Every Woman Counts

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This section includes information about Every Woman Counts (EWC). EWC is a comprehensive, public health program that assists uninsured and underinsured individuals whose household income is at or below 200 percent of the Department of Health and Human Services (HHS) poverty guidelines in obtaining high quality cancer screening and follow-up services. In addition to offering screening and diagnostic services, the program is designed to facilitate regular rescreening of women with normal or benign breast and/or cervical conditions to provide diagnostic services for individuals presenting with symptoms and/or abnormal screening results, and to refer for treatment when necessary. The goal of the program is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved.

Every Woman Counts (EWC)

‹‹Every Woman Counts (EWC) is managed by the Department of Health Care Services (DHCS), Benefits Division.››

Components of EWC include the following:

- Health education and outreach activities
- Breast and cervical cancer screening and diagnostic services
- Quality assurance and improvement through professional education and evaluation of clinical and claims data
- Recipient care coordination to ensure women are screened regularly and at recommended intervals
- Provision of diagnostic services for individuals presenting with symptoms and/or abnormal screening results
- Referral to treatment when necessary

The program is funded by both federal and state dollars. Federal funds are received from the Centers for Disease Control and Prevention. State funds are received from two tobacco taxes and general funds.

Breast and cervical cancer early detection and screening services are provided in all counties of the state.

Regional Contractors

The Regional Contractors are local representatives of EWC. The Regional Contractors are public and private agencies that ensure low-income individuals receive breast and cervical cancer screening services. The Regional Contractors are responsible for recruitment, training, and maintenance of the EWC provider network and providing tailored health education for eligible recipients.

Activities

Regional Contractors conduct the following activities:

- Recruit and train EWC Primary Care Providers (PCPs)
- Support EWC providers to participate in breast and/or cervical health service delivery networks
- Conduct local targeted outreach and public education
- Address gaps in the delivery of these services
- Provide technical assistance for development of recipient tracking and follow-up systems that facilitate annual rescreening and timely referrals for individuals with abnormal findings
- ‹‹Provide technical assistance and training for the Every Woman Counts Detecting Early Cancer (DETEC) enrollment and data application.››
- Provide technical assistance and training to ensure PCPs meet the Core Program Performance Indicators (CPPI), which measure quality outcomes

Provider Participation Requirements – PCPs

All PCPs must contact the Regional Contractor in their area for information about enrollment. Regional contractors determine who may be enrolled as a PCP based on the need to complete service networks in a geographic area or improve access to care for targeted populations.

‹‹A PCP must:››

- Be a Medi-Cal provider in good standing and licensed in the state of California.
- ‹‹Enroll in the EWC program through a Regional Contractor.
- Complete and sign a *Primary Care Provider Enrollment Agreement* (PCPEA).
- Have Internet access to obtain an EWC 14-character recipient identification number in the Every Woman Counts DETEC application. This identification number is required for hard copy or electronic claim submission.

Prior to providing services, all new PCPs must receive training about program standards and requirements, submission of hard copy or electronic claims, recipient's enrollment and submission of outcome data via Every Woman Counts DETEC. New PCPs are eligible to render services only after the effective date of enrollment, as stated in the EWC welcome letter. PCPs must adhere to all requirements contained in the Primary Care Provider Enrollment Agreement, EWC clinical standards and data submission requirements.››

Referral Providers

Referral providers are those who receive referrals from PCPs to render any screening or diagnostic services. Referral providers must be Medi-Cal providers in good standing and licensed in the state of California. Referral providers do not enroll in EWC or sign a provider agreement. Examples of referral providers include the following:

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

In order to bill, EWC referral providers must have the recipient's 14-character ID number and certification dates provided by the PCP. Claims submitted without the recipient's ID number will be denied.

‹‹After the PCP verifies the recipient's eligibility for and enrolls the recipient in EWC, the PCP must communicate the recipient ID number to the referral provider.›› The referral provider must confirm that the certification dates listed on the Recipient ID card are valid for the date services are rendered. The referral provider may then submit a claim for payment, according to EWC guidelines.

Referral providers must report their screening and diagnostic findings to the PCP, who is responsible for submitting data and outcomes to EWC and for coordinating further care or follow-up.

Payments from Recipient Disallowed

‹‹Referral and PCPs must not attempt to obtain payment from recipients for co-payments or the balance of costs of covered breast and/or cervical cancer screening or diagnostic services.›› Payment received by providers from EWC in accordance with the Medi-Cal fee structure, constitutes payment in full.

PCPs and referral providers agree to disclose any non-covered services to the patient and to receive their written authorization before the service is provided.

LA County Waiver Program, RHC, FQHC and IHS Guidelines

Providers who render services for the following special programs may bill only as an EWC Primary Care Provider using an NPI number that is actively enrolled, and must submit claims according to EWC guidelines. These special programs cannot submit claims as a referring provider:

- LA County Waiver Program
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Indian Health Centers (IHS)

‹‹All other requirements in this *Every Woman Counts* provider manual section apply to these special program providers.›› Questions may be directed to the Telephone Service Center (TSC) at 1-800-541-5555.

Assessment of Tobacco Use and Referral for Smoking Cessation

Due to federal regulations, PCPs are required to assess tobacco use in every individual enrolled into EWC and refer those who do use tobacco to a cessation program. Screening for tobacco use is to be completed by the PCP at the time of enrollment or recertification and recorded on the *Recipient Application* (DHCS 8699). The provider must keep a copy of the recipient-signed form on file.

Assessment is encouraged to be performed at every office visit and is not a separately reimbursable procedure. Tobacco assessments and cessation referrals must be documented and maintained in the recipient's medical record.

Tobacco Cessation Referral Resource Suggestions

The California Smoker's Helpline provides many valuable resources for users of tobacco products and health care providers. The helpline can be accessed online at *www.californiasmokershelpline.org* or by calling 1-800-NO-BUTTS (1-800-662-8887).

The California Tobacco Control Program provides information about a variety of topics, including help with quitting and local tobacco control efforts. Information can be found on the California Department of Public Health website (*www.cdph.ca.gov*) in the "Programs" section.

The Center for Tobacco Cessation provides training and technical assistance to organizations statewide to increase their capacity in tobacco cessation. Information is available at the website *www.centerforcessation.org*.

Recipient Eligibility Criteria

The following information describes recipient eligibility criteria.

Age: Cervical Cancer Screening

Women must be 21 years of age or older to be eligible for cervical cancer screening. EWC follows the U.S. Preventive Services Task Force (USPSTF) recommendations. ‹‹The USPSTF recommends that clinicians screen for cervical cancer in women 21 to 29 years of age every three years with the cervical cytology (Pap test) alone.›› For women 30 to 65 years of age, the USPSTF recommends screening either with the Pap test alone every three years, screening with the high-risk human papillomavirus (HPV) test alone (primary HPV testing) every five years, or screening with both tests together (co-testing) every five years. Women should talk to their clinician to choose which strategy is right for them. The USPSTF continues to recommend against screening in women younger than 21 years of age and in women older than 65 years of age who have had adequate prior screening.

Since EWC serves many women who are rarely or never screened, the program does not have an upper age limit for EWC recipients in order to provide services to individuals who have not had adequate screening. Providers should use their clinical judgement and base their decision on the patient's previous history of screening and medical history when delivering cervical cancer screening services.

Age: Breast Cancer Screening

Women 40 years of age or older at average risk for breast cancer are eligible for breast cancer screenings consisting of individual risk assessment, counseling and mammogram every 1 to 2 years, as well as necessary follow-up breast diagnostic services. Women of any age who are considered high risk for cancer (BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20 percent or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history) are eligible for annual screening mammograms in conjunction with a Breast Magnetic Resonance Imaging (MRI).

‹‹Age: Breast Cancer Diagnostic Services

Any individual (women and men) of any age presenting with breast cancer symptoms are eligible for breast diagnostic services.››

Warning signs and/or symptoms of breast cancer include, but are not limited to, the following:

- Palpable mass or lumps in the breast
- Changes in size or shape of the breast
- Changes in skin texture or color (dimpling, puckering, redness, scaliness or thickening) of the breast or nipple skin
- Nipple retraction or inversion
- Axillary lymphadenopathy or swelling
- Nipple discharge
- Breast pain

Warning signs and/or symptoms may occur with conditions other than breast cancer.

Transgender and Gender Diverse Services

‹‹In all EWC sections, regardless of the gender stated, EWC benefits and policies apply to individuals of any gender identity as long as the procedure is clinically indicated.

EWC covers:

- Breast cancer screening and diagnostic services for cisgender women, transgender women who have taken or are taking hormones, and transgender men who have not had a bilateral mastectomy.
- Cervical cancer screening and diagnostic services for all individuals with a cervix.
- Diagnostic breast services for individuals of any age who are experiencing symptoms suggestive of breast cancer.››

For instructions on overriding gender differences for procedures, refer to the *Transgender and Gender Diverse Services* section in the appropriate Part 2 provider manual.

Income Eligibility Guidelines

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

‹‹EWC Income Eligibility Guidelines Table
200 Percent of the 2025 HHS Poverty Guidelines by Family/Household Size
Effective April 1, 2025, through March 31, 2026

Number of Persons Living in Family/Household	Monthly Gross Household Income (in dollars)	Annual Gross Household Income (in dollars)
1	$2,608	$31,300
2	$3,525	$42,300
3	$4,442	$53,300
4	$5,358	$64,300
5	$6,275	$75,300
6	$7,192	$86,300
7	$8,108	$97,300
8	$9,025	$108,300
For each additional person add:	$917	$11,000››

Providers should note the following:

- A family/household is a group of two or more persons who are related by birth, marriage, or adoption and who live together.
- ‹‹The poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of Title 42 of the United States Code section 9902(2).›› The EWC program income eligibility guidelines are updated accordingly based on the HHS federal poverty guidelines.
- “Gross household income” means the sum of incomes (before taxes and other deductions) of the individual(s) living in the family/household from sources identified by the U.S. Census Bureau. Monthly gross income for migrant farm workers and other seasonally employed persons may be computed by averaging gross income received during the previous 12 months.

U.S. Census Bureau sources of income are:

- Money wages or salary
- Net income from non-farm self-employment
- Net income from farm self-employment
- Social Security
- Dividends, interest (on savings or bonds), income from estates or trusts, net rental income or royalties
- Public assistance or welfare payments
- Pension and annuities
- Unemployment compensation/disability insurance
- Workers' compensation
- Child support
- Veterans' pension
- Alimony

Health Insurance

For an individual to be eligible for EWC, their PCP must certify that they are uninsured or underinsured, based on the individual's self-report.

‹‹Recipients may be certified as underinsured for EWC if all the following conditions are met:››

- Either no Medi-Cal coverage or limited scope Medi-Cal such as:
  - Medi-Cal for pregnancy or emergency service only, or
  - Medi-Cal with unmet Share of Cost (SOC) obligations
- Either no other public or private insurance coverage or other limited health insurance, such as:
  - Other health insurance co-payments or deductible obligations that cannot be met
  - Other health insurance benefit restrictions, public or private, which exclude services available through EWC

Residency

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

Eligibility Period

‹‹A recipient is eligible for EWC for one year, starting on the date when the Every Woman Counts DETEC recipient certification is completed.›› This eligibility period does not change if the recipient transfers to another PCP. The eligibility period is for the recipient, not the provider. Re-enrollment or recertification can only occur annually, when a recipient's one-year recipient eligibility period ends.

Example:

A recipient sees PCP provider A on February 1. Provider A establishes the patient's eligibility and enrolls the patient on this date by entering information into the DETEC form. The recipient's eligibility period spans from this date, February 1, to the following January 31 (one year).

Then, the recipient visits provider B in June, four months after seeing provider A. Provider B finds the recipient in the EWC application using the recipient's last name and date of birth. Provider B confirms eligibility, updates the Recipient Information in DETEC and recertifies the patient under their NPI. The recipient remains eligible only until January 31, as previously established. Each provider maintains separate records, but the recipient's dates of eligibility are not affected.

30-day Retroactive Eligibility Period

Claims for services provided prior to but within 30 days of the recipient certification date on the EWC recipient's identification (ID) card are eligible for reimbursement. The recipient certification date is the first date in the date range that is listed in the data field labeled "Valid:" on the recipient ID card.

Payer of Last Resort

EWC is the payer of last resort and pays providers only for breast and/or cervical screening and diagnostic services not covered by other programs.

Notice of Privacy Practices

The *Notice of Privacy Practices* (NPP) describes how medical information about recipients may be used and disclosed and how recipients can gain access to this information. The provider is responsible for distributing the NPP to each recipient at the time of enrollment and at annual recertification. The NPP form can be downloaded from the Medi-Cal website. NPP versions are available in English, Arabic, Chinese (Cantonese and Mandarin), Farsi, Hmong, Khmer, Korean, Russian, Spanish, Tagalog and Vietnamese.

The NPP does not need to be indicated in the patient's medical record.

EWC Applicant Consent/Signature Policy

To remove barriers for enrollment, there are multiple ways to get consent from a potential EWC recipient:

- In-person/physical ("wet-ink") signature
- Electronic and/or digital signature
- Verbal Consent/Signature

In-Person/Physical (“wet-ink”) Signature

A “wet-ink” signature refers to an applicant or a person who is acting on the applicant’s behalf (Authorized Representative) signing their name with a pen (“wet ink”) on DHCS 8699 Form. This includes mailing of the EWC Recipient Application.

Electronic and/or Digital Signature

The Uniform Electronic Transactions Act, California Civil Code, Section 1633.2, defines electronic signatures as an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record. For purposes of this title, a “digital signature,” as defined in subdivision (d) of Section 16.5 of the Government Code, is one form of electronic signature. Regardless of the type of electronic signature collected, EWC providers must ensure that they are able to store and easily access a record of the electronic signature in the case record.

Requirements

A valid electronic and/or digital signature on a EWC Recipient Application must meet the following requirements:

- The EWC applicant, or someone acting as an authorized agent for the EWC applicant, must take an affirmative action to indicate concurrence.
- The record of the signature must be maintained electronically by the EWC provider and linked to the document to which the signature attests.

Electronic and/or Digital Signature Options

The following methods may be used to meet the electronic and/or digital signature requirements for EWC:

- Handwritten signature input onto an electronic signature pad.
- Handwritten signature, mark, or command input on a display screen (for example, stylus device used to sign a document displayed on a touch screen)
- Digitized image of a handwritten signature that is attached to an electronic record
- ‹‹Typed name (for example, in the Every Woman Counts DETEC application)››
- Unique identifier (for example, code, password, or PIN)
- Electronically recorded sound (for example, voice recording and, telephonic signatures)
- The process of using a mouse to click a button (such as an “I Agree” button)
- Digital signature, as defined in Section 16.5 of the Government Code.

Verbal Consent/Signature

For applicants who are physically unable to sign, providers should complete the DHCS 8699 Form on behalf of the applicant/client. To accept a verbal signature, the following process must be followed:

1. Read the EWC Recipient Application aloud to the individual/the person who is acting on applicant’s behalf (Authorized Representative).
2. Complete each field of the EWC Recipient Application, on behalf of the applicant, based on the applicant verbal response/consent (field numbers #1 through 68, pages 4 through 6).
3. Read the consent language aloud to the individual/the person who is acting on the applicant’s behalf (Authorized Representative), as it is stated in Declarations on the signature page and initial each of the lines on page 6.
4. Ask that the individual/the person who is acting on applicant’s behalf (Authorized Representative) verbally acknowledge their consent.
5. Print the name and relationship to the applicant of the person acting on applicant’s behalf (Authorized Representative), or the PCP clinic staff name and position of person completing the form, on line 70 of page 6.
6. Write (print) their name and “verbal consent” on line 73 of the application and date on line 74.

7. Sign and date page 6 of the EWC Recipient Application to confirm eligibility.
8. Sign and date lines 17 through 19 on page 10.
9. Place and maintain a copy of the application in the client's medical file.

Due to the nature of telephonic modalities, the EWC provider must arrange for the client to receive their identification card along with pages one, two and three of the application. PCP staff must receive the client's consent to mail their identification card and application to them and confirm the address. EWC PCP may also fax or e-mail a copy of the identification card to the referral provider(s) along with the referral, so the referral providers can verify enrollment.

‹‹Every Woman Counts DETEC Application

Once the provider has collected recipient demographic information, obtained a signed recipient application, and established recipient eligibility for EWC and obtained a signed recipient application, the PCP may enroll the recipient in the program using the Every Woman Counts DETEC application in the Provider Portal.

Enrollment instructions may be found in the Every Woman Counts Detecting Early Cancer (DETEC) User Guide.››

Recipient ID Number and Recipient ID Card

EWC recipients are identified by a 14-character recipient identification number (ID) that is computer generated when the online *Enroll Recipient* form is completed and submitted.

Providers should print out both the online recipient information form (by pressing the “print” button) and a copy of the Recipient ID card.

Note: All claims from enrolled PCPs and/or Medi-Cal referral providers must be submitted with this 14-character recipient ID number. Medi-Cal referral providers must obtain this ID number from the PCP or the recipient.

Required Forms to be Kept in the Medical Record

The following forms must be kept in the medical record:

- Completed pages of the *Recipient Application* (DHCS 8699)
- Printed *Recipient Information Form*
- Copy of the Recipient ID Card
- Printed DETEC breast and/or cervical cancer screening cycle data forms as proof of required data entry

Once the forms have been scanned into the medical record, the original documents may be securely discarded.

Optional Worksheets

EWC also uses paper worksheets that can be printed from the EWC program page on the Medi-Cal website and completed manually. Worksheets are intended to assist providers in gathering relevant information that will later be entered into the Every Woman Counts DETEC application.

Clinical Policy and Program Standards

General EWC Policies/Standards

- All contacts with a recipient should be documented in the medical record.
- PCPs must maintain a network of referral providers.
- A Clinical breast exam (CBE) and pelvic exam, if performed, must be documented in the medical record including size and location of any findings.

- ‹‹PCPs must notify recipients of test results within specified timeframes and document notification in the medical record:
  - Normal results within 30 calendar days (notification from radiologist for screening mammogram is sufficient)
  - Abnormal results within 14 calendar days
  - Cancer diagnosis within seven calendar days
- PCP should make at least three (3) attempts to contact the recipient either by mail, electronically or by phone; and at least one method of contacting recipients should verify if notification was received. That can be done via certified mail/first class mail that requires a recipient signature or via electronic communication, such us dedicated secure messaging platforms and applications, encrypted email services, and Electronic Health Record (EHR) chat. Recipients should provide written consent specifying their preferred method of notification.
- A PCP shall document all attempts to notify the recipient as specified in this section and retain this documentation in the recipient's records.››
- Referrals for required diagnostic evaluation must be made within 14 calendar days from receipt of abnormal results.
- The maximum elapsed time between abnormal result and final diagnosis is 60 days.
- Referrals for treatment for a diagnosis of breast or cervical cancer or other pre-cancerous or cancer-related diagnoses must be made within seven calendar days from receipt of results.
- The maximum elapsed time between a diagnosis of cancer or other pre-cancerous diagnoses and initiation of treatment is 60 days.
- PCPs must assist patients with a diagnosis of cancer to secure treatment including enrollment into the Breast and Cervical Cancer Treatment Program (BCCTP).
- PCPs are required to submit data on every EWC recipient.

Breast Cancer Screening and Diagnostic Policies/Standards

- During office visits, EWC PCPs should offer counseling to all recipients about what age to start screening, how often to screen and individual breast cancer risk factors.
- Screening mammograms CPT® codes 77067 (Screening mammography) and 77063 (Screening digital breast tomosynthesis) are available to the recipients at average risk starting at age 40 and is reimbursable once every 365 days.
- All other breast services do not have an age or gender limit.
- There is no upper age limit in the program, but EWC recommends following national guidelines on when to stop breast cancer screening.
- CBE is no longer a recommended modality of screening per national guidelines, but it can be offered as part of the office visit/physical exam.
- Both screening and diagnostic MRIs are covered under EWC.
- Screening breast MRI is recommended in conjunction with a mammogram when a recipient has a BRCA gene mutation, a first-degree relative who is a BRCA carrier or a lifetime risk of 20 percent or greater as defined by risk assessment models.
- Breast MRI should never be done alone as a breast cancer screening tool.
- Findings from CBE (if performed), diagnostic imaging and biopsy should be correlated. When findings are not in agreement, follow-up should be done to reach a final diagnosis.
- Abnormal CBEs require follow-up, despite negative mammography findings. Further diagnostic testing to determine the etiology of an abnormality is required.

Cervical Cancer Screening and Diagnostic Policies/Standards

- Screening includes either:
  - ‹‹Clinician-collected:
    - ❖ Pap test alone every three years beginning at age 21 or older or,
    - ❖ Pap test and HPV screening (co-test) every five years for age 30 and older or,
    - ❖ Primary HPV test every five years for age 30 and older
  - Patient-collected/self-collected HPV primary screening in women ages 30 and older
    - ❖ The Enduring Guidelines Committee recommends self-collection HPV testing at three-year intervals, while the draft United States Preventative Services Task Force (USPSTF) guidelines propose five-year intervals. It is unknown what the final USPSTF guidelines will state. EWC providers can adopt either interval strategy. If a provider chooses the three-year strategy, ensure there is a way to identify tests that are self-collected in medical records.››

- ❖ ‹‹**Note:** Clinician-collected cervical specimens are preferred, and self-collected vaginal specimens are acceptable for primary HPV screening of asymptomatic average-risk individuals. Repeat testing in three years is recommended following HPV-negative screens using self-collected vaginal specimens.››

- Screening ends at age 65 for recipients with adequate negative prior screening (three consecutive negative Pap tests or two negative co-tests/primary HPV tests within 10 years with the most recent occurring in the past five years).
  - EWC does not have an upper age limit for recipients without adequate prior screening
- EWC will pay for an initial pelvic exam to determine the presence of a cervix.
- Recipients without a cervix should not be screened unless there is a history of high-grade pre-cancer or cervical cancer, or a hysterectomy was performed for unknown reasons and the medical records are unavailable.
- Annual screening can be done for those patients who are high risk (exposed to diethylstilbestrol (DES) in-utero, immunocompromised, or a history of cervical cancer).
- High-risk patients over the age of 65 may continue to be screened.
- EWC recommends using the American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines for follow up of abnormal results.
- Coverage for HPV genotyping, billed with CPT code 87625 (infectious agent detection by nucleic acid [DNA or RNA] Human Papillomavirus [HPV], types 16 and 18 only, includes type 45, if performed) is available as follow-up to Primary HPV screening.

Core Program Performance Indicator

The Core Program Performance Indicators (CPPIs) and related performance benchmarks were developed by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)/Center for Disease Control and Prevention (CDC). The purpose of the CPPIs is to ensure screening of priority populations; timely and complete diagnostic follow-up of abnormal breast and/or cervical cancer screening results; and timely treatment initiation for program recipients diagnosed with breast and/or cervical cancer or pre-cancerous cervical conditions.

Core Program Performance Indicators Table

Item Number	Core Program Performance Indicators	CDC Benchmark
1	Percentage of women aged 30 and older receiving their first cervical cancer screening through the program who have never been screened or have not screened within the last 10 years	Equal to or greater than 35 percent
2	Percentage of cervical cancer screening records with planned and completed diagnostic follow-up	Equal to or greater than 90 percent
3	Percentage of cervical cancer screening records with planned and completed diagnostic follow-up: Time between screening and final diagnosis less than or equal to 60 days	Equal to or greater than 75 percent
4	Percentage of cervical cancer records with a final diagnosis of HSIL, CIN2, CIN3/CIS or invasive cervical cancer that have treatment started	Equal to or greater than 90 percent
5	Percentage of cervical cancer records with a final diagnosis of HSIL, CIN2, CIN3/CIS or invasive cervical cancer: Time between final diagnosis and treatment less than or equal to 60 days	Equal to or greater than 80 percent
6	Percentage of breast cancer screening records with abnormal results and completed diagnostic follow-up	Equal to or greater than 90 percent
7	Percentage of breast cancer screening records with completed follow-up: Time between abnormal screening and final diagnosis less than or equal to 60 days	Equal to or greater than 75 percent
8	Percentage of breast cancer records with a final diagnosis of ‘CIS, other’, DCIS or invasive breast cancer that have treatment started	Equal to or greater than 90 percent
9	Percentage of breast cancer records with a final diagnosis of ‘CIS, other’, DCIS or invasive breast cancer: Time between final diagnosis and treatment less than or equal to 60 days	Equal to or greater than 80 percent

Case Management and Patient Navigation for EWC Recipients

Definition and Purpose

Case management refers to the services performed by a PCP to establish and maintain a system of essential support services to ensure that an EWC recipient receives timely and appropriate breast and/or cervical cancer screening, diagnostic services and treatment (if necessary). Case management may also be referred to as patient navigation. Case management involves identifying and resolving recipient barriers to receiving and completing recommended services, which includes the follow-up of a recipient with abnormal results and/or informing a recipient with normal results of appropriate rescreening intervals.

Case Management Requirements

Although patient navigation services vary based on an individual's needs, at a minimum, EWC PCPs are required to:

- Have a tracking system in place to do the following:
  - Bring patients back in for routine screenings,
  - Notify patients of results,
  - Refer for further diagnostic testing and treatment as necessary,
  - Ensure that all tests and diagnostic services are completed, results received, and patient has been notified of the results and further plans.
- Assess an individual patient's barriers to care (for example: barriers can include if an individual patient needs transportation or translation assistance.)
- Assist with resolution of identified barriers.
- Provide patient education and support as needed.
- Document all patient contacts in the medical record including notification of test results.
- Collect and submit required data in DETEC.

Case Management Billing and Payment

EWC pays PCPs for reporting outcomes of recipients' breast and/or cervical cancer procedures in DETEC. The only cycles eligible for reimbursement for case management services are those with findings that require immediate work-up and an additional referral together with coordination of services. EWC does not pay for case management for recipients who require routine or short-term follow-up re-screening. Payment for case management will be based on submission of complete, accurate data.

Case management is billed using HCPCS code T1017. T1017 is payable only to providers enrolled as PCPs in EWC and only for recipients enrolled in the EWC program. Although the T1017 description is in units of 15 minutes, for EWC the quantity of units allowed for reimbursement is only one unit per recipient per provider per calendar year regardless of the time required to complete case management services. The amount reimbursed is $50. The date of service for a case management claim is the date the cycle was completed and submitted in DETEC.

Data Collection and Data Entry

Funding for the EWC program is dependent on data reported by providers and is used to make program improvements and for quality assurance of individual clinics.

Data Entry Requirements:

- Maintain complete and accurate recipient data in DETEC.
- Submit all data for every screening event/cycle within 30 days of receipt regardless of results.
- Submit complete results and plan for each patient.
- Correct data errors and input missing data as requested by EWC.
- Copies of the DETEC screening breast and/or cervical cancer data forms must be filed in the patient's medical record as proof of data entry.

For complete information about data collection and data entry, refer to the Every Woman Counts Detecting Early Cancer (DETEC) User Guide

Work-Up Status Definitions

PCPs must select one of the following options in Every Woman Counts DETEC:

- Work-up complete: This status should be selected for the recipient whose diagnostic procedures are completed, and a diagnosis has been determined.
- Lost to Follow-up:
  - ‹‹This status should be selected for recipients who required immediate diagnostic work-up but providers were unable to reach them after at least three (3) attempts to contact the recipient either by mail, electronically or by phone.
  - A PCP shall document all attempts to notify the recipient as specified in this section and retain this documentation in the recipient's records.

Note: At least one method of contacting recipients should verify if notification was received**.** That can be done via certified mail/first class mail that requires a recipient signature or via electronic communication, such us dedicated secure messaging platforms and applications, encrypted email services, and Electronic Health Record (EHR) chat. Recipients should provide written consent specifying their preferred method of notification.››

- Refused Care: This status should be selected for recipients who required immediate diagnostic work-up but
  - Refused clinical procedure(s) or appointments
  - Failed to respond to telephone messages or certified letter, but letter was delivered
  - Failed to schedule or keep appointments
  - Moved
  - Obtained health insurance
  - Changed EWC PCP for any reason
- Died before Work-up Complete: This status should be selected for recipients that died before the imaging/diagnostic procedure(s) was performed.

For complete information on data collection and data entry, refer to the Every Woman Counts Detecting Early Cancer (DETEC) User Guide.

Breast and Cervical Cancer Treatment Program (BCCTP)

BCCTP offers treatment through the Medi-Cal program for individuals with breast and/or cervical cancer who meet eligibility criteria.

EWC PCPs are authorized to enroll eligible individuals in the Breast and Cervical Cancer Treatment Program (BCCTP). The BCCTP has two programs for which individuals may be eligible. The federal BCCTP provides full-scope Medi-Cal to eligible individuals who meet all the federal criteria. The state-funded BCCTP (limited scope Medi-Cal) benefits cover breast and/or cervical cancer treatment and related services to any individual, including men, who does not meet the federal criteria. BCCTP enrollment information is available from BCCTP eligibility specialists at:

Phone: 1-800-824-0088
Email: BCCTP@dhcs.ca.gov
Fax: 1-916-440-5693

‹‹BCCTP guidelines also are available on the Medi-Cal Provider Portal and more information can be found on the Welcome to the Breast and Cervical Cancer Treatment Program web page on the DHCS website.››

Note: All BCCTP applicants must be determined ineligible for full-scope county Medi-Cal for BCCTP to complete its eligibility determination. If the applicant qualifies for full-scope county Medi-Cal, they cannot be approved for BCCTP.

Referral to BCCTP

Individuals who are enrolled in EWC and are diagnosed with breast cancer (including in situ) and/or cervical cancer, cervical intraepithelial neoplasia 2 or 3 can be referred into BCCTP. Providers should fill in the box on the DETEC Screening Cycle Data form that states, “Patient enrolled in BCCTP. Check only if you have completed the BCCTP enrollment process.” Providers should go to the BCCTP page on the Medi-Cal website and follow the program enrollment procedures. If the recipient has a breast or cervical cancer that is not on the drop-down menu of qualifying diagnoses for BCCTP enrollment, the provider should call BCCTP and request to speak with a manager for further instructions.

EWC Additional Testing to Confirm Diagnosis

If a provider determines more testing is needed for an individual from outside EWC before confirming a cancer diagnosis, the provider may perform testing under EWC as long as the testing is a program covered service. The provider must understand that once billing occurs in EWC, the same data requirements apply as if the individual were screened within EWC. This means complete screening cycle data must be submitted in DETEC.

Approved Procedures

The following CPT and HCPCS codes are benefits of EWC. All the codes are available for EWC primary care and referral providers with the exception of codes 99211 and T1017. Refer to the ICD-10-CM Code and Additional Information columns in the tables below.

EWC CPT and HCPCS codes are eligible for reimbursement only if they are submitted with the appropriate ICD-10-CM codes shown in tables 1a, 1b, 1c, 2a and 2b. Appropriate cervical cancer screening and diagnostic ICD-10-CM codes are shown in tables 1a, 1b and 1c. Appropriate breast cancer screening and diagnostic ICD-10-CM codes are shown in tables 2a and 2b.

Providers may select up to two EWC approved ICD-10-CM codes as shown in tables 1a, 1b, 1c, 2a and 2b. Claims submitted with diagnosis codes not represented on tables 1a, 1b, 1c, 2a and 2b will be denied.

Codes billed for breast-related services have no age and gender restrictions, except for 77063 and 77067 which are reimbursable services for recipients 40 years of age or older who are at average risk for breast cancer.

Codes billed for cervical-related services are reimbursable for recipients with a cervix who are 21 years of age or older.

Table 1a

Cervical Cancer Screening ICD-10-CM Codes
Z01.411, Z01.419, Z01.42, Z11.51, Z12.4, Z12.72, Z21, Z40.01, Z40.02, Z78.0, Z80.49, Z85.40 thru Z85.42, Z85.44, Z87.410 thru Z87.412, Z87.891, Z90.710 thru Z90.712, Z90.721, Z90.722, Z90.79, Z92.0, Z92.25

Table 1b

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

Table 1c

Colposcopy and Cervical Biopsy ICD-10-CM Codes
C53.0, C53.1, C53.8, C53.9, D06.0, D06.1, D06.7, D06.9, D07.2, D26.0, N87.0, N87.1, N88.0, N89.0, N89.1, N89.3, N89.4, R87.610 thru R87.616, R87.619, thru R87.625, R87.628, R87.810, R87.811, R87.820, R87.821

Table 2a

Breast Cancer Screening Related ICD-10-CM Codes
Z12.31, Z12.39, Z15.01, Z15.02, Z15.09, Z17.0, Z17.1, Z77.123, Z77.128, Z77.22, Z77.9, Z78.0, Z78.9, Z79.810, Z79.818, Z79.890, Z80.0, Z80.3, Z80.41, Z80.8, Z80.9, Z85.038, Z85.3, Z85.40, Z85.43, Z85.71, Z85.72, Z85.79, Z85.9, Z90.10 thru Z90.13, Z91.89, Z92.3, Z92.89, Z98.82, Z98.86

Table 2b

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

Approved Procedures, CPT Codes Key

CPT Code	Description	ICD-10-CM Code	Additional Information
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified	see table 2b	N/A
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion	see table 2b	N/A
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	see table 2b	N/A
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	see table 2b	N/A
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	see table 2b	N/A
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion	see table 2b	N/A
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	see table 2b	N/A
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion	see table 2b	N/A
10021	Fine needle aspiration; biopsy, without imaging guidance; first lesion	see table 2b	N/A
19000	Puncture aspiration of cyst of breast	see table 2b	N/A
19001	Puncture aspiration of cyst of breast; each additional cyst	see table 2b	Use in conjunction with code 19000. If imaging guidance is performed, see code 76942

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19081	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including stereotactic guidance	see table 2b	Codes 19081 thru 19086 should not be used in conjunction with 19281 thru 19288 codes for image guidance placement of a localization device without image guided biopsy
19082	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous, each additional lesion, including stereotactic guidance	see table 2b	Same as for 19081
19083	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; first lesion, including ultrasound guidance	see table 2b	Same as for 19081
19084	Biopsy, breast, with placement of breast localization device(s), and imaging of the biopsy specimen, percutaneous; each additional lesion, including ultrasound guidance	see table 2b	Same as for 19081 Use in conjunction with 19083
19085	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; first lesion	see table 2b	Same as for 19081
19086	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; magnetic resonance guidance; additional lesion	see table 2b	Same as for 19081

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	see table 2b	For fine needle aspiration, use codes 10004 thru 10008 or 10021
19101	Biopsy of breast; open, incisional	see table 2b	N/A
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions	see table 2b	N/A
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	see table 2b	N/A
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker	see table 2b	Use in conjunction with code 19125
19281	Placement of breast localization device(s), percutaneous; first lesion, including mammographic guidance	see table 2b	Codes 19281 thru 19288 should not be used in conjunction with 19081 thru 19086 codes for breast biopsies that include image guidance, placement of localization device, and imaging of specimen
19282	Placement of breast localization device(s), percutaneous; each additional lesion, including mammographic guidance	see table 2b	Same as for 19281 Use in conjunction with 19281

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
19283	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance	see table 2b	Same as for 19281
19284	Placement of breast localization device(s), percutaneous; each additional lesion, including stereotactic guidance	see table 2b	Same as for 19281 Use in conjunction with 19283
19285	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance	see table 2b	Same as for 19281
19286	Placement of breast localization device(s), percutaneous; each additional lesion, including ultrasound guidance	see table 2b	Same as for 19281 Use in conjunction with 19285
19287	Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion, including magnetic resonance guidance	see table 2b	Codes 19281 thru 19288 should not be used in conjunction with 19081 thru 19086 codes for breast biopsies that include image guidance, placement of localization device, and imaging of specimen
19288	Placement of breast localization device, percutaneous; magnetic resonance guidance; each additional lesion	see table 2b	Same as for 19287
57452	Colposcopy of the cervix including upper/adjacent vagina	see table 1c	Cannot be billed in conjunction with any office visits or consults or with codes 57454 thru 57456

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
57454	Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults
57455	Colposcopy of the cervix, with biopsy	see table 1c	Cannot be billed in conjunction with any office visits or consults
57456	Colposcopy of the cervix, with endocervical curettage	see table 1c	Cannot be billed in conjunction with any office visits or consults
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	see table 1c	Reimbursable only if used for evaluation of leukoplakia or other suspicious visible cervical lesion or abnormal Pap when colposcopy is not readily available. Cannot be billed in conjunction with 57452, 57454 thru 57456
57505	Endocervical curettage (not done as part of dilation and curettage)	R87.619	Reimbursable only if billed in conjunction with 58100, as the initial workup of AGC/atypical endometrial cells. Cannot be billed in conjunction with 57452, 57454 thru 57456
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	R87.619	Reimbursable only if billed in conjunction with 57505. Cannot be billed in conjunction with 57452, 57454 thru 57456

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy	D06.0 thru D06.9 and R87.619	Reimbursable only for evaluation of adenocarcinoma in situ (AIS) and AGC subcategories except AGC/atypical endometrial cells in all women over age 35 and younger women with risk factors for endometrial neoplasia, such as, but not limited to, obesity or unexplained or anovulatory bleeding. Must be performed with colposcopy and used in conjunction with 57452 thru 57456
76098	Radiological examination, surgical specimen	see table 2b	N/A
76641	Ultrasound, complete examination of breast including axilla, unilateral	see tables 2a and 2b	When this service is performed on both breasts, on the same date of service, providers should bill the code on two separate claim lines, (once with modifier RT and once with modifier LT) and one unit of service for each line. This will designate a bilateral procedure was performed. If only billing either 26 or TC, each line should also include the appropriate component modifier on the first modifier position of the claim line followed by the anatomical modifier.

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
76642	Ultrasound, limited examination of breast including axilla, unilateral	see tables 2a and 2b	Same as for 76641
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	see table 2b	N/A
77046	Magnetic resonance imaging (MRI), breast, without contrast; unilateral	see tables 2a and 2b	Breast MRI is recommended in conjunction with a mammogram when a client has a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20 percent or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history Breast MRI can be used to assess areas of concern on a mammogram, or to evaluate a client with a history of breast cancer after completing treatment Breast MRI should never be done alone as a breast cancer screening tool Breast MRI is <u>not</u> covered to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77047	Magnetic resonance imaging (MRI), breast, without contrast; bilateral	see tables 2a and 2b	Same as for 77046
77048	Magnetic resonance imaging (MRI), breast, including computer-aided detection (CAD), without and with contrast material(s), when performed; unilateral	See tables 2a and 2b	Same as for 77046
77049	Magnetic resonance imaging (MRI), breast, including computer-aided detection (CAD), without and with contrast material(s), when performed; bilateral	See tables 2a and 2b	Same as for 77046
77053	Mammary ductogram or galactogram, single duct, radiological supervision and interpretation	See table 2b	N/A
77063	Screening digital breast tomosynthesis, bilateral	see tables 2a and 2b	Screening digital breast tomosynthesis, bilateral, should be listed separately in addition to code for primary procedure 77067. Limited to one screening per 365 days, any provider. Reimbursable service for recipients 40 years of age or older who are at average risk for breast cancer. Reimbursable service in conjunction with a breast MRI for recipients of any age with a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20 percent or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history.

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77065	Diagnostic mammography, including computer-aided detection (CAD); unilateral	see table 2b	Reimbursable if the recipient either: • Has distinct signs and symptoms for which a diagnostic mammogram is indicated, or • Has a history of breast cancer, or • Is asymptomatic, but on the basis of history and other significant factors diagnostic mammogram is indicated and appropriate Codes 77065 and 77066 are not reimbursable when billed for the same day for the same recipient
77066	Diagnostic mammography, including computer-aided detection (CAD); bilateral	see table 2b	Same as 77065

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
77067	Screening mammography, bilateral	see tables 2a and 2b	Limited to one screening per 365 days, any provider. Reimbursable service for recipients 40 years of age or older who are at average risk for breast cancer. Reimbursable service in conjunction with a breast MRI for recipients of any age with a BRCA gene mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20 percent or greater as defined by risk assessment models such as BRCAPRO that depend largely on family history.
81025	Urine pregnancy test	see table 1c	This code may only be billed with one or more of the following codes: 57452, 57454 thru 57456, 57500, 57505, 58100, 58110.
87624	HPV - high risk types	Z11.51 and table 1c	Covered only for recipients 30 years of age and older. Use of modifier 33 indicates the service was provided in accordance with USPSTF A or B recommendations.

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
87625	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	R87.615, R87.810 and Z11.51	R87.810, R87.615 and Z11.51 covered only for recipients age 30 and older Use of modifier 33 indicates the service was provided in accordance with USPSTF A or B recommendations
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician	see tables 1a and 1b	Use in conjunction with code 88142, 88164, 88174 or 88175
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	see tables 1a and 1b	N/A
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	see tables 1a and 1b	N/A
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	see tables 1a and 1b	N/A
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site;	see table 2b	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
88173	Cytopathology, evaluation of fine needle aspirate; interpretation and report	see table 2b	N/A
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	see tables 1a and 1b	N/A
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	see tables 1a and 1b	N/A
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site	see table 2b	N/A
88305	Level IV – Surgical pathology, gross and microscopic examination	see tables 1b and 2b	N/A
88307	Level V, gross and microscopic examination, requiring microscopic evaluation of surgical margins	see tables 1b and 2b	N/A
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	see table 2b	N/A
88332	Pathology consultation during surgery, each additional tissue block, with frozen section(s)	see table 2b	N/A
88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure).	see tables 1b, 1c and 2b	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody	see tables 1b, 1c and 2b	N/A
88360	Morphometric analysis, tumor immunochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual	see table 2b	N/A
88364	In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure	see tables 1b and 2b	N/A
88365	In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure	see tables 1b and 2b	N/A
88366	In situ hybridization (eg,FISH), per specimen; each multiplex probe stain procedure	see tables 1b and 2b	N/A
88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure	see tables 1b and 2b	N/A
88368	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure	see tables 1b and 2b	N/A
88369	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure	see tables 1b and 2b	N/A
88373	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure	see tables 1b and 2b	N/A

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
88374	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure	see tables 1b and 2b	N/A
88377	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure	see tables 1b and 2b	N/A
‹‹98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion	see tables 1a, 1b, 2a and 2b	N/A››

Approved Procedures Key, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	see tables 1a, 1b, 2a and 2b	N/A
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A

Approved Procedures Key, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	see tables 1a, 1b, 2a and 2b	N/A
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	N/A

Approved Procedures Key, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	see tables 1a, 1b, 2a and 2b	This service is paid only for women who receive both breast cancer screening and cervical cancer screening during the visit.

Approved Procedures Key, HCPCS Codes

HCPCS Code	Description	ICD-10-CM Code	Additional Information
A4217	Sterile water/saline, 500 ml	see tables 1b and 2b	N/A
G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	see table 2b	Reimbursable if the recipient either: • has distinct signs and symptoms for which a diagnostic mammogram is indicated • has a history of breast cancer • is asymptomatic, but on the basis of history and other significant factors diagnostic mammogram is indicated and appropriate Diagnostic breast tomosynthesis should be listed separately in addition to 77065 or 77066 limit

Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code	Additional Information
G2010	Remote evaluation of recorded video and/or images submitted by an established patient	see tables 2a and 2b	Store and forward, including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
J7030	Infusion, normal saline solution, 1000 cc	see tables 1b and 2b	N/A
J7040	Infusion, normal saline solution, sterile (500 ml equals one unit)	see tables 1b and 2b	N/A
J7050	Infusion, normal saline solution, 250 cc	see tables 1b and 2b	N/A
J7120	Ringers lactate infusion, up to 1000 cc	see tables 1b and 2b	N/A
Q3014	Telehealth originating site facility fee	see tables 1a, 1b, 2a and 2b	N/A

Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code	Additional Information
T1013	Sign language or oral interpreter services, per 15 minutes	see tables 1a, 1b, 2a and 2b Once per day, per recipient, per provider Oral interpretive services not covered	N/A
T1014	Telehealth transmission, per minute, professional services bill separately	see tables 1a, 1b, 2a and 2b	N/A
T1017	Targeted case management, each 15 minutes	This code can be billed only by EWC primary care providers. It is not available to referral providers. see tables 1a, 1b, 2a and 2b Once per recipient, per provider, per calendar year	N/A

Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code	Additional Information
Z7500	Examining or treatment room use	see tables 1a, 1b, 2a and 2b	N/A
Z7506	Operating room or cystoscopic room use; first hour	see tables 1b and 2b	N/A
Z7508	Operating room or cystoscopic room use; first subsequent half hour	see tables 1b and 2b	N/A
Z7510	Operating room or cystoscopic room use; second subsequent half hour	see tables 1b and 2b	N/A
Z7512	Recovery room use	see tables 1b and 2b	N/A
Z7514	Room and board, general nursing care for stays of less than 24 hours, including ordinary medication	see tables 1b and 2b	N/A
Z7610	Miscellaneous drugs and medical supplies	see tables 1a, 1b, 2a and 2b	N/A

Quick Reference Sheets

The following figures are quick reference sheets for covered procedures under the EWC program.

- EWC Covered Procedures

EWC Covered Procedures

Only the procedures listed below are covered under the Every Woman Counts (EWC) Program for “Breast and Cervical Primary Care Providers.” Providers must have only EWC-approved ICD-10-CM code(s) listed on the claim to be eligible for payment. For the list of appropriate CPT specific ICD-10-CM codes, refer to the “Approved Procedures” heading in this manual section.

Note: Procedure code definitions may require modifiers.

CPT Codes:

00400 – Anesthesia, integumentary system anterior trunk

10004 – Fine needle aspiration biopsy; without imaging; each additional lesion

10005 – Fine needle aspiration biopsy including ultrasound guidance first lesion

10006 – With 10005; each additional lesion

10007 – Fine needle aspiration biopsy, including fluoroscopic guidance first lesion

10008 – With 10007; each additional lesion

10011 – Fine needle aspiration biopsy including MRI guidance; first lesion

10012 – With 10011: each additional lesion

10021 – Fine needle aspiration; without imaging Guidance

19000 – Puncture aspiration of cyst of breast

19001 – With 19000; each additional cyst

19081 – Biopsy, with localization device placement and imaging of biopsy specimen, percutaneous; stereotactic guidance first lesion

19082 – With 19081; each additional lesion

19083 – Biopsy, with localization device placement and imaging of biopsy specimen, percutaneous; US guidance; first lesion

19084 – With 19083; each additional lesion

19085 – Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous magnetic resonance; first lesion

19086 – With 19085; each additional lesion

19100 – Needle Core biopsy; without imaging guidance

19101 – Biopsy of breast, open, incisional

19120 – Excisional Biopsy, open

19125 – Excision of lesion, identified by preop placement of radiomarker; single lesion

19126 – With 19125; each additional lesion

19281 – Localization device placement, percutaneous; mammographic guidance; first lesion

19282 – With 19281; each additional lesion

19283 – Localization device placement, percutaneous; stereotactic guidance first lesion

19284 – With 19283; each additional lesion

19285 – Localization device placement, percutaneous; US guidance; first lesion

EWC Covered Procedures (continued)

CPT Codes

19286 – With 19285; each additional lesion

19287 – Placement of breast localization device, percutaneous; magnetic resonance guidance; first lesion

19288 – with 19287; each additional lesion

57452 – Colposcopy

57454 – Colposcopy w/bx of cervix and ECC

57455 – Colposcopy w/bx of cervix

57456 – Colposcopy w/ECC

57500 – Biopsy of cervix

57505 – Endocervical curettage, w/58100

58100 – Endometrial sampling, w/57505

58110 – Endometrial sampling with colposcopy

76098 – X-ray Exam, surg specimen

76641 – Ultrasound, unilateral, include axilla; complete

76642 – Ultrasound, unilateral, include axilla; limited

76942 – US guidance for needle placement; imaging, supervise & interpret

77046 – MRI, breast, without contrast unilateral

77047 – With 77046; bilateral

77048 – MRI, breast, including CAD, with and without contrast materials, unilateral

77049 – With 77048; bilateral imaging, supervise & interpret

77063 – Screening digital breast tomosynthesis, bilateral

77065 – Diagnostic mammography unilateral includes CAD

77066 – Diagnostic mammography; bilateral includes CAD

77067 – Screening mammogram bilateral

81025 – Urine pregnancy test

87624 – Infect agent detect by DNA or RNA; HPV, high-risk types

87625 – Human Papillomavirus (HPV), type 16 and 18 only, includes type 45, if performed

88141 – Pap, physician interpretation

88142 – Pap, liquid, based (LBP); man scrng

88143 – Cytopathology-C/V, LBP, manual

88164 – Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

88172 – Cytopathology of FNA; to determine adequacy of specimen

88173 – Interp/report for eval of FNA

88174 – LBP, auto screen

88175 – LBP, auto screen w/man rescrn.

88305 – Level IV Surg path exam

88307 – Level V Surg path exam

88341 – Immunohistochemistry, each additional single a/b stain

88342 – Immunohistochemistry

88360 – Morphometric analysis, tumor immunohistochemistry; manual

99070 – Supplies/material, not inc w/OV

EWC Covered Procedures (continued)

CPT code (continued)

99202 – OV; new pt. 20 min

99203 – OV; new pt. 30 min

99204 – OV; new pt. 45min

99211 –OV; est.pt.5 min*

99212 – OV; new pt. 10 min

99213 – OV; est. pt. 15 min

99214 – OV; est. pt. 25 min

HCPCS Codes

A4217 – Sterile water/saline, 500 ml

G0279 –Digital diagnostic, breast; unilateral or bilateral, tomosynthesis

G2010 – Remote eval; est. pt.

J7030 – Infus, norm sal sol, 1000 cc

J7040 – Infus, norm sal sol, sterile 500 mL equals 1 unit

J7050 – Infus, norm sal sol, 250 cc

J7120 – Ringers lact infus, up to 1000 cc

Q3014 – Telehealth originating site facility fee

T1013 – Sign lang interpretive serv/15 min

T1014 – Telehealth transmission, per minute, professional services bill separately

T1017 – Case Mgmt. – Immediate follow-up (EWC PCP only)

Z7500 – Exam or Tx Rm use

Z7506 – OR Cysto Rm use, first hour

Z7508 – OR Cysto Rm use, 1st sub half hour

Z7510 – OR Cysto Rm use, 2nd sub half hour

Z7512 – Recovery Rm use

Z7514 – Rm/Brd gen nurse care, less than 24hr

Z7610 – Misc. drugs and medical supply

Commonly Used Modifiers◊

26 – Professional Component

51 – Multiple surg procedure

99 – Multiple Mod (e.g., AG+51)

AG – Primary Surgeon/Procedure

KX – Facilitates claim processing in instances where the patient's gender conflicts with the billed procedure code

TC – Technical Component

UA – Surgical supplies w/no anesthesia or other than general anesthesia, provided in conjunction with surgical procedure code

EWC Reminders

Program covered cancer screening and diagnostic services are free.

Payment for program-covered services is at Medi-Cal rates.

Balance billing is prohibited.

If non-covered services are recommended, written acknowledgment of cost and payment agreement must be obtained from the EWC recipient.

Only Primary Care Providers (PCPs) can enroll women and obtain the Recipient ID number.

Claims must be submitted with the woman's EWC Recipient ID number (14-digit identification number).

Only PCPs may claim for case management.

EWC enrollment is valid for 12 months; then, if eligible, the woman can be recertified/re-enrolled.

All providers must verify current eligibility before rendering services.

All services and findings must be reported to the PCP.

Billing and Claim Completion

EWC and Medi-Cal are separate programs; however, EWC relies on Medi-Cal billing procedures to process both hard copy and electronic claims.

PCPs are required to use only a National Provider Identification (NPI) number to bill for services covered by EWC.

When a PCP acquires an NPI, the Medi-Cal Provider ID number (legacy number) is end-dated and all client records associated with that Provider ID are transferred to the new NPI. Therefore, any claims submitted under the legacy number will be denied.

EWC services are billed using either the *CMS-1500* or *UB-04* claim. Providers submitting the UB-04 should follow the instructions in the *UB-04 Completion: Outpatient Services* section of the Part 2 provider manual. Providers submitting the *CMS-1500* should follow the instructions in the *CMS-1500 Completion* section of the Part 2 provider manual. Electronic billing is done as per Medi-Cal electronic billing instructions.

Modifiers

Modifiers are required for some program procedures. Medi-Cal rules for use of modifiers apply to EWC.

Recipient ID Number Required

The 14-character recipient ID number must be entered on each claim whether hard copy or electronic. Claims submitted without the 14-character ID number will be denied. The recipient application should not be attached to the claim but must be retained by the PCP in the recipient’s medical record instead.

Where To Submit Claims

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

Medical Services (*CMS-1500*)

California MMIS Fiscal Intermediary
P. O. Box 15700
Sacramento, CA 95852-1700

Outpatient Services (*UB-04*)

California MMIS Fiscal Intermediary
P. O. Box 15600
Sacramento, CA 95852-1600

Claims submitted to the wrong address will be forwarded appropriately, but processing will be delayed. To order pre-addressed envelopes for claim submission (thereby ensuring that claims are sent to the correct address), refer to the appropriate *Forms Reorder Request* section of this manual or call the Telephone Service Center (TSC) at 1-800-541-5555. For more information about claim submission requirements, refer to the appropriate submission and timeliness instructions section in this manual.

Program Inquiries

For questions about EWC claims or claims procedures, providers may call the TSC at 1-800-541-5555.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
◊	For a complete list of approved Medi-Cal modifiers, refer to the relevant section of the Medi-Cal Provider Manual.
*	This code is only available for referral providers.