

**FY
2018**



Women's Health Connection Policy and Procedure Manual



DIVISION OF PUBLIC AND BEHAVIORAL HEALTH WOMEN'S HEALTH CONNECTION IN
PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK
FUNDED THROUGH THE NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION
PROGRAM (NBCCEDP)

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Program Overview

Program Overview

In 1990, Congress passed The Breast and Cervical Cancer Mortality Prevention Act due to an increase in the number of low-income and uninsured women being diagnosed with breast cancer. This bill authorized the Centers for Disease Control and Prevention (CDC) to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide high-quality and timely breast and cervical cancer screening and diagnostic services to low-income, and uninsured women. The bill created the first national cancer screening program in the United States. NBCCEDP funds 67 programs including all 50 states, the District of Columbia, five US territories, and eleven tribes or tribal organizations.

In 1997, The Nevada Division of Public and Behavioral Health formerly known as the Nevada State Health Division, received funding from NBCCEDP to establish the Women's Health Connection (WHC) Program. Since its implementation, WHC has been federally funded through NBCCEDP and has provided breast and cervical cancer screening services to over **57,536** women. WHC's objective is to reduce breast and cervical cancer morbidity and mortality rates to medically underserved women in Nevada. This is accomplished through education, screening, and early diagnosis. As a result of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354), women who are enrolled and active in Women's Health Connection program for breast and cervical cancer screenings and diagnosed with breast or cervical cancer have access to treatment services through Medicaid and or expanded Medicaid.

The Division of Public and Behavioral Health entered into a multi-year contract in 2011 with Access to Healthcare Network (AHN) to administer the Women's Health Connection program. This partnership increases the access to primary and specialty healthcare services for breast and cervical cancer screenings for Nevada women.

The priority population for WHC are women between the ages of 21 to 64 years old. The priority populations for cervical cancer screening are women 21 to 64 years of age and 40 to 64 years of age for breast cancer screenings.

"The mission of Chronic Disease Prevention and Health Promotion is to maximize the health of Nevadans by improving policy, systems and environment that influence quality of life"

Case Management

Case Management Services

Care coordination/case management services involves collaborating with providers to meet the health needs of women. NBCCEDP evaluates WHC's performance through Minimum Data Elements (MDEs), which are quality assurance measures. MDE's contain screening and diagnostic data which is submitted bi-annually in April and October. NBCCEDP has set core performance indicators with benchmarks to ensure timely, complete, and accurate data is collected.

Core Program Performance Indicators			
Indicator Type	DQIG Item	Program Performance Indicator	CDC Standard
Screening	6a.	Initial Program Pap Tests; Rarely or Never Screened	≥ 20%
	19e.	Mammograms Provided to Women ≥ 50 Years of Age	≥ 75%
Cervical Cancer Diagnostic Indicators	11a.	Abnormal Screening Results with Complete Follow-Up	≥ 90%
	16.d.	Abnormal Screening Results; Time from Screening to Diagnosis > 90 Days	≤ 25%
	17	Treatment Started for Diagnosis of HSIL, CIN2, CIN3, CIS, Invasive	≥ 90%
	18.d.	HSIL, CIN2, CIN3, CIS; Time from Diagnosis to Treatment > 90 Days	≤ 20%
	18.g.	Invasive Carcinoma; Time from Diagnosis to Treatment > 60 Days	≤ 20%
Breast Cancer Diagnostic Indicators	20.a.	Abnormal Screening Results with Complete Follow-Up	≥ 90%
	25.d.	Abnormal Screening Results; Time from Screening to Diagnosis > 60 Days	≤ 25%
	26	Treatment Started for Breast Cancer	≥ 90%
	27.d.	Breast Cancer; Time from Diagnosis to Treatment > 60 Days	≤ 20%

WHC provides case management services to ensure that patients receive timely and appropriate screening and diagnostic services. WHC does not reimburse for treatment services. If a woman diagnosed with cancer and not eligible for Medicaid services, WHC will refer to other treatment resources. Staff will explain the importance of follow-up services, and assist with scheduling appointments. Case management services will also assess the patient for barriers that could possibly hinder her from keeping follow-up appointments and taking action on recommendations. Case management services conclude when a patient is determined to have a final diagnosis not requiring treatment or when a patient initiates or refuses treatment.

- Care Coordinators work closely with patients to ensure that the patient receives the appropriate services in a timely manner
- Coordinate the patient's care with provider(s)
- Review clinical records for appropriateness of recommended care
- Ensure recommended diagnostic procedures are completed within time frames
- Maintain timely contact with patients and document all contacts using a tracking system
- Assess patients for barriers and provide assistance (Transportation, work schedule, etc.)
- If diagnosed with cancer, assist patient with Medicaid application and track Medicaid approval, and or refer to other treatment resources

Responsibilities: WHC and Providers

WHC Responsibilities to Providers:

- Ensure provider contracts are established
- Provide training, technical assistance, and professional education resources to enrolled providers
- Provide WHC enrollment forms, reporting forms, and promotional materials
- Ensure all providers meet quality standards. i.e. MQSA CLIA
- Reimburse providers for screening and diagnostic services within 30 days of reimbursement
- Ensure case management services are provided to eligible women
- Refer eligible women to treatment services
- Maintain ongoing provider communication in regards to policies and procedures.
- Maintain a central patient tracking system

Provider Responsibilities to WHC:

- Providers must attend WHC orientation training
- Providers are responsible for following WHC eligibility screening protocols
- Enrollment form must be completed and signed by patient and submitted with the initial screening visit within **30 days** of initial screening date
- Ensure that patients receive eligible screening and diagnostic services covered under the program
- Notify patient verbally or in writing of results within **10 days** of receiving results and explain abnormal results and processes to obtain diagnostic services
- According to NRS 457, providers **MUST** report all cancer diagnoses to the Cancer Registry <http://www.leg.state.nv.us/NRS/NRS-457.html>
- Provide patients with educational materials and recommendations for breast and cervical cancer screening intervals as per screening guidelines as well as the importance of importance of timely follow-up of diagnostic procedures.
- Additional screening results must be submitted within **30 days** of procedure date
- All abnormal results must be faxed within **48 hours** to ensure timely follow-up and to initiate case management services
- Diagnostic results must be submitted within **48 hours** of procedure date
- If a woman refuses diagnostic procedures/treatment, the *Patient Refusal Form* must be completed and faxed to WHC within **48 hours** of form signed
- All billing claim forms must be submitted within **30 days** of the date of service
- Ensure patients are not be billed for reimbursable program services
- Ensure women are recalled and screened at appropriate screening intervals (WHC will not reimburse for unnecessary “over-screening”)
- Maintain patient confidentiality
- Assemble documents for provider site audits
- Initial screening visit form must be completed and signed by the clinician and submitted within **30** days of the date of service

Eligibility Screening & Enrollment

Determining Eligibility

WHC expects providers to encourage eligible women to pursue health insurance coverage. Federal law mandates that the WHC Program is the "payor of last resort." If breast and cervical cancer services are available through any other state compensation program, under an insurance policy or federal or state health benefits program, prepaid health services, WHC funding may not be used.

WHC eligibility components:

- Must be at least 21 years of age
- Must be at or below 250% of federal poverty level (see chart)
- Nevada Resident
- Underinsured
- Transgender women (male to female) 40 years and above who have taken or are taking hormones can receive breast cancer screening services
- Transgender women (female to male) 21 years and above who have not undergone bilateral breast mastectomy and hysterectomy can receive breast and/or cervical cancer screening services

Fiscal Year 2018 Income Guidelines		
Number of People in Household	Household Income Before Taxes	
	Yearly 250% FPL	Monthly 250% FPL
1	\$30,150	\$2,513
2	\$40,600	\$3,383
3	\$51,050	\$4,254
4	\$61,500	\$5,125
5	\$71,950	\$5,996
6	\$82,400	\$6,867
7	\$92,850	\$7,738
8	\$103,300	\$8,608
For each additional person, add \$4,180 per year		

Underinsured Policy

The intent of the underinsured policy is to relieve financial burdens which may prevent the patient from receiving cancer screening or diagnostic testing. WHC will reimburse at Medicare's allowable rate. If the provider accepts payment from WHC there should be no outstanding balance to the patient.

A patient covered under a health insurance plan that does not fully cover breast and cervical cancer screenings and/or diagnostics and has an insurance deductible of \$100.00 or more is considered underinsured under the WHC policy. Underinsured status also includes co-pays for covered breast and cervical cancer screenings.

Guidelines:

- Underinsured women must be deemed eligible for WHC services by Access to Healthcare Network (AHN) prior to deductible or co-pay reimbursement
- WHC will reimburse providers for deductibles and co-pays for WHC covered services
- WHC will reimburse providers at the Medicare allowable rates
- Reimbursable providers must be part of WHC provider network

Steps to Reimbursement:

1. Providers will bill patient's insurance company first
2. If the patient has an outstanding balance following insurance processing, the patient will contact Access to Healthcare Network for eligibility verification and enrollment into WHC
3. Patient will submit bill(s) to AHN for reimbursement

Methods of Enrollment into WHC Program

1. Enrollment at the PCP's Office

A Woman enrolls into WHC by completing the *WHC Enrollment Form*. The provider shall determine eligibility based on a woman's age, income and insurance status. A woman is considered enrolled in WHC on the date screening services are performed, not before.

WHC will not pay for services prior to the enrollment date.

2. Enrollment through the AHN Helpline Call Center

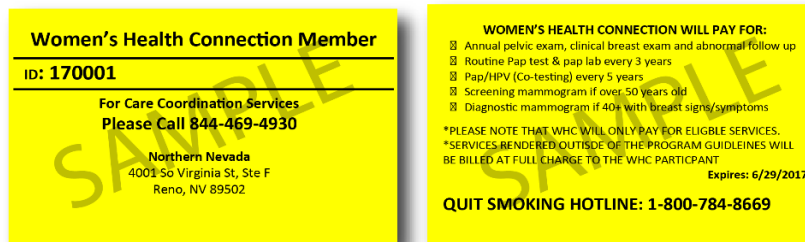
A woman who established eligibility through WHC AHN Helpline, will receive a welcome letter in the mail, list of participating providers, and *WHC Enrollment Form*. When the patient arrives at the PCP's office for her scheduled appointment she should present the partially completed WHC Enrollment Form (page 1 of the form). A woman is considered enrolled in WHC Program on the date that eligible screening services were performed and not before.

WHC will not pay for services performed before the date of service at the provider's office.

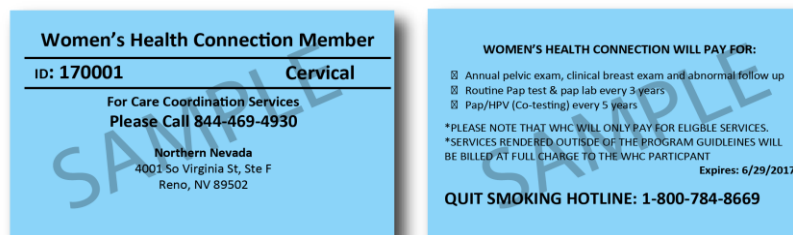
Women's Health Connection Member ID Card

Every woman screened must be assigned a card. To verify a patient's enrollment in WHC, please advise every woman to present this card to the provider at the time of each appointment.

Card for women ages 40-64:



Card for women ages 21-39:



Card for the CAP program



Reimbursable Screening Services

Breast Screening Services reimbursed by WHC

A Woman 40 years of age or older, enrolled in WHC, are eligible to receive the following services annually:

- 40 – 49 years: Clinical breast exam (CBE) only, **not eligible for a screening mammogram**
- 40 – 49 years: If CBE is abnormal, WHC will reimburse for diagnostic mammogram or ultrasound
- 50 years and older: Clinical breast exam and screening mammogram
 - Screening mammograms must be ordered for all patients aged 50 years and over using the *WHC Mammography and Ultrasound Referral Form*. The form must include the results of the clinical breast exam and be signed and dated by the ordering clinician.

Cervical Screening Services reimbursed by WHC

Women 21-64 years of age enrolled in WHC shall receive the following services annually or as indicated by the clinician:

- 21-29 years old:
 - Pelvic exam
 - Pap Test
 - Every 3 years, unless there is an abnormal result
 - Diagnostic services after an abnormal screening result
 - Referral for treatment
- 30-64 years old:
 - Pelvic exam
 - Co-test (Pap and HPV)
 - Every 5 years, unless there is an abnormal result
 - Diagnostic services after an abnormal screening result
 - Referral for treatment

Cervical cancer screening is not recommended for women older than age 65 who have had adequate screening and are not at high risk. If a woman over the age of 64 needs to be screened and is eligible to receive Medicare benefits, but is not enrolled, she should be encouraged to enroll in Medicare. Women enrolled in Medicare Part B are not eligible for WHC.

WHC **will pay** for a PCP visit under the following circumstances:

- WHC will pay for a Pap test or co-testing on women who have had a hysterectomy with or without removal of the cervix if the hysterectomy was due to cervical cancer
- If a Pap test or co-test is unsatisfactory or false-positive the patient should have a repeat test immediately. The unsatisfactory result is not to be considered in the Pap (3 year) and co-testing (5 year) period of the cervical cancer screening schedule
- If patient presents new breast symptoms before annual screening date
- To offer a second office visit to another PCP if the first visit was unsatisfactory
- **All office visits should be billed through the standard office visit CPT codes: 99201-99203 for “new patients” and 99211-99213 for “established patients”. A “new patient” is defined as a woman who is new to WHC and/or at their first annual appointment with WHC. If the patient hasn’t been seen within three years they are considered a new patient. If less than three years they are considered an established patient. CPT codes 99204, 99205 and 99214 are not appropriate for WHC screening visits**

WHC **will not** pay for a PCP visit under the following circumstances:

- To discuss normal screening results (including mammogram with BIRADS 0-3)
- If a patient returns to her existing provider and is not eligible for a screening test, and the provider performs a screening test anyway, WHC will NOT pay for the office visit or the lab fee for the screening
- WHC will not pay for an initial mammogram screening without a CBE corresponding performed.

PLEASE NOTE:
*Mammography and
Ultrasound Referral Form
are valid for **60 days** after
date of issue by PCP,
otherwise patient must
wait until her next annual*

Annual Breast and Cervical Cancer Screening Visit Form

- Review patient history from page 1 (*WHC Enrollment Form*)
- Fill out the *Clinical Breast Exam Findings* section
 - Clients ages 40 and above are eligible to receive an annual clinical breast exam
 - If there is an abnormal finding, refer patient for diagnostic services. Imaging results must be reviewed by clinician before referral to breast specialist
- Fill out the *Reason for Imaging* section
 - If the patient is eligible for a routine screening mammogram (50 years and above), *complete Mammography and Ultrasound Referral Form*
 - If the patient is eligible for diagnostic services (40 years and above) due to abnormal clinical breast exam findings, *complete Mammography and Ultrasound Referral Form*. Results must be reviewed by clinician before referral to breast specialist
 - For breast specialist referral, *complete Breast Specialist Referral Form*
- Fill out the *Pelvic Exam Findings* section
 - All patients are eligible to receive an annual pelvic exam, unless the woman had a total hysterectomy not due to cervical cancer
 - If an abnormal pelvic is noted that is referred to the cervical specialist, describe the abnormality in the notes field of the form
 - If an abnormal pelvic is noted that is not referred to the cervical specialist, describe the abnormality in the notes field of the form
 - For cervical specialist referral, *complete Cervical Specialist Referral Form*
- Fill out the *Reason for Pap/HPV Test* section
 - Co-testing (Pap and HPV test) is the recommended method for cervical cancer screening
 - The WHC Program will reimburse Pap tests every 3 years and co-testing (Pap and HPV test) every 5 years after normal Pap results for women who have an intact cervix, or for women who have had a hysterectomy due to cervical neoplasia
- Clinician should discuss exam results with patient and indicate any concerns in the notes field
- Any test results must be delivered verbally or in writing to patients within **10 days** of test result receipt
- All *WHC Enrollment* and *Annual Screening Visit Forms* must be submitted signed and dated to the appropriate WHC office within **30 days** of date of service
- **All WHC Enrollment Forms with abnormal findings must be faxed to WHC within 48 hours upon receipt of any abnormal screening results- Fax 775-284-1918**

Reimbursable Diagnostic Services

If a woman receives an abnormal screening test at any time, the appropriate diagnostic workup must be completed within **60 days** from the date of the abnormal test. The woman will be assigned a Care Coordinator to assist with the diagnostic workup process ensuring a final diagnosis is reached and treatment is initiated. WHC Care Coordinators can be reached at **844-469-4930**.

Breast Diagnostic Services reimbursed by WHC

A women **50 years** of age and older enrolled in WHC shall receive diagnostic services for the following screening results:

Normal CBE and Abnormal Screening Mammography Test Results

- **BI-RADS Category 0** (Assessment Incomplete) – Additional imaging is required
- **BI-RADS Category 3** (Probably Benign) – If this is the first ever mammogram, additional imaging is required. (Please refer to breast algorithm for further follow up, located as an attachment)
- **BI-RADS Category 4** (Suspicious Abnormality) – Refer to specialist
- **BI-RADS Category 5** (Highly Suggestive of Malignancy) – Refer to specialist Women **40 years** and older enrolled in WHC shall receive diagnostic services with the following screening results:

Abnormal CBE and Diagnostic Evaluation (Mammogram and Ultrasound) Test Results

- **BI-RADS Category 0** (Assessment Incomplete) – Additional imaging is required
- **BI-RADS Category 1** (Negative) – If certain of abnormality or mass is persistent refer to specialist. If not certain of abnormality, repeat CBE in 30 days by PCP, if mass is not persistent follow routine screening, if mass is persistent refer to specialist
- **BI-RADS Category 2** (Benign) – Correlate physical findings with diagnostic imaging evaluation and assure finding is concordant, if finding is concordant follow routine screening, if finding is discordant, refer to specialist
- **BI-RADS Category 3** (Probably Benign) – Refer to specialist
- **BI-RADS Category 4** (Suspicious Abnormality) – Refer to specialist
- **BI-RADS Category 5** (Highly Suggestive of Malignancy) – Refer to specialist

Abnormal CBE results include:

Discrete palpable mass suspicious for cancer, Bloody/serous nipple discharge, Nipple/areolar scaliness, and Skin dimpling/retraction

Important! Specialist Referrals

WHC Care Coordinator will select specialist to process the referral. Once referral has been processed WHC will notify PCP.

Other Breast Diagnostic Services

- Consultant-Repeat CBE
- Surgical consultation
- Mammary ductogram or galactogram single duct
- MRI with or without contrast. Breast MRI can be reimbursed in conjunction with a mammogram when a patient has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history. Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a patient with a past history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed for by the program to assess the extent of disease in a woman who is already diagnosed with breast cancer - **Prior approval required**
- Biopsy (Fine Needle biopsy (FNA), core needle biopsy, and excisional biopsy)
Some pre-operative testing is allowed with prior approval from WHC. These procedures should be medically necessary for the planned surgical procedure

Breast Specialist Services

WHC **will pay** for a consultation with a specialist under the following circumstances:

- To discuss follow-up if CBE is normal and screening imaging results are BI-RADS 4 or BI-RADS 5
- To discuss follow-up if CBE is abnormal and diagnostic imaging results are BI-RADS Category 0, 3, 4, & 5
- **All consultation visits should be billed through the standard office visit CPT codes: 99201-99205 for “new patients” and 99211-99214 for “established patients”. A “new patient” is defined as a woman who is new to the WHC and/or is at their first annual appointment with the WHC. If the patient hasn’t been seen in three years they are considered a new patient. If less than three years they are considered an established patient. Consultations billed as 99204 or 99205 must meet the criteria for these codes of moderate complexity for 45 minutes or high complexity for 60 minutes, respectively, during a new patient visit. A summary report of this visit must be attached to the reimbursement request**

WHC **will not** pay for a consultation with a specialist under the following circumstances:

- To discuss normal/benign screening results depending on global period
- If diagnostic imaging is not performed before initial specialist visit. All imaging results must be presented at time of initial visit
- An office visit that is billed concurrently with a procedure will not be reimbursed through the WHC
- Post-op office visit (This is included in the procedure reimbursement)
- If the purpose of office visit is for treatment
- For patients who have a **BI-RAD Category 0 – Assessment Incomplete** mammogram result and additional imaging is recommended, WHC will not pay for an office visit to give the patient another referral form for the additional imaging. The PCP shall fax the Mammography and Ultrasound Referral Form ordering the additional imaging to the imaging facility following verbal notification to the patient
- To discuss mammogram results which are paid through another payment sources other than WHC
- To discuss diagnostic or treatment plans for non-WHC covered health conditions

WHC does not pay for breast cancer treatment services. WHC will assist with referral to Medicaid (eligible under the Medicaid Treatment Act) or other treatment resources.

Schedule for follow-up/return visits:

- Once a diagnostic workup has been completed, WHC will pay the specialist for one short term follow-up visit. Short-term is defined as 6 months from the date of last specialist visit. The patient must have imaging performed prior to the short term follow up with the specialist if their initial mammogram was a BI-RAD 3. If the results from that visit are negative, normal, or benign and not suspicious for cancer, the patient must resume normal screening with a PCP.
- Patients may be referred into WHC for a diagnostic follow-up by a PCP if they have had a prior mammogram by a non-program payment source which yielded an abnormal result, and they meet program eligibility requirements. A clinical breast exam must be performed and a copy of the abnormal mammogram results must be included in the medical records before referral to specialist.

Breast Specialist Referral Form

- Review PCP section of the form for CBE findings and imaging results
- Only the initial visit requires a referral from the PCP. For each additional visit, a new *Breast Specialist Referral Form* must be completed
- Indicate if the office visit is a repeat CBE exam or a surgical consultation
- Indicates the type of recommended/performed diagnostic procedure(s)
- Indicate the final diagnosis
- Indicate date of service date(s)
- Complete treatment status information
- Specialist should discuss exam results with patient and indicate any concerns in the notes field
- Specialist must sign and date the bottom of the page
- All completed *Breast Specialist Referral Forms* must be faxed to WHC within **48 hours** of office visit at **775-284-1918** to ensure timely and adequate follow-up
- Any test results must be delivered verbally or in writing to patients within **10 days** of test result receipt

Cervical Diagnostic Services reimbursed by WHC

A women **21 years** and older enrolled in WHC shall receive diagnostic services for the following screening results:

Abnormal Pelvic Exam Results

Abnormal cervix (Suspicious for cervical cancer) – Refer to specialist

- Abnormal cervix (Not suspicious for cancer) – Refer to specialist

Abnormal Co-Test (Pap and HPV) Screening Results

- **ASC-US** -Atypical squamous cells of undetermined significance Pap test with **positive HPV** test - Refer to specialist for colposcopy
- **ASC-H** - Atypical squamous cells cannot exclude HSIL Pap test with negative or **positive HPV** test– Refer to specialist for colposcopy
- **LSIL** - Low grade squamous intraepithelial lesion Pap test with **negative or positive HPV** test - Refer to specialist for colposcopy
- **HSIL** -High grade squamous intraepithelial lesion Pap test with **negative or positive HPV** test - Refer to specialist

- **Squamous cell carcinoma Pap test with negative or positive HPV test** – Refer to specialist for biopsy and further evaluation
- **AGC** - Atypical glandular cells Pap test with **negative or positive HPV test** – Refer to specialist for colposcopy with endometrial sampling
- **AIS** - Endocervical adenocarcinoma in situ Pap test with **negative or positive HPV test** – Refer to specialist for colposcopy
- **Adenocarcinoma Pap test with negative or positive HPV test** – Refer to specialist for biopsy and further evaluation
- **Positive HPV and Negative Pap** - Repeat co-test in 1 year

Abnormal Pap test Screening Results

- **ASC-US** – Atypical squamous cells of undetermined significance – Repeat test in 1 year
- **ASC-H** – Atypical squamous cells cannot exclude HSIL – Refer to specialist for colposcopy
- **LSIL** – Low grade squamous intraepithelial lesion - Refer to specialist for colposcopy
- **HSIL** - High grade squamous intraepithelial lesion – Refer to specialist for colposcopy
- **Squamous cell carcinoma** – Refer to specialist for biopsy and further evaluation
- **AGC** – Atypical glandular cells – Refer to specialist for colposcopy with endometrial sampling
- **AIS** – Endocervical adenocarcinoma in situ – Refer to specialist for colposcopy
- **Adenocarcinoma** – Refer to specialist for biopsy and further evaluation

Other Cervical Diagnostic Services

- Repeat pelvic exam
 - Repeat unsatisfactory Pap test
 - Colposcopy (with or without biopsy)
 - Local excision of lesion (polyp)
 - Endocervical Curettage (ECC)
 - Cold Knife Conization (CKC) - **Prior approval required**
 - LEEP - **Prior approval required**
 - Endometrial biopsy - **Prior approval required**
- Some pre-operative testing is allowed with prior approval.**

Cervical Specialist Services

WHC **will pay** for a consultation with a specialist under the following circumstances:

- To discuss diagnostic follow-up after an abnormal pelvic exam
- To discuss diagnostic follow-up after an abnormal Co-Test or abnormal Pap test
- **All consultation visits should be billed through the standard office visit CPT codes: 99201-99205 for “new patients” and 99211-99213 for “established patients”. A “new patient” is defined as a woman who is new to the WHC and/or is at their first annual appointment with the WHC. If the patient hasn’t been seen in three years they are considered a new patient. If less than three years they are considered an established patient. Consultations billed as 99204 or 99205 must meet the criteria for these codes of moderate complexity for 45 minutes or high complexity for 60 minutes, respectively, during a new patient visit. A summary report of this visit must be attached to the claim.**

WHC **will not** pay for a consultation with a specialist under the following circumstances:

- To discuss normal screening results
- An office visit that is billed concurrently with a procedure will not be reimbursed through the WHC
- Post-op office visit (This is included in the procedure reimbursement)

- Purpose of office visit is for treatment
- To discuss screening results which are paid through another payment sources other than WHC
- To discuss diagnostic or treatment plans for non-WHC covered health conditions
- WHC does not pay for cervical cancer treatment services. WHC will assist with referral to Medicaid (eligible under the Medicaid Treatment Act) or other treatment resources

Schedule for follow-up/return visits:

- Surveillance after one year following a positive HPV test and negative Pap test
- **For the management of women with abnormal screening results the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:**
<http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.aspx>
- Patients may be referred into WHC for a diagnostic follow-up up if they had a prior Pap or co-test performed by a non-program payment source which yielded an abnormal result, and they meet program eligibility requirements. A clinical pelvic exam must be performed and a copy of the abnormal test results must be included in the medical records before referral to specialist

Cervical Specialist Referral Form

- Review PCP section of the form for pelvic exam findings and Pap test results
- Only the initial visit requires a referral from the PCP. For each additional visit, a new *Cervical Specialist Referral Form* must be completed
- Indicate if the office visit is a repeat pelvic exam or a gynecologic consultation
- Indicate the type of recommended/performed diagnostic procedure(s)
- Indicate the final diagnosis with recommended treatment information and date of services date(s)
- Specialist should discuss exam results with the patient and indicate any concerns in the notes field
- Specialist must sign and date the bottom of the page
- All original *Cervical Specialist Referral Forms* must be submitted to the appropriate WHC office within **30 days** of date of service
- All completed *Cervical Specialist Referral Forms* must be faxed to WHC within **48 hours** of office visit at **775-284-1918** to ensure timely and adequate follow-up
- Any test results must be delivered verbally or in writing to patients within **10 days** of test result receipt

For the management of woman with abnormal screening results the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:
<http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.aspx>

Medicaid Assistance for Treatment of Breast and Cervical Cancer

If a patient is diagnosed with cancer and needs treatment, a WHC Care Coordinator can be reached at 844-469-4930.

Women who apply for Breast and Cervical Cancer Medicaid must meet the following requirements:

- At or below 250% of Federal Poverty Level (FPL)
- Woman between the age of 21 to 64 years old
- Nevada resident
- Must be uninsured or underinsured
 - A woman is considered underinsured when she:
 - Is in a period of exclusion (such as pre-existing condition exclusion or an HMO affiliation period)
 - Is not actually covered for treatment of breast or cervical cancer
 - Has contract healthcare coverage through Indian Health Services or Tribal Clinics
- Not eligible under any other Medicaid eligibility group

WHC care coordinators complete and submit Referral Form 2591-EM to the Division of Welfare and Supportive Services for approval. The following documentation must also be submitted:

- Proof of age, income, Nevada residency
- Proof of U.S. Citizenship, U.S. National or Alien Status and

Eligibility begins the date on which the Care Coordinator determines the woman meets the above eligibility requirements and ends if the woman does not file an application for assistance by the last day of the month following the month during which eligibility was determined. Regular eligibility begins the first day of the first eligible month.

If a woman is diagnosed with cancer through the WHC and is eligible for Medicaid, the services rendered through WHC that lead to diagnosis will need to be billed to Medicaid. Claims will be denied by WHC.

For more information regarding Women's Health Connection & Medicaid Treatment for Breast & Cervical Cancer please refer to the resource section

Reimbursement and Billing

WHC reimburses at Nevada Medicare allowable rates. A list of allowable CPT codes and reimbursement rates may be found in attachment.

Billing and claims for services

- All billing claim forms for services provided to eligible patients must be received at the appropriate WHC office within **30 days** of the date of service

Reno Office

4001 South Virginia Street, Suite F

Reno, NV 89502

Phone 844-469-4930

Fax 775-284-1918

**ALL ENROLLMENTS, SPECIALIST
BILLING, PATHOLOGY & IMAGING**



- **Do not mail your claim to the Division of Public and Behavioral Health WHC state office in Carson City**
- Claims will only be paid if the appropriate medical reports and/or exam forms are submitted with the billing claim. Appropriate medical reports and/or exam forms are described below
- If a woman is diagnosed with cancer through the WHC and is eligible for Medicaid, the services rendered through WHC that lead to diagnosis will need to be billed to Medicaid. Claims will be denied by WHC

Incomplete claims **will be returned** to providers with a request for additional information. All corrected claims must be re-submitted within **30 days** from denial date.

Providers agree to accept the payable amount as payment in full. If the provider disagrees with the payable amount the provider has **30 days** from the date the check was issued to dispute any payable amounts.

Fiscal Year 2018 runs from 06/30/2017 to 06/29/2018

All Fee for Service CPT Codes run from 06/30/2017 to 06/29/2018

*New CMS CPT Codes that go into effect 1/1/18 will not be honored until 6/29/18

PLEASE NOTE: WHC must have the original completed enrollment documents for the client, or payment for any screening/diagnostic services will be denied.

Reimbursement for Breast and Cervical Screening Services by PCP

Submit the following original paperwork to the appropriate WHC office:

- Original *WHC Enrollment Form* – completed and signed
- *Annual Screening Visit Form* – completed and signed
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Imaging Facilities

Before billing for services, you must ensure that the patient has a proper referral form (*Mammography and Ultrasound Referral Form*) from a contracted PCP. This form must be signed and dated by the clinician.

Submit the following original paperwork to the appropriate WHC office:

- Imaging report
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Breast Specialists

Before billing for services, you must ensure that the patient has a *Breast Specialist Referral Form* from a contracted PCP and the top portion of the form is completed. The form must be completed, signed and dated by specialist.

Submit the following original paperwork to the appropriate WHC office:

- *Breast Specialist Referral Form*
- Any documentation pertaining to the diagnostic procedure performed
- Pathology results
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Cervical Specialists

Before billing for services, you must ensure that the patient has a *Cervical Specialist Referral Form* from a contracted PCP and the top portion of the form is completed. The form must be completed, signed and dated by specialist

Submit the following original paperwork to the appropriate WHC office:

- *Cervical Specialist Referral Form*
- Any documentation pertaining to the diagnostic procedure performed
- Pathology results

Billing Claim Form with WHC covered CPT codes

Reimbursement for Laboratory Facilities (Pap tests, HPV test, Pathology reports)

Submit the following original paperwork to the appropriate WHC office:

- Pap test or pathology result
- Billing Claim Form with WHC covered CPT codes

Reimbursement for Anesthesia

Submit the following original paperwork to the appropriate WHC office:

- Billing Claim Form with WHC covered CPT codes

Reimbursement for Ambulatory Surgery Centers

Submit the following original paperwork to the appropriate WHC office:

- Billing Claim Form with WHC covered CPT codes

WHC Directory

If you have questions or concerns about how WHC is working with your organization, please do not hesitate to call WHC program staff. Our goal is to make sure that WHC works the best it possibly can for providers and patients. And as a part of our Quality Management Program, both providers and patients may be asked to participate in a satisfaction survey.

Access to Healthcare Women's Health Connection Staff

Reno Corporate Office
4001 South Virginia Street, Suite F
Reno, NV 89502
Phone 844-469-4930

Sherry Rice
Chief Executive Officer
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Chief Financial Officer
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WHC Care Coordinator
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WHC Care Coordinator
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WHC Claims Processor
Phone: 844-469-4930 ext. 267
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Email:
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Jaime Rodriguez
WHC Care Coordinator
Phone: 844-469-4930 ext. 222
Fax: 775-284-1918
Email:
jrodriguez@accesstohealthcare.org

Las Vegas Office
3075 E. Flamingo Rd., Suite 118
Las Vegas, NV 89121
Phone: (844) 469-4930
Fax: (775) 284-1918

Mariela Moreno
WHC Care Coordinator
Phone: 844-469-4930, ext. 407
Fax: 775-284-1918
Email:
mmoreno@accesstohealthcare.org

AHN Helpline: 1-844-469-4934

www.accesstohealthcare.org

Care Coordination Line: 1-844-469-4930

State of Nevada Women's Health Connection Staff

Nevada Division of Public and Behavioral Health
Chronic Disease Prevention and Health Promotion Section
Women's Health Connection
4150 Technology Way Suite 210, Carson City, NV 89706

<http://dpbh.nv.gov/>

<http://dpbh.nv.gov/Programs/WHC/Women's Health Connection - Home/>

Rani Reed
Population Health & Community Services
Manager
Phone: 775-687-7581
Fax: 775-684-4245
Email: rrreed@health.nv.gov

Kellie Ducker
Program Coordinator
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Fax: 775-684-4245
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Shawna Pascual
Provider Compliance & Training Coordinator
Phone: 775-684-4241
Fax: 775-684-4241
Email: shawnapascual@health.nv.gov

Tom Weber, MPH
Evaluator and Data Analyst
Phone: 775-684-5834
Fax: 775-684-4245
Email: thweber@health.nv.gov

Provider Resources

The NBCCEDP follows screening recommendations from the United States Prevention Services Task Force (USPSTF). For more information on USPSTF recommendations, please refer to their web-site at:

Breast Cancer Screening

<http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm>

Cervical Cancer Screening

<http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>

Nevada Cancer Coalition, Women's Health Connection & Medicaid Treatment for Breast and Cervical Cancer

<http://www.nevadacancercoalition.org/whc-medicaid>

Cancer Registry

<http://www.leg.state.nv.us/NRS/NRS-457.html>

Who must report to the cancer registry?

- A health care provider that diagnoses or provides treatment for cancer or other neoplasm.
- Facilities, medical laboratory, or hospitals that provides screening, diagnostic or therapeutic services to patients with respect to cancer or other neoplasm.

For the management of women with abnormal screening results the program follows the American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations. Please follow the link for recommendations:

<http://www.asccp.org/ConsensusGuidelines/tabid/7436/Default.asp>

WHC ENROLLMENT FORM FY18

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

APPLICANT ENROLLMENT INFORMATION

SSN: _____ DOB: _____ Age: _____ Birth Place: _____

Last Name: _____ First: _____ Middle Initial: _____ Maiden Name: _____

Street address: _____ City: _____ State: **NV** Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Highest grade completed (Circle one): 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Occupation: _____ Industry: _____ Marital status: Single Married Divorced Separated Widowed

Hispanic: Yes No Language: English Spanish Other: _____ Race: White Black American Indian Asian Eskimo Native Hawaiian Pacific Islander Other: _____

How did you hear about our Program? Doctor Family/friend Radio/TV Self Health Fair AHN Other: _____

APPLICANT ELIGIBILITY INFORMATION

Do you have Medical Insurance? Yes No If yes, list name and coverage: _____

Medicare Part B Yes No Medicaid for yourself Yes No

Number of people in household: _____ What is your household income before taxes? Monthly: \$ _____ Yearly: \$ _____

APPLICANT MEDICAL HISTORY INFORMATION

Breast History

Are you experiencing breast symptoms? Yes No

Describe: _____

Do you have breast implants? Yes No

Have you ever had a mammogram? Yes No

Date of last mammogram (MM/DD/YYYY): _____

Breast cancer in family? Self Mother Daughter

Sister None Unknown

Cervical History

Have you ever had a Pap test? Yes No

Date of last Pap test (MM/DD/YYYY): _____

Date of last menstrual period (MM/DD/YYYY): _____

Age menses started: _____

Hysterectomy? Yes No

If yes, was hysterectomy due to cervical cancer?

Yes No

Are you on any hormone replacement therapy?

Yes No

General History

What is your current height? _____ What is your current weight? _____

Are you physically active? Yes No

Smoking Status: Never Current Former (Date quit MM/DD/YYYY)

Are you exposed to secondhand smoke? Yes No

If you are over 50 years of age, have you ever been screened for colorectal cancer? Yes No

Have you diagnosed with any of these illnesses:

Diabetes Gestational Diabetes High Blood Pressure High Cholesterol

Stroke Cancer, type of cancer: _____

FOR OFFICE USE ONLY

WHC Member ID: 18 Clinic Name: _____ Date Eligible: _____

If client is a current smoker and was referred to 1-800-QUIT-NOW, indicate date (MM/DD/YYYY): _____

Comments:

WHC ENROLLMENT FORM FY18

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

APPLICANT ENROLLMENT INFORMATION

Numero de Seguro Social:	Fecha de Nacimiento(MES/DIA/AÑO):	Edad:	Lugar de Nacimiento:
Apellido:	Primer Nombre:	Inicial:	Apellido de Soltera:
Dirección:		Ciudad:	Estado: NV Código Postal:
Telefono de Casa:		Telefono de Trabajo:	Celular:
Correo Electronico:		Educación más alta (Circule uno): 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+	

Ocupación:	Industria:	Estado Civil: <input type="checkbox"/> Soltera <input type="checkbox"/> Casada <input type="checkbox"/> Divorciada <input type="checkbox"/> Separada <input type="checkbox"/> Viuda	
Origen Hispano: <input type="checkbox"/> Si <input type="checkbox"/> No	Idioma: <input type="checkbox"/> Ingles <input type="checkbox"/> Español <input type="checkbox"/> Otro:	Raza: <input type="checkbox"/> Blanco <input type="checkbox"/> Negro <input type="checkbox"/> Indio Americano/Nativo de Alaska <input type="checkbox"/> Asiático <input type="checkbox"/> Nativo de Hawaii <input type="checkbox"/> Isleño del Pacifico <input type="checkbox"/> Otra:	
¿Cómo se enteró de este programa? <input type="checkbox"/> Doctor <input type="checkbox"/> Familiar/Amigo <input type="checkbox"/> Radio/TV <input type="checkbox"/> Si Mismo <input type="checkbox"/> Feria de Salud <input type="checkbox"/> AHN <input type="checkbox"/> Otro: _____			

APPLICANT ELIGIBILITY INFORMATION

¿Tiene Seguro Médico? Si No Si indico sí, indique el nombre y el tipo de cobertura: _____

Medicare Parte B Si No Medicaid para usted Si No

Número de personas en el hogar: _____ ¿Cuál es el ingreso de su hogar antes de impuestos? Mensual: \$ _____ Anual: \$ _____

APPLICANT MEDICAL HISTORY INFORMATION

<p>Historial de Mama</p> <p>¿Tiene algún problema en los senos? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>Describe: _____</p> <p>¿Tiene implantes de senos? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>¿Ha recibido una mamografía? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>Fecha de la última mamografía (MES/DÍA/AÑO): _____</p> <p>¿Cáncer de mama en la familia? <input type="checkbox"/> Yo <input type="checkbox"/> Madre <input type="checkbox"/> Hija <input type="checkbox"/> Hermana <input type="checkbox"/> Nadie <input type="checkbox"/> No se</p>	<p>Historial Cervical</p> <p>¿Ha recibido un Papanicolaou? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>Fecha de la última prueba de Papanicolaou (MES/DÍA/AÑO): _____</p> <p>Fecha de su último ciclo menstrual(MES/DÍA/AÑO): _____</p> <p>Edad que inicio su menstruación: _____</p> <p>¿Ha tenido una histerectomía? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>¿Si indico sí, la causa fue por tener cáncer cervical? <input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>¿Está recibiendo terapia de reemplazo hormonal? <input type="checkbox"/> Sí <input type="checkbox"/> No</p>
---	---

Historia General

¿Cuál es su estatura actual? _____ ¿Cuál es su peso actual? _____

¿Es usted físicamente activa? Sí No

¿Fuma?: Nunca Sí fumo Antes (Fecha que dejo de fumar (MES/DÍA/AÑO)): _____

¿Está expuesta al humo de segunda mano? Sí No

Si es mayor de 50 años de edad, ¿alguna vez ha recibido la prueba del cáncer colorrectal? Sí No

¿Ha sido diagnosticada con alguna de estas enfermedades?:
 Diabetes Diabetes Gestacional Alta Presión Colesterol Derrame Cerebral Cáncer, Tipo de Cáncer: _____

FOR OFFICE USE ONLY

WHC Member ID: 18 Clinic Name: _____ Date eligible: _____

If client is a current smoker and was referred to 1-800-QUIT-NOW, indicate date (MM/DD/YYYY): _____

Comments:

WHC ENROLLMENT FORM FY18

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network (AHN)

You are completing this form based on your presumptive eligibility for the WHC program. If you are referred to seek insurance coverage through Medicaid or the health exchange marketplace, the WHC program will keep your information and track your insurance status to ensure you receive timely breast and cervical cancer screening. You may receive health promotion and screening reminders from the WHC program.

Should you be determined eligible for this program, you have the following rights and responsibilities:

Participation rights:

- If you meet the WHC's eligibility criteria (age, income and insurance status), you may be eligible to receive a clinic/doctor visit, Pap smear, and clinical breast exam at no cost. Beginning at age 50 years, you may become eligible for a screening mammogram at no cost. Ask your Healthcare Provider to tell you which specific services will be paid by the WHC and how often you may receive them. Your clinic/doctor will let you know when you are due to return for your next Pap test and/or mammogram. Services provided to you that do not follow the WHC's schedule of services may become your financial responsibility
- If you have an abnormal screening test result, the clinic/doctor will work with the WHC to help you obtain further diagnostic tests. The WHC does not pay for treatment but will assist you with the referral for treatment. Your health care provider at the clinic or your doctor can tell you which specific services the WHC can pay for and those that are not covered
- Case management services through WHC if any abnormal results are found in order to receive timely and appropriate diagnostic and treatment services
- Provide client feedback. You are encouraged to contact the WHC program at any time. You may also receive questionnaires from WHC program. Please take time to complete and return client questionnaires.

Participation responsibilities:

- Sign the *Client Refusal Form* to refuse procedures/treatment that go against the doctors recommendations
- Update contact information as it changes so the WHC may send mail, email, phone, or text message screening appointment reminders, health and scheduled service information
- Provide consent for the release of my medical information from my doctor, clinic, laboratory, radiology unit and/or hospital to the WHC. Identifying information such as name, address, social security number, and/or other identifying information will only be used by this program. It may be used to let me know if I need follow up exams. Other information may be used for studies done by the WHC to learn more about women's health. These studies will not use any name or other identifying information
- Follow-up with clinic/doctor if there are abnormal results and to participate in additional diagnostic procedures until a final diagnosis is reached.

Usted está llenando este formulario basado en su presunta elegibilidad para el programa Mujeres en Conexión Para la Salud (WHC, por sus siglas en Ingles). Si usted es referido a buscar cobertura de seguro a través de Medicaid o el mercado de cambio de la salud, el programa WHC mantendrá su información y el seguimiento de su estado de seguro para asegurarse de que usted reciba la detección del cáncer de cuello uterino y de mama a tiempo. Usted puede que reciba promociones de salud y recordatorios de detección del programa WHC.

En caso de estar determinado elegible para este programa, usted tiene los siguientes derechos y responsabilidades:

Derechos del participante:

- Si usted cumple con los criterios de elegibilidad del WHC (edad, ingresos y estado de seguro médico), usted puede ser elegible para recibir una visita a la clínica/médico, prueba de Papanicolaou y examen clínico de mama, sin costo alguno. A partir de los 50 años de edad, usted puede ser elegible para una mamografía sin costo alguno. Pregunte a su proveedor de atención médica que le diga qué servicios específicos serán pagados por el WHC y con qué frecuencia los recibirá. Su clínica / médico le hará saber cuándo este programado para volver a su próxima prueba de Papanicolaou y / o mamografía. Servicios prestados a usted que no siguen el programa de WHC pueden llegar a ser su responsabilidad financiera.
- Si usted tiene un resultado anormal de la prueba de detección, la clínica /médico trabajará con WHC para ayudarle a obtener más pruebas de diagnóstico. WHC no paga por el tratamiento, pero le ayudará con la remisión para el tratamiento. Su proveedor de atención médica en la clínica le puede decir cuales servicios específicos WHC puede pagar y los que no están cubiertos.
- Servicios de manejo del caso a través de WHC si se encuentra algún resultado anormal con el fin de recibir los servicios apropiados de diagnóstico y tratamiento.
- Proporcionar reacción o comentarios de los clientes. Se le alienta a ponerse en contacto con el programa WHC en cualquier momento. También puede recibir cuestionarios del programa WHC. Por favor, tómese el tiempo para completar y devolver los cuestionarios al cliente.

Responsabilidades del participante:

- Firmar el formulario de Rechazo de cliente para rechazar procedimientos/ tratamientos que van en contra de las recomendaciones de los médicos.
- Actualizar la información de contacto a medida que cambia así el programa WHC puede enviar correo, correos electrónicos, mensajes de texto con información de salud y recordatorios de citas o servicio programado.
- Proporcionar consentimiento para la liberación de mi información médica de mi médico, clínica, laboratorio, unidad de radiología y / o en el hospital a WHC. Información de identificación, tales como nombre, dirección, número de seguro social, y / u otra información de identificación sólo será utilizada por este programa. Puede ser utilizado para hacerme saber si se necesita dar un seguimiento con exámenes. Otra información se puede usar para estudios realizados por el programa WHC para aprender más sobre la salud de la mujer. Estos estudios no utilizarán ningún nombre u otra información de identificación.
- Dar seguimiento con la clínica/médico si hay resultados anormales y hay que participar en los procedimientos de diagnóstico adicionales hasta que se alcance un diagnóstico final.

I authorize WHC to send text message screening reminders to me on my provided cell phone number. Text message charges from my cell phone provider may apply./Autorizó a WHC enviar recordatorios de detección de mensajes de texto mi número de teléfono celular proporcionado. Se pueden aplicar cargos adicionales por mensajes de texto por la compañía de mi teléfono celular. YES/SÍ No

I understand that knowingly providing false information could jeopardize my enrollment in the program. I have read and understand the explanation above about the WHC. My signature verifies my consent to participate in the program and that I meet the eligibility information. I understand that my participation in the program is voluntarily and I may drop out of the program and withdraw my consent at any time./Entiendo que al dar información falsa podría poner en peligro mi inscripción en el programa. He leído y entendido la explicación anterior sobre el programa de Mujeres en Conexión Para la Salud. Mi firma verifica mi consentimiento para participar en el programa y que cumpla con la información de elegibilidad. Entiendo que mi participación en el programa es voluntaria y que puede abandonar el programa y retirar mi consentimiento en cualquier momento.

Signature of Applicant/Firma del Apicante:

Date/Fecha:

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network

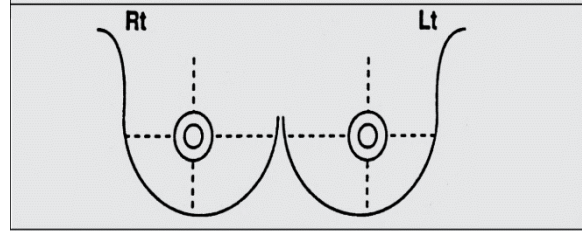
ANNUAL SCREENING VISIT FORM

Last Name: _____ First: _____ Date of birth: _____
(MM/DD/YYYY)

CLINICAL BREAST EXAM (CBE) FINDINGS

- Does client have breast symptoms? Yes No
- Normal
 - Benign (fibrocystic changes, pain & tenderness)
 - Discrete palpable mass-previous diagnosed as benign
 - Not performed (Explain in notes)
 - Refused

Please indicate abnormality and size on diagram below



- *Bloody/serous nipple discharge
 - *Discrete palpable mass-suspicious for cancer
 - *Nipple/areolar scaliness
 - *Skin dimpling/retraction
- * Diagnostic services (Mammogram and/or Ultrasound must be completed first before referral to specialist)**
- Confirmation of Breast Cancer Diagnosis

REASON FOR IMAGING (PLEASE REMIND CLIENT TO SCHEDULE APPT. WITHIN 60 DAYS)

- Did client have previous screening mammogram? Yes No Date (MM/DD/YYYY): _____ Location: _____
- Routine screening mammogram (**Only for clients age 50+**)
 - Diagnostic mammogram and/or ultrasound (**Only for clients age 40+ with an abnormal CBE results**)
 - Diagnostic mammogram (**Only for clients age 40+ with an abnormal CBE results**)
 - Ultrasound (**Only for clients age 40+ with an abnormal CBE results**)
 - Imaging done outside WHC, client referred for diagnostic services only Referral Date (MM/DD/YYYY): _____
Imaging results: _____

Notes:

PELVIC EXAM FINDINGS

- Has the client had a hysterectomy? Yes No If yes, is the cervix present? Yes No
- Was the hysterectomy due to CIN or invasive cervical cancer Yes No
- Normal
 - Abnormal: Not Suspicious for cervical cancer (Explain in notes)
 - Not performed (Explain in notes)
 - Not indicated or not needed
 - Refused
 - Abnormal: Suspicious for cervical cancer-**must be referred to Specialist**
 - Cervical Polyp
 - Client is pregnant, EDC (MM/DD/YYYY): _____

REASON FOR PAP/HPV TEST

- Previous Pap test? Yes No Unknown Date (MM/DD/YYYY): _____ Result: _____
- Routine screening Co-test – Pap and HPV test (Every 5 years)
 - Routine screening Pap test (Every 3 years)
 - Client under surveillance for a previous abnormal test
 - Co-test/Pap done outside WHC, client referred for diagnostic services only Referral Date (MM/DD/YYYY): _____
Test result(s): _____
 - No test performed – Pap/HPV test not due
 - Refused
 - Not ordered (Explain in notes)

Notes:

PLEASE FAX ALL ABNORMAL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918

Clinician's Signature: _____ Date of Service (MM/DD/YYYY): _____

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received:

CaST ID#:

Date entered:

0	3	2	0	0	1														
---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CERVICAL EXPANSION 21-39 YEARS OLD

WHC ENROLLMENT FORM FY18

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

APPLICANT ENROLLMENT INFORMATION

SSN: _____ DOB: _____ Age: _____ Birth Place: _____

Last Name: _____ First: _____ Middle Initial: _____ Maiden Name: _____

Street address: _____ City: _____ State: **NV** Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____ Highest grade completed (Circle one): 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Occupation: _____ Industry: _____ Marital status: Single Married Divorced Separated Widowed

Hispanic: Yes No Language: English Spanish Other: _____ Race: White Black American Indian Asian Eskimo Native Hawaiian Pacific Islander Other: _____

How did you hear about our Program? Doctor Family/friend Radio/TV Self Health Fair AHN Other: _____

APPLICANT ELIGIBILITY INFORMATION

Do you have Medical Insurance? Yes No If yes, list name and coverage: _____

Medicare Part B Yes No Medicaid for yourself Yes No

Number of people in household: _____ What is your household income before taxes? Monthly: \$ _____ Yearly: \$ _____

APPLICANT MEDICAL HISTORY INFORMATION

Cervical History

Have you ever had a Pap test? Yes No
Date of last Pap test (MM/DD/YYYY): _____
Date of last menstrual period (MM/DD/YYYY): _____
Age menses started: _____
Hysterectomy? Yes No
If yes, was hysterectomy due to cervical cancer? Yes No
Are you on any hormone replacement therapy? Yes No

General History

What is your current height? _____ What is your current weight? _____
Are you physically active? Yes No
Smoking Status: Never Current Former (Date quit MM/DD/YYYY)
Are you exposed to secondhand smoke? Yes No
If you are over 50 years of age, have you ever been screened for colorectal cancer Yes No
Have you diagnosed with any of these illnesses:
Diabetes Gestational Diabetes High Blood Pressure High Cholesterol Stroke Cancer, type of cancer: _____

FOR OFFICE USE ONLY

Member ID: 18 cer Clinic Name: _____ Date Eligible: _____

nt is a current smoker and was referred to 1-800-QUIT-NOW, indicate date (MM/DD/YYYY): _____

Comments:

CERVICAL EXPANSION 21-39 YEARS OLD

WHC ENROLLMENT FORM FY18

WOMEN'S HEALTH CONNECTION (WHC) IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

APPLICANT ENROLLMENT INFORMATION

Numero de Seguro Social: _____ Fecha de Nacimiento(MES/DIA/AÑO): _____ Edad: _____ Lugar de Nacimiento: _____

Apellido: _____ Primer Nombre: _____ Inicial: _____ Apellido de Soltera: _____

Dirección: _____ Ciudad: _____ Estado: **NV** Código Postal: _____

Telefono de Casa: _____ Telefono de Trabajo: _____ Celular: _____

Correo Electronico: _____ Educación más alta (Circule uno): 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

Ocupación: _____ Industria: _____ Estado Civil: Soltera Casada Divorciada Separada Viuda

Origen Hispano: Si No Idioma: Ingles Español Raza: Blanco Negro Indio Americano/Nativo de Alaska
 Asiático Nativo de Hawaii Isleño del Pacifico Otra: _____

¿Cómo se enteró de este programa? Doctor Familiar/Amigo Radio/TV Si Mismo Feria de Salud AHN Otro: _____

APPLICANT ELIGIBILITY INFORMATION

¿Tiene Seguro Médico? Si No Si indico sí, indique el nombre y el tipo de cobertura: _____

Medicare Parte B Si No Medicaid para usted Si No

Número de personas en el hogar: _____ ¿Cuál es el ingreso de su hogar antes de impuestos? Mensual:\$ _____ Anual:\$ _____

APPLICANT MEDICAL HISTORY INFORMATION

Historial Cervical

¿Ha recibido un Papanicolaou? Sí No
Fecha de la última prueba de Papanicolaou (MES/DÍA/AÑO): _____
Fecha de su último ciclo menstrual(MES/DÍA/AÑO): _____
Edad que inicio su menstruación: _____
¿Ha tenido una histerectomía? Sí No
¿Si indico sí, la causa fue por tener cáncer cervical? Sí No
¿Está recibiendo terapia de reemplazo hormonal? Sí No

Historia General

¿Cuál es su estatura actual? _____ ¿Cuál es su peso actual? _____
¿Es usted físicamente activa? Sí No
¿Fuma?: Nunca Sí fumo Antes (Fecha que dejo de fumar (MES/DÍA/AÑO)): _____
¿Está expuesta al humo de segunda mano? Sí No
Si es mayor de 50 años de edad, ¿alguna vez ha recibido la prueba del cáncer colorrectal? Sí No
¿Ha sido diagnosticada con alguna de estas enfermedades?:
 Diabetes Diabetes Gestacional Alta Presión Colesterol Derrame Cerebral Cáncer, Tipo de Cáncer: _____

FOR OFFICE USE ONLY

WHC Member ID: 18 cer Clinic Name: _____ Date Eligible: _____

If client is a current smoker and was referred to 1-800-QUIT-NOW, indicate date (MM/DD/YYYY): _____

Comments:

CERVICAL EXPANSION 21-39 YEARS OLD

WHC ENROLLMENT FORM FY18

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network (AHN)

You are completing this form based on your presumptive eligibility for the WHC program. If you are referred to seek insurance coverage through Medicaid or the health exchange marketplace, the WHC program will keep your information and track your insurance status to ensure you receive timely breast and cervical cancer screening. You may receive health promotion and screening reminders from the WHC program.

Should you be determined eligible for this program, you have the following rights and responsibilities:

Participation rights:

- If you meet the WHC's eligibility criteria (age, income and insurance status), you may be eligible to receive a clinic/doctor visit, pelvic exam and Pap smear at no cost. Ask your Healthcare Provider to tell you which specific services will be paid by the WHC and how often you may receive them. Your clinic/doctor will let you know when you are due to return for your next Pap test and/or mammogram. Services provided to you that do not follow the WHC's schedule of services may become your financial responsibility
- If you have an abnormal screening test result, the clinic/doctor will work with the WHC to help you obtain further diagnostic tests. The WHC does not pay for treatment but will assist you with the referral for treatment. Your health care provider at the clinic or your doctor can tell you which specific services the WHC can pay for and those that are not covered
- Case management services through the WHC if any abnormal results are found in order to receive timely and appropriate diagnostic and treatment.
- Provide client feedback. You are encouraged to contact the WHC program at any time. You may also receive questionnaires from WHC program. Please take time to complete and return client questionnaires.

Participation responsibilities:

- Sign the *Client Refusal Form* to refuse procedures/treatment that go against the doctors recommendations
- Update contact information as it changes so the WHC may send mail, email, phone, or text message screening appointment reminders, health and scheduled service information
- Provide consent for the release of my medical information from my doctor, clinic, laboratory, radiology unit and/or hospital to the WHC. Identifying information such as name, address, social security number, and/or other identifying information will only be used by this program. It may be used to let me know if I need follow up exams. Other information may be used for studies done by the WHC to learn more about women's health. These studies will not use any name or other identifying information
- Follow-up with clinic/doctor if there are abnormal results and to participate in additional diagnostic procedures until a final diagnosis is reached.

Usted está llenando este formulario basado en su presunta elegibilidad para el programa Mujeres en Conexión Para la Salud (WHC, por sus siglas en Ingles). Si usted es referido a buscar cobertura de seguro a través de Medicaid o el mercado de cambio de la salud, el programa WHC mantendrá su información y el seguimiento de su estado de seguro para asegurarse de que usted reciba la detección del cáncer de cuello uterino y de mama a tiempo. Usted puede que reciba promociones de salud y recordatorios de detección del programa WHC.

En caso de estar determinado elegible para este programa, usted tiene los siguientes derechos y responsabilidades:

Derechos del participante:

- Si usted cumple con los criterios de elegibilidad del WHC (edad, ingresos y estado de seguro médico), usted puede ser elegible para recibir una visita a la clínica/médico, examen pélvico y prueba de Papanicolaou sin costo alguno. Pregunte a su proveedor de atención médica que le diga qué servicios específicos serán pagados por el WHC y con qué frecuencia los recibirá. Su clínica / médico le hará saber cuándo este programado para volver a su próxima prueba de Papanicolaou. Servicios prestados a usted que no siguen el programa de WHC pueden llegar a ser su responsabilidad financiera.
- Si usted tiene un resultado anormal de la prueba de detección, la clínica / médico trabajará con WHC para ayudarle a obtener más pruebas de diagnóstico. WHC no paga por el tratamiento, pero le ayudará con la remisión para el tratamiento. Su proveedor de atención médica en la clínica o su médico le puede decir cuales servicios específicos WHC puede pagar y los que no están cubiertos.
- Servicios de manejo del caso a través de WHC si se encuentra algún resultado anormal con el fin de recibir los servicios apropiados de diagnóstico y tratamiento.
- Proporcionar reacción o comentarios de los clientes. Se le alienta a ponerse en contacto con el programa WHC en cualquier momento. También puede recibir cuestionarios del programa WHC. Por favor, tómese el tiempo para completar y devolver los cuestionarios al cliente.

Responsabilidades del participante:

- Firmar el formulario de Rechazo de cliente para rechazar procedimientos/ tratamientos que van en contra de las recomendaciones de los médicos.
- Actualizar la información de contacto a medida que cambia así el programa WHC puede enviar correo, correos electrónicos, mensajes de texto con información de salud y recordatorios de citas o servicio programado.
- Proporcionar consentimiento para la liberación de mi información médica de mi médico, clínica, laboratorio, unidad de radiología y / o en el hospital a WHC. Información de identificación, tales como nombre, dirección, número de seguro social, y / u otra información de identificación sólo será utilizada por este programa. Puede ser utilizado para hacerme saber si se necesita dar un seguimiento con exámenes. Otra información se puede usar para estudios realizados por el programa WHC para aprender más sobre la salud de la mujer. Estos estudios no utilizarán ningún nombre u otra información de identificación.
- Dar seguimiento con la clínica/médico si hay resultados anormales y hay que participar en los procedimientos de diagnóstico adicionales hasta que se alcance un diagnóstico final.

I authorize WHC to send text message screening reminders to me on my provided cell phone number. Text message charges from my cell phone prov apply./Autorizó a WHC enviar recordatorios de detección de mensajes de texto mi número de teléfono celular proporcionado. Se pueden aplicar car; adicionales por mensajes de texto por la compañía de mi teléfono celular. YES/Sí No

I understand that knowingly providing false information could jeopardize my enrollment in the program. I have read and understand the explanation at the WHC. My signature verifies my consent to participate in the program and that I meet the eligibility information. I understand that my participation program is voluntarily and I may drop out of the program and withdraw my consent at any time./Entiendo que al dar información falsa podría poner en inscripción en el programa. He leído y entendido la explicación anterior sobre el programa de Mujeres en Conexión Para la Salud. Mi firma verifica mi consentimiento para participar en el programa y que cumplo con la información de elegibilidad. Entiendo que mi participación en el programa es volun puede abandonar el programa y retirar mi consentimiento en cualquier momento.

Signature of Applicant/Firma del Apicante:

Date/Fecha:

ANNUAL SCREENING VISIT FORM
WOMEN AGES 21-39

Last Name: _____ First: _____ Date of birth: _____
(MM/DD/YYYY)

Client must be age 21-39 or above to receive these services. Medical history can be found on the
Presumptive Eligibility Enrollment Form.

PELVIC EXAM FINDINGS

Has the client had a hysterectomy? Yes No If yes, is the cervix present? Yes No
Was the hysterectomy due to CIN or invasive cervical cancer Yes No

- Normal
- Abnormal: Not Suspicious for cervical cancer (Explain in notes)
- Not performed (Explain in notes)
- Not indicated or not needed
- Refused
- ABNORMAL: SUSPICIOUS FOR CERVICAL CANCER-
MUST BE REFERRED TO SPECIALIST
- Cervical Polyp
- Client is pregnant, EDC
(MM/DD/YYYY): _____

REASON FOR PAP/HPV TEST

Previous Pap test? Yes No Unknown

Date (MM/DD/YYYY): _____

Result: _____

- Routine screening Co-test – Pap and HPV test (Every 5 years for women ages 30-39 only)
- Routine screening Pap test (Every 3 years)
- Client under surveillance for a previous abnormal test
- Co-test/Pap done outside WHC, client referred for diagnostic services only
Referral Date (MM/DD/YYYY): Test
result(s):
- No test performed – Pap/HPV test not due
- Refused
- Not ordered (Explain in notes)

Notes:

BILLING CPT CODES

New Patient

- 99201** New Patient; history, exam, straightforward decision-making; 10 minutes
- 99202** New Patient; expanded history, exam, straightforward decision-making; 20 minutes

Established Patient

- 99211** Established Patient; evaluation and management, may not require presence of physician; 5 min
- 99212** Established Patient; history, exam, straightforward decision-making; 10 min
- 99213** Established Patient; expanded history, exam, low complexity decision-making; 15 min

PLEASE FAX ALL ABNORMAL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918

Clinician's Signature: _____ Date of Service (MM/DD/YYYY): _____

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received:

CaST ID#:

Date entered:

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MAMMOGRAPHY AND ULTRASOUND REFERRAL FORM

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Last Name: _____

First: _____

Date of birth: (MM/DD/YYYY) _____

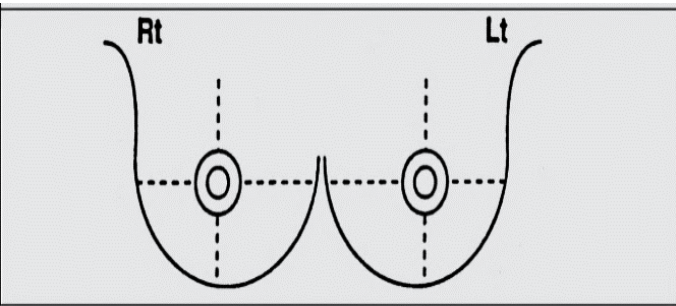
Age: _____ WHC Member ID: 18 _____

Date of Appt.: (MM/DD/YYYY) _____

Imaging Facility: _____

CLINICAL BREAST EXAM (CBE) FINDINGS

Please indicate abnormality and size on diagram below



CBE Results:

- Normal
- Benign (fibrocystic changes, pain & tenderness)
- Bloody/serous nipple discharge
- Discrete palpable mass-suspicious for cancer
- Discrete palpable mass-previous diagnosed as benign
- Nipple/areolar scaliness
- Not performed (Explain in notes)
- Refused
- Skin dimpling/retraction

Primary Care Provider: _____

Date of CBE (MM/DD/YYYY): _____

REASON FOR IMAGING

Did client have previous screening mammogram? Yes No

Date of mammogram (MM/DD/YYYY): _____ Location: _____

- Routine screening mammogram (**Only for clients age 50+**)
- Diagnostic mammogram and/or ultrasound (**Only for clients age 40+ with an abnormal CBE results**)
- Diagnostic mammogram (**Only for clients age 40+ with an abnormal CBE results**)
- Ultrasound (**Only for clients age 40+ with an abnormal CBE results**)
- Mammary ductogram or galactogram
- Imaging done outside WHC, client referred for diagnostic services only Referral Date (MM/DD/YYYY): _____
- Imaging results:
 - Additional Mammographic Views
 - Film comparison to evaluate and Assessment Incomplete Mammogram

PRIMARY CARE PROVIDER MUST GIVE CLIENT A COPY OF THIS FORM TO TAKE TO APPOINTMENT

Ordering Clinician Signature: _____

Issue Date (MM/DD/YYYY): _____

PLEASE FAX ALL ABNORMAL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received:

CaST ID#:

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Date entered:

BREAST SPECIALIST REFERRAL FORM

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Last Name: _____ First: _____ Date of birth: _____
(MM/DD/YYYY)

Primary Care Provider: _____ Phone#: (____) _____ Fax#: (____) _____

CONTACT A WHC CARE COORDINATOR TO SCHEDULE AN APPOINTMENT WITH THE SPECIALIST AT 844-469-4930

Specialist Name: _____ Date of Appt. (MM/DD/YYYY): _____

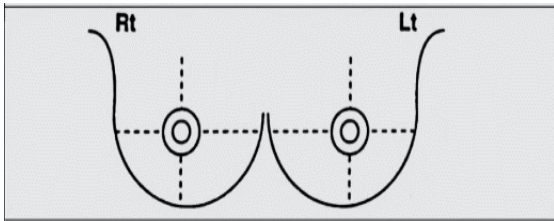
CLINICAL BREAST EXAM (CBE) AND DIAGNOSTIC EVALUATION FINDINGS

CBE Results:

- Normal
- Benign (including fibrocystic changes)
- Discrete palpable mass-suspicious for cancer
- Bloody/serous nipple discharge
- Nipple/areolar scaliness
- Skin dimpling/retraction

Date of CBE (MM/DD/YYYY): _____

Please indicate abnormality and size on diagram below



Imaging Results:

- Diagnostic Mammogram/Ultrasound
- BI-RADS 0 BI-RADS 4
- BI-RADS 1 BI-RADS 5
- BI-RADS 2 Unsatisfactory result
- BI-RADS 3

Date of Imaging (MM/DD/YYYY): _____

Notes:

Primary Clinician Signature: _____ Date (MM/DD/YYYY): _____

TO BE COMPLETED BY SPECIALIST FOR EACH OFFICE VISIT

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Consult Repeat CBE

<input type="checkbox"/> Normal exam
<input type="checkbox"/> Benign
<input type="checkbox"/> Discrete palpable mass-suspicious for Cancer
<input type="checkbox"/> Bloody/serous nipple discharge
<input type="checkbox"/> Nipple/Areolar scaliness
<input type="checkbox"/> Skin dimpling/retraction

Date of Service (MM/DD/YYYY): _____

_____ | <input type="checkbox"/> Surgical Consultation

<input type="checkbox"/> Review results/discuss f/up
<input type="checkbox"/> Biopsy/FNA recommended
<input type="checkbox"/> No intervention-Routine f/up
<input type="checkbox"/> Short term f/up in _____ months
<input type="checkbox"/> Surgery or TX recommended

Date of Service (MM/DD/YYYY): _____

_____ | <input type="checkbox"/> Diagnostic Procedures recommended/performed

<input type="checkbox"/> Cyst Aspiration
<input type="checkbox"/> Fine Needle Aspiration (FNA)
<input type="checkbox"/> Fine Needle Aspiration with imaging
<input type="checkbox"/> Percutaneous vacuum biopsy with imaging
<input type="checkbox"/> Needle Core Biopsy
<input type="checkbox"/> Needle Core Biopsy with imaging
<input type="checkbox"/> Stereotactic Biopsy
<input type="checkbox"/> Excisional Biopsy
<input type="checkbox"/> *Ultrasound
<input type="checkbox"/> Ductogram or Galactogram
<input type="checkbox"/> *MRI
*Prior authorization required

Date of Service (MM/DD/YYYY): _____ | <input type="checkbox"/> Final Diagnosis

<input type="checkbox"/> Cancer not diagnosed-follow routine screening
<input type="checkbox"/> Lobular carcinoma in situ (LCIS)
<input type="checkbox"/> Ductal carcinoma in situ (DCIS)
<input type="checkbox"/> Invasive cancer
<input type="checkbox"/> Cancer not diagnosed-short term f/up in _____ months
<input type="checkbox"/> Cancer not diagnosed-short term f/up in _____ months with mammogram and/or ultrasound

Date of Service (MM/DD/YYYY): _____ |
|---|---|--|--|

Treatment Status:

- Treatment not needed
 - Treatment started
 - Treatment refused
- Treatment Facility: _____

Notes:

Specialist Signature: _____ Date (MM/DD/YYYY): _____

PLEASE FAX ALL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918 and to referring physician

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received: _____

CaST ID#:

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Date entered: _____

CERVICAL SPECIALIST REFERRAL FORM

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Last Name: _____ First: _____ Date of birth: _____
 (MM/DD/YYYY)
 Primary Care Provider: _____ Phone#: (____) _____ Fax#: (____) _____

Contact WHC Care Coordinator to schedule appointment with Specialist at 844-469-4930

Specialist Name: _____ Date of Appt. (MM/DD/YYYY): _____
 Specialist Phone#: (____) _____ Specialist Fax#: (____) _____

PELVIC EXAM AND PAP FINDINGS

Has the client had a hysterectomy? Yes No
 If yes, is the cervix present? Yes No
 Was the hysterectomy due to CIN or invasive cervical cancer
 Yes No

Pelvic Exam Results:

- Normal
- Not performed (Explain in notes)
- Abnormal cervix-Suspicious for Cervical Cancer
- Abnormal cervix-Not suspicious for Cervical Cancer
- Not performed (Explain in notes)
- Not indicated or not needed
- Refused

Date of Pelvic Exam (MM/DD/YYYY): _____
 Notes: _____

Cytology Results:

- Pap Specimen Type: Liquid Conventional
- Negative for intraepithelial lesion or malignancy
 - ASC-US
 - Low Grade SIL (LSIL)
 - AGC
 - ASC-H
 - High Grade SIL (HSIL)
 - Squamous Cell Carcinoma
 - Adenocarcinoma

Date of Pap (MM/DD/YYYY): _____
 HPV Test: Negative Positive Not done
 Date of HPV Test (MM/DD/YYYY): _____

Primary Clinician Signature: _____ Date (MM/DD/YYYY): _____

TO BE COMPLETED BY SPECIALIST FOR EACH OFFICE VISIT

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Repeat Pelvic Exam

<input type="checkbox"/> Normal exam
<input type="checkbox"/> Suspicious for Cancer
<input type="checkbox"/> Not Suspicious for Cancer
<input type="checkbox"/> Other

Date of Service (MM/DD/YYYY): _____

_____ | <input type="checkbox"/> Gynecologic Consultation

<input type="checkbox"/> Review results/discuss f/up
<input type="checkbox"/> Biopsy recommended
<input type="checkbox"/> No intervention-Routine f/up
<input type="checkbox"/> Short term f/up in ____ months
<input type="checkbox"/> Surgery or TX recommended

Date of Service (MM/DD/YYYY): _____

_____ | <input type="checkbox"/> Diagnostic Procedures recommended/performed

<input type="checkbox"/> Colposcopy without Biopsy
<input type="checkbox"/> Colposcopy with Biopsy
<input type="checkbox"/> Colposcopy with ECC
<input type="checkbox"/> *LEEP
<input type="checkbox"/> *CKC
<input type="checkbox"/> *Endometrial Biopsy
<input type="checkbox"/> Excision of Endocervical Polyp(s)

* Prior authorization required

Date of Service (MM/DD/YYYY): _____ | <input type="checkbox"/> Final Diagnosis

<input type="checkbox"/> Normal/Benign Reaction/Inflammation
<input type="checkbox"/> HPV/Condylomata/Atypia
<input type="checkbox"/> CIN I
<input type="checkbox"/> CIN II
<input type="checkbox"/> CIN III
<input type="checkbox"/> Low Grade SIL (LSIL)
<input type="checkbox"/> High Grade SIL (HSIL)
<input type="checkbox"/> Invasive Carcinoma
<input type="checkbox"/> Other
<input type="checkbox"/> Short term f/up in _____ months

Date of Service (MM/DD/YYYY): _____ |
|--|---|--|--|

Treatment Status:

- Treatment not needed
- Treatment refused
- Treatment started Date Treatment started (MM/DD/YYYY): _____
 Treatment Facility: _____

Notes: _____

Specialist Signature: _____ Date (MM/DD/YYYY): _____

PLEASE FAX ALL RESULTS TO WHC CARE COORDINATOR WITHIN 48 HOURS AT 775-284-1918 and to referring physician

WOMEN'S HEALTH CONNECTION OFFICE USE ONLY

Date received: _____ CaST ID#: _____

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 Date entered: _____



access to HEALTHCARE

Please do not schedule the surgery/procedure until you have received the processed referral back from WHC

PATIENT INFORMATION

Name:	DOB:
--------------	-------------

Today's Date:	Verification of insurance status: <input type="checkbox"/> Medicaid <input type="checkbox"/> Amerigroup <input type="checkbox"/> HPN <input type="checkbox"/> Uninsured
---------------	--

SURGERY INFORMATION

Surgeon:

Name of Facility/Surgery Center:

Expected Date of Surgery:

Name of Surgery/Procedure:

CPT Code(s):	<input type="checkbox"/> Global Period _____ days <input type="checkbox"/> No Global
--------------	--

Reason for Surgery/Procedure:

WHC Anesthesia Group: CPT code: 00400	Length of Surgery:
--	--------------------

Preoperative Testing CPT Codes:

WHC Pathology Provider:

PROVIDER OFFICE INFORMATION

Requesting Clinician:	Phone:
-----------------------	--------

Clinical Signature:

PLEASE FAX COMPLETED FORM TO 775-284-1918 FOR WHC APPROVAL

Fax Attn: Sandra Griselda Ivy Mariela Jaime

<input type="checkbox"/> Approved	
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<input type="checkbox"/> Denied	
---------------------------------	--

Care Coordinator	Date:
Michelle Kling, RN	Date:

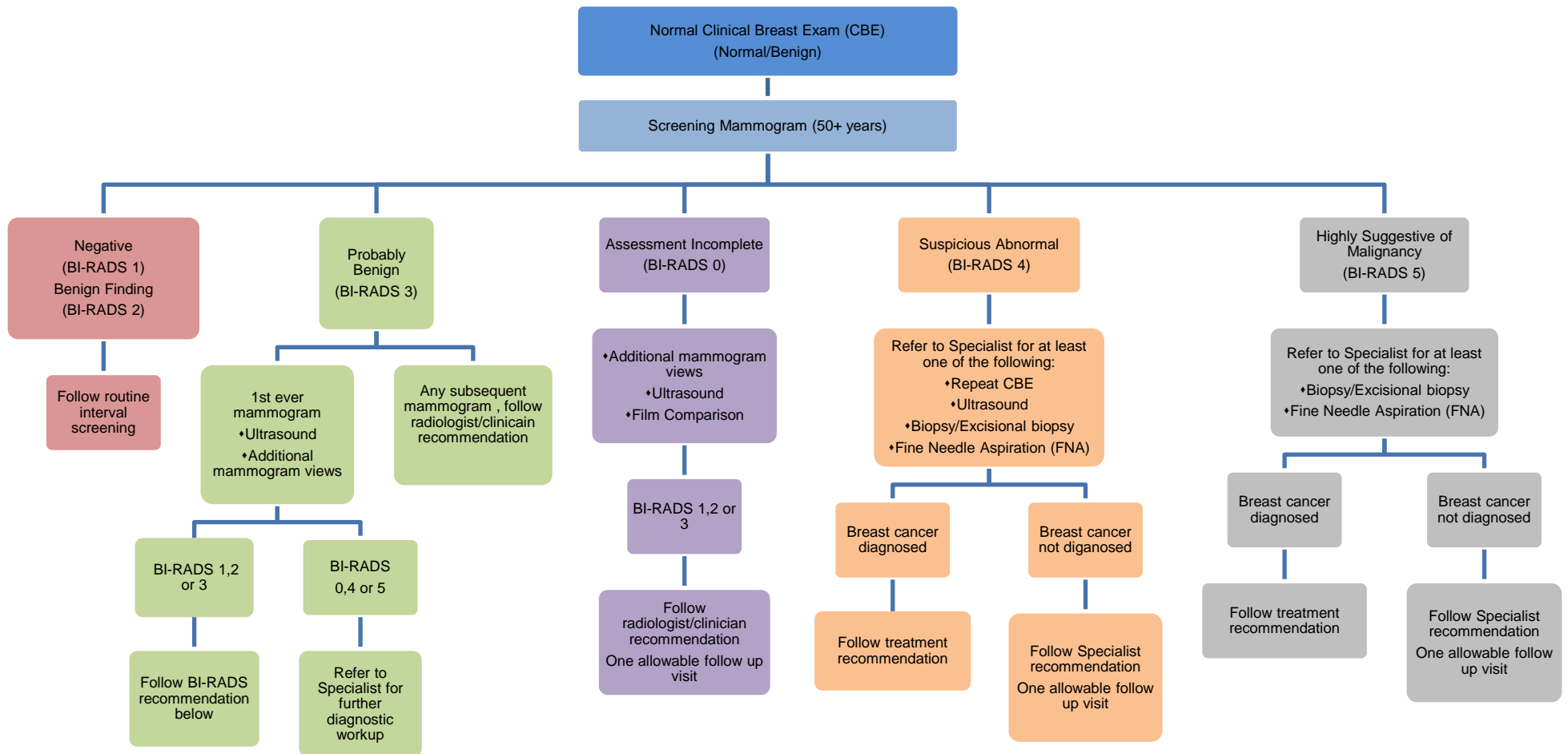
I, the undersigned, do attest that the above information is accurate and the above surgery/procedure conforms to the standard of care and is in compliance with the policies and procedures of the Women's Health Connection program.

State ID #

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State of Nevada – Women’s Health Connection Program in Partnership with Access to Healthcare Network

Normal Clinical Breast Exam (CBE) Algorithm

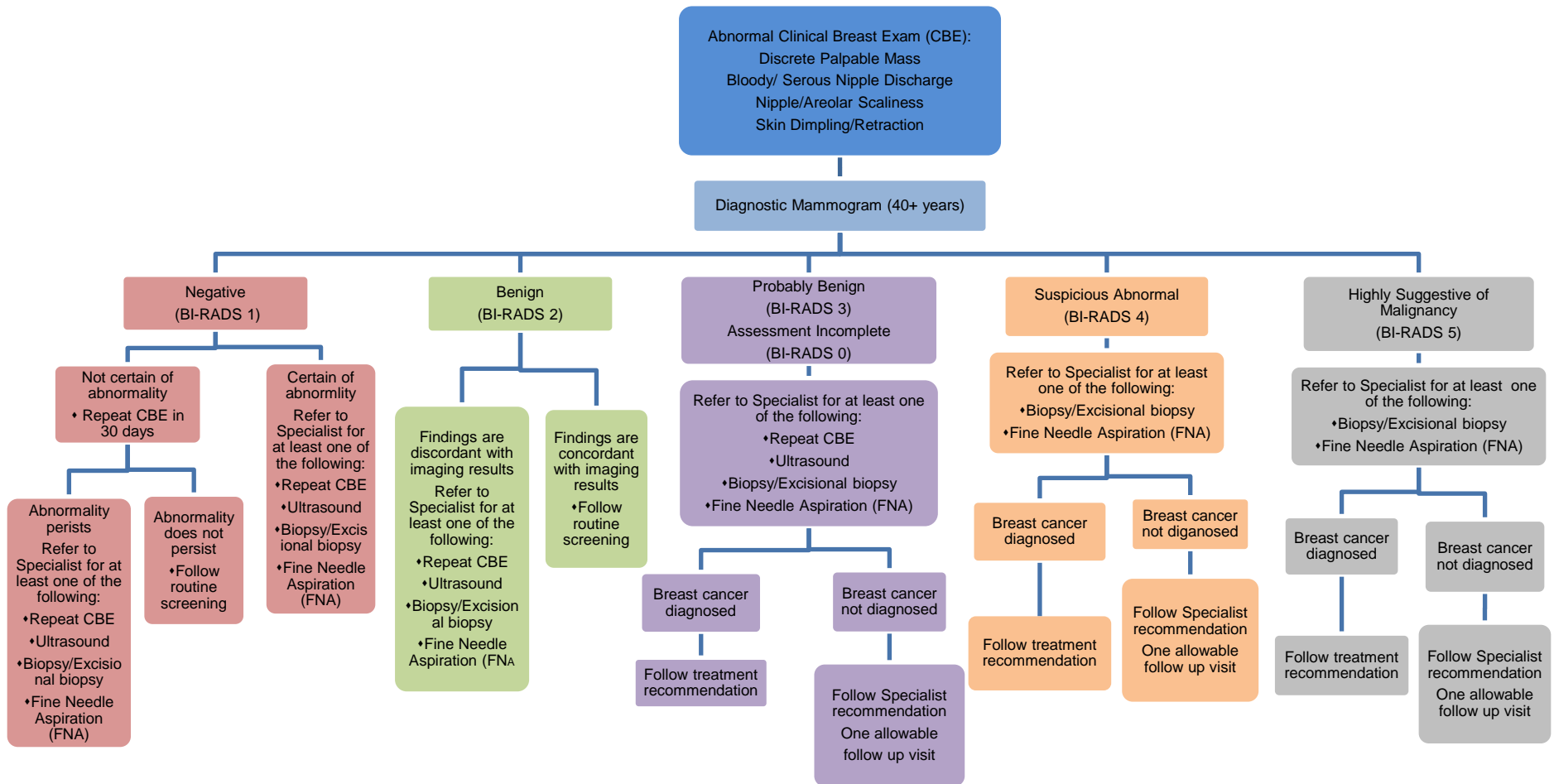


Breast Imaging Report and Data System (BI-RADS) was developed by the American College of Radiology (ACR) to standardize mammography reports. It is also used for breast ultrasound and MRI.

- BI-RADS Category 0 (Assessment is Incomplete) — Used for indicating that further tests and/or records are needed before a final assessment category can be assigned.
- BI-RADS Category 1 (Negative) — Continue routine interval screening.
- BI-RADS Category 2 (Benign Findings) — Continue routine interval screening.
- BI-RADS Category 3 (Probably Benign) — Initial short-interval follow-up examination, usually in 6 months, followed by another examination in 6 months, then annually until stability is demonstrated for a minimum of 2 to 3 years. Women at increased risk should be referred to a breast specialist. Category 3 is not recommended for screening mammograms; it is intended for use with diagnostic mammograms only.
- BI-RADS Category 4 (Suspicious Abnormality) — Requires an intervention, usually biopsy.
- BI-RADS Category 5 (Highly Suggestive of Malignancy) — Requires biopsy.

State of Nevada – Women’s Health Connection Program in Partnership with Access to Healthcare Network

Abnormal Clinical Breast Exam (CBE) Algorithm



Breast Imaging Report and Data System (BI-RADS) were developed by the American College of Radiology (ACR) to standardize mammography reports. It is also used for breast ultrasound and MRI.

BI-RADS Category 0 (Assessment is Incomplete) — Used for indicating that further tests and/or records are needed before a final assessment category can be assigned.

BI-RADS Category 1 (Negative) — Continue routine interval screening

BI-RADS Category 2 (Benign Findings) — Continue routine interval screening

BI-RADS Category 3 (Probably Benign) — Initial short-interval follow-up examination, usually in 6 months, followed by another examination in 6 months, then annually until stability is demonstrated for a minimum of 2 to 3 years. Women at increased risk should be referred to a breast specialist. Category 3 is not recommended for screening mammograms only

BI-RADS Category 4 (Suspicious Abnormality) — Requires intervention, usually biopsy

BI-RADS Category 5 (Highly Suggestive of Malignancy) — Requires biopsy

State of Nevada – Women’s Health Connection Program in Partnership with Access to Healthcare Network Pelvic Exam Algorithm





Women's Health Connection Program (WHC) in Partnership with Access to Healthcare Network

Client Refusal Form

Date: __/__/____ (MM/DD/YYYY)

Client Name: _____

Date of Birth: __/__/____ (MM/DD/YYYY)

SSN: ____-____-____

I, _____, have been informed by my doctor that I should have the procedure/treatment described below.

Name of procedure/treatment:

I am refusing this procedure/treatment because:

- I have had the need for this procedure/treatment explained to me.
- I know that not having this procedure/treatment at this time is against my doctor's advice and may be harmful to my health. My abnormality may lead to cancer if I do not have this procedure/treatment.
- I know what this procedure/treatment is for. I know why I need it. I know how it is done.
- I know that signing this form does not stop me from having this procedure/treatment done later.
- I know how to get money to help me pay for the procedure/treatment.
- I know that I am still part of the Women's Health Connection program.
- I have read all of the information above and know what it means. I am choosing to refuse the above procedure/treatment at this time.

Client Signature: _____ Date: __/__/____ (MM/DD/YYYY)

Submitted by: _____ Date: __/__/____ (MM/DD/YYYY)

State ID #

0	3	2	0	0	1									
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Women's Health Connection Program (WHC) en Asociación con Access to Healthcare Network

Forma de Rechazo del Cliente

Fecha: ____ / ____ / ____

Nombre: _____

Fecha De Nacimiento: _____

Yo, _____, he sido informado por mi médico que debería tener el procedimiento / tratamiento se describe a continuación.

Nombre del procedimiento / tratamiento:

Me niego a este procedimiento / tratamiento porque:

- He tenido la necesidad de este procedimiento / tratamiento me sea explicado.
- Sé que el no tener este procedimiento / tratamiento en este momento está en contra de lo que aconseja mi médico y puede ser perjudicial para mi salud. Mi anomalía puede conducir a cáncer si no tengo este procedimiento / tratamiento.
- Sé para lo que es este procedimiento / tratamiento. Yo sé por qué lo necesito. Yo sé cómo se hace.
- Sé que al firma este formulario no me impide tener este procedimiento / tratamiento después.
- Yo sé cómo conseguir dinero para ayudarme a pagar el procedimiento / tratamiento.
- Sé que sigo siendo parte del programa de Mujeres en Conexión.
- He leído toda la información anterior y se lo que significa. Estoy eligiendo rechazar el procedimiento / tratamiento en este momento.

Firma del cliente: _____ Fecha: ____ / ____ / ____

Por favor envíe esta carta con la firma dentro del sobre incluido.

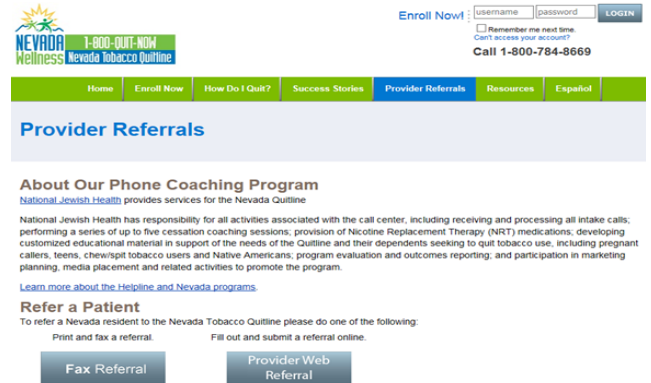
Submitted by: _____ Date: ____ / ____ / ____

State ID #

0	3	2	0	0	1										
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Referring A Client to the Nevada Tobacco Quitline

Log onto: www.nevadatobaccoquitline.com Select the tab labeled **“Provider Referral”**



Option 1: Select the **“Fax Referral”** button

FAX REFERRAL FORM

To be contacted by the Nevada Tobacco Quitline fax this completed form to: 1-800-261-6259

FOR QUITLINE REFERRAL PLEASE FAX COMPLETED FORM TO: 1-800-261-6259

Enter client and office/clinic information



Fax the form to **1-800-261-6259**

Option 2: Select the **“Provider Web Referral”** button

Provider Referral Form

Want to refer a patient to the Quitline? Please complete the provider referral form below

Enter client information and select the **“next”** button

Provider Referral Form

Want to refer a patient to the Quitline? Please complete the provider referral form below

Enter office/clinic information and select the **“next”**

Provider Referral Form

Want to refer a patient to the Quitline? Please complete the provider referral form below

Select the box next to the authorization statement and select the **“submit”** button

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

- Reimbursement rates are based on Nevada's Medicare rates. The total payment is not to exceed the approved rates.
- If the provider bills for services that are less than the approved rates, the provider will be reimbursed at the billed amount.
- Provider must accept Medicare's reimbursement rates as payment in full for services rendered. **Balances may not be billed to the patient.**
- Providers are encouraged to give WHC patients a written estimate of additional charges that are not covered under the program prior to procedure.
- Provider is encouraged to write off charges not reimbursed by the program.
- Ambulatory Surgical Center (ASC) services are surgical procedures identified by Centers for Medicare & Medicaid Services (CMS) annually. The CMS definition of covered facility services includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure.
- All billing claims must indicate an associated ICD-10 code for reimbursement.

OFFICE VISITS

CPT Code	Code Description	Rate
99201	New patient - history, exam, straightforward decision-making; 10 minutes	\$ 45.34
99202	New patient - expanded history, exam, straightforward decision-making; 20 minutes	\$ 77.05
99203	New patient - detailed history, exam, straightforward decision-making; 30 minutes	\$ 111.18
99204	New patient - comprehensive history, exam, moderate complexity decision making; 45 minutes - Consultations must meet the criteria of this code. This code is not appropriate for screening visits	\$ 168.50
99205	New patient - comprehensive history, exam, moderate complexity decision making; 60 minutes - Consultations must meet the criteria of this code. This code is not appropriate for screening visits	\$ 212.02
99211	Established patient - evaluation and management, may not require presence of physician; 5 minutes	\$ 20.93
99212	Established patient - history, exam, straightforward decision-making; 10 minutes	\$ 45.00
99213	Established patient - expanded history, exam, low complexity decision-making; 15 minutes	\$ 75.18
99214	Established patient - detailed history, exam, moderately complex decision-making; 25 minutes	\$ 110.51

- Office visits are face-to-face office visits focusing on 3 key components with the patient: history, exam, and decision-making.
- **"New Patient,"** defined as a patient new to WHC, first annual appointment and/or has **NOT** been seen by a **WHC** provider within 3 years.
- **"Established Patient,"** defined as patient **has** been seen within the last 3 years.
- All consultation visits should be billed through the standard "new patient" office visit code.
- CPT codes 99204 or 99205 must meet certain criteria by complexity for 45 minutes or high complexity for 60 minutes, during a new patient visit.
- A summary report must be attached to the reimbursement request.
- **"No Show"** visits, program or patient **cannot** be billed.

RADIOLOGY

CPT Code	Code Description	Rate		
		Global	26: Professional	TC: Technical
76098	Radiologic exam, surgical specimen	\$ 17.21	\$ 8.33	\$ 8.87
76641	Ultrasound, complete examination of breast including axilla, unilateral	\$ 112.24	\$ 37.68	\$ 74.56
76642	Ultrasound, limited examination of breast including axilla, unilateral	\$ 92.25	\$ 35.14	\$ 57.12
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	\$ 62.61	\$ 33.32	\$ 29.28

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WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

RADIOLOGY				
CPT Code	Code Description	Rate		
		Global	26: Professional	TC: Technical
77053	Mammary ductogram or galactogram, <i>single duct</i>	\$ 61.12	\$ 18.85	\$ 42.27
77065	Diagnostic mammography, <i>unilateral, includes CAD</i>	Use CPT code G0206		
77066	Diagnostic mammography, <i>bilateral, includes CAD</i>	Use CPT code G0204		
<ul style="list-style-type: none"> A diagnostic mammogram can be performed as the initial screening mammogram for women with cosmetic/reconstructive implants, history of breast cancer, and abnormal CBE results 				
77067	Screening mammography, <i>bilateral</i>	Use CPT code G0202		
<ul style="list-style-type: none"> For women age 50+ 				
G0202	Digital Screening Mammography, <i>bilateral</i>	\$ 141.89	\$ 38.02	\$ 103.87
G0204	Digital Diagnostic Mammography, <i>bilateral</i>	\$ 175.71	\$ 49.94	\$ 125.77
G0206	Digital Diagnostic Mammography, <i>unilateral</i>	\$ 138.47	\$ 40.16	\$ 98.31
G0279	Diagnostic digital breast tomosynthesis, <i>unilateral or bilateral</i>	\$ 57.52	\$ 31.17	\$ 26.35
<ul style="list-style-type: none"> Bill separately with CPT code G0204 or G0206 Until further notice, please replace the following CPT codes: <ul style="list-style-type: none"> 77065 use G0206 77066 use G0204 77067 use G0202 				
77058	Magnetic Resonance Imaging (MRI), <i>breast, with and/or without contrast, unilateral</i>	\$ 565.26	\$ 84.42	\$ 480.84
<ul style="list-style-type: none"> Approval required Breast MRI can be reimbursed in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history Breast MRI can also be used to better assess areas of concern on a mammogram or for evaluation of a client with a history of breast cancer after completing treatment Breast MRI should never be done alone as a breast cancer screening tool Breast MRI cannot be reimbursed for to assess the extent of disease in a woman who is already diagnosed with breast cancer 				
77059	Magnetic Resonance Imaging (MRI), <i>breast, with and/or without contrast, bilateral</i>	\$ 561.55	\$ 84.42	\$ 477.13
<ul style="list-style-type: none"> Approval required Breast MRI can be reimbursed in conjunction with a mammogram when a client has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history Breast MRI should never be done alone as a breast cancer screening tool 				
77063	Screening digital breast tomosynthesis, <i>bilateral</i>	\$ 57.52	\$ 31.17	\$ 26.35
<ul style="list-style-type: none"> For women age group 50+ annually Bill separately with CPT code G0202 				

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

BREAST DIAGNOSTIC PROCEDURES

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
10021	Fine needle aspiration w/o guidance; breast	\$ 126.86	\$ 72.31	\$ 72.85
<ul style="list-style-type: none"> 88172, 88173 may be billed by the lab/pathology 				
10022	Fine needle aspiration w/imaging guidance; breast	\$ 146.66	\$ 67.99	\$ 93.31
<ul style="list-style-type: none"> May be billed with code 76942 88172, 88173 may be billed by the lab/pathology 				
19000	Puncture aspiration of cyst of breast	\$ 117.50	\$ 45.51	\$ 80.75
19001	Puncture aspiration of cyst of breast, each additional cyst, bill with code 19000	\$ 27.96	\$ 22.77	No Price
<ul style="list-style-type: none"> 19000 may be billed once per breast 19000 may be billed with 76942 19001 may be billed for each additional lesion <p>No Global fee</p> <p>Office visit codes on the day of the procedure are not payable</p>				
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion	\$ 724.11	\$ 176.75	\$ 521.64
19082	each additional lesion, including stereotactic guidance	\$ 599.16	\$ 88.91	No Price
<ul style="list-style-type: none"> 19081 may only be billed once per breast regardless of the number of biopsies 19082 may be billed for one additional lesion 76098 may be billed for each specimen 88305 may be billed for up to 3 biopsy specimens per breast Facility fee may only billed once Office visit codes on the day of the procedure are not payable <p>No global fee allowed</p> <p>Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion</p>				
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion	\$ 702.51	\$ 166.29	\$ 521.64
19084	each additional lesion, including ultrasound guidance	\$ 575.98	\$ 82.81	No Price
<ul style="list-style-type: none"> 19083 may only be billed once per breast regardless of the number of biopsies 19084 may be billed for one additional lesion 76098 may be billed for each specimen 88305 may be billed for up to 3 biopsy specimens per breast Facility fee may only billed once Office visit codes on the day of the procedure are not payable <p>No global fee allowed</p> <p>Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion</p>				
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	\$ 1,068.84	\$ 194.19	\$ 521.64
19086	each additional lesion, including magnetic resonance guidance	\$ 856.57	\$ 96.58	No Price
<p>Approval required</p> <ul style="list-style-type: none"> 19085 may only be billed once per breast regardless of the number of biopsies 19086 may be billed for one 76098 may be billed for each specimen 				

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

BREAST DIAGNOSTIC PROCEDURES

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
	<ul style="list-style-type: none"> 88305 may be billed for up to 3 biopsy specimens per breast For surgical specimen radiography, use 76098 Facility fee may only billed once <p>Office visit codes on the day of the procedure are not payable</p> <p>No global fee allowed</p> <p>Do not report 19081-19086 in conjunction with 19281-19288, 76098, 76942, 77002, 77021 for same lesion</p>			
19100	Biopsy of breast, percutaneous, needle core w/o imaging guidance	\$ 156.54	\$ 72.68	\$ 521.64
	<ul style="list-style-type: none"> 19100 and 19100 Facility may only be billed once per breast Imaging guidance (10022, 19290, 19291, 19295, 77031, 77032) and mammograms cannot be billed with 19100 Facility fee may only billed once 88305 may be billed for up to 3 biopsy specimens per breast <p>Office visit codes on the day of the procedure are not payable</p> <p>No global fee allowed</p>			
19101	Biopsy of breast, open, incisional	\$ 354.17	\$ 230.23	\$ 1,007.05
	<ul style="list-style-type: none"> 19101 may be billed only once per breast 76098 may be billed for each specimen Facility fee may only billed once 88305 may be billed for up to 3 biopsy specimens per breast 00400 may be billed for the total anesthesia provide Imaging guidance (10022,19290, 19291, 19295, 77031, 77032 and mammograms cannot be billed with 19101 <p>Office visit codes on the day of the procedure and during the 10 day post-operative period are not payable</p> <p>10 day global period</p>			
19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	\$ 512.10	\$ 430.09	\$ 1,007.05
19125	Excision of breast lesion identified by placement of radiological marker, single lesion	\$ 567.39	\$ 477.21	\$ 1,007.05
	<ul style="list-style-type: none"> 19125 may only be billed once per breast regardless of the number of biopsies 19126 may be billed for one additional lesion <p>90-day global period</p>			
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	\$ 168.34	\$ 167.34	No Price
	<ul style="list-style-type: none"> 76098 may be billed for each specimen 88305 may be billed for up to 3 biopsy specimens per breast 00400 may be billed for the total anesthesia provided Facility fee may only billed once 19120FA may be billed with a facility code Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day post-operative period are not payable <p>90-day global period</p>			

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

BREAST DIAGNOSTIC PROCEDURES

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
19281	Placement of breast localization device, percutaneous, mammographic guidance; first lesion	\$ 250.36	\$ 106.01	No Price
19282	each additional lesion, including mammographic guidance (in conjunction with 19281)	\$ 174.16	\$ 53.19	No Price
<ul style="list-style-type: none"> May be billed with 19120, 19125 19282 may be billed for each additional lesion 19281 may not be billed with mammograms or 76645 <p>Office visit codes on the day of the procedure are not payable</p> <p>No global fee allowed</p> <p>Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion</p>				
19283	Placement of breast localization device, percutaneous, stereotactic guidance; first lesion	\$ 282.92	\$ 107.03	No Price
19284	each additional lesion, including stereotactic guidance (in conjunction with 19283)	\$ 213.40	\$ 53.84	No Price
<ul style="list-style-type: none"> May be billed with 19120, 19125 19284 may be billed for each additional lesion 19283 may not be billed with mammograms or 76645 <p>Office visit codes on the day of the procedure are not payable</p> <p>No global fee allowed</p> <p>Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion</p>				
19285	Placement of breast localization device, percutaneous, ultrasound guidance; first lesion	\$ 542.02	\$ 90.78	No Price
19286	each additional lesion, including ultrasound (in conjunction with 19285)	\$ 473.42	\$ 45.56	No Price
<ul style="list-style-type: none"> May be billed with 19120, 19125 19282 may be billed for each additional lesion 19281 may not be billed with mammograms or 76645 <p>Office visit codes on the day of the procedure are not payable</p> <p>No global fee allowed</p> <p>Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion</p>				
19287	Placement of breast localization device, percutaneous, magnetic resonance guidance; first lesion	\$ 907.52	\$ 135.65	No Price
<p>Approval required</p> <ul style="list-style-type: none"> May be billed with 19120, 19125 19288 may be billed for each additional lesion 19287 may not be billed with mammograms or 76645 				
19288	each additional lesion, including magnetic resonance (in conjunction with 19287)	\$ 731.18	\$ 67.67	No Price
<ul style="list-style-type: none"> Office visit codes on the day of the procedure are not payable No global fee allowed Do not report 19281-19288 in conjunction with 19081-19086, 76942, 77002, 77021 for same lesion 				

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

CYTOLOGY BREAST

CPT Code	Code Description	Rate		
		Global	26: Professional	TC: Technical
88172	Evaluation of fine needle aspirate	\$ 59.28	\$ 38.53	\$ 20.75
88173	Evaluation of fine needle aspirate, <i>interpretation</i>	\$ 159.40	\$ 75.22	\$ 84.17

- To be used with 10021, 10022

CERVICAL DIAGNOSTIC PROCEDURE

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
57452	Colposcopy of the cervix, <i>without biopsy</i>	\$ 112.79	\$ 95.72	\$ 50.24

- May be billed only once
- Office visit codes on the day of the procedure are not payable

No global period

57454	Colposcopy with biopsy of the cervix and endocervical curettage	\$ 157.66	\$ 140.59	\$ 62.09
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- 57454 may be billed only once regardless of the number of biopsies performed
- 88305 may be billed with 57454 for up to 4 specimens to reflect multiple biopsy sites on the cervix & one (1) ECC biopsy
- Office visit codes on the day of the procedure are payable

No global period

57455	Colposcopy of the cervix with biopsy	\$ 147.36	\$ 114.70	\$ 64.96
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- May be billed only once
- 88305 may be billed with 57455 for up to 3 specimens to reflect multiple biopsy sites on cervix
- Office visit codes on the day of the procedure are payable

No global period

57456	Colposcopy of the cervix with endocervical curettage	\$ 139.04	\$ 106.75	\$ 62.45
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- May be billed only once
- 88305 may be billed once with 57456
- Office visit codes on the day of the procedure are payable

No global period

57460	Colposcopy with loop electrode biopsy of the cervix.	\$ 292.75	\$ 168.06	\$ 173.34
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Authorization is required

- Reimbursed one time only as a diagnostic procedure
- 57460 may not be billed with colposcopy: 57452, 57454, 57455, or 57456
- 88307 may be billed for up to 4 specimens per cervical procedure
- Office visit codes on the day of the procedure are not payable

No global period

57461	Colposcopy with loop electrode conization of the cervix.	\$ 331.16	\$ 193.85	\$ 186.62
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Authorization is required

- Reimbursed one time only as a diagnostic procedure
- 57461 may not be billed with colposcopy: 57452, 57454, 57455, or 57456
- 88307 may be billed for up to 4 specimens per cervical conization procedure
- 88305 may not be billed with 57461
- 00400 may be billed for the total anesthesia provided

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

CERVICAL DIAGNOSTIC PROCEDURE

CPT Code	Code Description	Rate		
		Non-Facility	Facility	ASC
Office visit codes on the day of the procedure are not payable No global period day surgery facility				
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration	\$ 132.57	\$ 78.76	\$ 81.47
<ul style="list-style-type: none"> 88305 may be billed with 57500 for up to 3 specimens to reflect multiple biopsy sites on cervix Office visit codes on the day of the procedure are not payable No global period				
57505	Endocervical Curettage	\$ 105.83	\$ 95.81	\$ 55.63
<ul style="list-style-type: none"> May be billed only once 88305 may be billed once with 57505 Office visit codes on the day of the procedure and during the 10-day postoperative period are not payable 10 day Global period				
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair, cold knife or laser.	\$ 318.38	\$ 285.73	\$ 1,066.87
Authorization is required <ul style="list-style-type: none"> May be billed only once 88307 may be billed with 57520 for up to 4 specimens per cervical conization procedure 00400 may be billed for the units of anesthesia provided Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable 90-day Global period				
57522	Loop electrode excision (LEEP)	\$ 272.14	\$ 251.73	\$ 1,066.87
Authorization is required <ul style="list-style-type: none"> May be billed only once 57522 and 57522 Facility may not be billed with colposcopy (57452, 57454, 57455, or 57456) 88307 may be billed with 57522 or 57522 Facility for up to 4 specimens per cervical conization procedure 00400 may be billed for the total units of anesthesia provided Office visit codes on the day before the procedure, the day of the procedure, and during the 90-day postoperative period are not payable 90-day Global fee period				
58100	Endometrial sampling (biopsy) with or without endocervical sampling, without cervical dilation and method	\$ 112.79	\$ 90.52	\$ 49.53
Authorization is required <ul style="list-style-type: none"> May be billed only once Must be billed with a colposcopy Office visit codes on the day of the procedure are not payable No global period				
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy	\$ 49.35	\$ 42.30	No Price
<ul style="list-style-type: none"> May be billed only once. Code related to another service and is always included in the global period of the other service 58110 must be billed with a colposcopy: 57452, 57454, 57455, 57456, or 57461 Reimbursable only after Pap test result of Atypical Glandular Cells (AGC) or greater, if client 35 or more years of age, or at risk for endometrial neoplasia 				

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WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

ANESTHESIA

CPT Code	Code Description	Rate
00400	Rates for time based codes are calculated using base units plus time spent (15 minutes = 1 unit). <i>Base unit is 3 x \$22.15 = \$66.45 + time unit spent</i>	\$ 22.15

CYTOLOGY CERVIX

CPT Code	Code Description	Rate
87624	Human Papillomavirus, <i>high-risk types</i>	\$ 48.14
	<ul style="list-style-type: none"> Used for cytology and HPV co-testing every 5 years When a conventional Pap tests results is ASC-US, a follow up office visit may be billed to complete the HPV test When a liquid based pap test results is ASC-US, the HPV test can be done on the original specimen and follow up visit for HPV testing cannot be billed Refer to cervical algorithms for indications for HPV testing 	
87625	Human Papillomavirus, <i>types 16 and 18 only</i>	\$ 48.14
	<ul style="list-style-type: none"> HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age Providers should specify the high-risk HPV DNA panel only Reimbursement of screening for low-risk HPV types is not permitted The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay CDC funds may be used for reimbursement of HPV genotyping 	
88141	Cytopathology (conventional Pap test), <i>cervical or vaginal, any reporting system, requiring physician interpretation</i>	\$ 33.62
	<ul style="list-style-type: none"> Only abnormal or reparative/reactive Pap results, as determined by the cytotechnologist, can be reimbursed for physician review Bill with codes 88142, 88143, 88164, 88174, 88175, technical pap service 	
88142	Cytopathology (liquid-based Pap test), <i>cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening under physician supervision</i>	\$ 27.79
	<ul style="list-style-type: none"> Pap tests are subject to frequency guidelines. See Provider Manual and Cervical Clinical Guidelines 	
88143	Cytopathology, <i>cervical or vaginal, collected in preservative fluid, automated thin layer preparation, manual screening and rescreening under physician supervision</i>	\$ 27.79
88174	Cytopathology, <i>cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system, under physician supervision</i>	\$ 29.31
88175	Cytopathology, <i>cervical or vaginal, collected in preservative fluid, automated thin layer preparation, screening by automated system and manual rescreening, under physician supervision</i>	\$ 36.34
	<ul style="list-style-type: none"> 88143, 88174 and 88175 No longer will be reimbursed at the 88142 rate 	

Women's Health Connection in Partnership with Access to Healthcare Network

WOMEN'S HEALTH CONNECTION REIMBURSEMENT SCHEDULE FY18

PATHOLOGY				
CPT CODE	CODE DESCRIPTION	RATE		
		Global	26: Professional	TC: Technical
88305	Surgical pathology/biopsy lab, breast or cervical specimens	\$ 71.09	\$ 40.32	\$ 30.77
88307	Surgical pathology, breast, excision of lesion	\$ 277.16	\$ 89.08	\$ 188.08
88331	Pathology consultation during surgery, first tissue block, frozen section, single specimen	\$ 100.64	\$ 66.90	\$ 33.74
88332	Each additional tissue block with frozen sections	\$ 54.59	\$ 33.10	\$ 21.49
88341	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	\$ 94.74	\$ 30.17	\$ 64.57
88342	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	\$ 111.22	\$ 37.78	\$ 73.44
SUPPLIES				
CPT Code	CODE DESCRIPTION	Rate		
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	\$ 15.50		
PREOPERATIVE TESTING				
Some pre-operative tests are allowed with pre-approved procedures. These procedures should be medically necessary for the planned surgical procedure. Please contact WHC care coordinator for pre-approval of these tests.				
CPT CODE	CODE DESCRIPTION	Rate		
		Global	26: Professional	TC: Technical
71010	Chest x-ray, 1 view frontal	\$ 23.49	\$ 9.42	\$ 14.07
71020	Chest x-ray, 2vw frontal & lateral	\$ 29.02	\$ 11.24	\$ 17.78
80048	Basic metabolic panel	\$ 11.60		
80053	Comprehensive metabolic panel	\$ 14.49		
81001	Urinalysis	\$ 4.35		
81025	Pregnancy test	\$ 8.67		
<ul style="list-style-type: none"> Should only be performed when there is concern that the client may be pregnant. This test should not be routinely performed 				
85014	Hematocrit	\$ 3.25		
85018	Hemoglobin	\$ 3.25		
85025	CBC with differential WBC count	\$ 10.66		
85027	CBC with differential	\$ 8.44		
93000	EKG	\$ 17.57		