will check to see if “Yes” was selected for a diagnostic work-up plan and then proceed, otherwise an error box will be seen when attempting to close out the cycle.

CM Plan-Selection of this button brings up the Case Management Master.

Breast Cancer Screening Cycle Services Summary Description of Navigation Buttons

Print Cycle Summary - Selection of this button will print out the saved information regarding screening cycles.

Save – Selection of this button saves all changes.

Exit – Selection of this button takes you back to the “BCC Master”. If you haven’t saved changes, a prompt to save with instructions will appear.

Case Management Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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Case Management Master

<p>Primary Client Contact Information</p> <p>Name: <input type="text"/></p> <p>Address: <input type="text"/></p> <p>Phone: <input type="text"/></p> <p>Relationship: <input type="text"/></p>	<p>Secondary Client Contact Information</p> <p>Name: <input type="text"/></p> <p>Address: <input type="text"/></p> <p>Phone: <input type="text"/></p> <p>Relationship: <input type="text"/></p>
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Contact Notes:

Assessment Date:

Social Resources Assessment	Medical Care/Service Status	Education and Counseling Assessment
<input type="checkbox"/> Social Support (e.g. family, church, friends) <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> None of the Above	<input type="checkbox"/> Medical Home <input type="checkbox"/> Transportation <input type="checkbox"/> Language Barrier <input type="checkbox"/> Unable to Leave Work <input type="checkbox"/> Child Care <input type="checkbox"/> Making Appointment <input type="checkbox"/> Financial Resources <input type="checkbox"/> Alternative Healing <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> None of the Above	<input type="checkbox"/> Concern about Procedure (e.g. discomfort, pain) <input type="checkbox"/> Embarrassment <input type="checkbox"/> Fear of Cancer <input type="checkbox"/> Overwhelmed by Information <input type="checkbox"/> Feelings of Anger, Sadness <input type="checkbox"/> Relationship with Spouse/Friends <input type="checkbox"/> Intimacy/Sexual Concerns <input type="checkbox"/> Body Image <input type="checkbox"/> Cost of Procedure <input type="checkbox"/> Loss of Employment <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> None of the Above

Service Plan Date:

Case Management Services

InitialDate	IdentifiedNeed	FollowupDate	Outcome
Add Service	Edit Service	Notes	Report
Save	Exit		

The assessment can be completed on this screen. **Assessment Date** is a required field to close out cycle. At least one box in each of the 3 columns has to be completed.

Case Management Master Navigation Buttons

Add Service – Selection of this button allows the case management plan to be completed.

Edit Service - Selection of this button allows adding results or making changes. It is accomplished by highlighting the service row and clicking on “Edit Service” or just double clicking on the line to be changed.

Notes – Selection of this button allows case management notes to be placed on “BCC Case Management Master Notes” screen.

Report – Selection of this button allows printing of the completed case management form for patient signature and placement in medical record.

Save - Selection this button saves any changes or updates in the “CM” prior to exiting. If this step is skipped, all changes/updates will be lost.

Exit – Selection of this button takes you back to the “BCC Breast Screening Master”. If you haven’t saved changes, a prompt to save with instructions will appear.

BCC Case Management Master Notes

APPLE, RED	DOB:	01/02/1962	Age:	45 Yrs., 5 Mos., 18 Days	ID:	9142543
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BCC Case Management Master Notes

<u>User</u>	<u>Note Date</u>	<u>Notes</u>
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Add	Save	Cancel	Report
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Description of Navigation Buttons

Add – Selection of this buttons allows adding of case management notes.

Save - Selection of this button saves any changes or updates in the C M Master Notes prior to exiting. If this step is skipped, all changes/updates will be lost.

Cancel – Selection of this button cancels the entry.

Case Management Service

APPLE, RED	DOB:	01/02/1962	Age:	45 Yrs., 5 Mos., 18 Days	ID:	9142543
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Case Management Service

Item #:

Identified Need:

Service/Referral:

Provider:

Initial Date:

Follow-up Date:

Outcome:

Save – Selection of this button is used each time an **Identified Need** is entered.

Save and Add New Item – Selection of this button allows addition of a new item after saving.

Exit – Selection of this button will take you back to the Case Management Master.

BCC Service Menu

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Service Add

CD Number: BCCA70197 Cycle #: Available Screening Funds:
 Service Date: Clinic Site: BCC Test Available Treatment Funds:

Services Provided

CBE: CBE Results: Pelvic: Pelvic Results:

Provider	BCC Code	Other Code	Results	Results Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Qty	Charge	Bill To	Bill Other	Bill Date	Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Add Test Save Receipt Exit

BCC Breast Service Add

Services provided and results in present cycle must be entered here. The “BCC Service Menu” must be completed to allow closure of the cycle.

CD Number - Assigned CD Number will be displayed.

Cycle Number - The cycles/sequences are represented by whole numbers (i.e., 1-5) and automatically populated. Whole numbers represent annual screening cycles. Short-term follow-ups are designated as a decimal (i.e., 1.1 designates short-term follow up from an abnormal screening). The basis for additional short-term follow-up (i.e., 1.2, 1.3) is based upon provider clinical judgment. Cycle number displayed will be referencing the appropriate screening cycle.

Clinic site - Indicates which clinic is responsible for the client.

Service Date - Indicates the date in which the client received services.

- Use the format mm/dd/yyyy when typing in service date.
- Note that if client has any other services performed on a different day, the process of entering a diagnostic service will have to be repeated.

Available Grant Funds - Shows an approximate balance of grant funds. This should be updated weekly.

Treatment Funds - Shows an approximate balance of grant funds. This should be updated weekly.

BCC Service Menu

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
-------------	-----------------	-------------------------------	-------------

BCC Breast Service Add

CD Number: BCCA70197 Cycle #: Available Screening Funds:
 Service Date: Clinic Site: Available Treatment Funds:

Services Provided

CBE: CBE Results: Pelvic: Pelvic Results:

Provider	BCC Code	Other Code	Results	Results Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Qty	Charge	Bill To	Bill Other	Bill Date	Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Add Test Save Receipt Exit

Services Provided

CBE – Click in box if CBE was provided.

CBE Results – If CBE was done, select result from the drop down menu.

Pelvic Exam – Click in box if pelvic exam was provided.

Pelvic Exam Results - If pelvic exam was done, select result from the drop down menu.

Note: CBE and pelvic exam are included in the office visit code for reimbursement

Provider - Provider is the clinician or subcontractor providing the service. A drop down box will display a complete list of all providers. Select appropriate provider.

Note: Contractors may add a new subcontractor name to the menu selection. However, they will be unable to remove the subcontractor name.

BCC Code – Either type in the CPT Code or use the drop down in the description field to select the procedure provided.

- If type CPT Code, description will automatically be depicted.
- If choose a description from the drop down menu, the CPT Code will automatically be depicted.
- If want to keep record of non-CDC CPT codes of client, click on 00000-Other, tab to **other code** field and place in CPT Code desired, then tab and a description

will appear to the right of the CPT Code. Remember, these CPT Codes will not be reimbursed by CDC.

BCC Service Menu Services Provided

Other Codes – A five digit data-entry field, the description for the code will be displayed to the right of this field

Results – To enter results, click on the “Results” drop down to pick the applicable result.

Results date– Indicates the date the results were received.

Quantity – Indicates the quantity of anesthesia.

Charge - Reflects CPT code reimbursement. If a service is covered by BCCS, the dollar amount will automatically populate in the required field.

Bill To - Indicate the funding source service performed will be charged to. If service is covered by BCCS, you may select “BCC” as the funding source from the drop down. If service is not covered by BCCS or intend to choose another funding source, chose “Other”. Then move to “Bill Other”.

Bill Other – Select from drop down the funding source to pay for service.

Bill Date - Date the bill is paid.

Delete – Selection of this button deletes an entire service line that was entered incorrectly, or if all services on that date were wrong. If just one or two fields are incorrect then just modify the existing service without deleting

Description of Navigation Buttons

Add Test – Selection of this button allows addition of other services. Another row will be duplicated below the first entry to record the service provided. In some cases you may have multiple services on the same day.

The program requires you to enter all tests/services associated with screening and/or diagnostics even if they are not billed to BCCS. An advantage of entering this information is to allow you to run financial reports available in the B & C Module.

Save – Selection of this button prevents loss of entered data. It is important to select this button before exiting.

Exit - Selection of this button will take you out of this screen and back to the “BCC Breast Cancer Screening Master”.

Breast Cycle Diagnosis and Treatment Screen

APPLE, TONI		DOB:	02/01/1961	Age:	46 Yrs., 4 Mos., 26 Days	ID:	9142763
Breast Cycle - Diagnosis							
CD Number	BCCA70197	Cycle #	273462				
Clinic	BCC Test	Chart #					
Diagnostic Evaluation Status	Evaluation in Progress; Additional Procedures Pending						
Date Evaluation Completed							
Final Diagnosis							
Staging Documents Sent to DSHS?	<input type="radio"/> Yes <input type="radio"/> No						
Date Staging Document Sent to DSHS							
Staging Results	Unknown						
<i>Explanation of Refused or Lost to Follow-Up Status</i>							

The user can get to this screen from the “**BCC Screening Master**”.

There must be a record of a screening cycle to be able to move to “Breast Cycle - Diagnosis” page. This section must be completed prior to close of cycle.

CD Number – Assigned CD Number will be displayed.

Clinic Number – Assigned Clinic Number will be displayed.

Chart Number – Assigned Chart Number will be displayed.

Breast Cycle Diagnosis and Treatment Screen

APPLE, TONI		DOB: 02/01/1961		Age: 46 Yrs., 4 Mos., 26 Days		ID: 9142763	
Breast Cycle - Diagnosis							
CD Number	BCCA70197	Cycle #	273462				
Clinic	BCC Test	Chart #					
Diagnostic Evaluation Status	Evaluation in Progress; Additional Procedures Pending						
Date Evaluation Completed							
Final Diagnosis							
Staging Documents Sent to DSHS?	<input type="radio"/> Yes <input type="radio"/> No						
Date Staging Document Sent to DSHS							
Staging Results	Unknown						
<i>Explanation of Refused or Lost to Follow-Up Status</i>							

Diagnostic Evaluation Status – One of the following diagnostic evaluation status must be selected from the drop down menu. Selections include:

- **Evaluation complete:**
 - Select this option if a final diagnosis has been reached.
- **Client refused needed procedures before a final diagnosis could be reached:**
 - Select this option if a final diagnosis cannot be reached because a client refused needed procedures. If this is selected, you will be required to complete the free-text portion in the “Explanation of Refused, Lost to Follow-Up or Status”. This documentation may be printed out and placed in the client’s medical record based upon your agency’s medical record policies.
- **Client is lost to follow-up:**
 - Select this option if three attempts to contact the client were unsuccessful, with the third attempt being by certified mail. If this is selected, you will be required to complete the free-text portion in the “Explanation of Refused, Lost to Follow-Up or Status”. This documentation may be printed out and placed in the client’s medical record based upon your agency’s medical record policies.
- **Evaluation in Progress; Additional Procedures Needed:**
 - Select this option if additional diagnostic services are needed to complete diagnosis.

Evaluation Completed - Enter the date (mm/dd/yy) when the evaluation was completed; will get an error box if you attempt to save without completing this field.

Final Diagnosis - Select a final diagnosis from the drop down menu. If breast cancer is not detected, you will stop here and go to the “BCC Breast Screening Master” to close the cycle.

If breast cancer is diagnosed, must complete rest of the screen/page.

Breast Cycle Diagnosis and Treatment Screen

Staging documents sent to DSHS?

Select "Yes" if:

- The following staging documents were sent to DSHS:
 - Required operative report
 - Required surgical pathology
 - Discharge summary (if applicable)

Select "No" if:

- Staging documents were not sent to DSHS.

Date staging documents sent to DSHS - Enter date when staging documents were sent to DSHS using the format mm/dd/yy.

Staging Results - Indicates staging results. Staging results obtained from the Texas Cancer Registry will be displayed as information is available.

- **Explanation of Refused, Lost to Follow-up or Status** – You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to "Save and Exit" from this page.

Breast Cycle Diagnosis and Treatment Screen

Breast Cycle - Treatment

Treatment Status for Breast Cancer

Date Treatment Initiated, Refused or Client Lost to Follow-up

Referred to Medicaid Treatment Act? Yes No

Date Form 1034 Faxed to State Office

Has Client Been Enrolled in Medicaid? Yes No

Hospital/Facility Where Treatment Initiated

Explanation of Treatment Not Needed, Refused or Lost to Follow-Up Status

Treatment Status - Select the treatment status from the drop down menu. The selections include:

- **"Treatment initiated or complete"** if treatment for breast cancer has begun.
- **"Client refused treatment"** if the client refused needed treatment. You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to "Save and Exit" from this page.
- **"Client is lost to follow-up"** if three attempts to contact the client have failed with the third attempt being a certified letter, if the client moved out of the state, or if the client died. You will be prompted to fill out the Explanation of Treatment

not needed, Refused, or Lost to Follow-up status field before being able to “Save and Exit” from this page.

Breast Cycle Diagnosis and Treatment Screen

- **“Treatment is scheduled or pending”** if treatment is being arranged, but there will be a delay of 90 days or more before treatment actually begins.
- **“Treatment not needed”** if client goes elsewhere for treatment, such as Mexico. You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to “Save and Exit” from this page.

Date treatment initiated, determined not needed, refused or client lost to follow-up – indicate the date of when treatment was initiated, determined not needed, refused or client lost to follow-up.

Referred to Medicaid Treatment Act?

Select “Yes” if:

- Client is found presumptively eligible for the Medicaid Treatment Act.

Select “No” if:

- Client is not eligible to apply for Medicaid Treatment Act.

Date Form 1034 faxed to State Office - Indicate date the Form 1034 (Medical Assistance for Breast and Cervical Cancer Application for Assistance) was faxed to DSHS. (Date format of mm/dd/yy).

Hospital/facility where treatment initiated - Indicates where treatment was initiated. A drop down menu will be displayed to make a selection. If a facility is not included on the menu, contact TWICES Help Desk.

Explanation of Treatment not Needed, Refused, Lost to Follow-up Status – You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to “Save and Exit” from this page.

Description of Navigation Buttons

CM Plan - Selection of this button allows review or updating of case management. Cycle cannot be closed without completion of the CM Assessment if indicated by results.

Save - Selection of this button prevents loss of entered data. It is important to select this button before exiting. Each button except for “Exit” acts as “save”.

Exit - Selection of this button will take you out of this screen and back to the “BCC Breast Cancer Screening Master”. In the “BCC Breast Cancer Screening Master” the cycle must now be closed as a final step in this cycle.

Diagnosis and Treatment Screen

When you exit the “BCC Master Breast Cancer Screening Master” it will take you to the “BCC Master”. At this point you may enter the “Add Cervical Cycle” or “Exit”, which takes you to the “Client Services Menu”. At this point “Main Menu” may be selected to search or enter a client using the “Client Information” selection.

Cervical Cancer Screening Cervical Screening Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Cervical Screening Master

CD Number: BCCA70197 Cycle #: 1.00
 Clinic: Chart #:

Screening History

Is this a short-term follow-up to a previous abnormal screening?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Has the client received an HPV vaccination?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Is this client a referral into BCC?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Date of HPV vaccination	<input type="text" value="6/8/2006"/>
Is there a history of dysplasia/cancer, HIV, HPV, immuno-compromised?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Is the client post menopausal?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Has the client had a hysterectomy?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is the client pregnant?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Was the hysterectomy for cervical cancer or neoplasia?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Has the client had a previous pap test?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
		Date of previous pap test	<input type="text" value="06/08/2006"/>
		Previous pap test results	<input type="text" value="Negative (Within Normal Li"/>

CD Number – Assigned CD Number will be displayed.

Clinic Number – Assigned Clinic Number will be displayed.

Chart Number – Assigned Chart Number will be displayed.

Cycle Number - The cycles/sequences are represented by whole numbers (i.e., 1-5) and automatically populated. Whole numbers represent annual screening cycles. Short-term follow-ups are designated as a decimal (i.e., 1.1 designates short-term follow up from an abnormal screening). The basis for additional short-term follow-up (i.e., 1.2, 1.3) is based upon provider clinical judgment.

BCC Cervical Cancer Screening Cycle Master

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Cervical Screening Master

CD Number: BCCA70197 Cycle #: 1.00
 Clinic: Chart #:

Screening History

Is this a short-term follow-up to a previous abnormal screening?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Has the client received an HPV vaccination?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Is this client a referral into BCC?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Date of HPV vaccination	<input type="text" value="6/8/2006"/>
Is there a history of dysplasia/cancer, HIV, HPV, immuno-compromised?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Is the client post menopausal?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Has the client had a hysterectomy?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is the client pregnant?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown
Was the hysterectomy for cervical cancer or neoplasia?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Unknown	Has the client had a previous pap test?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
		Date of previous pap test	<input type="text" value="06/08/2006"/>
		Previous pap test results	<input type="text" value="Negative (Within Normal Li"/>

Must answer all radio button questions. If try to save and a data element is missing, an error box will pop up and inform what field needs entry.

Is this a short-term follow-up to a previous abnormal screening?

SELECT "YES" if a client is returning for a short- term follow-up visit.

Select "No" if client is returning for an annual or biannual visit.

To determine a **short-term follow-up**, consider the purpose of the visit. It is not the amount of time that passes between tests, but rather the reason that the amount of time passed. For example –

- A planned delay, such as a clinician wanting some time to pass before re-evaluating, would begin a new cycle.
- If the clinician wanted immediate diagnostic tests, but the woman or a scheduling problem delayed the tests, then the tests are a continuation of the abnormal screening cycle.

Is this client a referral into BCCS?

Select "Yes" if they were referred to this program by a medical professional because of possible symptoms for cervical cancer.

Is there a history of dysplasia/cancer, HIV, HPV, immuno-compromised?

Select "Yes" if:

- Client has a medical history of cervical dysplasia, CIN I, CIN II, CIN III, CIS, cervical cancer, HPV, HIV, or if she is immuno-compromised.
- Selecting "Yes" indicates **high risk** and client is eligible to receive annual paps based on clinician's judgement.

BCC Cervical Cancer Screening Cycle Master**Is there a history of dysplasia/cancer, HIV, HPV, immuno-compromised?**

Select "No" if client has no history of cervical dysplasia, cervical cancer, HPV, HIV or she is immuno-compromised.

Select "Unknown" if client is unsure whether they have ever had cervical dysplasia, cervical cancer, HPV, or HIV.

Has the client had a hysterectomy?

Select "Yes" if:

- The client has ever had a complete or partial hysterectomy for any reason;
- You will need to answer the next question **“Was the hysterectomy for cervical cancer or neoplasia?”**

Select "No" if client has never had a hysterectomy.

Was the hysterectomy for cervical cancer or neoplasia?

Select "Yes" if the hysterectomy was performed to treat cervical cancer or neoplasia.

Select "No" if the hysterectomy was for some other purpose.

Select "Unknown" if the purpose of the hysterectomy is unknown.

Note: BCCS services provided to women whose hysterectomies were for reasons other than cervical cancer or neoplasia are non-reimbursable.

Note: BCCS will cover a pelvic examination to determine if clients' cervix is present.

Has the client received an HPV vaccination?

Select "Yes" if:

- Client did receive an HPV vaccination. Indicate the date of vaccination in the space provided. (Format mm/dd/yy, mm/yy, or yyyy)

Select "No" if:

- Client did not receive an HPV vaccination.

Select "Unknown" if:

- The client is unsure whether she received this vaccination.

Note: BCCS does not cover the HPV vaccination.

BCC Cervical Cancer Screening Cycle Master

Is the client postmenopausal?

Select “Yes” if:

- The client is postmenopausal.

Select “No” if:

- The client is not postmenopausal.

Is the client pregnant?

Select “Yes” if client is pregnant.

Select “No” if client is not pregnant.

Has the client had a previous pap test?

Select “Yes” if:

- client has had a Pap test prior to this visit
 - document date of last pap (mm/dd/yy)
 - document result of last pap via drop down menu
 - will get an error box prompting if have not entered pap date and result prior to “Save” and “Exit”

Select “No” if client has not had a previous pap test.

Select “Unknown” if client does not know if had a pap test.

NOTE: If the client was been referred to the BCCS contractor by another health care provider because of an abnormal pap, then enter No or Unknown to the question above if pap prior to the abnormal pap was not performed or is unknown. Then enter the abnormal pap that caused the referral to BCCS into the Services menu and select “Other” in the “Bill To” field.

Cervical Cancer Screening Cycle Master Screen

Screening Tests

Did the client receive a pelvic exam this screening cycle? Yes No *For an overview of BCC cervical screening guidelines, click here:*

Was the cervix present? Yes No

Is a diagnostic workup planned for this client? Yes No

Cycle Closed? Yes No Is next visit needed? Yes No Next Visit Date

Services Performed

ServiceDate	BCCCode	Description	CBE	Pelvic	OtherCode	ResultsDate	Result	BillTo	BillDate

Screening Tests

Did the client receive a pelvic exam this screening cycle?

Select "Yes" if:

- Client received a pelvic examination.
- Must answer **“Was the cervix present”**

Select “No” if:

- Client did not receive a pelvic examination;
- **“Was the cervix present”** will be grayed out if answered “No”.

Was the cervix present?

Select "Yes" if enough of the cervix was present to perform a cervical Pap test.

Select “No” if the cervix was not present, necessitating a vaginal Pap test.

If a pap smear is unsatisfactory and is not processed or screened by the laboratory, it should not be billed or paid for. Examples of this are a broken slide beyond repair or missing identification information. The lab would phrase:

"UNSATISFACTORY FOR EVALUATION, Specimen rejected because of"

If a pap smear is processed and screened by the laboratory, but found to be unsatisfactory for technical reasons, it should be billed and paid for. Examples of this are obscuring blood, air drying or scant squamous cells. The lab would phrase:

"UNSATISFACTORY FOR EVALUATION, Specimen processed and examined but unsatisfactory for evaluation of epithelial abnormality because of"

Overview - Selecting this button will display the BCCS Cervical screening guidelines.

Cervical Cancer Screening Cycle Master Screening Tests

Is a diagnostic workup planned for this client?

This screen defaults to “NO” at this stage of the cycle.

Select "Yes" if while in the services screen, there was an abnormal result for service or test.

Cycle Closed – defaults to “NO” until a definitive diagnosis has been reached.

- A closed cycle is where all screening results have been recorded as well as diagnostics if needed,
- This question must be answered to close a cycle and
- Cycle has to be closed for approval for payment of last procedure.

Next Visit Date - Date of next screening or short term follow up. The next visit date will be the start of a new cycle. May be entered as mm/dd/yy or mm/yy.

However, prior to closing of a cycle, “Next Visit Date” may be used for future planned visits within the present cycle.

Cervical Cancer Screening Cycle Master

Screening Tests

Did the client receive a pelvic exam this screening cycle? Yes No *For an overview of BCC cervical screening guidelines, click here:* [OVERVIEW](#)

Was the cervix present? Yes No

Is a diagnostic workup planned for this client? Yes No

Cycle Closed? Yes No Is next visit needed? Yes No Next Visit Date

Services Performed

ServiceDate	BCCCode	Description	CBE	Pelvic	OtherCode	ResultsDate	Result	BillTo	BillDate
[Empty table body]									

[Add Service](#) [Edit Service](#) [Diagnosis/Treatment](#) [CM Plan](#) [Print Cycle Summary](#) [Save](#) [Exit](#)

Services Performed

This area lists all screening and diagnostic services and status toward achieving a final diagnosis.

Description of Navigation Buttons

Add Service - Selection of this button takes you to the “BCC Service” Menu to document a service provided for Cervical Cancer screening or diagnostics.

Edit Service – Selection of this button allows adding results or making changes. It is accomplished by highlighting and clicking on “Edit Service” or just double clicking on the line to be changed.

Diagnosis/Treatment - Selection of this button will take you to the “Diagnostics/Treatment” screen for Cervical Cancer. If there is an abnormal result the system will check to see if you selected “Yes” for a diagnostic work-up plan and you may proceed, otherwise you will get an error box when you attempt to close out the cycle.

CM Plan - Selection of this button brings up the Case Management Master. **For reference refer to page III-62.**

Print Cycle Summary - Selection of this button will print out the saved information regarding screening cycles.

Save – Selection of this button saves all changes.

Exit – Selection of this button takes you back to the “BCC Master”. If you haven’t saved changes, a prompt to save with instructions will appear.

Cervical Cancer Screening Cycle BCC Service Menu

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Service Add

CD Number: BCCA70197 Cycle #: Available Screening Funds:
 Service Date: Clinic Site: BCC Test Available Treatment Funds:

Services Provided

CBE: CBE Results: Pelvic: Pelvic Results:

Provider	BCC Code	Other Code	Results	Results Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Qty	Charge	Bill To	Bill Other	Bill Date	Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Add Test Save Receipt Exit

Services provided and results in present cycle must be entered here. The “BCC Service Menu” must be completed to allow closure of the cycle.

CD Number - Assigned CD Number will be displayed.

Service Date - Indicates the date in which the client received services.

- Use the format mm/dd/yyyy when typing in service date.
- Note that if client has any other services performed on a different day, the process of entering a diagnostic service will have to be repeated.

Cycle Number - The cycles/sequences are represented by whole numbers (i.e., 1-5) and automatically populated. Whole numbers represent annual screening cycles. Short-term follow-ups are designated as a decimal (i.e., 1.1 designates short-term follow up from an abnormal screening). The basis for additional short-term follow-up (i.e., 1.2, 1.3) is based upon provider clinical judgment. Cycle number displayed will be referencing the appropriate screening cycle.

Clinic Site - Indicates which clinic is responsible for the client.

Available Grant Funds - Shows an approximate balance of grant funds. This should be updated weekly.

Treatment Funds - Shows an approximate balance of grant funds. This should be updated weekly.

Cervical Cancer Screening Cycle BCC Service Menu

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Service Add

CD Number: BCCA70197 Cycle #: Available Screening Funds:
 Service Date: Clinic Site: BCC Test Available Treatment Funds:

Services Provided

CBE: CBE Results: Pelvic: Pelvic Results:

Provider	BCC Code	Other Code	Results	Results Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Qty	Charge	Bill To	Bill Other	Bill Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
				Delete <input type="checkbox"/>

Add Test Save Receipt Exit

Services Provided

CBE – Click in box if CBE was provided.

CBE Results – If CBE was done, select result from the drop down menu.

Pelvic Exam – Click in box if pelvic exam was provided.

Pelvic Exam Results - If pelvic exam was done, select result from the drop down menu.

NOTE: CBE and pelvic exam are included in the office visit code for reimbursement.

Provider - Provider is the clinician or subcontractor providing the service. A drop down box will display a complete list of all providers. Select appropriate provider.

Note: Contractors may add a new subcontractor name to the menu selection. However, they will be unable to remove the subcontractor name.

BCC Code – Either type in the CPT Code or use the drop down in the description field to select the procedure provided.

- If type CPT Code, description will automatically be depicted.
- If choose a description from the drop down menu, the CPT Code will automatically be depicted.
- If want to keep record of non-CDC CPT codes of client, click on 00000-Other, tab to **other code** field and place in CPT Code desired, then tab and a description

will appear to the right of the CPT Code. Remember, these CPT Codes will not be reimbursed by CDC.

Other Codes – A five digit data-entry field, the description for the code will be displayed to the right of this field.

Results – To enter results, click on the “Results” drop down to pick the applicable result.

Result Date — Indicates the date the results were received.

Quantity – Indicates the quantity of anesthesia.

Charge - Reflects CPT code reimbursement. If a service is covered by BCCS, the dollar amount will automatically populate in the required field.

Bill To - Indicate the funding source service performed will be charged to. If service is covered by BCCS, you may select “BCC” as the funding source from the drop down. If service is not covered by BCCS or intend to choose another funding source, chose “Other”. Then move to “Bill Other”.

Bill Other – Select from drop down the funding source to pay for service.

Bill Date - Date the bill is paid.

Delete – Selection of this button deletes an entire service line that was entered incorrectly, or if all services on that date were wrong. If just one or two fields are incorrect then just modify the existing service without deleting

Cervical Cancer Screening Cycle BCC Service Menu

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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BCC Breast Service Add

CD Number: BCCA70197 Cycle #: Available Screening Funds:
 Service Date: Clinic Site: BCC Test Available Treatment Funds:

Services Provided

CBE: CBE Results: Pelvic: Pelvic Results:

Provider	BCC Code	Other Code	Results	Results Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Qty	Charge	Bill To	Bill Other	Bill Date	Delete
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Add Test Save Receipt Exit

Description of Navigation Buttons

Add Test – Selection of this button allows addition of other services. Another row will be duplicated below the first entry to record the service provided. In some cases you may have multiple services on the same day.

The program requires you to enter all tests/services associated with screening and/or diagnostics even if they are not billed to BCCS. An advantage of entering this information is to allow you to run financial reports available in the B & C Module.

Save – Selection of this button prevents loss of entered data. It is important to select this button before exiting.

Exit - Selection of this button will take you out of this screen and back to the “ BCC Breast Cancer Screening Master.

Cervical Cycle Diagnosis

APPLE, TONI	DOB: 02/01/1961	Age: 46 Yrs., 4 Mos., 26 Days	ID: 9142763
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Cervical Cycle - Diagnosis

CD Number	BCCA70197	Cycle #	195297
Clinic	BCC Test	Chart #	

Diagnostic Evaluation Status	Evaluation in Progress; Additional Procedures Pending
Date Evaluation Completed	
Final Diagnosis	
Staging Documents Sent to DSHS?	<input type="radio"/> Yes <input type="radio"/> No
Date Staging Document Sent to DSHS	
Staging Results	Unknown

Explanation of Refused or Lost to Follow-Up Status

The user can get to this screen from the “**BCC Screening Master**”.

There must be a record of a screening cycle to be able to move to “Breast Cycle - Diagnosis” page. This section must be completed prior to close of cycle.

CD Number – Assigned CD Number will be displayed.

Clinic Number – Assigned Clinic Number will be displayed.

Chart Number – Assigned Chart Number will be displayed.

Diagnostic Evaluation Status – One of the following diagnostic evaluation status must be selected from the drop down menu. Selections include:

- **Evaluation complete:**
 - Select this option if a final diagnosis has been reached.
- **Client refused needed procedures before a final diagnosis could be reached:**
 - Select this option if a final diagnosis cannot be reached because a client refused needed procedures. If this is selected, you will be required to complete the free-text portion in the “Explanation of Refused, Lost to Follow-Up or Status”. This documentation may be printed out and placed in the client’s medical record based upon your agency’s medical record policies.

Cervical Cycle Diagnosis

- **Client is lost to follow-up:**
 - Select this option if three attempts to contact the client were unsuccessful, with the third attempt being by certified mail. If this is selected, you will be required to complete the free-text portion in the “Explanation of Refused, Lost to Follow-Up or Status”. This documentation may be printed out and placed in the client’s medical record based upon your agency’s medical record policies.
- **Evaluation in Progress; Additional Procedures Needed:**
 - Select this option if additional diagnostic services are needed to complete diagnosis.

Evaluation Completed - Enter the date (mm/dd/yy) when the evaluation was completed; will get an error box if you attempt to save without completing this field.

Final Diagnosis - Select a final diagnosis from the drop down menu. If breast cancer is not detected, you will stop here and go to the “BCC Breast Screening Master” to close the cycle.

If breast cancer is diagnosed, must complete rest of the screen/page.

Staging documents sent to DSHS?

Select “Yes” if:

- The following staging documents were sent to DSHS:
 - Required operative report
 - Required surgical pathology
 - Discharge summary (if applicable)

Select “No” if:

- Staging documents were not sent to DSHS.

Date staging documents sent to DSHS - Enter date when staging documents were sent to DSHS using the format mm/dd/yy.

Staging Results - Indicates staging results. Staging results obtained from the Texas Cancer Registry will be displayed as information is available.

- **Explanation of Refused, Lost to Follow-up or Status** – You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to “Save and Exit” from this page.

Cervical Cycle Treatment

Cervical Cycle - Treatment

Treatment Status for Cervical Cancer

Date Treatment Initiated, Refused or Client Lost to Follow-up

Referred to Medicaid Treatment Act? Yes No

Date Form 1034 Faxed to State Office

Has Client Been Enrolled in Medicaid? Yes No

Hospital/Facility Where Treatment Initiated

Explanation of Treatment Not Needed, Refused or Lost to Follow-Up Status

Treatment Status - Select the treatment status from the drop down menu. The selections include:

- **"Treatment initiated or complete"** if treatment for breast cancer has begun.
- **"Client refused treatment"** if the client refused needed treatment. You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to "Save and Exit" from this page.
- **"Client is lost to follow-up"** if three attempts to contact the client have failed with the third attempt being a certified letter, if the client moved out of the state, or if the client died. You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to "Save and Exit" from this page.
- **"Treatment is scheduled or pending"** if treatment is being arranged, but there will be a delay of 90 days or more before treatment actually begins.
- **"Treatment not needed"** if client goes elsewhere for treatment, such as Mexico. You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to "Save and Exit" from this page.

Date treatment initiated, determined not needed, refused or client lost to follow-up – indicate the date of when treatment was initiated, determined not needed, refused or client lost to follow-up.

Referred to Medicaid Treatment Act?

Select "Yes" if:

- Client is found presumptively eligible for the Medicaid Treatment Act.

Select "No" if:

- Client is not eligible to apply for Medicaid Treatment Act.

Cervical Cycle Treatment

Date Form 1034 faxed to State Office - Indicate date the Form 1034 (Medical Assistance for Breast and Cervical Cancer Application for Assistance) was faxed to DSHS. (Date format of mm/dd/yy).

Hospital/facility where treatment initiated - Indicates where treatment was initiated. A drop down menu will be displayed to make a selection. If a facility is not included on the menu, contact the TWICES Help Desk.

Explanation of Treatment not Needed, Refused, Lost to Follow-up Status – You will be prompted to fill out the Explanation of Treatment not needed, Refused, or Lost to Follow-up status field before being able to “Save and Exit” from this page.

CM Plan - Selection of this button allows review or updating of case management. Cycle cannot be closed without completion of the CM Assessment if indicated by results.

Save - Selection of this button prevents loss of entered data. It is important to select this button before exiting.

Exit - Selection of this button will take you out of this screen and back to the “BCC Breast Cancer Screening Master”. In the “BCC Breast Cancer Screening Master” the cycle must now be closed as a final step in this cycle.

When you exit the “BCC Master Breast Cancer Screening Master” it will take you to the “BCC Master”. At this point you may enter the “Add Cervical Cycle” or “Exit”, which takes you to the “Client Services Menu”. At this point “Main Menu” may be selected to search or enter a client using the “Client Information” selection.

TWICES Billing Business Rules

Allow billing for screening tests after results are recorded and tests are normal (i.e., the screening cycle is completed).

Allow billing for screening tests after the results are recorded and if a result is abnormal, the first diagnostic test has been administered.

Allow billing for the first diagnostic test after the test result is recorded, the next diagnostic test is administered, and a case management assessment is completed.

Allow billing for each additional diagnostic test after the test result is recorded and the next diagnostic test is administered.

If there is only one diagnostic test required (as in the case of a cervical screening), allow that test to be billed if the diagnosis has been completed, and is one that doesn't require treatment.

Should treatment be required, allow billing of the one/last diagnostic test when treatment is initiated.

Case management must be assessed for any client with an abnormal screening result. Case management may be paid on final diagnosis or start of treatment if cancer is the diagnosis.

Section IV

Appendices

**APPENDIX A : ALLOWABLE CPT CODES AND
REIMBURSEMENT RATES REVISED 9/2007**

Procedure	CPT Code	Reimbursement
Screening Mammogram	77057	84.74
Screening Mammogram producing direct digital image, bilateral, all views*	G0202	84.74
Office Visit - New Patient Only - 10 minutes	99201	36.48
Office Visit – New Patient Only - 20 minutes	99202	64.77
Office Visit – New Patient Only - 30 minutes	99203	96.57
Office Visit - Established Patient; face-to-face - 10 minutes	99212	38.13
Office Visit - Established Patient; face-to-face - 15 minutes	99213	52.20
Office Visit – Office Consultation, 15 minutes	99241	50.12
Office Visit – Office Consultation, 30 minutes	99242	88.06
Office Visit - Office Consultation, 40 minutes	99243	122.39
Office Visit – Office Consultation, 60 Minutes	99244	172.66
Diagnostic Mammogram (unilateral)	77055	77.69
Diagnostic Mammogram producing direct digital image, unilateral, all views**	G0206	77.69
Diagnostic Mammogram (bilateral)	77056	96.44
Diagnostic Mammogram producing direct digital image, bilateral, all views***	G0204	96.44
Aspiration of Breast Cyst	19000	108.64
Aspiration of each additional cyst	19001	26.97
Needle Core Breast Biopsy	19100	132.27
Facility fee with needle core biopsy	100FX	333.00
Percutaneous Needle Core, using imaging guidance	19102	223.44
Incisional Breast Biopsy	19101	304.18
Facility fee with incisional breast biopsy	101FX	446.00

Procedure	CPT Code	Reimbursement
Excisional Breast Biopsy	19120	411.73
Facility fee with excisional breast biopsy	120FX	510.00
Vacuum Assisted Device	19103	576.92
Excision of breast lesion/ preoperative placement of radiological marker, single lesion	19125	442.17
Facility fee with excision of breast lesion / preoperative placement of radiological marker, single lesion	125FX	510.00
Each additional lesion (used with 19125)	19126	165.35
Preoperative placement of needle localization wire, breast	19290	156.52
Facility fee with preoperative placement of needle localization wire, breast	290FX	333.00
Preoperative placement of needle localization wire, breast, each additional lesion (used with 19290)	19291	70.22
Image-guided placement, metallic localization clip, percutaneous, during breast biopsy (list separately in addition to code for primary procedure) (use in conjunction with codes 19102, 19103)	19295	92.39
Stereotactic localization guidance for breast biopsy or needle placement, each lesion, radiological supervision and interpretation	77031	363.82
Mammographic guidance for needle placement, breast, each lesion, radiological supervision and interpretation	77032	80.06
Anesthesia/excision of breast cyst, per point (up to 6 points)	00400	18.41
Radiological examination, surgical specimen	76098	24.69
Ultrasound, breast, unilateral or bilateral	76645	69.31
Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	76942	142.94
Fine Needle Aspiration, without placement, imaging supervision and interpretation	10021	132.09
Interpretation and Report of Fine Needle Aspiration	88173	134.66

Procedure	CPT Code	Reimbursement
Surgical pathology, gross and microscopic examination (breast or cervical)	88305	101.83
Pap Smear - physician's interpretation (Bethesda System)	88141	22.40
Pap Smear - cytologist's interpretation (Bethesda System)	88164	14.76
Pap Smear - liquid based, cytologist's interpretation (Bethesda System)	88142	28.31
Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; manual screening and rescreening under physician supervision	88143	28.31
Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system under physician supervision	88174	28.31
Cytopathology, cervical, collected in preservative fluid, automated thin layer prep; screening by automated system and manual rescreening under physician supervision	88175	28.31
HPV amplified probe technique, used for management of ASC-US pap tests	87621	49.04
Colposcopy	57452	112.20
Colposcopy with biopsy and endocervical curettage	57454	161.52
Colposcopy with endocervical curettage	57456	140.91
Surgical Pathology, gross and microscopic examination (cervix, conization)	88307	170.10
Conization of the cervix (excision)	57520	300.01
Loop Electrode Excision	57460	312.58
Case management for abnormal breast cancer screening, (abnormal CBE or mammogram, diagnostic tests required)	99910	100.00
Case management for abnormal cervical cancer screening (diagnostic test required)	88810	50.00
Case management for referred in client with qualifying breast or cervical diagnosis for application to the Medicaid Treatment Act	44410	100.00
TREATMENT ONLY CODES		
Office Visit – In Conjunction with Treatment Only Visit	99214	41.46
Cryotherapy	57511	82.10
Laser	57513	161.47
Loop Electrode Excision	57522	202.93

ALL RATES AND PROCEDURES ARE SUBJECT TO APPROVAL BY CDC

- * Reimbursement at the same rate as 77057 per CDC policy
- ** Reimbursement at the same rate as 77055 per CDC policy
- *** Reimbursement at the same rate as 77056 per CDC policy



**Texas Department of State Health Services
Breast and Cervical Cancer Control Services
Comprehensive Case Management Form**

Contractor, Clinic Name:	Case Manager:	Patient ID Number:	Chart Number:
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CLIENT INFORMATION

Name:	Date of Birth:	Social Security No.:	Daytime Phone:
Screening/Diagnosis results:	Other Contact Information:		
	Name:	Address:	Phone: Relationship:

ASSESSMENT DATE

Social Resources Assessment	Medical Care/Service Status	Education and Counseling Assessment
<input type="checkbox"/> Social Support (e.g., Family, Church, Friends) <input type="checkbox"/> Other	<input type="checkbox"/> Medical Home <input type="checkbox"/> Transportation <input type="checkbox"/> Language Barrier <input type="checkbox"/> Unable to leave work <input type="checkbox"/> Child Care <input type="checkbox"/> Making Appointment <input type="checkbox"/> Financial Resources <input type="checkbox"/> Alternative Healing <input type="checkbox"/> Other	<input type="checkbox"/> Concern about procedure (e.g., discomfort, pain) <input type="checkbox"/> Embarrassment <input type="checkbox"/> Fear of cancer <input type="checkbox"/> Overwhelmed by information <input type="checkbox"/> Feelings of anger, sadness <input type="checkbox"/> Relationship with spouse/friends <input type="checkbox"/> Intimacy/sexual concerns <input type="checkbox"/> Body image <input type="checkbox"/> Cost of procedures <input type="checkbox"/> Loss of employment <input type="checkbox"/> Other

SERVICE PLAN DATE

Identified Need	Service/Referral	Provider	Date of Initial Svc./Ref.	F/U Date	Outcome of Service/Referral

STATEMENT OF UNDERSTANDING

I understand that my participation in the BCCCP means that I agree to additional evaluation and/or treatment if any of my test results are abnormal.	
(Signed): _____	Date: _____



Departamento Estatal de Servicios de Salud de Texas
Programa para el control del cáncer cervical y del cáncer del seno
Formulario de información comprehensiva para la administración de casos

Contratista, Nombre de la clínica:	Administrador del caso:	Número de identificación del paciente:	Número del expediente:
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INFORMACIÓN DEL CLIENTE

Nombre:	Fecha de nacimiento:	Número de Seguro Social:	Teléfono durante el día:	
Resultados de exámenes o diagnóstico:	Información sobre otra persona de contacto:			
	Nombre:	Dirección:	Teléfono:	Relación:

INFORMACIÓN DE EVALUACIÓN

Evaluación de los recursos sociales	Estatus de atención médica/servicios	Evaluación de educación y asesoramiento
<input type="checkbox"/> Apoyo social (por ejemplo: familia, iglesia, amigos) <input type="checkbox"/> Otro	<input type="checkbox"/> Hogar médico <input type="checkbox"/> Transportación <input type="checkbox"/> Barrera de idiomas <input type="checkbox"/> No puede salir del trabajo <input type="checkbox"/> Cuidado de niños <input type="checkbox"/> Hacer una cita <input type="checkbox"/> Recursos económicos <input type="checkbox"/> Curación alternativa <input type="checkbox"/> Otro	<input type="checkbox"/> Preocupación sobre el procedimiento (por ejemplo: incomodidad, dolor) <input type="checkbox"/> Vergüenza <input type="checkbox"/> Miedo al cáncer <input type="checkbox"/> Abrumada por la información <input type="checkbox"/> Sensaciones de enojo, tristeza <input type="checkbox"/> Relación con su cónyuge/sus amigos <input type="checkbox"/> Preocupación sobre las relaciones sexuales o la intimidad <input type="checkbox"/> Imagen del cuerpo <input type="checkbox"/> Costo del procedimiento <input type="checkbox"/> Pérdida del empleo <input type="checkbox"/> Otro

FECHA DEL PLAN DE SERVICIOS

Necesidad identificada	Servicio/Envío	Proveedor	Fecha del servicio/envío inicial	Fecha de	Resultado del servicio/envío

DECLARACIÓN DE ENTENDIMIENTO

Yo entiendo que mi participación en el Programa para el control del cáncer cervical y del cáncer del seno significa que estoy dispuesta a participar en evaluaciones o tratamientos si los resultados de las pruebas resultan anormales.

(Firma): _____ Fecha: _____

INSTRUCTIONS FOR COMPLETING THE COMPREHENSIVE CASE MANAGEMENT FORM

Note: Contractors must use this form to assess needs. The use of this form for planning services is voluntary. Contractors may choose to document case management services in the client's medical records.

Contractor, Clinic Name: Enter the name of the BCCCP contractor and the clinic name if different from the contractor.

Case Manager: Enter the name of the case management staff completing the assessment and plan. If more than one person makes entries on the form, the primary person responsible for case management services should be listed in the box and all others will make initials next to the item assessed or planned.

Patient ID Number: Enter the assigned BCCCP client number.

Chart Number: Enter the client's chart number.

CLIENT INFORMATION

Enter the client's first and last names, date of birth, social security number, and daytime telephone number in the appropriate spaces.

Enter the screening or diagnosis result that prompted this assessment for case management services.

Enter the contact information for the individual identified by the client as the person most likely to know how to contact them if you are unable to locate them.

ASSESSMENT DATE

Enter the date the assessment is completed.

Under **Social Resources**, **Medical Care/Service Status**, and **Education and Counseling Assessment**, mark the box next to each item if the client identifies it as an issue, problem or need with which they require assistance. For more detailed information, document in the client's medical record.

For identified needs not listed, mark "Other" and enter additional needs that are identified during the assessment or planning phases.

SERVICE PLAN DATE

Enter the date the written plan is developed.

Under **Identified Need**, enter the needs whose boxes were marked during the Assessment phase.

In the **Service/Referral** column, enter the planned service or referral, and the name of the entity/person providing the service or the name of the entity/person the client is being referred to in the **Provider** column.

Enter the date the service is scheduled to begin under **Date of Initial Service/Referral**. If the service is an appointment, enter the appointment date.

Enter the date the case manager followed up on the status of the service in the **Follow Up Date** column.

Enter the outcome, e.g., completed, rescheduled, no show, in the **Outcome of Service/Referral** column.

STATEMENT OF UNDERSTANDING

The client's signature and date of signature are required at the time the assessment is completed.



Medicaid Treatment Act Guidelines for Determination of Qualifying Diagnosis

Appendix C:

The Department of State Health Services is providing the following guidance to healthcare providers and Breast and Cervical Cancer Services (BCCS) contractors to facilitate their determination of qualifying diagnoses for the Medicaid Treatment Act.

Cervical Cancer Qualifying Diagnosis

Qualifying pre-cancerous cervical diagnoses are biopsy-confirmed:

- ◀CIN III
- ◀Severe dysplasia
- ◀Carcinoma or adenocarcinoma *in situ*

Qualifying malignancies of the cervix are biopsy-confirmed:

- ◀Squamous cell carcinoma
- ◌Adenocarcinoma
- ◌Invasive endocervical adenocarcinoma
- ◌Small cell carcinoma
- ◌Invasive cervical cancer
- ◌Invasive neoplasm
- ◌Malignant neoplasia
- ◌Melanoma
- ◌Sarcoma
- ◌Glassy cell
- ◌Adenoid cystic
- ◌Adenosquamous carcinoma

Breast Cancer Qualifying Diagnosis

A **qualifying pre-cancerous breast diagnosis*** is biopsy confirmed:

- ◌Ductal carcinoma *in situ* (DCIS)

Qualifying breast cancer diagnoses must be biopsy-confirmed.

◌On the pathology report, the diagnosis and/or the specimen description must include at least one of the following phrases: **“breast cancer”, “breast carcinoma”, or “breast malignancy”**

◌On those pathology reports with a breast cancer diagnosis, the report must include at least one of the following words: **“infiltrating” or “invasive”**

Classification of the majority of breast cancer types:

1. Ductal Carcinomas:

- ◌Invasive
- ◌Comedo
- ◌Inflammatory
- ◌Medullary
- ◌Mucinous (colloid)
- ◌Papillary or Micropapillary
- ◌Scirrhous
- ◌Tubular
- ◌Cribiform

2. Lobular Carcinoma:

- ◌Invasive

3. Nipple Carcinoma:

- ◌Paget’s disease

4. Other Carcinomas:

- ◌Carcinoma, NOS (not otherwise specified)
- ◌Undifferentiated carcinoma
- ◌Phyllodes tumor
- ◌Sarcoma
- ◌Primary lymphoma
- ◌Secretory
- ◌Apocrine
- ◌Metaplastic
- ◌Carcinoma with endocrine differentiation
- ◌Adenoid cystic carcinoma

Breast and Cervical Cancers

For **original cancers**, terms such as “compatible with” and “consistent with” do not qualify as definitive diagnoses. If the pathologist is certain the finding is breast or cervical cancer as described above, then it must be clearly stated in the final pathology report.

For **recurrent cancers**, an unequivocal diagnosis of malignancy is required. However, since many metastatic cancers may look the same, the primary does not need to be explicitly diagnosed. Terms such as “compatible with” and “consistent with” a breast or cervical cancer are acceptable. For example, a diagnosis such as “metastatic adenocarcinoma consistent with the prior breast primary” would be acceptable.

*The diagnosis of lobular carcinoma in situ (LCIS) is not considered a qualifying precancerous or breast cancer diagnosis for referral to Medicaid under the Treatment Act.

Title 25. Health Services
Part 1. Department of State Health Services
Chapter 61. Chronic Diseases
Subchapter C. Breast and Cervical Cancer Services

§61.31. Purpose. These sections implement requirements and procedures for the delivery of screening, diagnostic, follow-up, and case management services for breast and cervical cancer through the Department of State Health Services Breast and Cervical Cancer Services.

§61.32. Federal Authorization and Requirements. The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Act), Public Law 101-354, and its re-authorization, the Women's Health Research and Prevention Amendments of 1998, Public Law 105-340, establish a program of grants to states, territories, and tribal organizations for early detection of and prevention of mortality from breast and cervical cancer. The Department of State Health Services, through a cooperative agreement with the Centers for Disease Control and Prevention and in compliance with the Act and its reauthorization, manages the delivery of breast and cervical cancer services statewide through Breast and Cervical Cancer Services.

§61.33. Providers. Health care providers serving women with incomes at or below 200% of the federal poverty level are eligible to apply as Breast and Cervical Cancer Services providers. Eligible applicants include, but are not limited to, community health centers, migrant health centers, local and regional health departments, family planning clinics, community cancer centers, hospitals, primary care programs, and other providers of health services to the target and priority populations.

§61.34. Client Eligibility Requirements.

(a) In order for a woman to be financially eligible for Breast and Cervical Cancer Services, the woman must:

(1) have a family income that does not exceed 200% of the current federal poverty level; and

(2) not have access to third-party payment for screening and/or diagnostic services.

(b) A woman age 40 or older that meets financial eligibility criteria is eligible for breast cancer screening and diagnostic services. A woman under age 40 that meets financial eligibility criteria is eligible for breast cancer diagnostic services only.

(c) A woman age 18 or older that meets financial eligibility criteria is eligible for cervical cancer screening and/or diagnostic services.

§61.36. Provider Applicant Requirements. To be funded to provide Breast and Cervical Cancer Services, applicants shall demonstrate:

- (1) evidence of a population in need;
- (2) evidence of ability to contact and serve priority populations;
- (3) evidence of ability to comply with tracking, follow-up, and reporting requirements;
- (4) evidence of ability to comply with quality assurance standards;
- (5) evidence of identified local diagnostic and treatment resources;
- (6) evidence of intent to comply with Department of State Health Services (department) screening policies and guidelines;
- (7) evidence of ability to apply financial eligibility standards;
- (8) evidence of ability to comply with all other department standards, policies, and requirements; and
- (9) evidence that Breast and Cervical Cancer Services funds will not be used to supplant existing funding for similar services.

§61.37. Screening Requirements. Participating providers shall provide or assure the provision of screening services in accordance with the following requirements:

- (1) breast cancer screening shall include a clinical breast examination and a mammogram;
- (2) cervical cancer screening shall include a clinical breast examination, pelvic examination, and a Pap test;
- (3) mammography and cytological laboratory services shall be delivered in compliance with quality assurance standards specified in the Breast and Cervical Cancer Services policy and procedures manual; and
- (4) abnormal screening results shall be confirmed by diagnostic procedures according to the protocols specified in the Breast and Cervical Cancer Services policy and procedures manual.

§61.39. Follow-up and Case Management Requirements. Participating providers shall:

(1) provide or assure provision of follow-up and case management services that comply with the Breast and Cervical Cancer Services policy and procedure manual; and

(2) ensure that women eligible for services who have abnormal breast or cervical cancer screening or diagnostic results receive follow-up services, including case management, until a diagnosis is reached and/or treatment for cancer is initiated.

§61.41. Payment for Services.

(a) Payment for clinical screening and diagnostic services shall be on a fee-for-service basis.

(b) Payment will be subject to audit by the Department of State Health Services (department). The department shall approve all covered procedures and payment rates, which shall not exceed the maximum state Medicare rates for that procedure. A list of procedures approved for payment shall be included in all requests for proposals and contracts.

(c) In accordance with department policy, providers may be allowed to bill for administrative and support services costs associated with the following activities:

- (1) eligibility determination;
- (2) public education and outreach;
- (3) professional education;
- (4) program management;
- (5) coalition and partnership development;
- (6) data collection and reporting; and
- (7) other activities authorized in advance.

(d) In order to bill for administrative and support services costs, a provider must request such funding in its annual proposed budget. Administrative and support services costs shall not exceed 10% of a provider's actual expenditures for clinical services.

§61.42. Client Fees. Participating providers may charge clients fees for services in accordance with the Breast and Cervical Cancer Services policy and procedures manual.

OVERALL ASSESSMENT OF FINDINGS CLASSIFICATIONS

The Breast Imaging Reporting and Data System (BIRADS) were developed by the American College of Radiology. The purpose of BI-RADS, which is now referred as Assessment Category Definitions, is to create a uniform system of reporting mammography results with a recommendation associated with each category. The BCCS Policy manual includes the fourth edition, which is the latest edition.

Negative (BI-RADS Category 1)

- There is nothing to comment on. The breasts are symmetrical and no masses, architectural disturbances, or suspicious calcifications are present.

Benign Finding(s) (BI-RADS Category 2)

- This is also a negative mammogram, but the interpreter may wish to describe a finding. Involution, calcified fibro adenomas, multiple secretory calcifications, fat containing lesions such as oil cysts, lymphomas, galactoceles, and mixed density hamartomas all have characteristic appearances, and may be labeled with confidence. The interpreter may describe intramammary lymph nodes, implants, etc. while still concluding that there is no mammographic evidence of malignancy.

Probably benign Finding(s) (BI-RADS Category 3)

- A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability. Data are becoming available that shed light on the efficacy of short interval follow-up. These will likely undergo future modification as more data accrue as to the validity of an approach, the interval required, and the type of findings that should be followed.

Suspicious Abnormality (BI-RADS Category 4)

- These lesions do not have the characteristic morphologies of breast cancer but have a definite probability of being malignant. The radiologist has sufficient concern to urge a biopsy. If possible, the relevant probabilities should be cited so that the patient and her physician can make the decision on the ultimate course of action.

Highly Suggestive of Malignancy (BI-RADS Category 5)

- These lesions have a high probability of being cancer. Appropriate action should be taken.

Known Biopsy-Proven Malignancy (BI-RADS Category 6)

- **This category has been added for breast lesions identified on the imaging study with biopsy proof of malignancy but prior to definitive therapies.**

Incomplete Assessment (BI-RADS Category 0): needs additional imaging evaluation

- This is almost always used in a screening situation and should rarely be used after a full imaging work up. A recommendation for additional evaluation should be made including the use of spot compression, magnification, special mammographic views, ultrasound, etc.
- Whenever possible, the present mammogram should be compared to previous studies. The radiologist should use judgment in how vigorously to pursue previous studies.

Unsatisfactory, film could not be interpreted by radiologist

- Mammogram was technically flawed.

Source: Final Mammography Quality Standards Act (MQSA) Regulations:
Effective April 28, 1999.

Source: 2007 National Comprehensive Cancer Network, Practice Guidelines in Oncology.

BETHESDA CATEGORY DEFINITIONS

Negative (within normal limits)

- There is nothing to comment on.

Atypical squamous cells (ASC)

- SC-US- atypical squamous cells of undetermined significance.
- SC-H – atypical squamous cells of undetermined significance, cannot exclude HSIL.

Low grade SIL (including HPV changes)

- Low-grade squamous intraepithelial lesion, encompassing: Cellular changes associated with HPV, mild (slight) dysplasia/cervical intraepithelial neoplasia grade 1 (CIN I).

High grade SIL

- High-grade squamous intraepithelial lesion, encompassing: moderate dysplasia/CIN II, severe dysplasia/CIN III, carcinoma in situ/CIN III.

Squamous cell cancer

- Invasive Cervical Carcinoma.

AGUS

- Atypical endocervical, endometrial, or glandular cells.

APPENDIX G Source of Income

Revised 9/2007

- 1) **Money, wages, or salary** includes earnings of children at least 14 years old, wages or salary received for work performed as an employee, including wages, salary, armed forces pay (include allotments from any armed forces received by a family group from a person not living in the household), commissions, tips, piece-rate payments, and cash bonuses earned. Overtime pay is estimated based on the person's history of receiving this pay.
- 2) **Net income from non-farm self-employment** includes gross receipts minus business expenses from one's own business, professional enterprise, or partnership, which result in the individual's net income.
- 3) **Net income from farm self-employment** includes gross receipts minus operating expenses from operation of a farm by the client or the client and his partners. Gross receipts include the value of products sold, government crop loans, and incidental receipts from the sale of wood, sand, mineral royalties, gravel, and similar items.
- 4) **Social Security and railroad retirement benefits** include Social Security pensions and survivor's benefits, permanent disability insurance payments made by the Social Security Administration (before deductions for medical insurance), and railroad retirement insurance checks from the federal government. Gross benefits from these sources are the amounts before deductions for Medicare insurance.
- 5) **Dividends and interest** include dividends from stock-holdings or membership in associations, interest on savings or bonds, and periodic receipts from estates or trust funds, and net royalties. These earnings are averaged for a 12-month period.
- 6) **Net income from rental of a house, homestead, store, or other property** includes net income from rental property, which is calculated by prorating and subtracting from gross receipts property taxes, insurance payments, bills for repair and upkeep of property, and interest on mortgage payments on the property. Capital expenditures and depreciation are not deductible.
- 7) **Income from mortgages or contracts** includes income the buyer promises to pay in fixed amounts over a period of time until the principle of the note is paid.
- 8) **Public assistance or welfare payments** include TANF, refugee assistance, SSI, general assistance (cash payments from a county or city).
- 9) **Pensions, annuities, and irrevocable trust funds** include pensions or retirement benefits paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company. Periodic payments from annuities, insurance, or irrevocable trust funds are also included.
- 10) **Veterans' pensions, compensation checks, and G.I. Benefits** include money paid periodically by the Veterans Administration to disabled members of the armed forces or to survivors of deceased veterans, subsistence allowances paid to veterans for education and on-the-job training and refunds paid to ex-servicemen as G.I. insurance premiums. (Include only that part of the educational allowance that is used for current living costs.)
- 11) **Educational loans, grants** include money received as scholarships by students for educational purposes. (Include only that part actually used for current living costs.)
- 12) **Unemployment compensation** includes compensation received from government

unemployment insurance agencies or private companies during periods of unemployment, and any benefits to strikers received from union funds.

13) Worker's compensation and disability payments include compensation received periodically from private or public insurance companies for injuries incurred at work. **14) Alimony** is a support payment to a divorced person by a former spouse.

15) Child support includes court-ordered child support, any maintenance or allowance used for current living costs provided by parents to a minor child who is a student, or any informal child support payments made by an absent parent for the maintenance of a minor child.

16) Regular cash support payments from friends or relatives received on a periodic basis more than three times a year.

17) Net income from the client's share of an inheritance. 18) Foster Care Payments include payments made to a household on behalf of a legally assigned foster child or foster adult.

19) Capital gains from sale of property.

Note: Income not described in items 1 through 19 is excluded in determining monthly gross income.