Arkansas BreastCare

Provider Manual

Arkansas Department of Health

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1. Program overview

Introduction

In 1995, the Arkansas Department of Health (ADH) entered into a five-year agreement with the Centers for Disease Control and Prevention in accordance with the Breast and Cervical Cancer Mortality Prevention Act, Public Law 101-354, to provide screening and diagnostic breast and cervical cancer control services. The mission of the Breast and Cervical Cancer Control Program (BCCCP) is to increase the rate of early detection of breast and cervical cancer and reduce morbidity from these diseases. The target population is low-income women aged 50 and older who are uninsured or underinsured. Enrollment and screening was started at Local Health Units (LHUs), Community Health Centers (CHCs), and Area Health Education Centers (AHECs).

State legislation was initiated in 1995 to extend coverage to include breast cancer treatment services for eligible women. The Breast Cancer Act of 1997 was signed into law on March 11, 1997, which established the Breast Cancer Control Program now called BreastCare. BreastCare is administered by ADH with guidance from the governor appointed Breast Cancer Control Advisory Board. BreastCare was implemented on February 16, 1999.

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

Updates

This manual will be updated as changes in policy and procedures occur. Initial notification of such changes may be in the form of official notices, e-mails, or messages on the ADH website www.arbreastcare.com. All changes made to the BreastCare policy will be incorporated into the BreastCare Provider Manual.

Client Eligibility

A client must meet the basic eligibility requirements as follows:

- Arkansas resident
- Age 21 to 64 for cervical screening and diagnostic services or 40 to 64 for breast screening and diagnostic services
- Under 40 with breast symptoms
- Income ≤ 250% of the Federal Poverty Level (FPL).
- Uninsured or Underinsured needing diagnostics and meets criteria for financial barrier

A participating Primary Care Provider (PCP) determines patient eligibility and enrolls the patient in the BreastCare Online System (BOS). The BOS assigns the patient to a plan.

The following chart reflects BreastCare coverage for breast and cervical cancer screening and diagnostics:

	Age 21-29	Age 30-39	Age 40-64
Cervical screening	Uninsured - covered (Thin Prep Pap every three years) Insured – not covered	Uninsured – covered (Thin Prep Pap every three years or Thin Prep/HPV every five years) Insured – not covered	Uninsured – covered (Co-test with Thin Prep Pap/HPV every five years or with Thin Prep Pap every three years) Insured - not covered
Breast screening	≥ 25 y.o. Screening MRI if “high risk” **AND** Uninsured or Underinsured	Screening Mammogram and MRI if “high risk” **AND** Uninsured or Underinsured	Uninsured – covered Insured – not covered
Diagnostics-breast or cervical	Covered when: Abnormal screening **AND/OR** Positive CBE **AND** Uninsured **OR** **Under**insured	Covered when: Abnormal screening **AND/OR** Positive CBE **AND** Uninsured **OR** **Under**insured	Covered Uninsured **Under**insured

Income Calculation

The income of every person in the household must be counted. A household consists of the patient, any person the patient takes care of, a domestic partner, and/or spouse. Alimony, child support, foster care, retirement and disability incomes are counted. Verification of income is not required.

Exception: High school and college students are counted in the household number, but their incomes are not counted in the total household income amount.

Underinsured Women

Underinsured women may be eligible for BreastCare services. Underinsured women are not eligible for screening. A woman with insurance is not eligible for BreastCare screening services. However, insured women who experience a financial barrier (underinsured) may be eligible for diagnostic testing following an abnormal breast or cervical screening result. The BOS has been updated to use the following criteria to determine whether a financial barrier exists for underinsured women.

Federal Poverty Level (FPL) Scale	***Co-payments, deductibles, or co-insurance***
≤ 100%	***And ≥ $50***
> 100% but ≤ 150%	***And ≥ $100***
≥ 150% but ≤ 200 %	***And ≥ $250***
> 200% but ≤ 250%	***And > $500***

Plan categories include:

Funding Source	***Plan***
Uninsured Federal	***C***
Uninsured State	***A***
Underinsured Federal	***B***
Underinsured State	***BA***

Ineligible Women

If a woman is ineligible for BreastCare, a referral is made to a community provider or Komen grantee.

BreastCare Identification Card

Once she is determined eligible, a BreastCare Identification Card is printed and issued to the patient at the time of enrollment or at the first visit. The card verifies an individual's eligibility until the expiration date on the card **unless** her circumstances change. The client is notified if her eligibility is ended or updated for any reason. Eligibility must be verified at each visit. To withhold information or to give false information in order to receive services from BreastCare may constitute fraud, which is against the law.

Loss of ID Card

When a BreastCare participant reports a lost identification (ID) card or she doesn't have it with her at the time of a visit, the PCP can reprint another card. If a patient does not present her ID card at the time of her visit, the provider may call her PCP or BreastCare to verify eligibility.

Enrollment Process

A woman must be enrolled through a participating PCP to be eligible for BreastCare services. A woman may enroll over the phone or in person for screening or diagnostic services. All women enrolled are issued the ***Welcome to BreastCare*** brochure and the ***Know Your Pap Choices*** pamphlet. She may be referred to the PCP by anyone including a nonparticipating PCP, mammography facility, or she may self-refer. A PCP is not required to enroll a woman who wants to receive her exam by another PCP or if she has been referred by a participating PCP. They are not required to enroll non-English speaking women without an adult interpreter. BreastCare cannot reimburse for services rendered **before** the woman is enrolled.

Self-referral

A woman may call a participating PCP to see if she is eligible and enroll in the program. If a woman is eligible, the PCP enrolls the patient into the BOS and an appointment is scheduled with the enrolling PCP for a clinical breast exam (CBE) and/or Pap test. After the exam is completed, the provider enters screening visit information into the BOS, within five days, and schedules the mammogram appointment based on the CBE result.

Non-Participating Primary Care Provider referral

A non-participating PCP may refer a patient to a PCP who is able to enroll patients in the program. If the patient is eligible, she is enrolled in the program. An appointment is made with the participating PCP for a CBE and/or Pap test and mammogram referral. However, if the patient has already received her CBE or Pap test, she may be enrolled for a mammogram only. All potentially eligible women should be referred to an enrolling provider for determination of eligibility and enrollment into BreastCare.

Mammography Facility Referral

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

Mammography Facility Responsibilities

The mammography facility receives orders for all screening, diagnostic, and follow-up mammograms from providers for BreastCare patients. When the mammogram is scheduled, personnel should record the PCP's name, the plan, and client ID number given by the referring PCP. If the woman does not have her card, eligibility and the client ID number may be verified by calling the referring PCP or BreastCare. The mammography facility sends the mammogram report to the appropriate PCP and a letter to the patient. Reminders sent by the mammography facility should instruct the patient to call her PCP to schedule her appointment and to bring her BreastCare ID card to the mammogram appointment. The facility should perform all necessary reimbursable procedures during the same appointment. A referral or preauthorization is not required for any covered radiology procedure.

Primary Care Provider (PCP) Participation

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

- Family/General Practice
- OB/Gynecologist (if requested)
- Internal Medicine
- Advanced Practice Nurses
- Community Health Centers

Role of PCP

- Determines eligibility and enrolls patients
- Performs CBE and/or pelvic exams and Pap tests
- Schedules mammograms and other breast or cervical procedures/appointments
- Follows-up on all abnormal test results appropriately and refers patients with abnormal results or cancer diagnosis to the Regional Care Coordinator
- Offers community resources to ineligible clients
- Enters clinic visit data and additional procedures in the BOS until final diagnosis is reached on each patient

Responsibilities of PCP

- As a *Breast*Care primary care provider, the PCP authorizes their name to be listed as a primary care provider and consents to release their name to women who require enrollment and screening through the program.
- A PCP agrees to enroll all eligible women and perform a CBE and Pap test if appropriate.
- A PCP orders the appropriate mammogram and enters the patient data in the BOS.
    - Missed appointments must be documented in the BOS by updating the appointment status on the Patient Management page.
- Receives mammogram and Pap test reports, enters results in BOS and follows up on any abnormal test result.
    - A woman with an abnormal mammogram or Pap test is referred to the Regional Care Coordinator.
- The PCP may refer patients only to BreastCare providers.
    - If the patient chooses to go to a non-BreastCare provider, she is responsible for the charges incurred.
- The PCP must use the BreastCare follow-up policy and procedures for all BreastCare patients.

The PCP must have access to the BreastCare Online System. After the public health service agreement is approved, go to https://health.arkansas.gov/adhinternetapps to request access. An e-mail will be sent with a link to set up the provider's password. Click on that link and enter a password of your choice. Then click on login. A BreastCare Online button will display on the left menu. When you are ready to enroll a patient, login and click on the BreastCare button.

Provider Participation Requirements

Physician and non–physician providers must be BreastCare providers to utilize the BreastCare billing and reimbursement system. To become a participating provider, an application must be completed online at the BreastCare New Provider Enrollment link. BreastCare will e-mail all of the completed documents to the provider to print, sign, and return via portal or mail to ADH, 4815 W. Markham, Slot 11, Little Rock, AR 72205. Physicians, Nurse Practitioners, and CRNAs must complete the Provider Name and Specialty Form. Group practices must submit their name, billing information if different from the group's address, and a Provider Name and Specialty Form with each physician /nurse in the group. Medical license and DEA license must be submitted for each clinician initially and upon each renewal. When a signed agreement is

received, the provider will be issued a BreastCare provider number for the group, each individual physician, and one number for a facility.

Mammography facilities must provide proof of Food and Drug Administration Mammography Quality Standards Act Certification or provisional certification. Mammogram results must be reported using the MQSA final assessment categories. Facilities must accept BreastCare orders

for mammogram and ultrasound procedures that have original signatures by ADH clinicians. Laboratories must provide proof of CLIA Certification.

It is the responsibility of the provider to verify insurance status, prior to rendering services. If the patient has obtained insurance since being enrolled in BreastCare, any services provided should be billed to the patient's insurance. **BreastCare is a payer of last resort and cannot pay for services that insurance will cover.** Consult with the RCC to determine whether the patient's BreastCare plan should be closed.

The provider may perform covered procedures subsequent to, and as indicated by, initial evaluation, unless prior approval is required. **The provider may not provide any non-covered services without full disclosure to the patient that said service will not be paid by BreastCare and the patient will be responsible.**

2. Coverage

Scope

The BreastCare program covers breast and cervical cancer screening and diagnostics for women who meet eligibility criteria and are enrolled in the program.

BreastCare Screening and Diagnostic Services: Breast	BreastCare Screening and Diagnostic Services: Cervical
Clinical Breast Exam	Pap Test, HPV Test
Screening mammogram/Screening MRI (If patient is high risk refer to Section 4 “Case Management”)	Colposcopy, Cervical Biopsy
All diagnostic services required for follow-up after an abnormal clinical breast exam or mammogram	All diagnostic services for follow-up after an abnormal Pap test

Covered Services

All BreastCare enrollees are informed of their coverage and are responsible for non-covered services. Refer to the BreastCare website for a complete listing of covered BreastCare procedure codes and rates.

Benefit Limits

Benefit limitations apply to all procedures. View Billing Manual on the ADH BreastCare website for an explanation of specific benefit limitations for each procedure code.

Mammograms

One screening mammogram per plan year is covered and must be performed in the same month as the previous year. Procedure code 77067 (Screening Mammogram) and 77063 (Tomosynthesis) are subject to the benefit limit. The procedure codes 77065 (Diagnostic Unilateral Mammogram), 77066 (Diagnostic Bilateral Mammogram) and G0279 (Tomosynthesis) are used for all other mammograms and are limited to three per plan year.

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

MRI

Two MRIs will be covered per plan year (Refer to Section 4 “Case Management”)

BreastCare will not cover a breast MRI to assess the extent of disease for staging in women diagnosed with breast cancer in preparation for treatment Pap tests

Pap/hrHPV Tests

BreastCare follows the US Preventive Services Task Force recommendations for cervical cancer screening. Women aged 21-39 are recommended to have a pap test every three years. Women aged 30-65 are recommended to have a pap test every three years, a pap/hrHPV test every 5 years, or a hrHPV test alone every 5 years. Established patients who have had normal results, are not high risk, and have a cervix are transitioned to either the three-year (36 months) or five-year (60 months) track based on the date of the last

documented Pap test. The laboratory performs the hrHPV test with each Pap test on the five-year track. The provider must mark Pap and hrHPV on the lab requisition. For those on the three-year track, hrHPV high risk reflex tests are performed on all ASC-US Pap results. Once a patient has selected a Pap track she must stay on that track for routine screening. She cannot alternate between tracks. It is no longer necessary to have three consecutive, negative Pap tests before reducing the frequency of screenings. *"Know Your Choices for Routine Pap Testing"* is an informational sheet developed for the patient so that she can make an informed decision about her Pap frequency and is given to women upon entering the program.

Exception: High risk women who have had hysterectomies for cervical cancer, DES exposure, are HIV positive, or have any other immunocompromising condition may need more intensive or alternate screening.

A patient who has had a hysterectomy for a benign condition and who does not have a cervix is **not eligible** to receive a Pap test. Pap tests are reimbursable only if the patient has a cervix or she has had a hysterectomy due to cervical cancer or is symptomatic.

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

Office visits
The procedure codes 99203, 99212, 99213 can be billed by family physicians, internal medicine physicians, gynecologists, surgeons, nurse practitioners and Community Health Centers. **Consultation visits** are billed using the **99203** procedure code.

Diagnostic Benefit Limits
A PCP referral is required for surgical consultation. The Regional Care Coordinator should also be notified of the need for a surgical consultation

Procedure code 99203 can be billed two times per plan year and two times per date of service. Procedure codes 99212 and 99213 can be billed four times per plan year and one time per date of service.

Each procedure code 80076 (hepatic function panel), 80053 (comprehensive metabolic panel), 85025 (complete blood count) and 85027 (hemogram and platelet count, automated) can be billed **preoperatively only** up to two times per year.

Procedure codes 57460 (colposcopy with loop electrode biopsy), 57461 (colposcopy with conization), 57520 (conization of cervix), and 57522 (conization of cervix) are payable only for diagnostic purposes with prior authorization (PA). Contact your Regional Care Coordinator to initiate the PA process.

BreastCare Provider Specialties

Certain provider types and specialties may perform *Breast*Care services. See the following table and codes, *Breast*Care Provider Types and Specialties. Each procedure code can only be performed by certain provider types and specialties and billed with certain diagnosis codes.

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01 02 03 04	Physician, M.D. Physician, M.D., Group Physician, D.O. Physician, D.O., Group	02 08 11 16 22 30 05 C3	Surgery: General/Oncology/ Family/General Practice Internal Medicine OB/GYN Pathology Radiology Anesthesia CRNA
05	Hospital	W7	Outpatient
09	Independent Laboratory	69	Independent Laboratory

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
10	Independent Radiology	*63*	Mammography
28	Ambulatory Surgical Center	A4	Ambulatory Surgical Center
49	Federally Qualified Health Center/Rural Health Center	F2	Federally Qualified Health Center/Rural Health Independent Free Standing
58	Nurse Practitioner	N3	Nurse Practitioner

Prior Authorization

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

NOTE: Prior authorization of a service does not guarantee reimbursement unless:
1. The participant is enrolled in BreastCare on the dates of service.
2. The service is provided by an ADH participating provider.
3. All other program requirements are met.

Prior Authorization request procedure

The following procedure must be followed for Prior Authorization (PA).

1. Complete and fax the Prior Authorization request, pathology report and recommendation for care to your RCC.

2. The RCC reviews the PA and the pathology report and notifies the provider of the approval or denial of the PA within 10 working days following receipt of the request.

3. If the PA is denied, the PA form is returned to the provider with an explanation of the denial.

4. If additional information is needed, the PA will be returned with an explanation of the reason for return. The Request for PA may be resubmitted with the required information.

5. If the request is approved, the PA will be returned to the provider with the assigned prior authorization number(s). Service may then be provided. The PA number must be entered on the claim to be reimbursed for the procedure. All claims for procedure codes requiring PA that do not have a PA number will be rejected.

Scope, frequency, and duration of authorization

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

Prior authorization is valid for the procedure codes and dates of service that BreastCare authorizes. When billing using the BreastCare Billing web-based application, enter the PA number when prompted.

PA numbers may be used only by the providers to whom they are issued. BreastCare issues PA numbers to “clinic” or “group” providers by request when appropriate. Clinic and group providers are sole-proprietor individual practices, or practice associations or partnerships of providers of the same provider type and has one revenue and tax liability of which is identified by a Federal Employer Identification Number. A PA number issued to a group practice is linked to the group provider number to bill for the authorized services. If procedure is performed in a hospital, a PA number will be issued for it as well.

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

3. Billing and Reimbursement

Claims Submission

Providers submit BreastCare claims using the following methods:

1. Online using the web-based BreastCare Billing System (preferred for faster processing)
    a. To get set up with access to the Breast Billing System, please complete and submit the BreastCare Billing System User Access Request form to BreastCare via fax or e-mail.

2. A paper claim form (using standard claim forms or BreastCare claim form)
    a. If you choose to submit paper claims instead of billing electronically, please mail the completed claims to:

Arkansas Department of Health
BreastCare Billing, Slot 11
4815 West Markham
Little Rock, AR 72205

General Reimbursement Guidelines

The methods used by the ADH to determine reimbursement rates for BreastCare services are fee-for-service and capitation based on the current Medicare allowable reimbursement rates. The participating provider agrees to accept the BreastCare fee-for-service and/or capitated reimbursement rates. The rates are revised annually to reflect the current Medicare rates. The provider agrees to not bill the patient for covered services. BreastCare is the payer of last resort.

The provider may not bill BreastCare for:
1. Completion of a form
2. A cancelled or missed appointment
3. A professional service rendered by phone or mail

Reimbursement for Screening and Diagnostic Procedures

BreastCare provides fee-for-service reimbursement for all screening and diagnostic procedure codes with modifiers 26, TC, or complete component. Professional and technical components may be billed separately. When procedures are performed by a physician in a facility rather than an office, use facility as place of service. The reimbursement amount will be the Medicare allowable for being performed in a facility.

Anesthesia, pathology, radiology, and lab may be billed separately. Providers must bill actual charges or up to the capitated limit. These codes should be used for excisional or incisional biopsies for diagnosis only.

Procedure codes 57460, 57461, 57520, 57522 are payable only for diagnostic purposes with prior approval only.

Automatic Deposit

BreastCare reimbursement by automatic deposit or Electronic Funds Transfer (EFT) is required. EFT allows the payments to be directly deposited into the provider's bank account. The provider must complete an Authorization for Automatic Electronic Funds Deposit as part of the contract. **If banking details change, please notify BreastCare immediately to avoid a delay in payments.** The BreastCare program makes all payments for claims by electronic funds transfer (EFT). Bank of America processes the EFT payments. Payments will show up as DFS, Inc Flex Plan.

Timely Filing

Claims should be filed as soon as possible following the date of service. Claims for services provided from July 1 – June 30 must be billed by August 15 of each year to receive reimbursement. Claims filed more than 365 days after the date of service are subject to denial or rejection by BreastCare

Refunds/Voids

If it is determined that a provider was over or underpaid, the provider must refund the payment in order for the claim to be rebilled correctly. A refund form must be submitted with the payment. A copy of the refund form can be found in the BreastCare Billing System under the Reports and Resources link.

Fraud and Abuse

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

4. Case management

Outcomes

Follow-up for patients that have been examined and/or referred for screening or diagnostic services is an integral part of patient care. Primary care providers document screening and diagnostic services and final outcomes in the BOS.

Performance standards

- The following performance standards are used for overall program evaluation, quality assurance, and outcome indicators:
- For abnormal screening results, follow-up for 90% of cases is completed within 60 days.
- The interval from screening to final diagnosis is no longer than 60 days. Complete follow-up means all definitive diagnostic procedures are performed and treatment is started if indicated. The result is documented in the BOS and the woman and is notified.
    - Exception: A patient that refuses care or are lost to follow-up must have this information documented in the BOS.
- The interval for Pap test screening for women aged 21 and older depends on past results and risk factors. Women with a history of normal results, normal risks and who are asymptomatic choose to be screened every three or five years. Women who have had hysterectomies for a benign condition are not screened for cervical cancer. Women with a history of cervical cancer or pre-cancer, HIV or other immunocompromising conditions may need more intensive or alternate screening.
- Notification reports should be run and printed on a monthly basis to identify where screening data and outcomes have not been entered into the BOS.

Follow-up

Providers are responsible for assuring that women with abnormal or inadequate screening tests receive appropriate follow-up. BreastCare requires that abnormal follow-up is completed in 60 days. Each provider must have an established breast and/or cervical follow-up policy, procedures, and tracking system in place. Providers should use the BreastCare policies and procedures for follow-up. Contact your RCC if you need assistance with abnormal follow-up.

Reporting

After a PCP sees a patient for a CBE and/or Pap test, schedules a mammogram and enters the test results, a claim is submitted for an office visit. **The PCP entering screening visit and results in the BOS is a condition of payment.** However, the PCP is responsible for updates to the BOS each time there is an appointment made or result received and when the patient is "lost to follow-up" or refuses services until the final diagnosis status is complete.

Follow-up and closure of all abnormal screening tests are necessary unless a patient refuses or is lost to follow-up. When a provider is aware that a patient refuses diagnostic work-up or is lost to follow-up, the provider refers this patient to the RCC. Manual or computerized tracking systems are acceptable. Mammogram/Pap test logs must be maintained and kept updated to track test results. The provider may contact the RCC for assistance in implementing an office reminder/tracking system.

Referrals for Case Management

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

- Reassesses the plan and its effectiveness as well as the client's compliance with the plan of care and, finally, evaluates each individual case.
- Develops resources and works to improve the utilization of existing resources in the counties he/she serves.
- Manages the delivery of services to meet the multiple needs of program participants with abnormal breast and/or cervical screening results or a diagnosis of cancer.
- Provides training and outreach to providers.

Case management services begin when the provider refers a client for assistance in obtaining care and ends when the client no longer needs case management services.

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

- Mammography - Suspicious abnormality (category 4) and highly suggestive of malignancy (category 5).
- Ultrasound - Solid mass suspicious for cancer.
- Pap – ASC-US with HPV Positive (>24 years), ASC-H, AGC, AGC-EM, AEC, LGSIL, HGSIL, Carcinoma-in-Situ (CIS), and squamous cell carcinoma.
- Abnormal clinical breast exam requiring a breast biopsy.
- Enrollees who are consistently non-compliant with follow-up and for any diagnostic treatment procedures.

- Enrollees that refuse follow-up or are lost to follow-up.

Providers contact their assigned RCC by phone to notify her of a patient who is eligible for case management services. A copy of the patient's applicable reports (mammogram, ultrasound or Pap/HPV) and the Care Coordinator Referral Form is completed and sent to the RCC, who then becomes responsible for entering the patient data online.

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

Referrals for Breast and Cervical Cancer

When a woman who is currently enrolled in BreastCare is diagnosed with breast or cervical cancer or cervical biopsy diagnosis of CIN II/ III or CIS, providers notify the RCC for possible transition to Breast and Cervical Cancer Treatment Assistance.

Referrals for Indigent Care

Uninsured patients needing diagnostic or treatment services that are not covered by the program are referred to an institution or provider in their community who offers free/reduced cost care or UAMS.

Helpful Resources

Visit https://www.komen.org/support-resources/tools/ or call the Komen Breast Cancer Hotline 1-877-GO KOMEN (465-6636)

Arkansas Cancer Coalition Resource Directory
https://arcancercoalition.org/directory/

American Cancer Society
https://www.cancer.org/treatment/support-programs-and-services/resource-search.html

Find Help
www.findhelp.org

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BreastCare Responsibilities

The BreastCare RCCs assist with tracking and follow-up, case management, quality assurance, and professional development. BreastCare is responsible for management of the overall data quality and integrity. The Minimum data element (MDE) report is submitted to Centers for Disease Control and Prevention every six months. An analysis of this report determines if Arkansas' BreastCare program meets the 11 required core indicators

The Adequacy of Follow-up for Breast Cancer Screening algorithm is used to monitor and evaluate abnormal breast and cervical follow-up. When a diagnostic work-up is required, a final diagnosis must be documented for follow-up to be considered adequate. Refused or lost to follow-up are exceptions. When a diagnostic work-up is required, the time from the CBE, mammogram, and/or Pap test to the final diagnosis must be no more than 60 days. The RCCs are responsible for obtaining follow-up data that has not been entered in the BOS.

Clinical Guidelines

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

Mammogram Management

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

Management of negative/*positive CBE*

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

Screening Mammogram

A screening mammogram is recommended for the asymptomatic patient (>40) with a normal CBE, including the patient with breast implants.

Diagnostic Mammogram

A diagnostic mammogram is recommended for a patient with symptoms, abnormal CBE, history of breast biopsy in recent past (< 12 month), or history of breast cancer. For symptomatic women <40 who have a normal CBE refer to the “Negative/Normal CBE” section on page 23.

Breast Density Results

Dense breast can only be found on a mammogram and describes different types of breast tissue in the breast. Dense breasts have a high amount of fibro glandular tissue and a low amount of fatty tissue. Dense tissue can be grouped into four categories:

Category	Description
A	Almost entirely fatty breast tissue
B	Scattered fibro glandular breast tissue
C	Heterogeneously dense breast tissue
D	Extreme dense breast tissue

Dense breast tissue may make it harder to read a mammogram and find breast cancer. Current USPSTF guidelines for follow up on dense breast tissue states that current evidence is not sufficient at this time.

Negative/Normal CBE

The following procedure is followed for a patient (40 and older) with a negative/normal CBE. Symptomatic women (including pain) who are under 40 with normal CBE do not need any further procedures.

1. Schedule a screening mammogram.

2. Complete and fax a physician order to the mammography facility.

3. If the screening mammogram is abnormal, schedule additional studies as recommended by the radiologist.

4. If the screening mammogram result is probably benign (BIRADS Category 3), schedule a diagnostic mammogram six months.

5. Notify patient of appointment date.

6. Document receipt of reports and follow-up plans in the BOS.

7. Contact the RCC with questions concerning results or recommendations.

Positive/Abnormal CBE

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

Note: Women with skin breakdown on the nipple and/or areola should be referred to a surgeon. Spontaneous nipple discharge, in the presence of a mass, requires a surgical consult. Breast pain, if the mammogram and CBE are negative, commonly indicates fibrocystic change. If conservative measures to relieve pain are unsuccessful, patient may be referred to RCC for possible surgical consult. Palpable mass/thickening requires results of US prior to surgical consult.

1. Schedule a diagnostic mammogram and /or US. Fax physician order to the mammography facility.

2. Advise the patient that a normal mammogram and or US does not eliminate the need for further evaluation of an abnormal CBE.

    a. If the radiologist did not perform a biopsy, and lesions found on US result in a diagnosis **other than** simple cyst/cystic mass or benign abnormality (lymph nodes, calcified fibroadenoma, skin calcification, foreign body, oil cyst, lipoma, galactocele, mixed-density hamartomas, or complicated cyst/probable fibroadenoma unchanged for 2-3 years), refer the patient for surgical consultation even in the presence of a normal diagnostic mammogram or ultrasound.

    b. If the radiologist performs a biopsy that results in a benign diagnosis that matches imaging results or if ultrasound results are other atypical results (flat epithelial atypia

(FEA), papilloma without atypia, fibroepithelial lesions favoring fibroadenoma, or radial scars) a surgical consultation is not required.

3. Refer the patient to the RCC.

4. Document results from reports and further follow-up in the BOS.

5. Contact the RCC if the radiologist's or surgeon's recommendations differ from the Patient Management Protocol.

> **NOTE:** The mammogram results must always be compared to the CBE result. A palpable solid mass must result in a surgical consultation and/or biopsy.
>
> A breast ultrasound is an additional study that helps determine whether a mass is cystic or solid. If an ultrasound result is benign, no further follow-up is required. All other ultrasound results with a positive CBE require a surgical consultation and/or biopsy.

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

MRI

Breast MRI Screening for High-Risk Women

All women enrolled in BreastCare should be assessed to determine if they are at high risk for breast cancer. If a woman is found to be high-risk, they should be referred for a screening mammogram **AND** a breast MRI *(MRI completed within six months)*. BreastCare will only cover two MRIs per plan year. A woman is considered high risk if she meets one or more of the following risk factors:

- Known BRCA1 or BRCA2 gene mutation
- First-degree relative (parent, brother, sister, or child) with a BRCA1 or BRCA2 gene mutation and has not had genetic testing themselves
- Radiation to chest between the ages of 10 and 30 years
- Lifetime risk of breast cancer of about 20-25% or greater (determined by risk assessment tools based mainly on family history) **Preferred**

Note: A woman is considered "high-risk" if she meets **at least one** of the above criteria. Using a risk assessment tool is preferred but having at least one of the risk factors listed is also acceptable.

A woman enrolled in BreastCare may receive a diagnostic breast MRI for the following reason:

- To better assess areas of concern on a mammogram
- To evaluate patient with history of breast cancer after completing treatment

Breast Biopsies

Breast biopsies are considered reimbursable procedures only when performed by participating surgical/ radiology providers, after preliminary image evaluation, on an outpatient basis, and in accordance with approved guidelines. Refer to a trained radiologist to allow for the least invasive and least costly approach when appropriate.

Cervical Cytology

BreastCare patients receive ThinPrep liquid-based Pap tests with normal results every three to five years depending on the track they have chosen. If a woman has had cervical cancer, CIN II/III, DES exposure, is HIV positive, or has other immunocompromised condition; she may need more intensive or alternate screening. A woman who has had a total hysterectomy for a benign condition does not receive a pelvic exam and Pap test. ADH will not cover pelvic exams and Pap tests on women who do not have a cervix; however, if a woman does not know if her cervix was removed, a pelvic exam may be done to determine anatomy. If a woman has had a hysterectomy due to cervical cancer or dysplasia, or if the cervical stump remains, the Pap test is reimbursable. HPV DNA reflex testing is performed only for ASC-US Pap results. All screening sites performing Pap tests must use participating cervical cytology laboratories. Claims submitted from other laboratories will be denied. The BreastCare client Identification number must be entered on the Pap Requisition form before being sent to the laboratory.

Pap test management protocol

Pap test results are reported according to the Bethesda 2014 Recommendations and must be managed according to the American Society of Colposcopy and Cervical Pathology (ASCCP). BreastCare and the RCCs use these guidelines to evaluate follow-up.

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

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

Colposcopy

Colposcopy services are covered for BreastCare clients but may only be performed by participating providers. BreastCare patients cannot be charged for colposcopy.

The BreastCare PCP should:

- Advise patient of the need for colposcopy
- Schedule an appointment for the patient with a BreastCare contracted colposcopy provider
- Fax referral to colposcopy provider with a copy of Pap and HPV reports
- Notify patient of appointment and enter into BOS
- Complete a referral to the RCC for case management

The colposcopy provider should send the colposcopy/biopsy result and recommendation to the referring provider; however, the primary care provider is responsible for obtaining the

colposcopy/biopsy result and entering results in the BOS. Final pathology may include conization, LEEP/LLETZ, or hysterectomy. The final diagnosis is the tissue diagnosis with the most severe result. Follow-up is based on ASCCP recommendations.

Notification of Pap Test/Mammogram Results

A system for tracking clients and providing the appropriate follow-up in the specified time frame should be maintained. A log system to assure that mammogram and Pap results are received and to document that the patient kept her referral appointment is recommended.

All attempts to contact a patient must be documented in the patient's record.

A. Pap test results

The Pap test results should be received by the Primary Care Provider **within 14 working days** from the date that the Pap test was received in the Cytology Lab. Follow-up is based on ASCCP Guidelines. Patients with abnormal results are referred to the RCC.

Abnormal Pap Test Results

The provider must attempt to notify all patients of any abnormal Pap test result. This includes all Pap tests that are to be repeated or need colposcopy and/or treatment before the next annual exam.

The initial attempt must be made **within two weeks** of the date the Pap test was read. It may be by telephone or face-to-face. If unable to reach the patient by telephone, send a letter.

Exception: If the initial letter is returned with no known forwarding address and the Provider has no other reasonable means of communicating with the patient, follow-up efforts may be stopped, and the patient is considered lost to follow-up. If there is no response within **two weeks and the initial letter did not return, send a Certified Letter to be accepted only by the patient.** If the letter is returned, document in record. Place in patient file and notify Regional Care Coordinator.

Upon patient notification of abnormal Pap results, the provider arranges for counseling and/or follow-up services.

B. Mammogram Results

The mammography facility sends all mammogram results to the PCP and the patient. Each provider should call the Regional Care Coordinator with any questions concerning results. Mammogram results should be received by the provider **within 10 working days** from the date the mammogram was done.

Clients with the following results are referred to the Regional Care Coordinator.

- Suspicious abnormality - consider biopsy
- Highly suggestive of malignancy
- Ultrasound-Solid mass suspicious for cancer

Negative mammogram results

When the results are reported as negative or benign finding, no follow-up is necessary if CBE is normal. The patient receives routine screening. Each mammography facility notifies the patient of the result.

Abnormal mammogram results

The provider makes at least one attempt to notify a patient of any abnormal mammogram result within two weeks of the date the mammogram is read. This includes all mammograms that are to be repeated or need diagnostic follow-up before the next annual exam. The initial attempt may be by telephone. If unable to reach the patient by telephone, send a letter.

Exception: If the initial letter is returned with no known forwarding address and the Provider has no other reasonable means of communicating with the patient; follow-up efforts may be stopped. If there is no response within **two weeks for suspicious abnormality and highly suggestive of malignancy and initial letter did not return, send a Certified Letter to be accepted only by the patient.** If the letter is returned, document in record. Place in patient file and notify RCC.

Upon patient notification of abnormal mammogram results, the provider arranges for counseling and/or follow-up services.

Pap Test/Mammogram Management Protocol

I. Policies:

A. Pap tests

Pap test results are managed based on ASCCP guidelines.

Patients with abnormal Pap results requiring colposcopy must be given an appointment with a BreastCare contract colposcopy provider.

Any woman with a biopsy result of CIN II/III, CIS, or squamous cell carcinoma should be referred to the RCC to determine eligibility for treatment assistance.

Cervical polyps are not neoplasia. A fungating cervical mass or abnormal Pap test does require diagnostic follow-up

NOTE: If Pap test is negative but patient is symptomatic for cervical cancer, refer patient for further testing. BreastCare reimburses for a GYN consult in this situation.

B. Referral for Contract Colposcopy

Patients are referred only to participating providers for colposcopy services. BreastCare patients should not be charged for colposcopy services. The provider makes the colposcopy appointment and refers the patient to the RCC.

C. Mammograms

CDC mandates that mammography facilities have Mammogram Quality Standards Act (MQSA) certification.

The provider uses the following descriptions of mammography findings and the Patient Management Protocol Chart to manage all patient mammogram results. Follow-up procedures are based on the clinical breast examination results. The provider must follow up on results of appointments.

Assessment is incomplete – **Category 0 -**This applies if additional studies are needed immediately, such as additional mammographic views, ultrasound, aspiration, etc. Procedures not reimbursable by BreastCare must be fully disclosed.

Negative – **Category 1**- This applies when there is nothing to comment on. The breasts are symmetrical, and no masses, architectural disturbances or suspicious calcifications are present.

Benign finding – **Category 2 -** This applies when there is no mammographic evidence of malignancy, but the mammographic may wish to describe a finding such as multiple secretory calcifications, calcified fibroadenomas, fat containing lesions, and any other findings that may be labeled with confidence. The client may not need any follow-up other than the routine screening.

Probably benign -Short-term follow-up – **Category 3 -** A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability.

Suspicious abnormality - Biopsy should be considered – **Category 4 -** This category applies to lesions that are not characteristic of breast cancer but have a definite probability of being malignant and may be of sufficient concern to warrant a biopsy.

Highly suggestive of malignancy – **Category 5 -** This applies when there is a high probability of cancer. Appropriate action should be taken.

Known Biopsy- Proven malignancy – **Category 6 –** This category is reserved lesions identified on imaging study with biopsy proof of malignancy prior to **Unsatisfactory** - This applies if the mammogram was technically unsatisfactory and could not be interpreted by the radiologist.

D. Referral for Surgical Consultation

A patient is referred only to contract providers for surgical consultation for an abnormal CBE and/or abnormal mammogram. A diagnostic mammogram must be performed before the patient sees a surgeon. The surgical consultants are responsible for performing a thorough clinical breast exam, reviewing mammogram results, and discussing treatment options with the patient. The surgeon may perform covered breast procedures, including excisional, non-excisional and stereotactic biopsies, without a referral or prior approval. The patient should not be billed.

E. Follow-up

The two basic principles related to follow-up are

1. When a diagnostic work-up is required, a final diagnosis **must** be recorded for follow-up to be considered adequate. Refused and lost to follow-up are exceptions.

2. When a diagnostic work-up is required, the time from the Pap test, CBE, and/or mammogram to the final diagnosis should be no more than 60 days.