

**WEST VIRGINIA BREAST AND CERVICAL CANCER SCREENING PROGRAM
POLICIES AND PROCEDURES MANUAL**

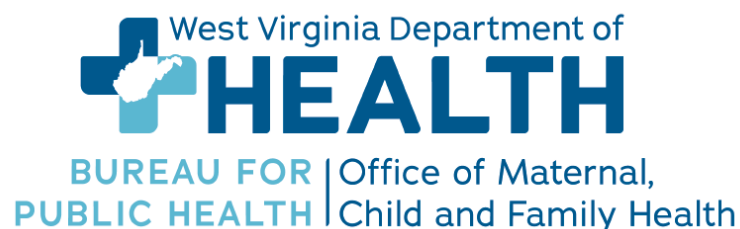


Office of Maternal, Child and Family Health
Bureau for Public Health
West Virginia Department of Health

350 Capitol Street, Room 427
Charleston, West Virginia 25301-3714

Phone: (304) 558-5388
Fax: (304) 558-7164

WVBCCSP Website:
<http://www.wvdhhr.org/bccsp>



1	General Administration
2	Program Administration
3	Patient Eligibility
4	Screening Provider Services and Patient Enrollment
5	Referral Provider Qualifications and Responsibilities
6	Breast Screening Services and Follow Up
7	Cervical Screening Services and Follow Up
8	Screening Provider Invoicing and Reimbursement
9	Case Management and The Medicaid Treatment Act
10	Quality Assurance
11	Public Education and Targeted Outreach
12	Appendix

TABLE OF CONTENTS

SECTION I: GENERAL ADMINISTRATION

1.1 Purpose	1
1.2 Introduction	1
1.3 Mission	2
1.4 Program Goals	2

SECTION II: PROGRAM ADMINISTRATION

2.1 Nondiscrimination	4
2.2 Confidentiality of Patient Information	4
2.3 Informed Consent	4
2.3a Consent Explanation and Definition.....	5
2.4 Patient Records	5
2.4a Record Retention.....	6
2.5 Personnel Policies	6

SECTION III: PATIENT ELIGIBILITY

3.1 Determining Patient Eligibility	7
3.2 Financial Eligibility Guidelines	7
3.3 Breast Screening Age, Medical Eligibility, & Risk Factors	7
3.3a Clinical Breast Examination (CBE) Eligibility.....	7
3.3b Screening Mammography Eligibility for Women 40-64 Years of Age with Average Risk...	8
3.3c Breast Cancer High Risk Factors.....	8
3.3d Supplemental Screening Eligibility for Women 25-64 Years of Age that are High Risk....	8
3.4 Breast Diagnostic Eligibility	9
3.4a Diagnostic Mammography Eligibility	9
3.4b Breast Ultrasound Eligibility	9
3.4c Breast Surgeon Consultation Eligibility	9
3.4d Fine Needle Aspiration/Breast Biopsy Eligibility	10
3.5 Cervical Screening Age and Medical Eligibility	10
3.5a Pelvic Examination Eligibility	10
3.5b Liquid-Based Pap Test Eligibility and HPV Testing	10
3.5c HPV Self Collection	11
3.5d High Risk	11
3.5e Liquid Based Pap Test Eligibility for Post-Hysterectomy Patients	11
3.6 Cervical Diagnostic Eligibility	11
3.6a Colposcopy Eligibility	11
3.7 Acute Care Visits	12

SECTION IV: SCREENING PROVIDER SERVICES AND PATIENT ENROLLMENT

4.1 Screening Provider Qualifications	13
4.2 Screening Provider Services	13
4.3 Screening Provider Responsibilities	14
4.4 Screening Provider and Patient Enrollment	14
4.4a Patient Enrollment for a Referral for Diagnostics	14
4.5 Required Screening Provider Forms	15
4.5a Client Enrollment - Consent for Release of Information and Confidentiality Form	15
4.5b Patient Data Form	15
4.5c Medical History Form	15
4.5d Referral Form	15
4.6 Tracking Logs	16

SECTION V: REFERRAL PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

5.1 Statewide Network of WVBCCSP Referral Providers	17
5.2 Mammography Providers Qualifications	17
5.3 Mammography Provider Services	17
5.4 Mammography Provider Responsibilities	17
5.5 Breast Ultrasound	18
5.6 Breast Ultrasound Provider Responsibilities	18
5.7 Breast Consultation	18
5.7a Breast Consultation Provider Qualifications	18
5.7b Provider Responsibilities	18
5.8 Breast Biopsy/Fine Needle Aspiration (FNA)	19
5.8a FNA Provider Qualifications	19
5.8b Breast Biopsy/Fine Needle Aspiration Provider Agreements	19
5.9 Additional Referral Provider Information	19
5.10 Preoperative Testing	20
5.11 General Anesthesia	20
5.12 Colposcopy	20
5.12a Colposcopy Provider Qualifications	20
5.12b Colposcopy Provider Responsibilities	20
5.13 Cytology Laboratory	21
5.13a Lab Qualifications	21
5.13b Cytology Laboratory Responsibilities	21

SECTION VI: BREAST SCREENING SERVICES & FOLLOW-UP

6.1 Introduction	22
6.2 Risk Factors for Breast Cancer	22
6.2a Risk Factors	22

6.2b Risk Assessment	23
6.3 Early Detection of Breast Cancer	23
6.4 Required Components of Breast Screening	23
6.5 General Guidelines for Patient Education	23
6.6 Breast Cancer Education	24
6.7 Clinical Breast Examination	24
6.7a Management of Abnormal Clinical Breast Exam	24
6.8 Screening Mammography	25
6.8a Mammography Referral	25
6.8b Mammography Results Reporting	26
6.8c Mammography Follow-Up and Tracking	26
6.8d Follow-Up for Normal CBE/Mammogram Results	26
6.8e Follow-Up for Abnormal CBE/Mammogram Results	26
6.8f Abnormal Mammography	26
6.9 Breast Ultrasound (US) Guidelines	26
6.9a Breast Ultrasound Referral	27
6.9b Ultrasound Results Reporting	27
6.9c Breast Ultrasound Follow-Up	27
6.10 Supplemental Screening	27
6.11 Fine Needle Aspiration (FNA)	28
6.11a Fine Needle Aspiration Referral	28
6.11b Fine Needle Aspiration Results Reporting	28
6.11c Fine Needle Aspiration Follow-Up	28
6.12 Breast Biopsy	28
6.12a Breast Biopsy Referral	28
6.12b Breast Biopsy Results Reporting	29
6.12c Breast Biopsy Follow-Up	29
6.13 Lost to Follow-Up Protocol	29

SECTION VII: CERVICAL SCREENING SERVICES & FOLLOW-UP

7.1 Introduction	30
7.2 Prevention and Early Detection of Cervical Cancer	30
7.3 Overview of the 2019 Cervical Cancer Screening and Colposcopy Guidelines for Cervical Screening of Patients Who Are Asymptomatic	31
7.4 Cervical Cancer Risk Factors	31
7.5 Required Components of Cervical Screening	33
7.6 General Guidelines for Patient Education	33
7.7 Cervical Cancer Education	33
7.8 Pelvic Examination	33
7.9 Pre-Clinic Client Preparation Instructions for Cervical Cancer Screening	34
7.10 Pap/HPV Test	34

7.10a Laboratory Services for Pap Test	34
7.10b Pap Test Protocol for Post-Hysterectomy Patients	34
7.11 HPV Self-Collection	35
7.11a Eligibility for HPV Self-Collection	35
7.11b Collection Process	35
7.11c Lab Processing	36
7.12 Follow-Up Guidelines for Liquid-Based Pap Test and HPV Results	36
7.13 Normal Pap/HPV Screening Results	36
7.14 Abnormal Screening Results	36
7.15 Cervical Cancer Screening Test Tracking	36
7.15a Screening Provider's Responsibilities	36
7.15b Screening Tracking	37
7.16 Colposcopy	37
7.16a Colposcopy Referral	37
7.16b Gynecologic Consults for Colposcopy	37
7.16c Colposcopy Reimbursement	37
7.16d Colposcopy Referral	37
7.16e Colposcopy Tracking and Follow-Up	38
7.16f Colposcopy Pathology Report	38
7.16g Colposcopy Results	38
7.17 Lost to Follow-Up Protocol	39
7.18 Cervical Cancer Rescreening: Introduction	39
7.19 Rescreening Reminder System	40
7.20 Ordering Forms and Lab Supplies	40

SECTION VIII: SCREENING PROVIDER INVOICING AND REIMBURSEMENT

8.1 General Billing Information	41
8.2 Underinsured Patients	41
8.3 Batch Invoicing Procedures	42
8.4 WVBCCSP Billing Forms	42
8.4a Client Enrollment-Consent Forms	42
8.4b Batch Invoice Form	42
8.4c Patient Data Form	43

SECTION IX: CASE MANAGEMENT & THE MEDICAID TREATMENT ACT

9.1 Purpose of the Medicaid Treatment Act (MTA)	44
9.2 Eligibility Guidelines	44
9.3 MTA Eligible Diagnoses	44
9.4 Screening Provider Responsibility for MTA Referral	45
9.5 WV Department of Human Services Responsibility (DoHS)	46
9.6 MTA Confirmation	46

9.7 WVCCSP Case Management Responsibilities	46
9.8 Questions Regarding MTA	47
9.9 Medicaid Citizenship and Identity Requirements	47

SECTION X: QUALITY ASSURANCE

10.1 Introduction	48
10.2 What is Meant by Quality Assurance?	48
10.2a Breast	48
10.2b Cervical	48
10.2c Provider Practice	48
10.3 Clinical Services	48
10.3a Screening Provider	48
10.3b Cytopathology (Pap Test) Contracted Laboratory	49
10.4 Monitoring	49
10.5 On-Site Reviews	49
10.6 Technical Assistance	49
10.7 Policy Clinical Guidance	49

SECTION IX: PUBLIC EDUCATION & TARGETED OUTREACH

11.1 Purpose	50
11.1a Education	50
11.1b Community Outreach	50
11.2 Priority Populations	50
11.3 Screening Provider Responsibilities	51
11.3a Staff and Agency Training	51
11.3b Patient Education	51
11.4 Public Education and Media Campaigns.....	51
11.5 Community Outreach Plan	52
11.5a Community Linkages for Outreach Events	52
11.6 Community Organizations	54

SECTION I - GENERAL ADMINISTRATION

1.1 Purpose

The purpose of this Policies and Procedures Manual is to define the West Virginia Breast and Cervical Cancer Screening Program's (WVBCCSP) standardized guidelines for screening Program eligible participants.

The manual contains policies and procedures of the WVBCCSP and serves as an operational reference for clinics participating in the Program. Screening providers are expected to conform to the policies and procedures contained in this manual and all future revisions. WVBCCSP Screening Providers are required to provide in-service training to existing and new staff members to assure Program compliance. All WVBCCSP screening provider staff are required to take the state-offered WVBCCSP Training annually.

This policy manual is not intended to be a set of clinical guidelines for the general U.S. population. Rather, it provides programmatic and reimbursement guidance.

Each screening provider must designate a staff member to receive WVBCCSP memorandums and program updates and to disseminate this information to the appropriate staff. The provider must send the contact's name to the WVBCCSP with the Memorandum of Understanding (MOU) and at any time during the year when the contact person has changed.

Throughout the manual, reference is made to the requirements and restrictions of the federal law which created the WVBCCSP, the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354), the Breast and Cervical Cancer Amendments of 1993 and various regulations and program guidelines established by the Centers for Disease Control and Prevention (CDC). A combination of these laws and regulations govern the Program's policies and procedures established by the West Virginia Bureau for Public Health (BPH).

Note: All provider staff must be familiar with Program policies and procedures to deliver quality care to participants.

1.2 Introduction

Title XV of the Public Health Service Act, known as the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) established a program of grants awarded to states for the detection and control of breast and cervical cancer. The grants are awarded to states via a cooperative agreement by the CDC through a competitive application process. The purpose of the funding is to provide early detection, screening and referral services for breast and cervical cancers with special emphasis placed on the participation of women of low income, racial/ethnic minorities, women never or rarely screened for cervical cancer and older women. Recipients of the grant funds are required by law to provide a comprehensive statewide public health screening program.

In 1992, the West Virginia Legislature enacted the Breast and Cervical Cancer Prevention and Control Act which statutorily created the Program within the Department of Health and Human Resources. The Bureau for Public Health (BPH) has been designated as the administrative entity for WVBCCSP and is housed in the Office of Maternal, Child and Family Health (OMCFH).

The 1996 West Virginia Legislature established the Breast and Cervical Cancer Diagnostic and Treatment Fund, which provides financial assistance for the medical care of medically and financially eligible patients. (Refer to the WVBCCSP website at www.wvdhhr.org/bccsp). The WVBCCSP Medical Advisory Committee is responsible for establishing procedures and requirements for participation.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA — The Act/Public Law 106-354) (see Appendix 1 of this manual) amends Title XIX of the Social Security Act to give states enhanced matching funds to provide Medicaid eligibility to a new group of individuals previously not eligible under the program. The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and need treatment for breast and/or cervical cancer, including pre-cancerous conditions and early-stage cancer. The Act also allows states to extend presumptive eligibility to applicants to ensure that the treatment needed begins as early as possible. The West Virginia Breast & Cervical Cancer Medicaid Treatment Act, commonly referred to as the Medicaid Treatment Act (MTA), became effective April 1, 2001.

1.3 Mission

The mission of the WVBCCSP is to prevent unnecessary disease, disability, and premature death due to cancer of the breast and/or cervix. The key to reducing illness and death from these cancers is early detection, diagnosis with timely follow-up and treatment. Routine screening can detect many cancers at early stages when more treatment options are available, and the likelihood of survival is improved. For early detection of breast cancer, the technology of choice among medical professionals, cancer specialists and public health experts alike is mammography. The universal screening tool for cervical cancer in asymptomatic women is the Pap test and/or HPV screening. Both screening technologies have been shown to have a significant impact on mortality.

1.4 Program Goals

- To ensure access to breast and cervical cancer screening services for all women who meet income, age, and medical eligibility guidelines with an emphasis on minority and never or rarely screened women.
- To ensure that all women screened by the WVBCCSP receive appropriate and timely follow-up, diagnosis, treatment, and case management.

- To broaden statewide public education to promote breast and cervical cancer screening in West Virginia, with an emphasis on reducing morbidity and mortality from breast and cervical cancer by reaching all populations.
- To offer educational opportunities to health professionals involved with breast and cervical cancer screening.
- To monitor and assess trends in breast and cervical cancer incidence, mortality and screening rates for West Virginia women to develop effective health promotion strategies.
- To establish linkages and partnerships with a broad range of stakeholders to bring additional resources to the WVBCCSP. (These coalitions will provide access to and information about the priority populations to expand upon the efforts of the WVBCCSP).
- To maintain and establish mechanisms through which the state can enhance quality assurance monitoring of screening procedures for breast and cervical cancer.
- To facilitate full Medicaid benefits for women who are under age 65, with no credible coverage and are identified through the WVBCCSP as in need of treatment for breast or cervical cancer. (These linkages and partnerships will provide access and information about priority populations, expanding the efforts of the WVBCCSP).

SECTION II - PROGRAM ADMINISTRATION

2.1 Nondiscrimination

The provider assures that, in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Title IX of the Education Amendment of 1973, as amended (20 U.S.C. 1681-1683 and 1685-1686), the Age Discrimination Act of 1975, as amended (42 U.S.C. 6101 et seq.), the Regulations issued thereunder by the U.S. Department of Health and Human Services (45 CFR parts 80, 84, 86 and 91), no individual shall, on the grounds of race, creed, age, color, natural origin, ancestry or sex be excluded from participation, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity described or regulated under the screening provider contract.

2.2 Confidentiality of Patient Information

The screening provider must safeguard the use and/or disclosure of any patient medical or social information of a confidential nature in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Provision of medical services and information contained in medical records of patients served under the WVBCCSP shall be considered confidential. A signed, dated, and witnessed Client Enrollment-Release of Information and Statement of Confidentiality Form (Y104) must be obtained and must become a permanent part of the patient's medical record. The form must be sent to the WVBCCSP office within one week of the initial visit. Patient medical records may be disclosed to physicians or medical facilities accepting a patient referral and to the WVBCCSP office.

Information may be disclosed in summary or other form which does not identify individuals, if such information is in compliance with applicable Federal and State regulations and the exchange of individual medical record information is in keeping with established medical standards and ethics.

2.3 Informed Consent

For ethical, medical and legal reasons, an informed consent documenting the patient's consent to receive breast and cervical cancer screening services must be signed by the participant prior to receiving any medical services.

The WVBCCSP provided Client Enrollment Release of Information and Statement of Confidentiality Form (Y104) must be verbally reviewed with the patient prior to signing the form. The form must also be signed, dated and witnessed by a clinical staff member. The signed form becomes a part of the patient's medical record and is required to be completed at the time of the initial screening enrollment visit and updated when there are changes to

the patient's address or last name. A new Client Enrollment form must be completed and signed annually to keep record current.

2.3a Consent Explanation and Definition

The legal premise underlying the necessity for informed consent is a person's right not to be touched intentionally without her permission. Without this authorization, any touching is considered battery and can be the basis of a civil lawsuit. More recently, lack of informed consent has been treated as negligent by courts and the issue of whether informed consent was obtained has become increasingly important in malpractice cases.

Informed consent is a process of education and discussion. Informed consent is the explanation of the proposed treatment to the patient. With appropriate descriptions of the proposed tests or procedures, the patient can evaluate available options and decide whether and how to proceed. The patient must have the opportunity to ask questions, and the clinician must be satisfied that the patient has understood the information conveyed. If the patient has difficulty reading, the provider staff must read or assist the patient with reading the form.

The WVBCSP Client Enrollment-Release of Information and Statement of Confidentiality Form (Y104) contains a general description of Program services the patient can expect to receive as a Program participant. Risks, as well as alternatives, should be discussed and explained. Consent to release information concerning any related care must be given by the patient.

2.4 Patient Records

WVBCSP screening providers must establish a medical record for every patient enrolled as a WVBCSP participant. The record must include a signed, dated and witnessed Client Enrollment-Release of Information and Statement of Confidentiality Form (Y104), Medical History Form (Y108), all Patient Data Forms (Y106), appropriate Program Referral Forms and appropriate Program Report Forms. These records must be maintained in accordance with accepted medical standards.

Patient records must be:

- Comprehensive and concise.
- Available upon request by the patient (patients must allow 24 to 48 hours for preparation of records for release).
- Documented in chart when encounters of a medical nature are performed via telephone.

- Signed by the clinician making the entry (signature, title and date must accompany each medical entry).
- Organized systematically to facilitate retrieval and compilation of information.
- Compliant with HIPAA.
- Shared freely with the provider accepting the referral for further diagnostic services.
- Made available to the Monitoring Team or WVBCCSP staff making a request to review.

2.4a Record Retention

All WVBCCSP Screening and/or Referral Providers must retain all records, documents and correspondence relative to the WVBCCSP contract as follows:

- Providers must retain all financial records, supporting documents, statistical records and other pertinent records for a period of five (5) years or until an audit is completed and resolved, whichever is later (45 CFR Parts 74 and 92).
- Reviews or audits of the records and documents which are required by WVBCCSP policies and procedures may be conducted at any reasonable time by State and Federal personnel and other persons duly authorized by the Bureau for Public Health. This review may include meetings with consumers, review of service records, review of service policy and procedural issues, review of staffing ratios and job descriptions, and meetings with any staff directly or indirectly involved in the provision of services.

2.5 Personnel Policies

Provider agencies must establish and maintain written personnel policies that comply with Federal and State requirements and Title VII of the Civil Rights Act of 1991. These policies shall include, but need not be limited to, staff recruitment, selection, performance evaluation, promotion, termination, compensation, benefits and grievance procedures.

If indicated, health professionals other than physicians (e.g. nurse practitioners, physician assistants, certified midwives) perform delegated medical functions, they must do so under protocols and/or standing orders approved by the facility Medical Director.

Personnel policies of facilities must provide for:

- Confidentiality of personnel records.
- Availability of an organizational chart and personnel policies for all personnel to review.
- Availability of job descriptions for all positions must be reviewed annually and updated when necessary to reflect changes in duties.

SECTION III - PATIENT ELIGIBILITY

3.1 Determining Patient Eligibility

Women 21-64 years of age who are residents of West Virginia with household income at or below 250% of the Federal Poverty level (FPL) are eligible for WVBCCSP services. Under the federal act, Title XV of the Public Health Services Act known as the Breast and Cervical Cancer Mortality Prevention Act of 1990, programs must give priority to providing services to low-income women.

WVBCCSP funds are to be used as a last resort for payment. A patient may have medical insurance and still qualify as a participant of the Program if her income is at or below 250% of the FPL. In this instance, third parties must be billed prior to billing WVBCCSP.

Exception: Any eligible Medicaid, Medicare Part B client, or Medicaid sponsored Health Maintenance Organization (HMO) enrollee is eligible for WVBCCSP patient navigation only as screening is a covered service under these insurance types.

The services provided by WVBCCSP are supported through federal funding. Eligibility for coverage and reimbursement is contingent upon the availability of these funds.

Note: Based on Public Law 101-354, men are not eligible to receive WVBCCSP screening and/or diagnostic services under WVBCCSP Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Screening Program (NBCCEDP). Men may be eligible for diagnostic breast cancer services under the WVBCCSP Diagnostic and Treatment Fund if they meet all other WVBCCSP eligibility guidelines. Men who are diagnosed with breast cancer may be eligible for Medicaid through the Medicaid Treatment Act.

3.2 Financial Eligibility Guidelines

The screening provider must determine patient financial eligibility by applying the following guidelines based upon the patient's verbal statement of gross monthly or annual income.

- Income is at or below 250% of the current FPL and uninsured.
- Underinsured (Medical insurance does not cover WVBCCSP screening and/or diagnostic services).
- Has an unmet deductible or a required co-payment for services covered by WVBCCSP that she is unable to pay.
- Total reimbursement cannot exceed the allowable Medicare rate.

3.3 Breast Screening Age, Medical Eligibility, and Risk Factors

3.3a Clinical Breast Examination (CBE) Eligibility

- 21-64 years of age.
- Not a participant in a program that provides these services (e.g. Family Planning).

CBEs are *optional* for screening purposes and at the discretion of the provider based on clinical judgment and national screening guidelines. If a woman presents with symptoms, a CBE is required.

3.3b Screening Mammography Eligibility for Women 40-64 Years of Age with average risk

- 40-64 years of age
- No mammogram with normal results in the previous 12 months

For women under the age of 40 with average risk, screening is not recommended. Those over the age of 65 who are not eligible for Medicare Part B, and those who are Medicare eligible but cannot pay the premium to enroll in Medicare, may receive screening through WVBCCSP based on current screening guidelines. For questions regarding eligibility for women over the age of 65, contact the program. For questions regarding screening recommendations, visit [American College of Radiology Appropriateness Criteria](#)

3.3c Breast Cancer High-Risk Factors

- Known genetic mutations.
- First-degree relatives with premenopausal breast cancer or known genetic mutations.
- History of radiation treatment to the chest area before the age of 30.
- A lifetime risk of 20% or more for development of breast cancer based on risk assessment models. Providers may choose a risk assessment model.
- Previous personal history of breast cancer.
- Family history of breast cancer.
- Never had children.
- First child was born after the age of 30.
- Abnormal biopsy results.
- Certain abnormal breast conditions, such as atypical hyperplasia or lobular carcinoma in-situ (LCIS).
- Highly dense breasts.

3.3d Supplemental screening Eligibility for Women 25-64 Years of Age that are high risk

All women should be offered breast cancer risk assessment beginning at the age of 25. The clinical provider can choose the risk assessment tool. Some examples are the Gail and Tyrer-Cuzick model. This should be documented on the Patient Data Form (Y106) or in the patient's electronic health record. The method of choice for supplemental screening is breast MRI. For those who cannot undergo an MRI, bilateral whole breast ultrasound is recommended. Ideally, women would have screening every six months (i.e. screening mammogram followed by a screening MRI in six months). However, the supplemental screening can be done at any time if she has an annual mammogram. All screening MRIs need prior approval from the program.

Without the documented breast cancer risk assessment, the screening mammogram will not be paid for by the WVBCCSP in women under 40 years old. Supplemental screening for eligible women also requires high-risk assessment documentation and is discussed in the next section.

Note: Computer Aided Detection (CAD) is not reimbursable through the WVBCCSP.

3.4 Breast Diagnostics Eligibility

3.4a Diagnostic Mammography Eligibility

Diagnostic Mammography is defined by the American College of Radiology (ACR) as "an x-ray examination of the breast on a woman who by virtue of symptoms and physical findings is considered to have substantial likelihood of having breast disease." Please note that for women under 30 years old who exhibit symptoms requiring diagnostic work-up, a mammogram is not recommended. To be approved for a diagnostic mammogram, the woman must be 30-64 years of age with one of the following abnormal Clinical Breast Examination (CBE) findings documented on the Patient Data form:

- Discrete Palpable Mass (Suspicious of Cancer)
- Bloody/Serous Nipple Discharge
- Nipple/Areolar Scaliness
- Skin Dimpling or Retraction
- Focal Pain or Tenderness

Note: WVBCCSP reimburses for a 6-month short-term follow up mammogram when recommended by a radiologist or breast surgeon.

3.4b Breast Ultrasound Eligibility

Ultrasonography, which utilizes high-frequency sound waves, is most useful if there is an abnormality detected on the mammogram which is not palpable. The Ultrasound examination can determine if the lesion is cystic or solid.

The following requirements must be met to reimburse for a breast ultrasound:

- Meets all current eligibility guidelines for enrollment in the WVBCCSP.
- Has finding on mammogram and ultrasound is recommended by a radiologist.
- Under the age of 40 and is symptomatic (i.e. palpable mass, nipple discharge, or inversion).
- Under the age of 29, has a palpable breast mass, and not appropriate for diagnostic mammogram due to age or other issues.

Please contact the program with any questions regarding ultrasound eligibility and approval.

3.4c Breast Surgeon Consultation Eligibility

Eligibility includes symptoms, physical findings, or mammography findings that indicate a substantial likelihood of having breast disease and the patient has one or more of the following abnormal CBE results documented on the Patient Data form:

- Discrete Palpable Mass (Suspicious of Cancer)
- Bloody/Serous Nipple Discharge
- Nipple/Areolar Scaliness
- Imaging recommending further work up
- Skin Dimpling or Retraction
- Focal Pain or Tenderness

Women may be referred to a surgeon pending diagnostic imaging results based on clinical judgment. While a surgical referral is recommended, it is not mandatory.

WVBCCSP Protocol for management of an abnormal CBE: Refer for a diagnostic imaging first and then refer to a surgeon for evaluation if needed within 60 days of abnormal CBE.

Two surgical consultations are reimbursed per breast issue per year. Additional visits may be covered pending program clinical review. Please reach out to the program with any questions.

3.4d Fine Needle Aspiration/Breast Biopsy Eligibility

- 25—64 years of age.
- Symptoms, physical findings and/or imaging findings reflect substantial likelihood of having breast disease.

3.5 Cervical Screening Age and Medical Eligibility

In theory, cervical cancer screening focuses on asymptomatic individuals. This requires education of health care professionals, the patient, and the public.

The screening exam includes an interview to collect demographic data, provide cervical cancer education, a Pap test and/or co-testing with HPV, and a pelvic exam.

Note: In this manual the word "Pap" refers to liquid-based Pap test.

3.5a Pelvic Examination Eligibility

- 21—64 years of age.
- Not a participant in a program that provides these services (e.g. Family Planning).
- Pelvic exams will be reimbursed when indicated by medical history, symptoms, or to verify the presence of a cervix.

3.5b Liquid-Based Pap Test Eligibility and HPV Testing

- 21-64 years of age.
- Not a participant in a program that provides these services (e.g. Family Planning).
- Women 21 years through 29 years of age are eligible for a Pap test (cytology only - no HPV) every three (3) years.
- Women 30-64 years of age are eligible for Pap testing alone every three years **or** co-testing with the combination of Pap testing with HPV testing every five years.
- Women 30-64 HPV test only every five years.
- Women 30-64 Self-collected HPV test only every three years.

Note: In this manual, the term HPV refers only to "High Risk" HPV (hrHPV)

3.5c HPV Self Collection

The HPV self-collection kits are available to WVBCCSP participants for primary HPV screening who are asymptomatic and at average risk.

- For women who have barriers to traditional screening.
- Must be collected by the patient in a health care setting.
- The site must have a policy in place which includes educating women on the need for follow-up for abnormal test results.
- Once a specimen is collected, the clinic will ship it to the specific contracted lab as per WVBCCSP guidance.
- Self-collection HPV screening is recommended every three years.

The site must have a policy in place to differentiate provider-collected specimens and patient-collected specimens and collect data. *Additional information can be found at [ASCCP](#)*

3.5d High Risk

Women are identified as high risk if they have any of the following: HIV infection, had organ transplant, immunocompromised from another health condition, or had DES exposure in utero.

The following services will be reimbursed by the program for eligible women that meet high risk requirements:

- Under the age of 30, annual pap testing.
- 30-64 years, annual pap testing **or** co-testing every three years.
- If an abnormal Pap test is obtained at any time, follow the 2019 “ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors”. These guidelines can be downloaded at <https://www.asccp.org/enduring-guidelines/asccp-2019-risk-based-management>

3.5e Liquid-Based Pap Test Eligibility for Post-Hysterectomy Patients

- If the cervix was not removed (partial hysterectomy), screening tests will be reimbursed according to the ASCCP 2019 Screening Guidelines.
- If the cervix was removed (total hysterectomy) due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer, Pap tests will be reimbursed per the ASCCP 2019 Screening Guidelines, every three (3) years for up to 20 years.
- If the cervix was removed for reasons other than cervical neoplasia or invasive cancer, Pap tests cannot be reimbursed through the WVBCCSP.

3.6 Cervical Diagnostic Eligibility

3.6a Colposcopy Eligibility

- 21-64 years of age with Pap test result in accordance with the ASCCP 2019 “Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors”.
- A visualized lesion on the cervix even when Pap test results are normal.
- 21-24 years of age with Pap test results in the previous six (6) months of HSIL, AGC or ASC-H. In this instance, a copy of the Pap test report must accompany the Client Enrollment Form (Y104) or Referral Form (Y202).

Note: Removal of a visualized cervical polyp, when Pap tests have normal results or are not due, may be reimbursed through the WV Diagnostic and Treatment Fund (CPT Code 57500 — Biopsy of excision of lesion).

All Diagnostic and Treatment Fund applications must be pre-approved. The application is located on the WVBCSP website. [WVBCSP website](#)

For questions regarding screening and follow up guidelines, visit <https://www.asccp.org/enduring-guidelines/asccp-2019-risk-based-management>

3.7 Acute Care Visits

WVBCSP does not reimburse for acute care visits. The WVBCSP is a screening program. However, if a WVBCSP enrolled patient comes to the clinic with a breast or cervical issue that is outside of her yearly screening date, the program will reimburse for referral services as outlined in the policy and procedures manual. The referral for additional services would be documented as "*Referral Previously Enrolled*" on the Patient Data form.

SECTION IV - SCREENING PROVIDER SERVICES and PATIENT ENROLLMENT

4.1 Screening Provider Qualifications

- Facilities operating under the direction of a West Virginia licensed practitioner are eligible to provide screening services.
- Providers must maintain current applicable federal and state licenses.

The following types of facilities are eligible to be screening providers:

- Local health departments, as created in West Virginia Public Health Law, Chapter 16-2-1, 16-2-2, and 16-2-3 of the West Virginia Code.
- For-profit and non-profit health centers.
- Other licensed medical personnel and agencies deemed qualified to provide screening services.
- Those bound by written agreement with WVBCCSP to provide screening services to WVBCCSP eligible patients.

Approved providers of clinical services include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives

4.2 Screening Provider Services

Screening Providers must be capable of and agree to perform the basic components for breast and cervical cancer screening which include:

- Pelvic examinations
- Pap tests and HPV screening
- Clinical breast examination (CBE) (optional)
- Breast health awareness
- Referrals for diagnostic or treatment procedures when appropriate
- Referrals to the Breast and Cervical Cancer Prevention and Treatment Act (BCC MTA), as necessary
- Appropriate and timely follow-up in accordance with WVBCCSP protocols
- Maintenance of a patient reminder system for annual rescreening visits
- Patient education
- Community Outreach
- Counseling on the importance of annual rescreening
- Screening for cardiovascular risk assessment and referral to the WV WISEWOMAN program as appropriate
- Document and maintain patient records for WVBCCSP services, including completing all required program forms

Note: All WVBCCSP patients have the right to decline any of the above services. If a patient declines any service, document the refusal on the appropriate section of the Patient Data form (Y106) and in the Progress Note.

4.3 Screening Provider Responsibilities

Screening Providers must be capable of and agree to perform the following:

- Provide services in accordance with standards reflected in the WVBCCSP Policies and Procedures Manual.
- Submit required forms in accordance with the WVBCCSP policy.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- Accept WVBCCSP payment as full compensation for covered services and not balance bill the patient.
- Maintain patient records for at least five (5) years from the last date of service in addition to the current year.
- Allow OMC FH monitoring team to conduct on-site quality assurance monitoring activities.

4.4 Screening Provider and Patient Enrollment

To enroll a woman as a participant in the WVBCCSP, the screening provider must:

- Determine eligibility based on income and age (refer to Eligibility Guidelines in Section III of this manual).
- Obtain a signed Client Enrollment-Release of Information and Statement of Confidentiality form (Y104).
- Complete a Patient Data form (Y106) marking visit type as **Initial**.
- Complete a Medical History form (Y108) or a facility's approved form.
- Provide required screening services.
- Accept the patient's verbal statement of gross monthly or yearly income. (Documentation or verification of income is not required).
- Complete Referral form (Y201) as indicated.

4.4a Patient Enrollment for a Referral for Diagnostics

- Determine eligibility based on income and age (refer to Eligibility Guidelines in Section III of this manual).
- Obtain a signed Client Enrollment-Release of Information and Statement of Confidentiality form (Y104).
- Complete a Patient Data form (Y106) marking visit type as Referral for Enrollment and document abnormal cervical cancer screening result and/or CBE findings within the appropriate sections of the Patient Data form.
- Complete referral form (Y202).

4.5 Required Screening Provider Forms

All data fields must be completed. No data field should be left blank. When not applicable, please note N/A. All signatures are required. Do not abbreviate the facility name.

4.5a Client Enrollment - Consent for Release of Information and Confidentiality Form

- Complete during the Initial visit and Referral for Enrollment visit.
- Complete when updating patient address or last name changes.
- Must be completed and updated annually during the "Annual Visit".
- Must be submitted to the Program within seven (7) days.
- Must be dated and signed by the patient and a witness.
- Maintain a copy in the medical record.

4.5b Patient Data Form

- Mark only one visit type.
- Complete all breast and cervical screening data.
- Record results of clinical breast exam, pelvic exam, Pap/HPV test results, any risk factors for breast cancer and smoking status/tobacco cessation referrals.
- Clinicians must sign and record the time spent with patients.
- A Patient Data Form must be submitted for every visit. See Section VIII for billing information.

4.5c Medical History Form

- Complete at Initial visit.
- Update annually by documenting any changes on the original Medical History Form or complete another Medical History Form or a Progress Note.
- Maintain the original in the patient's medical record. Do not send a copy to the WVBCCSP.

Note: A Medical History Form or electronic health record may be used in place of the WVBCCSP Medical History Form (Y108), provided that the record captures the history components required by the WVBCCSP.

4.5d Referral Form

Screening Provider completes a Referral Form each time a referral is made for:

- Mammography, Screening
- Mammography, Diagnostic
- Fine Needle Aspiration
- Surgical Consultation
- Breast Ultrasound
- MRI

- Puncture Aspiration of Cyst
- Breast Biopsy
- Colposcopy with or without biopsy

The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to referral appointment.

A copy of the Client Enrollment Form and WVBCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit with the screening provider.

*Please note, the Referral Form may be incomplete pending awaiting test results. It is **mandatory** to send the Referral Form within 7 days of the initial visit even if all test results are not available. Complete test results should be sent to the Program as soon as available or with the monthly WVBCCSP Batch Invoice Form.

4.6 Tracking Logs

Complete the following for tracking purposes:

- Mammography Activity Log (Y206)
- HPV/Pap Test Activity Log (Y112)
- Colposcopy Activity Log (Y306).

Clinics may use their own tracking system if WVBCCSP patient's referral and all diagnostic procedures are documented. Clinics are also expected to track self-collected vs provider-collected HPV samples.

SECTION V - REFERRAL PROVIDER QUALIFICATIONS and RESPONSIBILITIES

5.1 Statewide Network of WVBCCSP Referral Providers

In addition to a network of Screening Providers, the WVBCCSP maintains a statewide provider network of participating Referral Providers. Program eligible women who have abnormal breast and/or cervical screening results are eligible for follow-up diagnostic/treatment services when referred by a WVBCCSP Screening Provider to a WVBCCSP Referral Provider. This comprehensive network ensures that women with abnormal screening results have access to the recommended follow-up/treatment.

Referral Providers include the following:

- Mammography Providers
- Breast Ultrasound Providers
- Breast MRI Providers
- Breast Consultation Providers (Surgeon Consult)
- Breast Biopsy Providers
- Colposcopy Providers
- Cytology Laboratory Provider
- Radiologists

5.2 Mammography Provider Qualifications

- Certification under requirements of the Mammography Quality Standards Act (MQSA) final rule 2023 and updated on September 10, 2024. The most recent updated version can be found at <https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-mqsa-and-mqsa-program>
- Bound by written agreement with WVBCCSP to provide mammography services for WVBCCSP eligible patients.

5.3 Mammography Provider Services

Provide appropriate mammography services for women referred from WVBCCSP Screening Providers.

5.4 Mammography Provider Responsibilities

- Mammogram reports are required to include a breast density assessment with an overall finding of dense breasts, or breasts are not dense, including additional detail about the level of density.
- Notify patients of their mammography results according to MQSA requirements.
- Submit copies of the Narrative report of radiologic findings to the referring screening provider.

- Submit copies of the Narrative report of radiologic findings to the WVBCCSP office (required for payment).
- Communicate WVBCCSP's reimbursement/invoicing procedures to any outside radiology group. Radiologists cannot balance bill the patient. Invoices must be submitted to the WVBCCSP and never to the patient.
- Maintain records and films for at least five (5) years from date of service.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- The mammography provider agrees to accept WVBCCSP payment as full compensation for services provided and must not balance bill the patient.

5.5 Breast Ultrasound

Ultrasound Providers must have a written agreement with the WVBCCSP to provide breast ultrasound services for WVBCCSP eligible women.

5.6 Breast Ultrasound Provider Responsibilities

- Provide appropriate ultrasound services for WVBCCSP eligible women.
- Submit copies of the Narrative report of radiologic findings to the referring screening provider and to the WVBCCSP office (required for payment).
- Maintain patient records and films for at least five (5) years from the last date of service in addition to the current year.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- The breast ultrasound provider agrees to accept WVBCCSP payment as full compensation for services provided and must not balance bill the patient.

5.7 Breast Consultation

Providers must have a written agreement with the WVBCCSP to provide services for WVBCCSP eligible women.

5.7a Breast Consultation Provider Qualifications

- Board certified surgeon or radiologist for imaging guided biopsies.
- Bound by a written agreement with the WVBCCSP to provide breast consultation services for women referred by WVBCCSP screening providers.

5.7b Provider Responsibilities

- Provide surgical evaluation of abnormal clinical breast or mammogram findings for women referred by WVBCCSP screening providers (required for payment).
- Submit report of findings and/or pathology report to referring screening provider and WVBCCSP.

- Maintain patient records for at least five (5) years from the last date of service in addition to the current year.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- The breast consultation provider agrees to accept WVBCCSP reimbursement as full compensation for services provided and not balance bill the patient.
- Two surgical consultations are reimbursed per breast issue per year. Additional visits may be covered pending program clinical review.

5.8 Breast Biopsy/Fine Needle Aspiration (FNA)

5.8a FNA provider qualifications

- Board certified surgeon or radiologist for imaging guided biopsies.
- Written agreement with WVBCCSP to provide breast biopsy services for women referred by WVBCCSP breast consultation providers.

5.8b Breast Biopsy/Fine Needle Aspiration Provider Responsibilities

- Provide biopsies of the breast for women referred by contracted breast surgeon or radiologist.
- Notify the facility that the woman is a participant of the WVBCCSP if the biopsy is done at a facility other than the surgeon's office.
- Submit copies of the pathology report to the referring screening provider and the WVBCCSP.
- Attach the diagnostic/pathology report along with a copy of the Referral form (Y202) to the CMS-1500 when billing WVBCCSP. This allows the Program to track patient follow up as required by the Program funder, the CDC, and will eliminate calls requesting pathology reports.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- The breast biopsy provider agrees to accept WVBCCSP payment as full compensation for services provided and not balance bill the patient.
- Maintain patient records for at least five (5) years from the last date of service in addition to the current year.

5.9 Additional Referral Provider Information

- Screening sites will refer women for surgical consultation using the Referral form (Y202). This alerts the surgeon to bill the WVBCCSP and not the patient.
- WVBCCSP will pay for breast biopsies for those women enrolled in the WVBCCSP. WVBCCSP will pay for two (2) surgical consultations each year, per abnormal CBE/mammogram finding (initial consultation plus a follow-up consultation).
- Additional surgical visits will be covered with prior approval from the program.

- A surgical consultation is not required for initial abnormal findings but is strongly recommended for those with findings that are highly suggestive of malignancy.
- Only those diagnostic procedures related to the breast can be billed by the provider/surgeon to WVBCCSP. The purpose of WVBCCSP is to provide early detection and screening for breast and cervical cancer. Therefore, the program is unable to cover acute visits for non-screening related issues (i.e. breast abscess).

5.10 Preoperative testing

Preop testing will be covered for women if required and must be performed at a WVBCCSP contracted facility and is limited to:

- Chest x-ray
- Electrocardiogram (EKG)
- Complete Blood Count (CBC)
- Basic Metabolic Panel (BMP)
- Prothrombin Time/ International Normalized Ratio (PT/INR)
- Urinalysis (UA)
- Urine Human chorionic Gonadotropin (HCG)
- COVID testing

5.11 General Anesthesia

General anesthesia is a covered service with the use of approved codes. See the WVBCCSP payment fee schedule for reimbursable codes.

5.12 Colposcopy

5.12a Colposcopy Provider Qualifications

Board Certified Obstetrician-Gynecologist; Board Certified Physician, or Advanced Practice Provider (APP) such as Nurse-Practitioner, Nurse Midwife, or Physician Assistant with training in colposcopy. Facilities should ensure that providers meet the standard qualifications to perform within their scope of practice.

5.12b Colposcopy Provider Responsibilities

- Provide colposcopy examination for women referred by the WVBCCSP screening providers.
- Provide colposcopy-directed biopsy when appropriate.
- Submit copies of the report of findings/pathology results to the screening provider and to the WVBCCSP office within 7 days of the results (required for payment).
- Maintain patient records for at least five (5) years from the last date of service in addition to the current year.

- When appropriate, bill third party payors, prior to billing WVBCCSP (Attach Explanation of Benefits (EOB) to invoice submitted to the WVBCCSP).
- The colposcopy provider agrees to accept WVBCCSP payment as full compensation for services provided and not balance bill the patient.

5.13 Cytology Laboratory

5.13a Lab Qualifications

- Must have Certification under the Clinical Laboratory Improvement Act (CLIA) level: high complexity.
- Have a written contract to provide interpretation of Liquid-based Pap tests and/or hrHPV testing for women referred by WVBCCSP screening providers.

5.13b Cytology Laboratory Responsibilities

- Accept Pap tests and/or hrHPV tests from WVBCCSP providers for interpretation.
- Provide hrHPV testing on applicable test specimens utilizing only FDA approved methodology.
- Submit the report to the screening provider and WVBCCSP.
- Maintain records and slides for at least five (5) years from the date of service if the result is negative or not suspicious for cancer.
- Maintain records and slides for 10 years if the result is abnormal.
- When appropriate, bill third party payors, prior to billing WVBCCSP.
- The laboratory agrees to accept WVBCCSP payment as full compensation for services provided and not balance bill the patient.

SECTION VI - BREAST SCREENING SERVICES & FOLLOW-UP

The chance of a woman having invasive breast cancer sometime during her life is a little less than one (1) in eight (8). The chance of dying from breast cancer is about one (1) in 46. Breast cancer death rates have been going down. This is likely the result of diagnosing cancer earlier and improved treatment options. According to the American Cancer Society, in 2022, about 2.3 million women were diagnosed with breast cancer worldwide and 670,000 died. There are more than 4 million breast cancer survivors in the United States. This includes women still being treated and those who have completed treatment (American Cancer Society 2025).

6.1 Introduction

Breast cancer is the most common cancer among women in the United States, other than skin cancer. It is the second leading cause of cancer death in women, after lung cancer.

6.2 Risk Factors for Breast Cancer

The exact cause of breast cancer is not known, however there are several risk factors that are associated with the development of the disease. Some risk factors such as alcohol consumption can be modified to decrease a woman's risk of developing the disease while others cannot (genetic predisposition). Other factors influence risk more than others and a woman's risk of developing breast cancer can change over time. Having a risk factor or even several risk factors, does not mean a woman will develop the disease.

6.2a Risk Factors

The following is a partial list of average risk factors associated with breast cancer:

Gender: Being a woman is the main risk factor for developing breast cancer. Breast cancer is more common in women than men. It is theorized that because a woman's breast cells are constantly being exposed to female hormones (a growth-promoting effect). Although men can develop the disease, women are approximately 100 times more likely to develop breast cancer than men.

Age: A woman's risk of developing breast cancer increases with age. Approximately eight (8) out of ten (10) breast cancers are found in women aged 50 and older.

Genetics: According to the American Cancer Society, approximately 5-10% of all breast cancer cases are hereditary, a result of gene mutations. The genes that are commonly mutated and that are thought to be linked to the development of breast cancer are BRCA 1 and BRCA 2.

History of Breast Cancer: Breast cancer risk is higher among women whose close relatives have the disease (mother, grandmother, sister and aunt). Having a first-degree blood relative with the disease (mother, sister and daughter) doubles the risk.

Menstrual Periods: Beginning menstruation at an early age (before age 12) or going through menopause later in life (after age 55) slightly increases a woman's risk.

6.2b Risk Assessment

- It is recommended that all women beginning at the age of 25, have a breast cancer screening risk completed (i.e. Gail Model, Tyrer-Cuzick). Providers may choose which assessment model to use. It is not required to use the in-depth assessment tools on all patients. However, it is required to assess and document risk factors.
- High-risk factors must be documented on the Patient Data Form (PDF) as well as on the Referral form.

6.3 Early Detection of Breast Cancer

The cause of breast cancer remains unknown. Because the source is not yet understood, early detection of breast cancer is the key to control. Early detection of breast cancer through mammography, patient education, and self-breast awareness are all important for survival rates. The (5) five-year relative survival rate is 99% in women with localized breast cancer. The importance of early detection is highlighted by the fact that the (5) five-year relative survival rate drops to only 32% with distant metastasis (ACS, 2024-2025).

6.4 Required Components of Breast Screening

Breast cancer screening involves commitment to an ongoing program of breast care by both the individual and the health care professional. In theory, breast cancer screening focuses on asymptomatic individuals. This requires education of health care professionals, patients, and the public.

The screening examination includes an interview to collect demographic data, breast cancer education, risk assessment, breast cancer screening options, breast self-awareness instructions, clinical breast exam (if applicable), and mammography (when age appropriate).

Note: Program Reimbursement guidelines are not a substitute for clinical judgment.

6.5 General Guidelines for Patient Education

Screening providers are required to share information and education on the early detection of breast cancer. The purpose of the education component is to provide patients with information necessary to understand screening procedures to enable patients to make informed decisions, and to motivate patients to comply with recommended guidelines for rescreening.

Providers should:

- Make education appropriate to the patient's age, lifestyle, culture, and medical history.
- Give patients the opportunity to ask questions.
- Encourage patients to verbalize an understanding of educational information presented.
- Present information in an easy to understand, non-technical manner.
- Refer women who use tobacco to a tobacco cessation QUITLINE or other cessation programs.

6.6 Breast Cancer Education

Breast Cancer information will include the following:

- Basic anatomy and physiology of the breast.
- Risk factors associated with breast cancer.
- Benefits of early detection of breast cancer.
- Importance of regular rescreening.

Components of breast care can include:

- Breast Self-Exam (BSE) Education and Breast Self-Awareness.
- Clinical Breast Exam (CBE) as indicated.
- Mammogram, when age appropriate.

6.7 Clinical Breast Examination

A clinical breast exam (CBE) should be performed on all symptomatic patients. A CBE is *optional* for asymptomatic and is not required for screening of asymptomatic patients.

6.7a Management of Abnormal Clinical Breast Exam

All abnormal CBEs and abnormal imaging require follow up testing as per recommendations.

Abnormal CBE results that result in a breast surgical consultation must be documented on the Patient Data Form and Referral Form as one of the following:

- Discrete palpable mass (suspicious of cancer)
- Bloody or serous nipple discharge
- Nipple or areola scaliness
- Skin dimpling or retraction
- Pain or focal tenderness

WVBCCSP will reimburse two (2) breast surgical consultations each year per breast problem (initial consultation plus one follow-up consultation). Additional surgical visits will be covered with prior approval from the program. A surgical consultation is no longer required for initial abnormal findings, but strongly recommended for findings that are highly suggestive of malignancy.

A Referral Form (Y202) must be completed by the screening provider. The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to referral appointment.

A copy of the Client Enrollment Form and BCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit with the screening provider.

Routinely, the patient is given a copy of the Referral Form and Patient Data Form by the screening provider and is instructed to take these to the breast surgeon. This prompts the

surgeon to bill the WVBCCSP and not the patient. This also documents the abnormal result that initiated the referral.

WVBCCSP Protocol for management of an abnormal breast screening result: Refer for diagnostic testing first and then refer to surgeon for evaluation **within 60 days** of abnormal CBE if needed.

Note: A normal mammogram result does not eliminate the need for further evaluation either from additional imaging (i.e. ultrasound) or referral to a surgeon when there has been an abnormal clinical breast examination finding. Please consult the American College of Radiologists Appropriateness Criteria for more information at [Breast Cancer Screening Recommendations](#) or [ACR Appropriateness Criteria](#).

6.8 Screening Mammography

- Screening providers are required to refer all WVBCCSP women ages 40-64 for a mammogram every 1 to 2 years. The WVBCCSP will reimburse for screening mammograms annually per the NBCCEDP guidelines.
- Program eligible women ages 30-39 that are determined to be high risk are eligible for screening mammograms. Refer to Section 6.2.
- It is recommended that all women beginning at the age of 25 have a breast cancer screening risk completed (i.e. Gail Model, Tyrer-Cuzick). Providers may choose which assessment model to use.
- High-risk factors must be documented on the Patient Data Form as well as on the Referral form.

6.8a Mammography Referral

Referral Process: When a WVBCCSP patient qualifies for mammography services, provide her with a completed Referral Form (Y202) and distribute copies as directed on the bottom of the form.

A Referral Form (Y202) must be completed by the screening provider. The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to the mammography appointment. This prompts the mammography site to bill the WVBCCSP and not the patient.

A copy of the Client Enrollment Form and BCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit with the screening provider.

The screening provider must also document the woman's CBE result, if completed, on the Patient Data and Referral forms. A clinical breast exam (CBE) should be performed on all symptomatic patients. A CBE is *optional* and is not required for screening.

6.8b Mammography Results Reporting

The mammography provider must send the results/narrative to:

- WVBCCSP (required for payment of mammography provider).
- Screening provider.
- Mammogram report must contain breast density reporting.

6.8c Mammography Follow-up and Tracking

It is the screening provider's responsibility to notify participants when their next screening is due. Screening providers must also maintain the Mammography Activity Log (Y206), or a tracking log of choice, and complete appropriate referrals for treatment and follow-up.

6.8d Follow-up for Normal CBE / Mammogram Results

When both CBE and mammogram results are normal, the client should return for routine screening.

6.8e Follow-up for Abnormal CBE / Mammogram Results

If the CBE or mammogram results are abnormal, it is the responsibility of the screening provider to ensure appropriate follow-up and referral.

Note: When a follow-up mammogram is ordered by the breast surgeon or radiologist, the WVBCCSP can only reimburse at six (6) month intervals.

6.8f Abnormal Mammography

Upon receipt of a patient's report showing abnormal mammography results, the screening provider must:

- Notify the patient of the findings and recommendations within seven (7) days.
- Refer the patient for further evaluation based on the radiological findings and recommendations.
- Contact the physician/surgeon to whom the patient was referred to within seven (7) days of the scheduled appointment to request follow-up information.
- Schedule the patient for further management/follow-up according to the physician's/surgeon's recommendations.
- Proceed to the Lost to Follow-Up Protocol when unable to reach. Refer to section 6.13.

6.9 Breast Ultrasound (US) Guidelines

To determine patient eligibility, refer to Section 3.4b.

- Ultrasound may only be performed by WVBCCSP approved mammography providers and breast surgeons.
- WVBCCSP Screening Providers complete the referral for a breast ultrasound.

6.9a Breast Ultrasound Referral

When it is determined that a patient needs a breast ultrasound, complete the Referral Form (Y202). The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to the US appointment. This prompts the imaging site to bill the WVBCCSP and not the patient.

A copy of the Client Enrollment Form and BCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit with the screening provider. The screening provider must also document the woman's CBE result if completed on the Patient Data and Referral forms. The CBE is optional for a Screening but is required if the woman is symptomatic.

6.9b Ultrasound Results Reporting

A copy of the ultrasound narrative must be distributed to:

- WVBCCSP (required for payment of ultrasound provider).
- Screening provider.

If an ultrasound is recommended and can be performed during the mammography appointment, it may be completed during the same appointment time. It is not necessary for the patient to return to the WVBCCSP screening provider to obtain an additional Referral Form.

6.9c Breast Ultrasound Follow-up

Based on the radiologist's findings and recommendations, the patient should be referred appropriately for further evaluation or routine scheduling. Upon receipt of the patient's report showing abnormal results, the screening provider must provide appropriate notification to the patient. Refer to the Lost to Follow-Up Protocol when unable to reach a participant. Refer to Section 6.13.

6.10 Supplemental Screening

WVBCCSP participants who are considered at a **high risk** of developing breast cancer are eligible for supplemental breast cancer screening.

- This includes a screening bilateral breast MRI or a bilateral whole breast ultrasound. These are in addition to the annual screening mammogram.
- Ideally, screening should occur every 6 months. For example, the screening mammogram, followed by screening breast MRI in 6 months. However, supplemental screening tests can occur at any time.
- Refer to Section 3.3c for breast cancer high risk factors.
- A screening MRI requires prior approval from the program.

6.11 Fine Needle Aspiration (FNA)

- Fine Needle Aspiration may only be performed by WVBCCSP contracted providers.
- Radiologists may perform this procedure if employed at a facility contracted to provide mammograms or breast ultrasound services.
- Either the screening provider or consulting surgeon can make referrals for Fine Needle Aspiration as necessary.
- To determine eligibility, refer to Section 3.4d.

6.11a Fine Needle Aspiration Referral

When it is determined that a patient needs a Fine Needle Aspiration Referral, complete the Referral Form (Y202). The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to the appointment. This prompts billing the WVBCCSP and not the patient.

6.11b Fine Needle Aspiration Results Reporting

A copy of the FNA pathology must be distributed to:

- WVBCCSP (required for payment of ultrasound provider)
- Screening provider

6.11c Fine Needle Aspiration Follow-up

- Based on the provider's findings and recommendations, the patient should be referred appropriately for further evaluation or routine scheduling.
- Upon receipt of a patient's report showing abnormal results, the screening provider must provide appropriate notification to the patient.
- Refer to Lost to Follow-Up Protocol when unable to reach participant. Refer to Section 6.13.

6.12 Breast Biopsy

- Breast biopsy may only be performed by WVBCCSP contracted surgeons.
- Either the screening provider or consulting surgeon must make referrals for breast biopsy as necessary.

6.12a Breast Biopsy Referral

When a WVBCCSP patient requires breast biopsy services, complete a Referral Form (Y202) and distribute as directed. If the breast biopsy is going to be performed at a facility other than a surgeon's office, it is the responsibility of the surgeon's office to send a copy of the Referral Form and Client Enrollment Form to that facility for billing purposes. The surgeon agrees to accept the WVBCCSP payment as full compensation for services and not balance bill the patient.

The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form should be provided to the patient with

instructions to take to the breast biopsy appointment. This prompts the billing the WVBCCSP and not the patient.

A copy of the Client Enrollment Form and BCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit.

6.12b Breast Biopsy Results Reporting

A copy of the pathology report must be distributed to:

- WVBCCSP (required for payment)
- Screening provider

6.12c Breast Biopsy Follow-up

- Based on the surgeon's findings and recommendations, the patient should be referred appropriately for further evaluation or routine scheduling.
- Upon receipt of a patient's report showing abnormal results, the screening provider must provide appropriate notification to the patient.

6.13 Lost to Follow-Up Protocol:

- Make a minimum of three (3) patient contact attempts. The first attempt to contact the patient must be initiated within seven (7) days of receipt of the abnormal mammography results. Contacts should be by the clinician via telephone unless the patient specified another method of notification.
- Document each attempt to contact a patient in the patient's medical record, along with the results of a successful contact.
- It is recommended to send a certified letter with a return receipt requested if unable to reach the patient after two telephone calls. A letter can be mailed via U.S. Postal Service first class mail in lieu of certified mail. The time between the receipt of abnormal mammogram results and mailing of the letter must not be more than six (6) weeks. The letter should communicate that this will be the last effort made to contact the patient.
- All written correspondence with the program participant should be easily understandable, using non-alarming language, and emphasize the importance of the patient contacting the screening provider for further information and follow-up. The patient should be given a specific contact person and time to call. The time between the receipt of test results and the mailing of the certified letter must not be more than six (6) weeks. The letter should communicate that this will be the last effort made to contact the patient.
- Document in the patient's medical record when attempts at contacting a patient are terminated. This is when the patient can be marked as Lost to Follow-Up.
- Notify the WVBCCSP if the patient is "Lost to Follow-up" or has "Refused" further recommended diagnostic services. This can be done using the Case Management Referral form or by contacting WVBCCSP. When calling the program, please provide dates of patient contact attempts.
- A participant is marked "Lost to Follow-Up" two weeks after the letter has been mailed with no response from the participant.

SECTION VII- CERVICAL SCREENING SERVICES & FOLLOW-UP

7.1 Introduction

The goal of cervical cancer screening is to find abnormal cells in the cervix or cervical cancer early, when it is more treatable and curable. The tests for cervical cancer screening include the HPV test and the Pap test. Regular screening can prevent cervical cancer and save lives. When found and treated early, cervical cancer often can be cured.

Cervical cancer is most diagnosed in women between the ages of 35 and 44 and is rarely found in women younger than 20. More than 20% of cervical cancers are found in women over 65. However, these cancers rarely occur in women who have been getting regular tests to screen for cervical cancer before they were 65.

Cervical cancer was once one of the most common causes of cancer death for American women. The cervical cancer death rate has dropped by more than half since the mid-1970s because of prevention and screening, although rates have stabilized in recent years. In women ages 30 to 44, however, rates have increased 1.7% each year from 2012 to 2019. In contrast, rates declined 11% each year for women ages 20 to 24, probably reflecting the first signs of cancer prevention from HPV vaccination. When "HPV testing" is mentioned in this manual and/or in the Consensus Guidelines, it refers to "High Risk" HPV types only.

7.2 Prevention and Early Detection of Cervical Cancer

Having regular cervical cancer screenings is the most effective way to identify precancerous lesions and conditions that can be treated and cured before they progress to cervical cancer. For women diagnosed with dysplasia lesions or carcinoma in situ, the likelihood of survival is almost 100% if they receive appropriate follow-up and treatment. For patients with invasive but localized cervical cancer, the five (5) year relative survival rate is 91.2%.

The widespread implementation of preventive services for the early detection of cervical cancer has been associated with substantial reductions in morbidity and mortality. Primarily because of extensive use of the Pap test, cervical cancer has declined by approximately 74%. In 2019, the American Society for Colposcopy and Cervical Pathology updated the screening guidelines and guidelines for the management of abnormal cervical cancer screening tests and cancer precursors. The 2019 Updated Screening and Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors can be found at: [ASCCP 2019 Risk Based Management - ASCCP](#)

Note: Program Reimbursement guidelines are not a substitute for clinical judgment.

7.3 Overview of the 2019 Cervical Screening and Colposcopy Guidelines for cervical screening of patients who are asymptomatic.

The following is an overview of the 2019 American Society of Colposcopy and Cervical Pathology (ASCCP) Screening Guidelines:

- Cervical screening should begin at age 21.
- Screening earlier than age 21, regardless of sexual history, could lead to more harm than benefit.
- Aged 21-29 Cytology alone every three years.
- Aged 30-64 years, screening for cervical cancer every 3 years with cytology alone, every 5 years with HPV testing alone, or every 5 years with co-testing. Refer to 7.11 for Self-Collected HPV frequency.
- Women who have had the HPV vaccine still need regular cervical screening based on the current guidelines.
- Women who have had their cervix removed (Hysterectomy) for a noncancerous condition (like fibroids) do not require cervical cancer screening.
- Women who have increased risk of cervical cancer due to risk factors should receive individualized follow up based on the [2019 ASCCP Risk-Based Management Consensus](#).
- Routine cytology screening and HPV testing should be discontinued in women over the age of 65 years and who have evidence of adequate negative prior screening results* and no history of a CIN2 or higher.

*Adequate negative prior screening results are defined as three consecutive negative cytology results or two consecutive negative co-tests within the previous ten (10) years, with the most recent test performed within the past five (5) years.

7.4 Cervical Cancer Risk Factors

There are several risk factors associated with cervical cancer. While these risk factors increase a woman's chance of developing cervical cancer, many women with these risks never develop the disease. As with breast cancer, there are certain risk factors that a woman can change to decrease her risk of developing the disease, but there are also those risk factors that cannot be changed. It is important to focus on risks which are reversible. The following is a partial list of risk factors associated with cervical cancer:

- Human Papillomavirus (HPV)
The most important risk factor associated with the development of cervical cancer is the human papillomavirus (HPV) infection. More than 95% of cervical cancer cases are caused by HPV. There are many different types of HPV. Certain types of HPV are passed from one person to another through sexual contact, which then infect the male and female genital organs, anal area, and oral cavity. There is currently no cure for HPV and the use of condoms during intercourse does not prevent the spread of the virus. HPV can also be passed from person to person by skin-to-skin contact with any infected area of the body, such as skin

around the genital area and the anal area which is not covered by the condom. However, it is still important to use condoms during sexual intercourse to prevent the spread of HIV and other sexually transmitted diseases.

- Tobacco Use

Tobacco products contain cancer causing chemicals that are absorbed by the body and carried throughout the bloodstream, exposing the body to harmful substances. Tobacco by-products are often found in the cervical mucus of women who use tobacco. It is believed that these substances damage the DNA of cervical cells and contribute to the development of cervical cancer. Women who use tobacco are twice as likely to develop the disease as non-tobacco users.

- Low Socioeconomic Status

Living below the Federal Poverty Limit can affect cervical cancer screening due to lack of resources. These barriers can include but are not limited to lack of health insurance, transportation to medical appointments, and childcare assistance. Health literacy can also affect cervical cancer screening rates. Women experiencing these challenges are often diagnosed with advanced stages of cervical cancer, which are less responsive to treatment.

- HIV Infection (human immunodeficiency virus)

HIV is the virus that causes acquired immune deficiency syndrome (AIDS) and is a risk factor in the development of cervical cancer. Being infected with HIV lowers a woman's immune system, making it less able to fight both HPV and early cancer.

- Immunocompromised

Other diseases may also increase the risk of cervical cancer due to lowering a woman's immune system. This can include lupus or other systemic diseases.

- Chlamydia Infection

Chlamydia is a common sexually transmitted disease caused by a bacterium *Chlamydia trachomatis*. Some studies have suggested that women who have a Chlamydia infection, or have had one in the past, may be at increased risk for developing cervical cancer.

- Long Term Use of Oral Contraception

Taking oral contraceptives long-term, typically more than five years, can increase the risk of cervical cancer. Research suggests the risk goes down after the oral contraceptives are stopped and returns to normal many years after stopping.

- Family History

Recent studies suggest that women whose mother or sister has had cervical cancer are more likely to get the disease themselves. It is believed that women with a family history of cervical cancer have an inherited condition that makes some women less able to fight off HPV infections than other women.

- Exposure to Diethylstilbestrol (DES)

DES was a hormonal drug given to women between 1938-1971 to prevent miscarriage. Women whose mothers took DES (when pregnant with them) develop clear-cell adenocarcinoma of the vagina or cervix more often than would normally be expected.

Having regular cervical cancer screening is the most effective way to identify pre-cancerous lesions that can be treated and cured before they progress to cervical cancer.

7.5 Required Components of Cervical Screening

Cervical cancer screening involves commitment to an ongoing program of cervical care by both the individual and the health care professional. *In theory, cervical cancer screening focuses on asymptomatic individuals.* This requires education of the health care professional, the patient and the public. The screening exam includes an interview to collect demographic data, provide cervical cancer education, a Pap test and/or HPV test, and pelvic examination.

7.6 General Guidelines for Patient Education

Screening providers are required to provide information and education about the prevention and early detection of cervical cancer. The purpose of the education component is to provide patients with information necessary to understand screening procedures and to motivate patients to comply with recommended guidelines for rescreening. This will allow patients to make an informed decision regarding screening and healthcare.

Providers must:

- Make education appropriate to the patient's age, lifestyle, culture, medical history, and health literacy.
- Give patients the opportunity to ask questions.
- Encourage patients to verbalize an understanding of educational information presented.
- Present information in a non-technical manner.
- Encourage shared decision making.

7.7 Cervical Cancer Education

The information provided must include the following:

- Basic anatomy and physiology of the cervix/female reproductive organs.
- Risk factors for cervical cancer.
- Benefits of the Pap and/or HPV test for prevention and early detection of cervical cancer.
- Importance of regular screening and appropriate intervals for screening.
- Referral to a tobacco quit line or cessation program for women who use tobacco.

7.8 Pelvic Examination

Screening Providers should perform a pelvic examination on all WVBCCSP patients at appropriate intervals. Approved providers of pelvic exams are physicians, physician assistants, nurse practitioners, and certified nurse midwives. The date, findings, recommendations, and any pertinent comments concerning the pelvic examination must be documented on the patient's Patient Data Form (Y106).

7.9 Pre-Clinic Client Preparation Instructions for Cervical Cancer Screening

When making the cervical cancer screening appointment, screening providers must advise the patient of the following:

- Do not use inserts such as tampons, spermicides, vaginal medications, or lubricants 48 hours prior to Pap/pelvic examination.
- Do not douche 48 hours prior cervical cancer screening/pelvic examination.
- Do not have intercourse 48 hours prior to cervical cancer screening/pelvic examination.
- Do not undergo cervical cancer screening/pelvic examination while menstruating.

7.10 Pap/HPV Test

Providers should perform cervical cancer screening tests on eligible WVBCCSP patients at appropriate intervals in accordance with the American Society for Colposcopy and Cervical Pathology (ASCCP) 2019 Updated Screening Guidelines for the Prevention and Early Detection of Cervical Cancer. [Guidelines - ASCCP](#)

Approved providers of cervical cancer screening tests are physicians, physician assistants, nurse practitioners, and certified nurse midwives. The date that the screening test was performed must be documented in the patient's medical record along with any pertinent comments concerning the screening test. Documentation is required on the Patient Data Form (Y106) and on the clinic's medical record. The screening provider must also maintain a cervical cancer screening test results tracking system. This must include whether testing was self-collected or clinician collected. Refer to Section 7.11 in this manual.

Note: The patient's prior screening test date must be documented on the Patient Data Form (Y106). Partial and estimated dates are acceptable.

7.10a Laboratory Services for Pap Test

All cervical cancer screening tests must be performed by a WVBCCSP screening provider and submitted to the contracted cytology lab for reimbursement to occur. Follow the guidelines for appropriately completing the cytology lab submissions to ensure that the WVBCCSP can be appropriately billed.

7.10b Pap Test Protocol for Post-Hysterectomy Patients

The need for a Pap test following a hysterectomy depends on the reasons for the surgery and the type of procedure done:

- If the cervix was not removed (partial hysterectomy): Pap tests will be reimbursed according to the (ASCCP) 2018 updated Screening Guidelines for Prevention and Early Detection of Cervical Cancer.
- If the cervix was removed (total hysterectomy) due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer: Pap tests will be reimbursed annually.
- If the cervix was removed completely for other reasons, screening will not be reimbursed.

- If it is unknown if the cervix is present, a pelvic exam may be performed to verify the presence of a cervix.

7.11 HPV Self-Collection

Use of self-collected vaginal specimens for primary HPV screening is an effective approach to expanding access to cervical cancer screening. Self-collection may reduce barriers at the patient level, clinician level, and system level. Patients should be provided with education regarding follow up testing and have a clear understanding of the need for follow up testing if HPV results are abnormal.

HPV self-collection is an option for women who are eligible for primary HPV screening only. Clinician collected cervical specimens are preferred, however self-collected vaginal specimens are an acceptable option for Primary HPV testing. The test collects a sample from the vaginal wall and is not a Pap Smear.

7.11a Eligibility for HPV Self-Collection

For the patient to be eligible for HPV self-collection, she should meet the following criteria:

- Unable to have or does not want a pelvic examination.
- Be at average risk for cervical cancer.
- Asymptomatic.
- Has no abnormal bleeding or discharge.
- Not Immunosuppressed.
- No recent abnormal Pap results*.
- Agreeable to return for further testing if results are abnormal.

*Adequate negative prior screening results are defined as three consecutive negative cytology results or two consecutive negative co-tests within the previous ten (10) years, with the most recent test performed within the past five (5) years.

7.11b Collection Process

- A provider order is required for the test.
- The self-collection kit used must be FDA approved for HPV screening self-collection and provided by WVBCSP.
- Sample must be collected in a health care setting, such as a clinic.
- Educate the patient about the need to follow up with the clinic for additional testing if results are abnormal.
- Provide the patient with the collection supplies along with directions on how to perform the test.
- Once collected, the patient will return the sample to clinic staff.

7.11c Lab processing

All cervical cancer screening tests must be performed by a WVBCCSP screening provider and submitted to the contracted cytology lab for reimbursement to occur. The lab will bill for specimen processing.

7.12 Follow-up Guidelines for Liquid-based Pap Test and HPV Results

The WVBCCSP follows the 2019 ASCCP Risk Based Management Guidelines, which are used for reporting cervical cytological findings and for follow up of abnormal results. If HPV self-collection is normal, a repeat test should be performed in three years.

If an abnormal Pap test/HPV is obtained at any time, refer to the 2019 Updated ASCCP Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors for follow-up of the abnormal Pap test/HPV result. The guidelines can be accessed at [ASCCP 2019 Risk Based Management - ASCCP](#).

7.13 Normal Pap/HPV Screening Results

The patient must be notified that her results are normal within seven (7) days of receipt of results. The patient must be advised of the recommended time to have her next screening test, according to 2018 ASCCP Screening Guidelines.

7.14 Abnormal Screening Results

If the screening test results are abnormal, it is the responsibility of the screening provider to provide the appropriate follow-up/referral.

- Notify the patient of the findings and recommendations within seven (7) days of receipt of an abnormal screening test result.
- Make an appointment for the patient to return to the clinic to discuss:
 - The screening test results.
 - Treatment and follow up options.
 - Future medical care.
 - Available assistance from the WVBCCSP for diagnostic/treatment services.

Engage in the Lost to Follow-Up Protocol if unable to reach the patient. See section 7.18 for Lost to Follow-Up Protocol.

7.15 Cervical Cancer Screening Test Tracking

7.15a Screening Provider's responsibilities:

- Maintain frequency of screens and notify the patients as screens become due.
- All test reports must be reviewed and the results entered into the clinic's screening test log and into each patient's medical record.
- Track self-collected vs clinician collected samples.
- All patients must be notified of their results within seven (7) days of receipt of results.
- Send testing results to WVBCCSP via mail or fax.

7.15b Screening Tracking

The screening provider must maintain the Cervical Cancer Screening Activity Log (Y112) or a tracking log of the provider's choice, as a record of patients receiving tests. The system must ensure:

- A report of results has been received from WVBCCSP contracted laboratory.
- The patient was notified.
- Appropriate treatment/follow-up was scheduled.

7.16 Colposcopy

7.16a Colposcopy Referral

When a WVBCCSP patient is referred to colposcopy services, the screening provider should complete a Referral Form (Y202) and send a copy of the Referral Form and Client Enrollment to the colposcopy provider. The original WVBCCSP forms should be maintained in the patient's record. A copy of the Client Enrollment Form and Referral Form will be provided to the patient with instructions to take to the referral appointment.

A copy of the Client Enrollment Form and BCCSP Referral Form is required to be sent to WVBCCSP **within 7 days** of the visit with the screening provider.

7.16b Gynecologic Consults for Colposcopy

The WVBCCSP will cover one pre-procedure visit with the performing provider. When the provider performs a colposcopy with biopsy, the follow-up visit to discuss the results of the biopsy and the fee for this visit is included in the cost of the original procedure as per the global CPT code.

7.16c Colposcopy Reimbursement

The WVBCCSP is limited by federal law from paying an amount for services that exceeds the amount that would be paid under Part B of Medicare. The WVBCCSP will reimburse for two (2) cervical biopsies and one endocervical curettage per colposcopy.

7.16d Colposcopy Referral

Family Planning Clients 21 years old and above

When a Family Planning Program patient meets the WVBCCSP protocol for a colposcopy referral (see Section III, Eligibility Guidelines), the patient must be 21 years of age and older with Pap test results in the previous 6 months of ASC-H, AGC, Adenocarcinoma, HSIL or Squamous Cell Carcinoma. The patient must also be enrolled in the WVBCCSP, which includes completion of the following forms:

- Patient Data Form (Y106).
- Mark Referral for Enrollment or Referral for Previously Enrolled in the visit type section.
- Client Enrollment Form (Y104).

- A copy of the screening test report must be submitted with the Client Enrollment Form (Y104).
- Medical History Form (Y108); if a facility captures the information on the Medical History form in a different format, the provider may submit the information to WVBCCSP in this format in lieu of Y108.
- Referral Form (Y202).

7.16e Colposcopy Tracking and Follow-Up

Follow-up Pap tests after colposcopy must be performed at the referring screening provider site in accordance with 2019 ASCCP Consensus Guidelines. Maintenance of a colposcopy tracking log is imperative to facilitate appropriate follow-up and tracking of WVBCCSP patients. Screening providers must complete the Colposcopy Activity Log (Y113) or a tracking log of the provider's choice for patients referred for colposcopy screening.

The log system must demonstrate that:

- The patient has kept her referral appointment for colposcopy.
- A report of diagnosis has been received.
- Appropriate follow-up was scheduled.

7.16f Colposcopy Pathology Report

The colposcopy provider must submit a copy of the pathology report to the WVBCCSP and the screening provider. The Screening provider must contact the colposcopy provider if a result is not received within fourteen (14) days of the appointment date.

7.16g Colposcopy Results

Upon receipt of the patient's colposcopy results, the screening provider must:

- Notify the patient of the results within 7 days.
- Schedule the patient for further management/follow-up, according to the recommendations of the physician. However, reimbursement will only be administered in accordance with the 2019 ASCCP Guidelines.
- Repeat Pap tests, following a colposcopy, must be performed by a WVBCCSP screening provider or Family Planning provider if referred into the Program for a colposcopy. WVBCCSP cannot reimburse the colposcopy provider for follow-up Pap tests.
- Assist in referral for treatment to the Diagnostic and Treatment Fund, Medicaid Treatment Act, or other available resources.
- Screening provider must notify the WVBCCSP if the patient is "Lost to Follow Up" or has "Refused" further recommended diagnostic services. This can be done by using the Case Management Referral Form or by contacting the Tracking and Follow-up Nurse. Please refer to the Lost to Follow up protocol 7.17.
- The date that the Pap test/HPV was obtained and any pertinent comments must be documented in the patient's medical record.

- Documentation is required on the Patient Data Form (Y106) and on the clinic's preferred physical examination document.
- The screening provider must also maintain a cervical cancer screening test tracking system.

7.17 Lost to Follow-Up Protocol:

- Make a minimum of three (3) patient contact attempts. The first attempt to contact the patient must be initiated within seven (7) days of receipt of the abnormal cervical cancer screening results. Contacts should be by the clinician via telephone unless the patient specified another method of notification.
- Document each attempt to contact a patient in the patient's medical record, along with the results of a successful contact.
- It is recommended to send a certified letter with a return receipt requested if unable to reach the patient after two telephone calls. A letter can be mailed via U.S. Postal Service first class mail in lieu of certified mail. The time between the receipt of abnormal screening results and mailing of the letter must not be more than six (6) weeks. The letter should communicate that this will be the last effort made to contact the patient.
- All written correspondence with the program participant should be easily understandable, using non-alarming language, and emphasize the importance of the patient contacting the screening provider for further information and follow-up. The patient should be given a specific contact person and time to call. The time between the receipt of test results and the mailing of the letter must not be more than six (6) weeks. The letter should communicate that this will be the last effort made to contact the patient.
- Document in the patient's medical record when attempts at contacting a patient are terminated. This is when the patient can be marked as Lost to Follow-Up.
- Notify the WVBCCSP if the patient is "Lost to Follow-up" or has "Refused" further recommended diagnostic services. This can be done using the Case Management Referral form or by contacting WVBCCSP. When calling the program, please provide dates of patient contact attempts.
- A participant is marked "Lost to Follow-Up" two weeks after the letter has been mailed with no response from the participant.

7.18 Cervical Cancer Rescreening: Introduction

Although one screening test may be useful to identify existing cancerous conditions, screening lowers mortality from cervical cancer more effectively if performed at regular intervals. Therefore, a primary objective of the WVBCCSP is to ensure that women are provided cervical cancer screening tests at regular intervals following their initial screening examinations. WVBCCSP providers are required to follow a rescreening policy to ensure that patients requiring annual rescreening return as recommended. The Program has established

screening intervals for cervical cancer screening (2018 ASCCP Pap Guidelines). Providers must follow Program eligibility guidelines as they implement the rescreening policy.

7.19 Rescreening Reminder System

Providers must implement a reminder system for rescreening to facilitate the return of women for their annual rescreening visit. The reminder system should be systematic, comprehensive, capturing both mammography and cervical cancer screening and applied consistently using acceptable clinical practices and Program policies. Providers must include one or a combination of the following tools as part of their reminder system:

- Logbooks documenting specific women who are due for their annual rescreening and indication that they were reminded.
- Tickler file with appointment cards for women who are due for rescreening.
- Computerized reminder programs.
- Chart stickers documenting counseling.

As an aspect of the reminder system, providers must implement the following to comply with the rescreening policy:

- Utilize a rescreening log as part of the reminder system for rescreening and as documentation that a woman was reminded.
- Contact the patient by mail or telephone one (1) to two (2) months prior to their annual rescreening date.
- Determine eligibility for rescreening AND schedule their appointment.
- Provide Pre-Clinic Client Preparation Instructions for Pap Tests if appropriate (See section 7.9 of this manual for Pre-clinic instruction guidelines).

7.20 Ordering Forms and Lab Supplies

All required forms and documents are located on the WVBCCSP website at www.wvdhhr.org/bccsp. Providers should order all WVBCCSP supplies by using the Supply Request Form. Forms can be found on the website. If hard copies of the forms are needed, please contact BCCSP directly.

WVBCCSP providers should contact the laboratory they have contracted to process Pap/HPV testing to obtain all supplies necessary for the collection of Pap tests.

These supplies include:

- Laboratory forms
- Shipping supplies
- Liquid-based Pap collection materials

SECTION VIII - SCREENING PROVIDER INVOICING and REIMBURSEMENT

8.1 General Billing Information

Acute care visits are NOT reimbursable.

- The only Ultrasound covered is "Ultrasound of Breast and/or axilla."
- The only MRI covered is unilateral or bilateral of the breast(s). Coverage is dependent on prior authorization from the program.
- Only WVBCCSP approved codes for program eligible women are covered. See payment fee schedule for reimbursement rates.
- WVBCCSP is always the payor of last resort.
- Participating providers may not balance bill the patient.
- Two (2) breast surgeon consultations per breast problem per year, unless prior approved by program.
- Bill WVBCCSP within 60 days of the date the service was performed.
- Reimbursement rates as well as CPT codes for all visit types are listed on the Batch Invoice. The Batch Invoice form is for use by *Screening* Providers only.

The Payment Fee Schedule is updated on an annual basis. The most current version, along with the previous year's form, is available on the WVBCCSP web site.

Federal law requires that providers who impose a charge for services must utilize a schedule of charges that is adjusted to reflect the income of the household. The law prohibits providers from charging a fee to any woman with an income less than 150% of the current FPL. Based on state Program guidelines, patients of the WVBCCSP whose income is at or below 250% of the FPL are not charged a fee for services. WVBCCSP funds are to be used as a last resort for payment. A patient may have medical insurance and still qualify as a participant of the Program if her income is below 250% of the FPL. In this instance, third parties must be billed prior to billing WVBCCSP. The provider must accept the patient's verbal statement of gross monthly or yearly income. Documentation or verification of income is not required. Per federal guidelines, the program can only reimburse up to the allowable Medicare rate. A copy of the results narrative report of radiologic findings of each patient's mammography/breast ultrasound must accompany the invoice submitted to the Program for payment to be made.

8.2 Underinsured Patients

A patient who meets the income guidelines of the Program is considered underinsured and eligible for Program services when she:

- Has private medical insurance that does not cover WVBCCSP services.
- Has a required deductible or co-payment that represents a deterrent to receipt of breast and cervical cancer screening services. Refer to Department of Human Services WV Income Maintenance Manual Chapter 22, Appendix A.

If a private insurance company provides coverage for WVBCCSP services, the insurance company must be billed prior to billing WVBCCSP. The program may pay additional costs if the total amount paid by all payors, does not exceed allowable Medicare rates. If there is a balance remaining after insurance and WVBSSCP has paid the claim, the balance may be billed to the patient.

8.3 Batch Invoicing Procedures

Invoice WVBCCSP for screening services for income eligible patients including those who are underinsured. WVBCCSP reimbursement for Screening Providers is based upon the visit type provided. The visit types are as follows:

- Initial Screening visit
- Annual Routine visit for breast *and* cervical
- Annual Breast *or* Cervical visit
- Repeat Pap or CBE
- Referral for Enrollment visit
- Referral for Previously Enrolled visit

8.4 WVBCCSP Billing Forms

8.4a Client Enrollment-Consent Form

Screening Providers must submit a completed Client Enrollment-Release of Information and Statement of Confidentiality Form (Y104) within one (1) week of the enrollment visit. Patient information is not entered into the payment system until this form is received by the Program. Therefore, invoices cannot be processed until WVBCCSP receives this form. Services should not be provided prior to the patient signing the Client Enrollment form. Providing these forms is necessary for reimbursement of cytology and referring provider services. All data elements must be recorded the Program forms in their entirety. The provider must complete client enrollment form annually.

8.4b Batch Invoice Form

The Batch Invoice form bills for screening services for multiple patients. Program reimbursement is dependent upon the visit type. The Batch Invoice form is updated on an annual basis. The most current version and previous fiscal year version is available on the WVBCCSP web site in a PDF and Excel version. The Excel sheet will automatically calculate all fields. The PDF version does not have the ability to automatically calculate the data, requiring staff to manually enter all data fields. Please choose the appropriate format based on your clinic's needs, while keeping in mind that the PDF version may increase data entry errors resulting in returned claims and delayed payments. The form should be completed electronically, not handwritten, and in its entirety. The only exception is the "wet" signature. A wet signature is a handwritten signature applied directly to a physical document using **BLUE INK**. The original Batch Invoice must be submitted with the Patient

Data form to the Program. Ensure that the form is completed in its entirety and the vendor (clinic) name is correct based on the WV Oasis (payment platform).

8.4c Patient Data form

A Patient Data form must be completed and attached to the Batch Invoice form for every visit that the Screening Provider submits for reimbursement. Only one visit type should be marked on the Patient Data form. Do not submit the Patient Data form until the HPV/Pap test results are recorded on the form.

- Complete Batch Invoice forms accurately with all required information, dated and signed by the provider or authorized representative including the signee's/provider's title.
- Submit the original Patient Data form (Y106) with Batch Invoice form (Y502) to the WBCCSP for payment WITHIN 60 DAYS OF THE DATE OF SERVICE.
- Check for accuracy of the BCCSP Number.
- Submit all claims within 60 days of expiration of screening providers MOU.
- Non-compliance from this established policy may result in the claim not being accepted.

NOTE: All invoices for services rendered up to and including June 29 of the fiscal year must be submitted by August 31 of the same year. If the invoices are not received by August 31 of the same year, they will be returned unpaid.

SECTION IX - CASE MANAGEMENT & THE MEDICAID TREATMENT ACT

9.1 Purpose of the Medicaid Treatment Act (MTA)

West Virginia was one of the first states to take advantage of the implementation of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA), Public Law 106-354. This law authorized each State to extend Medicaid eligibility and full Medicaid benefits to otherwise uninsured women under age 65 who are identified through the NBCCEDP Grantee (WVBCCSP) as being in need of treatment for breast or cervical cancer, including pre-cancerous conditions.

West Virginia Medicaid provides full benefit coverage to women or men diagnosed with breast and/or cervical cancer, including pre-cancerous conditions, who meet the following eligibility guidelines.

9.2 Eligibility Guidelines

- Must be a West Virginia resident.
- Must be 64 years old or younger.
- Must be enrolled in the WVBCCSP, but does not have to meet income guidelines.
- There are no income or asset tests for this special population of women to receive Medicaid per Legislation.
- Must need and receive ACTIVE treatment for breast and/or cervical cancer or eligible pre-cancerous conditions (breast or cervix must be primary site of cancer). Refer to Section 9.3, MTA Eligible Diagnoses.
- Must be uninsured or without credible insurance coverage as determined by Medicaid.
- Not eligible for any other type of Medicaid coverage.

9.3 MTA Eligible Diagnoses

- Breast or Cervical Cancer
- Pre-Cancerous Breast found on excisional biopsy
- Atypical Ductal Hyperplasia
- Pre-Cancerous Cervical (based on Colposcopy result, not Pap test) *
- CIN I, II, III; CIS, LSIL, HSIL
- Atypical Glandular cells (cervical only, endometrial and uterine are not eligible)
- Squamous cell carcinoma
- Adenocarcinoma

Note: *Pap test results do not qualify a woman for MTA enrollment.

9.4 Screening Provider Responsibility for MTA Referral

When a West Virginia woman has been diagnosed with breast or cervical cancer, including a pre-cancerous condition as listed above and meets the eligibility guidelines for MTA, the screening provider will:

- Enroll the client in WVBCCSP, if not previously enrolled.
- Provide the applicant with a CDC Certificate of Diagnosis form to be completed by the diagnosing physician with an eligible diagnosis. The BCCSP Screening Provider may complete the CDC Certificate of Diagnosis if unable to obtain from referral provider.
- Provide the applicant with the BCC Medicaid Application (DFA-BCC-I).
- Submit the completed CDC Certificate and BCC Medicaid Application to the WVBCCSP Case Management Nurse. This can be submitted by either the screening provider or the applicant to expedite the process.

Send the following forms to the WVBCCSP Case Management Nurse:

- Completed Medicaid Application form (DFA-BCC-1)
- Signed CDC Certificate of Diagnosis (COD) for Medicaid Coverage/Eligibility

WVBCCSP

BCC Case Manager

350 Capitol Street, Room 427

Charleston, West Virginia 25301-3714

Fax (304)558-7164

Client Enrollment Visit for MTA:

The screening provider is responsible for completing BCCSP Enrollment Documentation. This is a billable service and is reimbursed on the Monthly Batch Invoice Form as "referral for MTA". The provider must submit the following forms:

- Client Enrollment Form
- Patient Data Form
- Batch Invoice Form
- Send the WVBCCSP Client Enrollment and Patient Data Forms as soon as possible to avoid delays in the MTA enrollment process. The Batch Invoice form can be submitted with the monthly billing.

Note: A woman diagnosed by a provider who does not participate in the WVBCCSP must be referred to a WVBCCSP screening provider for enrollment.

9.5 WV Department of Human Services Responsibility (DoHS)

DoHS is required to:

- Verify that the participant has a CDC Certificate of Diagnosis and BCC Medicaid application.
- Verify age (21-64 years).
- Verify applicant has no credible insurance.
- Verify applicant is a West Virginia resident.
- Evaluate for other Mandatory Medicaid categories.

Note: Proof of income is required by DoHS for full Medicaid evaluation.

9.6 MTA Confirmation

Most applicants receive immediate confirmation of their application and are eligible for coverage of their treatment as follows:

- A Medicaid card is sent by mail within seven (7) to ten (10) days.
- Coverage begins the first day of the month in which the diagnosis was made.
- Coverage begins up to three (3) months retroactively for women who are eligible based on the date of diagnosis.

Coverage continues for the patient until active treatment ends as determined by the treating physician(s) and/or Medicaid Medical Director.

9.7 WVBCCSP Case Management Responsibilities

The WVBCCSP Case Management Nurse works with the DoHS to enroll the applicant by ensuring that all documents required for eligibility are provided to DoHS.

WVBCCSP forwards the DFA-BCC-1, CDC COD, and letter of eligibility to applicant's local DoHS office.

Once the WVBCCSP receives notification from the DoHS of the applicant's enrollment, the BCC Case Management Nurse will:

- Complete a needs assessment with the patient.
- Obtain pathology reports.
- Confirm active treatment with physician documentation.
- Follow up with participants during treatment to assess needs and help in overcoming barriers to care.
- Disenroll from MTA after active treatment has been completed with physician verification.
- Encourage the woman to return to the WVBCCSP screening provider.

9.8 Questions Regarding MTA

Questions about patient eligibility or enrollment into the MTA should be directed to:

WVBCC Case Management Nurse

350 Capitol Street, Room 427

Charleston, West Virginia 25301-3714

Telephone: 304-558-5388 Toll Free: 1-800-642-8522

9.9 Medicaid Citizenship and Identity Requirements

Effective July 1, 2006, all Medicaid applicants or recipients must provide proof documents to verify identity and U.S. citizenship before receiving Medicaid benefits. For a list of acceptable Proof of Identity and U.S. Citizenship documents, please visit [Your Guide to Medicaid](#) or contact your county DoHS office.

All applicants and recipients must be given a reasonable opportunity to provide documents to establish U.S. citizenship or nationality and identity. Current recipients continue to receive benefits until determined ineligible. Medicaid is closed only after the recipient is given a reasonable opportunity to present evidence or fails to make a good faith effort to provide proof. Applicants are not approved until the required verification is supplied. For assistance, contact your local Department of Human Services office or call 1-800-642-8589.

SECTION X - QUALITY ASSURANCE

10.1 Introduction

Quality Assurance is essential if the early detection of breast and cervical cancer is to be an effective tool for controlling cancer. Assuring quality requires that all providers of clinical services, laboratories, program staff, advisory boards, partners, and educators are committed to following the WVBCCSP policies and procedures.

10.2 What is meant by Quality Assurance?

Quality Assurance is a continuous process of monitoring, assessing, and improving defined by the following subcategories:

10.2a Breast

Programs will ensure the quality of any screening procedure for breast cancer and in the case of mammography, will require American College of Radiology (ACR) accreditation. Programs must meet requirements of Public Law 102-539. Certification under requirements of the Mammography Quality Standards Act (MQSA) final rule 2023 and updated on September 10, 2024. The most recent updated version can be found at <https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-mqsa-and-mqsa-program>

10.2b Cervical

Programs will ensure the quality of any screening procedure for cervical cancer HPV and Pap Test will require Clinical Laboratory Improvement Amendments (CLIA) of 1988. The most recent CLIA updates can be found at <https://www.cdc.gov/clia/php/about/index.html>.

10.2c Provider Practice

Programs will ensure the quality of screening services by health care providers participating in the program through routine reviews and audits.

10.3 Clinical Services

10.3a Screening Provider

Screening providers must comply with the WVBCCSP protocols for screening, follow-up, and reporting. Providers must ensure that:

- Clinicians are appropriately qualified; refer to Section IV (4.1) Provider Qualifications and Responsibilities, for general qualifications.
- All basic components are included in the screening examination and documented in the patient's medical record.
- Appropriate confidential patient records are maintained.
- Patients are systematically identified and tracked to assure timely follow-up and/or referrals.
- All results of further diagnostic screenings/procedures are reported to the WVBCCSP.
- Patients are notified when they are due to return for a recommended screening.

10.3b Cytopathology (Pap test) Contracted Laboratory

All WVBCCSP Liquid-based Pap and HPV testing must be sent to the contracted laboratory for cytopathology screening services.

10.4 Monitoring

The screening provider agrees that a program and facility review may be conducted at any reasonable time by State and Federal personnel and other persons duly authorized by the Bureau for Public Health, including the OMC FH Quality Assurance Monitoring Team. All quality assurance monitoring reviews will be scheduled at least 30 days in advance but may be scheduled sooner if amenable to provider schedules. When scheduling a monitoring review with the screening provider clinic, the Quality Assurance Monitoring Team will provide a detailed letter describing the process prior to the visit.

Such review may include, but is not limited to:

- Meetings with consumers.
- Review of medical records.
- Review of service policies and procedures.
- Review of staffing ratios and job descriptions.
- Meetings with any staff directly or indirectly involved in the provision of services.
- Observation of program clinical examination.
- Review of facility accommodation and safety measures.

10.5 On-Site Reviews

The screening provider agrees to on-site reviews from OMC FH staff of all patient records and Program information as it relates to the terms of the program contract. The OMC FH monitoring team will be given access to all information necessary and permitted to observe WVBCCSP examinations to ensure that patient care standards are met and that services are provided in accordance with the WVBCCSP policies.

10.6 Technical Assistance

All technical assistance needs that are identified as a result of the monitoring review will be followed up by Program staff. The WVBCCSP staff are responsible to assist the provider in meeting all expectations of the contract agreement. **Please note, monitors do not interpret report findings nor provide technical assistance to the provider staff.**

10.7 Policy Clinical Guidance

The WVBCCSP Medical Director provides clinical and administrative oversight to ensure the program meets quality assurance standards consistent with the NBCCEDP. The Medical Advisory Committee, composed of a multidisciplinary team of physicians, nurses, and other healthcare professionals from various specialties, support this effort. This committee is consulted on program policy changes and revisions as needed.

For additional information regarding quality assurance monitoring, refer to the “Quality Assurance Monitoring Guidelines”.

SECTION XI- PUBLIC EDUCATION & TARGETED OUTREACH

11.1 Purpose

The purpose of public education and targeted outreach activities is to increase screening rates among WVBCSP's priority populations and to raise awareness of breast and cervical cancer prevention throughout the broader community. The goal is to reduce mortality and morbidity from these cancers through timely detection and early intervention.

11.1a Education

These activities aim to:

- Increase women's knowledge, skills, and motivation to pursue recommended screenings.
- Educate women on screening and follow-up processes to improve adherence to clinical guidelines.
- Enhance women's ability to identify and access WVBCSP-affiliated screening services.
- Disseminate culturally sensitive, easy-to-understand, and age-appropriate educational materials through traditional outlets and digital platforms, including social media.

11.1b Community Outreach

Public and community education is important, but not sufficient. Outreach efforts must be intentionally linked to screening services to ensure that women move from awareness to action. It is the responsibility of the WVBCSP community outreach liaisons to design and implement outreach strategies that incorporate clear pathways for scheduling appointments, addressing barriers to care (e.g., transportation, childcare, health literacy), and supporting follow-up efforts. Providers are strongly encouraged to collaborate with their regional community outreach specialists to develop outreach campaigns that include specific protocols for connecting women directly to participating WVBCSP clinics. This includes having scheduling systems or referral processes in place during community events. Handing out brochures is not enough. Outreach must serve as an active bridge to clinical services to ensure women receive the full continuum of breast and cervical cancer screening and follow-up care.

All community events supported by WVBCSP should include structured clinic linkages and documented procedures to facilitate appointment scheduling and ongoing patient engagement.

11.2 Priority Populations

Education and outreach campaigns should promote the importance of breast and cervical cancer screening for all women in West Virginia and encourage participation in WVBCSP screening services. While the program is available to all eligible women, additional outreach may focus on women who may be less likely to receive regular screenings due to factors such as income, geographic location, or limited access to healthcare.

This includes women with household incomes at or below 250% of the Federal Poverty Level and those who have never been screened for cervical cancer. This may also include those living in rural or medically underserved areas. WVBCCSP may also identify other groups of women based on screening data and tailor outreach efforts to increase awareness and participation among those populations.

The program is committed to supporting screening efforts across the state and ensuring that all eligible women can receive timely breast and cervical cancer screening and necessary follow-up services.

11.3 Screening Provider Responsibilities

11.3a Staff and Agency Training

The WVBCCSP staff are available to train providers and clinic staff. Training sessions include:

- Technical Assistance (guidelines, forms completion, and billing).
- Referral process and tracking guidelines.
- Review of educational materials available to help inform women about good breast and cervical health.
- Discussion of community outreach strategies.

The WVBCCSP provider clinics should ensure that all staff and providers working with the WVBCCSP attend the training session annually per program requirements.

11.3b Patient Education

All providers MUST educate WVBCCSP women about breast and cervical health at the patient's initial and annual visits. The purpose of education is to inform patients about the importance of routine screening, help them understand the procedures involved, and encourage adherence to recommended guidelines for breast and cervical cancer screening. Education should also emphasize the importance of timely follow-up if abnormal results are found; including the need for diagnostic testing or additional evaluation. Providers must ensure that women understand both the screening process and the next steps in care if an abnormal result occurs. All patient education must be clearly documented in the medical record. Education should also be provided in lay terms that the patient can comprehend.

11.4 Public Education and Media Campaigns

All public education messages and media campaigns should be designed in collaboration with the WVBCCSP Community Outreach Liaisons. These WVBCCSP staff members assist providers with the development of advertisements, public service announcements, social media posts, special interest stories, and press releases. All messages that appear in the media should:

- Promote the benefits of early detection of breast and cervical cancer.
- Prioritize low income and never or rarely screened.

11.5 Community Outreach Plan

Screening providers should develop an outreach plan to disseminate information about breast and cervical cancer screening and the importance of early detection to the women in their community. These plans should emphasize population-based screening, as well as recruiting WVBCCSP eligible women. Providers are encouraged to work with the Community Outreach Liaison to develop and implement a Community Outreach Plan.

11.5a Community Linkages for Outreach Events

Community outreach is most effective when it is directly linked to clinical services, ensuring that women move from education and awareness to actual screening and follow-up care. Outreach events should be designed not only to inform but to actively connect women to WVBCCSP screening services. Every outreach event is an opportunity to remove barriers, create trust, and facilitate access to breast and cervical cancer screening.

To support strong clinic-community connections, providers and their outreach partners should implement protocols and tools that guide women toward timely screening appointments and appropriate follow-up care.

Core Principles for Clinic-Community Linkages:

- Outreach should never stand alone. Linkages must be built into event design.
- Staff conducting outreach must be trained on how to refer women to screening services.
- Protocols must be in place to document and follow up on each interaction that leads to a referral.

Recommended Strategies and Best Practices:

1. Designate a Point of Contact at the Clinic

Each clinic should identify a Community Linkage Coordinator, Patient Navigator, or Front Office Staff Member responsible for:

- Accepting referrals from outreach events.
- Reaching out to women to schedule appointments.
- Tracking follow-up actions and ensuring women attend their screenings.
- This person should work closely with the WVBCCSP Community Outreach Liaison to stay informed about upcoming events and outreach plans.

2. Create a Standardized Referral Form

The WVBCCSP has created a simple, standardized referral form for outreach events. This includes:

- Patient name and preferred contact information
- Patient demographics
- Type of screening needed (breast, cervical, or both)
- Preferred clinic (if applicable)
- Health insurance and income level (to determine WVBCCSP eligibility)

3. Integrate with the WV Connections FindHelp Platform

Clinics can register on the WV Connections resource platform <https://wvconnections.findhelp.com/> and set up an agency profile to accept and respond to electronic referrals from WVBCCSP outreach staff. Outreach staff can search for participating WVBCCSP clinics within WV Connections and submit referrals directly through the platform. WV Connections can help locate social service resources to assist with any barriers to care.

4. Offer On-Site Scheduling or Pre-Registration

At community events, staff should be equipped to:

- Schedule screening appointments on-site using clinic scheduling systems.
- Pre-register women and collect intake information to expedite their clinic visit.
- Provide printed appointment cards or reminder texts.

5. Use Patient Navigators or Peer Educators

If available, patient navigators can:

- Attend outreach events to answer questions and explain the screening process.
- Provide one-on-one follow-up support to referred women.
- Help women coordinate appointments, diagnostic testing, and follow-up.
- Clinics can also train peer educators or volunteers to serve as ambassadors during events and reinforce trust in clinic services.

6. Track and Monitor Referrals

Clinics should work with the WVBCCSP Outreach Liaison and Epidemiologist to develop a referral log or tracking sheet to monitor:

- How many women were referred from each event.
- How many scheduled an appointment.
- How many completed screening.

7. Include Follow-Up Protocols

After an outreach event, the designated clinic contact should:

- Call referred women within 3–5 business days.
- Make at least three attempts to reach each referred woman.
- Document outcomes (scheduled, not interested, unreachable, needs rescheduling).
- Notify the outreach team of completed appointments and any unresolved issues.

Examples of Community Linkage Activities:

- Health Fair Partnership: Set up a laptop or tablet at your booth to schedule screening appointments on the spot. Include a patient navigator to explain next steps.
- Church Outreach: Provide referral slips to attendees and collect them at the end of service. Have a clinic representative follow up with a call that week.
- Back-to-School Events: Work with school nurses or family resource centers to promote WVBCCSP services to parents and caregivers.

- Mobile Screening Units: Schedule mammogram van days in coordination with large outreach events and refer women directly to the mobile unit.

11.6 Community Organizations

To educate, reach and recruit women for screening, providers should consider partnering with local community organizations. Examples of potential partners include:

- Faith-based organizations, churches, women's/men's groups, youth groups, church associations
- Food distribution sites-such as food pantries and food banks
- Local Department of Health and Department of Human Services
- Local YWCA/YMCA/Salvation Army/Goodwill/Mountain Mission
- Community Educational Outreach Services (formerly WV Extension Homemakers)
- Optometrists, dentists, primary care providers
- Hospitals
- Local businesses
- Public housing facilities
- Public schools, Head Start parents/grandparents
- Community Action groups
- Women's shelters, homeless shelters
- Quilt guilds
- General Federation of Women's Clubs
- VIN Medical Alliance Chapters
- Public libraries
- Neighborhood post offices, fire departments, volunteer fire departments
- Cosmetology schools, hairdressers/barbers, nail technicians.
- Adult female detention centers

Appendix A

Public Law

Public Law 101-354
101st Congress

An Act

To amend the Public Health Service Act to establish a program of grants for the detection and control of breast and cervical cancer.

Aug. 10, 1990
[H.R. 4790]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Breast and
Cervical Cancer
Mortality
Prevention Act
of 1990.
42 USC 201 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast and Cervical Cancer Mortality Prevention Act of 1990".

SEC. 2. ESTABLISHMENT OF PROGRAM OF GRANTS TO STATES FOR PREVENTION AND CONTROL OF BREAST AND CERVICAL CANCER.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after title XIV the following new title:

"TITLE XV—PREVENTIVE HEALTH MEASURES WITH RESPECT TO BREAST AND CERVICAL CANCERS

"SEC. 1501. ESTABLISHMENT OF PROGRAM OF GRANTS TO STATES.

42 USC 300k.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs—

"(1) to screen women for breast and cervical cancer as a preventive health measure;

"(2) to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services;

"(3) to develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;

"(4) to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer;

"(5) to establish mechanisms through which the States can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; and

"(6) to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

"(b) GRANT AND CONTRACT AUTHORITY OF STATES.—A State receiving a grant under subsection (a) may expend the grant to carry out

the purpose described in such subsection through grants to, and contracts with, public or nonprofit private entities.

42 USC 300f.

"SEC. 1502. REQUIREMENT OF MATCHING FUNDS.

"(a) **IN GENERAL.**—The Secretary may not make a grant under section 1501 unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such section, to make available non-Federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than \$1 for each \$3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

"(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—

"(1) **IN GENERAL.**—Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(2) **MAINTENANCE OF EFFORT.**—In making a determination of the amount of non-Federal contributions for purposes of subsection (a), the Secretary may include only non-Federal contributions in excess of the average amount of non-Federal contributions made by the State involved toward the purpose described in section 1501 for the 2-year period preceding the first fiscal year for which the State is applying to receive a grant under such section.

"(3) **INCLUSION OF RELEVANT NON-FEDERAL CONTRIBUTIONS FOR MEDICAID.**—In making a determination of the amount of non-Federal contributions for purposes of subsection (a), the Secretary shall, subject to paragraphs (1) and (2) of this subsection, include any non-Federal amounts expended pursuant to title XIX of the Social Security Act by the State involved toward the purpose described in paragraphs (1) and (2) of section 1501(a).

42 USC 300m.

"SEC. 1503. REQUIREMENTS WITH RESPECT TO TYPE AND QUALITY OF SERVICES.

"(a) **REQUIREMENT OF PROVISION OF ALL SERVICES BY DATE CERTAIN.**—The Secretary may not make a grant under section 1501 unless the State involved agrees—

"(1) to ensure that, initially and throughout the period during which amounts are received pursuant to the grant, not less than 60 percent of the grant is expended to provide each of the services or activities described in paragraphs (1) and (2) of section 1501(a), including making available screening procedures for both breast and cervical cancers;

"(2) subject to subsection (b), to ensure that—

"(A) in the case of breast cancer, both a physical examination of the breasts and the screening procedure known as a mammography are conducted; and

"(B) in the case of cervical cancer, both a pelvic examination and the screening procedure known as a pap smear are conducted;

"(3) to ensure that, by the end of any second fiscal year of payments pursuant to the grant, each of the services or activities described in section 1501(a) is provided; and

"(4) to ensure that not more than 40 percent of the grant is expended to provide the services or activities described in paragraphs (3) through (6) of such section.

"(b) **USE OF IMPROVED SCREENING PROCEDURES.**—The Secretary may not make a grant under section 1501 unless the State involved agrees that, if any screening procedure superior to a procedure described in subsection (a)(2) becomes commonly available and is recommended for use, any entity providing screening procedures pursuant to the grant will utilize the superior procedure rather than the procedure described in such subsection.

"(c) **QUALITY ASSURANCE REGARDING SCREENING FOR BREAST CANCER.**—The Secretary may not make a grant under section 1501 unless the State involved agrees that the State will assure the quality of any screening procedure for breast cancer conducted pursuant to such section and, in the case of mammography, will provide that—

"(1) the equipment used to perform the mammography will be specifically designed for mammography and will meet appropriate radiologic standards for mammography;

"(2) the mammography will be performed by an individual who—

"(A) is licensed by a State to perform radiological procedures; or

"(B) is certified as qualified to perform radiological procedures by an appropriate organization;

"(3) the results of the mammography will be interpreted by a physician who—

"(A) is certified as qualified to interpret radiological procedures by an appropriate board; or

"(B) is certified as qualified to interpret screening mammography procedures by an appropriate program for assuring the qualifications of the individual with respect to such interpretations; and

"(4) with respect to the first screening mammography performed on a woman for which payment is made pursuant to section 1501(a), there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(d) **QUALITY ASSURANCE REGARDING SCREENING FOR CERVICAL CANCER.**—The Secretary may not make a grant under section 1501 unless the State involved agrees that the State will assure the quality of any screening procedure for cervical cancer conducted pursuant to such section and, in the case of the pap smear (or other cytological screening procedure replacing the pap smear pursuant to subsection (b)), will provide—

"(1) the maximum number of cytology slides that any individual may screen in a 24-hour period;

"(2) requirements that a clinical laboratory maintain a record of—

"(A) the number of cytology slides screened during each 24-hour period by each individual who examines cytology slides for the laboratory; and

"(B) the number of hours devoted during each 24-hour period to screening cytology slides by such individual;

Records.

"(3) criteria for requiring rescreeing of cytological preparations, such as—

"(A) random rescreeing of cytology specimens determined to be in the benign category;

"(B) focused rescreeing of such preparations in high risk groups; and

"(C) for each abnormal cytological result, rescreeing of all prior cytological specimens for the patient, if available;

"(4) periodic confirmation and evaluation of the proficiency of individuals involved in screening or interpreting cytological preparations, including announced and unannounced on-site proficiency testing of such individuals, with such testing to take place, to the extent practicable, under normal working conditions;

"(5) procedures for detecting inadequately prepared slides, for assuring that no cytological diagnosis is rendered on such slides, and for notifying referring physicians of such slides;

"(6) requirements that all cytological screening be done on the premises of an appropriately qualified laboratory;

"(7) requirements for the retention of cytology slides by laboratories for appropriate periods of time; and

"(8) requirements of periodic inspection of cytology services by persons capable of evaluating the quality of cytology services.

"(e) ISSUANCE BY SECRETARY OF GUIDELINES WITH RESPECT TO QUALITY OF MAMMOGRAPHY AND CYTOLOGICAL SERVICES.—

"(1) IN GENERAL.—The Secretary shall establish guidelines for assuring the quality of any mammography and cytological screening procedure conducted pursuant to section 1501(a). Such guidelines with respect to mammography shall include the provisions of paragraphs (1) through (4) of subsection (c), and such guidelines with respect to cytological screening procedures shall include the provisions of paragraphs (1) through (8) of subsection (d).

"(2) APPLICABILITY WITH RESPECT TO GRANTS.—The Secretary may not make a grant under section 1501 unless the State involved agrees that the State will, with respect to any mammography or cytological screening procedure conducted pursuant to such section, ensure that the procedure is conducted in accordance with the guidelines issued by the Secretary under paragraph (1).

"(3) RESPONSIBILITY OF STATES IN ABSENCE OF GUIDELINES.—With respect to circumstances in which a State receives a grant under section 1501 before the issuance of guidelines under paragraph (1), this subsection may not be construed to affect in such circumstances the obligation of the State pursuant to subsection (a)(1) to provide for screening procedures and referrals or the obligations under subsections (c) and (d) with respect to providing for quality in the screening procedures.

42 USC 300n.

"SEC. 1504. ADDITIONAL REQUIRED AGREEMENTS.

"(a) PRIORITY FOR LOW-INCOME WOMEN.—The Secretary may not make a grant under section 1501 unless the State involved agrees that low-income women will be given priority in the provision of services and activities pursuant to paragraphs (1) and (2) of section 1501(a).

"(b) LIMITATION ON IMPOSITION OF FEES FOR SERVICES.—The Secretary may not make a grant under section 1501 unless the State

involved agrees that, if a charge is imposed for the provision of services or activities under the grant, such charge—

“(1) will be made according to a schedule of charges that is made available to the public;

“(2) will be adjusted to reflect the income of the woman involved; and

“(3) will not be imposed on any woman with an income of less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

“(c) STATEWIDE PROVISION OF SERVICES.—

“(1) IN GENERAL.—The Secretary may not make a grant under section 1501 unless the State involved agrees that services and activities under the grant will be made available throughout the State, including availability to members of any Indian tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act).

“(2) WAIVER.—The Secretary may waive the requirement established in paragraph (1) for a State if the Secretary determines that compliance by the State with the requirement would result in an inefficient allocation of resources with respect to carrying out the purpose described in section 1501(a).

“(d) RELATIONSHIP TO ITEMS AND SERVICES UNDER OTHER PROGRAMS.—The Secretary may not make a grant under section 1501 unless the State involved agrees that the grant will not be expended to make payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such item or service—

“(1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

“(2) by an entity that provides health services on a prepaid basis.

“(e) COORDINATION WITH OTHER BREAST AND CERVICAL CANCER PROGRAMS.—The Secretary may not make a grant under section 1501 unless the State involved agrees that the services and activities funded through the grant shall be coordinated with other Federal, State, and local breast and cervical cancer programs.

“(f) LIMITATION ON ADMINISTRATIVE EXPENSES.—The Secretary may not make a grant under section 1501 unless the State involved agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant.

“(g) RESTRICTIONS ON USE OF GRANT.—The Secretary may not make a grant under section 1501 unless the State involved agrees that the grant will not be expended to provide inpatient hospital services for any individual.

“(h) RECORDS AND AUDITS.—The Secretary may not make a grant under section 1501 unless the State involved agrees that—

“(1) the State will establish such fiscal control and fund accounting procedures as may be necessary to ensure the proper disbursal of, and accounting for, amounts received by the State under such section; and

“(2) upon request, the State will provide records maintained pursuant to paragraph (1) to the Secretary or the Comptroller of the United States for purposes of auditing the expenditures by the State of the grant.

"(i) **REPORTS TO SECRETARY.**—The Secretary may not make a grant under section 1501 unless the State involved agrees to submit to the Secretary such reports as the Secretary may require with respect to the grant.

42 USC 300n-1.

"SEC. 1505. DESCRIPTION OF INTENDED USES OF GRANT.

"The Secretary may not make a grant under section 1501 unless—

"(1) the State involved submits to the Secretary a description of the purposes for which the State intends to expend the grant;

"(2) the description identifies the populations, areas, and localities in the State with a need for the services or activities described in section 1501(a);

"(3) the description provides information relating to the services and activities to be provided, including a description of the manner in which the services and activities will be coordinated with any similar services or activities of public or nonprivate entities; and

"(4) the description provides assurances that the grant funds be used in the most cost-effective manner.

42 USC 300n-2.

"SEC. 1506. REQUIREMENT OF SUBMISSION OF APPLICATION.

"The Secretary may not make a grant under section 1501 unless an application for the grant is submitted to the Secretary, the application contains the description of intended uses required in section 1505, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this title.

42 USC 300n-3.

"SEC. 1507. TECHNICAL ASSISTANCE AND PROVISION OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.

"(a) **TECHNICAL ASSISTANCE.**—The Secretary may provide training and technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1501. The Secretary may provide such technical assistance directly or through grants to, or contracts with, public and private entities.

"(b) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.—

"(1) **IN GENERAL.**—Upon the request of a State receiving a grant under section 1501, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out such section and, for such purpose, may detail to the State any officer or employee of the Department of Health and Human Services.

"(2) **CORRESPONDING REDUCTION IN PAYMENTS.**—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments under the grant under section 1501 to the State involved by an amount equal to the costs of detailing personnel (including pay, allowances, and travel expenses) and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

"SEC. 1508. EVALUATIONS AND REPORTS.

42 USC 300n-4.

"(a) **EVALUATIONS.**—The Secretary shall, directly or through contracts with public or private entities, provide for annual evaluations of programs carried out pursuant to section 1501.

"(b) **REPORT TO CONGRESS.**—The Secretary shall, not later than 1 year after the date on which amounts are first appropriated pursuant to section 1509(a), and annually thereafter, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report summarizing evaluations carried out pursuant to subsection (a) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this title as the Secretary determines to be appropriate.

"SEC. 1509. FUNDING.

42 USC 300n-5.

"(a) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this title, there are authorized to be appropriated \$50,000,000 for fiscal year 1991, and such sums as may be necessary for each of the fiscal years 1992 and 1993.

"(b) **SET-ASIDE FOR TECHNICAL ASSISTANCE AND PROVISION OF SUPPLIES AND SERVICES.**—Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 20 percent for carrying out section 1507."

Approved August 10, 1990.

LEGISLATIVE HISTORY—H.R. 4790 (S. 2283):**HOUSE REPORTS:** No. 101-543 (Comm. on Energy and Commerce).**SENATE REPORTS:** No. 101-380 accompanying S. 2283 (Comm. on Labor and Human Resources).**CONGRESSIONAL RECORD,** Vol. 136 (1990):

June 18, considered and passed House.

Aug. 3, considered and passed Senate, amended. House concurred in Senate amendment.

Appendix B
Medicaid Treatment Act

1.24 BREAST AND CERVICAL CANCER MEDICAID COVERAGE GROUP (BCC) APPLICATION PROCESS

1.24.1 APPLICATION PROCESS

To be eligible for Breast and Cervical Medicaid (BCC), the client must:

- Be enrolled in the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSP) through the office of Maternal, Child and Family Health (OMCFH) and the Center for Disease Control (CDC).
- Be diagnosed with breast or cervical cancer or certain pre-cancerous conditions and actively receiving cancer treatment.
- Be a woman under age 65 who is not receiving Medicare benefits.
- Be uninsured or under-insured or otherwise lacking creditable medical coverage.
 - IMM Chapter 22, Appendix A identifies the different types of insurance benefits that will affect BCC eligibility and the types of insurance that a client can have while still having BCC Medicaid.
- Not be eligible for a mandatory Medicaid coverage group.

The application process must be completed in the following order:

- Before a client can be approved for BCC Medicaid, they must be an active participant in the WVBCCSP. To enroll in WVBCCSP, the client must:
 - Contact a WVBCCSP Screening Provider who will determine eligibility for WVBCCSP, assist the client with the completion of the DFA-BCC-1, and provide a blank CDC Certificate of Diagnosis for the client's treating physician to fill out and sign.
 - The Screening Provider will fax the completed DFA-BCC-1 to WVBCCSP who will verify current enrollment in their program. The client's treating physician will fax the completed CDC Certificate of Diagnosis to WVBCCSP.
 - WVBCCSP will then forward the DFA-BCC-1, CDC Certificate of Diagnosis and a Letter of Eligibility stating that the client is enrolled in WVBCCSP to the client's local DOHS Office.
- Once the Worker receives the DFA-BCC-1, CDC Certificate of Diagnosis, and the Letter of Eligibility from WVBCCSP, the Worker must enroll the client into the Presumptive

Phase of BCC, assuming all other BCC requirements are met. Follow the eligibility system instructions for coding BCC using PRD-38. While the client is in the Presumptive Phase of BCC, the Worker will determine if the client is eligible for any mandatory Medicaid coverage groups.

- The Worker must contact the client and arrange for a Medicaid application to be completed and to request any additional information needed to determine eligibility.
- If the Worker determines that the client is NOT eligible for a mandatory Medicaid coverage group, the Worker must disenroll the client from the Presumptive Phase of BCC and enroll them in Regular BCC Medicaid. Follow the eligibility system instructions for coding BCC using PRD-38. Scan documents into the client's case file and make thorough case comments.
- If the client is eligible for a mandatory Medicaid coverage group, disenroll the client from the Presumptive Phase of BCC Medicaid and approve the new Medicaid coverage group. Scan appropriate documents to the client's case and make thorough case comments.
- Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

NOTE: At application, if a worker receives the DFA-BCC-1 or the CDC Certificate of Diagnosis directly from the client or medical facility, do not approve the client for BCC Medicaid. In the eligibility system, create a Request for Assistance and scan the documents to the client's file. Mail the DFA-BCC-1 and the CDC Certificate to WVBCCSP. If the client is determined eligible for WVBCCSP, WVBCCSP will then fax the completed DFA-BCC-1, the CDC Certificate of Diagnosis, and a Letter of Eligibility to the client's local DOHS office for a Worker to process and determine eligibility for BCC Medicaid.

NOTE: To be eligible for BCC, the client must first be a patient of the WVBCCSPP. WVBCCSPP has separate eligibility guidelines from BCC. While BCC Medicaid does not have an income limit, WVBCCSPP has an income limit of 250% FPL. For more information on the West Virginia Breast and Cervical Cancer Screening Program, contact WVBCCSPP at 304-558-5388 or 1-800-642-8522.

1.24.2 REDETERMINATION PROCESS

An annual redetermination for Breast and Cervical Cancer Medicaid (BCC) is required. For the redetermination, the West Virginia Breast and Cervical Cancer Screening Program (WVBCCSPP), which is managed through the Office of Maternal Child and Family Health (OMCFH), sends the client a blank DFA-BCC-1 Medicaid application and a CDC Certificate of Diagnosis form. The client is responsible for having their doctor complete the blank CDC Certificate of Diagnosis stating the client is still actively receiving cancer treatment. The treating physician will fax the completed CDC Certificate of Diagnosis to WV BCCSP.

If the client remains eligible for WVBCCSPP, the completed DFA-BCC-1 application and the CDC Certificate of Diagnosis are then forwarded by WVBCCSPP to the client's local DOHS Office. Once the Worker receives the required documents from WVBCCSPP, the review process must be completed by the Department. The Worker sends the client a Medicaid application to determine if the client is eligible for one of the mandatory Medicaid coverage groups. The BCC case remains open in Regular BCC while the determination is being made. Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

If determined eligible for a mandatory Medicaid group, the BCC coverage is terminated and takes the Worker approves the client for the appropriate mandatory Medicaid coverage group.

If the client is not eligible for a mandatory Medicaid coverage group, complete the required override for BCC Medicaid and confirm the benefit. The Worker must scan the documents into the client's case record and make appropriate case comments.

If the client needs disenrolled from WVBCCSPP due to age, obtaining other insurance, no longer a West Virginia resident, treatment completion or death, the WVBCCSPP Case Manager will notify the local DOHS office. The Worker will then need to determine eligibility for any other types of Medicaid before termination.

1.24.3 COMMUNICATIONS WITH THE BREAST AND CERVICAL SCREENING PROGRAM (WVBCCSP)

To ensure that needed services are not delayed after approval for Breast and Cervical Cancer Medicaid (BCC) and that BCC has current information about individuals who are closed or denied, the Worker must follow the procedures outlined below:

- Follow the eligibility system instructions for coding BCC using PRD-38.
- Print the current address screen which must include the applicant's name.
- Write the status of the case on the bottom of the printout. Examples include, but are not limited to approved for BCC, or ineligible for BCC because eligible for another mandatory coverage group.
- Fax the printout along with any other pertinent documentation to the attention of WVBCCSP at 304-558-7164.
- Other avenues of communication with WVBCCSP include:
 - By mail at The Office of Maternal, Child and Family Health, Attn: WVBCCSP, 350 Capitol Street, Room 427, Charleston, WV 25301-3715.
 - By phone at 304-558-5388 or 1-800-642-8522. These phone numbers can be given to the public.
 - WVBCCSP's website has further information about their program. Their web address is <https://DoHS.wv.gov/bccsp/Pages/default.aspx>.

Appendix C

Diagnostic and Treatment Fund

WEST VIRGINIA CODE: §16-33-7

§16-33-7. Establishment of breast and cervical cancer diagnostic and treatment fund.

(a) There is hereby established the breast and cervical cancer diagnostic and treatment fund which shall provide financial assistance for the medical care of indigent patients for diagnostic and treatment services for breast and cervical cancer.

(b) The fund may be comprised of moneys appropriated to the fund by the Legislature, allocated to the fund by the federal government and all other sums designated for deposit in the fund from any source, public or private.

(c) The fund shall be administered by the office of maternal and child health within the bureau of public health. The bureau shall file an annual report with the Joint Committee on Government and Finance describing the operation and status of the fund, acts, policies, practices or procedures of the bureau in implementing the provisions of this article, and the bureau's recommendations as to changes in law or policy which it deems necessary or appropriate.

(d) Nothing in this article may be construed or interpreted to mean that covered diagnostic and treatment services are required to be provided by the bureau or the department. Nothing in this article shall be construed to mandate funding for the breast and cervical diagnostic and treatment fund or to require any appropriation by the Legislature to the fund.

Appendix D
WVBCCSP Information Updates