Medi-Cal Provider Training 2019

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Fresno
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Chula Vista
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San Marcos
San Diego

Every Woman Counts
The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP’s easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at http://www.medi-cal.ca.gov/education.asp.

Free Services for Providers

Provider Seminars and Webinars
Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives
The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit
The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!
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Introduction

Purpose

The purpose of this module is to provide information on eligibility requirements, program benefits and billing for recipients enrolled in the Every Woman Counts (EWC) program when services are rendered by Primary Care Providers (PCPs) and qualified referral providers enrolled in EWC.

Module Objectives

- Define the EWC program
- Describe providers’ program enrollment requirements to render services
- Review recipient eligibility criteria
- Explain when and how to bill for EWC case management
- Identify program-covered services
- Highlight specific billing requirements

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.
Program Overview

The EWC program is a state and federally funded comprehensive public health program.

The mission of the EWC program is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and integrated preventive services with special emphasis on the underserved.

The EWC program provides timely and appropriate breast and cervical cancer screening, diagnostic, case management and patient navigation services. The other components of the program are public health education, outreach, quality assurance, improvement through professional education and evaluation of clinical data. The EWC program, in coordination with the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), helps low-income, uninsured and underinsured individuals obtain high quality breast and cervical cancer screenings and diagnostic services.

The EWC program provides cervical cancer screening and diagnostic services to women 21 years of age and older and breast cancer screening and diagnostic services to women 40 years of age and older. The program also provides breast diagnostic services to symptomatic individuals of any age. Services are provided in all counties of the state.

The goal of the program is to prevent the devastating effects of breast cancer and cervical cancer by reducing morbidity and mortality rates of Californians.

Recipient Age Eligibility

- Women must be 21 years of age and older to be eligible for cervical cancer screening and diagnostic services.
- Women must be 40 years of age and older to be eligible for breast cancer screening and diagnostic services.
- Individuals of any age presenting with breast cancer symptoms are eligible for breast cancer diagnostic services (as of January 1, 2017).

Transgender Services

In all EWC sections, regardless of the gender stated, EWC benefits and policies apply to individuals of any gender identity as long as the procedure is medically necessary. The recipient’s medical record must support medical necessity for the procedure.
Financial Eligibility Criteria

The Federal Health and Human Services (HHS) poverty guidelines are used to determine financial eligibility for EWC. To qualify for breast and cervical cancer screening services, individuals must have a household income at or below 200 percent of the HHS poverty guidelines.

- “Gross household income” means the sum of income (before taxes and other deductions) of the individual(s) living in the household.
- Migrant farm workers and other seasonally employed persons may be computed by averaging total gross income received during the previous 12 months.
- The HHS poverty guidelines are adjusted annually, and the EWC income criteria are also updated accordingly.

### EWC INCOME ELIGIBILITY GUIDELINES

#### 200 Percent of the 2018 Health and Human Services (HHS) Poverty Guidelines by Household Size

**Effective April 1, 2018, through March 31, 2019**

<table>
<thead>
<tr>
<th>Number of Persons Living in Household</th>
<th>Monthly Gross Household Income</th>
<th>Annual Gross Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,023</td>
<td>$24,280</td>
</tr>
<tr>
<td>2</td>
<td>$2,743</td>
<td>$32,920</td>
</tr>
<tr>
<td>3</td>
<td>$3,463</td>
<td>$41,560</td>
</tr>
<tr>
<td>4</td>
<td>$4,183</td>
<td>$50,200</td>
</tr>
<tr>
<td>5</td>
<td>$4,903</td>
<td>$58,840</td>
</tr>
<tr>
<td>6</td>
<td>$5,623</td>
<td>$67,480</td>
</tr>
<tr>
<td>7</td>
<td>$6,343</td>
<td>$76,120</td>
</tr>
<tr>
<td>8</td>
<td>$7,063</td>
<td>$84,760</td>
</tr>
<tr>
<td>For each additional person, add:</td>
<td>$720</td>
<td>$8,640</td>
</tr>
</tbody>
</table>
Health Insurance

To be eligible for EWC, an individual’s PCP must certify they are uninsured or underinsured based on the individual’s self-report. Recipients may be certified as underinsured for EWC if they have:

- Limited scope Medi-Cal (pregnancy or emergency)
- Medi-Cal with unmet Share of Cost (SOC) obligations
- Private insurance with co-payments or deductibles that cannot be met
- Private insurance with benefit restrictions that exclude services available through EWC

NOTE
Inability to meet SOC or copayment obligation is self-reported.

For more information, refer to the Every Woman Counts (ev woman) section in the Part 2 provider manual.

Residency

Eligible individuals must have a California address. If homeless, the individual must have a location on file where they can be contacted and/or receive mail.

Eligibility Period

Individuals are eligible for EWC for one year, starting on the date the DETecting Early Cancer (DETEC) Recipient Information form is completed and submitted. The eligibility period does not change if the recipient transfers to another PCP. It is important to note that the eligibility period is for the recipient and not the provider. Re-enrollment or recertification can only occur annually when a recipient’s one-year recipient eligibility period ends.

Scenario

Recipient enrolls with 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 February 1, to the following January 31 (one year).

Furthermore, the recipient visits Provider B in June, four months after seeing Provider A. Provider B creates a new recipient record by updating the information in DETEC; however, the recipient still remains eligible only until January 31, as previously established. Each provider maintains separate records, but the recipient’s dates of eligibility are not affected.

Payer of Last Resort

EWC is the payer of last resort, paying providers only for breast and/or cervical screening and diagnostic services not covered by other programs.
Cancer Detection and Treatment Branch

The Cancer Detection and Treatment Branch (CDTB) is part of the California Department of Health Care Services’ Benefits Division. CDTB manages multi-faceted public health programs for cervical cancer prevention, breast and cervical cancer screening and diagnosis, and prostate cancer treatment. These services are offered through the EWC and IMProv Access, Counseling & Treatment for Californians with Prostate Cancer (IMPACT) programs.

CDTB Components
• Health education and outreach activities
• Clinical services
• Quality assurance and improvement through professional education and evaluation of clinical data
• Patient care coordination to ensure individuals are screened regularly and that follow-up occurs when needed
• Breast and cervical cancer early detection and screening services that are provided in all counties of the state

Funding
• Funding for this program is by both federal and state dollars.
• Federal funds are received from the Centers for Disease Control and Prevention (CDC) and the NBCCEDP as authorized by the Acts of 1990 (Public Law 101-354).
• State funds are received through a tax on tobacco (mandated by the California Breast Cancer Act of 1993) and the General Fund.

EWC and Medi-Cal

EWC and Medi-Cal are two separate programs. However, EWC relies on the Medi-Cal billing procedures to process hard copy and electronic claims.
Regional Contractors

The EWC program is implemented through 10 Regional Contractors (RCs). Each RC has at least one clinical coordinator and one health educator. RCs are EWC local representatives. The regional structure allows EWC to work with communities to ensure low-income individuals receive breast and cervical cancer screening and diagnostic services by addressing the needs of the local population and working closely with the Primary Health Care Providers (PCP).

Regional Contractors web page: (www.dhcs.ca.gov/services/Cancer/EWC/Pages/RegionalContractors.aspx)

Clinical Guidelines

EWC services are performed in accordance with CDTB clinical guidelines. The guidelines are available online in the Every Woman Counts Provider Orientation (http://qap.sdsu.edu/programs/providers/materials/index.html) and by request through the 10 RCs.

Regional Contractors Activities

RCs conduct the following activities on behalf of CDTB:

- Recruit and train EWC PCPs
- Support EWC providers to participate in breast and/or cervical health service delivery networks
- Conduct local targeted outreach and education
- 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 the development of recipient tracking and follow-up systems that facilitate annual rescreening and timely referrals for individuals with abnormal findings
- Provide technical assistance and training for entering recipient information, eligibility and data in the EWC data entry application known as DETEC
- Provide technical assistance and training in data entry to meet the Core Program Performance Indicators (CPPIs) measuring quality outcomes
- Provide guidance to support recipients receiving timely and appropriate services
Primary Care Providers

PCPs are clinical entities that agree to enroll individuals, provide screening and diagnostic services and coordinate diagnostic services and referral to treatment as part of case management. PCPs also collect, enter and report recipient outcome data.

PCP Requirements

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), CDTB clinical standards and data submission requirements.

A PCP must:
- Be a Medi-Cal provider in good standing and licensed in the state of California
- Enroll in the program through an RC
- Complete and sign a Primary Care Provider Enrollment Agreement (PCPEA)
- Have Internet access to enroll a recipient into EWC and obtain the 14-character identification number required for hard copy/electronic claim submissions
- Complete the DETEC online enrollment and data forms

PCP Responsibilities

- Inform Referral Provider of covered services, individual’s eligibility status and the 14-character ID
- Refer to providers who agree to bill only for EWC covered services
- Verify recipient’s eligibility or that the certification period is valid for date of service
- Deliver EWC program services in accordance with EWC program clinical quality standards
- Accept Medi-Cal rates as payment in full. Do not bill recipients for any EWC program services
- Provide disclosure to recipients about services that are not covered by EWC and receive patient consent prior to provision of these services
- Assess tobacco use for each recipient and refer users to the tobacco cessation program
- Provide notification to recipients of screening, diagnostic procedures and test results within specified time frames and document notification in the medical record
- Collect recipient data and report to the EWC program
- Maintain a network of Referral Providers
- Refer recipients for diagnostic evaluation and/or treatment as needed
PCP Categories

EWC-enrolled PCPs may fall into one of two categories:

- Enrolled to provide breast cancer screening services. Breast cancer screening-only providers may bill the program approved procedures marked with a “◆”.
- Enrolled to provide both breast and cervical cancer screening services marked with a “■”.

NOTE
Providers are encouraged to, and most elect to, provide both breast and cervical cancer screening services.

Referral Providers

Referral providers are Medi-Cal providers in good standing who receive referrals from EWC PCPs to render specialty and ancillary care services to EWC recipients. Referral providers are not required to be enrolled as EWC providers, and referral services do not need to be preauthorized.

Referral providers can include any of the following:

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

Referral providers may bill EWC for all procedure codes marked with a “❖” in the list under the “Approved Procedures.”

Referral Provider Requirements

- Referral providers should use the EWC recipient’s 14-character ID number for their claims to be processed and not denied.
- Referral providers can render only the EWC program-covered services that are permitted for referral providers.
- Referral providers must report their screening and diagnostic findings to the EWC-enrolled PCP who is responsible for submitting data and outcomes to EWC and for coordinating further care or follow-up.
- Referral providers accept Medi-Cal rates as payment in full. Do not bill recipients for any EWC program services.
- Referral providers offer disclosure to a recipient about services that are not covered by EWC and receive patient consent prior to provision of these services.
Enrollment Application

To enroll an individual into EWC, the PCP must ensure that:

- The recipient is not eligible for more comprehensive coverage through the Affordable Care Act and meets the EWC eligibility criteria.
- The Recipient Eligibility Form (DHCS 8699) is signed by the woman and the PCP staff, and that all pages of the form are kept in the medical chart for each of the woman’s annual certification period(s).
- With each certification, the woman signs the Consent to Participate in Program and Privacy Statement (DHCS 8478) form to agree to the program conditions and to acknowledge receipt of the Notice of Privacy Practices (NPP).
- A signed Consent form and a copy of all pages of the NPP must be kept in the patient file.
- Enrollment data is entered into the DETEC. A woman is considered enrolled in EWC once eligibility information is entered into DETEC and a 14-digit recipient ID number is generated. Until this information is entered into DETEC, the woman is not enrolled. Providing services to individuals before EWC enrollment may compromise payment for services rendered.
- A printed copy of the enrollment data, including the Recipient ID Card, is placed in the medical chart.
- The recipient is given a copy of the ID Card.

Important Points

1. EWC recipients are identified by a 14-character ID.
2. The recipient ID number is computer generated after the online Recipient Information form is completed and submitted.
3. Providers must certify that the recipient is eligible for the program.
4. EWC enrollment needs to be certified annually.
5. Women must be at least 21 years of age to be eligible for cervical cancer screening and diagnostic services.
6. Women must be at least 40 years of age to be eligible for breast cancer screening and diagnostic services.
7. Individuals of any age presenting with breast cancer symptoms are eligible for breast cancer diagnostic services (as of January 1, 2017).
8. The signed Recipient Eligibility Form, Consent to Participate in Program form and a copy of the Recipient ID Card must be kept in the recipient’s file by the PCP.
9. Providers should print and keep a copy of the completed DETEC Screening Cycle Data form in the recipient’s file as evidence of data submission.
Every Woman Counts

RECIPIENT ELIGIBILITY FORM

Medical Record Number

Recipient ID

This section to be completed by recipient

1. Last Name

2. First Name

3. Middle Initial

4. Date of birth (MM-DD-YYYY)

5. Mother’s Maiden Name

6. Address

7. City

8. State

9. ZIP Code

10. Telephone

11. Are you Hispanic or Latino?
   Yes □ No □ Unknown □

12. Select all that apply to you:
   ■ Asian Indian
   ■ Cambodian
   ■ Chinese
   ■ Filipino
   ■ Japanese
   ■ Korean
   ■ Laotian
   ■ Vietnamese
   ■ Other Asian
   ■ American Indian or Alaska Native
   ■ Asian
   ■ Black or African American
   ■ Pacific Islander
   ■ White
   ■ Unknown

13. (Select one if Asian)

14. (Select one if Pacific Islander)

15. Total household income (before taxes):

16. Total number of persons living together on this income:

17. Health insurance:
   17a. Do you have health insurance?
       Yes □ No □ Unknown □
   17b. If Yes, which type?
       ■ Medi-Cal
       ■ Medicare Part B
       ■ Family PACT
       ■ Private insurance
       ■ Other □

18. Tobacco Use:
   □ 18a. Do you smoke tobacco now?
       Yes □ No □
   □ 18b. Do you use other tobacco products now?
       Yes □ No □

I certify that the above information is correct and complete:

Recipient Signature

Date Signed

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

19. □ Meets EWC program age, income, and insurance criteria:
   [ ≥ 40 years of age for Breast Services or ≥ 21 years of age for Cervical Services]
   [ ≥ 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]

20. □ Signed EWC consent form

21. □ Breast and Cervical Cancer Treatment Program—See page 2 for additional referral requirements

I have determined that this woman is eligible for EWC services.

For recipients who answered Yes to □ Item 18a or 18b above, I have notified clinician to assess smoking status and refer to tobacco cessation resources.

Primary Care Provider Staff Certifying Signature

Date Certified

*Eligibility determination policies and information are located in the Can Detect Portion of the Medi-Cal Manual.

DHCS 8699 (Rev 1/13)

Complete all fields. Place original in patient chart.

Sample: Recipient Eligibility Form – Page 1
Every Woman Counts

RECIPIENT ELIGIBILITY FORM (continued)

BCCTP Enrollment Date: ______________________

The purpose of this enrollment is to only refer the recipient to BCCTP Breast Cancer Treatment:

☐ Breast Final Diagnosis Date: ______________________

Breast Final Diagnosis (check one): ______________________

☐ Atypical Ductal Hyperplasia (ADH)
☐ Lobular Neoplasia
☐ Lobular Carcinoma in Situ (LCIS)
☐ Atypical Lobular Hyperplasia (ALH) Ductal
☐ Carcinoma In Situ, Comedo Type Ductal
☐ Carcinoma In Situ, Non-Comedo Type
☐ Infiltrating Ductal Carcinoma
☐ Infiltrating Lobular Carcinoma
☐ Medullary Carcinoma
☐ Mucinous or Colloid Carcinoma
☐ Papillary Carcinoma
☐ Tubular Carcinoma
☐ Paget’s Carcinoma of the Breast
☐ Malignant Phyllodes Tumor
☐ Metastatic Cancer with Breast Primary
☐ Carcinosarcoma
☐ Primary Non-Hodgkin’s Lymphoma
☐ Inflammatory Breast Carcinoma
☐ Adenoid Cystic Carcinoma
☐ Breast Malignancy NOS

The purpose of this enrollment is to only refer the recipient to BCCTP Cervical Cancer Treatment:

☐ Cervical Final Diagnosis Date: ______________________

Cervical Final Diagnosis (check one): ______________________

☐ High Grade Squamous Cell Intraepithelial Lesion (HSIL)
☐ Adenoid Cystic Carcinoma
☐ Cervical Intraepithelial Neoplasia II (CIN II)
☐ Cervical Intraepithelial Neoplasia III (CIN III)
☐ Atypical Glandular Cells of Undetermined Significance (AGUS)
☐ Adenocarcinoma In Situ (ACIS)
☐ Adenocarcinoma
☐ Squamous Cell Carcinoma
☐ Adenoma Malignum
☐ Adenosquamous Carcinoma
☐ Glassy Cell Carcinoma
☐ Carcinoid Carcinoma
☐ Small Cell Carcinoma or Neuroendocrine Carcinoma
☐ Metastatic Cancer with Cervical or Endocervical Primary
☐ Cervical Sarcoma
☐ Cervical Melanoma
☐ Mesonephric Carcinoma
☐ Moderate Dysplasia
☐ Severe Dysplasia
☐ Carcinoma In Situ
☐ Malignant Mixed Mullerian Tumor
☐ Cervical Malignancy NOS

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

22. ☐ Meets EWC program age, income and insurance criteria.
   [ ≥ 40 years of age for Breast Services or ≥ 21 years of age for Cervical Services]
   • [ ≥ 200% Federal Poverty Level; Fayer of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]
23. ☐ Signed EWC consent form

* I have determined that this woman is eligible for BCCTP enrollment.

Primary Care Provider Staff Certifying Signature ______________________ Date Certified ________________

*Eligibility determination policies and information are located in the Cancer Detection Programs’ Section of the Medi-Cal Manual.

DHCS 8699 (Rev 1/13) Complete all fields. Place original in patient chart.

Sample: Recipient Eligibility Form – Page 2
Every Woman Counts

RECIPIENT ELIGIBILITY FORM (continued)

PRIVACY STATEMENT

The information requested on this form is required by the Department of Health Care Services (DHCS), Every Woman Counts (EWC) for purposes of client identification and data collection. This information may be transferred to federal, state, and local agencies for purposes of verifying eligibility and other purposes related to administering EWC. Furnishing the information requested on this form is mandatory. Failure to provide the required information may result in the denial of eligibility.

The Information Practices Act of 1977 and the Federal Privacy Act require DHCS to provide the following information: that privacy and confidentiality of all personal, confidential, and sensitive information, in whatever medium (oral, paper or electronic) must be protected. DHCS considers all information about individuals private, unless such information is determined to be a public record. DHCS and EWC policy is to protect privacy and prevent the loss of information through accidental misuse, sabotage, criminal activity, or natural disaster.

Legal references authorizing maintenance of this information: Government Code Section 6250-6265, Government Code Section 11019.9, Health and Safety Code Section 131085. All information will be protected as described in the Department’s Cancer Detection & Treatment Branch CDTB Notice of Privacy Practices. You have the right to inspect or obtain a copy of records kept by the CDS regarding your health care, as described in the CDTB Notice of Privacy Practices. Contact the California Department of Health Care Services, Every Woman Counts 1616 Capitol Avenue, Suite 74-421 P.O. Box 997377, Sacramento, CA 95899-7377, or call (916) 449-5306.
Every Woman Counts (EWC) Program

RECIPIENT ELIGIBILITY FORM ADDENDUM

Effective January 1, 2017, EWC provides breast **diagnostic** services to **symptomatic** recipients of any age in accordance with Assembly Bill (AB) 1795 (Atkins, Chapter 68, Statutes of 2016). Please see the following link for the full bill text:

Prior to January 1, 2017, EWC provided diagnostic services to women age 40 and older who presented with symptoms and/or signs of breast cancer. AB 1795 enables EWC to provide diagnostic services to symptomatic recipients of any age.

If you are under age 40, please indicate whether you have one or more of the following symptoms:

- Palpable mass, lump or swelling in the breast or the underarm;
- Changes in size or shape of the breast;
- Changes in skin texture and color (dimpling, puckering, redness, scaliness, or thickening) of the breast or nipple;
- Nipple retraction or inversion;
- Nipple discharge; and/or
- Other: change or feeling of the breast ________________

**I certify that the above information is true and correct to the best of my knowledge:**

<table>
<thead>
<tr>
<th>Recipient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**PROVIDER USE ONLY** Eligibility Checklist

In addition to Eligibility Checklist please verify that the recipient is under age 40 and has one or more of the symptoms listed above.

<table>
<thead>
<tr>
<th>Primary Care Staff Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
EVERY WOMAN COUNTS PROGRAM
CONSENT TO PARTICIPATE IN PROGRAM AND PRIVACY STATEMENT

The Department of Health Care Services (Department) pays for some tests to detect breast and/or cervical cancer for women who are low income, uninsured or underinsured, and cannot pay for these services. Most women do NOT have cancer. For the few who do, finding the cancer early may save their lives. Signing this form means that you want to take part in the Every Woman Counts program. This consent is valid for one year. You must sign a new consent form for each year you take part in the EWC program. You can stop taking part in the program at any time.

To participate in the EWC program, you must provide your name, address, date of birth, income, and some health history. This information must be provided or you will not be allowed to participate. Other information, such as your social security number (if you have one) will be asked, but you do not have to provide it to be screened. The EWC program is authorized to collect and maintain the information provided by you when applying for this program under the California Revenue and Taxation Code, Section 30451.6, 42; United States Code 1501; and 45 Code of Federal Regulations, Sections 160-164. All information will be protected as described in the EWC program Notice of Privacy Practices (NPP), which you are being given with this consent. Your primary care provider (PCP) will provide you with your screening results. Your PCP will keep your medical record on file and will send medical data to the EWC program to request payment, to use for utilization of health care operations, research, and in some cases, for coordination of treatment. Information may be shared with other programs in the Department and other governmental agencies. Your PCP may also share your personal information with other health professionals to assist you in obtaining recommended services. Information may be disclosed when required by law, such as for workers’ compensation purposes. You have the right to inspect or obtain a copy of records kept by the EWC program regarding your health care, as described in the NPP.

Your name will not be used in any report that is public. Your name, date of birth, address, and social security number may be shared with other participating providers in the program for purposes of avoiding duplication of enrollment.

You will get a copy of this consent to keep. Please talk to your primary care provider if you have any questions.

I, __________________________ (please print your name) have provided correct and complete information and agree to take part in the Department’s EWC program. I also agree to let my personal and medical facts be used, as explained above. I understand that by signing this form, I agree to take part in the EWC program for one year, and for participation in the EWC program next year, I must sign a new consent to participate.

______________________________  ______________________________
Signature                       Date

I have received and read the Notice of Privacy Practices.

______________________________  ______________________________
Signature                       Date

COMPLETE ONLY IF WITNESS IS NECESSARY: I have read the information on this form to the patient whose name is listed above. I conclude, to the best of my knowledge and belief, that the patient understands the information, is willing to take part in the program, and agrees to the terms of this consent.

______________________________  ______________________________
Signature                       Date

Every Woman Counts
Benefits Division, MS 4600
P.O. Box 997417, Sacramento, CA 95899-7417
Phone (916) 449-5300
Internet Address: http://dhcs.ca.gov/EveryWomanCounts

DHCS 8478 (Rev. 2/15)
Enrollment Process

You need the following to enroll a recipient into EWC:

- A desktop computer or laptop
- Access to the Internet
- National Provider Identifier (NPI) and Provider Identification Number (PIN)
- A printer

**NOTE**
To be able to access “Transaction Services,” you need to have a Medi-Cal POS/Internet Network Agreement on file with California Medicaid Management Information System (California MMIS) Fiscal Intermediary. California MMIS Fiscal Intermediary is the Department of Health Care Services’ (DHCS) Fiscal Intermediary.

To access the Internet website for EWC:

- Go to (www.medi-cal.ca.gov).
- Click the “Transactions” tab which directs you to the “Login to Medi-Cal” page.
- Enter the Medi-Cal NPI number for the enrolled EWC and PIN (password).
- Click the “Programs” tab.
- Click the “Every Woman Counts” tab.
- The provider is automatically directed to the “DETEC – Recipient Search” screen.
- In the “DETEC – Recipient Search” screen, the provider must first search for the recipient. If the recipient is returning, the provider can either enter the existing recipient ID number or the last name and Date of Birth (DOB). If the recipient is new to the provider, enter the last name and DOB to verify that she has not been enrolled in the past.

**NOTE**
A recipient should have only one recipient ID number in DETEC. Do not create a new recipient ID number. Use the existing number.

Required Online Forms

The following online forms are required, and are completed and submitted via DETEC.

- DETEC – *Enroll Recipient*
- DETEC – *Recipient Information*

After submission of the required online forms via DETEC, the PCP must print, sign and date the print copies of the DETEC enrollment form and the computer-generated recipient ID card and place the original copy in the patient’s medical record. It is recommended that providers use the Step-by-Step Provider User Guide for complete instructions on how to enroll a recipient into the EWC program and how to submit required forms via DETEC.
Required Data
In accordance with the PCPEA and to be eligible for case management payment, the PCP must submit complete cancer screening cycle data, including work-up status, referral, final diagnosis and treatment status. Data must be submitted via DETEC within 30 days after receipt of all required information for all recipients served. Providers who do not submit data are at risk for disenrollment.

The PCP must submit the following breast cancer screening cycle data via DETEC:
- Current breast symptoms
- Clinical breast exam results
- Mammogram history
- Reason for current mammogram
- Current mammogram results
- Additional breast imaging results
- Other breast diagnostic procedures performed, results must be included
- Work-up status
- Final diagnosis
- Treatment information

The PCP must submit the following cervical cancer screening cycle data via DETEC:
- Previous Pap test history
- Reason for current Pap test
- Specimen type
- Current Pap test results
- Other cervical procedures performed, results must be included
- Work-up status
- Final diagnosis
- Treatment information
Payable Services

EWC covers only breast and cervical cancer screening-related services that are payable to either a PCP or a Referral Provider as identified by a symbol next to each procedure code. The symbol identifies which provider can render each procedure code.

- PCPs enrolled to provide breast cancer screening services only are identified with a ♦
- PCPs enrolled to provide breast and cervical cancer screening services are identified with a ●
- Referral providers are identified with a ●

**NOTE**

Providers must have the appropriate ICD-10-CM diagnosis code(s) specified as the primary or secondary diagnosis code on the claim to be eligible for payment.
Approved Procedures with ICD-10-CM Diagnosis Codes

Providers must have an appropriate ICD-10-CM diagnosis code(s) specified as the first or second diagnosis code on the claim to be eligible for payment.

Cervical cancer screening ICD-10-CM codes are shown in tables 1a, 1b and 1c. Breast cancer screening ICD-10-CM codes are shown in tables 2a and 2b.

### Table 1a
**Cervical Cancer Screening ICD-10-CM Codes**

| Z01.411, Z01.419, Z01.42, Z11.51, Z12.4, Z15.01, Z15.02, Z21, Z40.01, Z40.02, Z78.0, Z80.41, Z80.49, Z85.3, | Z85.40 – Z85.44, Z87.410 – Z87.412, Z87.891, Z90.710 – Z90.712, Z90.721, Z90.722, Z90.79, Z92.0, Z92.25 |

### Table 1b
**Cervical Cancer Screening and Diagnosis ICD-10-CM Codes**

| A63.0, B20, B97.35, B97.7, C51.8, C53.0, C53.1, C53.8, C53.9, C55, C57.7 – C57.9, C76.3, C80.1, D06.0, D06.1, D06.7, D06.9, D07.0, D07.2, D07.30, D25.0, D26.0, D49.511 – D49.59, N72, N84.0, N84.1, N84.8, N84.9, N85.9, N86, N87.0, N87.1, N87.9, N88.0 – N88.2, N88.4, | N88.8, N88.9, N89.0, N89.1, N89.3, N89.4, N89.8, N89.9, N93.0, N93.1, N93.9, N94.10 – N94.12, N94.19, N94.89, N95.0, R10.2, R87.610 – R87.616, R87.619 – R87.625, R87.628, R87.810, R87.811, R87.820, R87.821 |

### Table 1c
**Colposcopy and Cervical Biopsy ICD-10-CM Codes**

<p>| C53.0, C53.1, C53.8, C53.9, D06.0, D06.1, D06.7, D06.9, D07.2, D26.0, N87.0, N87.1, N88.0, N89.0, N89.1, N89.3, N89.4, | R87.610 – R87.616, R87.619, – R87.625, R87.628, R87.810, R87.811, R87.820, R87.821 |</p>
<table>
<thead>
<tr>
<th>Table 2a</th>
<th>Breast Cancer Screening Related ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Z12.31, Z12.39, Z15.01, Z15.02, Z15.09, Z17.0, Z17.1, Z77.123, Z77.128, Z77.9, Z78.0, Z78.9, Z79.810, Z79.818, Z79.890, Z80.0, Z80.3, Z80.41, Z80.8, Z80.9, Z85.038, Z85.3, Z85.40, Z85.43, Z85.71, Z85.72, Z85.79, Z85.9, Z90.10 – Z90.13, Z91.89, Z92.3, Z92.89, Z98.82, Z98.86</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2b</th>
<th>Breast Cancer Diagnosis ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C43.52, C44.501, C44.511, C44.521, C44.591, C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C77.0, C77.3, C79.2, C79.81, D03.52, D04.5, D05.00 – D05.02, D05.10 – D05.12, D05.80 – D05.82, D05.90 – D05.92, D17.1, D17.20 – D17.24, D17.30, D17.39, D17.72, D17.79, D18.01, D22.5, D23.5, D24.1, D24.2, D24.9, D48.5, D48.60 – D48.62, D49.2, D49.3, I80.8, N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.21, N60.22, N60.29, N60.31, N60.32, N60.39, N60.41, N60.42, N60.49, N60.81, N60.82, N60.89, N60.91, N60.92, N60.99, N61, N62, N63, N64.0 – N64.4, N64.51 – N64.53, N64.59, N64.81, N64.82, N64.89, N64.9, N65.0, Q83.0 – Q83.3, Q83.8, Q83.9, Q85.8, Q85.9, R23.4, R59.0, R59.1, R59.9, R92.0 – R92.2, R92.8</td>
</tr>
</tbody>
</table>
# EWC Reimbursable CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>ICD-10-CM Code/Table</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>00400</td>
<td>Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>10021</td>
<td>Fine needle aspiration; without imaging guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>10022</td>
<td>Fine needle aspiration; with imaging guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19000</td>
<td>Puncture aspiration of cyst of breast</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19001</td>
<td>each additional cyst</td>
<td>see table 2b</td>
<td>Use in conjunction with code 19000. If imaging guidance is performed, see code 76942.</td>
</tr>
<tr>
<td>19081</td>
<td>Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including stereotactic guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19082</td>
<td>each additional lesion, including stereotactic guidance</td>
<td>see table 2b</td>
<td>Use in conjunction with 19081.</td>
</tr>
<tr>
<td>19083</td>
<td>Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including ultrasound guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19084</td>
<td>each additional lesion, including ultrasound guidance</td>
<td>see table 2b</td>
<td>Use in conjunction with 19083.</td>
</tr>
<tr>
<td>19100</td>
<td>Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)</td>
<td>see table 2b</td>
<td>For fine needle aspiration, use code 10021. For image guided breast biopsy, see code 10022.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>19101</td>
<td>open, incisional</td>
<td>see table 2b</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 (except 19300), open, male or female, one or more lesions</td>
<td>see table 2b</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>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19126</td>
<td>each additional lesion separately identified by a preoperative radiological marker</td>
<td>see table 2b</td>
<td>Use in conjunction with code 19125.</td>
</tr>
<tr>
<td>19281</td>
<td>Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19282</td>
<td>each additional lesion, including mammographic guidance</td>
<td>see table 2b</td>
<td>Use in conjunction with 19281.</td>
</tr>
<tr>
<td>19283</td>
<td>Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19284</td>
<td>each additional lesion, including stereotactic guidance</td>
<td>see table 2b</td>
<td>Use in conjunction with 19283.</td>
</tr>
<tr>
<td>19285</td>
<td>Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>19286</td>
<td>each additional lesion, including ultrasound guidance</td>
<td>see table 2b</td>
<td>Use in conjunction with 19285.</td>
</tr>
<tr>
<td>57452</td>
<td>Colposcopy of the cervix including upper/adjacent vagina</td>
<td>see table 1c</td>
<td>Cannot be billed in conjunction with any office visits or consults or with codes 57454 – 57456.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>57454</td>
<td>with biopsy(s) of the cervix and endocervical curettage</td>
<td>see table 1c</td>
<td>Cannot be billed in conjunction with any office visits or consults.</td>
</tr>
<tr>
<td>57455</td>
<td>Colposcopy of the cervix, with biopsy</td>
<td>see table 1c</td>
<td>Cannot be billed in conjunction with any office visits or consults.</td>
</tr>
<tr>
<td>57456</td>
<td>Colposcopy of the cervix, with endocervical curettage</td>
<td>see table 1c</td>
<td>Cannot be billed in conjunction with any office visits or consults.</td>
</tr>
<tr>
<td>57500</td>
<td>Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)</td>
<td>see table 1c</td>
<td>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.</td>
</tr>
<tr>
<td>57505</td>
<td>Endocervical curettage (not done as part of dilation and curettage)</td>
<td>R87.619</td>
<td>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.</td>
</tr>
<tr>
<td>58100</td>
<td>Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)</td>
<td>R87.619</td>
<td>Reimbursable only if billed in conjunction with 57505. Cannot be billed in conjunction with 57452, 57454 – 57456.</td>
</tr>
<tr>
<td>58110</td>
<td>Endometrial sampling (biopsy) performed in conjunction with colposcopy</td>
<td>D06.0 – D06.9 and R87.619</td>
<td>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.</td>
</tr>
<tr>
<td>76098</td>
<td>Radiological examination, surgical specimen</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>76641</td>
<td>Ultrasound, complete examination of breast including axilla, unilateral</td>
<td>see tables 2a and 2b</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>76642</td>
<td>Ultrasound, limited examination of breast including axilla, unilateral</td>
<td>see tables 2a and 2b</td>
<td></td>
</tr>
<tr>
<td>76942</td>
<td>Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>77065</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral</td>
<td>see tables 2a and 2b</td>
<td>Reimbursable if the recipient either:</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Has distinct signs and symptoms for which a diagnostic mammogram is indicated, or</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Has a history of breast cancer, or</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Is asymptomatic, but on the basis of history and other significant factors diagnostic mammogram is indicated and appropriate</td>
</tr>
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<td></td>
<td>Codes 77065 and 77066 are not reimbursable when billed for the same day for the same recipient.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Limited to two procedures per year per provider. An approved Treatment Authorization Request (TAR) can override the frequency limit for code 77066.</td>
</tr>
<tr>
<td>77066</td>
<td>Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral</td>
<td>see tables 2a and 2b</td>
<td>Same as CPT 77065</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>77067</td>
<td>Screening mammography, bilateral, including computer-aided detection (CAD) when performed</td>
<td>see tables 2a and 2b</td>
<td>Limited to one screening per year, any provider, unless overridden with an approved TAR. Reimbursable with modifier U7 and 99, as appropriate. Restricted to individuals 40 years of age or older.</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test</td>
<td>see table 1c</td>
<td>This code may only be billed with one or more of the following codes: 57452, 57454 – 57456, 57500, 57505, 58100, 58110.</td>
</tr>
<tr>
<td>87624</td>
<td>Human Papillomavirus (HPV), high-risk types</td>
<td>N87.0, R87.610 – R87.612, R87.619 and Z11.51</td>
<td>Z11.51 is covered only for recipients age 30 and older.</td>
</tr>
<tr>
<td>88141</td>
<td>Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician</td>
<td>see tables 1a and 1b</td>
<td>Use in conjunction with code 88142, 88164, 88174 or 88175.</td>
</tr>
<tr>
<td>88142</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision</td>
<td>see tables 1a and 1b</td>
<td></td>
</tr>
<tr>
<td>88143</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision</td>
<td>see tables 1a and 1b</td>
<td></td>
</tr>
<tr>
<td>88164</td>
<td>Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision</td>
<td>see tables 1a and 1b</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>88172</td>
<td>Cytopathology, evaluation of fine needle aspirate; immediate cytohistlogic study to determine adequacy for diagnosis, first evaluation episode, each site;</td>
<td>see tables 2a and 2b</td>
<td></td>
</tr>
<tr>
<td>88173</td>
<td>interpretation and report</td>
<td>no ICD-10 code restrictions</td>
<td></td>
</tr>
<tr>
<td>88174</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision</td>
<td>see tables 1a and 1b</td>
<td></td>
</tr>
<tr>
<td>88175</td>
<td>with screening by automated system and manual rescreening or review, under physician supervision</td>
<td>see tables 1a and 1b</td>
<td></td>
</tr>
<tr>
<td>88305</td>
<td>Level IV – Surgical pathology, gross and microscopic examination</td>
<td>no ICD-10 code restrictions</td>
<td></td>
</tr>
<tr>
<td>88307</td>
<td>Level V, gross and microscopic examination, requiring microscopic evaluation of surgical margins</td>
<td>no ICD-10 code restrictions</td>
<td></td>
</tr>
<tr>
<td>88341</td>
<td>Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure.</td>
<td>Refer to tables 1b, 1c, and 2b</td>
<td></td>
</tr>
<tr>
<td>88342</td>
<td>Immunohistochemistry (including tissue immunoperoxidase), each antibody</td>
<td>see tables 1b, 1c and 2b</td>
<td></td>
</tr>
<tr>
<td>88360</td>
<td>Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual</td>
<td>see table 2b</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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<tr>
<td>99070</td>
<td>Supplies and materials (except spectacles), provided by the physician over and above those usually included in the office visit or other services rendered (list drugs, trays, supplies, or materials provided)</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>Average of 20 minutes. An expanded problem-focused history/exam with straightforward medical decision-making.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>Average of 30 minutes. A detailed history/exam, with medical decision-making of low complexity.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>Average 10 minutes, which requires at least two of the following: A problem-focused history, a problem-focused examination, straightforward medical decision-making.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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.</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>ICD-10-CM Code/Table</td>
<td>Additional Information</td>
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</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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.</td>
</tr>
<tr>
<td>99241</td>
<td>Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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 codes 10022, 57452, 57454 – 57456, 58110, 76098, 76645, 76942, 77055, 77056, 99242 or 99243.</td>
</tr>
<tr>
<td>99242</td>
<td>Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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 codes 10022, 57452, 57454 – 57456, 58110, 76098, 76645, 76942, 77032, 77055, 77056, 99241 or 99243.</td>
</tr>
<tr>
<td>99243</td>
<td>Office or other outpatient visit for the evaluation and management of a new or established patient – consultation only</td>
<td>see tables 1a, 1b, 2a and 2b</td>
<td>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 codes 10022, 57452, 57454 – 57456, 58110, 76098, 76645, 76942, 77055, 77056, 99242 or 99243.</td>
</tr>
</tbody>
</table>
# EWC Reimbursable HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>ICD-10-CM Code/Table</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4217</td>
<td>Sterile water/saline, 500 ml</td>
<td>see tables 1a, 1b, 2a and 2b</td>
</tr>
<tr>
<td>J7030</td>
<td>Infusion, normal saline solution, 1000 cc</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>J7040</td>
<td>Infusion, normal saline solution, sterile (500 ml = 1 unit)</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>J7050</td>
<td>Infusion, normal saline solution, 250 cc</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>J7120</td>
<td>Ringers lactate infusion, up to 1000 cc</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>T1013</td>
<td>Sign language or oral interpreter services, per 15 minutes.</td>
<td>see tables 1a, 1b, 2a and 2b Once per day, per recipient, per provider. Oral interpretive services not covered.</td>
</tr>
<tr>
<td>T1017</td>
<td>Targeted case management, each 15 minutes.</td>
<td>see tables 1a, 1b, 2a and 2b Once per recipient, per provider, per calendar year.</td>
</tr>
<tr>
<td>Z7500</td>
<td>Examining or treatment room use</td>
<td>see tables 1a, 1b, 2a and 2b</td>
</tr>
<tr>
<td>Z7506</td>
<td>Operating room or cystoscopic room use; first hour</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>Z7508</td>
<td>first subsequent half hour</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>Z7510</td>
<td>second subsequent half hour</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>Z7512</td>
<td>Recovery room use</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>Z7514</td>
<td>Room and board, general nursing care for stays of less than 24 hours, including ordinary medication</td>
<td>see tables 1b and 2b</td>
</tr>
<tr>
<td>Z7610</td>
<td>Miscellaneous drugs and medical supplies</td>
<td>see tables 1a, 1b, 2a and 2b</td>
</tr>
</tbody>
</table>
## BREAST ONLY Primary Care Provider Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) Program for “Breast Only Primary Care Providers.” Providers must have an appropriate ICD-10 code CMS listed as the first and/or second diagnosis code on the claim to be eligible for payment. For the list of appropriate CPT specific ICD-10-CM codes please refer to the Every Woman, EWC section of the Medi-Cal Provider Manual: [http://files.medi-cal.ca.gov/pubs/documents/Manuals/Mopathic/Everywoman.pdf](http://files.medi-cal.ca.gov/pubs/documents/Manuals/Mopathic/Everywoman.pdf).

**Procedure Code Definitions (May Require Modifier)**

<table>
<thead>
<tr>
<th>CPT 4 codes</th>
<th>CPT 4 codes</th>
<th>HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>06040 – Anesthesia, integral system anterior trunk</td>
<td>76099 – X-ray exam, x-ray specimen</td>
<td>A4217 – Sterile water-100 ml</td>
</tr>
<tr>
<td>10021 – Fine needle aspiration; without imaging guidance</td>
<td>76441 – Ultrasound, unilateral, include axilla complete</td>
<td>J7040 – Influr, norm sal sol, 1000 cc</td>
</tr>
<tr>
<td>10022 – Fine needle aspiration; with imaging guidance</td>
<td>76442 – Ultrasound, unilateral, include axilla limited</td>
<td>J7049 – Influr, norm sal sol, sterile 500 ml + 1 unit</td>
</tr>
<tr>
<td>19000 – Puncture aspiration of cyst of breast</td>
<td>76492 – US guidance for needle placement; imaging, supervise &amp; interpret</td>
<td>J7060 – Influr, norm sal sol, 250 cc</td>
</tr>
<tr>
<td>19001 – With 19000: each additional cyst</td>
<td>77065 – Diagnostic mammography; unilateral includes CAD</td>
<td>J7120 – Ringertens lact influr, up to 1000 cc</td>
</tr>
<tr>
<td>19081 – Biopsy, with localization device placed and imaging of biopsy specimen, percutaneous stereotactic guidance; first lesion</td>
<td>77066 – Diagnostic mammography; bilateral includes CAD</td>
<td>T1013 – Sign lang interpretive serv 15 min</td>
</tr>
<tr>
<td>19082 – With 19081: each additional lesion</td>
<td>77067 – Screening mammogram bilateral</td>
<td>T1017 – Case Mgmt - Immediate follow-up (PCP only)</td>
</tr>
<tr>
<td>19083 – Biopsy, with localization device placed and imaging of biopsy specimen; percutaneous; US guidance; first lesion</td>
<td>88172 – Cytopathology of FNA to determine adequacy of specimen</td>
<td>Z5750 – Exam or Tx Rm use</td>
</tr>
<tr>
<td>19084 – With 19083: each additional lesion</td>
<td>88305 – Level IV Surg path exam</td>
<td>Z5756 – OR, or Cysto Rm use, first hour</td>
</tr>
<tr>
<td>19100 – Needle Core biopsy; without imaging guidance</td>
<td>88307 – Level V Surg path exam</td>
<td>Z5756 – OR, or Cysto Rm use, 1st sub halflhr</td>
</tr>
<tr>
<td>19101 – Biopsy of breast, open, incisional</td>
<td>88331 – Immunohistochemistry, each additional single a/b stain</td>
<td>Z7510 – OR, or Cysto Rm use, 2nd sub halflhr</td>
</tr>
<tr>
<td>19120 – Excisional Biopsy, open</td>
<td>88341 – Immunohistochemistry</td>
<td>Z7512 – Recovery Rm use</td>
</tr>
<tr>
<td>19125 – Excision of lesion, identified by preop plent of radnomark; simple lesion</td>
<td>88360 – Morphometric analysis, tumor immunohistochemistry; manual</td>
<td>Z7314 – Radiogind enr uaf care, less than 2hr</td>
</tr>
<tr>
<td>19126 – With 19125: each additional lesion</td>
<td>99976 – Supplies/material, not incw/ov</td>
<td>Z5419 – Misc. drugs and medical supply</td>
</tr>
<tr>
<td>19281 – Localization device placement, percutaneous mammographic guidance; first lesion</td>
<td>99202 – OV; new pt 20 min</td>
<td><em>Commonly Used Modifiers</em></td>
</tr>
<tr>
<td>19282 – With 19281: each additional lesion</td>
<td>99212 – OV; new pt 10 min</td>
<td>04 – Professional Component</td>
</tr>
<tr>
<td>19283 – Localization device placement, percutaneous stereotactic guidance; first lesion</td>
<td>99213 – OV; est pt 15 min</td>
<td>51 – Multiple surg procedure</td>
</tr>
<tr>
<td>19284 – With 19283: each additional lesion</td>
<td>99221 – OV; new pt 10 min</td>
<td>99 – Multiple Mod (eg. AG + 51)</td>
</tr>
<tr>
<td>19285 – Localization device placement, percutaneous US guidance; first lesion</td>
<td>99231 – OV; new pt 15 min</td>
<td>AG – Primary Surgeon/Procedure</td>
</tr>
</tbody>
</table>

*Commonly Used Modifiers*:

- 04 – Professional Component
- 51 – Multiple surg procedure
- 99 – Multiple Mod (eg. AG + 51)
- AG – Primary Surgeon/Procedure
- FN – facilitates claim processing in instances where the patient’s gender conflicts with the billed procedure code
- TC – Technical Component
- UA – Surgical supplies who needn’t or other than general anesthesia, provided in conjunction with surgical procedure code.

### EWC REMINDERS

- Program covered cancer screening and diagnostic services are FREE.
- Payment for program-covered services is at Medi-Cal rates.
- Balance billing is prohibited!
- If non-covered services are recommended, written acknowledgment of cost and payment agreement must be obtained from the EWC recipient.
- Only Primary Care Providers (PCP) can enroll women and obtain the Recipient ID.
- Claims must be submitted with the woman’s EWC Recipient ID (14 digit identification number).
- Only PCPs may claim for case management.
- EWC enrollment is valid for 12 months; then, if eligible, the woman can be re-certified/re-enrolled.
- All providers must verify current eligibility before rendering services.
- All services and findings must be reported to the PCP.

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Sample: Breast Only Primary Care Provider Covered Procedures Worksheet
## BREAST & CERVICALC Primary Care Provider Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) Program for "Breast and Cervical Primary Care Providers." Providers must have an appropriate CPT and/or HCPCS codes listed as the first and/or second diagnosis code on the claim to be eligible for payment. For the list of appropriate CPT & HCPCS codes please refer to evewoman, the EWC section of the Medi-Cal Provider Manual: [http://files.medi-cal.ca.gov/evewoman/evewomanヱWC.pdf](http://files.medi-cal.ca.gov/evewoman/evewomanヱWC.pdf)

### Procedure Code Definitions (May Require Modifier*)

#### CPT Codes

- **0400** – Anesthesia, inpatient (system, except trunk)
- **10021** – Fine-needle aspiration; without imaging guidance
- **10022** – Fine-needle aspiration; with imaging guidance
- **19060** – Percutaneous aspiration of cyst of breast
- **19061** – With 10,000; each additional cyst
- **19081** – Breast, with localization device placement and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion
- **19082** – With 19081; each additional lesion
- **19083** – Breast, with localization device placement and imaging of biopsy specimen, percutaneous; US guidance; first lesion
- **19084** – With 19083; each additional lesion
- **19100** – Needle core biopsy; without imaging guidance
- **19181** – Biopsy of breast, open, incisional
- **19182** – Excisional biopsy, open
- **19125** – Excision of lesion, identified by preop plan of radiomammogram, single lesion
- **19126** – With 19125, each additional lesion
- **19281** – Localization device placement, percutaneous; mammographic guidance; first lesion
- **19282** – With 19281; each additional lesion
- **19283** – Localization device placement, percutaneous; stereotactic guidance; first lesion
- **19284** – With 19283; each additional lesion
- **19285** – Localization device placement, percutaneous; US guidance; first lesion
- **19286** – With 19285; each additional lesion
- **57452** – Colposcopy
- **57454** – Colposcopy w/bx of cervix and ECC
- **57455** – Colposcopy w/bx of cervix
- **57456** – Colposcopy w/ECC
- **57590** – Biopsy of cervix
- **57585** – Endocervical curettage, w/SLH

#### HCPCS Codes

- **A4217** – Sterile water, 500 ml
- **J0080** – Infla, norm sul sol, 1000 cc
- **J0081** – Infla, norm sul sol, 50 cc
- **J1239** – Ringers lact infla, up to 1000 cc
- **J1813** – Sign lang interpretive serv; 15 min
- **T1817** – Case Mgmt – Immediate follow-up (PCP only)
- **27500** – Exam or Tx Rm use, first hour
- **27506** – OR or Cysto Rm use, first hour
- **27510** – OR or Cysto Rm use, 2nd hour
- **27512** – Recovery Rm use
- **27514** – Intralab gen surg care, less than 24 hr
- **27610** – Misc. drugs and medical supply

### Commonly Used Modifiers:

- **56** – Professional Component
- **ST** – Multiple surg procedure
- **99** – Multiple Mod (e.g. AG+SI)
- **KA** – Primary Surgeon Procedure
- **KX** – Facilitates claim processing in instances where the patient’s gender conflicts with the billed procedure code
- **TC** – Technical Component
- **UA** – Surgical supplies who anaesthesia or other than general anaesthesia, provided in conjunction with surgical procedure code.

### EWC REMINDERS

- Program covered cancer screening and diagnostic services are covered in full.
- Payment for program covered services is at Medi-Cal rates.
- Balance billing is prohibited.
- If non-covered services are recommended, written acknowledgment of cost and payment agreement must be obtained from the EWC recipient.
- Only Primary Care Providers (PCPs) can enroll women and obtain the Recipient ID.

- Claims must be submitted with the woman’s EWC Recipient ID# (4 digit identification number).
- Only PCPs may claim for care management.
- EWC enrollment is valid for 12 months; then, if eligible, the woman can be resubmitted for enrollment.
- All providers must verify current eligibility before rendering services.
- All services and findings must be reported to the PCP.

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Sample: Breast and Cervical Primary Care Provider Covered Procedures Worksheet

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30 June 2018
# REFERRAL Provider Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) Program for "Breast and Cervical Referral Providers." Providers must have an appropriate ICD-10-CM code(s) listed as the first and/or second diagnosis code on the claim to be eligible for payment. For the list of appropriate CPT specific ICD-10-CM codes please refer to eowc: the EWC section of the Medi-Cal Provider Manual: [http://files.medicall.ca.gov/pubsdocuments/publications/manuals/empls/eowoman.pdf](http://files.medicall.ca.gov/pubsdocuments/publications/manuals/empls/eowoman.pdf)

<table>
<thead>
<tr>
<th>Procedure Code Definitions (May Require Modifiers)</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 00400 – Anesthesia, intravenous system anterior trunk</td>
<td>□ A4317 – Sterile suture, online, 500 ml</td>
</tr>
<tr>
<td>□ 10021 – Fine needle aspiration; without imaging guidance</td>
<td>□ J7039 – Infus, norm sol sol, 1000 cc</td>
</tr>
<tr>
<td>□ 10022 – Fine needle aspiration; with imaging guidance</td>
<td>□ J7040 – Infus, norm sol sol, sterile 500 ml – 1 unit</td>
</tr>
<tr>
<td>□ 19000 – Procedure aspiration of cyst of breast</td>
<td>□ J7050 – Infus, norm sol sol, 250 cc</td>
</tr>
<tr>
<td>□ 19001 – With 19000; each additional cyst</td>
<td>□ J7120 – Ringers lact infus, up to 1000 cc</td>
</tr>
<tr>
<td>□ 19002 – With 19001; each additional lesion</td>
<td>□ T1413 – Sign lang interpretive serv/15 min</td>
</tr>
<tr>
<td>□ 19003 – Biopsy, with localization device placed and imaging of biopsy specimen; percutaneous; stereotactic guidance; first lesion</td>
<td>□ T2596 – Exam or Tx Run use, first hour</td>
</tr>
<tr>
<td>□ 19004 – With 19003; each additional lesion</td>
<td>□ T2598 – OR or Cysto Run use, 1st sub halthr</td>
</tr>
<tr>
<td>□ 19100 – Needle Core biopsy; without imaging guidance</td>
<td>□ T2710 – OR or Cysto Run use, 2nd sub halthr</td>
</tr>
<tr>
<td>□ 19120 – Excisional Biopsy, open</td>
<td>□ T2712 – Recovery Run use</td>
</tr>
<tr>
<td>□ 19125 – Excision of lesion, identified by pre op plan of radiation; single lesion</td>
<td>□ T2751 – Rm Bed 60 min care, less than 24 hr</td>
</tr>
<tr>
<td>□ 19126 – With 19125; each additional lesion</td>
<td>□ T2760 – Misc. drugs and medical supply</td>
</tr>
<tr>
<td>□ 19201 – Localization device placed, percutaneous; mammographic guidance; first lesion</td>
<td>□ 77065 – Diagnostic mammography; unilateral includes CAD</td>
</tr>
<tr>
<td>□ 19202 – With 19201; each additional lesion</td>
<td>□ 77066 – Diagnostic mammography; bilateral includes CAD</td>
</tr>
<tr>
<td>□ 19230 – Localization device placed, percutaneous; stereotactic guidance; first lesion</td>
<td>□ 77067 – Screening mammogram, bilateral</td>
</tr>
<tr>
<td>□ 19231 – Cyst mammogram</td>
<td>□ 81020 – Urine pregnancy test</td>
</tr>
<tr>
<td>□ 19281 – Localization device placed, percutaneous; stereotactic guidance; first lesion</td>
<td>□ 85264 – Infus agent date by DNA or RNA; HPV, high-risk types</td>
</tr>
<tr>
<td>□ 19282 – With 19281; each additional lesion</td>
<td>□ 85161 – Pap, physician interpretation</td>
</tr>
<tr>
<td>□ 19283 – Localization device placed, percutaneous; stereotactic guidance; first lesion</td>
<td>□ 85163 – Pap, liquid-based (LB2), mst sern</td>
</tr>
<tr>
<td>□ 19284 – With 19283; each additional lesion</td>
<td>□ 85174 – Cystopathology-CV, LB, manual</td>
</tr>
<tr>
<td>□ 19285 – Localization device placed, percutaneous; stereotactic guidance; first lesion</td>
<td>□ 85164 – Pap, conv. Slide, manual sern</td>
</tr>
<tr>
<td>□ 19296 – With 19285; each additional lesion</td>
<td>□ 85172 – Cystopathology of FNA, to determine adequacy of specimen</td>
</tr>
<tr>
<td>□ 57452 – Colposcopy</td>
<td>□ 85173 – Inter/report for eval of FNA</td>
</tr>
<tr>
<td>□ 57454 – Colposcopy w/ex of cervix and ECC</td>
<td>□ 85174 – LBp, auto screen w/mam regn.</td>
</tr>
<tr>
<td>□ 57455 – Colposcopy w/ex of cervix</td>
<td>□ 85805 – Level IV Surg path exam</td>
</tr>
<tr>
<td>□ 57456 – Colposcopy w/CC</td>
<td>□ 85807 – Level V Surg path exam</td>
</tr>
</tbody>
</table>

*Commonly Used Modifiers:*

- 26 – Professional Component
- 51 – Multiple surg procedure
- 99 – Multiple med (eg AG-51)

**EWC REMINDERS**

- Program covered cancer screening and diagnostic services are FREE.
- Payment for program-covered services is at Medi-Cal rates.
- Balance billing is prohibited!
- If non-covered services are recommended, written acknowledgment of cost and payment agreement must be obtained from the EWC recipient.
- Only Primary Care Providers (PCP) can enroll women and obtain the Recipient ID.
- Claims must be submitted with the woman’s EWC Recipient ID: (14 digit identification number).
- Only PCPs may claim for care management.
- EWC enrollment is valid for 12 months; then, if eligible, the woman can be recertified re-enrolled.
- All providers must verify current eligibility before rendering services.
- All services and findings must be reported to the PCP.

Sample: Referral Provider Covered Procedures Worksheet

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June 2018 31
Case Management Coverage

Case management HCPCS code T1017 is only eligible for reimbursement for findings that require immediate work-up and an additional referral together with coordination of services. EWC does not pay separately for case management services for individuals who require routine or short-term follow-up re-screening.

Case management HCPCS code T1017 is payable for PCPs enrolled in the EWC program and only payable to PCPs after submission of complete outcome data via DETEC.

Reimbursement for case management HCPCS code T1017 is $50.00. Reimbursement is paid once per recipient, per provider, per calendar year.

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. This form facilitates accurate and complete data entry.

Payment for case management is based on online 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, screening results, provider’s discretion or patient request, additional data will need to be submitted to qualify for case management.
- PCPs that 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.

NOTE
PCPs who provide both breast and cervical cancer screening services must submit both breast and cervical screening data; however, only one claim for case management is reimbursed per recipient per calendar year.
### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09-12**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Medicare (X) Medicaid</td>
</tr>
<tr>
<td>2.</td>
<td>Patient's Name</td>
</tr>
<tr>
<td>3.</td>
<td>City</td>
</tr>
<tr>
<td>5.</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>6.</td>
<td>Claim Type</td>
</tr>
<tr>
<td>9.</td>
<td>Modifier</td>
</tr>
<tr>
<td>11.</td>
<td>Date of Service</td>
</tr>
<tr>
<td>12.</td>
<td>Provider Name</td>
</tr>
</tbody>
</table>

#### Sample: Breast and Cervical Cancer Screening Billed

**With Annual Case Management – CMS-1500 form**

**Every Woman Counts**

**December 2018**

33
Sample: Hospital Clinic Billing for Routine Mammogram (UB-04)
Knowledge Review

1. The recipient’s 14-character ID is computer generated after the online Recipient Information form is completed and submitted.
   True ☐   False ☐

2. EWC benefits and policies apply to individuals of any gender identity as long as the procedure is medically necessary.
   True ☐   False ☐

3. A primary diagnosis is required on the claim.
   True ☐   False ☐

4. Claims can be submitted either via hard copy or Computer Media Claims (CMC).
   True ☐   False ☐

5. EWC recipient ID numbers will always have the alpha character “A” in the 4th place of the ID number.
   True ☐   False ☐

6. To qualify to bill for the case management fee HCPCS code T1017, the PCP provider is required to have submitted all clinical information using the online DETEC forms.
   True ☐   False ☐

7. The nine-digit ZIP code entered in Box 31a must match the billing provider’s nine-digit code on file for claims to be paid correctly.
   True ☐   False ☐

8. When billing for some program procedure codes in EWC, Medi-Cal providers will need to use the appropriate modifier based on the code being billed.
   True ☐   False ☐

9. Referral providers must obtain the recipient’s 14-digit identification number from the PCP or the recipient for claims submission.
   True ☐   False ☐

10. Providers can attempt to obtain payment for co-payments or balance of cost of screenings/diagnostic services.
    True ☐   False ☐

Answer Key: 1) True; 2) True; 3) True; 4) True; 5) True; 6) True; 7) True; 8) True; 9) True; 10) False
Where to Submit Claims

Claims can be submitted either by hard copy or electronically using the CMS-1500 or UB-04. Providers who choose to submit hard copy claims must send to the appropriate address for their claim type, as follows:

**Medical Services (CMS-1500)**
California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA  95852-1700

**Outpatient Services (UB-04)**
California MMIS Fiscal Intermediary
P.O. Box 15600
Sacramento, CA  95852-1600

**Billing EWC Claims Electronically**
Electronic billing is done per Medi-Cal electronic billing instructions.
Resource Information

References

The following reference materials are available in the Medi-Cal provider manual and include program and eligibility information.

Provider Manual References

Part 2

Every Woman Counts (ev woman)
Every Woman Counts – CMS-1500 (ev woman exc)
Every Woman Counts – UB-04 (ev woman exub)

Other References

Every Woman Counts web page:
(http://www.dhcs.ca.gov/services/Cancer/ewc/Pages/default.aspx)

Medi-Cal website:
(www.medi-cal.ca.gov)

To access the EWC web page, under the “Programs” tab, click the “Every Woman Counts” link.

EWC Regional Contractors web page:
(www.dhcs.ca.gov/services/cancer/EWC/Pages/RegionalContractors.aspx)

Additional EWC information and resources:
(https://qap.sdsu.edu)
# Appendix

## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCCTP</td>
<td>Breast and Cervical Cancer Treatment Program</td>
</tr>
<tr>
<td>CBE</td>
<td>Clinical Breast Exam</td>
</tr>
<tr>
<td>CCCCP</td>
<td>California Colon Cancer Control Program</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDS</td>
<td>Cancer Detection Treatment Branch</td>
</tr>
<tr>
<td>CMC</td>
<td>Computer Media Claims</td>
</tr>
<tr>
<td>CPPI</td>
<td>Core Program Performance Indicators</td>
</tr>
<tr>
<td>DETEC</td>
<td>DETecting Early Cancer</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>EWC</td>
<td>Every Woman Counts</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Health Care Procedure Coding System</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases – 10th Revision, Clinical Modification</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IMPACT</td>
<td>IMProving Access, Counseling &amp; Treatment for Californians with Prostate Cancer</td>
</tr>
<tr>
<td>NBCCEDP</td>
<td>National Breast and Cervical Cancer Early Detection Program</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Providers</td>
</tr>
<tr>
<td>PCPEA</td>
<td>Primary Care Provider Enrollment Agreement</td>
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<tr>
<td>PIN</td>
<td>Provider Identification Number</td>
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<td>POS</td>
<td>Point of Service</td>
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<tr>
<td>RC</td>
<td>Regional Contractor</td>
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<tr>
<td>SOC</td>
<td>Share of Cost</td>
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