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)

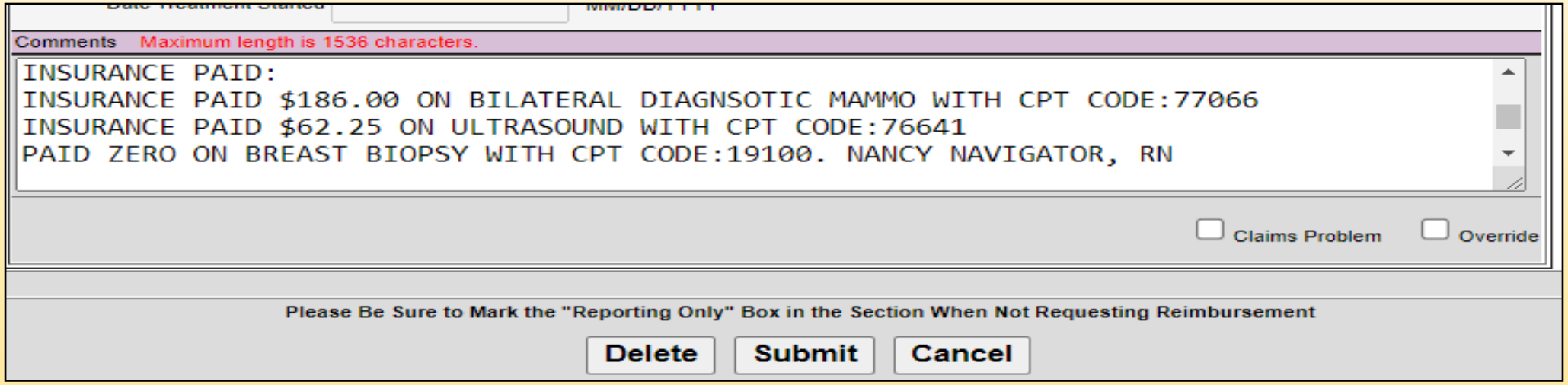
HEALTH INSURANCE

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)



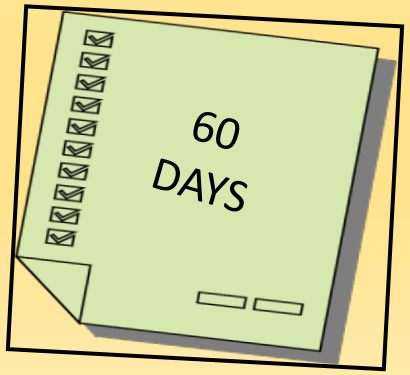
CPT Code: 77066 $ 186.00 Mammography, diagnostic follow – up (bilateral)

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



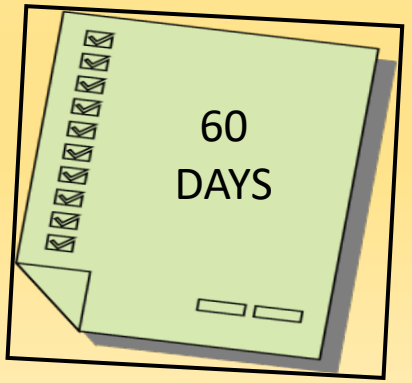
BILLING TIMEFRAMES (CONTINUED)

- 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).**

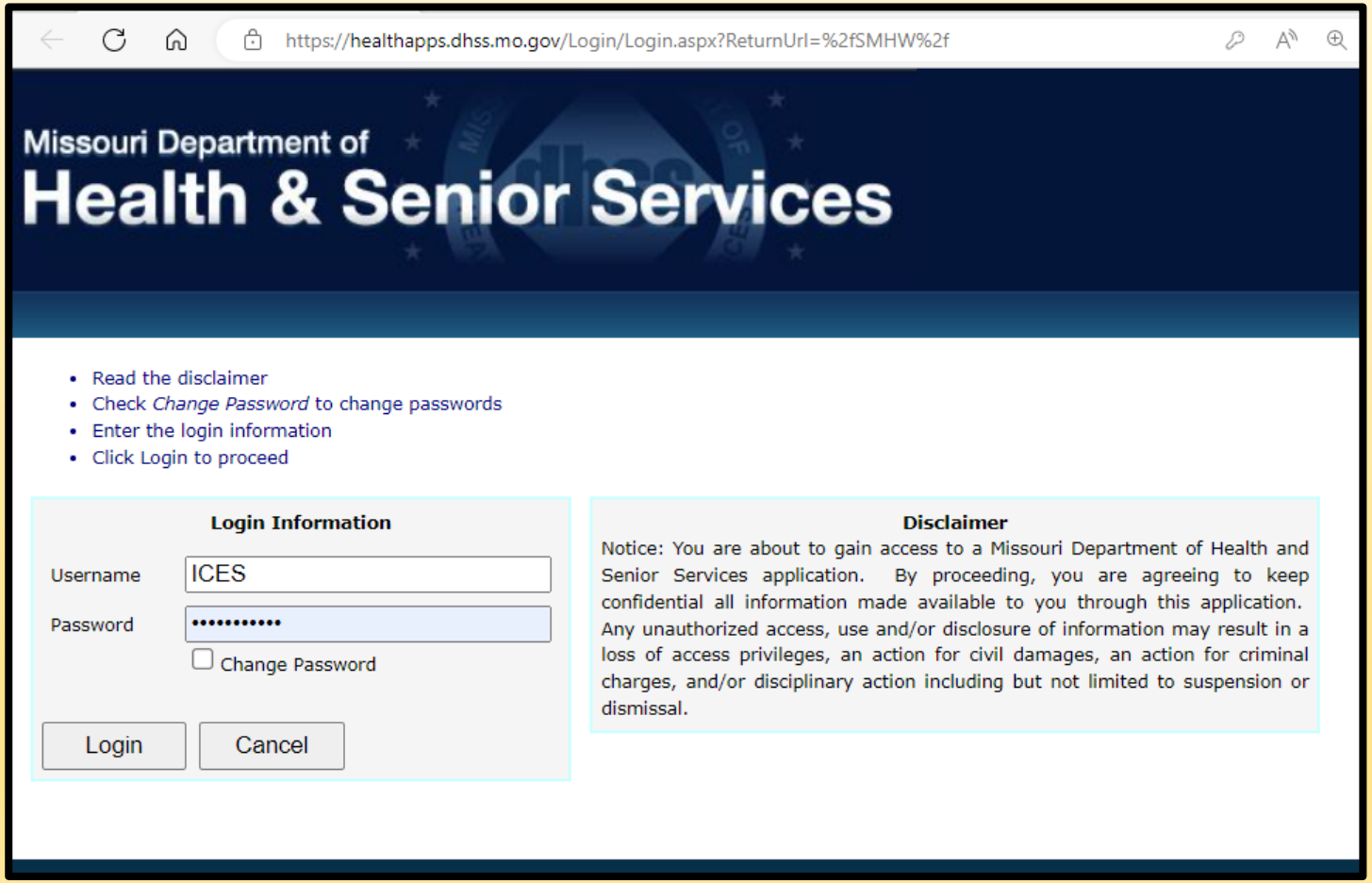
- After receiving authorization with A.S.A.P. and a user log-in, go to https://healthapps.dhss.mo.gov/smhw/. Enter MOHSAIC with your log-in and password. The main screen will open. Do not use Internet Explorer, use Google Chrome or Microsoft Edge.

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.

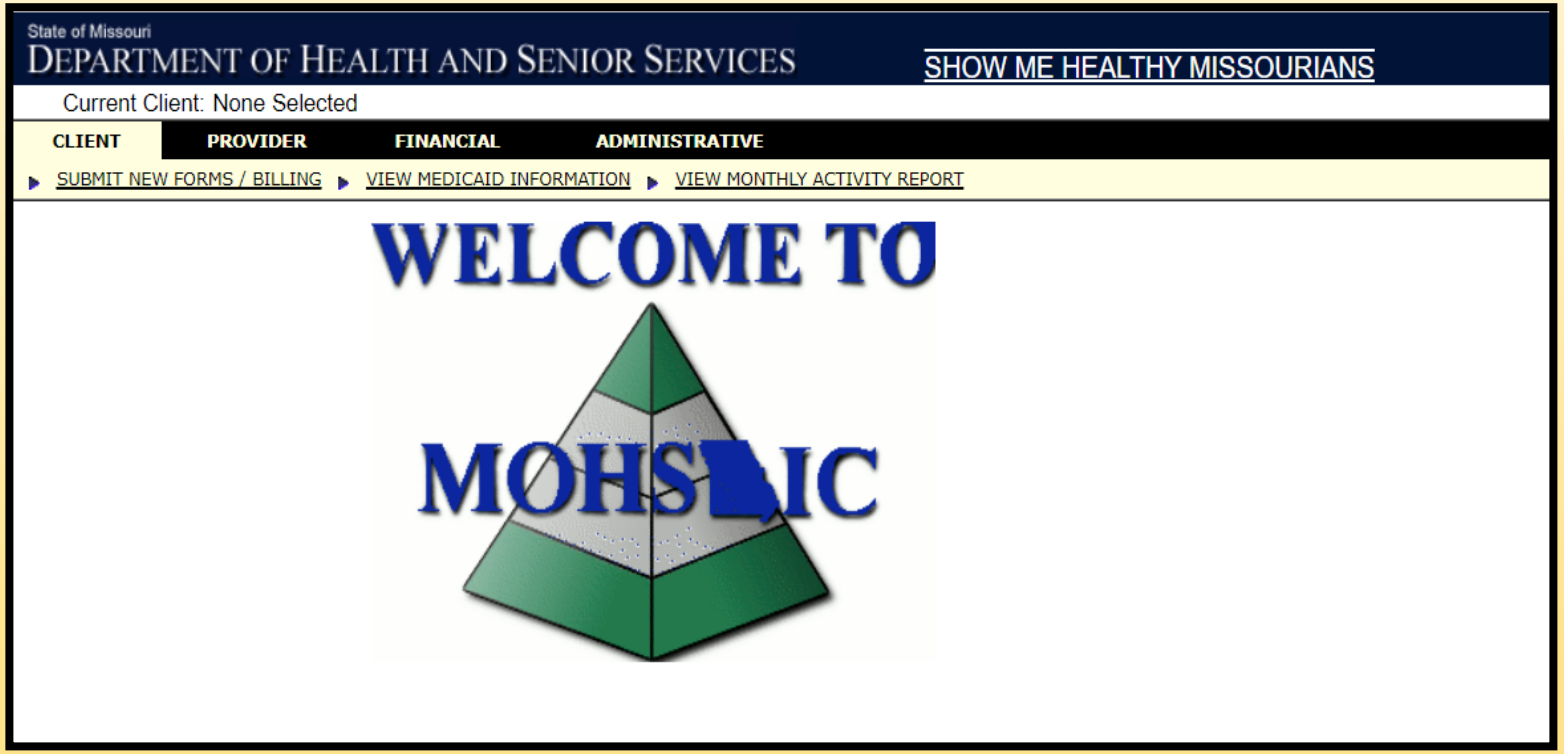
- If you save the MOHSAIC link into your favorites, make it the simple link https://healthapps.dhss.mo.gov/smhw/. Do not add anything, the link will not work.

FORM ENTRY INTO MOHSAIC (CONTINUED)



Log-in screen for entry to MOHSAIC

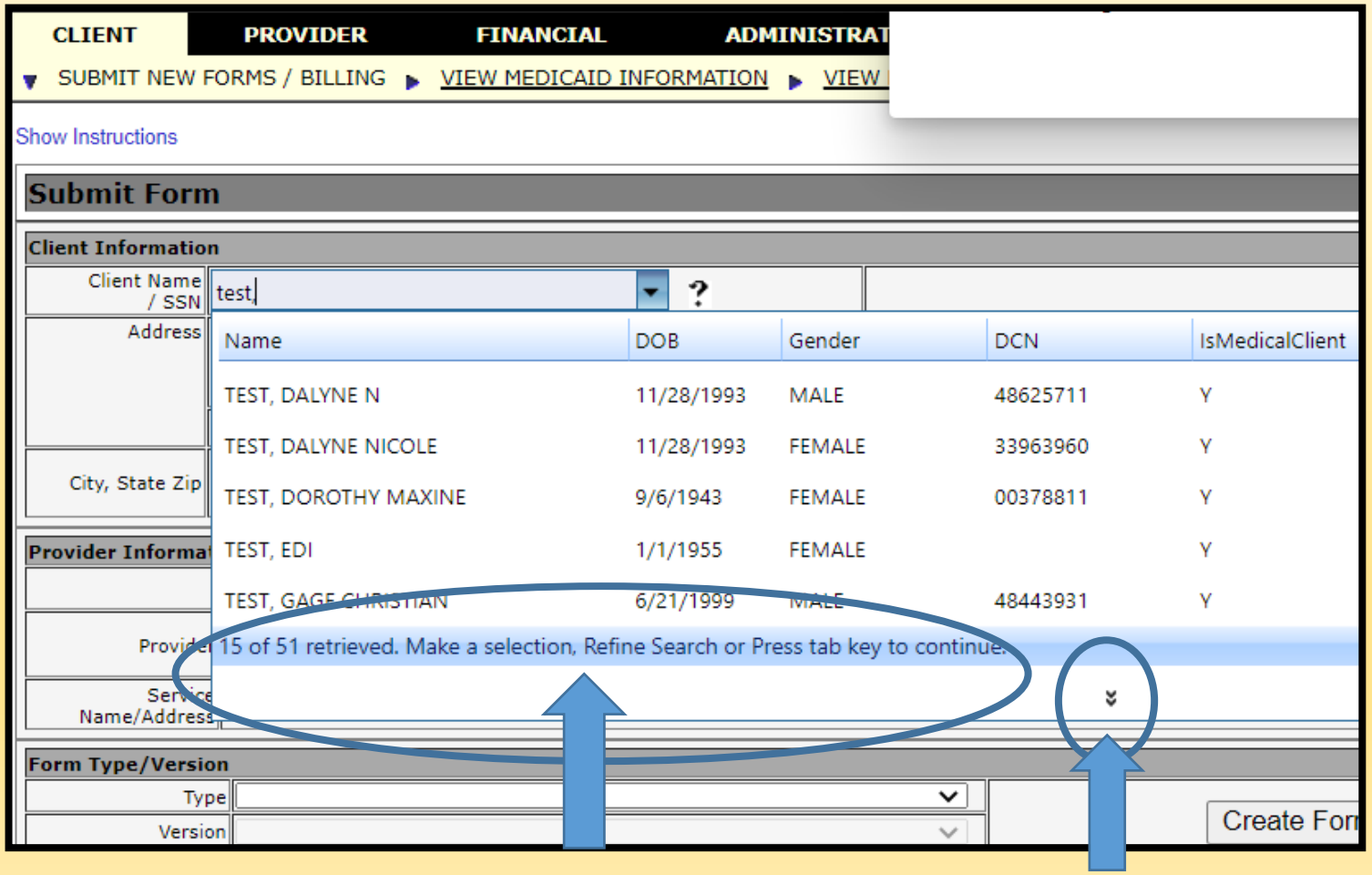
FORM ENTRY INTO MOHSAIC (CONTINUED)



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)

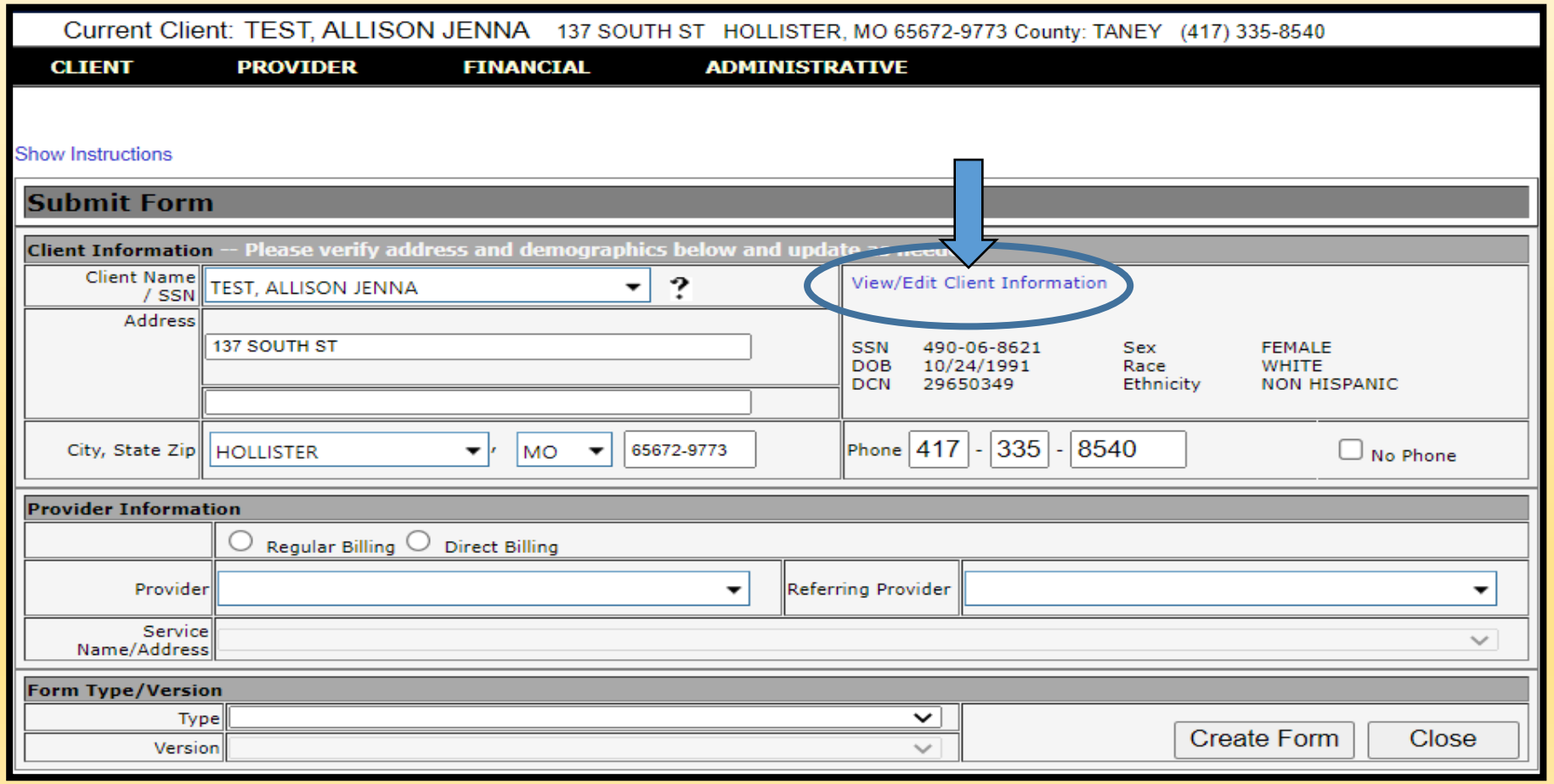
TEST VERSION



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

FORM ENTRY INTO MOHSAIC (CONTINUED)

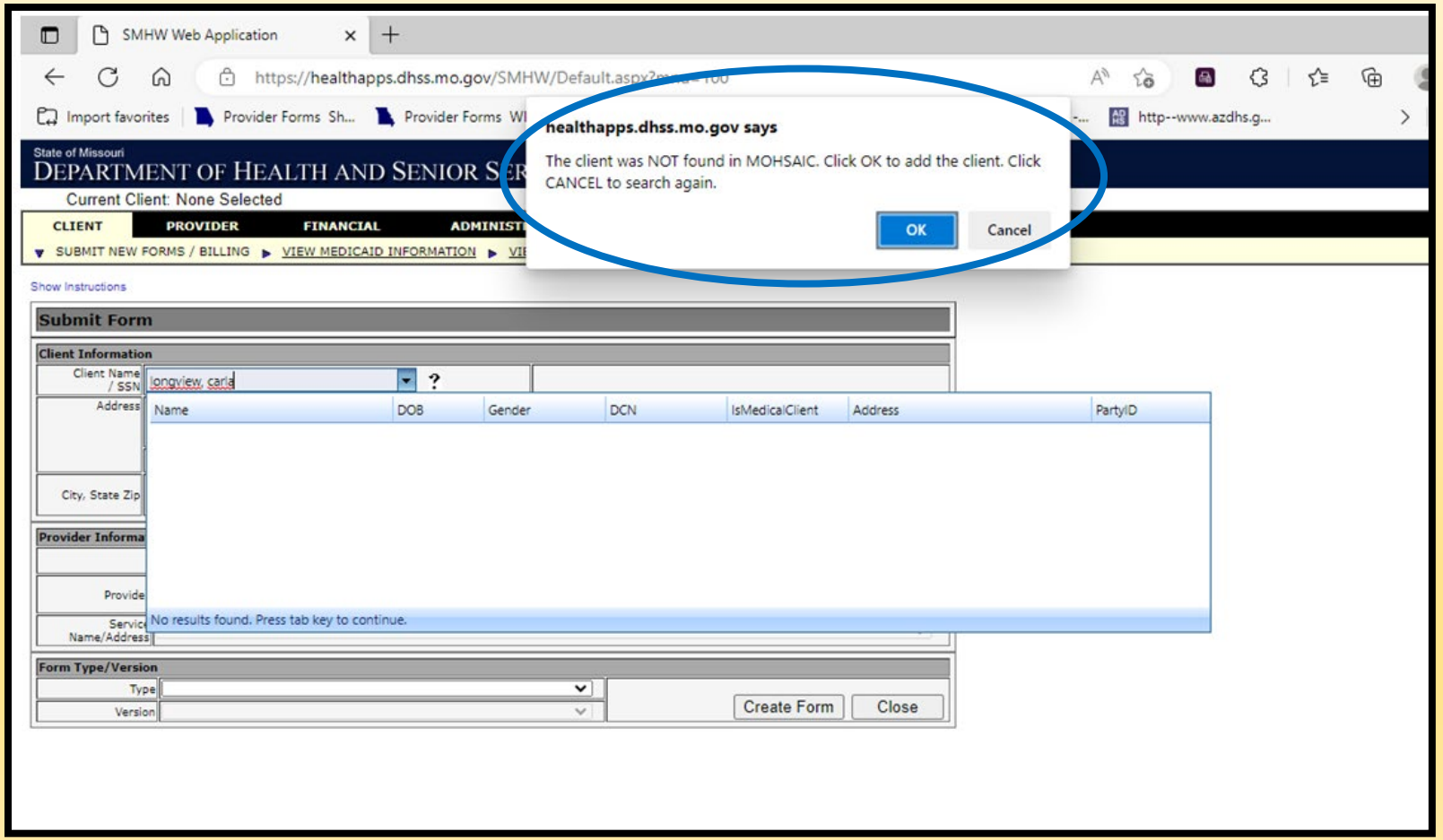
TEST VERSION



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

FORM ENTRY INTO MOHSAIC (CONTINUED)

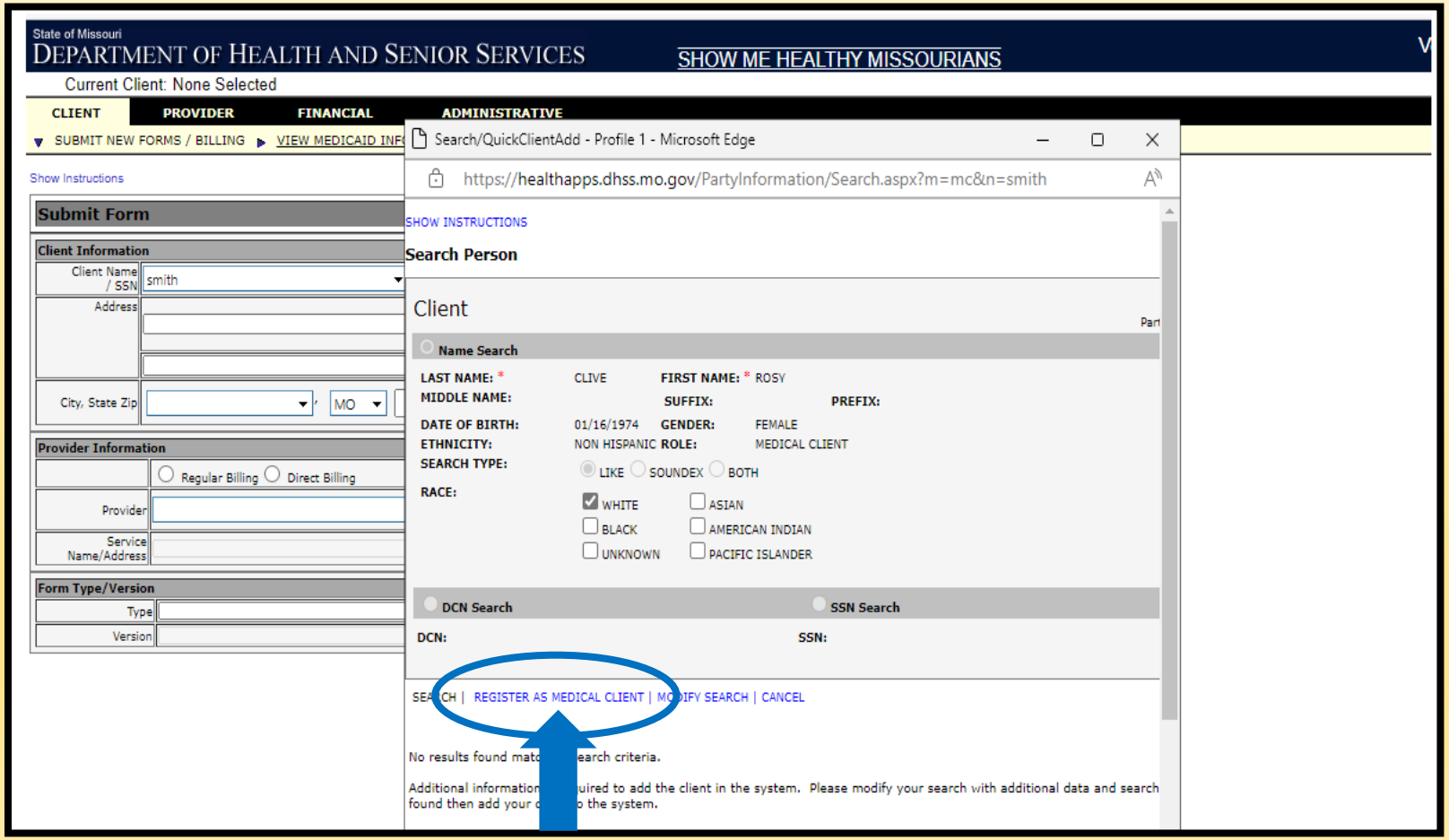
TEST VERSION



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



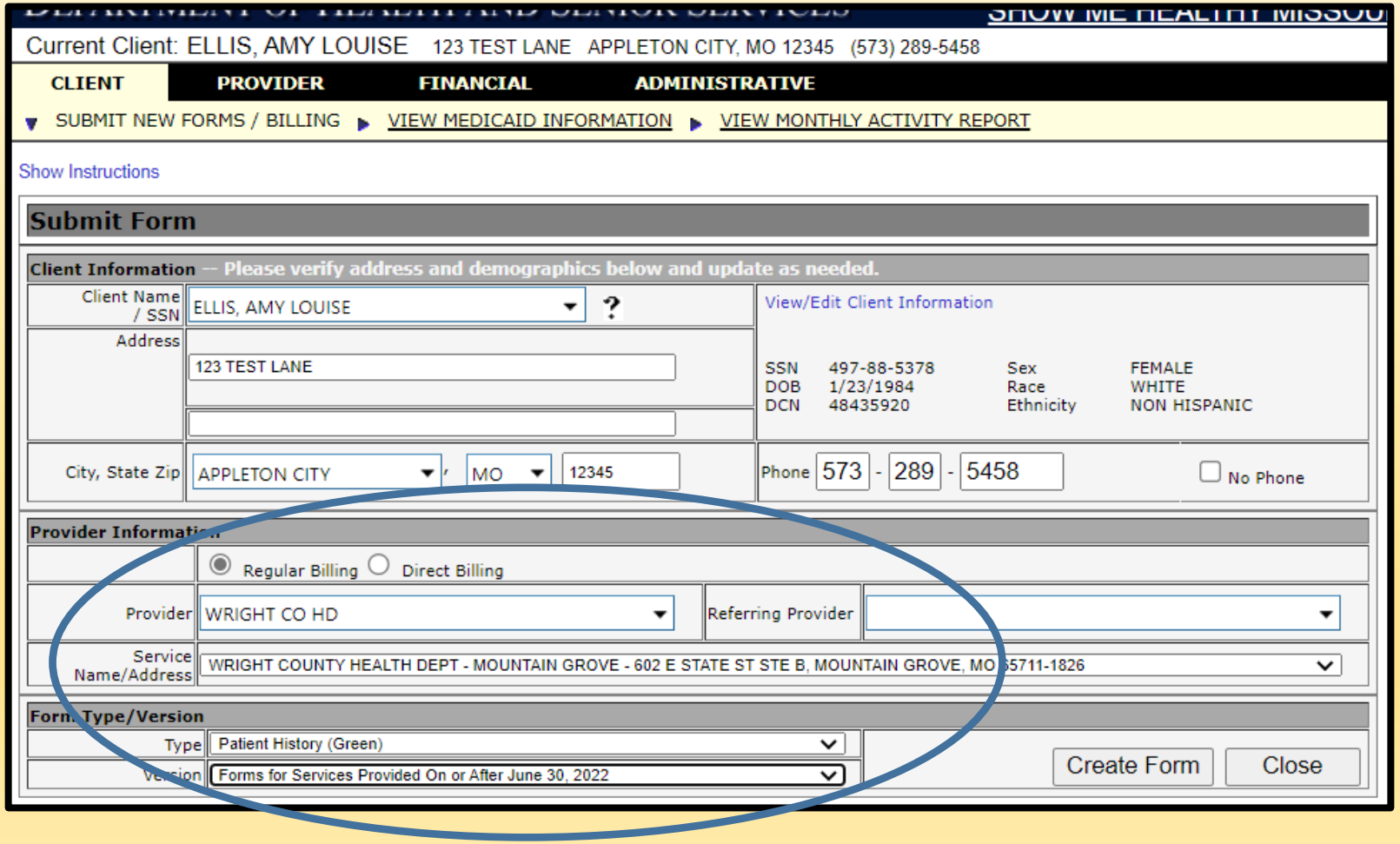
Enter the patient's information and then select "Register as medical client". This will allow you to move forward and enter forms.

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



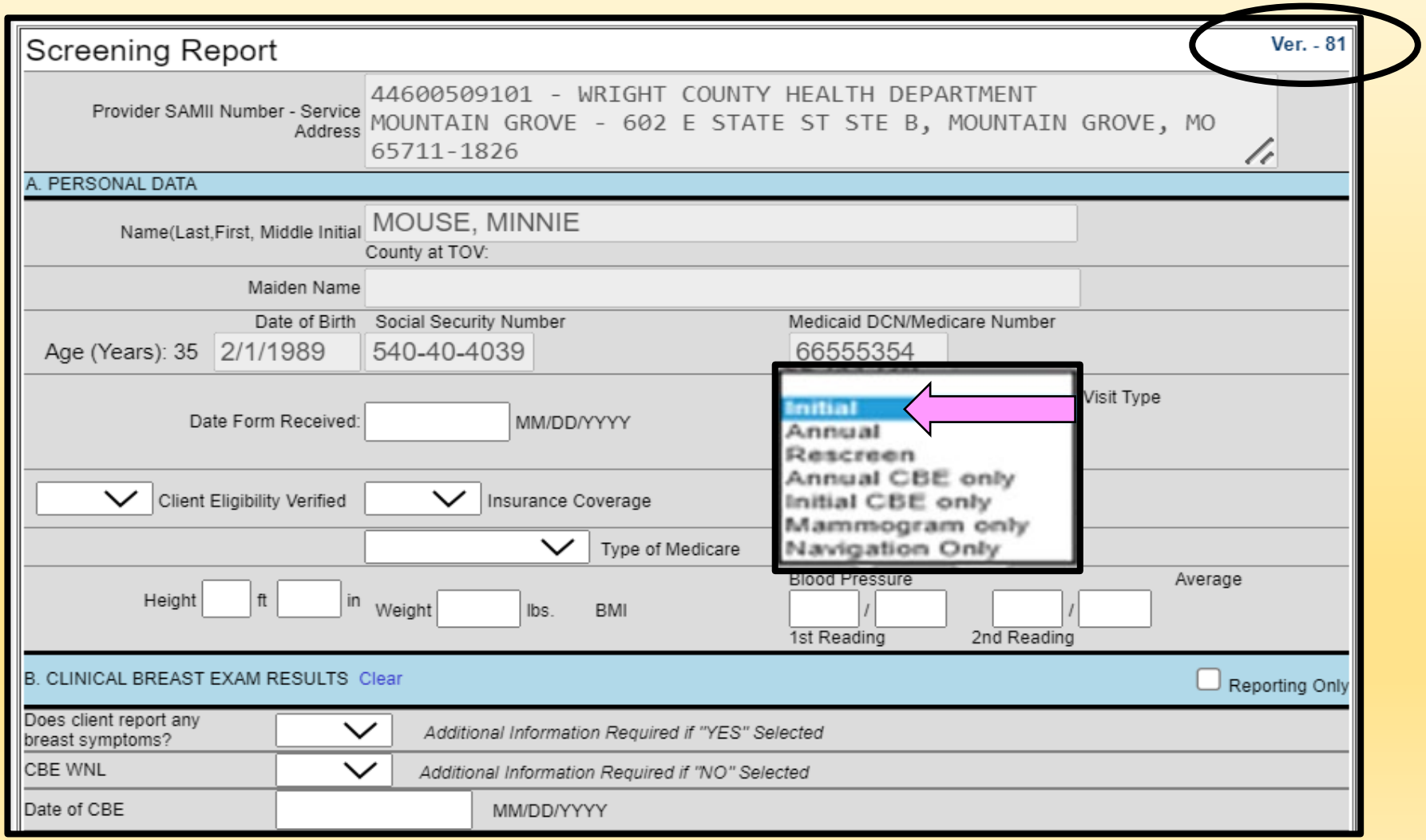
SMHW – MOHSAIC FORM BASICS

- 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



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

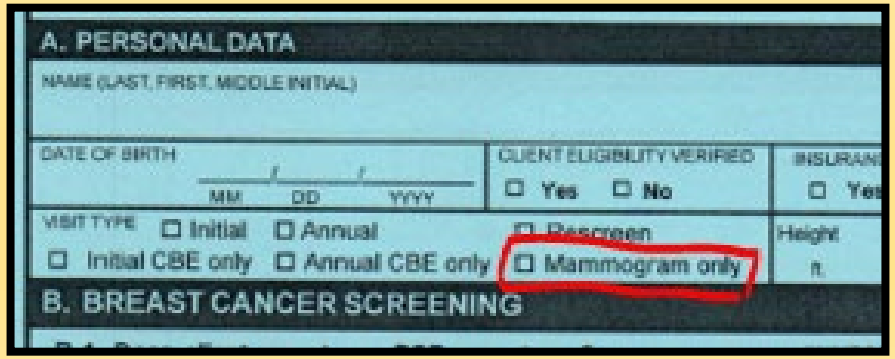
A patient 40 to 64 years old, has an appointment scheduled on a mammogram van. When submitting the reimbursement MOHSAIC claim form, note this as a mammogram van visit. For clinical best practice, a CBE should be completed at a well-woman check-up (annually). Please encourage and document the conversation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

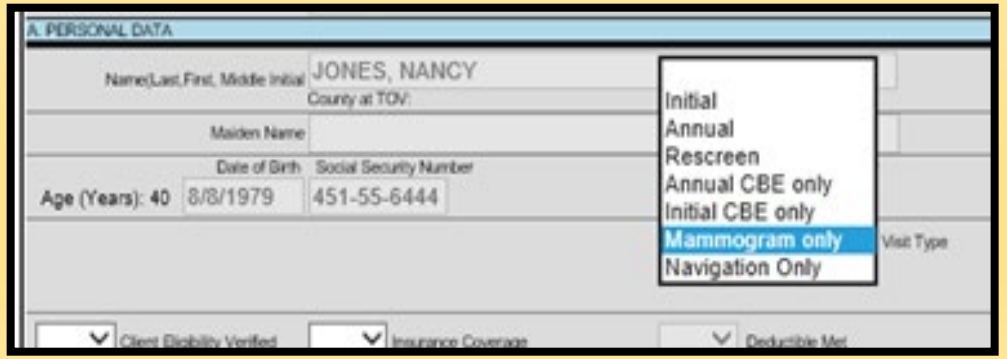
If the patient receives a screening mammogram at a brick-and-mortar breast imaging center, the same example will apply. A patient may be referred to your breast imaging center after a CBE was completed with a practitioner.

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

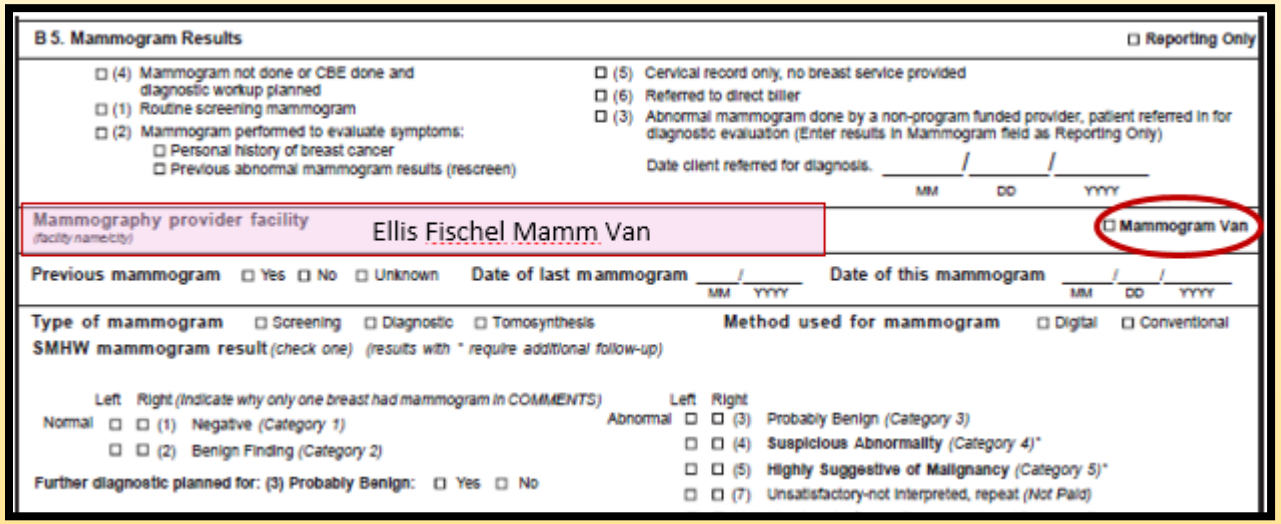


SCREENING BLUE FORM - PAPER



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 (facility name/city) Ellis Fischel Mamm Van ☐ Mammogram Van

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

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

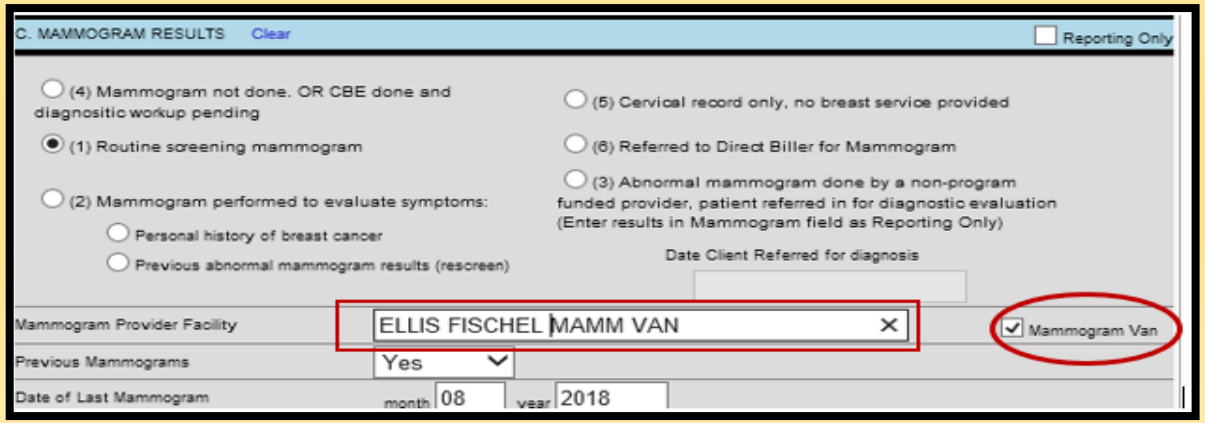
SMHW mammogram result (check one) (results with * require additional follow-up)

	Left	Right	(Indicate why only one breast had mammogram in COMMENTS)		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)*
					☐	☐	(7) Unsatisfactory-not interpreted, repeat (Not Paid)

Further diagnostic planned for: (3) Probably Benign: ☐ Yes ☐ No

PAPER FORM

MOHSAIC FORM


C. MAMMOGRAM RESULTS Clear ☐ Reporting Only

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

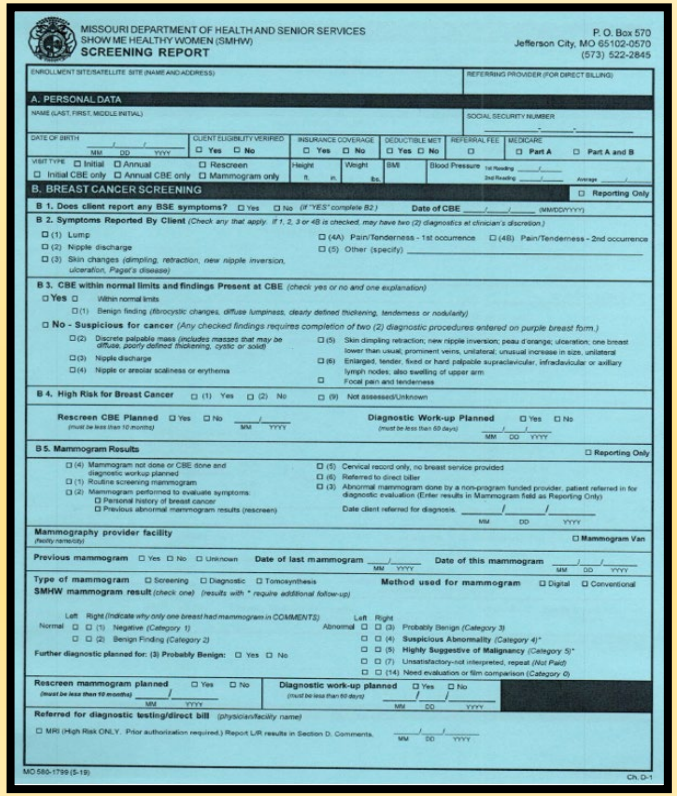
○ (5) Cervical record only, no breast service provided
○ (6) Referred to Direct Biller for Mammogram
○ (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date Client Referred for diagnosis

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")



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/SATELLITE SITE (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 ☐ | MEDICARE ☐ Part A ☐ Part A and B

VISIT TYPE ☐ Initial ☐ Annual ☐ Rescreen ☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only | Height ft. in. | Weight lbs. | BMI | Blood Pressure 1st Reading ____/____ 2nd Reading ____/____ Average ____/____

B. BREAST CANCER SCREENING ☐ Reporting Only

B 1. Does client report any BSE symptoms? ☐ Yes ☐ No (If "YES" complete B2.) **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
☐ (2) Nipple discharge
☐ (3) Skin changes *(dimpling, retraction, new nipple inversion, ulceration, Paget's disease)*
☐ (4A) Pain/Tenderness - 1st occurrence ☐ (4B) Pain/Tenderness - 2nd occurrence
☐ (5) Other (specify) ____

B 3. CBE within normal limits and findings Present at CBE *(check yes or no and one explanation)*

☐ **Yes** ☐ Within normal limits
☐ (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)*
☐ (3) Nipple discharge
☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling retraction; new nipple inversion; peau d'orange; ulceration; one breast lower than usual, prominent veins, unilateral; unusual increase in size, unilateral
☐ (6) Enlarged, tender, fixed or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm
☐ Focal pain and tenderness

B 4. High Risk for Breast Cancer ☐ (1) Yes ☐ (2) No ☐ (9) Not assessed/Unknown

Rescreen CBE Planned ☐ Yes ☐ No ____/____ (MM YYYY) (must be less than 10 months)
Diagnostic Work-up Planned ☐ Yes ☐ No ____/____/____ (MM DD YYYY) (must be less than 60 days)

B 5. Mammogram Results ☐ Reporting Only

☐ (4) Mammogram not done or CBE done and diagnostic work-up 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 (facility name/city) ☐ Mammogram Van

Previous mammogram ☐ Yes ☐ No ☐ Unknown **Date of last mammogram** ____/____ (MM 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)*
Abnormal ☐ ☐ (3) Probably Benign *(Category 3)*
☐ ☐ (4) Suspicious Abnormality *(Category 4)**
☐ ☐ (5) Highly Suggestive of Malignancy *(Category 5)**
☐ ☐ (7) Unsatisfactory-not interpreted, repeat *(Not Paid)*
☐ ☐ (14) Need evaluation or film comparison *(Category 0)*

Further diagnostic planned for: (3) Probably Benign: ☐ Yes ☐ No

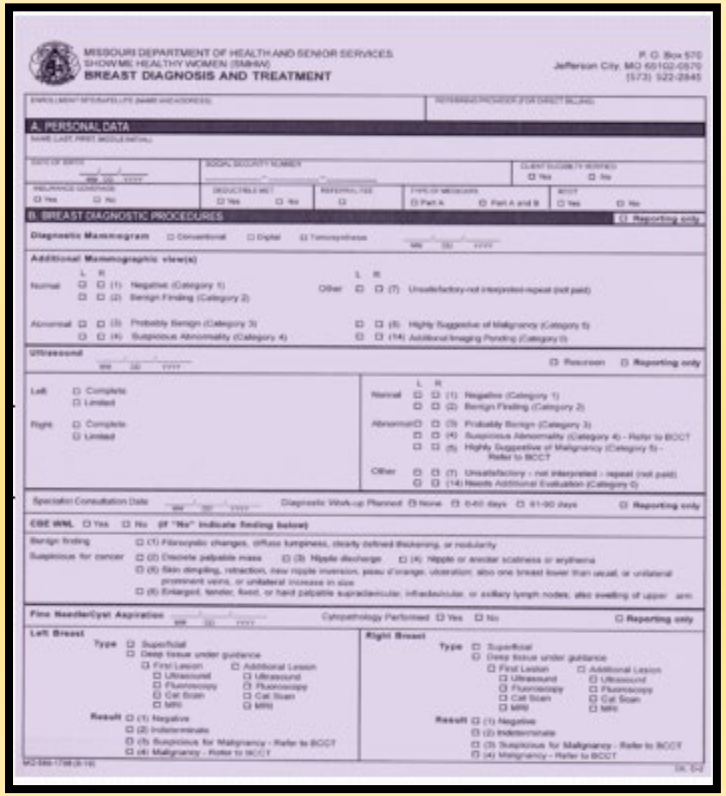
Rescreen mammogram planned ☐ Yes ☐ No ____/____ (MM YYYY) (must be less than 10 months)
Diagnostic work-up planned ☐ Yes ☐ No ____/____/____ (MM DD YYYY) (must be less than 60 days)

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 580-1799 (5-19) Ch. D-1

Refer to forms

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



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

A. PERSONAL DATA

B. BREAST DIAGNOSTIC PROCEDURES ☐ Reporting only

Diagnostic Mammogram ☐ Conventional ☐ Digital ☐ Tomosynthesis (MM DD YYYY)

Additional Mammographic view(s)

L R
Normal ☐ ☐ (1) Negative (Category 1)
☐ ☐ (2) Benign Finding (Category 2)
Other ☐ ☐ (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) Additional Imaging Pending (Category 0)

Ultrasound (MM DD YYYY) ☐ Rescreen ☐ Reporting only

Left ☐ Complete ☐ Limited
Right ☐ Complete ☐ Limited

L R
Normal ☐ ☐ (1) Negative (Category 1)
☐ ☐ (2) Benign Finding (Category 2)
Abnormal ☐ ☐ (3) Probably Benign (Category 3)
☐ ☐ (4) Suspicious Abnormality (Category 4) - Refer to BCCT
☐ ☐ (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT
Other ☐ ☐ (7) Unsatisfactory - not interpreted - repeat (not paid)
☐ ☐ (14) Needs Additional Evaluation (Category 0)

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)

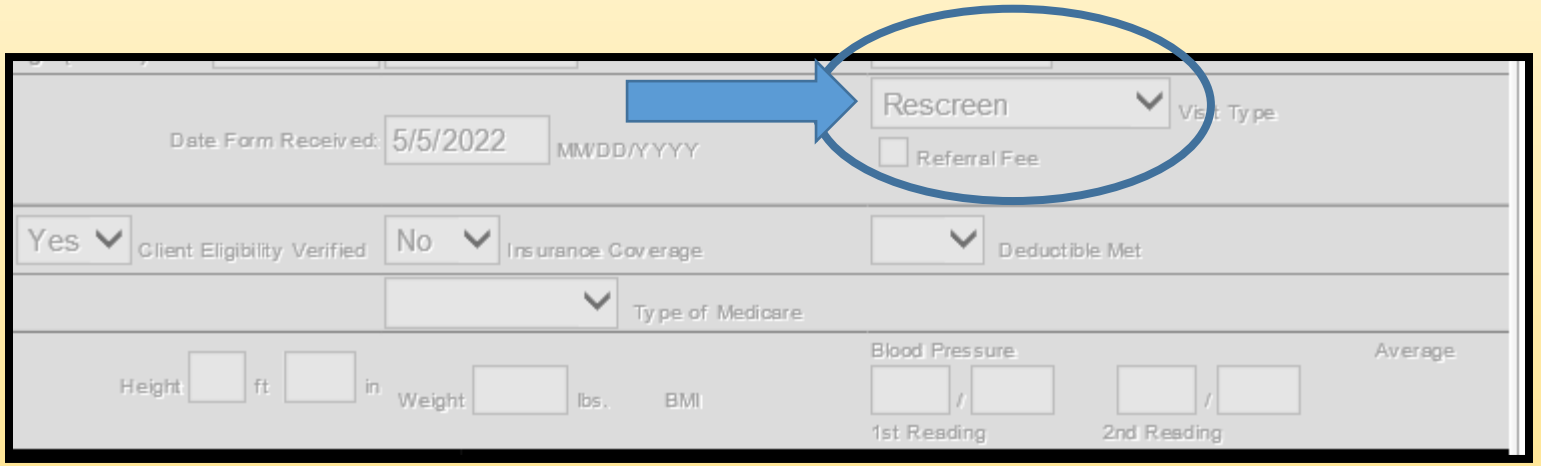
Benign finding ☐ (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity
Suspicious for cancer ☐ (2) Discrete palpable mass ☐ (3) Nipple discharge ☐ (4) Nipple or areolar scaliness or erythema
☐ (6) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration;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

Fine Needle/Cyst Aspiration (MM DD YYYY) 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

REPORTING DIAGNOSTIC RESCREEN (MAMMOGRAM)



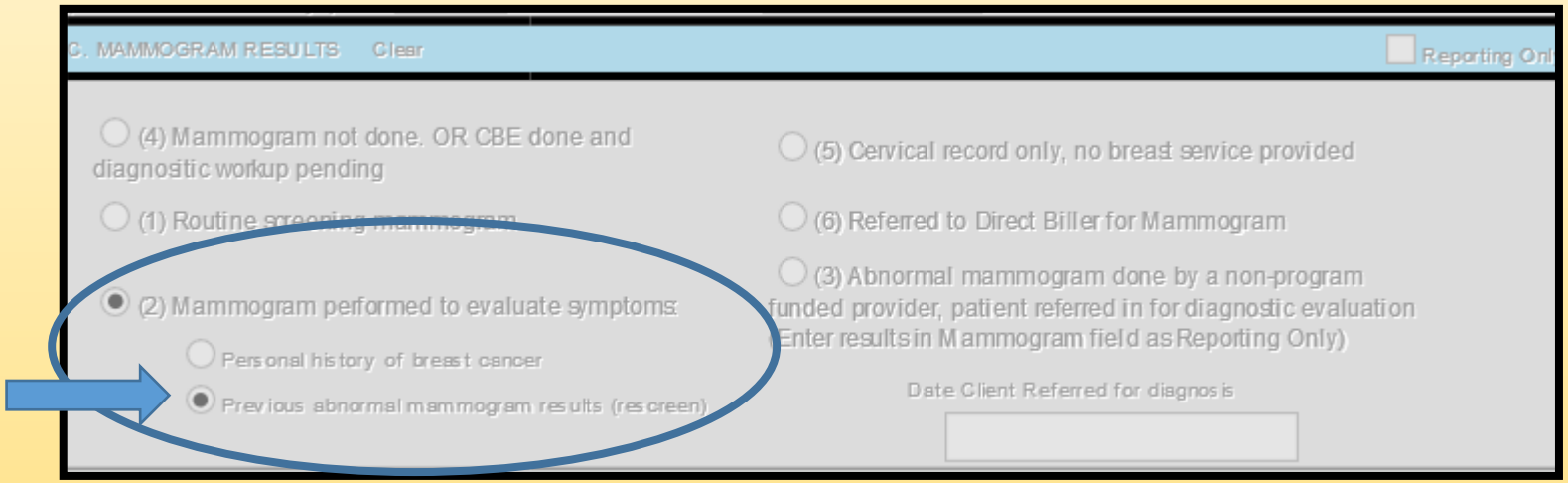
MOHASIC Blue Screening Form

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



MOHSAIC Blue Screening Form

RESCREENING NOTE:

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

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

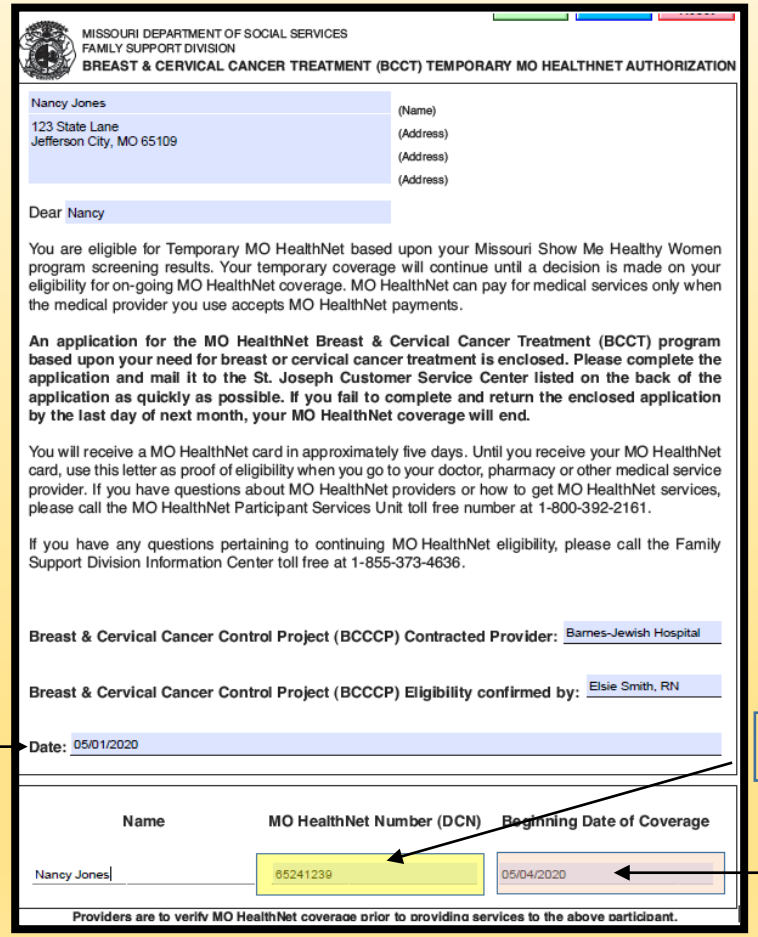
PRESUMPTIVE (PE) BCCT FORM

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



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)
(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	65241239	05/04/2020

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

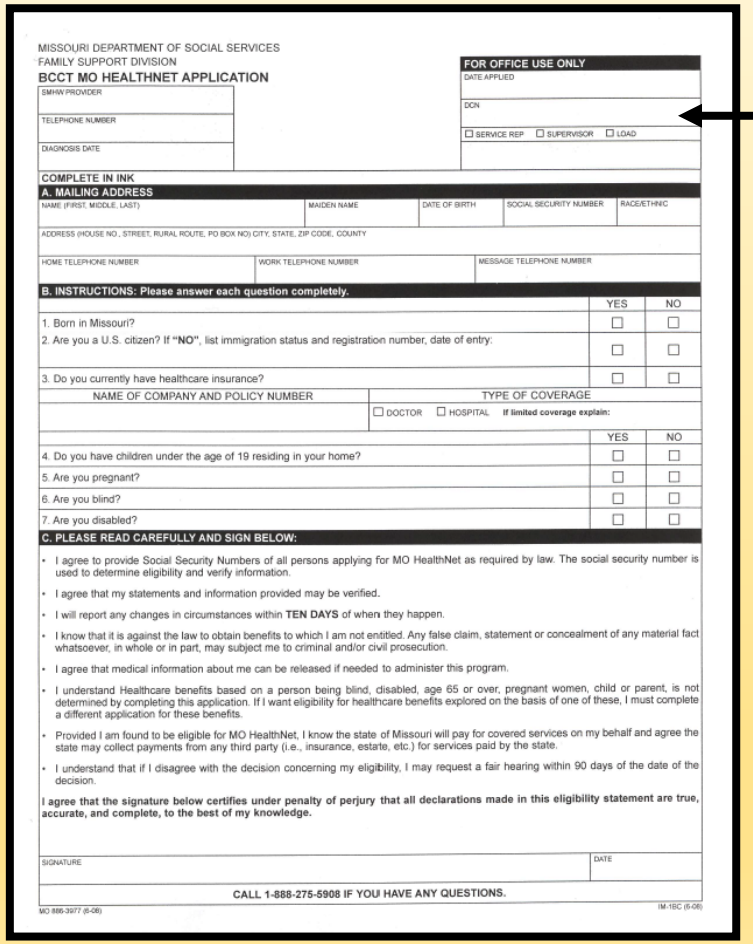
Date enrolled in SMHW

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.



MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
BCCT MO HEALTHNET APPLICATION

SMHW PROVIDER
TELEPHONE NUMBER
DIAGNOSIS DATE

FOR OFFICE USE ONLY
DATE APPLIED
DCN
☐ SERVICE REP ☐ SUPERVISOR ☐ LOAD

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.

	YES	NO
1. Born in Missouri?	☐	☐
2. Are you a U.S. citizen? If **"NO"**, list immigration status and registration number, date of entry:	☐	☐
3. Do you currently have healthcare insurance?	☐	☐

NAME OF COMPANY AND POLICY NUMBER | TYPE OF COVERAGE ☐ DOCTOR ☐ HOSPITAL **If limited coverage explain:**

	YES	NO
4. Do you have children under the age of 19 residing in your home?	☐	☐
5. Are you pregnant?	☐	☐
6. Are you blind?	☐	☐
7. Are you disabled?	☐	☐

C. PLEASE READ CAREFULLY AND SIGN BELOW:

- 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 886-3977 (6-08) IM-1BC (6-08)

The DCN must be entered

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

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.

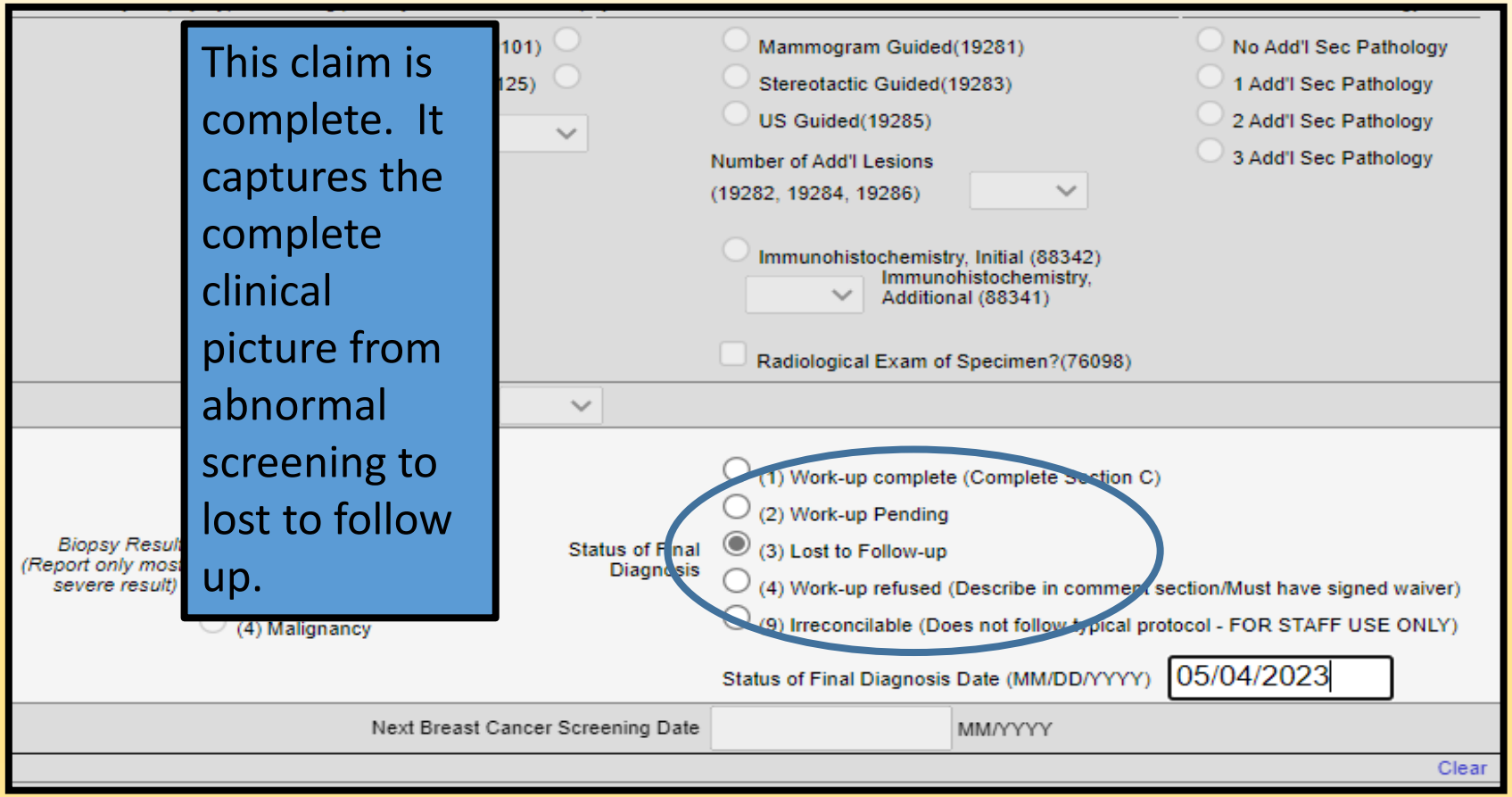
ABNORMAL CERVICAL SCREENING RESULTS (CONTINUED)

- 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.

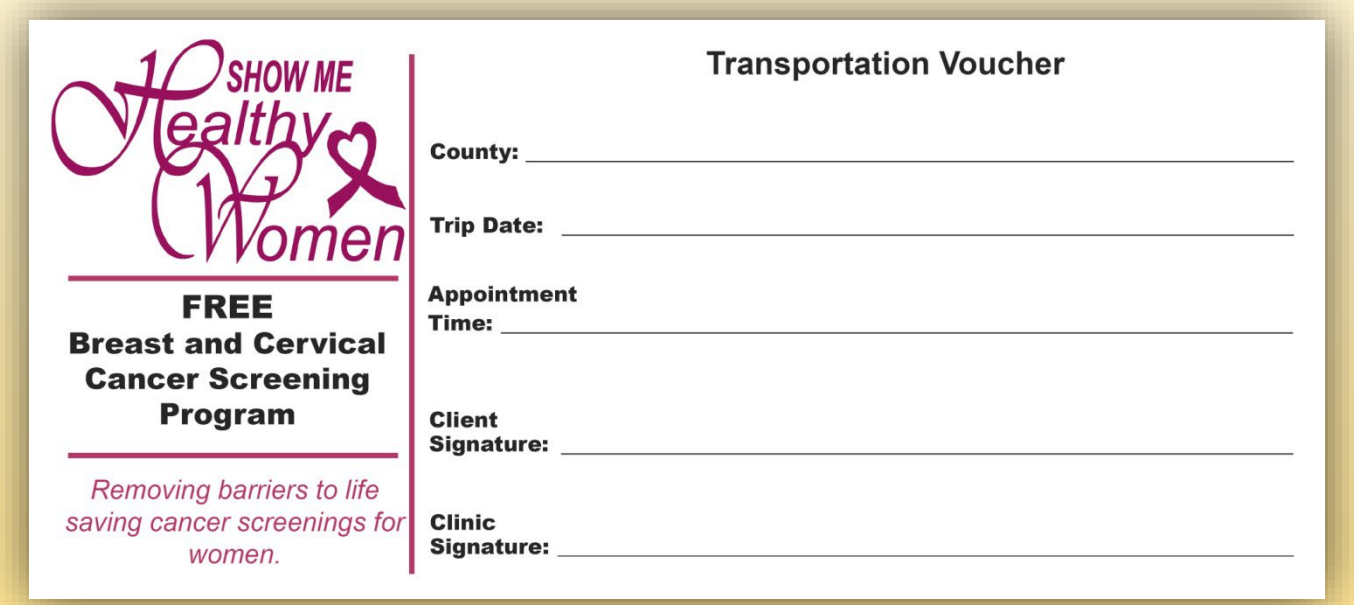
- SMHW will only reimburse for additional diagnostic services if the client continues to meet SMHW eligibility guidelines and follow ASCCP guidelines.

LOST TO FOLLOW UP (EXAMPLE)

TEST VERSION



TRANSPORTATION VOUCHER



<u>Free</u> 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

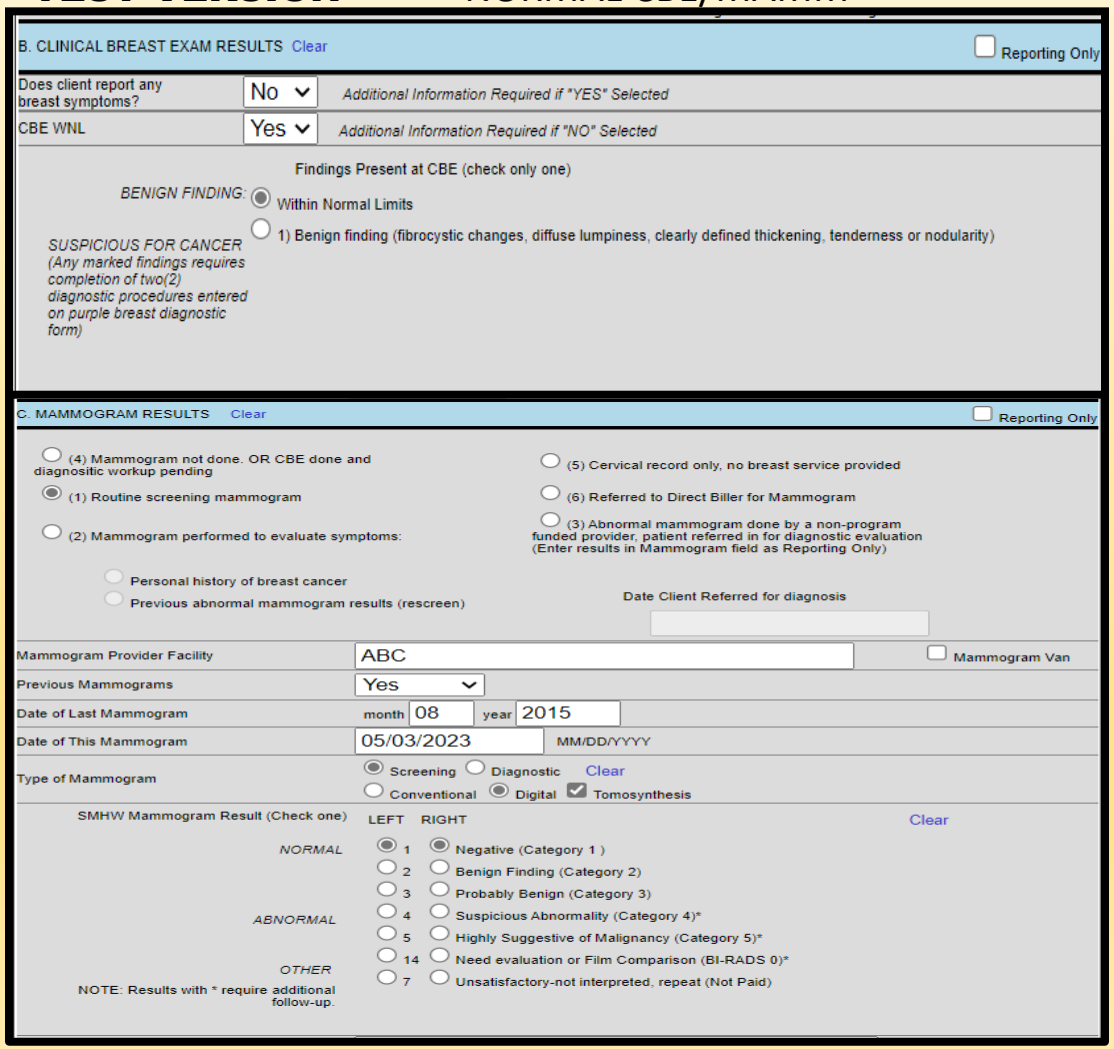
REQUEST FROM SMHW FOR ADDITIONAL INFORMATION

- 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)

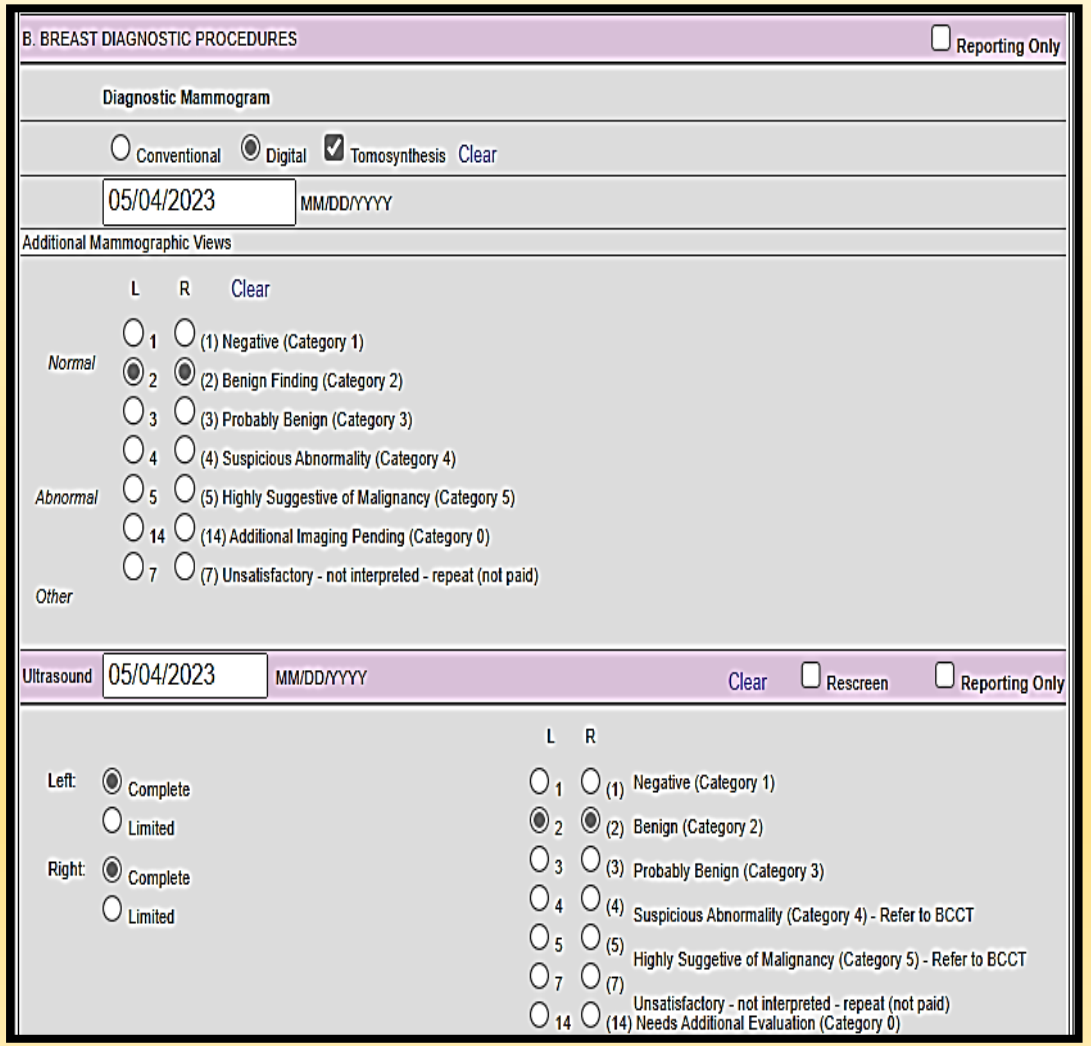
DIAGNOSTIC WITH A NORMAL SCREENING

TEST VERSION

NORMAL CBE/MAMM



DIAGNOSTIC BREAST FOLLOW-UP

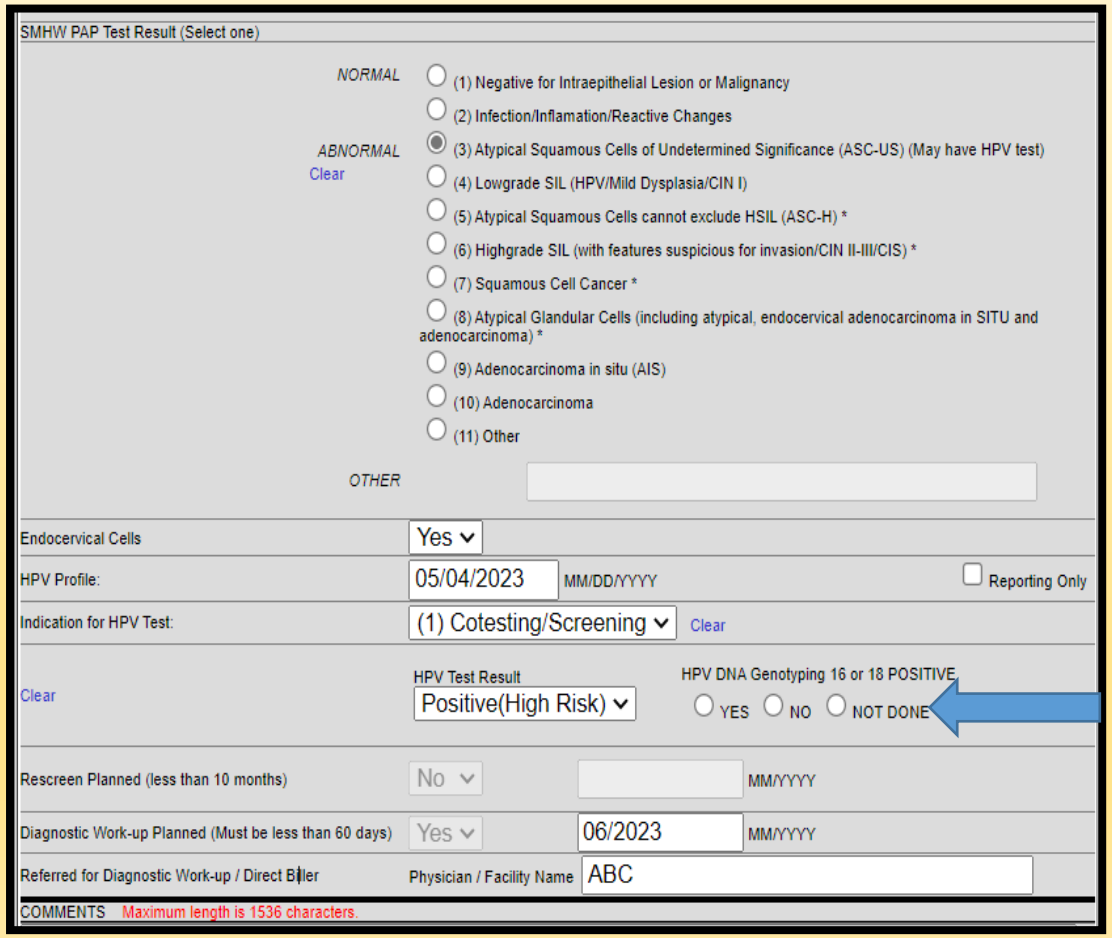


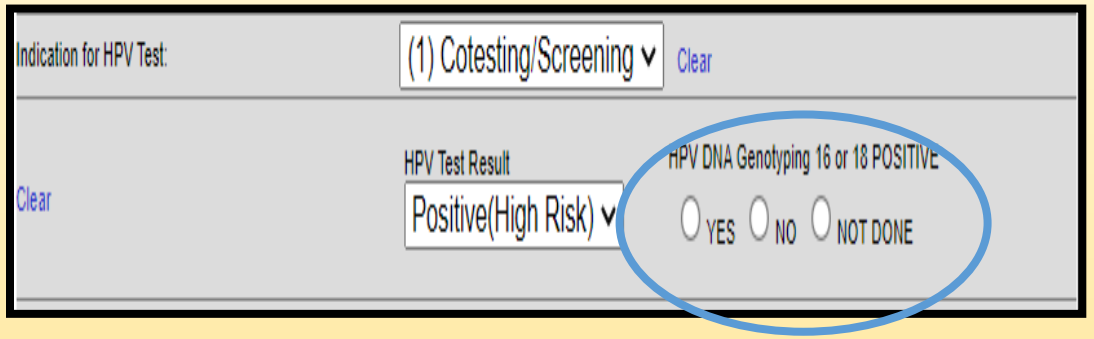
INCOMPLETE FORM EXAMPLE

TEST VERISON

MISSING HPV/DNA

MISSING INFORMATION

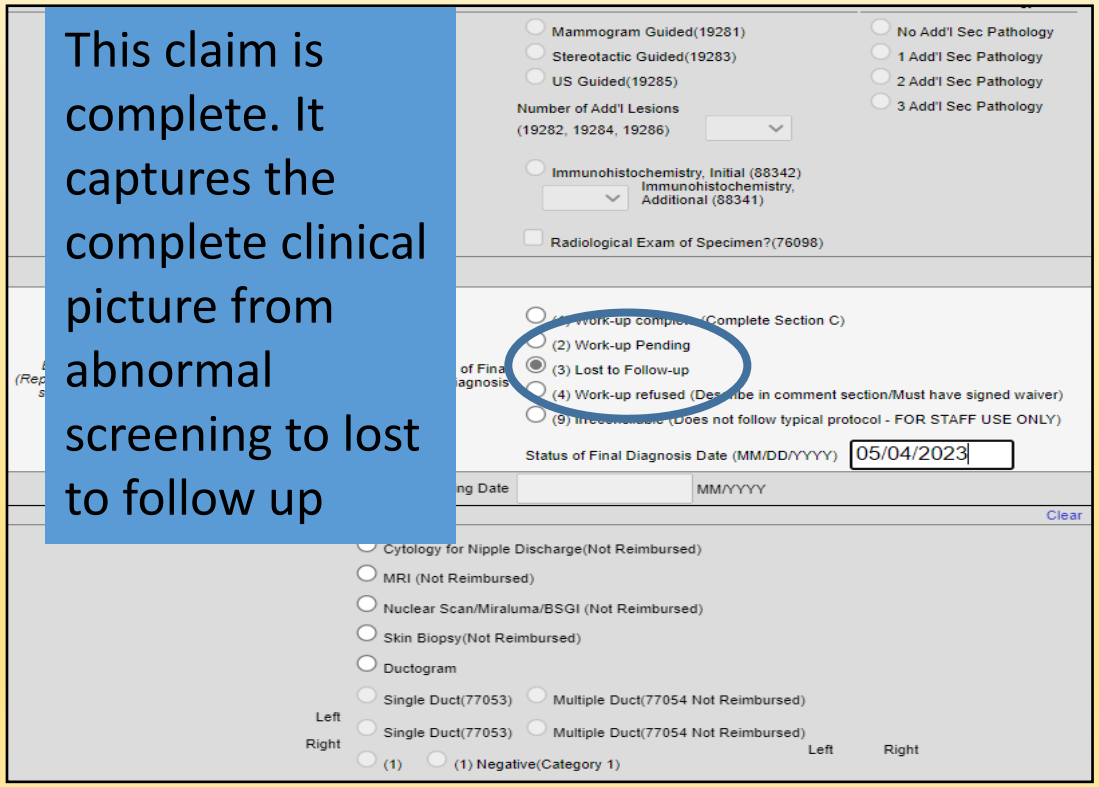




Complete the Yes, No or Not Done

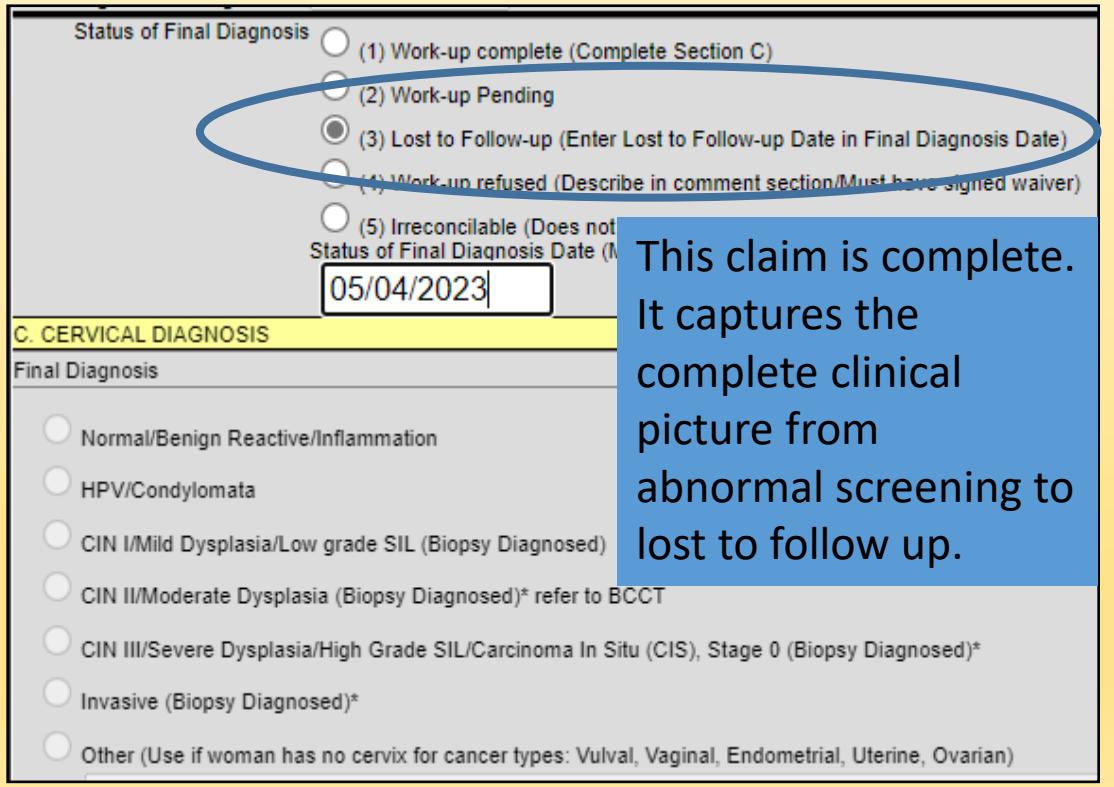
EXAMPLE OF LOST TO FOLLOW UP

Diagnostic Breast (Purple Form)



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

Diagnostic Cervical (Yellow Form)



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???