

Every Woman Counts

This section includes information about Every Woman Counts (EWC). EWC is a comprehensive, public health program that assists uninsured and underinsured women whose household income is at or below 200 percent of the Department of Health and Human Services (HHS) poverty guidelines in obtaining high quality cancer screening and follow-up services. In addition to offering screening and diagnostic services, the program is designed to facilitate regular rescreening of women with normal or benign breast and/or cervical conditions and to provide follow-up services for women with possible diagnoses of breast and/or cervical cancer, including referral for treatment when necessary. The goal of the program is to affect the devastating effect of breast and cervical cancer by reducing morbidity and mortality rates in this population of California women.

Every Woman Counts (EWC)

Every Woman Counts (EWC) is the multi-faceted program managed by the Department of Health Care Services (DHCS), Benefits Division, Cancer Detection and Treatment Branch.

Components of EWC include the following:

- Health education and outreach activities
- Breast and cervical cancer screening and diagnostic services
- Quality assurance and improvement through professional education and evaluation of clinical and claims data
- Patient care coordination to ensure women are screened regularly and at recommended intervals
- Follow-up services for women with possible diagnoses of breast and/or cervical cancer, including referral for treatment when necessary

The program is funded by both federal and state dollars. Federal funds are received from the Centers for Disease Control and Prevention. State funds are received from two tobacco taxes and general funds.

Breast and cervical cancer early detection and screening services are provided in all counties of the state.

**EWC and Medi-Cal
Work Together**

EWC and Medi-Cal are separate programs; however, EWC relies on Medi-Cal billing procedures to process both hard copy and electronic claims.

Regional Contractors

The Regional Contractors are local representatives of EWC. The Regional Contractors are public and private agencies that ensure low-income women receive breast and cervical cancer screening services. The Regional Contractors are responsible for recruitment, training, and maintenance of the EWC provider network and providing tailored health education for eligible recipients.

Clinical Standards

EWC services are performed in accordance with EWC clinical standards, which are available through 10 Regional Contractors statewide and online at www.medi-cal.ca.gov.

Activities

Regional Contractors conduct the following activities:

- Recruit and train EWC primary care providers (PCPs)
- Support EWC providers to participate in breast and/or cervical health service delivery networks
- Conduct local targeted outreach and education for low-income, high-risk women
- Address gaps in the delivery of these services
- Coordinate professional education about breast and/or cervical cancer screening and related subjects
- Provide technical assistance for development of patient tracking and follow-up systems that facilitate annual rescreening and timely referrals for women with abnormal findings
- Provide technical assistance and training in entering recipient information, eligibility, and data into the EWC data entry application known as DETEC (DETecting Early Cancer)
- Provide technical assistance and training with data entry to meet the Core Program Performance Indicators (CPPI) measuring quality outcomes

Provider Participation Requirements

All PCPs must contact the Regional Contractor in their area for information and orientation before rendering EWC services. Prior to providing services, all new PCPs must receive training about program standards and requirements, submission of hard copy or electronic claims, and submission of outcome data via DETEC. New PCPs are eligible to render services only after the effective date of enrollment, as stated in the EWC welcome letter. PCPs must adhere to all requirements contained in the Primary Care Provider Enrollment Agreement (PCPEA), EWC clinical standards and data submission requirements.

A Primary Care Provider must:

- Be a Medi-Cal provider in good standing and licensed in the state of California.
- Enroll in the program through a Regional Contractor.
- Complete and sign a *Primary Care Provider Enrollment Agreement*.
- Have Internet access.

Internet Access Required

PCPs must have Internet access to obtain the 14-character recipient identification number that is required for hard copy or electronic claim submission, and for completing DETEC online enrollment and data forms. See “Online Recipient Information Form” in this section for further instructions.

Regional Contractors
Enroll PCPs

Regional Contractors determine who may be enrolled as a PCP based on the need to complete service networks in a geographic area or improve access to care for targeted populations.

PCP Categories

EWC-enrolled PCPs fall into two categories:

- Those who may only be paid for breast cancer screening services. These PCPs may bill the program for procedure codes marked with a diamond (◆) in the list under the “Approved Procedures” heading of this section.
- Those who may be paid for both breast and cervical cancer screening services. These PCPs may bill the program for procedure codes marked with a square (■) in the list under the “Approved Procedures” heading of this section.

NPI Billing Requirement

PCPs are required to use only a National Provider Identification (NPI) number to bill for services covered by EWC.

When a PCP acquires an NPI, the Medi-Cal Provider ID number (legacy number) is end-dated and all client records associated with that Provider ID are transferred to the new NPI. Therefore, any claims submitted under the legacy number will be denied.

Referral Providers

Referral providers are those who receive referrals from PCPs to render any screening or diagnostic services. Referral providers must be Medi-Cal providers in good standing and licensed in the state of California. Referral providers do not enroll in EWC or sign a provider agreement. Examples of referral providers include the following:

- Anesthesiologists
- Laboratories
- Mammography facilities
- Pathologists
- Radiologists
- Surgeons

Claimable Procedures
for Referral Providers

Referral providers may bill EWC for all procedure codes marked with a dot (●) in the list under the “Approved Procedures” heading located in this section.

Referral Providers
Rely on PCPs

In order to bill, EWC referral providers must have the recipient’s 14-character ID number provided by the PCP. Claims submitted without the recipient’s ID number will be denied.

After the PCP verifies the recipient’s eligibility for and enrolls her in EWC, the PCP must communicate the recipient ID number to the referral provider. The referral provider may then submit a claim for payment, according to EWC guidelines.

Referral providers must report their screening and diagnostic findings to the PCP, who is responsible for submitting data and outcomes to EWC and for coordinating further care or follow-up.

**Payments from
Recipient Disallowed**

Referral and Primary Care providers must not attempt to obtain payment from recipients for co-payments or the balance of costs of breast and/or cervical cancer screening or diagnostic services. Payment received by providers from EWC in accordance with the Medi-Cal fee structure, constitutes payment in full.

**LA County Waiver
Program, RHC and
FQHC Guidelines**

Providers who render services for the following special programs may bill only with a EWC provider number and must submit claims according to EWC guidelines:

- LA County Waiver Program
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

All other requirements in this section apply to these special program providers. Questions may be directed to the Telephone Service Center (TSC) at 1-800-541-5555.

Assessment of Tobacco Use and Referral for Smoking Cessation

PCPs are required to assess every woman screened through EWC and refer those who do use tobacco to a cessation program. Screening for tobacco use is to be completed by the PCP at time of enrollment or recertification and recorded on the *Recipient Eligibility Form*. The provider must keep a copy of the recipient-signed form on file.

Assessment is encouraged to be performed at every office visit and is not a separately reimbursable procedure. Tobacco assessments and cessation referrals must be documented and maintained in the recipient's medical record.

Tobacco Cessation Referral Resource Suggestions

The California Smoker's Helpline provides many valuable resources for users of tobacco products and health care providers. The helpline can be accessed online at www.californiasmokershelpline.org or by calling 1-800-NO-BUTTS (1-800-662-8887).

The California Tobacco Control Program provides information about a variety of topics, including help with quitting and local tobacco control efforts. Information can be found on the California Department of Public Health website www.cdph.ca.gov in the "Programs" section.

The Center for Tobacco Cessation provides training and technical assistance to organizations statewide to increase their capacity in tobacco cessation. Information is available at the website www.centerforcessation.org.

Breast and Cervical Cancer Treatment Program (BCCTP)

PCPs working in connection with EWC are authorized to enroll eligible individuals in the Breast and Cervical Cancer Treatment Program (BCCTP). The BCCTP has two programs for which individuals may be eligible. The federal BCCTP provides full-scope Medi-Cal to eligible women who meet all the federal criteria. The state-funded BCCTP only provides cancer treatment and related services to any individual, including men, who does not meet the federal criteria. BCCTP enrollment information is available from BCCTP eligibility specialists at 1-800-824-0088. BCCTP guidelines also are available on the Medi-Cal website at www.medi-cal.ca.gov.

Referral to BCCTP

BCCTP offers treatment through the Medi-Cal program for individuals with breast and/or cervical cancer who meet eligibility criteria. Family PACT (Planning, Access, Care and Treatment) Program providers may also enroll patients into BCCTP.

Diagnoses Obtained Through EWC

Women who are already in EWC and are diagnosed with breast cancer (including in situ) and/or cervical cancer, cervical intraepithelial neoplasia II (CIN II) or CIN III can be referred into BCCTP. Providers should fill in the box on the *DETEC Screening Cycle Data* form that states, "Patient enrolled in BCCTP. Check ONLY if you have completed the BCCTP enrollment process." Providers should go to the BCCTP website and follow the program enrollment procedures. If the patient has a breast or cervical cancer that is not on the drop down menu of qualifying diagnoses for BCCTP enrollment, the provider should call BCCTP and request to speak with a manager for further instructions.

Diagnoses Obtained Outside EWC

Individuals who meet only the EWC program income and insurance eligibility criteria (but not age or gender) can be referred to BCCTP through EWC PCPs. The provider must confirm that the patient meets income and insurance EWC eligibility criteria, and that the patient has presented documented proof of breast cancer (including in situ) and/or cervical cancer, CIN II or CIN III. The provider must be able to present this documentation upon request. In addition, the patient completes the *Recipient Eligibility Form* on paper, and the provider completes the eligibility form verifying current financial and demographic information.

For women who meet all EWC eligibility criteria, the PCP must complete the *DETEC Enroll Recipient* form online and select the field labeled, "The purpose of this enrollment is to only refer the recipient to BCCTP for Breast [or Cervical] Cancer treatment," indicating the patient is being referred to BCCTP. PCPs must enter the qualifying diagnosis and submit the EWC enrollment data. If the patient has a breast or cervical cancer that is not on the drop-down menu of qualifying diagnoses for BCCTP enrollment, the provider should call BCCTP and request to speak with a manager for further instructions. No other data is required. The provider must keep recipient-signed documentation of the *Recipient Eligibility Form* on file. Providers then are to follow BCCTP enrollment procedures.

For information about billing an office visit for the verification of a cancer diagnosis, or for more BCCTP information, contact the Eligibility Specialist at 1-800-824-0088. Additional information can be found at www.medi-cal.ca.gov.

EWC Additional Testing to Confirm Diagnosis

If a provider determines more testing is needed for a woman from outside EWC before confirming a cancer diagnosis, the provider may perform testing under EWC as long as the testing is a program covered service. The provider must understand that once billing occurs in EWC, the same data requirements apply as if the woman were screened within EWC. This means complete screening cycle data must be submitted using the online DETEC Screening Cycle Data forms.

Provider Data-Reporting Requirements

Funding for the EWC Program is dependent on data reported by providers. Providers must maintain complete, accurate and timely recipient data using the appropriate DETEC online forms. Several guidelines for data maintenance include:

- Each recipient has a 365-day certification period when she is eligible to receive services.
- DETEC will guide PCPs in how to submit screening procedures and dates.
- DETEC will allow changes to data already submitted.
- PCPs may update screening and follow-up forms for an additional 365 days after the recipient's eligibility has expired.
- PCPs must ensure that all recipient screening, diagnostic, and treatment data have been entered through DETEC.

Recipient Eligibility Criteria

The following information describes recipient eligibility criteria.

Age

Women must be 21 years of age or older to be eligible for cervical cancer screening consisting of a Pap test, a pelvic examination to perform a Pap test and the necessary follow-up cervical diagnostic services.

Women must be 40 years of age or older to be eligible for breast cancer screening consisting of a Clinical Breast Exam (CBE) and mammogram, as well as necessary follow-up breast diagnostic services.

Note: Only certain providers are eligible to render cervical cancer screening and diagnostic services. See "Provider Participation Requirements" on a preceding page of this section.

Income Eligibility Guidelines

The federal HHS poverty guidelines are used to determine financial eligibility for EWC. To qualify for breast and cervical cancer screening services, recipients must have a household income at or below 200 percent of the HHS poverty guidelines.

The HHS poverty guidelines are adjusted annually and the EWC income criteria are likewise updated accordingly.

The table below lists the EWC income criteria based on the 2015 HHS poverty guidelines.

EWC INCOME ELIGIBILITY GUIDELINES

200 Percent of the 2015 HHS Poverty Guidelines by Household Size
Effective April 1, 2015, through March 31, 2016

Number of Persons Living in Household	Monthly Gross Household Income	Annual Gross Household Income
1	<u>\$1,962</u>	<u>\$23,540</u>
2	<u>\$2,655</u>	<u>\$31,860</u>
3	<u>\$3,349</u>	<u>\$40,180</u>
4	<u>\$4,042</u>	<u>\$48,500</u>
5	<u>\$4,735</u>	<u>\$56,820</u>
6	<u>\$5,429</u>	<u>\$65,140</u>
7	<u>\$6,122</u>	<u>\$73,460</u>
8	<u>\$6,815</u>	<u>\$81,780</u>
For each additional person, add:	<u>\$694</u>	<u>\$8,320</u>

“Gross household income” means the monthly sum of incomes (before taxes and other deductions) of the individual(s) living in the household from sources identified by the U.S. Census Bureau. Monthly gross income for migrant farm workers and other seasonally employed persons may be computed by averaging total gross income received during the previous 12 months.

U.S. Census Bureau sources of income are:

- Money wages or salary
- Net income from non-farm self-employment
- Net income from farm self-employment
- Social Security
- Dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties
- Public assistance or welfare payments
- Pension and annuities
- Unemployment compensation/disability insurance
- Workers' compensation
- Child support
- Veterans' pension
- Alimony

Health Insurance

For a woman to be eligible for EWC, her PCP must certify that she is uninsured or underinsured, based on the woman's self-report.

Recipients may be certified as underinsured for EWC if all three of the following conditions are met:

- No Medicare Part B coverage
- Either no Medi-Cal coverage or limited scope Medi-Cal such as:
 - Medi-Cal for pregnancy or emergency service only, or
 - Medi-Cal with unmet Share of Cost (SOC) obligations
- Either no other public or private insurance coverage or other limited health insurance, such as:
 - Other health insurance co-payments or deductible obligations that cannot be met
 - Other health insurance benefit restrictions, public or private, which exclude services available through EWC

Residency

Eligible women must have a California address.

Eligibility Period	<p>A recipient is eligible for EWC for one year, starting on the date when the DETEC <i>Recipient Information</i> form is completed and submitted. This eligibility period does not change if the recipient transfers to another PCP. The eligibility period is for the recipient, not the provider. Re-enrollment or recertification can only occur annually, when a recipient's one-year recipient eligibility period ends.</p> <p><u>Example:</u> A recipient sees PCP provider A on February 1. Provider A establishes the patient's eligibility on this date by entering information into the DETEC form. The recipient's eligibility period spans from this date, February 1, to the following January 31 (one year).</p> <p>Then, the recipient visits provider B in June, four months after seeing provider A. Provider B finds the recipient in the EWC application using the recipient's last name and date of birth. Provider B creates a new recipient record by updating the Recipient Information in DETEC. The recipient remains eligible only until January 31, as previously established. Each provider maintains separate records, but the recipient's dates of eligibility are not affected.</p>
Payer of Last Resort	<p>EWC is the payer of last resort, and pays providers only for breast and/or cervical screening and diagnostic services not covered by other programs.</p>
Types of Forms and Worksheets	<p>EWC uses two types of forms:</p> <ul style="list-style-type: none"> • Paper forms and worksheets that may be downloaded from the EWC program page on the Medi-Cal website. These worksheets and forms can be photocopied and are completed by hand. • Online forms that are completed and submitted via DETEC.
Required Forms	<p>The following forms are required and the original must be kept in the recipient's medical record.</p> <ul style="list-style-type: none"> • <i>Recipient Eligibility Form</i> • <i>Consent to Participate in Program and Privacy Statement</i> <p>The following online forms are required, and are completed and submitted via DETEC.</p> <ul style="list-style-type: none"> • DETEC - <i>Enroll Recipient and Recipient Information</i> forms • DETEC - <i>Breast and Cervical Cancer Screening Cycle Data</i> forms

PCPs must print, sign and date the print copies of these DETEC forms and place the original copy in the patient medical record. This is evidence that data was entered in support of case management claims.

Optional Worksheets

EWC also uses paper worksheets that can be printed from the EWC program page on the Medi-Cal website and completed manually. Worksheets are intended to assist providers in gathering relevant information that will later be entered online via the DETEC forms. It is recommended that the worksheet be completed and kept in the recipient's medical record as evidence for case management claims.

Notice of Privacy Practices

The *Notice of Privacy Practices* (NPP) describes how medical information about recipients may be used and disclosed and how recipients can gain access to this information. The provider is responsible for distributing the NPP to each recipient at the time of enrollment and at annual recertification. The NPP form can be downloaded from the Medi-Cal website at www.medi-cal.ca.gov. NPP versions are available in English, Arabic, Chinese (Cantonese and Mandarin), Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog and Vietnamese.

Patient Consent Form

Once every 12 months, recipients must complete the paper form titled *Consent to Participate in Program* (DHCS 8478). The consent form both assures privacy and informs the recipient that the Department of Health Care Services (DHCS) and other governmental agencies may use some of the medical data for an evaluation of the program's effectiveness.

The consent form includes a signature line on which the recipient acknowledges receipt of the NPP.

The consent form may be downloaded from the Medi-Cal website at www.medi-cal.ca.gov. Providers must not create their own forms. A signed consent form must be kept in the recipient's medical record. Providers should not send a copy of the consent form to DHCS.

Recipient Eligibility Forms

The paper *Recipient Eligibility Form* (available in English and Spanish) is required. This form enables provider staff or the recipient to complete her income and eligibility data. The form and detailed instructions for completing it may be downloaded on the Medi-Cal website at www.medi-cal.ca.gov. The *Recipient Eligibility Form* should be signed by the recipient and by the provider who determines that the recipient meets eligibility criteria for the program. The signed copy must be kept in the recipient's medical record. Providers may use either the English or Spanish *Recipient Eligibility Form*.

Online Recipient Information Form

Once the provider has collected recipient demographic information, established recipient eligibility for EWC and obtained signed recipient eligibility and consent forms, the PCP may enroll the recipient in the program using the online DETEC *Enroll Recipient* form. To access DETEC data entry forms:

- Access www.medi-cal.ca.gov
- Click the "Transactions" tab
- Click "Login"
- Enter User ID (National Provider Identifier [NPI]) and Personal Identification Number (PIN) (password)
- Select the Prgms (Programs) tab
- Click the "Every Woman Counts (EWC)" link

The PCP starts the enrollment process by entering demographic information in the online *Recipient Search* form. The first two letters of the recipient's last name and her date of birth are required. The provider clicks the "Go" button to reach the online *Enroll Recipient* form. If the recipient is new to the program, the provider inputs information obtained directly from the *Recipient Eligibility* form. Entered information includes the recipient's name, mother's maiden name (if the recipient provides it), date of birth, address, telephone number and ethnicity. After the DETEC *Enroll Recipient* form is completed and submitted online, the recipient is assigned a 14-character recipient identification number.

Recipient ID Number

EWC recipients are identified by a 14-character recipient identification number (ID) that is computer generated when the online *Enroll Recipient* form is completed and submitted.

Note: All claims from enrolled PCPs and/or Medi-Cal referral providers must be submitted with this 14-character recipient ID number. Medi-Cal referral providers must obtain this ID number from the PCP or the recipient.

Viewing Breast and Cervical Cancer Screening Cycles Online

PCPs are allowed to view current and previous screening cycles online. DETEC can show up to three cycles at a time. The oldest cycle is locked and not accessible. The two most recent cycles are accessible. A cycle that includes errors in case management data entry will be identified by a "!".

DETEC Breast/Cervical Cancer Screening Cycle Forms

The recipient's PCP is required to input her clinical information using the DETEC *Breast/Cervical Cancer Screening Cycle Data* forms as part of the service and before the case management fees for HCPCS code T1017 (targeted case management) can be paid. Data must be submitted within 30 days after the practice receives all required information. Clinical information is used to evaluate effectiveness and quality of EWC.

Case Management: HCPCS Code T1017 Restrictions

HCPCS code T1017 is payable only to providers enrolled as PCPs in EWC and only for recipients enrolled in the EWC program. T1017 is not a benefit of Medi-Cal programs. Although the T1017 description is in units of 15 minutes, for EWC the quantity of units allowed for reimbursement is only one unit per recipient per provider per calendar year regardless of the time required to complete case management services. The amount reimbursed is \$50.

Only complete and compliant "immediate work-up cycles" are eligible for reimbursement. An "immediate work-up" is the screening cycle which requires coordination of referral services and additional data reporting via the DETEC data reporting system. When a recipient does not require immediate follow-up (e.g. the findings are normal, or the findings require re-screening earlier than is routinely recommended) no additional payment shall be made and code T1017 may not be billed.

**Case Management:
Payment Policy**

In DETEC, breast and cervical cancer each have their own one-page form that includes both screening cycle and follow-up data. It is anticipated this will facilitate accurate and complete data entry.

- Payment for case management will be based on submission of complete, accurate data.
- For abnormal results or findings, immediate work-up is advised and additional data will need to be submitted to qualify for case management.
- If immediate work-up is selected, whether based on clinical findings, results, provider's discretion or patient request, additional data will need to be submitted to qualify for case management.
- PCPs who provide both breast and cervical cancer screening are not required to submit both screening forms at the same time as a requirement for case management.
- Despite providing a recipient with both breast and cervical cancer screening services in the year, the PCP is only eligible for one case management payment per recipient per year.

Approved Procedures

The following CPT-4 and HCPCS codes are benefits of EWC. The key at the bottom of each listing shows the providers who may be paid for each procedure code. Providers should review the key carefully to see if they qualify to bill the listed service. Providers must have an appropriate ICD-9-CM code(s) specified as the first or second diagnosis code on the claim to be eligible for payment.

Cervical cancer screening ICD-9-CM codes are shown in tables 1a, 1b and 1c. Breast cancer screening ICD-9-CM codes are shown in tables 2a and 2b.

Table 1a	
Cervical Cancer Screening ICD-9-CM V Codes	
<u>V08, V10.3, V10.40, V10.41, V10.42, V10.43, V10.44, V13.22, V13.23, V13.24, V15.7, V15.82, V16.40, V16.41, V16.49, V45.77, V47.5, V49.81,</u>	<u>V50.41, V50.42, V65.45, V67.01, V68.81, V72.31, V72.32, V73.81, V76.2, V84.01, V84.02, V87.46, V88.01, V88.02, V88.03</u>

Table 1b	
Cervical Cancer Screening and Diagnosis ICD-9-CM Codes	
<u>042, 078.11, 079.4, 079.53, 179, 180.0, 180.1, 180.8, 180.9, 184.8, 184.9, 195.3, 199.1, 218.0, 219.0, 233.1, 233.2, 233.30, 233.31, 239.5, 616.0, 616.9, 621.0, 621.9, 622.0, 622.10, 622.11, 622.12, 622.2, 622.3, 622.4, 622.6, 622.7, 622.8, 622.9, 623.0, 623.1, 623.5,</u>	<u>623.9, 625.0, 625.8, 625.9, 626.6, 626.7, 626.9, 627.1, 760.76, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05, 795.06, 795.07, 795.08, 795.09, 795.10, 795.11, 795.12, 795.13, 795.14, 795.15, 795.16, 795.18, 795.19</u>

Table 1c	
Colposcopy and Cervical Biopsy ICD-9-CM Diagnosis Codes	
<u>180.0, 180.1, 180.8, 180.9, 219.0, 233.1, 233.31, 622.11, 622.12, 622.2, 623.0, 623.1, 795.00, 795.01, 795.02, 795.03, 795.04, 795.05,</u>	<u>795.06, 795.07, 795.08, 795.09, 795.10, 795.11, 795.12, 795.13, 795.14, 795.15, 795.16, 795.18, 795.19</u>

Table 2a	
Breast Cancer Screening Related V Codes	
<u>V07.4, V07.51, V07.59, V10.05, V10.3, V10.40, V10.43, V10.72, V10.79, V10.90, V15.3, V15.89, V16.0, V16.3, V16.41, V16.8,</u>	<u>V16.9, V43.82, V45.71, V45.83, V49.81, V49.89, V76.10, V76.11, V76.12, V76.19, V84.01, V84.02, V84.09, V86.0, V86.1</u>

Table 2b	
Breast Cancer Diagnosis (clinical and diagnostic) ICD-9-CM Codes	
<u>172.5, 173.50, 173.51, 173.52, 173.59, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 196.0, 196.3, 198.2, 198.81, 214.1, 214.8, 216.5, 216.8, 217, 228.01, 232.5, 233.0, 238.2, 238.3, 239.2, 239.3, 451.89, 610.0, 610.1, 610.2, 610.3, 610.4, 610.8,</u>	<u>610.9, 611.0, 611.1, 611.2, 611.3, 611.4, 611.5, 611.6, 611.71, 611.72, 611.79, 611.81, 611.82, 611.83, 611.89, 611.9, 612.0, 757.6, 759.6, 782.8, 785.6, 793.80, 793.81, 793.82, 793.89</u>

- May be billed to Every Woman Counts by referral providers.
- ◆ May be billed to Every Woman Counts only by PCPs authorized to provide breast cancer services.
- May be billed to Every Woman Counts only by PCPs authorized to provide breast and cervical cancer services.

<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
00400 ●◆■	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	see table 2b	
10021 ●◆■	Fine needle aspiration; without imaging guidance	see table 2b	
10022 ●◆■	Fine needle aspiration; with imaging guidance	see table 2b	
19000 ●◆■	Puncture aspiration of cyst of breast	see table 2b	
19001 ●◆■	each additional cyst	see table 2b	Use in conjunction with code 19000. If imaging guidance is performed, see code 76942.
<u>19081</u> ●◆■	<u>Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including stereotactic guidance</u>	<u>see table 2b</u>	
<u>19082</u> ●◆■	<u>each additional lesion, including stereotactic guidance</u>	<u>see table 2b</u>	<u>Use in conjunction with 19081</u>
<u>19083</u> ●◆■	<u>Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including ultrasound guidance</u>	<u>see table 2b</u>	
<u>19084</u> ●◆■	<u>each additional lesion, including ultrasound guidance</u>	<u>see table 2b</u>	<u>Use in conjunction with 19083</u>

- May be billed to Every Woman Counts by referral providers.
- ◆ May be billed to Every Woman Counts only by PCPs authorized to provide breast cancer services.
- May be billed to Every Woman Counts only by PCPs authorized to provide breast and cervical cancer services.

<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
19100 ●◆■	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	see table 2b	For fine needle aspiration, use code 10021. For image guided breast biopsy see code 10022
19101 ●◆■	open, incisional	see table 2b	
19120 ●◆■	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions	see table 2b	
19125 ●◆■	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	see table 2b	
19126 ●◆■	each additional lesion separately identified by a preoperative radiological marker	see table 2b	Use in conjunction with code 19125.
19281 ●◆■	<u>Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance</u>	<u>see table 2b</u>	
19282 ●◆■	<u>each additional lesion, including mammographic guidance</u>	<u>see table 2b</u>	<u>Use in conjunction with 19281</u>

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
19283 ●◆■	<u>Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance</u>	<u>see table 2b</u>	
19284 ●◆■	<u>each additional lesion, including stereotactic guidance</u>	<u>see table 2b</u>	<u>Use in conjunction with 19283</u>
19285 ●◆■	<u>Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance</u>	<u>see table 2b</u>	
19286 ●◆■	<u>each additional lesion, including ultrasound guidance</u>	<u>see table 2b</u>	<u>Use in conjunction with 19285</u>
57452 ●■	Colposcopy of the cervix including upper/adjacent vagina	see table 1c	Cannot be billed in conjunction with any office visits or consults or with codes 57454 – 57456.
57454 ●■	with biopsy(s) of the cervix and endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults.
57455 ●■	Colposcopy of the cervix, with biopsy	see table 1c	Cannot be billed in conjunction with any office visits or consults.
57456 ●■	Colposcopy of the cervix, with endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults.
57500 ●■	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	see table 1c	Reimbursable only if used for evaluation of leukoplakia or other suspicious visible cervical lesion or abnormal Pap when colposcopy is not readily available. Cannot be billed in conjunction with 57452, 57454 – 57456.

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
57505 ●■	Endocervical curettage (not done as part of dilation and curettage)	795.00	Reimbursable only if billed in conjunction with 58100, as the initial workup of AGC/atypical endometrial cells. Cannot be billed in conjunction with 57452, 57454 – 57456.
58100 ●■	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	795.00	Reimbursable only if billed in conjunction with 57505. Cannot be billed in conjunction with 57452, 57454 – 57456.
58110 ●■	Endometrial sampling (biopsy) performed in conjunction with colposcopy	233.1 and 795.00	Reimbursable only for evaluation of adenocarcinoma in situ (AIS) and AGC subcategories except AGC/atypical endometrial cells in all women over age 35 and younger women with risk factors for endometrial neoplasia, such as, but not limited to, obesity or unexplained or anovulatory bleeding. Must be performed with colposcopy and used in conjunction with 57452 – 57456.
76098 ●◆■	Radiological examination, surgical specimen	see table 2b	
76645 ●◆■	Ultrasound, breast(s) (unilateral or bilateral), B-scan and/or real time with image documentation	see tables 2a and 2b	

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
76942 ●◆■	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	see table 2b	
77055 ●◆■	Mammography; unilateral	see tables 2a and 2b	Cannot be billed in conjunction with 77056.
77056 ●◆■	bilateral	see tables 2a and 2b	Cannot be billed in conjunction with 77055.
77057 ●◆■	Screening mammography, bilateral (two view film study of each breast)	see tables 2a and 2b	
81025 ●■	Urine pregnancy test	see table 1c	This code may only be billed with one or more of the following codes: 57452, 57454 – 57456, 57500, 57505, 58100, 58110.
87621 ●■	Infectious agent detection by nucleic acid (DNA or RNA); papillomavirus, human, amplified probe technique	622.11, 795.00, 795.01, 795.02, 795.03 and V73.81	V73.81 is covered only for recipients age 30 and older.
88141 ●■	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician	see tables 1a and 1b	Use in conjunction with code 88142, 88164, 88174 or 88175.

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
88142 ●■	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	<u>see tables 1a and 1b</u>	
<u>88143</u> ●■	<u>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation;with manual screening and rescreening under physician supervision</u>	<u>see tables 1a and 1b</u>	
88164 ●■	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	<u>see tables 1a and 1b</u>	
<u>88172</u> ●◆■	<u>Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site;</u>	<u>see tables 2a and 2b</u>	
88173 ●◆■	interpretation and report	<u>no ICD-9 code restrictions</u>	

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
88174 ●■	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	see tables 1a and 1b	
88175 ●■	with screening by automated system and manual rescreening or review, under physician supervision	see tables 1a and 1b	
88305 ●◆■	Level IV – Surgical pathology, gross and microscopic examination	no ICD-9 code restrictions	
88307 ●◆	Level V, gross and microscopic examination, requiring microscopic evaluation of surgical margins	no ICD-9 code restrictions	
88342 ●◆	Immunohistochemistry (including tissue immunoperoxidase), each antibody	see tables 1b, 1c and 2b	

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
88360 ●◆■	Morphometric analysis, tumor immunochemistry (<u>eg, Her-2/neu, estrogen receptor/progesterone receptor</u>), <u>quantitative or semiquantitative, each antibody; manual</u>	<u>see table 2b</u>	
99070 ●◆■	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	<u>see tables 1a, 1b, 2a and 2b</u>	
99202 ◆■	Office or other outpatient visit for the evaluation and management of a new patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average of 20 minutes. An expanded problem focused history/exam with straightforward medical decision-making.
99203 ■	Office or other outpatient visit for the evaluation and management of a new patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average of 30 minutes. A detailed history/exam, with medical decision-making of low complexity.
99204 ■	Office or other outpatient visit for the evaluation and management of a new patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average of 45 minutes. A comprehensive history/exam, with medical decision-making of moderate complexity. This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
99211 ●	Office or other outpatient visit for the evaluation and management of an established patient	<u>see tables 1a, 1b, 2a and 2b</u>	May not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically 5 minutes are spent performing or supervising these services.
99212 ◆■	Office or other outpatient visit for the evaluation and management of an established patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average 10 minutes, which requires at least two of the following: A problem-focused history, a problem-focused examination, straightforward medical decision-making.
99213 ◆■	Office or other outpatient visit for the evaluation and management of an established patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average 15 minutes, which requires at least two of the following: An expanded problem-focused history, an expanded problem-focused exam, low complexity medical decision-making.
99214 ■	Office or other outpatient visit for the evaluation and management of an established patient	<u>see tables 1a, 1b, 2a and 2b</u>	Average 25 minutes, which includes at least two of the following: A detailed history, a detailed exam, moderate-complexity medical decision-making. This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
99241 ●	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 15 minutes, which includes all three of the following: a problem-focused history, a problem-focused exam, straightforward medical decision-making. Cannot be billed in conjunction with CPT-4 codes 10022, 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 77055, 77056, 99242 or 99243.
99242 ●	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 30 minutes, which includes all three of the following: An expanded problem-focused history, an expanded problem-focused exam, straightforward medical decision-making. Cannot be billed in conjunction with CPT-4 codes 10022, 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 77032, 77055, 77056, 99241 or 99243.

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<u>CPT-4 Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>	<u>Additional Information</u>
99243 ●	Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only	see tables 1a, 1b, 2a and 2b	Average 40 minutes, which includes all three of the following: A detailed focused history, a detailed focused exam, low-complexity medical decision-making. Cannot be billed in conjunction with CPT-4 codes 10022, 57452, 57454, 57455, 57456, 58110, 76098, 76645, 76942, 77055, 77056, 99241 or 99242.

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HCPCS Code	Description	ICD-9-CM Code
A4217 ●◆■	Sterile water/saline, 500 ml	see tables 1a, 1b, 2a and 2b
G0202 ●◆■	Screening mammography, producing direct digital image, bilateral, all views	see tables 2a and 2b
G0204 ●◆■	Diagnostic mammography, direct digital image, bilateral, all views	see tables 2a and 2b Cannot be billed with HCPCS code G0206.
G0206 ●◆■	Diagnostic mammography, producing direct digital image, unilateral, all views	see tables 2a and 2b Cannot be billed with HCPCS code G0204.
T1013 ●◆■	Sign language or oral interpreter services, per 15 minutes.	see tables 1a, 1b, 2a and 2b Once per day, per recipient, per provider. Oral interpretive services not covered.
T1017 ◆■	Targeted case management, each 15 minutes.	see tables 1a, 1b, 2a and 2b Once per recipient, per provider, <u>per calendar year.</u>
X7700 ●◆■	Administered intravenous solution; initial, up to 1000 ml, including related supplies	see tables 1b and 2b
X7702 ●◆■	each additional 1000 ml, including related supplies	see tables 1b and 2b
Z7500 ●◆■	Examining or treatment room use	see tables 1a, 1b, 2a and 2b

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<u>HCPCS Code</u>	<u>Description</u>	<u>ICD-9-CM Code</u>
Z7506 ●◆■	Operating room or cystoscopic room use; first hour	<u>see tables 1b and 2b</u>
Z7508 ●◆■	first subsequent half hour	<u>see tables 1b and 2b</u>
Z7510 ●◆■	second subsequent half hour	<u>see tables 1b and 2b</u>
Z7512 ●◆■	Recovery room use	<u>see tables 1b and 2b</u>
Z7514 ●◆■	Room and board, general nursing care for stays of less than 24 hours, including ordinary medication	<u>see tables 1b and 2b</u>
Z7610 ●◆■	Miscellaneous drugs and medical supplies	<u>see tables 1a, 1b, 2a and 2b</u>

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Case Management Coverage

The only cycles eligible for reimbursement for case management services (T1017) are those with findings that require immediate work-up and an additional referral together with coordination of services. EWC does not pay separately for case management for recipients who require routine or short-term follow-up re-screening.

T1017 is payable only to PCPs enrolled in the EWC program. This code is payable only to PCPs after submission of complete outcome data via DETEC.

To report results, use DETEC *Recipient Information* and *Breast/Cervical Cancer Screening Cycle* forms. Recipient cycle records must be complete to be eligible for case management reimbursement.

Case Management Coding

HCPCS code T1017 should be used to bill for the case management covered service.

Case Management Reimbursement

The annual allowance is \$50. Case management will be paid once per recipient, per provider, per calendar year.

Digital Mammogram Reimbursement

HCPCS codes G0202, G0204 and G0206 for digital mammograms are paid at the Medi-Cal rate for digital mammograms.

Claim Completion	EWC services are billed using either the <i>CMS-1500</i> or <i>UB-04</i> claim. Providers submitting the <i>UB-04</i> should follow the instructions in the <i>UB-04 Completion: Outpatient Services</i> section of the Part 2 provider manual. Providers submitting the <i>CMS-1500</i> should follow the instructions in the <i>CMS-1500 Completion</i> section of the Part 2 provider manual. Electronic billing is done as per Medi-Cal electronic billing instructions.				
Modifiers	Modifiers are required for some program procedures. Medi-Cal rules for use of modifiers apply to EWC.				
Recipient ID Number Required	The 14-character recipient ID number must be entered on each claim whether hard copy or electronic. Claims submitted without the 14-character ID number will be denied. Consent and recipient eligibility forms should not be attached to the claim but must be retained by the PCP in the recipient's medical record instead.				
ICD-9-CM Code Requirements	ICD-9-CM diagnosis codes are required on claims for diagnostic mammograms provided through EWC and must be appropriate for the clinical situation. For other screening and diagnostic services, the provider may enter an appropriate code.				
Where To Submit Claims	<p>Claims can be submitted either hard copy or electronically using the <i>CMS-1500</i> or <i>UB-04</i>. Providers who choose to submit hard copy claims <u>must</u> send to the appropriate address for their claim type, as follows:</p> <table border="0" style="margin-left: 40px;"> <tr> <td style="text-align: center;"><u>Medical Services (CMS-1500)</u></td> <td style="text-align: center;"><u>Outpatient Services (UB-04)</u></td> </tr> <tr> <td style="text-align: center;">Xerox State Healthcare, LLC P. O. Box 15700 Sacramento, CA 95852-1700</td> <td style="text-align: center;">Xerox State Healthcare, LLC P. O. Box 15600 Sacramento, CA 95852-1600</td> </tr> </table> <p>Claims submitted to the wrong address will be forwarded appropriately, but processing will be delayed. To order pre-addressed envelopes for claim submission (thereby ensuring that claims are sent to the correct address), refer to the appropriate <i>Forms Reorder Request</i> section of this manual or call the Telephone Service Center (TSC) at 1-800-541-5555. For more information about claim submission requirements, refer to the appropriate submission and timeliness instructions section in this manual.</p>	<u>Medical Services (CMS-1500)</u>	<u>Outpatient Services (UB-04)</u>	Xerox State Healthcare, LLC P. O. Box 15700 Sacramento, CA 95852-1700	Xerox State Healthcare, LLC P. O. Box 15600 Sacramento, CA 95852-1600
<u>Medical Services (CMS-1500)</u>	<u>Outpatient Services (UB-04)</u>				
Xerox State Healthcare, LLC P. O. Box 15700 Sacramento, CA 95852-1700	Xerox State Healthcare, LLC P. O. Box 15600 Sacramento, CA 95852-1600				
Program Inquiries	For questions about EWC claims or claims procedures, providers may call the TSC at 1-800-541-5555.				