The organization of the Cancer Screening/Follow-Up Section has been returned to the previous format to assist in access of information. All breast cancer information is presented together followed by cervical cancer information to facilitate clear instruction.

Minimal Requirements for a Cancer Screening Visit Matrix

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# MINIMAL REQUIREMENTS FOR A CANCER SCREENING VISIT

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<th>INITIAL VISIT</th>
<th>ANNUAL VISIT</th>
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<tbody>
<tr>
<td><strong>Comprehensive Health History to include:</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Family history of breast/genital/colon-rectal cancers</td>
<td>(Health History and Physical Examination Form)</td>
<td>(Interval Health History and Physical Examination Form)</td>
</tr>
<tr>
<td>• LMP or date of menopause</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Contraceptive method if childbearing age</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Documentation of HRT or ERT if menopausal</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Date of last Pap/mammogram and results</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Previous abnormal Pap, diagnostics, treatments</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Previous breast problems, diagnostics, treatments</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Assessment for breast/cervical cancer risk factors</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Physical Examination to include:</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Documentation of general appearance and mental status</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Height/Weight/BMI</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Blood pressure</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Clinical breast examination (Using MammaCare® Technique)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Pelvic examination that includes visualization of the vulva, vagina, cervix/vaginal cuff and thorough bimanual including adnexae</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Rectal exam (age 50 and as indicated for others)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Other as needed</td>
<td>Required</td>
<td>Required</td>
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<tr>
<td><strong>Laboratory:</strong> Pap test (as indicated by age guidelines)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Fecal occult blood testing (ages 50 and older)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• 3 kits given with instructions</td>
<td>Required</td>
<td>Required</td>
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<tr>
<td>• If positive, refer to M.D.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Hemoglobin</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>• STD testing</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td>• If indicated by history/exam</td>
<td>If indicated</td>
<td>If indicated</td>
</tr>
<tr>
<td><strong>Referral for annual mammogram (age ≥ 40)</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Counseling:</strong> (Documentation in medical record required)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>- ACH-40 (“Improving Health for Women”) – CSEM given/counseled and patient verbalized understanding</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Monthly BSE/Annual CBE</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Pap/Mammogram rescreening recommendations</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Regular exercise</td>
<td>Required</td>
<td>Required</td>
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<tr>
<td>• Adequate diet (low fat, high fiber, 5 fruits/vegetables daily)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Osteoporosis/prevention and bone density testing</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Risks/Benefits of HRT if menopausal</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Contraception if needed</td>
<td>Required</td>
<td>Required</td>
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<tr>
<td>• Smoking risks/cessation and referral</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Immunization needs/update</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• STD risk counseling if indicated</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>• Ovarian Cancer Screening at age 50 (age 25 if family history) (Locations: UKMC; Hardin, Mason, Floyd, McCracken, and Pulaski County Health Centers) call 1-800-766-8279 for appt.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Documentation of Return Clinic Appointments</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Follow-up of Abnormal Test Results</strong></td>
<td>Required</td>
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BREAST CANCER SCREENING

Early diagnosis of breast cancer offers women more treatment options and greatly reduces mortality. Early diagnosis is aided by the triad of monthly breast self-exam (BSE), annual clinical breast exam (CBE) and, if age appropriate, regular mammography screening.

A. BREAST CANCER RISK FACTORS:
   1. Female age 40 or older
   2. First degree relative (mother, sister, daughter) with history of breast cancer before the age of 50 (pre-menopausal)
   3. Personal history of a benign breast condition
   4. Early menarche (prior to age 12)
   5. Late menopause (after age 52)
   6. No pregnancies or first pregnancy after age 30
   7. Obesity and a high fat diet may also contribute to the development of breast cancer

B. BREAST SCREENING HISTORY:
   1. Include dates and results of previous mammograms
   2. Elicit personal history of breast symptoms including pain, tenderness, nipple discharge, palpable mass or skin changes
   3. Document any personal history of breast cancer and previous biopsies or treatments
   4. Screen for risk factors (listed above)

C. CLINICAL BREAST EXAMINATION AND MAMMOGRAPHY
   1. All females should be taught monthly BSE beginning at age 20. Counseling shall be documented in the medical record at the initial and annual visits.

   2. A clinical breast exam is recommended annually on all females beginning at age 20. The CBE does not need to be repeated outside of annually unless a physician orders more frequent examinations or the patient reports a change in her breast. During their cancer screening visits, women shall be informed to report any changes of their breasts noticed between clinical examinations to the Nurse Case Manager (NCM) at the Local Health Department (LHD) as soon as possible. Also, see “Accepting Referrals from Outside Providers” in the Administrative Reference (AR). If the previous CBE was performed by an outside provider, thorough documentation of the exam done by that provider must be obtained, reviewed by the examining nurse at the LHD and placed in the patient’s chart.

   3. The required method for performing the clinical breast exam and teaching SBE is the MammaCare Method® using the principles of positioning, three levels of palpation, and recommended search patterns.

   4. Routine screening mammograms will begin at age 40 and are recommended on an annual basis. In menstruating women, the mammogram should be scheduled about 2 weeks after the LMP.
5. Women age 30 and older with an abnormal clinical breast examination should be referred for a diagnostic mammogram. If the woman is under the age of 30, an ultrasound is usually preferred as a substitution for the mammogram due to the typically dense breast tissue hindering interpretation of the test; however the radiologist may choose to do a diagnostic mammogram in this age group if appropriate.

6. Women with a family history (mother, sister or daughter) of pre-menopausal breast cancer (before the age of 50) and with a NORMAL CBE should begin yearly screening mammograms 10 years earlier than family member’s breast cancer diagnosis (no younger than age 25). If patient is unable to remember 1st degree family member’s age, begin screening mammogram at age 35.

7. Women that have been diagnosed with either of 4 lesions; atypical hyperplasia, radial scar, papillomatosis, or lobular cancer in situ by biopsy, will need to begin annual screening mammograms.

8. Women with breast implants should be scheduled for an annual screening mammogram beginning at age 40 unless clinical complaint (i.e., pain in breast).

9. Women that have had chest wall radiation will need to begin annual screening mammograms 10 years after radiation completed (no younger than age 25).

10. Women post mastectomy will need annual diagnostic mammogram of the opposite breast.

D. MAGNETIC RESONANCE IMAGING (MRI)

Determination of the need for an MRI for patients will be determined by the contracted breast surgeon or radiologist.

An MRI may be reimbursed as it is noted in the “Approved CPT Codes and Reimbursement Rates for Breast and Cervical Cancer Screening and Follow-up” listing found in this Cancer Screening/Follow-up Section and shown below.

- KWCS will reimburse Breast MRI when performed 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.

- KWCS will reimburse Breast MRI when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment.

- KWCS will not reimburse Breast MRI when performed alone as a breast cancer screening tool.
• KWCSP will not reimburse Breast MRI when performed to assess the extent of disease in women who are already diagnosed with breast cancer.

_The information below is from the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin 103, April 2009, reaffirmed 2013. If the contracted surgeon or radiologist determines that a patient requires further testing that is not reimbursed by the KWCSP an attempt to find other resources may be made._

“Further genetic risk assessment is recommended for women who have more than a 20%-25% chance of having an inherited predisposition to breast or ovarian cancer. These women include:

• Women with a personal history of both breast cancer and ovarian cancer
• Women with ovarian cancer and a close relative—defined as mother, sister, daughter, grandmother, granddaughter, aunt—with ovarian cancer, premenopausal breast cancer, or both
• Women of Ashkenazi Jewish decent with breast cancer who were diagnosed at age 40 or younger or who have ovarian cancer
• Women with breast cancer at 50 or younger and who have a close relative with ovarian cancer or male breast cancer at any age
• Women with a close relative with a known BRCA mutation

Genetic risk assessment may also be appropriate for women with a 5%-10% chance of having hereditary risk, including:

• Women with breast cancer by age 40
• Women with ovarian cancer, primary peritoneal cancer, or fallopian tube cancer or high grade, serous histology at any age
• Women with cancer in both breasts (particularly if the first cancer was diagnosed by age 50)
• Women with breast cancer by age 50 and a close relative with breast cancer by age 50
• Women with breast cancer at any age and two or more close relatives with breast cancer at any age (particularly if at least one case of breast cancer was diagnosed by age 50)
• Unaffected women with a close relative that meets one of the previous criteria”

E. PATIENT EDUCATION ON BREAST HEALTH

1. Counseling with documentation at the initial and annual visits shall include teaching BSE using the MammaCare method, individual breast cancer risk factors and the importance of annual CBE with regular mammogram screenings if age appropriate.
2. Patients with either an abnormal CBE or mammogram result will have documented counseling done as appropriate.
BREAST CANCER FOLLOW-UP

POST BREAST DIAGNOSTICS OR TREATMENT

Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment (if applicable), the contracted qualified clinician (breast surgeon, radiologist, etc.) will provide an order for the patient’s next screening. If this is not received, the NCM must contact the contracted qualified clinician to obtain an order. Even if the patient has a diagnosis with a benign finding, the clinician must give an order for the patient’s next screening schedule after follow-up of an abnormal screening test result.

A. SURGICAL REFERRALS

1. Women with an abnormal CBE must be referred for surgical consultation regardless of diagnostic mammogram or ultrasound results unless CBE is done by radiologist and found to be negative/benign. Thorough documentation by the radiologist shall be required.
2. Any patient with a bloody nipple discharge (unilateral or bilateral) requires a referral to a surgeon for evaluation.
3. Any patient with a spontaneous (without nipple stimulation) and/or unilateral nipple discharge requires a referral to a surgeon for evaluation.
4. Bilateral non-bloody discharge that occurs only with nipple stimulation does not need referral to a surgeon. This type of nipple discharge may be due to fibrocystic changes (usually greenish), hormonal imbalance, pregnancy, lactation and some medications (oral contraceptives, phenothiazides, anti-hypertensives, tranquilizers). If the clinician (MD or ARNP) determines the need for further evaluation of this type of nipple discharge, it typically is to either a gynecologist or endocrinologist.
5. If a patient presents with a “breast lump” that she has discovered on BSE but both the CBE and mammogram (or ultrasound) are normal, she may be referred to a surgeon for a second opinion. The patient may also be referred to another contracted provider for a second opinion for other concerns she may have regarding her care during screening. For KWCSV eligible patients, the second opinion will be reimbursed by the program for services listed on the approved CPT codes list found in the CCSG.
6. A patient who has a personal history of breast cancer shall be scheduled for a surgical consult with her annual mammogram regardless of CBE or mammogram result. This will be reimbursed by the KWCSV for program eligible women.
7. After an initial abnormal finding, when there is an order from a contracted qualified clinician (breast surgeon, radiologist, etc.) for frequent follow-up mammograms, ultrasounds, CBEs or surgical consults, these services will be paid for by the KWCSV until the patient has been released into normal routine screening by this provider. These follow-up services may show normal or abnormal findings. However, the continued frequent screening services will be reimbursed by the program until the patient is released to routine screening. National standards recommend frequent follow-up to continue for up to 2-3 years for specific original findings on radiology testing and clinical findings. This determination will be made by the contracted qualified clinician (radiologist or breast surgeon).
B. **FOLLOW-UP**

1. Patients with an abnormal mammogram or ultrasound result shall be notified by the health department within 10 working days of receiving the result or within 30 days of the procedure, whichever comes first.

2. Referrals for a surgical consult, requested additional mammography views or request for a breast ultrasound must be made within 3 weeks (21 days) of abnormal CBE or receipt of abnormal mammogram.

3. A final diagnosis must be made within 60 days of the abnormal CBE or abnormal mammogram result (from date screened).

4. Copies of results from consults & diagnostic procedures (including pathology reports) will be received and placed in the medical record within 30 days of the consult or diagnostic procedure.

5. The month and year the next mammogram is due will be documented on the CH3A. A patient with normal screening results will follow the appropriate routine screening guidelines unless there is a reported change in her breasts. For patients who have been scheduled for abnormal test follow-up with a contracted provider, the order for the next mammogram or other future screening and diagnostic procedures shall be provided by the contracted qualified clinician (breast surgeon, radiologist, etc.) and noted in the patient’s chart. The NCM shall inform the patient of her next screening or diagnostic procedure that is ordered.

C. **TREATMENT**

Patients that have been screened/diagnosed through KWCSP may be eligible for the treatment fund if diagnosed with pre-cancer/cancer of breast. For more information and forms related to BCCTP, please refer to their website at [http://chfs.ky.gov/dms/bcctp](http://chfs.ky.gov/dms/bcctp).

To be eligible for Medicaid, an applicant or recipient shall be a citizen of the United States as verified through documented evidence presented during initial application as required in 907 KAR 1:011. The LHD shall verify patient’s identity and citizenship by viewing the patient’s driver license and birth certificate. For patients who were born in Kentucky and do not have a copy of their birth certificate or for more information about the citizenship documentation requirement, contact the Department for Medicaid Services at 502-564-6204. Other patients will need to contact Vital Statistics in their state of birth in order to obtain an original birth certificate. A passport may also be used for documentation of both identity and citizenship.

Complete the Pre-screening Eligibility Form using the Medicaid Web application. Then, complete application and call Medicaid for confirmation number. The original signed application, Pre-screening Eligibility Form and proof of identity and citizenship should be maintained in the patient’s chart in the administrative section.

As stated on the Department for Medicaid Services BCCTP website, some patients may require longer than the standard period of treatment and may be granted a Medicaid eligibility extension. An eligibility extension form (MAP - 813D Breast and Cervical Cancer Treatment Program Extension) can be obtained from the department's Web site or by calling toll-free (866) 818-0073.
During the initial BCCTP application process, the **NCM shall inform the patient to contact the NCM two weeks prior to the end of her Medicaid eligibility period** if her treatment plan will extend past that eligibility period. Extension requests must be initiated by the treating physician. **The NCM will assist the physician in obtaining an extension form to complete on the patient’s behalf.** When extension request review is completed, recipients will receive a notice of their new eligibility status. The link for information related to the BCCTP is [http://chfs.ky.gov/dms/bcctp](http://chfs.ky.gov/dms/bcctp).

### Treatment Program Eligibility Information

- A Pap test, mammogram, ultrasound or MRI does not provide a definitive diagnosis of pre-cancer or cancer. These are considered screening tests. A patient must have a **biopsy** that confirms either a diagnosis of **cancer or pre-cancer** of the cervix or breast for her to be eligible for the BCCTP.
- Cancer or pre-cancer of the vagina, vulva, labia or uterine/endometrial lining do not make a patient eligible for the BCCTP. The BCCTP is for cancer or pre-cancer treatment of the breast or cervix for women diagnosed through the KWCSP.
- A biopsy result of **CIN II Moderate Dysplasia or greater** on a biopsy of the cervix is required for a patient to be considered eligible clinically for the BCCTP.
- Once the biopsy diagnosis is confirmed, the NCM will begin the process of ensuring that an application is completed for the patient to be enrolled with Medicaid (BCCTP).
- The NCM is responsible for initiating the BCCTP application when a final diagnosis has been received and patient eligibility determined. Support staff at the LHD may assist or perform the application process.

Below, are some conditions that are considered pre-cancerous conditions when found on a biopsy. If the patient receives one of these diagnoses or a diagnosis of cancer, she is eligible for the BCCTP.

**Breast Pre-cancerous Conditions**
- Lobular carcinoma-in-situ
- Atypical hyperplasia
- Benign Phylloides tumors
- Some types of papillomatosis
- Radial scar sometimes referred to as sclerosing lesions

### D. BI-RADS Classification of Mammogram Results and Management

**Category 0: Assessment Incomplete**

This category indicates the need for additional imaging, which will be recommended by the radiologist or old films required for comparison.

**Category 1: Negative**

Recommendation should be made for routine follow-up according to the screening guidelines. Notify the patient when it is time for re-screening.

(Refer to surgeon if CBE is abnormal)

**Category 2: Benign Finding**

Recommendation should be made for routine follow-up according to the screening guidelines. Notify the patient when it is time for re-screening.
Category 3: **Probably Benign**
Follow-up should be provided according to the radiologist’s recommendation. Usually the radiologist will recommend a repeat mammogram in six months. Counsel the patient on the results of the mammogram and provide a re-screening appointment. (Refer to surgeon if CBE is abnormal)

Category 4: **Suspicious Abnormality**
A biopsy should be considered. Refer to a surgeon for further evaluation. Counsel the patient on the results of the mammogram and assure that arrangements are made for the surgical consultation.

Category 5: **Highly Suggestive of Malignancy**
There is probability of cancer. Refer to a surgeon for further evaluation. Counsel the patient on the results of the mammogram and assure that the arrangements are made for the surgical consultation.

Category 6: **Known Biopsy-Proven Malignancy-Appropriate Action Should Be Taken**
This category is reserved for lesions identified on the imaging study with biopsy proof of malignancy prior to definitive therapy.
ALGORITHM FOR BREAST CANCER SCREENING FOLLOW-UP

ANNUAL CLINICAL BREAST EXAMINATION

NORMAL & BENIGN FINDINGS ON CBE
(Includes fibrocystic changes & normal nodularity)

1. REPEAT CBE IN ONE YEAR
2. ANNUAL SCREENING MAMMOGRAM IF AGE 40 AND OLDER
3. IF SCREENING MAMMOGRAM IS ABNORMAL, PATIENT TO BE NOTIFIED WITHIN 10 DAYS OF RECEIVING THE RESULT OR WITHIN 30 DAYS OF THE PROCEDURE (whichever comes first)
4. A FINAL DIAGNOSIS OBTAINED WITHIN 60 DAYS OF DETECTION OF THE ABNORMALITY (from date screened)
5. OBTAIN SCREENING MAMMOGRAM WRITTEN REPORT WITHIN 60 DAYS OF THE PROCEDURE

ABNORMAL CBE
(Discrete mass or abnormal thickening)

1. BREAST ULTRASOUND (ages 29 and under)
2. DIAGNOSTIC MAMMOGRAM (ages 30 & older) and ultrasound if needed
3. SURGICAL REFERRAL APPOINTMENT WITHIN 3 WEEKS OF DISCOVERY OF ABNORMAL CBE (Regardless of ultrasound and/or mammogram results - unless CBE repeated by radiologist and normal/benign result - must have thorough documentation from radiologist)
4. FINAL DIAGNOSIS OBTAINED WITHIN 60 DAYS OF DETECTION OF ABNORMALITY (from date screened)
5. RECORDS TO BE RECEIVED WITHIN 30 DAYS OF CONSULT/PROCEDURES
6. FOLLOW RECOMMENDATIONS OF SURGEON AND/OR RADIOLOGIST
CERVICAL CANCER SCREENING

Routine periodic screening encourages early identification of precancerous conditions of the cervix and early stage diagnosis of cervical cancer. Most cervical cancer can be PREVENTED with detection and early treatment of precancerous lesions.

A. CERVICAL CANCER RISK FACTORS
   This is an overall list of factors and/or behaviors which may increase the risk for cervical cancer. Some factors on this list are not considered when making the determination for a patient’s Pap screening interval. See “Cervical Cancer Screening Guidelines” for factors that are used to determine when a patient is considered “high-risk” and not eligible for increasing the time interval between screenings.
   
   1. History of HPV and/or Dysplasia
   2. Multiple (3 or more) sexual partners in lifetime
   3. A sex partner with multiple sex partners
   4. A sex partner who has had a partner with HPV/dysplasia/cervical cancer
   5. Cigarette smoking (any amount)
   6. Beginning sexual intercourse at a young age (age 18 or less)
   7. History of 2 or more sexually transmitted infections
   8. Intrauterine exposure to diethylstilbestrol (DES)
   9. Infrequent screening (>5 years since last Pap)
   10. Immunosuppressed (HIV/AIDS, diabetes, transplant recipient, chronic steroid use, auto-immune disorders)

B. CERVICAL SCREENING HISTORY
   1. Elicit date and result of last Pap test
   2. Determine if a previous history of an abnormal Pap and/or HPV
   3. Determine if history of a previous colposcopy & biopsy and/or treatment
   4. Screen for risk factors (listed above)
   5. Screen for history of abnormal bleeding patterns

PELVIC EXAMINATION

The purpose of this section is to outline components of a pelvic exam, when to start screening, and how often to continue screening.

The pelvic examination serves multiple purposes, including the assessment of the vulva, vagina, cervix, uterus and adnexa. The pelvic examination includes:
   - inspection of the external genitalia, urethra and introitus;
   - examination of the vagina and cervix; and
   - bimanual examination of the uterus, cervix, adnexa and ovaries.

If indicated, rectovaginal examination is performed as a part of the examination. Some health care providers incorporate the rectovaginal examination as part of the routine examination.
Annual pelvic examination is a routine part of the preventive care for all women 21 years of age and older even if they do not need a Pap smear. A bimanual pelvic examination is generally not necessary at the initial reproductive health visit. A general physical examination, including an external genital examination, may be done because it allows assessment of secondary sexual development, reassurance and education. A “teaching” external-only genital examination can provide an opportunity to familiarize adolescents with normal anatomy, assess adequacy of hygiene and allow the health care provider an opportunity to visualize the perineum for any anomalies. Pelvic examination need only be performed in adolescents when it is likely to yield important information regarding conditions such as amenorrhea, abnormal bleeding, vaginitis, presence of a possible foreign body, pelvic pain, pelvic mass or a sexually transmitted disease (STD). If the patient has had sexual intercourse, screening for STDs is important. Refer to STD Guidelines.

Refer any abnormal finding on the pelvic examination to a midlevel or higher clinician or a contracted gynecologist for further evaluation.

Adapted from ACOG Committee Opinion, Number 431, May 2009.

**CERVICAL CANCER SCREENING GUIDELINES**

Patients with a cervical history of CIN2, CIN3 or cervical cancer, in utero exposure to DES or who are immunocompromised, as stated above, are considered high-risk patients when determining their cancer screening interval options.

**Notes:**

*The physician who treats a patient’s CIN2, CIN3 or cervical cancer will determine the interval between future screenings and the length of screening surveillance, including possible extension of screening past the age of 65.*

**FOR ALL PATIENTS WHO ARE SENT TO A CONTRACTED GYNECOLOGIST OR COLPOSCOPIST:**

Once her diagnostic procedures are complete and she has a diagnosis and treatment if applicable, the contracted clinician (gynecologist or colposcopist) who diagnoses and/or treats will provide an order for the patient’s future screening schedule. If this is not received, the NCM must contact this provider to obtain an order. If a patient has a history of colposcopy at another provider’s office, the records and order for future screening schedule should be obtained from that office.

1. **WOMEN AGES 21-29:**
   without a history of CIN2, CIN3 or cervical cancer, or in utero exposure to DES and who are not immunocompromised (non high-risk patient) should have cytology screening every 3 years. Also, see notes above for patients who have a history including colposcopy. Pap tests should begin at 21 years of age (may be done earlier at clinician’s discretion based on
abnormal clinical findings). If the patient is a minor with a potentially life-threatening test result (includes “Adenocarcinoma-In-Situ”, “HSIL” or “ASC-H” result) and cannot be contacted, the parent or guardian may be contacted (KRS 214.185(6)). Minors shall be made aware of this policy at the screening visit.

2. **WOMEN AGES 30-65:**

   without a history of CIN2, CIN3, cervical cancer, or in utero exposure to DES and who are not immunocompromised (non high-risk patient) have two options for cervical cancer screening and must be offered both options by the LHD. Also, see notes above for patients who have a history including colposcopy. One recommendation for screening is **cytology every 3 years**. Another option for women in this age group, who want to lengthen the screening interval, is screening with a combination of cytology and HPV testing every 5 years (“co-testing”).

   Screening by co-testing which includes Pap test and HPV High Risk DNA testing is the preferred standard for non-high risk patients in this age group and all grantees of the CDC NBCCEDP grant must offer this option to patients who do not have any contraindications listed in the previous paragraph. The decision will be made by the patient. “Women choosing co-testing to increase their screening interval should be aware that positive screening results are more likely with HPV-based strategies than with cytology alone and that some women may require prolonged surveillance with additional frequent testing if they have persistently positive HPV results. The percentage of U.S. women undergoing co-testing who will have a normal cytology test result and a positive HPV test result (and who therefore require additional testing) ranges from 11% among women age 30 to 34 years to 2.6% among women age 60 to 65 years.” A percentage rate was not reported for women ages 35-59.

   *The High Risk HPV DNA panel will only be covered by the KWCSP when testing meets the criteria stated in the notes on the “Approved CPT Codes” listing in the CCSG.*

**SPECIAL POPULATIONS:**

Women with the following conditions should be screened according to orders from the contracted gynecologist regardless of their age: immunosuppression (i.e., renal transplant, etc.), HIV infection, history of CIN2, CIN3, cervical cancer or DES exposure in utero. If uncertain of whether a patient’s condition/disease would cause immunosuppression, consult your medical director or contracted clinician.

According to CDC April and May/June 2012 guidance newsletters, **women who have had cervical cancer should continue screening indefinitely** as long as they are in reasonable health. The exact intervals of this screening are not clear, but the recommendations define it as “every 3 years after a period of intense screening”. The NCM shall contact the contracted provider to determine screening guidelines for these patients. The type of follow-up will often be determined by the provider according to the extent of the cancer.
WOMEN FOLLOWING HYSTERECTOMY

- Women at any age following a hysterectomy with removal of the cervix who do not have a positive history of CIN2, CIN3 or cervical cancer:
  - Should not be screened for vaginal cancer using any modality according to the ACS-ASCCP-ASCP screening guidelines released in November 2012.

- Women at any age following a hysterectomy with removal of the cervix who have a positive history of CIN2, CIN3 or cervical cancer:
  - Should be screened as stated in the preceding section titled “Special Populations”. Vaginal/vulvar/labial Pap tests or biopsies shall be performed by the LHD contracted clinician (gynecologist or colposcopist) for patients with a history of CIN2, CIN3, cervical cancer or for an abnormal physical finding during an exam performed at the LHD.

SCREENING AND REIMBURSEMENT INFORMATION FOR VAGINAL, LABIAL OR VULVAR PROCEDURES

Women 21-39 years of age:
- with no health insurance, Medicare or Medicaid
- who have a household income at or below 250% of the federal poverty level
- with a history of treatment for CIN 2, CIN 3 or cervical cancer

Vaginal Pap tests and/or diagnostic follow-up may be reimbursed by state preventative block grant funds, local funds or other resources when the criteria above is met. Vaginal Pap tests and/or diagnostic follow-up will be performed by the contracted clinician (gynecologist or colposcopist).

Women 40-64 years of age:
- with no health insurance, Medicare or Medicaid
- who have a household income at or below 250% of the federal poverty level
- with a history of treatment for CIN 2, CIN 3 or cervical cancer

Vaginal Pap tests and/or diagnostic follow-up shall be reimbursed by KWCSP federal funds when the above criteria are met. Vaginal Pap tests and/or diagnostic follow-up will be performed by the contracted clinician (gynecologist or colposcopist).

Women of any age:
- If a vulvar or labial lesion is found during an examination, the patient shall be informed that this abnormal finding will need follow-up to rule out cancer. Vulvar and labial screening/diagnostic follow-up will be performed by the
contracted clinician (gynecologist or colposcopist). Vulvar or labial procedures may not be reimbursed by the KWCSP or state preventative block grant funding.

- Follow-up for any abnormal findings of the vagina, vulva or labia will be determined by the gynecologist who performs the screening and/or diagnostic procedures for the patient.

**WOMEN OLDER THAN 65**

Women older than 65 with documentation of adequate negative prior screening, who are not otherwise at high risk for cervical cancer and have no history of CIN2, CIN3 or cervical cancer within the last 20 years should not be screened. Adequate negative prior screening is three consecutive negative cytology results or two consecutive negative co-tests within the 10 years before cessation of screening, with the most recent test occurring within the past 5 years.

**WOMEN IN ABNORMAL FOLLOW-UP**

Guidance for follow-up of an abnormal Pap test result is found under the heading of MANAGEMENT OF ABNORMAL PAP TEST RESULTS in the CCSG. This should be referenced when planning case management. However, the contracted qualified clinician (gynecologist, colposcopist, etc.) who provides the colposcopy and/or treatment will direct patient care. Services that can be reimbursed are found on the approved CPT code list found in the CCSG. Medical providers and patients shall be made aware of services that can be reimbursed. Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment if applicable, the contracted clinician who diagnoses and/or treats will provide an order for the patient’s next screening. If this is not received, the NCM must contact this provider to obtain an order.

**WOMEN WHO HAVE RECEIVED HPV VACCINE**

Women who have received the HPV vaccine should continue to be screened according to the age-appropriate guidelines.

# Age – Delineated Cervical Cancer Screening Schedule

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Screening Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages &lt; 21</td>
<td>No Screening</td>
</tr>
<tr>
<td>Ages 21-29</td>
<td>Screen Every 3 yr (annually if History of CIN2/3, HIV positive, immunosuppressed, history of DES exposure)</td>
</tr>
<tr>
<td>Ages 30-65</td>
<td>History of CIN2/3, HIV-positive, immunosuppressed, history of DES exposure</td>
</tr>
<tr>
<td>Ages &gt; 65</td>
<td>Discontinue screening IF: (1) Adequate negative prior screening* (2) No CIN2 or greater within 20 years (3) No exposure to DES in utero (4) No history of cervical cancer (5) Not immunosuppressed</td>
</tr>
</tbody>
</table>

*Adequate negative prior screening is three consecutive negative cytology results or two consecutive negative co-tests within the 10 years before cessation of screening, with the most recent test occurring within the past 5 years.
CERVICAL CANCER FOLLOW-UP

A. THE BETHESDA 2001 SYSTEM
The Bethesda System for reporting cervical and/or vaginal cytology is the recognized system for reporting results. The LHD is required to contract with a laboratory that uses this system of reporting. The state computerized reporting options for Pap test findings and the protocols for management of abnormal findings are based on the Bethesda 2001 System.

SPECIMEN ADEQUACY
- Satisfactory
- Unsatisfactory

GENERAL CATEGORIZATION
- Negative for Intraepithelial Lesion or Malignancy (NIL)
- Epithelial Cell Abnormality

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY WITH:
- Presence of Organisms
  - Trichomoniasis
  - Candida
  - Shift in vaginal flora suggestive of bacterial vaginosis
  - Bacterial morphology consistent with Actinomyces
  - Cellular changes consistent with Herpes simplex virus
- Reactive cellular changes
  - Inflammation
  - Radiation effects
  - IUD effects
  - Metaplasia (normal)
  - Atrophy

EPITHELIAL CELL ABNORMALITIES PRESENT

Squamous Cell Abnormality
- Atypical Squamous Cells of Undetermined Significance (ASC-US)
- Atypical Squamous Cells cannot exclude a High-Grade Lesion (ASC-H)
- Low Grade Squamous Intraepithelial Lesion (LSIL)
- High Grade Squamous Intraepithelial Lesion (HSIL)
- Squamous Cell Carcinoma

GLANDULAR CELL ABNORMALITY (AGC)
- Atypical endocervical, glandular or endometrial cells
- Adenocarcinoma-In-Situ or Adenocarcinoma
B. PATIENT EDUCATION ON CERVICAL HEALTH
   1. Counseling on cervical cancer risk factors, Human Papillomavirus (HPV) testing and risk reduction (including smoking cessation) during screening visits is required.
   2. Counseling on the HPV vaccination shall be provided to the patient and the parent of minors when applicable.
   3. Patients must have documented counseling as appropriate.

C. FOLLOW-UP
   1. Refer patient if abnormal cervix or polyps visualized.
   2. Patients with abnormal Pap test shall be notified within 10 working days from the date the Pap test is received at the clinic.
   3. Referral appointments must be made within 3 weeks (21 days) of the clinic receiving the abnormal Pap test result. Any delay in meeting this timeframe must be documented in the patient’s medical record, including any “1st available” appointment.
   4. A final diagnosis must be made within 60 days of the Pap test screening. The final diagnosis is based on colposcopy and biopsy results.
   5. Results of referrals including colposcopy, biopsy path reports, cryotherapy, Loop electrosurgical excision procedure (LEEP) procedure and pathology reports, Cold Knife Conization (CKC) procedure and pathology reports and Laser treatment documentation must be received within 30 days of the procedure.
   6. The month and year the next Pap test is due is to be documented on the progress note. The nurse's note should include the doctor’s or colposcopist’s name, date and source of the order (verbal order, doctor’s office note in chart, etc.) for the next screening or diagnostic procedure.

D. MANAGEMENT OF ABNORMAL PAP TEST RESULTS
   (Numbers correspond to PSRS submission)

   Follow-up for any abnormal findings of the vagina, vulva or labia will be determined by the contracted clinician (gynecologist or colposcopist) who performs the screening and/or diagnostic procedures for the patient. Also, see SCREENING AND REIMBURSEMENT INFORMATION FOR VAGINAL, LABIAL OR VULVAR PROCEDURES

   #1 SATISFACTORY / NEGATIVE FOR INTRAEPITHELIAL LESION

   Refer patient if abnormal cervix or polyps visualized

   Management of Women Age 30 and older with Co-Testing:

   CYTOLOGY NEGATIVE- HPV NEGATIVE (COTESTING)
   • SEE CERVICAL CANCER SCREENING GUIDELINES AT THE BEGINNING OF THE CERVICAL CANCER SCREENING SECTION for scheduling patient’s next screening unless she is currently in abnormal follow-up. If the current Pap result was part of follow-up for a previous abnormal, refer to physician’s order for next screening.
CYTOLOGY NEGATIVE-HPV POSITIVE (CO-TESTING)


Women cotesting HPV positive, cytology negative should be followed with either:

**Option 1)** Repeat Cotesting in 1 year if this was her first co-test. **If this was her second follow-up co-test,** with result of ASCUS OR HPV positive, she should be referred for colposcopy. If the second follow-up co-test is Cytology Negative and HPV Negative, then Repeat Co-Testing @ 3 years.

OR

**Option 2)** perform immediate HPV DNA Typing / genotype-specific testing for HPV16 alone or for HPV 16/18. **AT THIS TIME CDC POLICY ONLY ALLOWS REIMBURSEMENT FOR HPV PANEL.**

If HPV 16 and HPV 18 is negative, rescreen in 1 year with co-testing. If HPV 16 or HPV 18 is positive, refer for colposcopy.

CYTOLOGY NEGATIVE BUT EC/TZ ABSENT/INSUFFICIENT

- AGES 21-29: routine screening (HPV testing is unacceptable)
- AGES 30 and OLDER:
  1. HPV Negative: routine screening
  2. HPV Positive: Cytology plus HPV testing in 1 year OR Genotyping
  3. HPV Unknown: HPV testing (Preferred) OR Repeat Cytology in 3 years (Acceptable). If HPV testing is negative then can return to Routine screening but if HPV is positive then will need to repeat Cytology and HPV test in 1 year OR Genotyping

SATISFACTORY/NEGATIVE FOR INTRAEPITHELIAL LESION WITH PRESENCE OF ORGANISMS OR REACTIVE CELLULAR CHANGES:

- Clinician consult to decide if treatment is indicated
- Repeat Pap test at next scheduled screening

ENDOMETRIAL OR GLANDULAR CELLS PRESENT ON A NEGATIVE PAP:

When there is a result of “endometrial cells in a woman past age 40” on a negative Pap test result, the NCM shall contact the contracted provider. The NCM will provide all pertinent medical history to the physician including past cervical history and test results, age, and current Pap results. The physician will determine follow-up for the patient. If the patient is KWCSP eligible, services on the approved CPT code list in the CCSG will be reimbursed by the program.
#2 ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE (ASC-US)


Women ages 21-24:
1. Repeat Cytology @ 12 months (Preferred)
   - NEG, ASCUS, LSIL results: need to Repeat Cytology @ 12 months and if Negative x 2 then return to routine screening. If this repeat is ASCUS or greater refer to colposcopy.
   - On the first repeat cytology if result is ASCUS-H, AGC, HSIL need to Refer for Colposcopy

2. Reflex HPV Testing (Acceptable)
   - If HPV Negative then return to Routine screening (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)
   - If HPV Positive then Repeat Cytology at 12 months (See two bullets under #1 for follow-up).

Women ages 25 and older:
1. HPV Testing (Preferred)
   - HPV Positive needs Referral for Colposcopy
   - HPV Negative will need Repeat Co-Testing @ 3 years (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)

2. Repeat Cytology at 1 year (Acceptable)
   - If Repeat is Negative go to Routine Screening (Cytology in 3 years if she is not considered high risk according to the criteria found under Cervical Screening Guidelines in the CCSG)
   - If Repeat is ASCUS or worse needs Referral for Colposcopy

#3 ATYPICAL SQUAMOUS CELLS CANNOT RULE OUT HIGH GRADE (ASC-H)

Women ages 21-24:
- Refer for colposcopy (immediate LEEP is unacceptable)

Women ages 25 and older:
- Refer for colposcopy evaluation regardless of HPV status

For patients under 21 who were screened prior to the 2009 ACOG screening guideline changes, refer patient to your contracted provider for ASC-H Pap results.
#4 LOW GRADE INTRAEPITHELIAL NEOPLASIA (CIN I, Mild dysplasia, HPV) (LSIL)

Women ages 21-24:
1. Repeat Cytology @ 12 months (Preferred)
   - NEG, ASCUS, LSIL results: need to Repeat Cytology @ 12 months and if Negative x 2 then return to routine screening. If this repeat is ASCUS or greater refer to colposcopy.
   - On the first repeat cytology if result is ASCUS-H, AGC, HSIL need to Refer for Colposcopy
2. Reflex HPV Testing (Acceptable)
   - If HPV Negative then return to Routine screening (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)
   - If HPV Positive then Repeat Cytology at 12 months (See two bullets under #1 for follow-up).

Women ages 25 and older:
With Negative HPV Test: Repeat Co-Testing @ 1 year (Preferred) OR Refer for Colposcopy (Acceptable). If Repeat Co-Testing is done and Cytology is Negative and HPV is Negative then may Repeat Co-Testing @ 3 years. If Repeat Co-Testing is done and Cytology is ASCUS or worse OR HPV Test is Positive then would Refer for Colposcopy.
   1. With No HPV Test: Refer for Colposcopy
   2. With Positive HPV Test: Refer for Colposcopy

For patients under 21 who were screened prior to the 2009 ACOG screening guideline changes, no follow-up required and patient should return for annual Pap screening until age 21.

#5 HIGH GRADE INTRAEPITHELIAL NEOPLASIA (CIN II, CIN III, Moderate-Severe dysplasia, or carcinoma-in-situ) (HSIL)

Women ages 21-24:
- Refer for Colposcopy evaluation (Immediate LEEP is unacceptable)

Women ages 25 and older:
- Refer for colposcopy evaluation or LEEP.
- The contracted provider shall perform a review of the cytology, colposcopy, and histology results when no lesion or only biopsy-confirmed CIN 1 is identified after colposcopy in women with HSIL Pap test reports. If the review yields a revised interpretation, management should follow guidelines for the revised interpretation; if a cytological interpretation of HSIL is upheld or if review is not possible, a diagnostic excisional procedure (e.g., LEEP) is preferred in nonpregnant patients.

For patients under 21 who were screened prior to 2009 ACOG screening guideline changes, refer patient to your contracted provider for HSIL Pap results.
#6 SQUAMOUS CELL CARCINOMA
- Refer to a qualified provider

#7 ADENOCARCINOMA OR ADENOCARCINOMA-IN-SITU
- Refer to a qualified provider

#8 UNSATISFACTORY
1. HPV unknown (any age): Repeat Cytology after 2-4 months
2. HPV Negative (age 30 and older): Repeat Cytology after 2-4 months
3. HPV Positive (age 30 and older): Repeat Cytology after 2-4 months OR Refer for Colposcopy (either is Acceptable)
   *If Repeat Cytology is:
   Abnormal: Manage per ASCCP guidelines (See Management of Abnormal Pap Test Results per CCSG)
   Negative: Routine Screening (HPV negative or unknown) OR Cotesting @ 1 year
   (HPV positive)
   Unsatisfactory: Refer for Colposcopy

#9 ATYPICAL GLANDULAR CELLS OF UNDETERMINED SIGNIFICANCE (AGC)
- Contact contracted provider for order of follow-up. The NCM will provide all pertinent medical history to the physician including past cervical history and test results, age, and current Pap results. The physician will determine follow-up for the patient. If the patient is KWCSP eligible, services on the approved CPT code list in the CCSG will be reimbursed by the program.

The Consensus Guidelines updated 2012-2013 for cervical follow-up are on the American Society for Colposcopy and Cervical Pathology website at [http://www.asccp.org/](http://www.asccp.org/). Due to copyright restrictions, we are unable to include the ASCCP algorithms in the CCSG. However, LHD nurses are encouraged to print the cytology follow-up algorithms from the ASCCP website for their own use.

E. TREATMENT
Patients that have been screened/diagnosed through KWCSP may be eligible for the treatment fund if diagnosed with pre-cancer/cancer of cervix (includes endocervical). For more information and forms related to BCCTP, please refer to their website at [http://chfs.ky.gov/dms/bcctp](http://chfs.ky.gov/dms/bcctp).

To be eligible for Medicaid, an applicant or recipient shall be a citizen of the United States as verified through documented evidence presented during initial application as required in 907 KAR 1:011. The LHD shall verify patient’s identity and citizenship by viewing the patient’s driver license and birth certificate. For patients who were born in Kentucky and do not have a copy of their birth certificate or for more information about the citizenship documentation requirement, contact the Department for Medicaid Services at 502-564-6204. Other patients will need to contact Vital Statistics in their state of birth in order to obtain an original birth certificate. A passport may also be used for documentation of both identity and citizenship.

Complete the Pre-screening Eligibility Form using the Medicaid web application. Then, complete application and call Medicaid for confirmation number. The original signed
application, Pre-screening Eligibility Form and proof of identity and citizenship should be maintained in the patient’s chart in the administrative section.

As stated on the Department for Medicaid Services BCCTP website, some patients may require longer than the standard period of treatment and may be granted a Medicaid eligibility extension. An eligibility extension form (MAP - 813D Breast and Cervical Cancer Treatment Program Extension) can be obtained from the department's website or by calling toll-free (866) 818-0073.

During the initial BCCTP application process, the NCM shall inform the patient to contact the NCM two weeks prior to the end of her Medicaid eligibility period if her treatment plan will extend past that eligibility period. Extension requests must be initiated by the treating physician. The NCM will assist the physician in obtaining an extension form to complete on the patient’s behalf.

When extension request review is completed, recipients will receive a notice of their new eligibility status. The link for information related to the BCCTP is http://chfs.ky.gov/dms/bcctp/.

**TREATMENT PROGRAM ELIGIBILITY INFORMATION**

- A Pap test, mammogram, ultrasound or MRI does not provide a definitive diagnosis of pre-cancer or cancer. These are considered screening tests.
- A patient must have a biopsy that confirms either a diagnosis of cancer or pre-cancer of the cervix or breast for her to be eligible for the BCCTP.
- Cancer or pre-cancer of the vagina, vulva, labia or uterine/endometrial lining do not make a patient eligible for the BCCTP. The BCCTP is for cancer or pre-cancer treatment of the breast or cervix for women diagnosed through the KWCSP.
- A result of HSIL on a biopsy of the cervix is required for a patient to be considered eligible clinically for the BCCTP.
- Once the biopsy diagnosis is confirmed, the NCM will begin the process of ensuring that an application is completed for the patient to be enrolled with Medicaid (BCCTP).
- The NCM is responsible for initiating the BCCTP application when a final diagnosis has been received and patient eligibility determined. Support staff at the LHD may assist or perform the application process.

Below, are some conditions that are considered pre-cancerous conditions when found on a biopsy. If the patient receives one of these diagnoses or a diagnosis of cancer, she is eligible for the BCCTP.

**Cervical Pre-cancerous Conditions**

- High grade squamous epithelial lesions (HSIL)
- Adenocarcinoma-in-Situ

**LOOP ELECTRICAL EXCISION PROCEDURE (LEEP), Diagnostic vs Treatment**

A local surgical procedure known as a LEEP or a cone biopsy can be considered either a diagnostic or treatment procedure.
A patient’s colposcopy biopsy may be benign, show mild dysplasia or a biopsy may not be performed. However, a physician may determine that it is necessary to perform a LEEP to obtain a more comprehensive or accurate specimen.

- When a patient’s colposcopy biopsy is benign, mild or a biopsy was not performed, a LEEP would be considered a **diagnostic** procedure and would be covered under the **KWCSP**.

- When a LEEP procedure is performed on a patient who had a colposcopy diagnosis of HSIL, the LEEP would be considered **treatment** and should be covered under the **BCCTP**.

The NCM shall ensure that the patient begins the application process for the BCCTP after receiving the colposcopy diagnosis of cancer or pre-cancer.

**F. POST COLPOSCOPY EVALUATION OR TREATMENT**

Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment (if applicable), the contracted qualified clinician (gynecologist, colposcopist, etc.) providing the colposcopy and/or treatment will provide an order for the patient’s next screening. If this is not received, the NCM must contact this provider to obtain an order. Even if the patient has a diagnosis with a benign finding, the contracted clinician who provided this diagnosis must give an order for the patient’s next screening schedule after follow-up of an abnormal screening test result.
TRACKING AND FOLLOW-UP REQUIREMENTS

The Local Health Department (LHD) is accountable for tracking patients with abnormal screening test results regardless of the patient’s age, income or insurance status, to ensure that all women receive the necessary re-screening or diagnostic follow-up services to reach a timely final diagnosis and begin treatment. This includes those patients where the screening occurred in another program such as family planning, pediatrics, or prenatal.

Each clinic site is responsible for assigning this tracking responsibility to a Registered Nurse, Advanced Registered Nurse Practitioner or Licensed Practical Nurse. The nurse that assumes this responsibility is referred to as the Nurse Case Manager (NCM).

Prior to assuming the role and responsibilities of NCM with the KWCSP, the nurse must complete the following educational modules on TRAIN:

- How to Best Utilize the State’s Breast and Cervical Cancer Screening and Treatment Programs (Course # 1009091)
- Cancer Screening and Follow-Up Using the Core Clinical Service Guide (Course # 1044117)
- Kentucky Public Health Nurse Case Management: Helping Women with Abnormal Breast and Cervical Cancer Screening Results (Course # 1013696)
- Documentation: Kentucky Public Health Nurse Case Management for Abnormal Breast and Cervical Cancer Screening Follow-up (Course # 1020005)

The following modules are highly recommended:

- Who are the Never and Rarely Screened? Kentucky Women Share Insights about the Impact of their Care and How You Can Make the Difference (Part 1 Course # 1010683, Part 2 Course # 1010684)

TRAINING IN ADDITION TO MODULES FOR NEW NURSE CASE MANAGERS

When there is a staff change for the NCM position, the Nursing or Clinical Supervisor must notify the Clinical Coordinator of the KWCSP at 502-564-3236, as soon as possible. Face-to-face training will be provided to each new NCM by the Clinical Coordinator. This training may be provided by ITV, telephonically or in person if required.

BACKUP NURSE CASE MANAGERS

There must also be another RN, LPN or APRN trained by the Clinical Coordinator or Case Management Coordinator assigned to your county and knowledgeable about cancer screening follow-up available to assume the Nurse Case Manager’s (NCM) role and responsibilities in the
event the NCM is absent for more than seven calendar days. A timely diagnosis is crucial to creating positive outcomes in cancer screening. All of the modules listed above are optional for the backup NCM who assumes this role during an absence of the assigned NCM.

Tracking and follow-up can be time consuming and therefore it is recommended that professional and support staff work as a team toward this effort. The NCM is required to provide patient contact, counseling, tracking, and follow-up while the support staff may assist the case manager by scheduling appointments, obtaining records, and electronic entry of data. The NCM shall review all patient appointment arrangements and medical records to provide detailed documentation in the Progress Notes of the patient’s medical chart. Administrative time is imperative for NCMs to meet program requirements. The NCM should assure that all aspects of the case management process are appropriately documented in the patient’s service record.

The NCM must have an organized manual or electronic tracking system in place to assure that patients receive appropriate and timely intervention. It is also strongly recommended that the ACH-58 Case Management Form side (in this section) be used to assist staff with this required tracking and follow-up. (See Administrative Reference for instructions on Data Collection side of form.)

It is the responsibility of the KWCSP Nurse Case Manager (NCM) to contact the patient, surgeon or oncologist to ensure the patient has begun treatment for a cancer or pre-cancerous condition. The patient must have had a service that either removed part or all of her cancer or received chemotherapy or radiation to reduce her cancer for her treatment to be considered started. The NCM does not continue to provide case management for treatment once a patient is on the treatment program (BCCTP). The patient’s care will be managed by her Kentucky Medicaid health care providers. The NCM does not need to request treatment records. However, the NCM must document on the CH-3 nursing notes, the type of treatment that began the patient’s care and the date that it was performed. The NCM shall document the source of this information (doctor’s name and specialty, patient, etc.).

For further testing and management after the initial abnormal result, patients who qualify for KWCSP should be case managed by the local health department according to program guidelines. However, when a patient has a medical home, the patient may be referred back to the primary care physician for follow-up management, after the patient is informed of the abnormal test and need for follow-up. Health departments should have good communication with local medical home providers so that each provider’s role and expectations are clear.

A flowchart outlining the case management guidelines can be found at the end of the Cancer Screening/Follow-up Section.

A. Informing the Patient of Abnormal Results

Patients with an abnormal Pap test or mammogram result must be notified within 10 working days from receipt of the abnormal test result or within 30 days from the test date (whichever comes first) following this plan of action:
1. Whenever possible, the NCM shall contact the patient by telephone and have her come to the clinic for face-to-face counseling for abnormal test results. It is expected that the clinic has emergency numbers for all “no home contact” patients. Guidance for “no home contact” patients and minors is found in KRS 214.185.

2. When the patient comes in to the Health Department for counseling, test results and recommendations for follow-up are reviewed with the patient, options discussed and a letter explaining the result in writing is given to the patient. Arrangements for follow-up are then made (see Section B). The visit shall be documented in the patient chart.

3. If the NCM is unable to make verbal contact with the patient by phone then an attempt to contact the patient by letter on the same day as the unsuccessful phone call is necessary. The letter shall inform the patient about the abnormal test result with instructions to contact the NCM at the health department.

4. If the patient does not respond within 10 working days after the letter is mailed, the nurse shall then send a certified letter to the patient informing her of her abnormal test results with instructions to contact the health department.

Once the above has been completed with no response then it is appropriate to document the patient as lost to follow-up.

B. Follow-up for Abnormal Test Results

All patients with abnormal lab tests need follow-up. Patients who meet eligibility criteria for KWCSP must be referred according to program guidelines to contracted specialists for further testing/evaluation. Other patients may have a medical home (regular source of medical care) outside of the local health department (LHD). The patient’s medical home/PCP can be determined at registration.

Medical homes may include private physicians, Passport providers, Primary Care Centers, FQHC’s, and Community Health Centers. These providers generally arrange and provide follow-up care for their patients. Each local health department should maintain open communication with primary care providers in their area to be sure there is agreement on roles and expectations for follow-up of patients with abnormal results.

B1. Follow-up Arrangements for KWSCP-eligible Patients

1. The NCM will schedule an appointment for the patient with a KWSCP contracted provider for the appropriate follow-up testing or evaluation. A referral letter and reports of the abnormal test results are sent to the contracted provider who will be seeing the patient.

2. The NCM tracks to see that the patient showed for the appointment and documents the visit in the patient’s chart.

3. The NCM collects reports from the contracted provider and makes arrangements for further diagnostic testing as ordered.

4. If the patient does not keep an appointment for a scheduled consult appointment, diagnostic procedure, treatment, or follow-up/repeat Pap, a certified letter will be sent to the patient within 10 working days of the missed appointment. No further follow up tracking is needed for these patients. If the patient reschedules a missed appointment
after receiving a certified letter and then does not keep that appointment, a second certified letter is not necessary.

5. All attempts of patient contact shall be documented in the progress notes (CH3A).

6. If the patient is a minor with a potentially life-threatening test result (includes a “HSIL” or “ASC-H” result on a Pap test or a “Suspicious Abnormality” or “Highly Suggestive of Malignancy” mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit.

B2. Follow-up Arrangements for Patients with a Medical Home

1. The NCM will schedule an appointment for the patient with their PCP for the appropriate follow-up testing or evaluation. A referral letter and reports of the abnormal test results along with past pertinent abnormal cervical cancer screening/diagnostic tests and results are sent to the Primary Care provider who will be seeing the patient. Document in the progress notes (CH3A) all transfer of care actions provided for the patient.

   NOTE: It is imperative that the PCP is informed of any of their patient’s abnormal test results. This will allow the PCP to assure that the patient receives the appropriate follow-up care.

2. If the patient is a minor with a potentially life-threatening test result (includes a “HSIL” or “ASC-H” result on a Pap test or a “Suspicious Abnormality” or “Highly Suggestive of Malignancy” mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit.

B3. Follow-Up Arrangements for Patients with a Medical Home Under Passport

1. The NCM will schedule an appointment for the patient with their PCP for the appropriate follow-up testing or evaluation. A referral letter and reports of the abnormal test result(s) along with past pertinent abnormal cervical cancer screening/diagnostic tests and results are to be sent to the PCP who will be seeing the patient. Document in the progress notes (CH3A) all transfer of care actions provided for the patient.

   NOTE: It is imperative that the PCP is informed of any of their patient’s abnormal test results. This will allow the PCP to assure that the patient receives the appropriate follow-up care.

2. If the patient is a minor with a potentially life-threatening test result (includes a “HSIL” or “ASC-H” result on a Pap test or a “Suspicious Abnormality” or “Highly Suggestive of Malignancy” mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit.

3. All attempts of contact with the patient and PCP shall be documented in the patient’s progress notes (CH3A).

C. Other Situations:

Patients who are not KWCSP eligible and do not have a medical home: Local Health Departments may screen some patients who are not eligible for KWCSP and do not have a medical home. Efforts should be made to find the patient a medical home. If that is not possible, then the LHD may manage these patients following KWCSP protocols and
providers. Efforts should be made to find other resources for financial assistance in these circumstances as they would not be covered by the KWCSP.

**Work-up Refused:** occurs when a patient has been notified and counseled (by phone or in person) regarding an abnormal result and either fails to keep a referral appointment for diagnostics/treatment or verbalizes her desire not to seek follow-up. The date of final contact should be noted in the service record (CH3A) and on ACH-58 Data Collection Form side (women 40–64 years old).

**Lost to Follow-up:** occurs when unable to inform and counsel the patient, either by phone or in person, regarding an abnormal test result. The date of the final contact attempt should be noted in the service record (CH3A) and on ACH-58 Data Collection Form side (women 40–64 years old).
## Kentucky Women's Cancer Screening Program

Approved CPT Codes and Reimbursement Rates for Breast and Cervical Cancer Screening and Follow-up

(Services may be provided either on site or off site as appropriate)

**Effective 07/01/2008**
**Revised 04/01/2014**

### Section A: Office Visits

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code Description</th>
<th>Foot Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Initial-brief evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>Initial-expanded evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Initial-detailed evaluation/management</td>
<td>1</td>
</tr>
<tr>
<td>99204</td>
<td>Initial-comprehensive evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>Complex-evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99211</td>
<td>Subsequent-brief evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>Subsequent-limited evaluation/management</td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Subsequent-expanded evaluation/management</td>
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</tr>
<tr>
<td>99385</td>
<td>Initial preventative medicine evaluation 21 - 39 yrs.</td>
<td>1</td>
</tr>
<tr>
<td>99386</td>
<td>Initial preventative medicine evaluation 40 - 64 yrs.</td>
<td>1</td>
</tr>
<tr>
<td>99395</td>
<td>Periodic preventative medicine evaluation 21 - 39 yrs.</td>
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</tr>
<tr>
<td>99396</td>
<td>Periodic preventative medicine evaluation 40 - 64 yrs.</td>
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</tr>
<tr>
<td>W9201</td>
<td>Initial-brief evaluation/management</td>
<td>2</td>
</tr>
<tr>
<td>W9202</td>
<td>Initial-expanded evaluation/management</td>
<td>2</td>
</tr>
<tr>
<td>W9203</td>
<td>Initial-detailed evaluation/management</td>
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<td>W9204</td>
<td>Initial-comprehensive evaluation/management</td>
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<td>W9205</td>
<td>Complex-evaluation/management</td>
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<td>W9211</td>
<td>Subsequent-brief evaluation/management</td>
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<td>W9212</td>
<td>Subsequent-limited evaluation/management</td>
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<tr>
<td>W9213</td>
<td>Subsequent-expanded evaluation/management</td>
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</tr>
<tr>
<td>W9385</td>
<td>Initial preventative medicine evaluation 21 - 39 yrs.</td>
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<tr>
<td>W9386</td>
<td>Initial preventative medicine evaluation 40 – 64 yrs.</td>
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<td>W9395</td>
<td>Periodic preventative medicine evaluation 21 - 39 yrs.</td>
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<tr>
<td>W9396</td>
<td>Periodic preventative medicine evaluation 40 - 64 yrs.</td>
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### Section B: Breast Cancer Screening and Diagnostic Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Foot Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>00400</td>
<td>Anesthesia for procedures on the integumentary system, anterior trunk, not otherwise specified.</td>
<td>3</td>
</tr>
<tr>
<td>10021</td>
<td>Fine needle aspiration without image guidance</td>
<td></td>
</tr>
<tr>
<td>10022</td>
<td>Fine needle aspiration with image guidance</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Additional Information</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>19000</td>
<td>Puncture aspiration of cyst of breast</td>
<td></td>
</tr>
<tr>
<td>19001</td>
<td>Puncture aspiration of cyst of breast, each additional cyst, used with CPT code 19000</td>
<td></td>
</tr>
<tr>
<td>19100</td>
<td>Breast biopsy, percutaneous, needle core, not using imaging guidance</td>
<td></td>
</tr>
<tr>
<td>19101</td>
<td>Breast biopsy, incisional, open</td>
<td></td>
</tr>
<tr>
<td>19120</td>
<td>Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions</td>
<td></td>
</tr>
<tr>
<td>19125</td>
<td>Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion</td>
<td></td>
</tr>
<tr>
<td>19126</td>
<td>Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker</td>
<td></td>
</tr>
<tr>
<td>19081</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion</td>
<td>4</td>
</tr>
<tr>
<td>19082</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion</td>
<td>4</td>
</tr>
<tr>
<td>19083</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion</td>
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<tr>
<td>19084</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion</td>
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<tr>
<td>19085</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion</td>
<td>4</td>
</tr>
<tr>
<td>19086</td>
<td>Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; each additional lesion</td>
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<tr>
<td>19281</td>
<td>Placement of breast localization device, percutaneous; mammographic guidance; first lesion</td>
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<tr>
<td>19282</td>
<td>Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion</td>
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<tr>
<td>19283</td>
<td>Placement of breast localization device, percutaneous; stereotactic guidance; first lesion</td>
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<tr>
<td>19284</td>
<td>Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion</td>
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<tr>
<td>19285</td>
<td>Placement of breast localization device, percutaneous; ultrasound guidance; first lesion</td>
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<td>19286</td>
<td>Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion</td>
<td>5</td>
</tr>
<tr>
<td>19287</td>
<td>Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion</td>
<td>5</td>
</tr>
<tr>
<td>19288</td>
<td>Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion</td>
<td>5</td>
</tr>
<tr>
<td>77053</td>
<td>Mammary ductogram or galactogram, single duct</td>
<td></td>
</tr>
<tr>
<td>77058</td>
<td>Magnetic Resonance Imaging, breast, with and/or without contrast, unilateral</td>
<td>6</td>
</tr>
<tr>
<td>77059</td>
<td>Magnetic Resonance Imaging, breast, with and/or without contrast, bilateral</td>
<td>6</td>
</tr>
<tr>
<td>88172</td>
<td>Cytopathology, evaluation of fine needle aspiration</td>
<td></td>
</tr>
<tr>
<td>88173</td>
<td>Cytopathology, interpretation and report of fine needle aspiration</td>
<td></td>
</tr>
<tr>
<td>88305</td>
<td>Surgical pathology, gross and microscopic examination</td>
<td></td>
</tr>
<tr>
<td>88307</td>
<td>Surgical pathology, gross and microscopic examination, requiring microscopic evaluation of margins</td>
<td></td>
</tr>
<tr>
<td>S0613</td>
<td>Clinical Breast Exam</td>
<td></td>
</tr>
</tbody>
</table>
Section C: Cervical Cancer Screening and Diagnostic Procedures

57452 Colposcopy of cervix, upper/adjacent vagina
57454 Colposcopy with biopsy of cervix & endocervical curettage
57455 Colposcopy with biopsy of the cervix
57456 Colposcopy with endocervical curettage
57460 Endoscopy (Colposcopy) with loop electrode biopsy(s) of the cervix
57461 Endoscopy (Colposcopy) with loop electrode conization of the cervix
57500 Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
57505 Endocervical curettage (not done as part of a dilation and curettage)
57520 Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522 Loop electrode excision procedure
58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)
87621 Papillomavirus, human, amplified probe
   • Hybrid Capture II from Digene-HPV Test (High Risk Typing, only)
   • Cervista HPV HR
88141 Conventional Pap test, cervical or vaginal any reporting system, requiring interpretation by physician
88142 Liquid-based Pap test (Thin-Prep)
88153 Pap test, thin layer preparation, automated thin layer preparation manual screening and rescreening
88164 Conventional Pap Test
88165 Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision
88174 Pap test, thin layer preparation, automated thin layer preparation automated screening
88175 Pap test, thin layer preparation, automated thin layer preparation automated screening and manual
Section D: Procedures that can be paid with state preventive block grant funds or other sources but cannot be reimbursed with KWCSP Federal Funds

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Unit Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>00940</td>
<td>Anesthesiology, vaginal (cervical) procedures (per unit)</td>
<td>9</td>
</tr>
<tr>
<td>19030</td>
<td>Injection procedure breast X-ray</td>
<td>9</td>
</tr>
<tr>
<td>76937</td>
<td>Ultrasound Guide for Vascular Access</td>
<td>9</td>
</tr>
<tr>
<td>77052</td>
<td>Computer Aided Detection (CAD)</td>
<td>9</td>
</tr>
<tr>
<td>77054</td>
<td>X-Ray of mammary ducts</td>
<td>9</td>
</tr>
<tr>
<td>88104</td>
<td>Cytopathology fl nongyn smears</td>
<td>9</td>
</tr>
<tr>
<td>99214</td>
<td>Office Visit/outpatient established</td>
<td>9</td>
</tr>
<tr>
<td>99215</td>
<td>Office Visit/outpatient established</td>
<td>9</td>
</tr>
<tr>
<td>W0166</td>
<td>Charge for use of hospital room</td>
<td>9</td>
</tr>
<tr>
<td>W9214</td>
<td>Office Visit/outpatient established</td>
<td>9</td>
</tr>
<tr>
<td>W9215</td>
<td>Office Visit/outpatient established</td>
<td>9</td>
</tr>
</tbody>
</table>

Section E: Foot Notes

1. Office visit CPT codes 99385 and 99386 codes shall be reimbursed at or below the 99203 rate. Office visit CPT codes 99395 and 99396 codes shall be reimbursed at or below the 99213 rate.

2. When this evaluation/management or preventative service is performed in-house by a Registered Nurse, code W920- should be billed instead of 9920- for a new patient. Code W921- instead of 9921- for established patients.

3. The KWCSP will reimburse LHDs at the rate $21.00 per unit of anesthesia. Medicare Base Units = 3 (Additional single units for time can be reported and included in the overall total number of units)

4. Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.

5. CPT Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.

6. Breast MRI:
   - KWCSP will reimburse Breast MRI when performed 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.
   - KWCSP will reimburse Breast MRI when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment.
   - KWCSP will not reimburse Breast MRI when performed alone as a breast cancer screening tool.
7. Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer are not allowed by the Program. Please refer the patients to the Breast and Cervical Cancer Treatment Program (BCCTP) in order for patients to receive treatment services.

8. HPV Testing:
   - 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 American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines.
   - HPV testing is not reimbursable as a primary screening test for women of any age or as an adjunctive screening test to the Pap for women under 30 years of age.
   - Due to the new cervical cancer screening guidelines, co-testing is an option for women 30-64 who meet specific clinical criteria and HPV co-testing will be reimbursed only for those women. For more details please refer to the cancer section in the Core Clinical Services Guide (CCSG).
   - Local Health Departments (LHDs) should specify the high-risk HPV DNA panel only; reimbursement of screening for low-risk HPV types is not permitted. The program will reimburse Cervista HPV HR; however, only at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay.
   - KWCSP funds cannot be used for reimbursement of genotyping (e.g., Cervista HPV 16/18).

9. These procedures cannot be reimbursed with KWCSP federal funds. However, LHDs may use their preventive state block grants funds or other sources to reimburse for these procedures.

Notes:
- Please refer to the Kentucky Women’s Cancer Screening Program Reimbursement Policy version 2.0 for details.
- CPT rates are based on the Center’s for Medicare & Medicaid Services’ physician fee schedule Non-Facility Price.
Able to contact pt by phone within 10 working days of receipt of abnormal test result or 30 days from procedure.

YES

Schedule counseling appointment.

Pt. shows for counseling appt.

NO

Send letter to pt. w/ regarding abnormal results & need to contact LHD.

YES-Schedule counseling appointment. See left side of diagram

NO-Send certified letter to pt.

Did pt. contact LHD within 10 working days of letter being mailed?

YES

Send certified letter within 10 working days of missed apt. & document pt. refused.

Counsel, give letter w/ result & schedule follow-up. Refer to LHD/Dx contracted provider or PCP.

Send copy of results, hx to LHD contracted provider.

Did patient keep appointment?

YES

NO

Send copy of results, hx to PCP.

YES-PCP follows pt.

Assure that result is obtained & documented. Evaluate results for further need of diagnostic services.

Does pt. require further diagnostics per report?

YES-Notify pt. & coordinate further dx procedures.

NO-Contact pt. & counsel regarding further screening recommendation.

Did pt. keep secondary dx follow-up appointments for services?

YES-Assure that results are obtained & documented. Contact pt. by phone within 10 working days of receipt or 30 days from procedure date to discuss further screening/dx results.

Could patient be reached by phone?

YES-Assure that pt. understands further screening recommendations.

NO-Document lost to follow-up

Response from pt. within 10 working days of certified letter.

NO-Document lost to follow-up. See left side of diagram.