

Breast and Cervical Cancer Services Policy Manual

Effective September 2019



TEXAS
Health and Human
Services

Medical and Social Services Division

Health, Developmental &

Independence Services

Family and Social Services

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Introduction - General Information

Purpose of Manual

The Texas Health and Human Services Commission (HHSC) Policy Manual for Breast and Cervical Cancer Services (BCCS) is a guide for HHSC contractors who deliver BCCS services in Texas. The manual has been structured to provide contractor staff with information needed to comply with BCCS administrative, clinical, financial, data and reporting policies.

To provide BCCS services, contractors are required to comply with specific federal and state laws outlined in the manual. The state rules that apply most specifically to BCCS in Texas are found in the Texas Administrative Code (TAC), Title 25 Part 1, Chapter 61, Subchapter C.

Program Authorization and Services

BCCS receives federal funding from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) which is authorized by 42 U.S.C. 300k, et seq. The program operates under the Texas Breast and Cervical Cancer Services rules, 25 TAC §§61.31 – 61.42.

Federal Medicaid law gives states the option to provide Medicaid assistance to women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and found to have breast or cervical cancer.¹

Texas provides Medicaid coverage to eligible women diagnosed with breast or cervical cancer by a BCCS program contractor.^{2,3}

BCCS program provides state funds for cervical dysplasia management and treatment services for BCCS-enrolled women.

BCCS enables women with low incomes to have access to high quality screening and diagnostic services for breast and cervical cancer. This is accomplished through an extensive network of contractors, and private and public stakeholders. BCCS funds cannot be used for inpatient hospital services if NBCCEDP funds are part of the payment.

¹ 42 U.S.C. §1396a(aa).

² Human Resources Code §32.024 (y) and (y-1).

³ In 2007, the 80th Texas Legislature adopted Human Resources Code §32.024 (y-1), authorizing any health care provider to refer eligible women in need of treatment for breast or cervical cancer to Medicaid. Effective September 1, 2007, any woman diagnosed with breast or cervical cancer and meets all eligibility requirements, as determined by BCCS policy for Medicaid for Breast and Cervical Cancer (MBCC), may receive Medicaid services.

BCCS Contractor Responsibilities

Contractors shall provide and/or assure the provision of breast and/or cervical cancer screening, diagnostic and support services including tracking, follow-up, patient navigation, and individual client education services. Although BCCS allows the provision of diagnostic services, contractors must ensure that program focus supports cancer screening, consistent with funding intent.

Contractor requirements also include: program management, eligibility determination, initiation of or referral to treatment if clinically indicated, quality management, professional development, recruitment including public education and outreach and data collection, including tracking and follow-up. Collectively, these components will ensure the achievement of performance measures.

Contractors are responsible for the coordination of a client's services from screening through diagnosis, if clinically warranted. Contractors who have expended their awarded funds shall continue to serve their existing BCCS eligible clients who are currently in the process of an approved care plan. Contractors shall ensure that existing clients receive services from qualified breast and cervical cancer providers to continue client care.

All contractors must have an established referral relationship and sub-contract with a qualified provider of each service that the contractor does not provide.

Duplication of BCCS services by multiple contractors will not be reimbursed. Contractors should have procedures in place to verify clients are not receiving services with another BCCS contractor prior to services being rendered. **NBCCEDP funds cannot be used to cover services covered by another public health program or private coverage (42 U.S.C. § 300m(d)).**

Program Management

The purpose of program management is to maximize available resources to implement and maintain BCCS components according to BCCS policies and procedures. Contractors are required to coordinate and administer program activities with supportive management systems.

Eligibility

Contractors are required to determine BCCS program eligibility of every client at enrollment and annually thereafter. Insurance status should be reassessed at each client visit.

Quality Management

Contractors are expected to ensure the quality of services by monitoring performance and identifying opportunities for improvement. Contractors must have policies and procedures to ensure healthcare providers follow evidence-based clinical guidelines and provide clinical services consistent with current nationally recognized standards of care.

Professional Development

Contractors are responsible for ensuring health care professionals provide BCCS services competently and with sensitivity to diverse patient cultures.

Recruitment

Contractors must establish and maintain outreach and inreach methods to recruit priority populations.

Data Collection

Contractors are required to comply with and utilize the web-based system Med-IT to collect and process breast and cervical cancer data, including reports and billing in accordance with the business requirements of the program.

Partnerships

Contractors must establish and maintain partnerships with coalitions, community-based organizations and other HHSC agencies that further the goal of providing breast and cervical cancer services in the proposed service area.

Performance Measures

Contractors are required to meet NBCCEDP performance measures. The following performance measures are used to assess, in part, the contractor's effectiveness in providing BCCS services:

Screening Indicators

- A minimum of 20% of all NBCCEDP-reimbursed screening Pap tests should be provided to program-eligible women who have never been screened for cervical cancer. Grantees may use either conventional or liquid-based cytology.
- A minimum of 75% of all NBCCEDP-reimbursed mammograms/MRIs should be provided to program-eligible women who are 50 years of age and older and not enrolled in Medicare-Part B.

Cervical Cancer Diagnostic Indicators

- A minimum of 90% of abnormal cervical screening results must have a complete follow-up with no more than 10% lost to follow-up, refused, and/or pending.
- The interval between initial screening and diagnosis of abnormal cervical cancer screenings should be 90 days or less for a minimum of 75% of the women with abnormal results.
- A minimum of 90% of HSIL, CIN II, CIN III, CIS, and invasive cervical cancer diagnoses must have started treatment.

- The interval between diagnosis and initiation of treatment for HSIL, CIN II, CIN III and CIS should be 90 days or less for a minimum of 80% of the women needing treatment.
- The interval between diagnosis and initiation of treatment for invasive cervical cancer should be 60 days or less for a minimum of 80% of the women diagnosed.

Breast Cancer Diagnostic Indicators

- A minimum of 90% of abnormal breast screening results must have a complete follow-up with no more than 10% lost to follow-up, refused, and/or pending.
- The interval between initial screening and diagnosis of abnormal breast cancer screenings should be 60 days or less for a minimum of 75% of women with abnormal results.
- A minimum of 90% of breast cancer diagnoses must have started treatment.
- The interval between diagnosis and initiation of treatment for breast cancer should be 60 days or less for a minimum of 80% of women needing treatment.

Administrative Indicators

- Contractors must serve a minimum of eighty-five percent (85%) of proposed unduplicated clients;
- Contractors must expend a minimum of ninety-five percent (95%) of the awarded funds;
- Contractors must submit Quarterly Match reports.

Contractors must comply with and utilize an online database system (Med-IT) to collect and process breast and cervical data, reports, and billing in accordance with the business requirements of the program, including Med-IT data entry within 30 days of services provided.

State Office Responsibilities

In partnership with its contractors, BCCS is responsible for attaining the goals and objectives of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). BCCS achieves program goals and objectives through implementation and monitoring of the following program components: program management, screening and diagnostic services, patient navigation, data management, quality assurance and quality improvement, evaluation, partnerships, and professional development.

Program Management

The purpose of program management is to maximize available resources to implement all BCCS components in accordance with established policies and procedures. The major management activities include:

- Completing annual work plan after final CDC award and submitting reports to CDC on time;
- Awarding and executing all contracts;
- Ensuring the expenditure of at least 95% of BCCS funds and meeting 100% match requirements;
- Performing utilization review of BCCS services provided, ensuring quality services and appropriate use of funding;
- Training all designated HHSC staff on program components and core performance indicators; and
- Updating and disseminating a BCCS Policy and Procedure Manual.

Screening and Diagnostic Services

The purpose of NBCCEDP screening and diagnostic services is to reduce mortality from breast and cervical cancer by detecting pre-cancerous and cancerous lesions at their earliest stages, by following recommended guidelines, algorithms and screening procedures.⁴

Data Management

The purpose of data management is to ensure availability of high-quality data for program planning, quality assurance, and evaluation. The purpose is also to train and provide technical assistance to contractors.

Quality Assurance (QA) and Quality Improvement (QI)

The goal of quality assurance is to meet the national Minimum Data Element (MDE) benchmarks to ensure clients are receiving quality care. BCCS coordinates with Quality Assurance staff to ensure timely quality assurance visits, appropriate review of findings, and implementation of plans to correct findings.

⁴ NBCCEDP law at 42 U.S.C. § 300m(b).

Evaluation

The purpose of evaluation is to assess the quality, effectiveness, and efficiency of BCCS implementation and to gather useful information to aid in planning, decision-making and improvement.

Partnerships

The purpose of coalition and partnership building is to expand and maximize resources, coordinate BCCS activities, overcome obstacles to the recruitment of priority populations, and promote the delivery of comprehensive breast and cervical cancer screening services.

Professional Education

The purpose of professional education is to assure that BCCS healthcare and allied health professionals receive training and exposure to current and evidence-based breast and cervical cancer screening guidelines.

Definitions

The following words and terms, when used in this manual, have the following meanings.

Breast Specialist

A general surgeon, radiologist, and obstetrician-gynecologist who has completed specialized training for management of breast disease.

Centers for Disease Control and Prevention (CDC)

Federal agency responsible for protecting the health and safety of all Americans, and for providing essential human services, especially for those people who are least able to help themselves. The CDC issues, funds, and develops policy for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Cervical Dysplasia (CD) Management and Treatment Services

Management and treatment services provided to women with biopsy-confirmed cervical dysplasia. CD procedures are reimbursed from non-federal funding, as NBCCEDP prohibits use of CDC grant funds for treatment.

Client

An individual who has been screened and has successfully completed the eligibility process. The terms "client" and "patient" may be used interchangeably in this manual.

Confidentiality

The state of keeping information private and not sharing it without permission.

Consultation

A type of service provided by a physician with expertise in a medical or surgical specialty, and who upon request of another healthcare provider assists with the evaluation and/or management of a patient.

Contractor

Any entity that HHSC has contracted with to provide services.

The contractor is the responsible entity even if there is a subcontractor involved who actually implements the services.

Disease Surveillance (for BCCS and MBCC purposes)

Periodic monitoring for disease progression to quickly identify and treat pre-cancerous and cancerous conditions.

Diagnosis

The recognition of disease status determined by evaluating the history of the client, the disease process, and the signs and symptoms present. Determining the

diagnosis may require microscopic (i.e. specimen evaluation), chemical (i.e. blood tests), and/or radiological examinations (i.e. x-rays).

Dual-Eligible

Eligible for programs providing the same or similar services.

Eligibility Date

Date the contractor determines an individual eligible for the program. The eligibility expiration date will be twelve months after the eligibility date.

Federal Poverty Level (FPL)

The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid, define eligibility income limits as some percentage of FPL.

Good Faith Effort

Making at least three (3) separate documented attempts to obtain treatment for clients with a pre-cancerous or cancerous breast or cervical diagnosis who do not meet the eligibility criteria for BCCS Cervical Dysplasia and/or Medicaid for Breast and Cervical Cancer (MBCC). Examples of good faith efforts include, but are not limited to seeking service(s) for clients through: American Cancer Society, Susan G. Komen for the Cure, LIVESTRONG or other healthcare providers and facilities through pro-bono, sliding fee scale, reduced payment plan, or sponsorship assistance.

Health and Human Services Commission (HHSC)

State agency with administration and oversight responsibilities for designated HHSC agencies.

Health Service Region (HSR)

Counties grouped within specified geographic service areas throughout the state.

Healthy Texas Women (HTW)

HTW is a state-funded program administered by HHSC to provide uninsured women with women's health and family planning services such as women's health exams, health screenings, and birth control.

Household (for the purpose of eligibility determination)

The household consists of a person living alone, or a group of two or more persons related by birth, marriage (including common law), or adoption, who reside together and are legally responsible for the support of the other person. If an unmarried applicant lives with a partner, **only** count the partner's income and children as part of the household group **if** the applicant and his/her partner have

mutual children together. Unborn children should also be included. Treat individuals who are 18 years of age as adults. No children aged 18 and older or other adults living in the home should be counted as part of the household group.

Informed Consent

The process by which a health care provider ensures that the benefits and risks of a diagnostic or treatment plan, the benefits and risks of other appropriate options, and the benefits and risks of taking no action are explained to a patient in a manner that is understandable to that patient and allows the patient to participate and make sound decisions regarding his or her own medical care.

Inreach

Activities that are conducted with the purpose of informing and educating existing clients within an organization about services they are not receiving but may be eligible to receive.

Intimate Partner Violence (IPV)

Physical, sexual, or psychological harm by a current or former partner or spouse. IPV may also be referred to as domestic violence or family violence.⁵

Medicaid

The Texas Medical Assistance Program, a joint federal and state program provided for in Texas Human Resources Code Chapter 32 and subject to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.). Medicaid reimburses for health care services delivered to low-income individuals who meet eligibility guidelines.

Medicaid for Breast and Cervical Cancer (MBCC)

Medicaid program that provides access to cancer treatment services for qualified women.

Minimum Data Elements (MDE)

A set of standardized data elements developed by CDC to monitor clinical services provided to BCCS-enrolled women.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

A federal program administered by the CDC that awards funds to Texas BCCS and other state and tribal grantees to help women who are low-income, uninsured, and underserved gain access to screening for early detection of breast and cervical cancer.

⁵ Human Resources Code Chapter 51

Outreach

Activities that are conducted with the purpose of informing and educating the community about services and increasing the number of clients.

Patient Navigation

Patient Navigation services refer to an individualized approach for each BCCS enrolled woman with an abnormal screening (other than exceptions noted in [Section II, Chapter 8](#)), diagnostic result or diagnosis of cancer, which involves establishing, brokering, and sustaining a system of available clinical and essential support services.

Provider

An individual clinician or group of clinicians who provide services.

Referral

The process of directing or redirecting (as a medical case or a person) to an appropriate specialist or agency for information, help, or treatment.

Underinsured

Inadequate access to insurance. Underinsured clients may have coverage which allows for preventive (screening) services but is limited or cost-prohibitive for additional workup.

Acronyms List

Acronym	Term
AGC	Atypical Glandular Cells
ASC-H	Atypical Squamous Cells: Cannot exclude High-grade Squamous Intraepithelial Lesion
ASC-US	Atypical Squamous Cells of Undetermined Significance
BCCS	Breast and Cervical Cancer Services
CAD	Computer Aided Detection
CD	Cervical Dysplasia
CDC	Centers for Disease Control and Prevention
CIN	Cervical Intraepithelial Neoplasia
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
DES	Diethylstilbestrol
DHHS	U.S. Department of Health and Human Services
DSHS	Department of State Health Services
EC	Endocervical
ECC	Endocervical Curettage
EMR	Electronic Medical Record
FPL	Federal Poverty Level

Acronym	Term
HIPAA	Health Insurance and Portability Accountability Act
HHSC	Health and Human Services Commission
HPV	Human Papillomavirus
HSIL	High-grade Squamous Intraepithelial Lesion
HSR	Health Service Region
HTW	Healthy Texas Women
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	Limited English Proficiency
LSIL	Low-grade Squamous Intraepithelial Lesion
MBCC	Medicaid for Breast and Cervical Cancer
MDE	Minimum Data Elements
MED-IT	Medical Information Tracking
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NILM	Negative for Intraepithelial Lesion or Malignancy
TAC	Texas Administrative Code
TMHP	Texas Medicaid Healthcare Partnership

Section I – Administrative Policies

Chapter 1 – Client Access

The contractor must ensure that clients are provided services in a timely and nondiscriminatory manner. The contractor must:

- Have a policy in place that delineates the timely provision of services;
 - ▶ Individuals deemed eligible for the BCCS Program should be given an appointment as soon as possible - no later than 30 days from initial request.
 - ▶ Clinic/reception room wait times should be reasonable so as not to present a barrier to service.
- Comply with all applicable civil rights laws and regulations including [Title VI of the Civil Rights Act of 1964](#), the [Americans with Disabilities Act of 1990](#), the Age Discrimination Act of 1975, and [Section 504 of the Rehabilitation Act of 1973](#), and ensure services are accessible to persons with [Limited English Proficiency \(LEP\)](#) and speech or sensory impairments at no cost to the person.
- Have a policy in place that requires qualified staff to assess and prioritize an individual's needs.
- Provide referral sources for individuals that cannot be served or cannot receive a specific service.
- Manage funds to ensure that established individuals continue to receive services throughout the budget year.
- Inform individuals of BCCS services and encourage them to bring required documentation to the initial visit for eligibility processing.

Chapter 2 – Abuse and Neglect Reporting

HHSC contractors must comply with state laws governing the reporting of suspected abuse and neglect of children, adults with disabilities, or individuals 65 years of age or older. Contractors must have an agency policy regarding abuse and neglect.

To report abuse or neglect, call the Texas Abuse Hotline **800-252-5400**, use the [secure website](#), or call any local or state law enforcement agency for cases that pose an imminent threat or danger to an individual.

Human Trafficking

HHSC mandates that contractors comply with state laws governing the reporting of abuse and neglect. Additionally, as part of the requirement that contractors comply with all applicable federal laws, BCCS contractors must comply with the federal anti-trafficking laws, including the Trafficking Victims Protection Act of 2000. (22 USC §7101, et seq.)

Contractors must have a written policy on human trafficking which includes the provision of annual staff training.

References for Human Trafficking Policy Development

[Human Trafficking into and within the United States](#): A review of the literature on human trafficking in the U.S. for the U.S. Department of Health and Human Services.

[Polaris Project](#): Contains links to victim and survivor support and other resources for healthcare providers and victims. Provides lists of common identifiable features of human trafficking victims in multiple settings.

[Rescue and Restore Campaign](#) by the U.S. Department of Health and Human Services: Contains multiple resources for healthcare providers, social service personnel, and law enforcement for identifying and aiding trafficking victims. Includes PowerPoint presentations for training purposes.

[Texas Human Trafficking Resource Center](#): A statewide directory connecting Health and Human Services staff, healthcare providers, stakeholders and potential victims of human trafficking to local, state and national resources to identify and help people affected by human trafficking.

Domestic and Intimate Partner Violence

Contractors must have a written policy related to assessment and prevention of domestic and intimate partner violence, including the provision of annual staff training.

Chapter 3 – Client Rights

Confidentiality

All contracting agencies must be in compliance with the [U.S. Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#) and established standards for protection of client privacy.

A contractor must document the individual's preferred method of follow-up for clinic services (cell phone, email, work phone) and the individual's preferred language. Contractor must verbally assure each individual the right to confidentiality. Contractors must comply with adult and child abuse and neglect reporting laws in Texas.

Contractors must ensure that all employees and volunteers receive training about client confidentiality during orientation and be made aware that violation of the law in regard to confidentiality may result in civil damages and criminal penalties. A BCCS healthcare provider's staff (paid and unpaid) must be informed during orientation of the importance of keeping client information confidential. All employees, volunteers, sub-contractors, board members and/or advisory board members must sign a confidentiality statement during orientation.

Non-Discrimination and Limited English Proficiency (LEP)

HHSC contractors must comply with state and federal anti-discrimination laws. These laws are contained in the [Health and Human Services Commission \(HHSC\) Uniform Terms and Conditions – Grant Version 2.15](#), Article IX, Section 9.21 (a-f) Civil Rights, the HHSC Special Conditions Version 1.1, Article V, Section 5.06 Services, and Information for Persons with Limited English Proficiency, which are part of a contractor's contract with the State.

Information about non-discrimination laws and regulations can be found on the [HHSC Civil Rights website](#).

Contract Terms and Conditions

To ensure compliance with non-discrimination laws, regulations, and policies, contractors must:

- Sign a written assurance to comply with applicable federal and state non-discrimination laws and regulations;
- Have a written policy that states the contractor does not discriminate on the basis of race, color, national origin, including limited English proficiency (LEP), sex, age, religion, disability, or sexual orientation;
- Have a policy that addresses individual rights and responsibilities that is applicable to all individuals requesting BCCS services;
- Have procedures for notifying the HHSC Civil Rights Office of any program or service-related discrimination allegation or complaint no more than ten (10) calendar days of the allegation or complaint;

- Ensure that all contractor staff is trained in the contractor’s non-discrimination policies, including policies for serving clients with LEP and individuals with disabilities, and HHSC complaint procedures;
- Notify all individuals who are applying for BCCS of the contractor’s non-discrimination policies and complaint procedures; and
- Prominently display civil rights posters in common areas, including lobbies and waiting rooms, front reception desk, and locations where individuals apply for services; posters can be found on the [Civil Rights Office website](#).

Questions concerning this section and civil rights matters can be directed to the HHSC Civil Rights Office.

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard, may be eligible for benefits and services under other HHSC programs. For more information, please visit the [Texas Veterans Portal](#).

Termination of Services

Contractors have the right to terminate services to an individual if the individual is disruptive, unruly, threatening, or uncooperative to the extent that the individual seriously impairs the contractor’s ability to effectively and safely provide services or if the individual’s behavior jeopardizes his or her own safety, clinic staff, or others.

An individual has the right to appeal the denial, suspension, or termination of services.

Any policy related to termination of services must be included in the contractor’s policy manual.

Resolution of Complaints

Contractors must ensure that individuals have the opportunity to express concerns about care received and to further ensure that those complaints are handled in a consistent manner. Contractors’ policy manuals must explain the process individuals may follow if they are not satisfied with the care received. If an aggrieved individual requests a hearing, a contractor shall not terminate services to the individual until a final decision is rendered by HHSC. Any complaint must be documented in the individual’s record.

Freedom of Choice

HHSC BCCS clients are guaranteed the right to voluntarily choose qualified BCCS providers without coercion or intimidation. Acceptance of BCCS must not be a prerequisite to eligibility for or receipt of any other service or assistance from the entity or individual that provided the service or assistance.

Research (Human Subject Clearance)

A HHSC BCCS contractor that wishes to participate in any proposed research that would involve the use of HHSC BCCS clients as subjects, the use of HHSC BCCS

clients' records, or any data collection from BCCS clients, must obtain prior approval from their own internal Institutional Review Board (IRB) and HHSC. For information about the process, contractors should contact the Department of State Health Services' (DSHS) IRB at InstitutionalReviewBoard@dshs.texas.gov. The IRB will review the materials and approve or deny the application.

The contractor must have a policy in place that indicates that prior approval will be obtained from HHSC, prior to instituting any research activities. The contractor must also ensure that all staff is made aware of this policy through staff training. Documentation of training on this topic must be maintained.

Chapter 4 – Client Records Management

HHSC contractors must have an organized and secure client record system. The contractor must ensure that the record is organized, readily accessible, and available to the client upon request with a signed release of information. The record must be kept confidential and secure, as follows:

- Safeguarded against loss or use by unauthorized persons;
- Secured by lock when not in use and inaccessible to unauthorized persons; and
- Maintained in a secure environment in the facility, as well as during transfer between clinics and in between home and office visits.

The written consent of the client is required for the release of personally identifiable information, except as may be necessary to provide services to the client or as required by law, with appropriate safeguards for confidentiality. HIV information should be handled according to [law](#).

When information is requested, contractors should release only the specific information requested. Information collected for reporting purposes may be disclosed only in summary, statistical, or other form that does not identify particular individuals. Upon request, clients transferring to other providers must be provided with a copy or summary of their record to expedite continuity of care. Electronic records are acceptable as medical records.

Contractors, providers, subrecipients, and subcontractors must maintain for the time period specified by HHSC all records pertaining to client services, contracts, and payments. Contractors must follow contract provisions, maintain medical records for at least seven years after the close of the contract, and follow the retention standards of the appropriate licensing entity. All records relating to services must be accessible for examination at any reasonable time to representatives of HHSC and as required by law.

Chapter 5 – Personnel Policy and Procedures

Contractors must develop and maintain personnel policies and procedures to ensure that all staff are hired, trained, and evaluated appropriately for their job position.

Personnel policies and procedures must include:

- Job descriptions;
- A written orientation plan for new staff to include skills evaluation and/or competencies appropriate for the position; and
- A performance evaluation process for all staff.

Job descriptions, including those for contracted personnel, must specify required qualifications and licensure. All staff must be appropriately identified with a name badge.

Contractors must show evidence that employees meet all required qualifications and are provided annual training. Job evaluations should include observation of staff/client interactions during clinical, counseling, and educational services.

Contractors shall establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain. All employees and board members must complete a conflict of interest statement during orientation. All medical care must be provided under the supervision, direction, and responsibility of a qualified Medical Director. The Breast and Cervical Cancer Services Program Medical Director must be a licensed Texas physician.

Contractors must have a documented plan for organized staff development. There must be an assessment of:

- Training needs;
- Quality assurance indicators; and
- Changing regulations/requirements.

Staff development must include orientation and in-service training for all personnel and volunteers. (Non-profit entities must provide orientation for board members and government entities must provide orientation for their advisory committees). Employee orientation and continuing education must be documented in agency personnel files.

Chapter 6 – Facilities and Equipment

HHSC contractors are required to maintain a safe environment at all times. Contractors must have written policies and procedures that address the handling of hazardous materials, fire safety, and medical equipment.

Hazardous Materials

Contractors must have written policies and procedures that address:

- The handling, storage, and disposing of hazardous materials and waste according to applicable laws and regulations;
- The handling, storage, and disposing of chemical and infectious waste, including sharps; and
- An orientation and education program for personnel who manage or have contact with hazardous materials and waste.

Fire Safety

Contractors must have a written fire safety policy that includes a schedule for testing and maintenance of fire safety equipment. Evacuation plans for the premises must be clearly posted and visible to all staff and clients.

Medical Equipment

Contractors must have a written policy and maintain documentation of the maintenance, testing, and inspection of medical equipment, including automated external defibrillators (AED). Documentation must include:

- Assessments of the clinical and physical risks of equipment through inspection, testing, and maintenance;
- Reports of any equipment management problems, failures, and use errors;
- An orientation and education program for personnel who use medical equipment; and
- Manufacturer recommendations for care and use of medical equipment.

Radiology Equipment and Standards

All facilities providing radiology services must:

- Possess a current Certificate of Registration from the Texas Department of State Health Services, Radiation Control Program;
- Have operating and safety procedures as required by Title 25 of the Texas Administrative Code Chapter 289 (entitled Radiation Control); and
- Post Notice to Employees, Texas Regulations for Control of Radiation.

For information on x-ray machine registration, see the [Texas Department of State Health Services, Radiation Control Program](#).

Smoking Ban

Contractors must have written policies that prohibit smoking in any portion of their indoor facilities. If a contractor subcontracts with another entity for the provision of health services, the subcontractor must comply with this policy.

Disaster Response Plan

Contractors must have written and oral plans that address how staff are to respond to emergency situations (i.e., fires, flooding, power outage, bomb threats, etc.). The disaster plan must identify the procedures and processes that will be initiated during a disaster and the staff (position/s) responsible for each activity. A disaster response plan must be in writing, formally communicated to staff, and kept in the workplace available to employees for review. For an employer with ten or fewer employees the plan may be communicated orally to employees.

For additional resources on facilities and equipment, see the [Occupational Safety and Health Administration website](#).

Chapter 7 – Quality Management

Contractors must use internal Quality Assurance/Quality Improvement (QA/QI) systems and processes to monitor services. Contractors must have the ability to meet the management standards prescribed in 2 CFR Part 200.

Contractors should integrate [Quality Management](#) (QM) concepts and methodologies into the structure of the organization and day-to-day operations. Quality Management programs can vary in structure and organization and will be most effective if they are individualized to meet the needs of a specific agency, services and the populations served.

Contractors are expected to develop quality processes based on four core QM principles that focus on:

- The client;
- Systems and processes;
- Measurements; and
- Teamwork.

Contractors must have a QM program individualized to their organizational structure and based on the services provided. The goals of the quality management program should ensure availability and accessibility of services, quality and continuity of care.

A QM program must be developed and implemented that provides for ongoing evaluation of services. Contractors should have a comprehensive plan for the internal review, measurement, and evaluation of services, the analysis of monitoring data, and the development of strategies for improvement and sustainability.

Contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with HHSC policies and basic standards will be assessed with the subcontracting entities.

The QM Committee, whose membership consists of key leadership of the organization, including the Executive Director/CEO and the Medical Director, and other appropriate staff where applicable, annually reviews and approves the quality work plan for the organization. (NOTE: The Medical Director must be a licensed Texas physician.)

The Quality Management Committee must meet at least quarterly to:

- Receive reports of monitoring activities;
- Make decisions based on the analysis of data collected;
- Determine quality improvement actions to be implemented; and
- Reassess outcomes and goal achievement.

Minutes of the discussion and actions taken by the committee and a list of the attendees must be maintained and made available during Quality Assurance/Quality Improvement reviews.

The comprehensive quality work plan at a minimum must:

- Include clinical and administrative standards by which services will be monitored;
- Include process for credentialing and peer review of clinicians;
- Identify individuals responsible for implementing monitoring, evaluating and reporting;
- Establish timelines for quality monitoring activities;
- Identify tools/forms to be utilized; and
- Outline reporting to the Quality Management Committee.

Although each organization’s quality program is unique, the following activities must be undertaken by all agencies providing client services:

- On-going eligibility, billing, and clinical record reviews to ensure compliance with program requirements and clinical standards of care;
- Utilization review;
- Tracking and reporting of adverse outcomes;
- Annual review of facilities to maintain a safe environment, including an emergency safety plan; and
- Annual review of policies, clinical protocols and standing delegation orders (SDOs) to ensure they are current; and
- Performance evaluations to include primary license verification, Drug Enforcement Administration and immunization status to ensure employees are current.

HHSC contractors who subcontract for the provision of services must also address how quality will be evaluated and how compliance with policies and basic standards will be assessed with the subcontracting entities including:

- Annual license verification (primary source verification); clinical record review;
- Billing and eligibility review;
- Utilization review;
- Facility on-site review;
- Annual client satisfaction evaluation process; and
- Child abuse training and reporting – subcontractor staff.

Data from these activities must be presented to the QM Committee. Plans to improve quality should result from the data analysis and reports considered by the committee and should be documented.

Care in Ambulatory Surgical Centers

Contractors are responsible for ensuring clients receive services that are of high quality and are safe. Ambulatory Surgical Centers that provide services for BCCS clients must be CMS certified, state licensed, and Joint Commission accredited as applicable; see the directory of licensed ambulatory surgical centers at: hhs.texas.gov/doing-business-hhs/provider-portals/health-care-facilities-regulation/ambulatory-surgical-centers. The contractor must ensure that their subcontractor(s) maintain certification to receive BCCS funds.

Mammography Quality Assurance

All BCCS contractors and subcontractors providing mammography services must:

- Possess a current Certification of Mammography Systems from DSHS Regulatory Licensing Unit, Mammography Certification Program (each mammography unit must be fully accredited or undergoing accreditation); and
- Possess a current mammography facility certificate from the appropriate agency certifying compliance with the U.S. Food and Drug Administration Mammography Quality Standards, at 21 CFR Part 900.

The [Mammography Radiation Control Program](#) may be contacted for certification questions and information on inspection results, escalated enforcement, or “cease and desist” status.

Cytology Quality Assurance

Contractors and subcontracting entities for screening and diagnostic cytology services must have current documentation that the agency meets all quality assurance standards required by the BCCS program as established under state and federal laws.

All cytology laboratories providing services to BCCS contractors/ subcontractors must:

- Possess a current, unrevoked, and unsuspended registration certificate issued by the U.S. Department of Health and Human Services under the terms of the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) (42 U.S.C. §263a);
- Use the 2001 Bethesda System for Reporting Cervical/Vaginal Cytological Diagnoses; and
- The lab must have a mechanism for expedited notification of Pap tests which are CIN III or greater, such that the clinic is notified no later than the next business day after the case is signed out.

HPV Quality Assurance

Contractors must assure the following for all HPV tests:

- Must be for high-risk oncogenic types; and
- Must be FDA approved and clinically validated.

Utilization Review

To ensure clients receive high quality care and funds are expended according to program policies, BCCS performs utilization review of billed services. Contractors not in compliance with utilization guidelines may be required to refund the BCCS program for services inappropriately billed at the end of the fiscal year.

Section II – Client Services and Community Activities

Chapter 1 – Eligibility Determination

General Eligibility

For an individual to receive BCCS services, three (3) general criteria must be met:

- Gross household income at or below 200% of the adopted Federal Poverty Level (FPL);
- Applicant is a Texas resident; and
- Without access to programs/benefits providing the same services.

Other Eligibility Factors:

- Undocumented applicants who meet the general eligibility criteria are program eligible.
- Applicant must meet age-specific eligibility criteria for screening and diagnostic services (See [Section II, Chapters 4-6](#)).
- Applicants may be dual-eligible for programs providing the same or similar services, such as Healthy Texas Women and/or Family Planning. In such cases, individual agencies should determine the best use of funds to meet client needs and maintain program requirements, however, clients with a primary need of cancer screening should be enrolled in BCCS.
- Applicants with access to preventive (screening) services whose coverage is insufficient for diagnostic workup are considered underinsured and may be enrolled for services. (See [Introduction, Definitions](#).)

Enrollment Date

Clients are eligible to start receiving services beginning with the date an application is completed and the client is determined eligible. Services rendered prior to the date the client is determined eligible will not be reimbursed.

Contractor Responsibilities

Contractors must develop an agency policy to determine BCCS eligibility. The policy shall be available during Quality Assurance (QA) visits and must address the following:

- Documents that are acceptable for verifying household income at or below 200% FPL (income must be recorded in client record and Med-IT);
- Use of [Form 1065](#), HHSC BCCS Eligibility Application; or,
- Use of a comparable paper or electronic screening and eligibility tool with required information. If a comparable eligibility screening tool is being used, it must be reviewed and approved by HHSC staff before use. Contractors must use the BCCS Eligibility Application until approval to use a comparable form is received. Contractor must maintain/retain proof of approval and shall make the approval available during QA visits.

Contractor eligibility policy must also ensure that:

- Client insurance status is assessed before service delivery;

- All clients are educated on and assessed for Marketplace (www.healthcare.gov) eligibility;
- General BCCS eligibility is determined prior to enrollment and annually thereafter;
- Clients age 65 and over do not meet eligibility unless client is ineligible for or unable to pay premiums for Medicare Part B.

If a woman is eligible to receive Medicare benefits and is not enrolled in Medicare, she should be encouraged to enroll. Women enrolled in Medicare Part B are not eligible to receive services. Women who are not eligible to receive Medicare Part B and Medicare-eligible women who cannot pay the premium to enroll in Medicare Part B are eligible to receive services. If a client cannot afford the additional expense of Medicare Part B Premiums, Medicaid-sponsored Medical Savings Programs may pay Medicare premiums, deductibles, and coinsurance amounts for eligible Medicare beneficiaries. The Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, the Qualified Individuals (QI-1), and the Qualified Disabled Working Individuals (QDWI) program are all called Medicare Savings Programs. More information about Medicare Savings Programs may be referenced at the following website: www.medicare.gov.

Screening and Eligibility Determination

- Use [Form 1065](#), HHSC BCCS Eligibility Application. Another eligibility screening form substitute (e.g., in-house form, electronic/automated form, phone interview, etc.) that contains the required information for determining eligibility and is approved by the BCCS program, may be used.
- The applicant is responsible for completing the HHSC BCCS Eligibility Application. If assistance is needed to complete the form, the contractor shall provide knowledgeable staff to assist.
- Special circumstances may occur in the disclosure of information by the applicant, documentation of pertinent facts, or events surrounding the applicant's application for services must be documented on the HHSC BCCS Eligibility Application. Special circumstances must also be documented in the Med-IT Data System in the notes section of the enrollment screen.

Household

Establishing household size is an important step in the eligibility process. Assessment of income eligibility relies on an accurate count of household members.

- One application may be completed for all household members being screened for eligibility. To expedite the process, it is acceptable to fill out the form once and photocopy the form for the number of household members needed. The household member's name listed under the household information in Section III can be highlighted/circled to indicate the intended client record in which the form will be filed. Each BCCS eligible applicant, who is a legal adult, is required to sign and date the form. The signature and date of anyone assisting the applicant to complete the form is also required. The form is filed in the client record.

- The contractor has discretion to document special circumstances in the calculation of household composition. Additionally, if a separate household group is established within the applicant's household based on the documentation gathered, document the basis used for determining separate households on the HHSC BCCS Eligibility Application.

Residency

To be eligible for BCCS, an individual must be physically present within the geographic boundaries of Texas (there is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purposes of BCCS eligibility). The individual must:

- Have the intent to remain within the state, whether permanently or for an indefinite period; and
- Not claim residency in any other state or country.

Income

To be eligible for BCCS services, applicants must provide verification of **gross** (before taxes) household income at or below 200% FPL. If the applicant is unable to provide verification, income may be self-declared by the applicant. Documentation of why an applicant self-declared income must be in the client record and in the Med-IT Data System.

NOTE: Applicants seeking Medicaid for Breast and Cervical Cancer (MBCC) may not self-declare income. This includes women who have been diagnosed with a qualifying cancer by BCCS contractors or other health care providers. Any applicant who will be assisted by a BCCS contractor to apply for MBCC must have verification of income documented in her client record and on the eligibility screen in Med-IT.

Calculation of Applicant's Federal Poverty Level Percentage

1. Determine the applicant's **household** size.
2. Determine the applicant's **total monthly income** amount.
3. Divide the applicant's **total monthly income** amount by the **maximum monthly income** amount at 100% FPL, for the appropriate **household size**.
4. Multiply by 100%.

The maximum monthly income amounts by household size are based on the Department of Health and Human Services [federal poverty guidelines](#). The guidelines are subject to change around the beginning of each calendar year.

Count income already received and any income the household expects to receive.

- Count terminated income in the month it was received. Use actual income and do not use conversion factors if terminated income is less than a full month's income.

Income Deductions

Dependent care expenses and payments made by a member of the household group shall be deducted up to the allowable amount:

- Legally obligated child support payments;
- \$200.00 per child per month for children under age 2;
- \$175.00 per child per month for children age 2-17; and
- \$175.00 per dependent adult with disabilities per month age 18 and over.

Monthly Income Calculation

When income is received in lump sums, at irregular intervals, or at longer intervals than monthly (i.e. contract labor, seasonal employment, lump sums, etc.), the total amount received will be divided over the period of time the income is expected to cover household expenses in order to determine a monthly income. Convert the amount using one of the following methods:

- Weekly income is multiplied by 4.33;
- Income received every two weeks is multiplied by 2.17;
- Income received twice a month is multiplied by 2.0; and
- Income received annually is divided by 12.

For seasonal income, count the total income for the months worked in the overall calculation of income.

The table below details sources of earned and unearned income that contribute to the calculation of gross household income as well as income that is exempt from being counted.

Types of Income	Countable	Exempt
Alimony*	Yes	No
Adoption Payments	No	Yes
Cash Gifts and Contributions*	Yes	No
Child Support Payments*	Yes	No
Child's Earned Income	No	Yes
Crime Victim's Compensation	No	Yes
Disability Insurance Benefits*	Yes	No

Types of Income	Countable	Exempt
Dividends, Interest, and Royalties*	Yes	No
Educational Assistance*	No	Yes
Energy Assistance	No	Yes
Foster Care Payment	No	Yes
In-Kind Income*	No	Yes
Job Training	No	Yes
Loans (Non-educational)*	Yes	No
Lump-Sum Payments*	Yes	Yes
Military Pay*	Yes	No
Mineral Rights*	Yes	No
Pensions and Annuities*	Yes	No
Reimbursements*	Yes	No
RSDI /Social Security Payments*	Yes	No
Self-Employment Income*	Yes	No
SSDI*	Yes	Yes
SSI Payments	No	No
TANF	No	Yes
Unemployment Compensation*	Yes	No

Types of Income	Countable	Exempt
Veteran's Administration*	Yes	Yes
Wages and Salaries, Commissions*	Yes	No
Worker's Compensation*	Yes	No

*Explanation of income provided below.

Alimony

Count support payment(s) to a divorced person by a former spouse.

Cash Gifts and Contributions

Count unless they are made by a private, non-profit organization on the basis of need; and total \$300.00 or less per household in a federal fiscal quarter (January–March, April–June, July–September, October–December). If these contributions exceed \$300.00 in a federal quarter, count the excess amount as income in the month received.

Exempt any cash contribution for common household expenses, such as food, rent, utilities, and items for home maintenance, if it is received from a non-certified household member who:

- Lives in the home with the certified household member,
- Shares household expenses with the certified household member, and
- Does not have a landlord/tenant relationship.

Child Support Payments

Count income after subtracting the maximum dependent care deduction from the total monthly income the household receives.

Disability Insurance Payments/SSDI

Countable. Social Security Disability Insurance is a payroll tax-funded, federal insurance program of the Social Security Administration.

Dividends, Interest and Royalties

Countable. Exception: Exempt dividends from insurance policies as income. Count royalties, minus any amount deducted for production expenses and severance taxes.

Educational Loans, Grants

Includes money received as scholarships by students for educational purposes. Count only that part actually used for current living costs.

In-Kind Income

Exempt. An in-kind contribution is any gain or benefit to a person that is not in the form of money/check payable directly to the household, such as clothing, public housing, or food.

Loans (Non-educational)

Count as income unless there is an understanding that the money will be repaid and the person can reasonably explain how he/she will repay it.

Lump-Sum Payments

Count as income in the month received if the person receives it or expects to receive it more often than once a year. Exempt lump sums received once a year or less, unless specifically listed as income.

Military Pay

Count military pay and allowances for housing, food, base pay, and flight pay, minus pay withheld to fund education under the G.I. Bill.

Mineral Rights

Countable. A payment received from the excavation of minerals such as oil, natural gas, coal, gold, copper, iron, limestone, gypsum, sand, gravel, etc.

Pensions and Annuities

Countable. A pension is any benefit derived from former employment, such as retirement benefits or disability pensions.

Reimbursements

Countable, minus the actual expenses. Exempt a reimbursement for future expenses only if the household plans to use it as intended.

RSDI/Social Security Payments

Count the Retirement, Survivors, and Disability Insurance (RSDI) benefit amount including the deduction for the Medicare premium, minus any amount that is being recouped for a prior RSDI overpayment.

Self-Employment Income

Count total gross earned, minus the allowable costs of producing the self-employment income.

Terminated Employment

Count terminated income in the month received. Use actual income and do not use conversion factors if terminated income is less than a full month's income. Income is terminated if it will not be received in the next usual payment cycle.

Unemployment Compensation Payments

Count the gross benefit less any amount being recouped for an Unemployment Insurance Benefit overpayment.

VA Payments

Count only the gross Veterans Administration (VA) payment, minus any amount being recouped for a VA overpayment. Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans.

Wages, Salaries, Tips and Commissions

Count the actual (not taxable) gross amount.

Worker's Compensation

Count the gross payment, minus any amount being recouped for a prior worker's compensation overpayment or paid for attorney's fees. NOTE: The Texas Workforce Commission (TWC) or a court sets the amount of the attorney's fee to be paid.

Adjunctive Eligibility

An applicant is considered adjunctively (automatically) **financially** eligible for BCCS services at an initial or renewal eligibility screening if she or a member of her household **is currently enrolled** in at least one of the programs listed below. An applicant must provide proof of active enrollment in the adjunctively eligible program. Acceptable eligibility verification documentation may include:

Program	Accepted Documentation
Children's Health Insurance Program (CHIP) Perinatal	CHIP Perinatal benefits card
Medicaid for Pregnant Women	"Your Texas Benefits" card (Medicaid card)*

Program	Accepted Documentation
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	WIC verification of certification letter, printed WIC-approved shopping list or recent WIC purchase receipt with remaining balance
Supplemental Nutrition Assistance Program (SNAP)	SNAP eligibility letter
Temporary Assistance for Needy Families (TANF)	TANF verification of certification letter

*NOTE: Presentation of the "Your Texas Benefits" card does not completely verify current eligibility in the Medicaid for Pregnant Women program. To verify eligibility, providers must call TMHP at 800-925-9126 or log on to [TexMedConnect](#) to check the member's Medicaid ID number (PCN).

If the applicant or the applicant's child (must be considered part of the household) is enrolled in the Children's Health Insurance Program (CHIP), she may be considered adjunctively eligible.

If the applicant's current enrollment status cannot be verified during the eligibility screening process, adjunctive eligibility would not be granted. Contractor would then determine eligibility according to usual protocols.

A copy of the accepted documentation must be kept in the client's record and available during QA reviews.

Client Fees

Clients shall not be charged administrative fees for items such as processing and/or transfer of medical records, copies of immunization records, etc.

Contractors are allowed to bill clients for services outside the scope of BCCS allowable services if the service is provided at the client's request and the client is made aware of his/her responsibility for paying the charges prior to services being rendered.

Continuation of Services

Contractors who have expended their awarded funds must continue to serve their **existing** eligible clients who are currently in the process of a care plan. It is allowable to obtain other funding to pay for these services (dependent on the funding source, this can be counted towards the match requirement. See [Section III, Chapter 2](#)).

Contractors who have expended their awarded funds are not required to enroll **new** clients. However, it is allowable to offer services at full-pay or on a sliding scale basis.

MED-IT Data and Billing System

Before entering a woman into the Med-IT database, contractors must determine whether the woman has ever received services funded by BCCS and has an existing Med-IT ID (a unique number assigned to each BCCS client) by doing a client search. This process can be completed by entering patient identifiers, which may include name, date of birth, and/or social security number.

Minimum PC requirements for Med-IT are:

- Any internet connection – For optimum performance and response time, contractor locations should have access to a broadband connection with a minimum of 1 MB upload speed and 2 MB download speed; and
- Microsoft Internet Explorer 11.0 or above.

Med-IT users must have access to the database and BCCS service providers must be listed in the database. New users may request access by completing [Form 5200](#), Med-IT New User Request. New providers must complete [Form 5201](#), Med-IT New Provider Request.

Chapter 2 – Informed Consent

General Informed Consent

Contractors must obtain the client’s written, informed, voluntary general consent to receive services prior to receiving any clinical services pursuant to applicable state and federal law. A general informed consent explains the types of services provided and how client information may be shared with other entities for reimbursement or reporting purposes. If there is a period of time of three years or more during which a person does not receive services, a new general consent must be signed prior to reinitiating delivery of services.

Consent information must be effectively communicated to every individual in a manner that is understandable. This communication must allow the person to participate, make sound decisions regarding her own medical care, and address any disabilities that impair communication (in compliance with Limited English Proficiency regulations). Only the person receiving services may give consent. For situations when the person is legally unable to consent, a legal guardian must consent on her behalf. Consent must never be obtained in a manner that could be perceived as coercive.

Clients entering BCCS for services must also sign consent authorizing the contractor to enter or view client protected health information in the statewide Med-IT database. If this statement is not included in the general consent, an additional consent must be developed for the client to sign and include with the general consent in the patient health record.

Clients receiving patient navigation services for clinical abnormalities must sign a consent to ongoing assessment for needs and care coordination planning.

HHSC contractors should consult a qualified attorney to determine the appropriateness of the consent forms utilized by their health care agency.

Clinical Informed Consent

The contractor must obtain the client’s informed consent for procedures as required by the Texas Medical Disclosure Panel.

Texas Medical Disclosure Panel Consent

The [Texas Medical Disclosure Panel \(TMDP\)](#) was established by the Texas Legislature to 1) determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients, and 2) establish the general form and substance of such disclosure. TMDP has developed a list of procedures that require full and specific disclosure (List A) for certain procedures. More information about the TMDP can be found in the [Texas Administrative Code \(TAC\)](#).

For all other procedures not listed on List A, the physician must disclose, through a procedure-specific [consent](#), all risks that a reasonable patient would want to know

about. This includes all risks that are inherent to the procedure (one which exists in and is inseparable from the procedure itself) and that are material (could influence a reasonable person in making a decision whether or not to consent to the procedure).

Chapter 3 – Clinical Policy

BCCS Contractor Clinical Responsibilities

Contractors must:

- Accept referrals for breast and cervical cancer services, funds permitting;
- Provide follow-up and navigation of clients with abnormal screening or diagnostic results (as stated in [Introduction, BCCS Contractor Responsibilities](#));
- Assist eligible clients in applying for MBCC, including eligible clients diagnosed outside the BCCS program;
- Make a Good Faith Effort to obtain treatment for clients with a pre-cancerous or cancerous breast or cervical diagnosis who do not meet the eligibility criteria for BCCS Cervical Dysplasia and/or Medicaid for Breast and Cervical Cancer (MBCC) (as stated in [Introduction, Definitions](#));
- Communicate with team members within your organization regarding program requirements of the BCCS program; and
- Provide and document monitoring and oversight of subcontractors and subcontracted services to ensure compliance with BCCS policies and standards.

Individual Health Records and Documentation

Contractors must ensure that a patient health record (medical record) is established for every client who obtains BCCS services.

All patient health records must be:

- Complete, legible, written in ink, and/or documented within an Electronic Medical Record (EMR). No erasures or deletions should occur within a health record;
- Accurate documentation of all clinical encounters, including those by telephone;
- Signed by the provider making the entry, including name of provider, provider title, and date for each entry.
 - ▶ Electronic signatures are allowable to document provider review of care.
 - ▶ Stamped signatures are not allowable.
- Readily accessible to assure continuity of care and availability to patients; and
- Systematically organized to allow easy documentation and prompt retrieval of information.

All patient health records must include:

- Client identification, personal data and eligibility assessment (including insurance assessment);
- Preferred language/method of communication;
- Patient contact information with the best way to reach patient in such a manner that facilitates continuity of care, assures confidentiality, and

adheres to Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations;

- A problem list, updated as needed at each encounter, indicating significant illnesses and medical conditions;
- A complete medication list, including prescription and non-prescription medications, as well as dietary supplements, updated at each encounter;
- A complete listing of all medication allergies and adverse reactions, and other allergic reactions, displayed in a prominent place, and confirmed or updated at each encounter; if the person has no known allergies, this should be properly noted.
- Documentation of the individual's past medical history to include all serious illnesses, hospitalizations, surgical procedures, pertinent biopsies, accidents, exposures to blood products, and mental health history;
- An individual's health risk survey and assessment, including past and current tobacco, alcohol, and substance use/abuse, domestic and/or intimate partner violence and/or abuse (for any positive result, the individual must be offered referral to a family violence shelter in compliance with [Texas Family Code, Chapter 91](#), occupational and environmental hazard exposure, environmental safety (e.g., seat belt use, car seat use, bicycle helmets, etc.), nutritional and physical activity assessment, and living arrangements, updated as appropriate at each encounter;
- At each encounter, an encounter-relevant history and physical examination pertinent to the person's reason for presentation;
- Assessment or clinical impression;
- Plan of care, consistent with diagnoses and assessments which in turn are consistent with clinical findings, including education/counseling, treatment, special instructions, scheduled visits and referrals;
- Appropriate laboratory and other diagnostic test orders, results, and follow-up as indicated;
- Documentation of recommended follow-up care, scheduled return visit dates, and follow-up for missed appointments;
- Documentation of informed consent or refusal of services, to include at a minimum:
 - ▶ General consent for care;
 - ▶ Informed consent for any surgical or invasive procedures as indicated;
 - ▶ For required or recommended services refused or declined by the person, documentation of the service offered, counseling provided, and the person's decision to decline;
- Documentation of client counseling and education, with attention to risks identified in the health risk assessment; and
- At every clinic visit, the record must be updated as appropriate, and the reason for the visit, any assessment made, and service provided must be documented.

NOTE: A comprehensive patient health record as described above does not have to be established for clients referred-in only for Medicaid for Breast and Cervical

Cancer (MBCC) assistance. For these clients, the BCCS contractor shall establish a Patient Navigation Record as determined in [Section II, Chapter 8](#).

Counseling and Education

For every woman who receives breast and/or cervical cancer screening and/or diagnostic services through BCCS, the service provider must effectively communicate and document the following information during the initial visit and update during follow-up visits as indicated by the client's risk assessment:

- Risk factors for breast and cervical cancer;
- Signs and symptoms of breast and cervical cancer;
- Importance of cancer screening at regular intervals;
- Limitations of screening, including limitations of imaging in women with dense breasts for breast services;
- Information on HPV and safe sex practices; and
- Information on the HPV vaccine for cervical services;
- BCCS services and eligibility may change from year to year; and
- Tobacco cessation information and quit line referral, if appropriate.

Tobacco Assessment and Quit Line Referral

All women receiving BCCS services must be assessed for tobacco use. Women who use tobacco should be referred to tobacco quit lines. The Texas American Cancer Society Quit Line is 877-YES-QUIT or 866-228-4327 (Hearing Impaired). The assessment and referral should be performed by agency staff and documented in the clinical record.

Follow-Up of Breast and Cervical Screening Results

The clinician must notify a woman of findings, reinforce the need for continued routine screening examination and provide the expected interval for her next routine screening examination. Contractors must attempt to notify each woman in writing of her regular screening due date.

Rescreening Eligibility

Rescreening is the process of returning for a breast and/or cervical cancer screening test at a predetermined interval (as per program guidelines) when no symptoms are present.

Women may return for rescreening if they continue to meet BCCS financial and clinical eligibility requirements. Women with a history of cancer may return for screening when they conclude their cancer treatment, if they continue to meet BCCS financial and clinical eligibility requirements.

Exceptions to Rescreening

Contractors are not required to rescreen a woman if the contractor has documented that she:

- Cannot be located or has moved from the contractor's service area;
- No longer meets the BCCS financial or clinical eligibility;
- Has Medicare Part B or other adequate health insurance which provides coverage for breast and/or cervical cancer screening and diagnostic testing;
- Refuses (in writing or verbally) to return for BCCS services.

Standing Delegation Orders and Procedures

Contractors must ensure that all clinical services are provided in compliance with statutes and rules governing medical and nursing practice consistent with national evidence-based clinical guidelines. When BCCS revises a policy, contractors need to incorporate the revised policy into their written protocols, standing delegation orders (SDOs), and procedures.

Standing Delegation Orders

When services are provided by unlicensed and licensed personnel, other than advanced practice nurses or physician assistants, whose duties include actions or procedures for a patient population with specific diseases, disorders, health problems or sets of symptoms, must have written standing delegation orders (SDOs) in place. SDOs are distinct from specific orders written for a particular individual. SDOs are instructions, orders, rules, regulations or procedures that specify under what set of conditions and circumstances actions should be instituted. The SDOs delineate under what set of conditions and circumstances an RN, LVN, or non-licensed healthcare provider (NLHP) actions or tasks may be initiated in the clinical setting, and provide authority for use with individuals when a physician or advanced practice provider is not on the premises, and or prior to being examined or evaluated by a physician or advanced practice provider. Example: SDO for assessment of Blood Pressure which includes an RN, LVN or NLHP that will perform the task, the steps to complete the task, the normal/abnormal range, and the process of reporting abnormal values.

Other applicable SDOs when a physician is not present on-site may include, but are not limited to:

- Obtaining a personal and medical history;
- Performing an appropriate physical exam and the recording of physical findings;
- Initiating/performing laboratory procedures;
- Administering or providing drugs ordered by voice communication with the authorizing physician;
- Handling medical emergencies – to include on-site management as well as possible transfer of client;
- Giving immunizations; or
- Performing pregnancy testing.

The SDOs must be reviewed, signed, and dated by the supervising physician who is responsible for the delivery of medical care covered by the orders and other appropriate staff, at least annually and maintained on-site.

Prescriptive Authority Agreements

When services are provided by Advanced Practice Registered Nurse(s) and/or Physician Assistant(s), it is the responsibility of the contractor to ensure that a properly executed prescriptive authority agreement (PAA), as required by [Texas Administrative Code Title 22, Part 9, Chapter 193](#), is in place for each such provider. This is true whether the provider is employed by the contractor or is providing services by subcontract with or referral by the contractor. The PAA must meet all the requirements delineated in the [Texas Occupations Code, Chapter 157](#).

The PAA need not describe the exact steps that an advanced practice registered nurse or physician assistant must take with respect to each specific condition, disease, or symptom. The PAA and any amendments must be reviewed at least annually, dated, and signed by the parties to the agreement. A copy of the current PAA must be maintained on-site where the advanced practice registered nurse or physician assistant provides care.

Chapter 4 – Breast Clinical Policy

Breast Cancer Screening Services

Breast Cancer Screening Eligibility

Breast screening refers to procedures including clinical breast examination (CBE), screening mammogram and MRI for women who present without symptoms suspicious for breast cancer.

The priority population for NBCCEDP mammography services is women between the ages of 50 and 64. If necessary, recruitment efforts should be concentrated on the priority population. For breast cancer screening to be most effective, the screening must be conducted at **regular intervals**.

Risk Screening and Individual Counseling

All women should have an assessment of their risk for breast cancer, updated periodically, to include the individual's age and ethnicity, personal and family history of breast cancer, other relevant genetic predisposition to breast cancer, and any history of chest radiation (particularly before age 30). Providers can choose whichever method they prefer to determine if a woman is at high risk for breast cancer.

All individuals should be counseled on breast awareness, and advised to be familiar with their breasts and to report any changes (such as a mass, lump, thickening, or nipple discharge) promptly.

Screening Frequency

The following considerations* apply to women 40 years of age and older who do not have a preexisting breast cancer or other high-risk breast lesion and who do not have a known underlying genetic mutation (such as a BRCA1 or 2 mutation, or other familial breast cancer syndrome) or a history of chest radiation at an early age.

- All individuals 50-64 years of age should be offered screening mammography every other year.
- The decision for screening mammography in women 40-49 years of age should be individualized:
 - ▶ While screening mammography may reduce breast cancer-related deaths in this population, the number of deaths prevented is less than in older populations and the number of false-positive mammography results and negative biopsies is higher.
 - ▶ Women who undergo regular screening mammography face a risk of the diagnosis and subsequent treatment of breast cancer that would not otherwise have become apparent or threatened their health during their lifetime (overtreatment).

- ▶ Women with a first-degree relative (parent, sibling, or child) with breast cancer are at increased risk and may benefit more from screening in their 40s than average-risk women.
- ▶ Women who place a higher value on the potential benefits of screening than on the potential harms may choose, and should be allowed, to undergo biennial screening beginning sometime between age 40 and 49.
- Digital mammography combined with breast tomosynthesis may improve the rate of cancer detection and decrease call-back rates in some women, although this practice may increase the total radiation dose.
- There is insufficient evidence to assess the balance of benefits and harms for the use of breast ultrasonography, magnetic resonance imaging, or other methods of adjunctive screening in women with dense breasts identified on an otherwise negative screening mammogram.

More frequent or earlier screening mammography may be considered in women with increased or uncertain individual breast cancer risk and in other circumstances where the balance of potential benefits and harms of screening is felt to justify it.

*Note that the recommendations for frequency of mammography screening described above come from the U.S. Preventive Services Task Force Recommendation Statement on Screening for Breast Cancer. The National Comprehensive Cancer Network recommends annual screening mammography be offered to all asymptomatic women 40 years of age and older. Links to both guidelines are provided in the References section immediately below.

Reimbursement guidelines for mammography screening:

- Ages 40 and older: Women may be screened annually.
- Ages under 40: Asymptomatic and without a history of breast cancer are not eligible for breast cancer screening services.

NOTE: Contractors must document high-risk assessment and any screening guideline exceptions for women ages 40-49 within Med-IT cycle notes.

Transgender Clients

Transgender women (male-to-female), and meet all program eligibility requirements are eligible to receive breast cancer screening and diagnostic services. Transgender men (female-to-male) may receive cancer screening if they meet program eligibility requirements.

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Those recommendations include for “transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use > 5 years, positive family history, BMI > 35).” Those preventive care recommendations can be found at transcare.ucsf.edu/guidelines/breast-cancer-women.

BCCS recommends that grantees and providers counsel all eligible women, including transgender men and women, about the benefits, potential harms, and limitations of screening and discuss individual risk factors to determine if screening is medically indicated.

Components of Breast Cancer Screening

The contractor must provide a complete breast cancer screening, which includes a mammogram, individualized client education, tobacco use assessment and Quit Line referral if indicated, and may include a clinical breast examination (CBE). The contractor must document the breast cancer screening components in the client's record and Med-IT.

A breast health history must be included as part of the breast cancer screening. The health history includes:

- Date and time intervals of previous mammograms;
- Results of previous mammograms;
- Date and results of the last CBE;
- Date and results of any previous breast surgery;
- Date of last menstrual period;
- Medication history, including current or previous use of hormones (hormone replacement therapy, oral contraceptives, etc.);
- Other risk factors for breast cancer (personal history of breast cancer, or family history of first degree relatives with breast cancer); and
- Description of breast symptoms, if any.

Clinical Breast Examination (CBE)

A CBE is not a pre-requisite for reimbursement for a screening mammogram by the BCCS program. Grantees should document if a CBE is not indicated for Minimum Data Element (MDE) records. CBEs must be performed by a physician, physician's assistant, nurse practitioner, certified nurse midwife, or additionally a qualified registered nurse with specialized training as required under standing delegation orders (SDO). The specialized RN CBE training must be documented in the personnel record (e.g. an educational certificate/degree or continuing education). Complete documentation of the CBE must be included in the patient health record and Med-IT.

A CBE is required prior to diagnostic testing, but a repeat CBE is not required for women referred to a BCCS contractor after an abnormal CBE or screening mammogram.

Screening Mammogram Special Circumstances

Additional views as used with a diagnostic mammogram (4-6 specified diagnostic views) can be used to screen women with the following special circumstances:

- Women with cosmetic or reconstructive breast implants; and/or
- Women with history of breast cancer and lumpectomy (partial mastectomy).

Screening Magnetic Resonance Imaging (MRI)

Breast MRI may be reimbursed by BCCS in conjunction with a screening mammogram after program approval. Contractors must request approval by completing [Form 5203](#), Breast MRI Pre-Authorization Request.

Women at high risk for breast cancer should undergo both screening MRI and screening mammogram annually. Women considered high risk for breast cancer include anyone with one or more of the following risk factors:

- A BRCA mutation;
- A first-degree relative who is a BRCA carrier;
- A lifetime risk of 20-25% or greater as defined by risk assessment models; or
- Radiation therapy to the chest when they were between the ages of 10 and 30 years.

Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment

Magnetic Resonance Imaging: Restrictions

- Breast MRI must never be performed alone as a breast cancer screening tool.
- Breast MRI cannot be reimbursed to assess the extent of disease for staging in women already diagnosed with breast cancer.
- All breast MRI procedures require pre-authorization.
- Pre-authorization form must be received **a minimum of three (3) business days** prior to the anticipated procedure date.
- MRI procedures must be performed in facilities with dedicated breast MRI equipment able to perform MRI-guided breast biopsies.

Imaging Reports – Screening mammogram/MRI

Radiology facilities must prepare a written report of the results of each radiologic examination, including screening mammography and MRI. This report must include the following:

- The name of the client and an additional client identifier;
- The name of the physician who interpreted the mammogram; and
- An overall final assessment of findings utilizing the BIRADS system of classification.

Breast Cancer Diagnostic Services

Breast Cancer Diagnostic Eligibility

Applicants ages 18 to 64 may be eligible for breast cancer diagnostic services if they have an abnormal breast cancer screening result and meet program eligibility requirements.

Managing Women with Abnormal Breast Cancer Screening Results

The management of women whose mammogram and/or CBE are abnormal relies on a body of scientific literature that is constantly growing and changing. Providers should follow standards established by such organizations as the National Comprehensive Cancer Network (www.nccn.org) and the American College of Radiology (www.acr.org).

Reimbursement for Complications of Breast Procedures

Contractors may request reimbursement for treatment costs associated with patient complications related to breast biopsy procedures that occur in the immediate post-procedure or post-operative period, excluding inpatient hospital services. Contractors may be reimbursed through a voucher system for approved charges up to \$3000 per occurrence from awarded contract funds. To request reimbursement, contractors must email Form 5205, Breast and Cervical Diagnostic Procedure Complication Reimbursement Request and supporting documents to BCCS program staff at BCCSprogram@hhsc.state.tx.us.

Supporting documents include:

- The client's Med-IT ID and date of service when treatment procedure(s) were performed on the client in question;
- A narrative summary detailing the breast biopsy procedure performed and any related complications which have been documented in the Navigation or Cycle Note section of the client's Med-IT record;
- All emergency room, surgical, and progress notes, etc. for the client related to complications of the procedure;
- The procedure note and/or operative report, etc. for the initial procedure; and
- A completed paper CMS-1500 form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the BCCS Program).

References

Siu, AL. Screening for breast cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2016;164(4):279-296. Available at annals.org/article.aspx?articleid=2480757.

National Comprehensive Cancer Network. (2018). NCCN clinical practice guidelines in oncology: Breast cancer screening and diagnosis. Version 2.2018. Available at www.nccn.org/professionals/physician_gls/f_guidelines.asp#breast_screening.

Chapter 5 – Cervical Clinical Policy

Cervical Cancer Screening Services

The cervical cancer priority population includes women who have never been screened. If necessary, recruitment efforts should be concentrated on the priority population. For cervical cancer screening to be most effective, the screening must be conducted at **regular intervals**.

Cervical Cancer Screening Management

Cervical cancer screening is primarily performed using the Pap test and the HPV DNA test. BCCS utilizes [United States Preventive Services Task Force \(USPSTF\)](#) cervical cancer screening recommendations.

Clinical and reimbursement guidelines for cervical screening:

- Ages 21-29: Cervical cytology (Pap smear) alone every three (3) years, with reflex human papillomavirus (HPV) testing when cytology reveals atypical squamous cells of undetermined significance (ASCUS).
- Ages 30-64: Cervical cytology (Pap smear) alone every three (3) years, with reflex HPV testing for ASCUS or cervical cytology and HPV co-testing every five (5) years (preferred).
- Ages under 21: Not eligible for cervical cancer screening.

Special Circumstances

Special circumstances may warrant alterations in screening intervals as determined by a clinician. Special circumstances must always be documented in Med-IT cycle notes. These may include:

- Clients considered high-risk (e.g. HIV+, immunosuppressed, exposed to Diethylstilbestrol (DES) in utero, history of cervical cancer, etc.);
- Clients who had a hysterectomy for CIN disease may continue screening for 20 years;
- Clients who have had cervical cancer may be screened indefinitely as long as they are in good health; and,
- Applicants who have had a hysterectomy for benign disease and the cervix is still present may be eligible for cervical cancer screening services. Funds can be used to pay for an initial examination to determine if the cervix is still present.

Transgender Clients

Transgender men (female-to-male) who have a cervix may receive BCCS cervical cancer screening services if other eligibility criteria are met. Transgender women (male-to-female) are not eligible for cervical services.

Components of Cervical Cancer Screening

The clinical components of cervical cancer screening are pelvic examination, Pap test, HPV test if indicated, clinical breast exam (CBE), client education, tobacco assessment, and Quit Line referral, if indicated. The contractor must document the CBE and cervical cancer screening components in the client's record and Med-IT.

A cervical health history must be included as part of the cervical cancer screening. The health history includes:

- Date and results of the last pelvic examination and Pap test;
- Date and results of any past diagnostic procedure(s) and/or treatment(s) for cervical disease;
- Date of last menstrual period and pregnancy history;
- Medication history, including current or previous use of hormones (hormone replacement therapy, oral contraceptives, etc.);
- Risk factors for cervical cancer; and
- Description of present pelvic symptoms.

Clinical components of cervical cancer screening must be performed by a physician, physician's assistant, nurse practitioner, certified nurse midwife, or a qualified registered nurse with specialized training as required under SDOs. The RN's specialized training for cervical cancer screening must be documented in the personnel record (e.g. an educational certificate/degree or continuing education).

Contractors must have policies and procedures to ensure healthcare providers follow evidence-based clinical guidelines and/or provide clinical services consistent with current nationally recognized standards of care.

HPV Testing

HPV DNA testing is a reimbursable procedure when used for screening with Pap testing (i.e., co-testing) and for follow-up of abnormal Pap results as per the [American Society for Colposcopy and Cervical Pathology \(ASCCP\)](#) algorithms.

- Reimbursement for low-risk HPV DNA panel is not permitted;
- HPV tests must be FDA approved and clinically validated.

Cervical Cancer Diagnostics

Cervical Cancer Diagnostic Eligibility

Applicants ages 18-64 who meet BCCS general requirements may receive diagnostic services. BCCS funded diagnostics services must be delivered according to the [ASCCP guidelines](#).

Follow-Up of Abnormal Cervical Screening

When the pelvic exam and/or cervical cancer screening test (Pap test) results are abnormal, further diagnostic follow-up is required. A normal Pap test does not rule out cancer if a woman has a cervical lesion on pelvic examination. A colposcopy

and/or cervical biopsy are allowed if determined appropriate by the clinician after an abnormal pelvic exam.

BCCS contractors must follow the algorithms for the management of the specific type of abnormal result and in consideration of special populations (e.g. pregnant women and clients age 20 years and younger or at high risk).

Components of Cervical Cancer Diagnostics

Diagnostic Procedures

Tests performed to confirm or rule out cancer when screening tests yield abnormal results include: colposcopy, cervical biopsy, endocervical curettage (ECC), and diagnostic excisional procedures. CBE is not required when a client is referred to BCCS after an abnormal pelvic exam or abnormal Pap test. Diagnostic procedures must be performed by qualified clinicians with specialized training (physicians, physician's assistants, nurse practitioners or certified nurse midwives).

Clinical Utilization Restrictions for Diagnostic Procedures

Diagnostic LEEP conization, laser conization, and cold knife conization **cannot** be performed on the following clients:

- Any age in the absence of HSIL, ASC-H or higher abnormality; and,
- Any age with histology CIN I or lesser abnormality for a duration less than two years and in the absence of HSIL or atypical glandular cells (AGC) on Pap tests.

Other Restrictions

The BCCS Program will monitor the use of facility/anesthesia services for cold knife conization, as well as utilization for LEEP.

Contractors are encouraged to develop subcontracts with practitioners having specialized training in the management of cervical disease including LEEP as an office-based procedure.

Consultations

Consultations (as defined in [Introduction, Definitions](#)) for follow-up of abnormal cervical results must be performed by healthcare providers with specialized training in the management of cervical disease, including skill performing invasive diagnostic procedures.

A consultation can only be performed by a healthcare provider who did not perform the original screening examination. If that healthcare provider is not a licensed physician, appropriate protocols must be established and documented for that provider. Consultations **must** involve direct examination of the client and are billed using office visit codes.

Access to Treatment

The following treatment options may be available for eligible clients with a qualifying diagnosis:

- General Revenue funds for Cervical Dysplasia Management and Treatment of clients who have qualifying diagnoses and are not eligible for MBCC. For a description of qualifying diagnoses, see the chapter entitled "Cervical Dysplasia Management and Treatment".
- Medicaid for Breast and Cervical Cancer (MBCC) for applicants who have qualifying breast or cervical cancer diagnoses and meet all other MBCC eligibility criteria. See [Section II, Chapter 7](#) and [Section IV, Appendix II](#) for guidance.

Office-Based Procedures Performed in an Ambulatory Surgical Center

Special circumstances may arise that necessitate an office-based diagnostic procedure being performed in an ambulatory surgical center. These services require pre-authorization **prior** to the client receiving services in an ambulatory surgical center or other outpatient facility. Contractors must submit [Form 5204](#), Office-based Procedures Performed in an Ambulatory Surgical Center Pre-authorization Request, along with any supporting documentation to BCCSprogram@hsc.state.tx.us **a minimum of three (3) business days prior to the anticipated date of the procedure**. BCCS will not reimburse for any office-based procedures performed in an ambulatory surgical center that have not received pre-authorization. Evidence of pre-authorization approval must be made available to BCCS review staff during Quality Assurance/Quality Improvement on-site visits. Special circumstances may include clients with a history of cervical cancer, obesity, cervical stenosis, vaginal stenosis or atrophy.

Reimbursement Following Complications of LEEP and LEEP Conization Procedures

Contractors may request reimbursement for treatment costs associated with patient complications related to LEEP and conization procedures that occur in the immediate post-procedure or post-operative period, excluding inpatient hospital services. Contractors may be reimbursed through a voucher system for approved charges up to \$3000 per occurrence from awarded contract funds. To request reimbursement, contractors must email [Form 5205](#), Breast and Cervical Diagnostic Procedure Complication Reimbursement Request Form and supporting documents to BCCS program staff at BCCSprogram@hsc.state.tx.us.

Supporting Documents include:

- The client's Med-IT ID number and date of service when treatment procedure was performed on the client in question;
- A narrative summary detailing the LEEP/conization procedure performed and any related complications which have been documented in the Case Management or Cycle Note section of the client's Med-IT record;

- All emergency room, surgical, and progress notes for the client related to complications of the procedure;
- The procedure notes and/or operative report for the initial procedure; and
- A completed paper CMS-1500 Health Insurance Claim Form detailing the procedures for which the contractor is seeking reimbursement (list all procedures related to the complication even if they are not typically reimbursable under the BCCS Program).

Chapter 6 – Cervical Dysplasia (CD) Management and Treatment

CDC strictly prohibits reimbursement of treatment services; however, contractors may receive limited state funding for management and treatment of cervical dysplasia (CD). Cervical dysplasia funds may **not** be used to reimburse for BCCS cervical screening or diagnostic services.

Cervical Dysplasia Eligibility

Applicants meet BCCS general eligibility criteria and have a definitive, biopsy-confirmed diagnosis of one of the following diagnoses:

- CIN I, CIN II, CIN II-III; or,
- High-grade dysplasia (severe dysplasia/CIN III) or CIS.

Contractors must assess clients with severe dysplasia/CIN III/CIS for MBCC eligibility before using CD funds to pay for treatment services. Undocumented applicants are eligible for CD services.

Components of Cervical Dysplasia Services

Cervical dysplasia management and treatment services may include:

- Follow-up testing and observation without treatment, e.g. cytology (Pap tests), HPV testing, colposcopy.
- Treatment using excision or ablation, e.g. cryotherapy, cervical conization.
- Patient Navigation– See [Section II, Chapter 8](#).

Reimbursement for Cervical Dysplasia Management and Treatment Services

Reimbursement for cervical dysplasia services is limited to the codes which begin with “CD”, “FCX”, and “FCD” listed separately in the BCCS Billing Guidelines. These codes must be billed in the Med-IT system. Contractors should bill CD services throughout the dysplasia plan of care and return clients to BCCS services once released to routine screening intervals by the provider.

BCCS contractors **must** submit specimens for program covered laboratory testing to a U.S. CLIA certified laboratory and adhere to all quality management requirements for cytology quality assurance as stated in [Section I, Chapter 7](#).

Office-based Procedures Performed in an Ambulatory Surgical Center

Special circumstances may arise that necessitate an office-based diagnostic procedure being performed in an ambulatory surgical center. These services require pre-authorization **prior** to the client receiving services in an ambulatory surgical center or other outpatient facility. Contractors must submit [Form 5204](#), Office-based Procedures Performed in an Ambulatory Surgical Center Pre-Authorization Request along with any supporting documentation to

BCCSprogram@hpsc.state.tx.us a minimum of three (3) business days prior to the anticipated date of the procedure. BCCS will not reimburse for any office-based procedures performed in an ambulatory surgical center that have not received pre-authorization. Evidence of pre-authorization approval must be made available to BCCS review staff during Quality Assurance/Quality Improvement on-site visits. A special circumstance may be an abnormal pelvic exam, a client with a history of cervical cancer, obesity, cervical stenosis, vaginal stenosis or atrophy.

Chapter 7 – Medicaid for Breast and Cervical Cancer (MBCC)

The Health and Human Services Commission (HHSC) administers the Medicaid for Breast and Cervical Cancer (MBCC) Program, a special Medicaid program authorized by federal and state laws to provide access to cancer treatment services through full Medicaid benefits to qualified women.^{6, 7, 8}

Medicaid for Breast and Cervical Cancer Eligibility

Applicants who need treatment must meet each of the following criteria:

- Diagnosed by a BCCS contractor or diagnosed by any physician and referred to a BCCS contractor for the application process;
- Have a qualifying diagnosis:
- At or below 200% of the federal poverty level; and
- Be uninsured, that is, she must not otherwise have creditable coverage. Creditable coverage is health care coverage that covers treatment for breast and cervical cancer, including current enrollment in Medicaid or Medicare Part A, Part B, or Part A & B.
 - ▶ NOTE: If the woman is enrolled in the Healthy Texas Women (HTW) Program at the time of diagnosis, she will be dis-enrolled from HTW in order to be enrolled in MBCC by Medicaid eligibility staff; and
- Under age 65; and
- U.S. citizen or eligible immigrant; and
- Texas resident.

Need Treatment

An individual is considered to need treatment for breast or cervical cancer if the initial screen under BCCS or, subsequent to the initial period of eligibility, the individual's treating health professional determines that:

1. Definitive treatment for breast or cervical cancer is needed, including treatment of a precancerous condition or early stage cancer, and including diagnostic services as necessary to determine the extent and proper course of treatment; and
2. More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

Disease surveillance is not considered to be active treatment for new applicants.

Clients receiving hormonal treatment and/or breast reconstruction are considered to be receiving treatment and **may remain eligible** for MBCC benefits if the client had initial treatment paid for by Medicaid. Clients with triple negative receptor breast cancer (TNRBC) receiving active disease surveillance are also considered to

⁶ 42 C.F.R. §435.213.

⁷ Human Resources Code Section §32.024(y) and (y-1).

⁸ Title 1 of the Texas Administrative Code Chapter 366, Subchapter D.

be receiving treatment and **may remain eligible** for MBCC benefits if active treatment was paid for by MBCC.

Active disease surveillance (for the purposes of determining eligibility for MBCC) is periodically monitoring disease progression to quickly treat cancerous and precancerous conditions arising from the presence of a previously diagnosed breast or cervical cancer.

Verification of Citizenship and Identity

As part of Public Law 109-171, Deficit Reduction Act of 2005, individuals declaring to be a United States (U.S.) citizen or nationals of the U.S. must provide evidence of citizenship when applying for or receiving Medicaid benefits. Documented verification must establish both citizenship and identity. The Medicaid citizenship and qualified immigrant rules apply to MBCC. In general, to be eligible for Medicaid an individual must either be a U.S citizen or a qualified immigrant.

Citizenship guidelines and verification requirements may be found at hhs.texas.gov/laws-regulations/handbooks/twh/part-a-determining-eligibility/a-300-citizenship.

If an applicant states that she is a citizen or legal immigrant, indicate on the last page of Form H1034 that she is **presumptively eligible**. If the BCCS Contractor (or health provider) is uncertain whether a woman meets citizenship and eligible immigrant requirements, the completed H1034 should be submitted for processing and determination, along with any citizenship or immigration documents the woman provides. If an applicant states that she does not meet citizenship requirements, an MBCC application may not be submitted.

For assistance with client eligibility and citizenship determination, call 2-1-1 or 877-541-7905.

Presumptive Eligibility

Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period before a full citizenship or legal immigrant eligibility determination is complete. Presumptive eligibility facilitates the prompt enrollment and immediate access to services for women who need treatment for breast or cervical cancer. The earliest date presumptive eligibility may begin is the day after the client received a biopsy-confirmed qualifying diagnosis.

Coverage

The earliest date a woman may be enrolled in full Medicaid coverage through MBCC is the **day after** a biopsy-confirmed qualifying diagnosis. Coverage may continue through the duration of her cancer treatment. MBCC services are not limited to the treatment of breast or cervical cancer. If a client has a question about their Medicaid benefits or wants to locate a Medicaid provider in their area, they can call the TMHP Medicaid Client Help Line at 800-335-8957.

A client can continue to receive full Medicaid benefits if they meet the eligibility criteria and provide proof from their treating physician that they are receiving

active treatment for breast or cervical cancer by returning Form H1551, Treatment Verification, along with Form H2340, Medicaid for Breast and Cervical Cancer Renewal, to HHSC before the end of the 6-month coverage renewal period.

If the client's cancer is in remission and the physician determines that the client only requires routine health screenings (e.g. annual breast examinations, mammograms and pap tests as recommended by the American Cancer Society and/or the U.S. Preventative Services Task Force), the client is not considered to be receiving treatment and MBCC coverage would not be renewed. If a client is later diagnosed with a new breast or cervical cancer, recurrence of breast or cervical cancer, or metastasis related to the primary qualifying diagnosis, she may re-apply for MBCC.

MBCC Responsibilities

BCCS State Office Responsibilities

BCCS program staff are responsible for reviewing the clinical documents and other required documents and submitting the information to HHSC Centralized Benefits Services (CBS) within 3-5 business days of receipt of the **complete** application package. **Once submitted for consideration at HHSC Centralized Benefits Services, BCCS staff cannot review application status and does not assist with or collect documents for pended MBCC applications.**

HHSC MBCC Eligibility Staff Responsibilities

HHSC Centralized Benefits Services (CBS) staff verify receipt of the H1034 application within 48 hours and process the application within two business days of receipt. If additional information is required, clients are placed on MBCC Presumptive and allowed 10 days to provide the required information. Eligibility for all applications will be determined within 45 calendar days of receipt of the application packet.

Form TF0001, Notice of Case Action, is sent the same day eligibility is determined. This notice informs clients of their Medicaid status with an effective date of coverage and notifies the client of their Medicaid Eligibility Determination Group number. Clients may contact 2-1-1 to request the status of their application and Medicaid number.

MBCC inquiries (from BCCS contractors) on client reinstatements, approvals, denials and final application status should be sent to CBS_MBCC@hhsc.state.tx.us.

BCCS Contractor Responsibilities

BCCS contractors are responsible for assisting women with completion of Form H1034, Medicaid for Breast and Cervical Cancer application, determining presumptive eligibility for qualified women, and assessing patient navigation needs. In situations where a BCCS contractor or subcontractor is unsure about a cancer diagnosis, the first step should be:

1. Review Guidelines for Determination of Qualifying Diagnosis;
2. If still unclear, the contractor should consult with their Medical Director or physician/provider staff regarding the diagnosis.

BCCS contractors should not submit a diagnosis to the BCCS Clinical team or BCCS Staff for evaluation prior to submitting an MBCC application. **If contractors submit applications to BCCS which are known to be ineligible for MBCC, BCCS may withhold or recover payment.**

Initial BCCS contractor/subcontractor responsibilities:

- Collection and review of documents to ensure eligible income, age, insurance, citizenship and biopsy-confirmed qualifying diagnosis;
 - ▶ Do not send bills, tax forms, or other financial statements or information to BCCS. Contractors shall retain proof of income in client record and document financial eligibility in Med-IT.
 - ▶ Verify that analysis of all biopsies has been performed by a U.S. CLIA certified laboratory.
 - ▶ Verify the date of specimen collection is documented (specimen collection date is typically found on the Pathology report, Operative record, or Procedure note);
- Assistance with the completion of the medical assistance application, Form H1034;
 - ▶ The name on Form H1034 must match the name on the client's social security card or legal identification. If names differ, contractors must provide clarification.
 - ▶ Write Driver's License and Alien ID numbers on the copy of the identification cards.
- Complete Med-IT data entry and billing prior to submitting the completed MBCC application to BCCS, including the Final Diagnosis and Treatment Screen for clients diagnosed with BCCS funds. The specific name of the treatment facility will be needed to facilitate closing out the cycle in Med-IT and for CDC reporting. Contact the Med-IT Data System Helpdesk (med-ithelpdesk@hhsc.state.tx.us) to add facilities to Med-IT.

BCCS contractors must submit the MBCC application and other required documents to BCCS no later than two (2) working days from the date presumptive eligibility determination is made (certification date at the bottom of page 6 of the application).

Submitted MBCC Application documents include:

- Form H1034;
- Final biopsy confirmed report for the qualifying diagnosis. Preliminary or temporary reports of qualifying diagnoses will not be accepted;
- Any other supportive documents that may be necessary to verify the date of specimen collection and need for cancer treatment. (e.g. operative record, procedure note or progress notes);
- If the diagnosis is more than six months old submit both of the following:

- ▶ Physician letter/office visit note or other documentation specifying need for active treatment; and
- ▶ Recent medical tests supporting the need for active treatment.
- To support a metastatic or recurrent cancer diagnosis, send:
 - ▶ Final biopsy-confirmed report of the original breast or cervical cancer diagnosis.
 - ▶ Diagnostic report(s) (e.g. CT scan, biopsy report, etc.) which indicate disease is "compatible with" and/or "consistent with" an original qualifying breast or cervical cancer diagnosis. For example, a diagnosis such as "metastatic adenocarcinoma consistent with the prior breast primary" would be acceptable. Many metastatic or recurrent cancers may look the same; the primary does not need to be explicitly diagnosed.

Following MBCC application submission, contractors may locate the application status in the clients Med-IT record. Contractors may also email the client Med-IT ID number to BCCS to confirm receipt of the application and supporting documents to MBCCApps@hsc.state.tx.us with subject line "Verify Receipt of MBCC Application."

Medicaid Reinstatement

A client previously enrolled in Medicaid under MBCC within the past 12 months, and who is no longer on Medicaid, but is still in active treatment or in need of active treatment for the original cancer may re-apply for MBCC. Reinstatements are handled directly by HHSC. The BCCS contractor may help the client by:

- Requesting Form H1551 (Treatment Verification Form) and Form H2340 by calling 2-1-1 or 877-541-7905;
- Assist with completing required documents; and/or
- Faxing the following documents to HHSC:
 - ▶ Form H1551 and Form H2340; and
 - ▶ Citizenship and identity verification.

State-to-State Transfers

State-to-State transfers are handled directly by HHSC. Please complete the following steps:

- **Do not** complete Form H1034.
- **Have client** call 2-1-1 or 877-541-7905.
- Have client request **Out-of-State MBCC application Form H2340-OS** and **Out-of-State treatment verification Form H1550**. 2-1-1 will send the documents to the client to complete and return to HHSC.

Pathology Specimens

Pathology specimens (original slides) collected and evaluated outside the U.S must be reviewed by a U.S. CLIA certified lab to determine a qualifying diagnosis. **The BCCS program and the client cannot be billed for the reading and interpretation of the specimen submitted to a U.S. CLIA lab.**

Options for specimen transport are:

- Client transported; or
- Lab-to-lab transported.

Chapter 8 – Patient Navigation Services

Clients often face significant barriers to accessing and completing cancer screening and diagnostics. Patient navigation is a strategy aimed to reduce disparities by helping women overcome those barriers. Patient navigation is defined as individualized assistance provided to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment services for those diagnosed with cancer.

Patient Navigation Activities

Although patient navigation services vary based on an individual client's needs, at a minimum, patient navigation for women served by the BCCS program must include the following activities:

- A written assessment of the client's barriers to cancer screening, diagnostic services, and initiation of cancer treatment.
- Client education and support.
- Resolution of client barriers (e.g., transportation, translation services).
- Client tracking and follow-up to monitor progress in completing screening, diagnostic testing, and initiating cancer treatment.
- Given the centrality of the client-navigator relationship, patient navigation must include a minimum of two, but preferably more, contacts with the client.
- Collection of data to evaluate the primary outcomes of patient navigation: client adherence to cancer screening, diagnostic testing, and treatment initiation. Clients lost to follow-up should also be tracked.

Assessment

Assessment is a cooperative effort between the client and patient navigator to examine and document the client's needs (diagnostic, treatment, and essential support services) through a process of gathering critical information from the client. The assessment includes consent and assurance of confidentiality between the client and Patient Navigator.

Planning

The plan uses short and long-term needs identified in the assessment to establish services planned, timeframes, and follow-up. As applicable, timeframes must be consistent with BCCS required screening and diagnostic intervals. Services must be completed no later than thirty (30) days from the date of the planned activity or prior to initiation of treatment, whichever is sooner.

Coordination

Coordination is the implementation of the service plan, including the appropriate use of available resources to meet the needs of the client. Coordination of services

may include scheduling appointments, making referrals, and obtaining and disseminating appropriate reports.

Monitoring

Monitoring is the ongoing assessment of the client's service plan to ensure that the client's needs are met. In addition to monitoring clients who are receiving patient navigation services, BCCS contractors must establish a system to monitor abnormal screening or diagnostic results for identifying clients who need to have patient navigation initiated.

Resource Development

Patient Navigators are responsible for identifying resources to meet client needs including dysplasia and cancer treatment services, regardless of client ability to pay. Documentation must be maintained in a resource directory developed specifically for detailing services that support BCCS-enrolled women with unmet needs.

Contractor Requirements

BCCS contractors must navigate:

- BCCS enrolled clients with abnormal screening or diagnostic results;
- Clients referred to BCCS with qualifying breast or cervical cancer diagnoses that are presumptively eligible for MBCC; and,
- Clients referred to BCCS for Cervical Dysplasia Management and Treatment. CD recipients must not be eligible for MBCC.

Patient navigation does not include eligibility determination or navigation of MBCC applicants whose presumptive eligibility determination was inaccurate.

Patient navigation is **not required** for:

- Clients with an abnormal CBE and/or screening mammogram followed by two normal diagnostic assessments/tests, e.g. diagnostic mammogram, ultrasound or referral to a breast specialist for a consultation where no further diagnostics are required.
- Clients with initial ASC-US unless colposcopy is indicated.

Terminating Patient Navigation

Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client:

- Completes screening and has a normal result;
- Completes diagnostic testing and has normal results;
- When a referral appointment for treatment has been attended;
- Client is documented as lost-to follow up or refused services; and/or

- A “Good Faith Effort” has been made according to BCCS Policy. (See [Introduction, Definitions](#)); or
- Initiates cancer treatment or refuses treatment.

When a client concludes her cancer treatment and has been released by her treating physician to return to a routine screening schedule, she may return to the program and receive all services, including patient navigation, as long as she continues to meet BCCS eligibility requirements.

Requirements for Patient Navigation Compliance

- Patient Navigation must include assessment and client consent using [Form 5202](#), Patient Navigation Consent. Agencies using alternate forms must maintain proof of HHSC approval onsite for Quality Assurance visits.
- A copy of the signed Patient Navigation Consent must be maintained in the client’s record. The assessment is to be conducted within 30 days from the date of referral for diagnostic procedures or prior to the initiation of the first diagnostic service, whichever is sooner.
- The assessment should be conducted in a face-to-face interview format, if possible. For non-face-to-face assessments, the client should sign and date the Patient Navigation Consent upon their next visit to the agency.
- The service plan must be documented in the Med-IT Data System Navigation screen and the client’s progress notes.
- Contractor must ensure that monitoring of abnormal results is conducted and documented at the contractor level.
- Contractor must contact clients with abnormal screening and non-cancerous diagnostic results no later than thirty (30) days following receipt of an abnormal result. All screening and diagnostic services must be documented; including procedure specific consent, if applicable.
- Contractor must contact clients with cancer diagnoses no later than two (2) weeks following the receipt of a cancer diagnostic result. All screening and diagnostic services must be documented; including procedure specific consent, if applicable.
- Within one month after completion of the patient navigation plan for a diagnosis of cancer or cervical dysplasia, the patient navigator must follow-up and document that the service was implemented.
- As additional needs are identified, they are recorded on the plan and the accompanying services and time frames are indicated.
- Contractors must develop and maintain a resource directory containing information on services that could support women with unmet needs who are eligible for BCCS, which may include Marketplace (www.Healthcare.gov) referral material.
- Contractors must document client refusal, lost to follow-up and “Good Faith Effort” as appropriate.

Navigation of MBCC Referrals

Referred-in MBCC applicants must be provided a needs assessment and MBCC application assistance if determined to meet presumptive eligibility. BCCS contractors may choose to provide patient navigation for MBCC referrals that were determined to be ineligible. If patient navigation is initiated for a client found to be ineligible for MBCC, BCCS contractors shall follow the client until treatment is initiated but may **not** bill BCCS for the patient navigation services provided. If patient navigation will not be initiated, the client should be provided with information about available local resources and referred to the diagnosing health professional.

Good Faith Effort

A Good Faith Effort is making at least three (3) separate documented attempts to obtain treatment for clients with a pre-cancerous or cancerous breast or cervical diagnoses who do not meet the eligibility criteria for CD and/or MBCC enrollment. Examples include, but are not limited to, seeking service(s) for clients through: American Cancer Society, Susan G. Komen for the Cure, LIVESTRONG or other healthcare providers and facilities through pro-bono, sliding fee scale, reduced payment plan, or sponsorship assistance.

Client Refusal of Services

The contractor must attempt to obtain in writing and document in the client record informed refusal from the client if the client fails to keep appointments or refuses recommended procedures. If the client cannot, or will not, sign an informed refusal the contractor must document verbal refusal. Before closing the client record as a refusal, a thorough review of the client's plan, recommendations and navigator's actions must be conducted to ensure proper closure.

Lost to Follow-Up

Before a contractor can consider a client as lost to follow-up, the contractor must have at least three separate documented attempts to contact the client, with the last attempt sent by certified mail. The contractor must allow sufficient time between contact attempts for the client to reply/respond to the contractor.

Client contact attempts can be made by:

- Office visit,
- Telephone,
- Home visit, and/or
- Mail.

Attempts to contact the client must be written or presented verbally (when appropriate) in the client's primary language, if limited English proficiency, including appropriate provisions for the visually and hearing impaired.

Chapter 9 – Community Education, Outreach & Inreach

To provide inreach, outreach, and education to the community, each contractor must establish a comprehensive inreach, outreach, and education plan. This plan will include the determination of the priority population, a recruitment work plan, inreach and outreach methods, and an evaluation of the effectiveness of recruitment strategies. Resources for evidence-based strategies can be found in The Community Guide and Cancer Control PLANET.

Contractors should have an array of materials and resources to aid in community awareness. Contractors must develop and maintain relationships with local partners/collaborators that can assist in the recruitment of the priority population.

Contractors must include in their outreach plans how they plan to do the following:

- Implement strategies to enroll clients in BCCS, including:
 - ▶ Identifying the priority populations to receive information;
 - ▶ Identifying the population(s) at highest risk for developing breast and/or cervical cancer; and
 - ▶ Establishing relationships with internal and external partners to reach eligible clients in the priority populations.
- Implement strategies to raise community awareness of MBCC including:
 - ▶ Educating partners such as subcontractors, other health care providers, community organizations, coalitions, and local advocacy groups about MBCC and how to appropriately refer a non-BCCS diagnosed client for MBCC screening; and
 - ▶ Educating clients diagnosed with breast or cervical cancer about MBCC eligibility requirements and how to apply for services.
- Provide information to each eligible woman in her primary language;
- Provide access to information that is culturally sensitive, linguistically appropriate, and available to the visually and hearing impaired;
- Conduct outreach activities specifically for clients age 50-64 years if less than 75% of all mammograms are provided to women ages 50-64;
- Conduct outreach activities specifically for clients who have never received cervical cancer screening if less than 20% of clients newly enrolled for cervical cancer screening have never had a pap test;
- Collect information describing how clients learned about BCCS, and enter data into the Med-IT Data system using the “Learned of Program” function on the enrollment screen; and
- Submit the agency’s comprehensive outreach and education plan within 30 days after the start of each contract term. Submit plans to BCCSprogram@hsc.state.tx.us.

Section III – Reimbursement and Reporting

Chapter 1 – Requirements for Reimbursement

Billing Procedures for BCCS Contractors

Contractors must accept Fee-For-Service (FFS) payment rates for screening, diagnostic, and patient navigation services specified in Med-IT.

BCCS client data shall be entered in Med-IT **no later than 30 days after provision of each service**. BCCS services and procedures that have met business rules will be marked approved to pay and submitted electronically to HHSC for processing through the State Comptroller. Paid claims will be deposited into the contractor's direct deposit account. Contractors may only be reimbursed for services listed in the BCCS Billing Guideline.

Completed MBCC applications shall not be submitted to HHSC until all client data and patient navigation billing has been entered in Med-IT.

Funding for Screening Mammograms/MRI

Reimbursement for screening mammograms/MRI for high-risk asymptomatic women ages 40-49 must be initially billed using the B codes listed in the BCCS Billing Guideline.

BCCS funds may not be used for breast cancer screening in clients under the age of 40.

Funds for Cervical Dysplasia (CD) Management and Treatment

Federal funds may never be applied to treatment services. Cervical dysplasia funds should be used for cervical dysplasia management and treatment services for women who meet BCCS eligibility criteria **and** have a definitive diagnosis (biopsy confirmed) of:

- CIN I, CIN II, CIN II-III; or
- CIN III or CIS if the client does not meet eligibility criteria for Medicaid for Breast and Cervical Cancer (MBCC). CIN III/CIS results should always be screened for MBCC eligibility **prior** to CD treatment enrollment. See [Section II, Chapter 6](#).

Chapter 2 – Reporting

Financial Reconciliation Report (FRR)

The FRR is the annual reconciliation report submitted to HHSC. Each grantee must report final financial results as part of the closeout process on each contract. This report is due no later than 60 days after the end of the applicable contract term, or 30 days after the last pay file is run, whichever is later. Send completed form to WHSFinance@hhsc.state.tx.us.

Match Report

Matching funds refer to non-federal resources (money and/or in-kind contributions). The CDC requires the BCCS program to provide \$1 in match for every \$3 CDC funding awarded. All BCCS contractors must secure, budget, expend, and report non-federal match. Match reports are submitted to HHSC on a quarterly basis to the email address WHSFinance@hhsc.state.tx.us.

Section IV – Appendices

Appendix I – MBCC Application Checklist

- **Incomplete MBCC applications cannot be submitted to BCCS.**
- If a contractor **deliberately** submits an MBCC application for a client not meeting presumptive eligibility, **BCCS may withhold or recover payment.**

1. MBCC Application (H-1034)

Answer all questions and fill-in every blank on the H-1034:

- Verify client’s legal name, date of birth, and social security number are correct.
- Verify presumptive eligibility has been met.
- Client has a biopsy-confirmed, qualifying diagnosis. (See *MBCC Guidelines for Determination of Qualifying Diagnosis.*)
- Date of diagnosis matches the collection date on the biopsy pathology report.
- Unpaid Medical Bills – Indicate yes or no, and months if applicable.
- Do not mark in “For DSHS Agency Use Only” section.

Attach copies of supporting documents:

- Final** pathology report with biopsy-confirmed, qualifying diagnosis (no highlighting)
- Documents to verify identity, U.S. citizenship, or legal immigrant status. (For questions, email the HHSC/MBCC Eligibility Specialist at cbs_mbcc@hhsc.state.tx.us.)
- If insurance termed or insurance does not cover cancer treatment:
 - Copy of insurance card; and
 - Letter or Explanation of Benefits from insurance company.
- If reinstatement or qualifying diagnosis more than 1 year ago:
 - Physician letter specifying active treatment needed or Form H1551; and
 - Recent medical documentation supporting need for active treatment.
- Do not fax tax forms, pay stubs, or any other financial documents:
 - Client may not self-declare income; financial documents must be kept with client chart.

2. Med-IT

Enter client details and patient navigation in Med-IT:

- Enrollment status is correct:

- "Active" - Client received BCCS services prior to the cancer diagnosis.
- "MBCC Referred-In" - Client never received BCCS services, was diagnosed by a non-BCCS provider and "referred in" for MBCC application only

- Navigation module is complete.
- Bill appropriate Patient Navigation code.

3. Fax H-1034 to BCCS at 512-776-7203.

- Send additional information requested by BCCS staff.
- BCCS nurse consultants review and fax to HHSC Centralized Benefits Services.
- BCCS does not assist with or collect documents for MBCC applications following submission to CBS.

4. Confirm Receipt with BCCS Staff.

- Status of MBCC application may be located in client's Med-IT record.
- Email MBCCApps@hsc.state.tx.us.
- Use Med-IT ID as patient identifier, exclude protected health information.

5. MBCC Application Status/Medicaid Number

- Clients may call 2-1-1.

Appendix II – Medicaid for Breast and Cervical Cancer Guidelines for Determination of Qualifying Diagnosis

Texas Breast and Cervical Cancer Services (BCCS) is providing the following guidance to healthcare providers and Breast and Cervical Cancer Services (BCCS) contractors to facilitate their determination of qualifying diagnoses for Medicaid for Breast and Cervical Cancer (MBCC). Analysis of all biopsies must be performed by a U.S. CLIA certified laboratory.

Cervical Cancer Qualifying Diagnoses

Qualifying pre-cancerous cervical diagnoses must be biopsy-confirmed*:

- High-grade dysplasia/Cervical intraepithelial neoplasia (CIN 2/3, or CIN 3)
- Carcinoma or adenocarcinoma in situ

Qualifying malignancies of the cervix must be biopsy-confirmed*:

- Squamous cell carcinoma
- Invasive endocervical adenocarcinoma
- Invasive cervical cancer
- Malignant neoplasia
- Sarcoma
- Adenoid cystic carcinoma
- Adenocarcinoma
- Small cell carcinoma
- Invasive neoplasm
- Melanoma
- Glassy cell carcinoma
- Adenosquamous carcinoma

*Cervical biopsy or endocervical sampling showing a qualifying pre-cancerous diagnosis or cervical malignancy qualifies as “biopsy confirmed”.

Breast Cancer Qualifying Diagnoses

Qualifying breast cancer diagnoses must be biopsy-confirmed. On the pathology report, the diagnosis and/or the specimen description may include at least one of the following phrases: “**breast cancer**,” “**breast carcinoma**” or “**breast malignancy**.”

Examples of the majority of breast cancer types:

1. Ductal Carcinomas:
 - a. Invasive
 - b. Inflammatory
 - c. Mucinous (colloid)
 - d. Scirrhus
 - e. Cribiform

- f. Comedo
- g. Medullary
- h. Papillary or Micropapillary
- i. Tubular
- j. Ductal carcinoma in situ (DCIS)
- 2. Lobular Carcinoma**:
- a. Invasive
- 3. Nipple Carcinoma:
- a. Paget's disease
- 4. Other Carcinomas:
- a. Carcinoma, NOS (not otherwise specified)
- b. Undifferentiated carcinoma
- c. All Phyllodes tumors
- d. Primary lymphoma
- e. Apocrine
- f. Sarcoma
- g. Secretory
- h. Metaplastic
- i. Carcinoma with endocrine differentiation
- j. Adenoid cystic carcinoma
- k. Any biopsy-proven malignancy identified in a biopsy of either breast

**The diagnosis of lobular carcinoma in situ (LCIS) is not considered a qualifying precancerous or breast cancer diagnosis for referral to MBCC.

To qualify as a breast cancer, the medical record documentation (e.g., operative report, procedure note) must clearly state that a biopsy was taken from at least one breast, and a pathology report for that biopsy must confirm the diagnosis of a qualifying malignant lesion. It is not necessary for the pathology report to describe the malignancy as definitively representing a breast primary, but it must be clear from the medical record documentation that a malignancy was identified on at least one biopsy of the breast.

Metastatic Breast and Cervical Cancers

For patients who present with cancers believed to be **metastatic from** the breast or cervix, if a diagnosis is made only on the basis of the metastatic tumor, a Medicaid application may be considered if no further diagnostic workup is planned before treatment is initiated and treatment will be based on the assumption that the primary source is breast or cervix, whether or not a primary tumor has been identified. The medical record documentation must clearly state that the primary source is believed to be breast or cervix and treatment will be initiated based on that assumption. Terms such as "compatible with" and "consistent with" a breast or cervical cancer are acceptable. For example, a diagnosis such as "metastatic adenocarcinoma consistent with a breast primary" would be acceptable.

For patients who present with cancers **metastatic to** the breast or cervix, malignancy diagnosed in a biopsy taken from a breast or the cervix constitutes a qualifying diagnosis.

Appendix III – BCCS Program Resource Guide

Patient Education

American Cancer Society

800-227-2345

www.cancer.org

- Guide to quitting smoking
- Prescription questions
- Cancer education classes

Beyond the Brochure: Alternative Approaches to Effective Health Communication

www.cdc.gov/cancer/nbccedp/pdf/amcbeyon.pdf

- CDC manual that provides guidance to more effective health communication
- Techniques
- Strategies
- Healthcare messaging

Susan G. Komen Breast Cancer Foundation

877-465-6636

- Education helpline
- Breast cancer information

National Cancer Institute Cancer Information Service

800-422-6237

TTY: 800-332-8615

www.nci.nih.gov

- What is cancer?
- Understanding treatment
- Prevention of cancer
- Free booklets on cancer
- Information & website in Spanish

Cancer Prevention and Control

www.cdc.gov/cancer

- Cancer information
- Information in Spanish
- Website in Spanish

Patient Advocacy/Support

American Cancer Society

800-227-2345

www.cancer.org

- Access to health care
- Clinical trials
- Stories of hope
- Financial issues
- Finding support groups

National Cancer Institute Cancer Information Service

800-422-6237

TTY: 800-332-8615

www.nci.nih.gov

- Clinical trials
- Support
- How to find treatment
- Coping with cancer

Susan G. Komen Breast Cancer Foundation

877-465-6636

- Finding breast services via an affiliate

Cancer Prevention and Control

www.cdc.gov/cancer

- Survivorship information

LIVESTRONG Foundation

www.livestrong.org

- Patient navigation
- Survivorship
- Clinical trial information
- One-on-one support
- Information for family members

Clinical Information

Susan G. Komen Breast Cancer Foundation

877-465-6636

- Grants for providers.

National Cancer Institute Cancer Information Service

800-422-6237

TTY: 800-332-8615

www.nci.nih.gov

- Clinical trials
- Research/funding
- Cancer statistics
- Cancer information
- Drug dictionary
- News releases
- Grants
- Provider training.

The Community Guide

www.thecommunityguide.org

- Strategies for providers to improve care
- Reminder systems
- Patient incentives
- Funding/grants
- Research
- Education program development
- Patient publications

Cochrane Collaboration

www.cochrane.org

Objective evidence-based strategies to improve healthcare delivery:

- Case management
- Provider reminder systems
- Provider feedback

Evidenced-Based Outreach Strategies

Cancer Control PLANET

cancercontrolplanet.cancer.gov

CDC/ACS sponsored website that provides step-by-step strategies in developing a cancer control plan based upon current research.

Community Health Worker Programs Materials—A Handbook for Enhancing Community Health Worker Programs: Parts I & II

www.cdc.gov/cancer/nbccedp/training/community.htm

Handbook for people who develop or manage community health worker programs in established health care settings and community outreach programs.

Outreach to Increase Screening for Breast and Cervical Cancer

<ftp://ftp.cdc.gov/pub/Publications/Cancer/nbccedp/training/outreach.htm>

A 3-part program designed to help improve and develop an outreach campaign for cervical/breast cancer screening includes:

- Training resources
- Lesson plans

Center for Sustainable Outreach (CSHO)

www.usm.edu/csho/non-managed_care_toolkit.html

Offers various toolkits & resources for a Community Health Worker program.

Evidence Based Interventions to Improve Screening Rate

Cancer Control PLANET

cancercontrolplanet.cancer.gov

CDC/ACS sponsored website that provides step-by-step strategies in developing a cancer control plan based upon current research.

Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees

www.cdc.gov/cancer/nbccedp/pdf/pruguide.pdf

Manual developed by Prudential Center for Healthcare Research that offers step-by-step strategies to improve mammography screening rates.

The Community Guide

www.thecommunityguide.org

- Client-based strategies;
- Helping clients to make informed decisions

Cochrane Collaboration

www.cochrane.org

Objective evidence-based strategies to improve healthcare delivery:

- Breast cancer;
- Gynecologic cancer
- Various health conditions
- Case management
- Provider reminder systems
- Training resources

Appendix IV – BCCS Resources and Contacts

BCCS Program Information

Resource	Contact Information
Fax	512-776-7203
Front Desk	512-776-7796
Med-IT Assistance	Med-ITHelpdesk@hsc.state.tx.us
Program Assistance	BCCSProgram@hsc.state.tx.us
Contract Support	WHSFinance@hsc.state.tx.us
BCCS Med-IT Training Registration	BCCSProgram@hsc.state.tx.us
BCCS Website	www.healthytexaswomen.org
Clinic Locator – BCCS/MBCC Service	www.healthytexaswomen.org

Medicaid for Breast and Cervical Cancer (MBCC) Information

Resource	Contact Information
Fax	512-776-7203
Application Receipt Verification	www.med-itweb.com
Application Status	MBCCApps@hsc.state.tx.us
Renewal Paperwork	2-1-1
Medicaid Provider Line	800-925-9126
Medicaid Covered Services	800-335-8957
TMHP	www.TMHP.com

Resource	Contact Information
Health and Human Services Commission (HHSC)-Centralized Benefit Services	CBS_MBCC@hhsc.state.tx.us
Transportation Assistance	877-MED-TRIP
Texas Medicaid Wellness Program	800-777-1178

Additional Cancer Resources

Resource	Contact Information
LIVESTRONG Foundation	www.livestrong.org 855-220-7777
American Cancer Society	www.cancer.org 800-227-2345
Patient Advocate Foundation (Access, Job Retention, Financial Assistance/Debt)	www.patientadvocate.org 800-532-5274
Clinical Trials	www.cancer.gov/clinicaltrials clinicaltrials.gov
CancerCare	www.cancercares.org