



*SHOW ME
Healthy
Women*

**PROVIDER
TRAINING 2024**

OBJECTIVES

On Completion, the participant will be able to

- Identify and understand Show Me Healthy Women Program (SMHW) Eligibility Criteria
- Identify information required to bill SMHW claims for clients with high deductible insurance
- Define acceptable timeframes for billing completed claims
- Introduction to Missouri Health Strategies Architectures and Information Cooperative (MOHSAIC) form entry

ADDITIONAL TOPICS

- MOHSAIC visit types based on program definitions
- CDC's High-Risk Criteria for Breast and Cervical Cancer Screening
- Mammography Van Screening Information
- Common errors found in billing for Screening vs. Diagnostic Exams
- Breast and Cervical Cancer Treatment (BCCT) Guidelines

ADDITIONAL TOPICS (CONTINUED)

- American Society for Colposcopy and Cervical Pathology (ASCCP) Information
- Transportation Voucher
- Patient Navigation

SMHW BASIC ELIGIBILITY CRITERIA

- Females 35-64 years of age
- Meet Income Guidelines
- Underinsured or not insured
 - Health Insurance does not cover services/Unable to pay deductible
- Has MO HealthNet with a spend-down, but has not met the spend-down
- Income eligible for Medicare Part B, but unable to pay premium (Medicare Part B covers breast and cervical cancer screenings)

ELIGIBILITY EXCLUSIONS

- Women who have a diagnosis of breast or cervical cancer are not eligible for SMHW
- Women currently being treated for breast or cervical cancer are not eligible for SMHW
- Women enrolled in prepaid/managed care and health plans, such as Health Maintenance Organizations [HMOs], Point of Service Plans [POS]
- Women with full MO HealthNet (ME Code 05) or (ME Code E2)

HEALTH INSURANCE

Show Me Healthy Women (SMHW) and WISEWOMAN programs are the **payors of last resort**

A client's insurance must be billed first. Once the Explanation of Benefits (EOB) has been received, list the dollar amount the insurance paid for each procedure with the corresponding CPT code in the comment section of the MOHSAIC reimbursement form

SMHW and WISEWOMAN will reimburse up to the total amount allowed per our guidelines

CLIENTS WITH HIGH DEDUCTIBLE HEALTH INSURANCE (EXAMPLE)

Date Treatment Started: MM/DD/YYYY

Comments **Maximum length is 1536 characters.**

INSURANCE PAID:
INSURANCE PAID \$186.00 ON BILATERAL DIAGNSOTIC MAMMO WITH CPT CODE:77066
INSURANCE PAID \$62.25 ON ULTRASOUND WITH CPT CODE:76641
PAID ZERO ON BREAST BIOPSY WITH CPT CODE:19100. NANCY NAVIGATOR, RN

Claims Problem Override

Please Be Sure to Mark the "Reporting Only" Box in the Section When Not Requesting Reimbursement

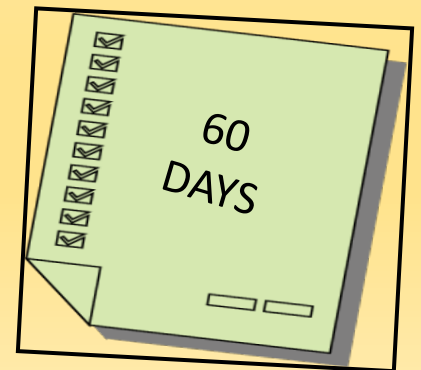
CPT Code: 77066 \$ 186.00 Mammography, diagnostic follow – up (bilateral)

CPT code: 76641 \$ 62.25 US, complete

CPT code: 19100 paid zero Breast biopsy

BILLING TIMEFRAMES

- Claims for reimbursement should be entered into MOHSAIC within **60** days of service
- Forms submitted beyond **60** days may be considered ineligible for reimbursement
- Submit final billing within **30** days of the closing of the grant year



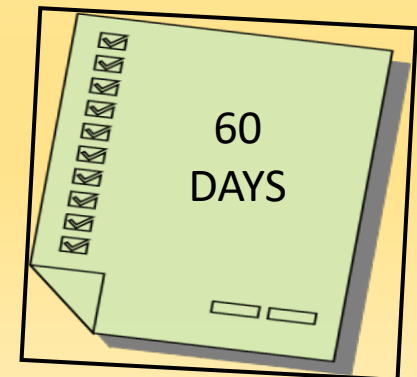
BILLING TIMEFRAMES (CONTINUED)

- Data submitted after the deadline cannot be reimbursed by SMHW or billed to the client

Reminder:

The SMHW grant year (FY 24) closed June 29, 2024.

June 30, 2024 – June 29, 2025 (FY25).



FORM ENTRY INTO MOHSAIC

- MOHSAIC is an online data system used to collect and manage client service records for SMHW and WISEWOMAN. To apply, applicants must submit a request through the **Missouri Department of Health and Senior Services Automated Security Access Process (A.S.A.P)**.
- After receiving authorization with A.S.A.P. and a user log-in, go to <https://healthapps.dhss.mo.gov/smhw/>. Enter MOHSAIC with your log-in and password. The main screen will open. Do not use Internet Explorer, use Google Chrome or Microsoft Edge.

FORM ENTRY INTO MOHSAIC (CONTINUED)

- MOHSAIC will ask to change your password every 30 to 60 days. MOHSAIC will lock you out if you do not log in for 30 days.
- If you save the MOHSAIC link into your favorites, make it the simple link <https://healthapps.dhss.mo.gov/smhw/>. Do not add anything, the link will not work.

FORM ENTRY INTO MOHSAIC (CONTINUED)

Missouri Department of
Health & Senior Services

- Read the disclaimer
- Check *Change Password* to change passwords
- Enter the login information
- Click Login to proceed

Login Information

Username

Password

Change Password

Disclaimer

Notice: You are about to gain access to a Missouri Department of Health and Senior Services application. By proceeding, you are agreeing to keep confidential all information made available to you through this application. Any unauthorized access, use and/or disclosure of information may result in a loss of access privileges, an action for civil damages, an action for criminal charges, and/or disciplinary action including but not limited to suspension or dismissal.

Log-in
screen for
entry to
MOHSAIC

FORM ENTRY INTO MOHSAIC (CONTINUED)

State of Missouri
DEPARTMENT OF HEALTH AND SENIOR SERVICES [SHOW ME HEALTHY MISSOURIANS](#)

Current Client: None Selected

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

▶ [SUBMIT NEW FORMS / BILLING](#) ▶ [VIEW MEDICAID INFORMATION](#) ▶ [VIEW MONTHLY ACTIVITY REPORT](#)

WELCOME TO



MOHSAIC

Click the “Client” button. Click “Submit New Forms/Billing”. Enter the SSN, DCN or the last and first name of the client separated by a comma. Do not click return/enter. MOHSAIC will look for the patient. Verify the correct patient is selected.

FORM ENTRY INTO MOHSAIC (CONTINUED)

TEST VERSION

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

▼ SUBMIT NEW FORMS / BILLING ► VIEW MEDICAID INFORMATION ► VIEW

Show Instructions

Submit Form

Client Information

Client Name / SSN test| ?

Address

Name	DOB	Gender	DCN	IsMedicalClient
TEST, DALYNE N	11/28/1993	MALE	48625711	Y
TEST, DALYNE NICOLE	11/28/1993	FEMALE	33963960	Y
TEST, DOROTHY MAXINE	9/6/1943	FEMALE	00378811	Y
TEST, EDI	1/1/1955	FEMALE		Y
TEST, GAGE CHRISTIAN	6/21/1999	MALE	48443931	Y

City, State Zip

Provider Information

Provider Name/Address

Provider 15 of 51 retrieved. Make a selection, Refine Search or Press tab key to continue.

Service Name/Address

Form Type/Version

Type

Version

Create Form

Select the correct patient.
The highlighted section shows you can scroll to pick the correct patient.

FORM ENTRY INTO MOHSAIC (CONTINUED)

TEST VERSION

Current Client: TEST, ALLISON JENNA 137 SOUTH ST HOLLISTER, MO 65672-9773 County: TANEY (417) 335-8540

CLIENT	PROVIDER	FINANCIAL	ADMINISTRATIVE
Show Instructions			
Submit Form			
Client Information -- Please verify address and demographics below and update as needed			
Client Name / SSN	TEST, ALLISON JENNA	View/Edit Client Information	
Address	137 SOUTH ST	SSN 490-06-8621 DOB 10/24/1991 DCN 29650349	Sex FEMALE Race WHITE Ethnicity NON HISPANIC
City, State Zip	HOLLISTER MO 65672-9773	Phone 417 - 335 - 8540	<input type="checkbox"/> No Phone
Provider Information			
	<input type="radio"/> Regular Billing <input type="radio"/> Direct Billing		
Provider		Referring Provider	
Service Name/Address			
Form Type/Version			
Type			
Version			
		<input type="button" value="Create Form"/>	<input type="button" value="Close"/>

To edit, select “View/Edit Client Information”. Enter the updated information.

FORM ENTRY INTO MOHSAIC (CONTINUED)

TEST VERSION

The screenshot shows a web browser window with the URL <https://healthapps.dhss.mo.gov/SMHW/Default.aspx?m...>. The page title is "SMHW Web Application". The main content area displays the "State of Missouri DEPARTMENT OF HEALTH AND SENIOR SERVICES" logo and the text "Current Client: None Selected". A navigation menu includes "CLIENT", "PROVIDER", "FINANCIAL", and "ADMINISTRATIVE". Below the menu are links for "SUBMIT NEW FORMS / BILLING" and "VIEW MEDICAID INFORMATION". A modal dialog box is open, titled "healthapps.dhss.mo.gov says", with the message: "The client was NOT found in MOHSAIC. Click OK to add the client. Click CANCEL to search again." The dialog has "OK" and "Cancel" buttons. The background form is partially obscured but shows sections for "Client Information" (with fields for Client Name/SSN, Address, City, State Zip) and "Form Type/Version" (with dropdowns for Type and Version, and "Create Form" and "Close" buttons).

If the client is not in the database, the screen will show the client is not found. Press the OK button to continue.

FORM ENTRY INTO MOHSAIC (CONTINUED)

TEST VERSION

State of Missouri
DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY MISSOURIANS

Current Client: None Selected

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

SUBMIT NEW FORMS / BILLING VIEW MEDICAID INFO

Search/QuickClientAdd - Profile 1 - Microsoft Edge
https://healthapps.dhss.mo.gov/PartyInformation/Search.aspx?m=mc&n=smith

SHOW INSTRUCTIONS

Submit Form

Client Information

Client Name / SSN: smith

Address:

City, State Zip: MO

Provider Information

Regular Billing Direct Billing

Provider:

Service Name/Address:

Form Type/Version

Type:

Version:

Search Person

Client

Name Search

LAST NAME: * CLIVE FIRST NAME: * ROSY
MIDDLE NAME: SUFFIX: PREFIX:
DATE OF BIRTH: 01/16/1974 GENDER: FEMALE
ETHNICITY: NON HISPANIC ROLE: MEDICAL CLIENT
SEARCH TYPE: LIKE SOUNDX BOTH
RACE: WHITE ASIAN
 BLACK AMERICAN INDIAN
 UNKNOWN PACIFIC ISLANDER

DCN Search SSN Search

DCN: SSN:

SEARCH | REGISTER AS MEDICAL CLIENT | MODIFY SEARCH | CANCEL

No results found match search criteria.
Additional information is required to add the client in the system. Please modify your search with additional data and search found then add your client to the system.

Enter the patient's information and then select "Register as medical client". This will allow you to move forward and enter forms.

FORM ENTRY INTO MOHSAIC (CONTINUED)

Select client section, enter last name, first name, DOB, gender, ethnicity, race and role then select register as a medical client. All these fields must be are entered, if not, it will not allow you to register as a medical client. If they have a SSN, click SSN search button and enter the SSN with no spaces or dashes. Click search at the bottom left corner. This will either provide search results and select the client or you must register them as medical client.

FORM ENTRY INTO MOHSAIC (CONTINUED)

TEST VERSION

DEPARTMENT OF HEALTH & SENIOR SERVICES SHOW ME HEALTH MISSOURI

Current Client: ELLIS, AMY LOUISE 123 TEST LANE APPLETON CITY, MO 12345 (573) 289-5458

CLIENT PROVIDER FINANCIAL ADMINISTRATIVE

▼ SUBMIT NEW FORMS / BILLING ► [VIEW MEDICAID INFORMATION](#) ► [VIEW MONTHLY ACTIVITY REPORT](#)

[Show Instructions](#)

Submit Form

Client Information -- Please verify address and demographics below and update as needed.

Client Name / SSN	ELLIS, AMY LOUISE	?	View/Edit Client Information	
Address	123 TEST LANE		SSN	497-88-5378
			DOB	1/23/1984
			DCN	48435920
			Sex	FEMALE
			Race	WHITE
			Ethnicity	NON HISPANIC
City, State Zip	APPLETON CITY	MO	12345	Phone 573 - 289 - 5458
				<input type="checkbox"/> No Phone

Provider Information

Regular Billing Direct Billing

Provider: WRIGHT CO HD Referring Provider: [Empty]

Service Name/Address: WRIGHT COUNTY HEALTH DEPT - MOUNTAIN GROVE - 602 E STATE ST STE B, MOUNTAIN GROVE, MO 65711-1826

Form Type/Version

Type: Patient History (Green)

Version: Forms for Services Provided On or After June 30, 2022

SMHW – MOHSAIC FORM BASICS

▪ Types of Forms:

Green

- History

Blue

- Screening Report

Purple

- Breast Diagnostic

Yellow

- Cervical Diagnostic

Gray

- Patient Navigation

Other Forms Needed for
Client's File:
Eligibility Form, Proof of Age-
Photo ID and Proof of Income
-Tax form/Paycheck Stubs

SCREENING REPORT (BLUE FORM) VISIT TYPES

Screening Report		Ver. - 81
Provider SAMH Number - Service Address	44600509101 - WRIGHT COUNTY HEALTH DEPARTMENT MOUNTAIN GROVE - 602 E STATE ST STE B, MOUNTAIN GROVE, MO 65711-1826	
A. PERSONAL DATA		
Name (Last, First, Middle Initial)	MOUSE, MINNIE	
County at TOV:		
Maiden Name		
Date of Birth	Social Security Number	Medicaid DCN/Medicare Number
Age (Years): 35 2/1/1989	540-40-4039	66555354
Date Form Received:	MM/DD/YYYY	Visit Type
<input type="checkbox"/> Client Eligibility Verified	<input type="checkbox"/> Insurance Coverage	Initial ← Annual Rescreen Annual CBE only Initial CBE only Mammogram only Navigation Only
<input type="checkbox"/> Type of Medicare		
Height	ft	in
Weight	lbs.	BMI
Blood Pressure		Average
1st Reading		2nd Reading
B. CLINICAL BREAST EXAM RESULTS Clear <input type="checkbox"/> Reporting Only		
Does client report any breast symptoms?	<input type="checkbox"/>	Additional Information Required if "YES" Selected
CBE WNL	<input type="checkbox"/>	Additional Information Required if "NO" Selected
Date of CBE	MM/DD/YYYY	

SMHW – MOHSAIC FORM ENTRY

INITIAL vs. ANNUAL vs. RESCREEN visit types

- Initial – First time to enroll in SMHW with the provider or greater than 5 years since last SMHW visit with the same provider (Initial or Initial CBE only)

Note: Even if the patient has been seen by the provider for multiple years – the FIRST time the client enrolls with a SMHW provider it is an INITIAL visit

- Annual – Any future SMHW visits or tests with the SMHW provider (Annual or Annual CBE only)
Note: Annual screening is 10 months or greater from the initial or the last annual visit.
- Rescreen – A rescreening visit can be done with an abnormal result that is less than 10 months from an initial or annual screen date. A rescreen CBE can be performed after 14 days or within 10 months of an initial CBE with the first-time reported pain/tenderness or a CBE deemed suspicious for cancer and after diagnostic testing confirms a non-cancer diagnosis.

SMHW – MOHSAIC FORM ENTRY (CONTINUED)

RESCREENING NOTE:

Use when entering a 6-month follow up diagnostic mammogram or rescreen CBE or cervical abnormalities after benign diagnostics.

If 10 months or more pass from the date of the annual/initial visit, patient must meet SMHW criteria for reimbursement.

A repeat pelvic exam is optional as a rescreen in less than ten (10) months if the previous abnormal pelvic exam reported to SMHW was not within normal limits due to an abnormal cervical finding.

SMHW – MOHSAIC FORM ENTRY (CONTINUED)

Mammogram Only – screening mammogram only with the CBE done elsewhere or a mammogram van visit.

Navigation Only – “Navigation-Only” allows payment for navigation services provided to a woman who meets age and income requirements and has group or private insurance to pay for the screening/diagnostic services.

HIGH RISK SCREENING FOR BREAST CANCER

During the visit, screen the patient and document the high-risk assessment. If the patient meets the high-risk criteria (next slides) SMHW may pay for a screening MRI.

SMHW will pay for an annual screening breast MRI as funding is available and with **prior approval**

Contact your RPC or Central Office to request screening MRI approval. Document the approval in the comment's section of the claim form.

HIGH RISK CRITERIA FOR BREAST CANCER (CONTINUED)

The HIGH RISK section should be marked YES if there is a:

- Known genetic mutation such as BRCA 1 or 2
- First-degree relative whom is a BRCA carrier (parent, full sibling or biological child)
- Lifetime risk of 20 - 25% or greater as defined by risk assessment models such as BRCAPRO, Tyrer-Cuzick or GAIL Model

If these criteria are not evident, mark NO.

If the clinician did not assess a patient for risk or high risk for breast and/or cervical cancer is unknown, mark NOT ASSESSED/UNKNOWN

HIGH RISK CRITERIA FOR CERVICAL CANCER

The HIGH RISK section should be marked YES if the client has:

- Human Immunodeficiency Virus (HIV)
- Had an organ transplant
- Immunocompromised with another health condition
- Diethylstilbestrol (DES) exposure in utero

If these criteria are not evident mark NO.

If the clinician did not assess a patient for risk or high risk for breast and/or cervical cancer is unknown, mark NOT ASSESSED/UNKNOWN.

MAMMOGRAPHY VAN SCREENING GUIDELINES

The mammography van should coordinate with primary care services for documentation of the clinical breast exam (CBE) to meet quality care guidelines and program requirements.

If a client presents at the mammography van and has not had a CBE, continue with screening services and refer them for primary care services to obtain a CBE.

Document the patient education regarding the CBE.

SMHW reimburses the provider for the office visit performing the CBE.

MAMMOGRAPHY VAN SCREENING GUIDELINES

A patient 40 to 64 years old, has an appointment scheduled on a mammogram van. When submitting the reimbursement MOHSAIC claim form, note this as a mammogram van visit. For clinical best practice, a CBE should be completed at a well-woman check-up (annually). Please encourage and document the conversation to promote the patient to receive a CBE with a well-woman check-up appointment. If the patient has completed a CBE, document where the CBE was completed in the comments section of the MOHSAIC reimbursement form.

MAMMOGRAPHY VAN SCREENING GUIDELINES

If the patient receives a screening mammogram at a brick-and-mortar breast imaging center, the same example will apply. A patient may be referred to your breast imaging center after a CBE was completed with a practitioner.

REPORTING SCREENING MAMMOGRAPHY VAN ONLY

- For Mammography Van providers, when billing for a *screening mammogram only* select the visit type as “Mammogram Only” and mark the “Mammography Van” box (next slide)
- Include the name of the facility providing the van and include the word “Van” by the facility name
 - Example: Ellis Fischel Van

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH MM / DD / YYYY

CLIENT ELIGIBILITY VERIFIED Yes No

INSURANCE Yes

VISIT TYPE Initial Annual Rescreen Mammogram only

Initial CBE only Annual CBE only

B. BREAST CANCER SCREENING

SCREENING BLUE
FORM - PAPER

A. PERSONAL DATA

Name (Last, First, Middle Initial) JONES, NANCY

County at TOV:

Maiden Name

Date of Birth 8/8/1979 Social Security Number 451-55-6444

Age (Years): 40

Initial
Annual
Rescreen
Annual CBE only
Initial CBE only
Mammogram only
Navigation Only

Visit Type

Client Eligibility Verified Insurance Coverage

SCREENING BLUE FORM -
MOHSAIC

EXAMPLE OF REPORTING SCREENING MAMMOGRAM ON MAMMOGRAPHY VAN

B 5. Mammogram Results Reporting Only

(4) Mammogram not done or CBE done and diagnostic workup planned
 (1) Routine screening mammogram
 (2) Mammogram performed to evaluate symptoms:
 Personal history of breast cancer
 Previous abnormal mammogram results (rescreen)

(5) Cervical record only, no breast service provided
 (6) Referred to direct biller
 (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date client referred for diagnosis: ____ / ____ / ____
MM DD YYYY

Mammography provider facility **Ellis Fischel Mamm Van** Mammogram Van

Previous mammogram Yes No Unknown Date of last mammogram ____ / ____ / ____ Date of this mammogram ____ / ____ / ____
MM YYYY MM DD YYYY

Type of mammogram Screening Diagnostic Tomosynthesis Method used for mammogram Digital Conventional
SMHW mammogram result (check one) (results with * require additional follow-up)

Left Right (Indicate why only one breast had mammogram in COMMENTS) Left Right
Normal (1) Negative (Category 1) Abnormal (3) Probably Benign (Category 3)
 (2) Benign Finding (Category 2) (4) Suspicious Abnormality (Category 4)*
 (5) Highly Suggestive of Malignancy (Category 5)*
Further diagnostic planned for: (3) Probably Benign: Yes No (7) Unsatisfactory-not interpreted, repeat (Not Paid)

PAPER FORM

MOHSAIC FORM

C. MAMMOGRAM RESULTS Clear Reporting Only

(4) Mammogram not done. OR CBE done and diagnostic workup pending
 (1) Routine screening mammogram
 (2) Mammogram performed to evaluate symptoms:
 Personal history of breast cancer
 Previous abnormal mammogram results (rescreen)

(5) Cervical record only, no breast service provided
 (6) Referred to Direct Biller for Mammogram
 (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date Client Referred for diagnosis: _____

Mammogram Provider Facility **ELLIS FISCHEL MAMM VAN** Mammogram Van

Previous Mammograms Yes

Date of Last Mammogram month 08 year 2018

SCREENING FORM VS. BREAST DIAGNOSTIC FORM

Use for a screening mammogram with normal SBE/CBE findings

Use for the entry of a 6-month diagnostic mammogram rescreen (typically in response to a previous "probably benign result or Cat 3 imaging")

Use for entry of diagnostic mammogram with abnormal SBE/CBE findings

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)
SCREENING REPORT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE (FACILITY NAME AND ADDRESS) _____ REFERRING PROVIDER FOR DIRECT BILLING _____

A. PERSONAL DATA
NAME (LAST, FIRST, MIDDLE INITIAL) _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH: MM / DD / YYYY CLIENT ELIGIBILITY VERIFIED: Yes No INSURANCE COVERAGE: Yes No DEDUCTIBLE MET: Yes No REFERRAL FEE: Part A Part A and B MEDICARE: Part A Part A and B

VISIT TYPE: Initial Annual Rescreen Mammogram only
 Initial CBE only Annual CBE only Mammogram only

B. BREAST CANCER SCREENING

B.1. Does client report any BSE symptoms? Yes No (If "YES" complete B.2) Date of CBE: MM / DD / YYYY

B.2. Symptoms Reported by Client (Check any that apply. If 1, 2, 3 or 4B is checked, may have two (2) diagnostics at clinician's discretion.)
 (1) Lump (4A) Pain/Tenderness - 1st occurrence (4B) Pain/Tenderness - 2nd occurrence
 (2) Nipple discharge (5) Other (specify) _____
 (3) Skin changes (dimpling, retraction, new nipple inversion, ulceration, Paget's disease)

B.3. CBE within normal limits and findings Present at CBE (check yes or no and one explanation)
 Yes No (specify) _____
 (1) Benign finding (fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)
 No - Suspicious for cancer (Any checked findings requires completion of two (2) diagnostic procedures entered on purple breast form.)
 (2) Discrete palpable mass (includes masses that may be diffuse, poorly defined thickening, cystic or solid) (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration, one breast lower than usual, prominent veins, unilateral, unusual increase in size, axillary lymph nodes, also swelling of upper arm.
 (3) Nipple discharge (6) Enlarged, tender, firm or hard palpable supraclavicular, infraclavicular or axillary lymph nodes, also swelling of upper arm.
 (4a) Nipple or areolar scaldiness or erythema (6a) Focal pain and tenderness

B.4. High Risk for Breast Cancer (1) Yes (2) No (3) Not assessed/Unknown
 Rescreen CBE Planned Yes No (must be less than 10 months) MM / DD / YYYY
 Diagnostic Work-up Planned Yes No (must be less than 60 days) MM / DD / YYYY

B.5. Mammogram Results Reporting Only
 (4) Mammogram not done or CBE done and diagnostic workup planned (5) Cervical record only, no breast service provided
 (1) Routine screening mammogram (6) Referred to direct biller
 (2) Mammogram performed to evaluate symptoms. (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation. (Enter results in Mammogram field as Reporting Only)
 (7) Personal history of breast cancer (8) Previous abnormal mammogram results (rescreen) Date client referred for diagnosis: MM / DD / YYYY

Mammography provider facility: _____ Mammogram Van (Auto-removal)

Previous mammogram Yes No Unknown Date of last mammogram: MM / DD / YYYY Date of this mammogram: MM / DD / YYYY

Type of mammogram Screening Diagnostic Tomosynthesis Method used for mammogram Digital Conventional

SMHW mammogram result (check one) (results with * require additional follow-up)
 Left: Right (Indicate why only one breast had mammogram in COMMENTS)
 Normal (1) Negative (Category 1) (2) Benign Finding (Category 2) (3) Probably Benign (Category 3) (4) Suspicious Abnormality (Category 4)* (5) Highly Suggestive of Malignancy (Category 5)*
 (6) Un satisfactory-not interpreted, repeat (Not Paid) (7) Un satisfactory-not interpreted, repeat (Not Paid) (14) Needs Additional Evaluation (Category 5)
 Further diagnostic planned for: (3) Probably Benign: Yes No

Rescreen mammogram planned Yes No (must be less than 10 months) MM / DD / YYYY
 Diagnostic work-up planned Yes No (must be less than 60 days) MM / DD / YYYY

Referred for diagnostic testing/direct bill (physician/facility name) _____
 MRI (High Risk ONLY - Prior authorization required.) Report L/R results in Section D, Comments. MM / DD / YYYY

MO 560-1799 (6-16) CH 0-1

Refer to forms

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)
BREAST DIAGNOSIS AND TREATMENT

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE (FACILITY NAME AND ADDRESS) _____ REFERRING PROVIDER FOR DIRECT BILLING _____

A. PERSONAL DATA
NAME (LAST, FIRST, MIDDLE INITIAL) _____ SOCIAL SECURITY NUMBER _____ CLIENT ELIGIBILITY VERIFIED: Yes No

DATE OF BIRTH: MM / DD / YYYY INSURANCE COVERAGE: Yes No DEDUCTIBLE MET: Yes No REFERRAL FEE: Part A Part A and B MEDICARE: Part A Part A and B

B. BREAST DIAGNOSTIC PROCEDURES Reporting Only

Diagnostic Mammogram Conventional Digital Tomosynthesis MM / DD / YYYY

Additional Mammographic views (L, R)
 Normal (1) Negative (Category 1) (2) Benign Finding (Category 2) (7) Unsatisfactory-not interpreted-repeat (not paid)
 Abnormal (3) Probably Benign (Category 3) (4) Suspicious Abnormality (Category 4) (5) Highly Suggestive of Malignancy (Category 5) (14) Needs Additional Evaluation (Category 5)
 Ultrasound Rescreen Reporting Only

Left: Complete Limited Right: Complete Limited

Specialist Consultation Date: MM / DD / YYYY Diagnostic Work-up Planned None 0-60 days 61-90 days Reporting Only

CBE WNL Yes No (If "No" indicate finding below)

Benign finding (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity
 Suspicious for cancer (2) Discrete palpable mass (3) Nipple discharge (4) Nipple or areolar scaldiness or erythema
 (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration, also one breast lower than usual, or unilateral prominent veins, or unilateral increase in size (6) Enlarged, tender, firm, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes, also swelling of upper arm.

Fine Needle/Aspiration _____ Cytopathology Performed Yes No Reporting Only

Left Breast: Type Superficial Deep tissue under guidance First Lesion Additional Lesion Ultrasound Ultrasound Fluoroscopy Fluoroscopy Cat Scan Cat Scan MRI MRI
 Result (1) Negative (2) Indeterminate (3) Suspicious for Malignancy - Refer to BCCT (4) Malignancy - Refer to BCCT

Right Breast: Type Superficial Deep tissue under guidance First Lesion Additional Lesion Ultrasound Ultrasound Fluoroscopy Fluoroscopy Cat Scan Cat Scan MRI MRI
 Result (1) Negative (2) Indeterminate (3) Suspicious for Malignancy - Refer to BCCT (4) Malignancy - Refer to BCCT

MO 560-1799 (6-16) SK 0-1

REPORTING DIAGNOSTIC RESCREEN (MAMMOGRAM)

The image shows a screenshot of a web-based form titled 'MOHASIC Blue Screening Form'. The form is divided into several sections. At the top, there is a 'Date Form Received' field with the value '5/5/2022' and a 'MMDD/YYYY' label. To the right of this is a 'Visit Type' dropdown menu with 'Rescreen' selected. A blue arrow points to this dropdown menu, which is also circled in blue. Below the date field is a 'Referral Fee' checkbox. The next section contains three dropdown menus: 'Client Eligibility Verified' (set to 'Yes'), 'Insurance Coverage' (set to 'No'), and 'Deductible Met'. Below these is a 'Type of Medicare' dropdown menu. The bottom section contains fields for 'Height' (in feet and inches), 'Weight' (in lbs.), 'BMI', and 'Blood Pressure' (with '1st Reading' and '2nd Reading' sub-fields and an 'Average' label).

MOHASIC Blue Screening Form

RESCREENING NOTE:

Use when entering a 6-month follow up diagnostic mammogram or rescreen CBE or cervical abnormalities after benign diagnostics.

If 10 months or more pass from the date of the annual/initial visit, patient will need to meet SMHW criteria for reimbursement.

MAMMOGRAM RESCREEN SECTION

RESCREENING NOTE:

Select (2) Mammogram performed to evaluate symptoms, previous mammogram results (rescreen)

3. MAMMOGRAM RESULTS Clear Reporting Only

(4) Mammogram not done, OR CBE done and diagnostic workup pending

(1) Routine screening mammogram

(2) Mammogram performed to evaluate symptoms:

Personal history of breast cancer

Previous abnormal mammogram results (rescreen)

(5) Cervical record only, no breast service provided

(6) Referred to Direct Biller for Mammogram

(3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

Date Client Referred for diagnosis

MOHSAIC Blue Screening Form

BREAST AND CERVICAL CANCER TREATMENT ACT (BCCT) GUIDELINES

- Client is enrolled in SMHW prior to tissue biopsy and has a screening or diagnostic test paid by SMHW
- Please note: If the only service reimbursed by SMHW is a referral fee, the client will not be eligible for BCCT

BCCT GUIDELINES (CONTINUED)

- Diagnosed with breast and/or cervical cancer, or cervical precancerous condition through a SMHW provider
- No source of health/medical insurance that covers treatment (even if a high deductible/Affordable Care Act)
- Meet SMHW eligibility guidelines
- Need treatment for breast and/or cervical cancers or precancerous conditions (next slide)

CLINICAL QUALIFIERS FOR BCCT

BREAST

- **Ultrasound** of “suspicious abnormality” (**BI-RADS category 4**)** or “highly suggestive of malignancy”
- (**BI-RADS category 5**)**
- Carcinoma in situ*
- Invasive breast cancer*

CERVICAL

- CIN 2/moderate dysplasia*
- CIN 3/severe dysplasia *
- CIS or AIS *
- Invasive cervical cancer *

*ELIGIBLE FOR FULL BCCT

**ELIGIBLE FOR PRESUMPTIVE BCCT

A presumptive BCCT application SHOULD always be submitted first

PRESUMPTIVE (PE) BCCT FORM

Correct Address

MO HealthNet Service Center

FSD Customer Relations Unit
101 Park Central Square
Springfield, MO 65806

E-mail

MRT.ProcessingCenter@dss.mo.gov

Fax: 573-526-9400

Date enrolled in SMHW

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
BREAST & CERVICAL CANCER TREATMENT (BCCT) TEMPORARY MO HEALTHNET AUTHORIZATION

Nancy Jones (Name)
123 State Lane (Address)
Jefferson City, MO 65109 (Address)

Dear Nancy

You are eligible for Temporary MO HealthNet based upon your Missouri Show Me Healthy Women program screening results. Your temporary coverage will continue until a decision is made on your eligibility for on-going MO HealthNet coverage. MO HealthNet can pay for medical services only when the medical provider you use accepts MO HealthNet payments.

An application for the MO HealthNet Breast & Cervical Cancer Treatment (BCCT) program based upon your need for breast or cervical cancer treatment is enclosed. Please complete the application and mail it to the St. Joseph Customer Service Center listed on the back of the application as quickly as possible. If you fail to complete and return the enclosed application by the last day of next month, your MO HealthNet coverage will end.

You will receive a MO HealthNet card in approximately five days. Until you receive your MO HealthNet card, use this letter as proof of eligibility when you go to your doctor, pharmacy or other medical service provider. If you have questions about MO HealthNet providers or how to get MO HealthNet services, please call the MO HealthNet Participant Services Unit toll free number at 1-800-392-2161.

If you have any questions pertaining to continuing MO HealthNet eligibility, please call the Family Support Division Information Center toll free at 1-855-373-4636.

Breast & Cervical Cancer Control Project (BCCCP) Contracted Provider: Barnes-Jewish Hospital

Breast & Cervical Cancer Control Project (BCCCP) Eligibility confirmed by: Elsie Smith, RN

Date: 05/01/2020

Name	MO HealthNet Number (DCN)	Beginning Date of Coverage
Nancy Jones	85241239	05/04/2020

Providers are to verify MO HealthNet coverage prior to providing services to the above participant.

DCN REQUIRED

START DATE OF
COVERAGE IS DATE
OF QUALIFYING
TEST

(FULL) BCCT/ BREAST AND CERVICAL CANCER TREATMENT ACT APPLICATION

*Complete the top
upper left box.*

Correct Address

**MO HealthNet Service
Center**

**FSD Customer Relations
Unit
101 Park Central Square
Springfield, MO 65806**

E-mail

[MRT.ProcessingCenter@dss.
mo.gov](mailto:MRT.ProcessingCenter@dss.mo.gov)

Fax: 573-526-9400

MISSOURI DEPARTMENT OF SOCIAL SERVICES FAMILY SUPPORT DIVISION BCCT MO HEALTHNET APPLICATION					FOR OFFICE USE ONLY	
EMHW PROVIDER			TELEPHONE NUMBER		DATE APPLIED	
DIAGNOSIS DATE					DCN	
					<input type="checkbox"/> SERVICE REP. <input type="checkbox"/> SUPERVISOR <input type="checkbox"/> LEAD	
COMPLETE IN INK						
A. MAILING ADDRESS						
NAME (FIRST, MIDDLE, LAST)			MAIDEN NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RACE/ETHNIC
ADDRESS (HOUSE NO., STREET, RURAL ROUTE, PO BOX NO) CITY, STATE, ZIP CODE, COUNTY						
HOME TELEPHONE NUMBER			WORK TELEPHONE NUMBER		MESSAGE TELEPHONE NUMBER	
B. INSTRUCTIONS: Please answer each question completely.						
1. Born in Missouri?					YES	NO
2. Are you a U.S. citizen? If "NO", list immigration status and registration number, date of entry:					<input type="checkbox"/>	<input type="checkbox"/>
3. Do you currently have healthcare insurance?					<input type="checkbox"/>	<input type="checkbox"/>
NAME OF COMPANY AND POLICY NUMBER			TYPE OF COVERAGE			
			<input type="checkbox"/> DOCTOR <input type="checkbox"/> HOSPITAL <i>If limited coverage explain:</i>			
4. Do you have children under the age of 19 residing in your home?					YES	NO
5. Are you pregnant?					<input type="checkbox"/>	<input type="checkbox"/>
6. Are you blind?					<input type="checkbox"/>	<input type="checkbox"/>
7. Are you disabled?					<input type="checkbox"/>	<input type="checkbox"/>
C. PLEASE READ CAREFULLY AND SIGN BELOW:						
<ul style="list-style-type: none"> I agree to provide Social Security Numbers of all persons applying for MO HealthNet as required by law. The social security number is used to determine eligibility and verify information. I agree that my statements and information provided may be verified. I will report any changes in circumstances within TEN DAYS of when they happen. I know that it is against the law to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatsoever, in whole or in part, may subject me to criminal and/or civil prosecution. I agree that medical information about me can be released if needed to administer this program. I understand Healthcare benefits based on a person being blind, disabled, age 65 or over, pregnant women, child or parent, is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis of one of these, I must complete a different application for these benefits. Provided I am found to be eligible for MO HealthNet, I know the state of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state. I understand that if I disagree with the decision concerning my eligibility, I may request a fair hearing within 90 days of the date of the decision. 						
I agree that the signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge.						
SIGNATURE					DATE	
CALL 1-888-275-5908 IF YOU HAVE ANY QUESTIONS.						
MO 888-2977 (8-08) IM-18C (8-08)						

The DCN must be entered

*Once a client is enrolled into
BCCT, they are qualified for
full MO HealthNet benefits.*

AMERICAN SOCIETY FOR COLPOSCOPY AND CERVICAL PATHOLOGY (ASCCP) CONSENSUS GUIDELINES

- The American Society for Colposcopy and Cervical Pathology (ASCCP) user friendly app for guidelines for managing abnormal cervical cancer screening test. Guidelines and algorithms can be viewed at <https://www.asccp.org>.

- The mobile phone application is located at <https://www.asccp.org/mobile-app>.



CERVICAL RESCREEN

Pelvic Examination:

A repeat pelvic exam is an option as a rescreen in less than ten (10) months if the previous abnormal pelvic exam was not within normal limits due to an abnormal **cervical** finding.

Pap Test:

Reimbursement occurs when a pap test is in accordance with ASCCP guidelines.

HPV DNA genotyping is not considered the same as HPV testing. SMHW does reimburse for HPV DNA genotyping.

HPV DNA specific genotyping 16/18 is an ASCCP option that recommends being done with normal pap/HPV positive results to determine if further diagnostic follow-up is needed. The provider can choose not to do genotyping and co-test (pap/HPV) in one year. Both are acceptable ASCCP options.

ABNORMAL CERVICAL SCREENING RESULTS

- Notify and explain to the client with abnormal screening findings the need for any additional diagnostic service(s).
- SMHW requires two documented attempts for client follow-up, on abnormal results.
- Direct telephone communication has been shown to be the most effective contact.

ABNORMAL CERVICAL SCREENING RESULTS (CONTINUED)

- If unable to reach client, a letter should be sent indicating there is need for additional diagnostic testing/treatment. For legal purposes, providers are encouraged to use a certified letter.
- If no response is received after the second attempt or the client refuses further diagnostics and/or treatments, notify your RPC.

ABNORMAL CERVICAL SCREENING RESULTS (CONTINUED)

- If abnormal screening results are pending for ten (10) months or longer, client eligibility must be checked and a new annual screening test must be performed prior to the initiation of further diagnostic studies.
- SMHW will only reimburse for additional diagnostic services if the client continues to meet SMHW eligibility guidelines and follow ASCCP guidelines.

LOST TO FOLLOW UP (EXAMPLE)

TEST VERSION

This claim is complete. It captures the complete clinical picture from abnormal screening to lost to follow up.

101) Mammogram Guided(19281) No Add'l Sec Pathology
125) Stereotactic Guided(19283) 1 Add'l Sec Pathology
 US Guided(19285) 2 Add'l Sec Pathology
 3 Add'l Sec Pathology

Number of Add'l Lesions (19282, 19284, 19286)

Immunohistochemistry, Initial (88342)
Immunohistochemistry, Additional (88341)

Radiological Exam of Specimen?(76098)

Biopsy Result (Report only most severe result)

(4) Malignancy

Status of Final Diagnosis

(1) Work-up complete (Complete Section C)
 (2) Work-up Pending
 (3) Lost to Follow-up
 (4) Work-up refused (Describe in comment section/Must have signed waiver)
 (9) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY)

Status of Final Diagnosis Date (MM/DD/YYYY)

Next Breast Cancer Screening Date MM/YYYY

Clear

TRANSPORTATION VOUCHER

 <p>FREE Breast and Cervical Cancer Screening Program</p> <p><i>Removing barriers to life saving cancer screenings for women.</i></p>	<p style="text-align: center;">Transportation Voucher</p> <p>County: _____</p> <p>Trip Date: _____</p> <p>Appointment Time: _____</p> <p>Client Signature: _____</p> <p>Clinic Signature: _____</p>
--	---

Free transportation is available for SMHW participants. Ask the client if she requires transportation, if she does, document in the patient chart when you arrange the transportation

TRANSPORTATION (CONTINUED)

SMHW/WW services qualify for transportation services, including initial office visits, lab visits, follow-up diagnostic office visits, lifestyle education sessions, and annual evaluation screenings.

Contact Show Me Healthy Women Staff for travel vouchers or questions regarding transportation arrangements.

PATIENT NAVIGATION ELIGIBILITY CRITERIA

- Females 35-64 years of age
- Income Guidelines at or below 250% of the federal poverty level
- Patient's insured status
- Client with barriers preventing them from obtaining screening services.
- "Navigation-Only" status allows payment for navigation services provided to a woman who meets age and income requirements and has insurance to pay for screening and diagnostic services.

PATIENT NAVIGATION (CONTINUED)

- **Six CDC required services:**

1. Written assessment of patient barriers to cancer screening
2. Patient education and support
3. Resolution of barriers to obtaining screening
4. Patient tracking and follow-up
5. Minimum of two (2) preferably more, patient contacts
6. Data collection to evaluate outcomes of patient navigation

PATIENT NAVIGATION (CONTINUED)

- A completed screening is the desired and expected outcome
- A minimum of 2 contacts must be documented
- A current patient history (green) form must be in MOHSAIC

PATIENT NAVIGATION (CONTINUED)

- Entry of a screening and/or diagnostic form will be entered
- SMHW will reimburse \$60.00 for each completed navigation form

REQUEST FROM SMHW FOR ADDITIONAL INFORMATION

- Diagnostic form without abnormal screening
- Incomplete form
- Missing a lost to follow up form (enter on the next step form, either diagnostic breast (purple) and/or diagnostic cervical (yellow))
- Mammogram on incorrect MOHSAIC form (rescreen mammograms)

DIAGNOSTIC WITH A NORMAL SCREENING

TEST VERSION

NORMAL CBE/MAMM

B. CLINICAL BREAST EXAM RESULTS [Clear](#) Reporting Only

Does client report any breast symptoms? Additional Information Required if *YES* Selected

CBE WNL Additional Information Required if *NO* Selected

Findings Present at CBE (check only one)

BENIGN FINDING: Within Normal Limits

SUSPICIOUS FOR CANCER
(Any marked findings requires completion of two(2) diagnostic procedures entered on purple breast diagnostic form)

1) Benign finding (fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)

C. MAMMOGRAM RESULTS [Clear](#) Reporting Only

(4) Mammogram not done. OR CBE done and diagnostic workup pending

(1) Routine screening mammogram

(2) Mammogram performed to evaluate symptoms:

Personal history of breast cancer

Previous abnormal mammogram results (rescreen)

(5) Cervical record only, no breast service provided

(6) Referred to Direct Biller for Mammogram

(3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

Date Client Referred for diagnosis

Mammogram Provider Facility Mammogram Van

Previous Mammograms

Date of Last Mammogram month year

Date of This Mammogram MM/DD/YYYY

Type of Mammogram Screening Diagnostic [Clear](#)

Conventional Digital Tomosynthesis

SMHW Mammogram Result (Check one) [Clear](#)

	LEFT	RIGHT
NORMAL	<input checked="" type="radio"/> 1 <input checked="" type="radio"/> Negative (Category 1)	
	<input type="radio"/> 2 <input type="radio"/> Benign Finding (Category 2)	
	<input type="radio"/> 3 <input type="radio"/> Probably Benign (Category 3)	
ABNORMAL	<input type="radio"/> 4 <input type="radio"/> Suspicious Abnormality (Category 4)*	
	<input type="radio"/> 5 <input type="radio"/> Highly Suggestive of Malignancy (Category 5)*	
OTHER	<input type="radio"/> 14 <input type="radio"/> Need evaluation or Film Comparison (BI-RADS 0)*	
	<input type="radio"/> 7 <input type="radio"/> Unsatisfactory-not interpreted, repeat (Not Paid)	

NOTE: Results with * require additional follow-up.

DIAGNOSTIC BREAST FOLLOW-UP

B. BREAST DIAGNOSTIC PROCEDURES [Clear](#) Reporting Only

Diagnostic Mammogram

Conventional Digital Tomosynthesis [Clear](#)

MM/DD/YYYY

Additional Mammographic Views

L R [Clear](#)

Normal

1 (1) Negative (Category 1)

2 (2) Benign Finding (Category 2)

3 (3) Probably Benign (Category 3)

4 (4) Suspicious Abnormality (Category 4)

Abnormal

5 (5) Highly Suggestive of Malignancy (Category 5)

14 (14) Additional Imaging Pending (Category 0)

7 (7) Unsatisfactory - not interpreted - repeat (not paid)

Other

Ultrasound MM/DD/YYYY [Clear](#) Rescreen Reporting Only

L R

Left: Complete

Limited

Right: Complete

Limited

1 (1) Negative (Category 1)

2 (2) Benign (Category 2)

3 (3) Probably Benign (Category 3)

4 (4) Suspicious Abnormality (Category 4) - Refer to BCCT

5 (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT

7 (7) Unsatisfactory - not interpreted - repeat (not paid)

14 (14) Needs Additional Evaluation (Category 0)

INCOMPLETE FORM EXAMPLE

TEST VERISON

MISSING HPV/DNA

MISSING INFORMATION

SMHW PAP Test Result (Select one)

NORMAL

- (1) Negative for Intraepithelial Lesion or Malignancy
- (2) Infection/Inflammation/Reactive Changes

ABNORMAL

- (3) Atypical Squamous Cells of Undetermined Significance (ASC-US) (May have HPV test)
- (4) Lowgrade SIL (HPV/Mild Dysplasia/CIN I)
- (5) Atypical Squamous Cells cannot exclude HSIL (ASC-H) *
- (6) Highgrade SIL (with features suspicious for invasion/CIN II-III/CIS) *
- (7) Squamous Cell Cancer *
- (8) Atypical Glandular Cells (including atypical, endocervical adenocarcinoma in situ and adenocarcinoma) *
- (9) Adenocarcinoma in situ (AIS)
- (10) Adenocarcinoma
- (11) Other

OTHER

Endocervical Cells

HPV Profile: MM/DD/YYYY Reporting Only

Indication for HPV Test: Clear

HPV Test Result Clear

HPV DNA Genotyping 16 or 18 POSITIVE YES NO NOT DONE

Rescreen Planned (less than 10 months) MM/YYYY

Diagnostic Work-up Planned (Must be less than 60 days) MM/YYYY

Referred for Diagnostic Work-up / Direct Biopsy Physician / Facility Name

COMMENTS Maximum length is 1536 characters.

Indication for HPV Test: Clear

HPV Test Result Clear

HPV DNA Genotyping 16 or 18 POSITIVE YES NO NOT DONE

**Complete the Yes,
No or Not Done**

EXAMPLE OF LOST TO FOLLOW UP

Diagnostic Breast (Purple Form)

This claim is complete. It captures the complete clinical picture from abnormal screening to lost to follow up

Mammogram Guided(19281) No Add'l Sec Pathology
 Stereotactic Guided(19283) 1 Add'l Sec Pathology
 US Guided(19285) 2 Add'l Sec Pathology
Number of Add'l Lesions (19282, 19284, 19286)
 Immunohistochemistry, Initial (88342) Immunohistochemistry, Additional (88341)
 Radiological Exam of Specimen?(76098)

Status of Final Diagnosis
 (1) Work-up complete (Complete Section C)
 (2) Work-up Pending
 (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date)
 (4) Work-up refused (Describe in comment section/Must have signed waiver)
 (5) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY)

Status of Final Diagnosis Date (MM/DD/YYYY)

Cytology for Nipple Discharge(Not Reimbursed)
 MRI (Not Reimbursed)
 Nuclear Scan/Miraluma/BSGI (Not Reimbursed)
 Skin Biopsy(Not Reimbursed)
 Ductogram
 Single Duct(77053) Multiple Duct(77054 Not Reimbursed)
Left Right
 (1) (1) Negative(Category 1)

Diagnostic Cervical (Yellow Form)

Status of Final Diagnosis
 (1) Work-up complete (Complete Section C)
 (2) Work-up Pending
 (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date)
 (4) Work-up refused (Describe in comment section/Must have signed waiver)
 (5) Irreconcilable (Does not follow typical protocol - FOR STAFF USE ONLY)

Status of Final Diagnosis Date (MM/DD/YYYY)

C. CERVICAL DIAGNOSIS

Final Diagnosis
 Normal/Benign Reactive/Inflammation
 HPV/Condylomata
 CIN I/Mild Dysplasia/Low grade SIL (Biopsy Diagnosed)
 CIN II/Moderate Dysplasia (Biopsy Diagnosed)* refer to BCCT
 CIN III/Severe Dysplasia/High Grade SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)*
 Invasive (Biopsy Diagnosed)*
 Other (Use if woman has no cervix for cancer types: Vulval, Vaginal, Endometrial, Uterine, Ovarian)

This claim is complete. It captures the complete clinical picture from abnormal screening to lost to follow up.

SMHW REGIONAL PROGRAM COORDINATORS CONTACT

- Mary Young, RN, Kansas City/Northwest Area 816-859-4887
- Missy Rice, RN, Southwest Area 417-693-3409
- Mary Costephens, RN, Southeast Area 573-536-1809
- Lisa Graessle, RN, Central/Northeast Area 573-522-2855
- Margaret Laycock, RN, St. Louis City and Area 314-657-1509

SMHW REGIONAL PROGRAM COORDINATORS CONTACT (CONTINUED)

- Mary.Young@uhkc.org
- Missy.Rice@health.mo.gov
- Mary.Costephens@health.mo.gov
- Lisa.Graessle@health.mo.gov
- Margaret Laycock (Laycockm@stlouis-mo.gov)



Missouri Department of Health & Senior Services

Show Me Healthy Women

930 Wildwood Drive, PO Box 570

Jefferson City, MO 65102-0570

Web address:

www.health.mo.gov/showmehealthywomen

Telephone: 573-522-2845

QUESTIONS/COMMENTS

Thank you for attending the
SMHW Annual Provider Training!

QUESTIONS/COMMENTS???

