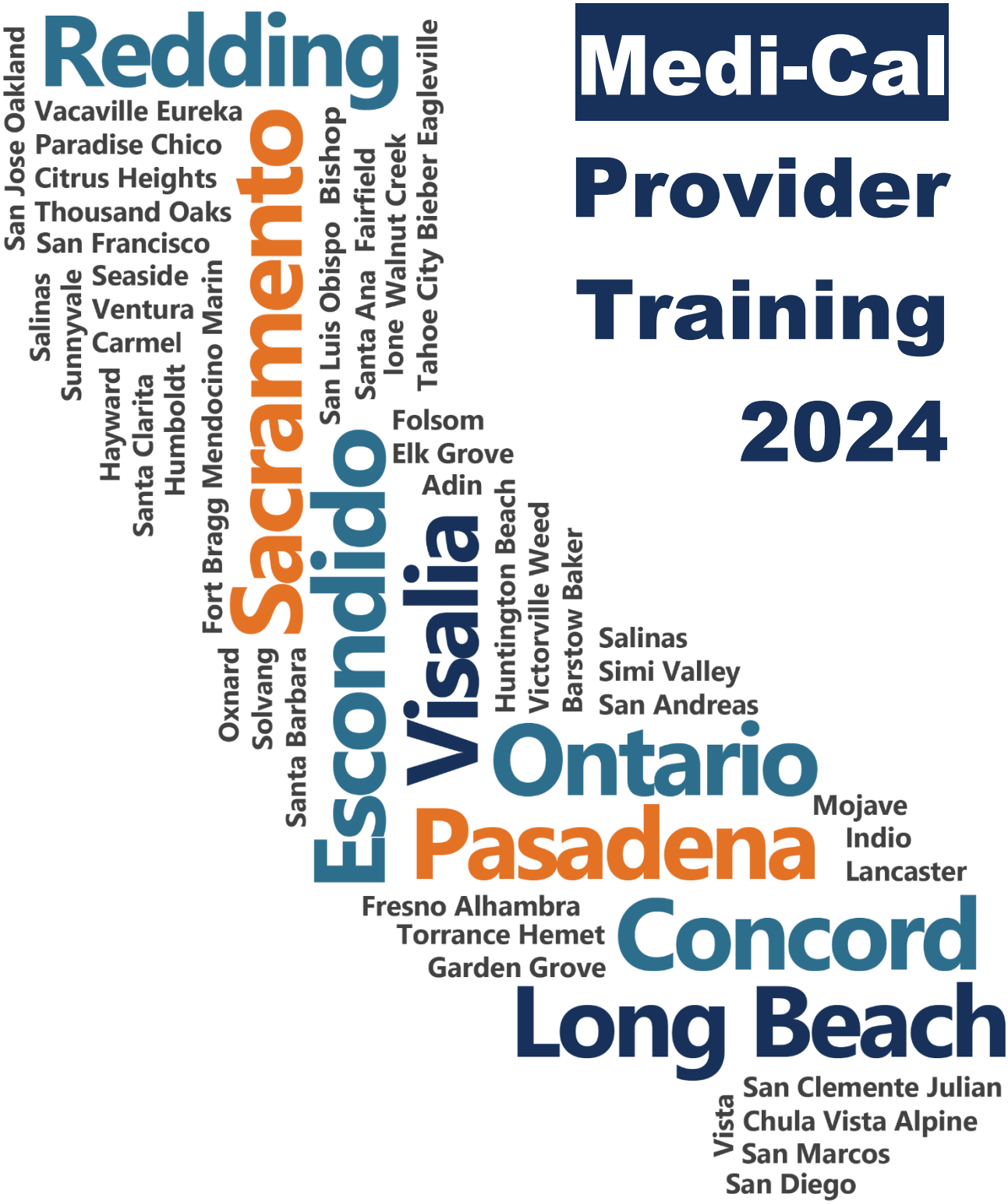

Medi-Cal Provider Training 2024

Every Woman Counts

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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Page updated: March 2024

Every Woman Counts

Introduction

Purpose

The purpose of this module is to provide information on eligibility requirements, program benefits and billing for recipients enrolled in Every Woman Counts (EWC) when services are rendered by enrolled EWC Primary Care Providers (PCPs) and qualified Referral Providers.

Module Objectives

- Define the EWC program
- Describe program enrollment requirements to render services
- Review recipient eligibility criteria
- Discuss EWC case management
- Identify program-covered services
- Highlight specific billing requirements

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Program Overview

The EWC program is a state and federally funded comprehensive public health program.

The mission of the EWC program is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and integrated preventive services with special emphasis on the underserved.

The EWC program provides timely and appropriate breast and cervical cancer screening, diagnostic, case management and patient navigation services. The other components of the program are public health education, outreach, quality assurance, improvement through professional education and evaluation of clinical data. The EWC program, in coordination with the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), helps low-income, uninsured and underinsured individuals obtain high quality breast and cervical cancer screenings and diagnostic services.

EWC provides cervical cancer screening and diagnostic services to individuals 21 years of age and older, breast cancer screening and diagnostic services to individuals 40 years of age and older, and breast diagnostic services to symptomatic individuals of any age. Services are provided in all counties of the state.

The goal of the program is to prevent the devastating effects of breast cancer and cervical cancer by reducing morbidity and mortality rates of Californians.

EWC and Medi-Cal Work Together

EWC and Medi-Cal are two separate programs. If an applicant is eligible for full scope Medi-Cal, they are not automatically eligible for EWC unless they have unmet Share of Cost (SOC) obligations. However, EWC relies on the Medi-Cal billing procedures to process both hard copy and electronic claims.

Funding

Funding for the EWC program is by both federal and state dollars. Federal funds are received from the Centers for Disease Control and Prevention (CDC) and the NBCCEDP as authorized by the Acts of 1990 (*Public Law 101-354*). State funds are received through a tax on tobacco (mandated by the California Breast Cancer Act of 1993) and the General Fund.

EWC Primary Care Providers (PCPs)

PCPs are the screening entry point for recipients and are the only providers who can enroll recipients through the EWC data entry application known as DETEC (DETecting Early Cancer). PCPs must be enrolled in EWC by completing and submitting a Primary Care Provider Enrollment Agreement (PCPEA) and are required to collect and report recipient outcome data. PCPs provide and coordinate screening and diagnostic services and referral to treatment as part of case management.

PCP Participation Requirements

Providers 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.

New PCPs are eligible to render services only after the effective date of enrollment, as stated in the EWC welcome letter. They must also receive training about program standards, requirements, covered procedures; submission of claims (electronic or hard copy) and submission of outcome data via DETEC. Only Medi-Cal providers in good standing who are enrolled in the EWC program can use DETEC.

For information on enrollment into the EWC program, recipient eligibility, clinical policy and program standards, case management, data entry and covered services, refer to the *Every Woman Counts* (ev woman) section of provider manual and the Step by Step DETEC User Guide.

PCPs must adhere to all requirements contained in the Primary Care Provider Enrollment Agreement (PCPEA), EWC clinical standards and data submission requirements as outlined in the *Every Woman Counts* (ev woman) provider manual section.

A PCP must:

- Be a Medi-Cal provider in good standing and licensed in the state of California.
- Enroll in the program through a Regional Contractor.
- Complete and sign a Primary Care Provider Enrollment Agreement (PCPEA).
- Have internet access to obtain the 14-character identification number required for hard copy/electronic claim submission and for completing the DETEC online enrollment and data forms.

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 a National Provider Identifier (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 (RHC)
- Federally Qualified Health Centers (FQHCs)
- Indian Health Centers (IHS)

Assessment of Tobacco Use and Referral for Smoking Cessation

Due to federal regulations, PCPs are required to assess 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 assessment and cessation referrals must be documented and maintained in the recipient's medical record.

PCP Responsibilities

- Verify recipient's eligibility or that the certification period is valid for date of service
- Deliver EWC program services in accordance with EWC program clinical quality standards
- Assess tobacco use for each recipient and refer users to the tobacco cessation program
- Accept Medi-Cal rates as payment in full. Do not bill recipients for any EWC program services
- Provide disclosure to recipients about services that are not covered by EWC and receive patient consent prior to provision of these services
- Provide notification to recipients of screening, diagnostic procedures and test results within specified time frames and document notification in the medical record
- Maintain a network of Referral Providers
- Refer to providers who accept Medi-Cal rates as payment in full
- Refer recipients for diagnostic evaluation and/or treatment as needed
- Collect recipient data and report to the EWC program

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 EWC recipients into 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

A BCCTP Overview is available on the Medi-Cal Providers website, 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 and/or cervical cancer can be referred into BCCTP. Providers should go to the BCCTP page on the Medi-Cal Providers website and follow the program enrollment procedures.

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.

Referral providers may include, but are not limited to, any of the following:

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

In order to bill, EWC referral providers must have the recipient's 14-charater 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 and enrolls them in EWC, the PCP must communicate the recipient's 14-character ID number given by them 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 a follow-up.

Payments from Recipient Disallowed

Referral and Primary Care Providers 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.

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 conducting local targeted outreach and public education.

Regional Contractors Enroll PCPs

Providers 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.

Activities

Regional Contractors conduct the following activities:

- Recruit and train EWC PCPs.
    - Support EWC providers to participate in breast and/or cervical health service delivery networks.
- Address gaps in the delivery of these services.
    - Coordinate professional education about breast and/or cervical cancer screening and related subjects.
    - Provide technical assistance for the 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 on the EWC data entry application known as DETEC (DETecting Early Cancer), including eligibility, enrollment and clinical data entry.
    - Provide technical assistance and training to ensure PCPs meet the Core Program Performance Indications (CPPI), which measures quality outcomes.
- Provide guidance to support recipients receiving timely and appropriate services.

For more information, refer to the Regional Contractors page on the DHCS website.

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 and diagnostic services. EWC follows the U.S. Preventative Services Task Force (USPSTF) recommendations.

EWC has a lower age eligibility criterion of 21 for cervical cancer screening and diagnostic services. Since EWC services 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 did not have 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 service.

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 mammograms every one to two 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).

Breast Cancer Diagnostic Services

Any individual (women and men) of any age presenting with breast cancer symptoms are eligible for breast diagnosis services. Warning signs and/or symptoms of breast cancer include, but are not limited to, the following:

- Palpable mass or lumps in breast.
- Changes in size or shape of breast.
- Changes in skin texture or color (dimpling, puckering, redness, scaliness or thickening) of 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 if the procedure is medically necessary. The patient's medical record must support medical necessity for the procedure.

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 limitations for procedures, refer to the *Transgender and Gender Diverse Services* section in the appropriate Part 2 provider manual.

Income Eligibility Guidelines

The federal Health and Human Services (HHS) poverty guidelines are used to determine financial eligibility for EWC. The HHS poverty guidelines are adjusted annually, and the EWC income criteria are adjusted accordingly. To qualify for breast and cervical cancer screening services, recipients must have a household income at or below 200 percent of the HHS poverty guidelines based on the individual's self-report. The HHS poverty guidelines are adjusted annually, and the EWC income criteria are adjusted accordingly.

The following table lists the EWC income criteria based on the 2024 HHS poverty guidelines.

EWC Income Eligibility Guidelines Table

200 Percent of the 2024 HHS Poverty Guidelines by Household Size

Effective April 1, 2024, through March 31, 2025

Number of Persons Living in Household	Monthly Gross Household Income (in dollars)	Annual Gross Household Income (in dollars)
1	$2,510	$30,120
2	$3,407	$40,880
3	$4,303	$51,640
4	$5,200	$62,400
5	$6,097	$73,160
6	$6,993	$83,920
7	$7,890	$94,680
8	$8,787	$105,440
For each additional person, add:	$897	$10,760

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 (HHS) under the authority of 42 U.S.C. 9902(2). The EWC Program income eligibility guidelines are updated accordingly based on the HHS FPG.

Monthly "gross household income" means the sum of incomes (before taxes and other deductions) of the person(s) in the family/household living in the 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

“Gross Household monthly income” includes the following:

- 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 the recipient is uninsured or underinsured based on the individual's self-report. Recipients may be certified as underinsured for EWC if all of the following conditions are met:

- Either no Medi-Cal coverage or limited scope of 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 deductibles that cannot be met, or
  - Other health insurance benefit restrictions, public or private, which exclude services available through EWC.

Note: Inability to meet SOC or copayment obligation is self-reported.

For more information, refer to *Every Woman Counts* (ev woman) section in the Part 2 provider manual.

Residency

Eligible individuals must have a California address or, if homeless, a location where the 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 DETEC *Recipient Information* form is completed and submitted online. The eligibility period does not change if the recipient transfers to another PCP. The eligibility period is for the recipient and not the provider. Re-enrollment or recertification can only occur annually when a recipient's one-year recipient eligibility period ends.

Eligibility Scenario

A recipient sees PCP Provider A on February 1. Provider A establishes the patient's eligibility on this date by entering information into the DETEC form. The recipient's eligibility period spans from February 1st to the following January 31st (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 still remains eligible only until January 31, as previously established when Provider A enrolled her. 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 (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. Case management is not billable during the retroactive period.

Payer of Last Resort

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

EWC Forms and Worksheets

EWC uses two types of forms:

- Paper forms and worksheets that may be downloaded from the EWC program page on the Medi-Cal website. These worksheets and forms can be photocopied and are completed by hand and intended to assist providers in gathering relevant information that will later be entered online via the DETEC forms.
- Online forms that are completed and submitted via the online data entry system DETecting Early Cancer (DETEC).

Transaction Center

Downloadable and printable versions of the EWC and DETEC forms may be found by logging into Transaction Center. To log into Transaction Center:

1. Navigate to *https://provider-portal.apps.prd.cammis.medi-cal.ca.gov/* to login. For more information on accessing the Provider Portal, refer to the Medi-Cal Provider Portal User Guide: Provider Organization.
2. Once in the Provider Portal, navigate to the Transaction Center, choose an NPI from the drop-down menu and select **Get Started**.

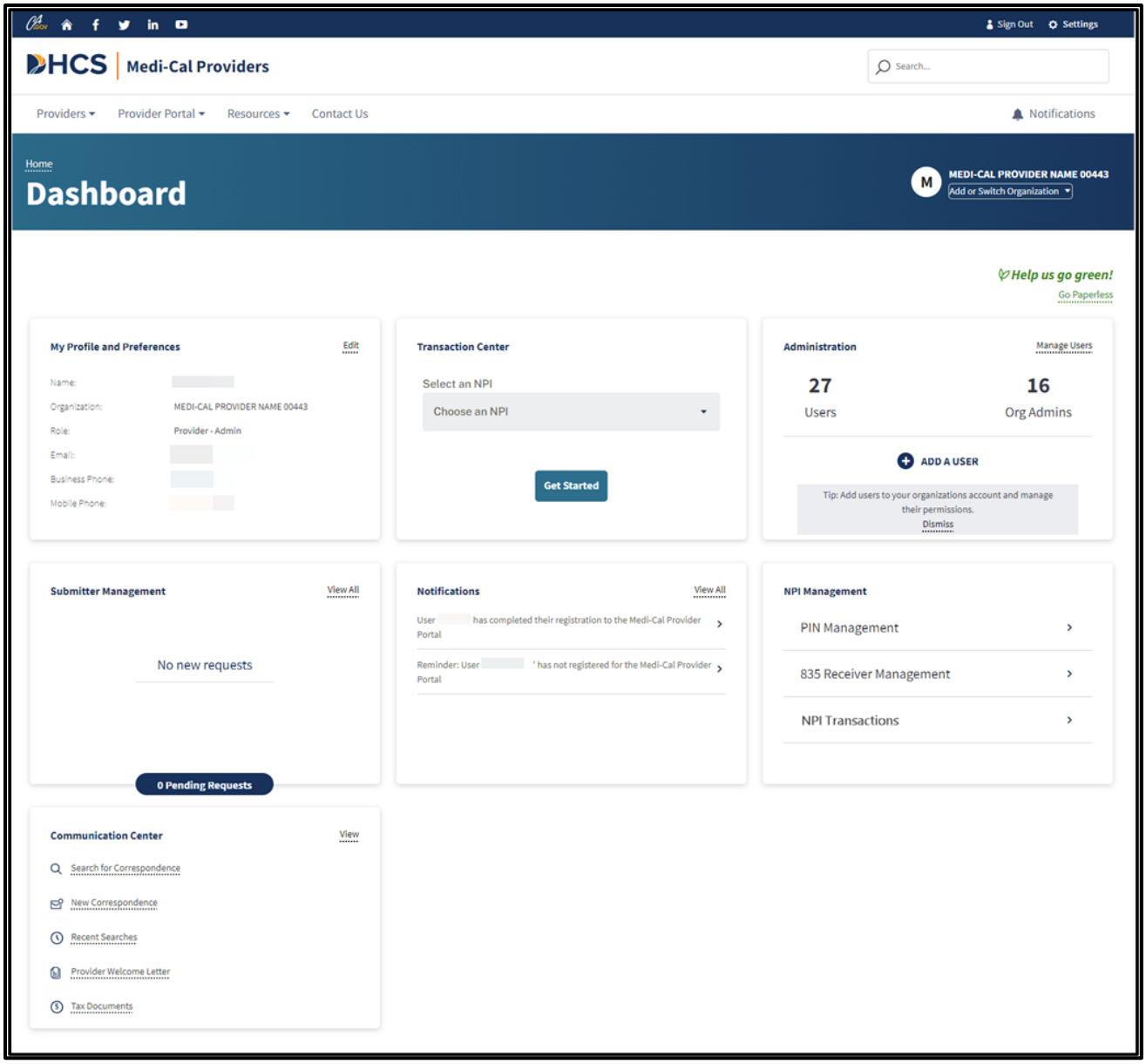


Figure 1.1: Provider Portal homepage/dashboard.

3. Navigate to the Enrollment section and select **Every Woman Counts (EWC)** link.

Note: Do not select the Breast and Cervical Treatment Program link. This link will not lead to the DETEC transaction.

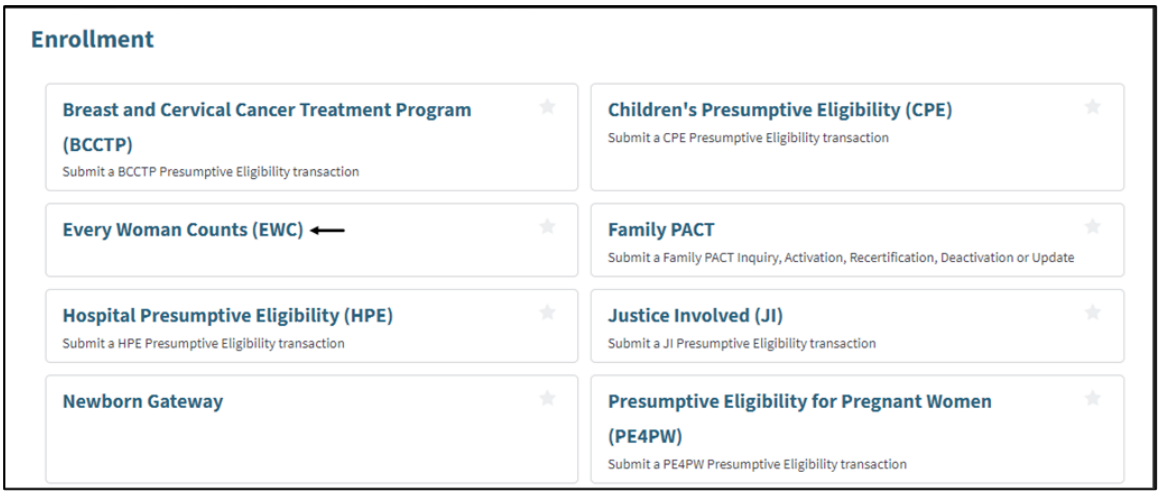


Figure 1.2: Enrollment section of the Transaction Center.

4. Once the Every Woman Counts link is selected, the EWC – DETEC page will load.

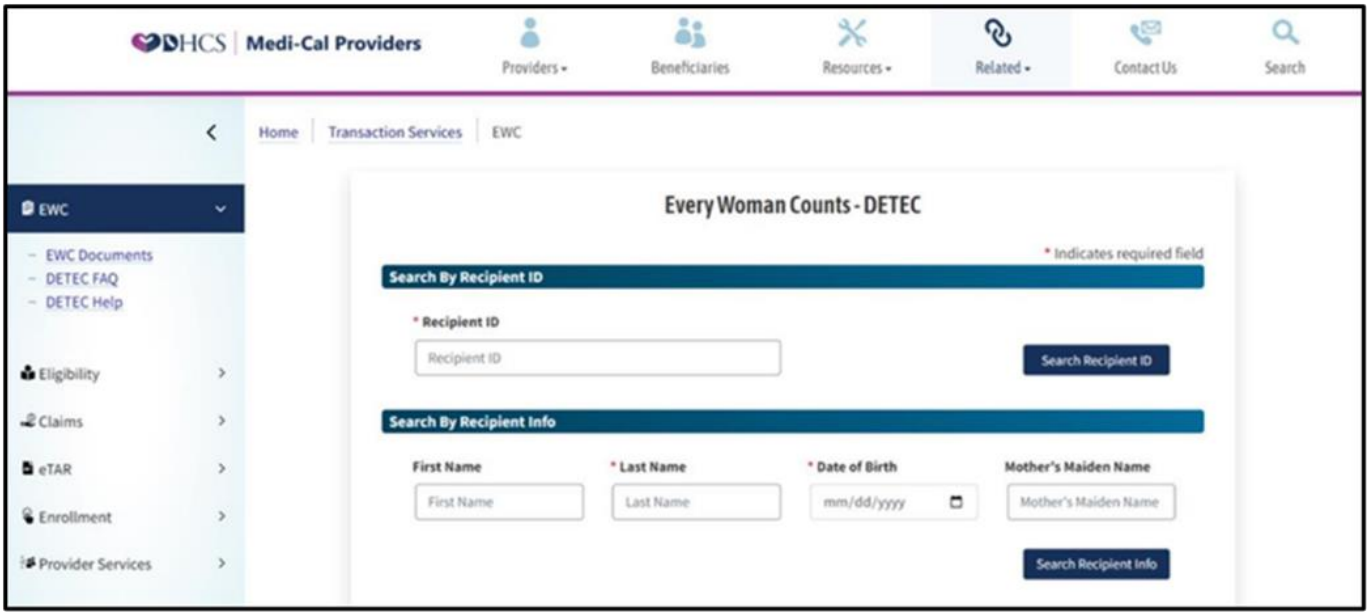


Figure 1.3: Every Woman Counts – DETEC page.

5. To quickly locate the EWC-DETEC forms, locate the navigation bar on the left-hand side of the screen under the EWC heading, and select **EWC Documents**.

Figure 1.4: EWC Navigation Bar.

6. Once the **EWC Manuals, Forms and Worksheets** page opens, the following will display:

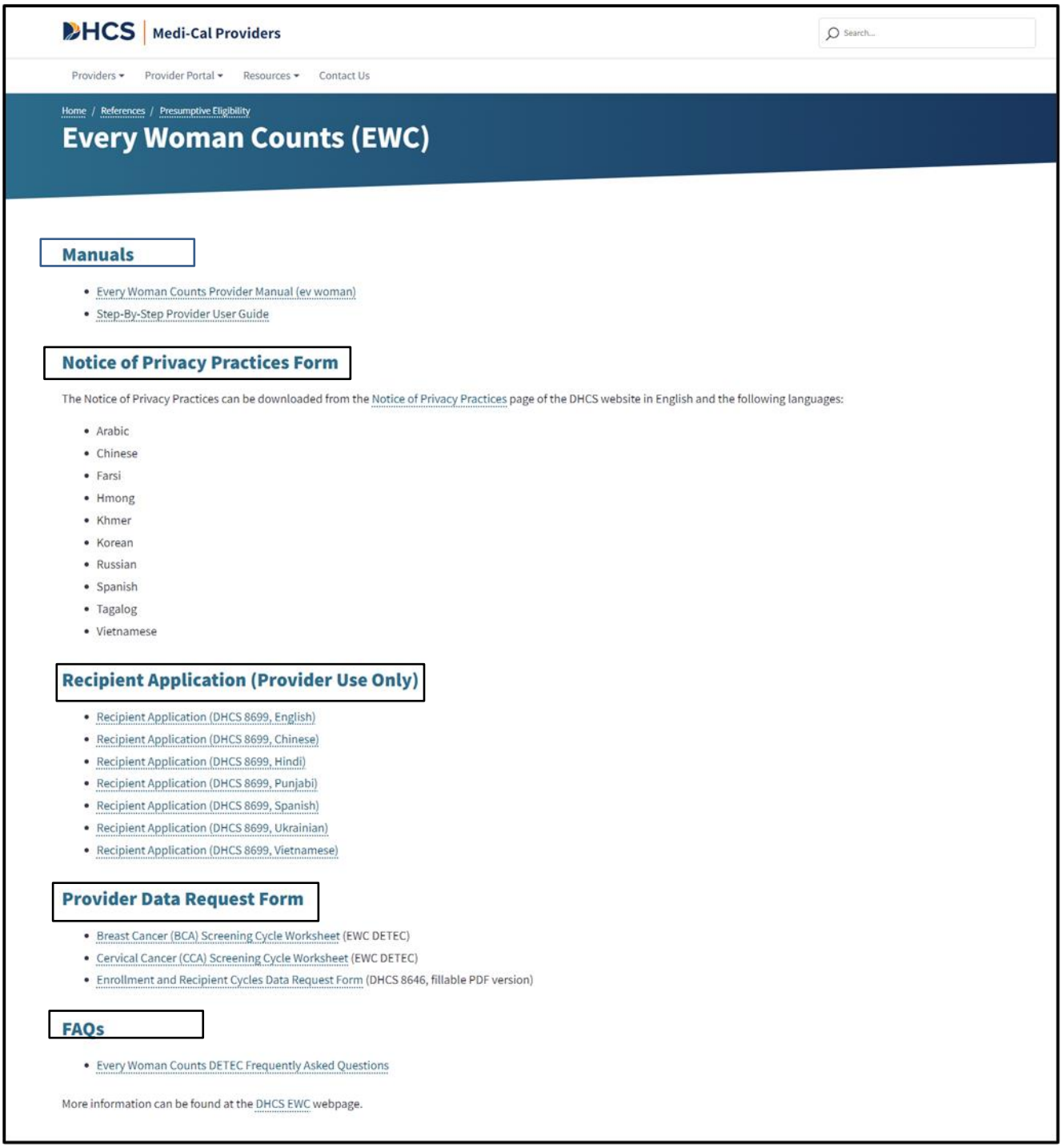


Figure 1.5: EWC Manuals, Forms and Worksheets page.

Recipient Application

The *Recipient Application* form (DHCS 8699) is required. This form enables provider staff or the recipient to complete their income and eligibility data. The original must be kept in the recipient's medical record. It should be signed by the recipient and by the provider who determines the eligibility criteria has been met. This is evidence that data was entered in support of case management claims.

PCPs must print, sign and date the print copies of these DETEC forms and place the original copy in the patient's medical record. Providers should **not** send a copy of the *Recipient Application* (DHCS 8699) to DHCS.

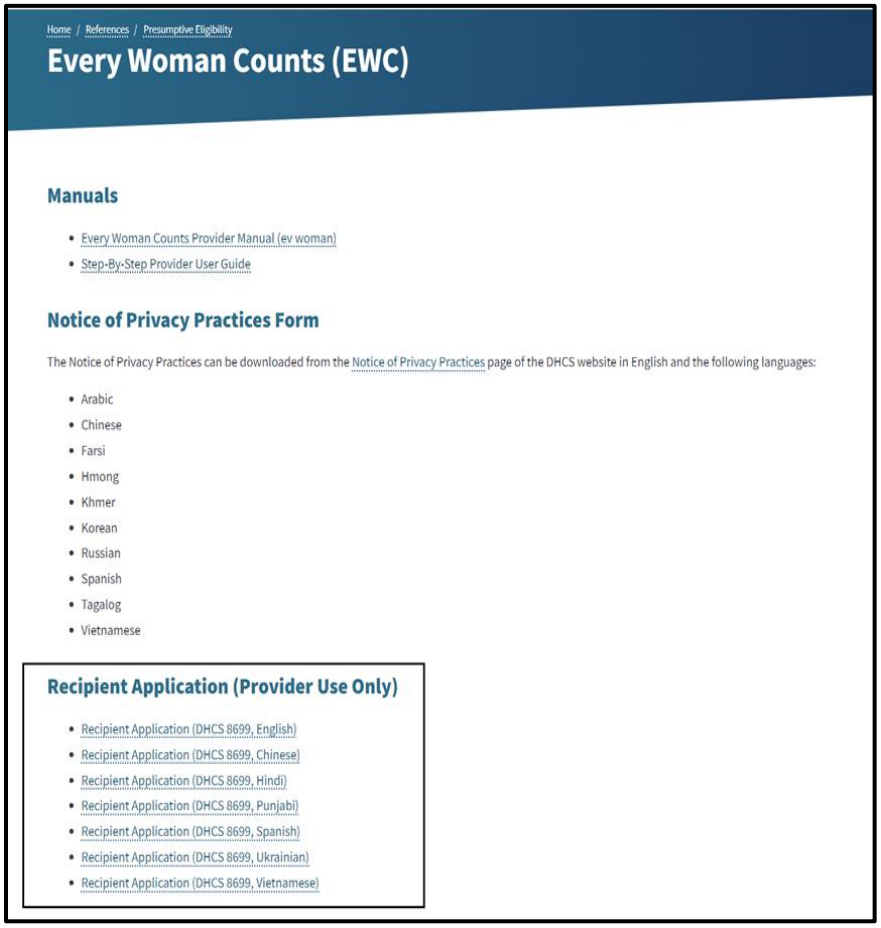


Figure 2.1: Recipient Application (Provider Use Only).

Once the provider has collected recipient demographic information, established recipient eligibility for EWC and obtained a signed recipient application, the PCP may enroll the recipient in the program using the online **DETEC *Enroll Recipient* form**.

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 (by pressing the “print card” button).

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.

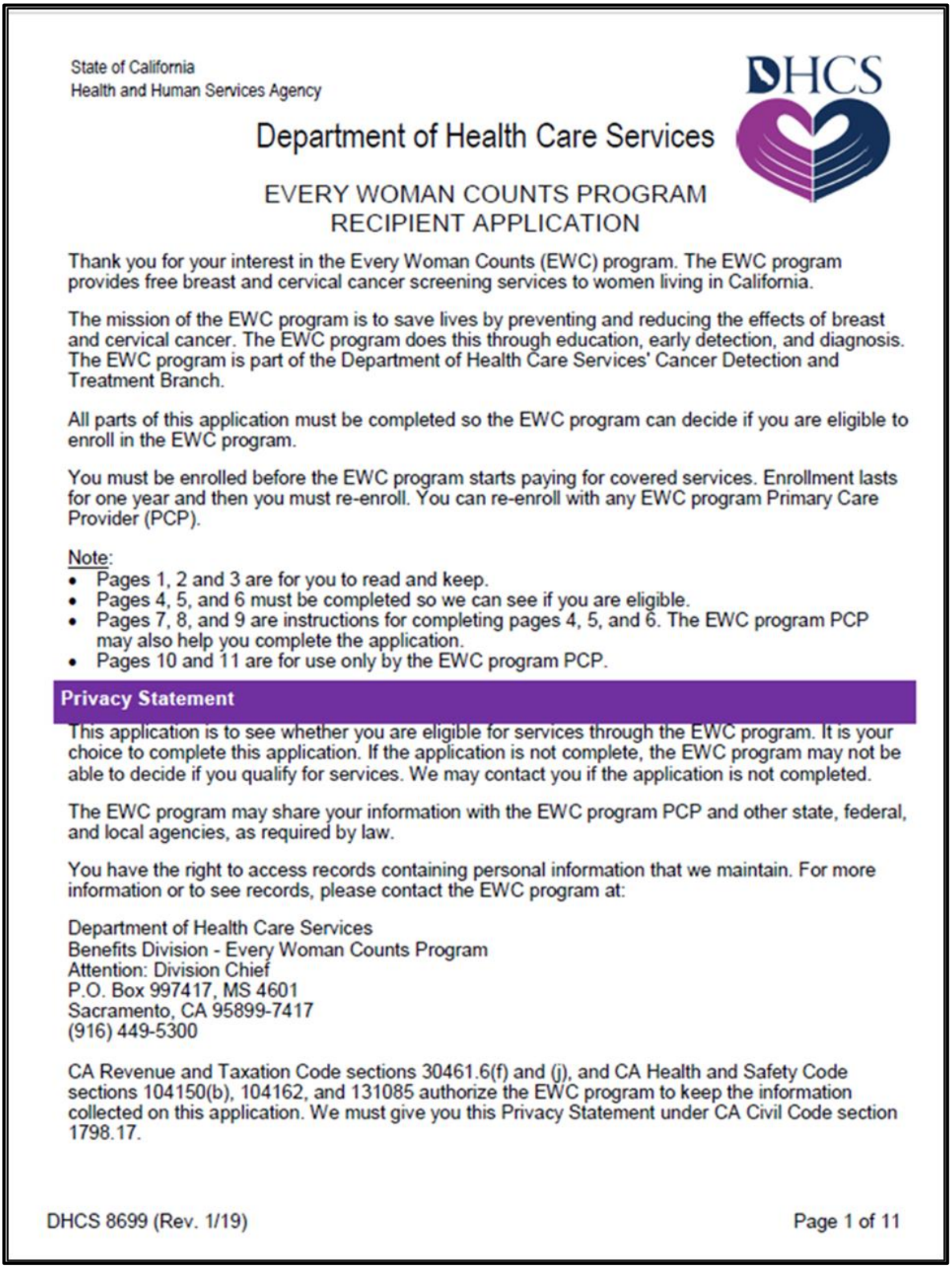
EWC Program Recipient Application

All parts of this application must be completed so the EWC program can decide if you are eligible to enroll in the EWC program. Note that:

- Pages **1, 2** and **3** are for you to read and keep.
- Pages **4, 5**, and **6** must be completed to determine eligibility.
- Pages **7**, **8**, and **9** are instructions for completing pages **4**, **5**, and **6**. The EWC program PCP may also help you complete the application.

Pages **10 and 11** are for use only by the EWC program PCP.

Below are the screenshots of the recipient application, minus pages 7 through 9 and page 11 because these pages contain instructions.



State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Thank you for your interest in the Every Woman Counts (EWC) program. The EWC program provides free breast and cervical cancer screening services to women living in California.

The mission of the EWC program is to save lives by preventing and reducing the effects of breast and cervical cancer. The EWC program does this through education, early detection, and diagnosis. The EWC program is part of the Department of Health Care Services' Cancer Detection and Treatment Branch.

All parts of this application must be completed so the EWC program can decide if you are eligible to enroll in the EWC program.

You must be enrolled before the EWC program starts paying for covered services. Enrollment lasts for one year and then you must re-enroll. You can re-enroll with any EWC program Primary Care Provider (PCP).

Note:
- Pages 1, 2 and 3 are for you to read and keep.
- Pages 4, 5, and 6 must be completed so we can see if you are eligible.
- Pages 7, 8, and 9 are instructions for completing pages 4, 5, and 6. The EWC program PCP may also help you complete the application.
- Pages 10 and 11 are for use only by the EWC program PCP.

Privacy Statement

This application is to see whether you are eligible for services through the EWC program. It is your choice to complete this application. If the application is not complete, the EWC program may not be able to decide if you qualify for services. We may contact you if the application is not completed.

The EWC program may share your information with the EWC program PCP and other state, federal, and local agencies, as required by law.

You have the right to access records containing personal information that we maintain. For more information or to see records, please contact the EWC program at:

Department of Health Care Services
Benefits Division - Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417
(916) 449-5300

CA Revenue and Taxation Code sections 30461.6(f) and (j), and CA Health and Safety Code sections 104150(b), 104162, and 131085 authorize the EWC program to keep the information collected on this application. We must give you this Privacy Statement under CA Civil Code section 1798.17.

DHCS 8699 (Rev. 1/19) Page 1 of 11

Figure 2.2: Every Woman Counts Program Recipient Application (Page 1 of 11).

State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

First Level Review and Formal Hearing Rights for the Every Woman Counts Program

You will be told if you are eligible for the EWC program or if you are not. If you do not agree with the eligibility decision, you have the right to ask for a first level review and/or formal hearing. You also have a right to a first level review and/or formal hearing if you disagree with the services you are getting under the EWC program.

You may not challenge the standards that the EWC program uses to make the eligibility decision. For example, if you think that the decision did not match the EWC program standards, you may ask for a first level review and/or formal hearing. But if you disagree with the EWC program standards, you may not ask for a first level review and/or formal hearing to try to change the EWC program standards.

If you wish to exercise your right to ask for a first level review and/or formal hearing, please submit a written request that includes the following:

- Your name, address and telephone number.
- The reason why you are requesting a first level review or formal hearing.
- Why you believe the decision is wrong.
- Your language preference, if you have trouble understanding English.
- The name, address, and telephone number of your authorized representative, if you choose to use one.

First Level Review: The written request for a first level review must be sent to the EWC program within 20 days of the decision you disagree with. Please keep a copy of your written request for your records. The EWC program will respond within 30 days of receipt of your request.

Mail your request for a First Level Review
Department of Health Care Services
Benefits Division - Every Woman Counts Program
Attention: Division Chief
P.O. Box 997417, MS 4601
Sacramento, CA 95899-7417

OR

Email your request for a First Level Review
CancerDetection@dhcs.ca.gov

The EWC program may contact you for more information. This contact may be by phone or in writing. The EWC program PCP may also be contacted for information.

Formal Hearing: The written request for a formal hearing must be sent to the Department of Social Services within 90 days of the decision you disagree with. If you have good cause why you were not able to file for a formal hearing within 90 days, you may still ask for a formal hearing to be scheduled. Please keep a copy of your written request for your records.

Mail your request for a Formal Hearing
Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 9 – 17 – 37
Sacramento, CA 94244-2430

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Figure 2.3: Every Woman Counts Program Recipient Application (Page 2 of 11).

State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION

Notice of Nondiscrimination

DHCS complies with applicable Federal and State civil rights laws. DHCS does not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation. DHCS does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

DHCS:

- Provides free aids and services to people with disabilities to communicate effectively with DHCS, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic formats and other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Office of Civil Rights, at **1-916-440-7370**, 711 (California State Relay) or email CivilRights@dhcs.ca.gov.

If you believe DHCS has failed to provide these services or you have been discriminated against in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with the Office of Civil Rights.

PO Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370, 711 (California State Relay)
Email: CivilRights@dhcs.ca.gov

If you need help filing a grievance, the Office of Civil Rights can help you. Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You can file electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or you can file by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, TTY 1-800-537-7697

You can get a complaint form at:
http://www.hhs.gov/ocr/office/file/index.html

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Figure 2.4: Every Woman Counts Program Recipient Application (Page 3 of 11).

State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM RECIPIENT APPLICATION

Tell us about you

1. First Name_____ 2. Middle Initial _____ 3. Last Name_____
4. Date of Birth (month / day / year) ___ ___ / ___ ___ / ___ ___ ___ ___
5. What is your sex? ☐ Female ☐ Transsexual: Male to Female ☐ Male ☐ Transsexual: Female to Male
6. Your Mother's Last Name When She Was Born (Maiden Name) _____
7. Address_____
8. City_____ 9. State_____ 10. Zip Code_____
11. Telephone number [(area code) number] (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
12. Email address_____
13. Social Security Number. List your number if you have one ___ ___ ___ - ___ ___ - ___ ___ ___ ___

The following information helps us decide if you are eligible for the EWC program.
Tell us about your household income.

We need to know how much money everyone in your household receives before paying taxes. If you file taxes, this is your "gross income."

14. Household income (before taxes and other deductions) $_____
15. Total number of persons living on this income_____

Now let us know about your health insurance

☐ 16. I do not have health insurance.

☐ 17. I have health insurance or a healthcare plan but cannot afford the share-of-cost, deductible, or co-pay

My health insurance is ☐ 18. Medi-Cal ☐ 19. Name of Insurance_____
20. My card or policy number is _____

21. My share-of-cost is $_____ per month.
22. My deductible is $_____ per year.
23. My co-pay is $_____ per visit.

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Figure 2.5: Every Woman Counts Program Recipient Application (Page 4 of 11).

State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM RECIPIENT APPLICATION

What EWC services do you need? (check all that apply)

If you have any symptoms in your breasts, please check what they are:

- ☐ 24. Change in the look or feel of your breast(s), such as change of color, size or shape
- ☐ 25. Swelling or thickening of your breast(s) tissue
- ☐ 26. Discharge from your nipple
- ☐ 27. Lump or hard knot in your breast(s)
- ☐ 28. Other:_____
- ☐ 29. Are you 21 or older seeking cervical cancer screening?
- ☐ 30. Are you 40 or older seeking breast cancer screening?

Tell us about your use of tobacco

31. Do you smoke tobacco now? ☐ No ☐ Yes
32. Do you use other tobacco products now? ☐ No ☐ Yes; If Yes, what _____

This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide if you are eligible.

Tell us about your race

33. Are you Hispanic or Latina? ☐ Yes ☐ No

Select all that apply to you:

- ☐ 34. American Indian or Alaskan Native
- ☐ 35. Asian (Specify below)
  - ☐ 36. Asian Indian ☐ 37. Cambodian ☐ 38. Chinese ☐ 39. Filipino ☐ 40. Hmong
  - ☐ 41. Japanese ☐ 42. Korean ☐ 43. Laotian ☐ 44. Vietnamese ☐ 45. Other Asian: _____
- ☐ 46. Black or African American
- ☐ 47. Pacific Islander (Specify below)
  - ☐ 48. Guamanian ☐ 49. Hawaiian ☐ 50. Samoan ☐ 51. Other Pacific Islander: _____
- ☐ 52. White
- ☐ 53. Other:_____ ☐ 54. Prefer not to answer

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Figure 2.6: Every Woman Counts Program Recipient Application (Page 5 of 11).

State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM RECIPIENT APPLICATION

The following information is confidential. It will not be used to decide if you are eligible.

Tell us about your gender identity and sexual orientation (Optional)

What is your gender? (check the box that best defines your current gender identity)

- ☐ 55. Female
- ☐ 56. Transgender: Male to Female
- ☐ 57. Male
- ☐ 58. Transgender: Female to Male
- ☐ 59. Non-binary (neither male nor female)
- ☐ 60. Another gender identity:_____

What sex was listed on your original birth certificate?

- ☐ 61. Female
- ☐ 62. Male

What do you think of yourself as?

- ☐ 63. Straight or heterosexual
- ☐ 64. Lesbian or gay
- ☐ 65. Bisexual
- ☐ 66. Queer
- ☐ 67. Another sexual orientation
- ☐ 68. Unknown

69. Declarations (Please read and initial each item)

_____ I understand that by signing this application, I am applying to the EWC program, which is a government-funded program. The EWC program pays for breast and/or cervical cancer screening services that may lead to a referral for treatment.

_____ This consent lasts for ONE YEAR from the date I sign it. I know that I must complete a new application each year to be in the EWC program.

_____ I understand I can stop being part of the EWC program at any time.

_____ If I obtain health insurance or other medical coverage, I will let the EWC program PCP know right away.

_____ I have received the **DHCS Notice of Privacy Practices** (NPP; not part of this application package).

_____ I have received the **Privacy Statement, First Level Review and Formal Hearing Rights,** and **Notice of Nondiscrimination** on pages 1, 2, and 3 of this application.

_____ I have received information about **how to get free or low-cost insurance.**

_____ I declare that the information that I have provided on pages 4, 5, and 6 is true and correct to the best of my knowledge. I understand that giving false information on this application may make me ineligible for the EWC program.

_____ I had help completing this application. 70. Name of who helped you_____

71. Signature of who helped, if applicable_____ 72. Date_____

Signatures

73. Yours _____ 74. Date_____

75. Person acting for EWC program applicant, if applicable_____ 76. Date_____

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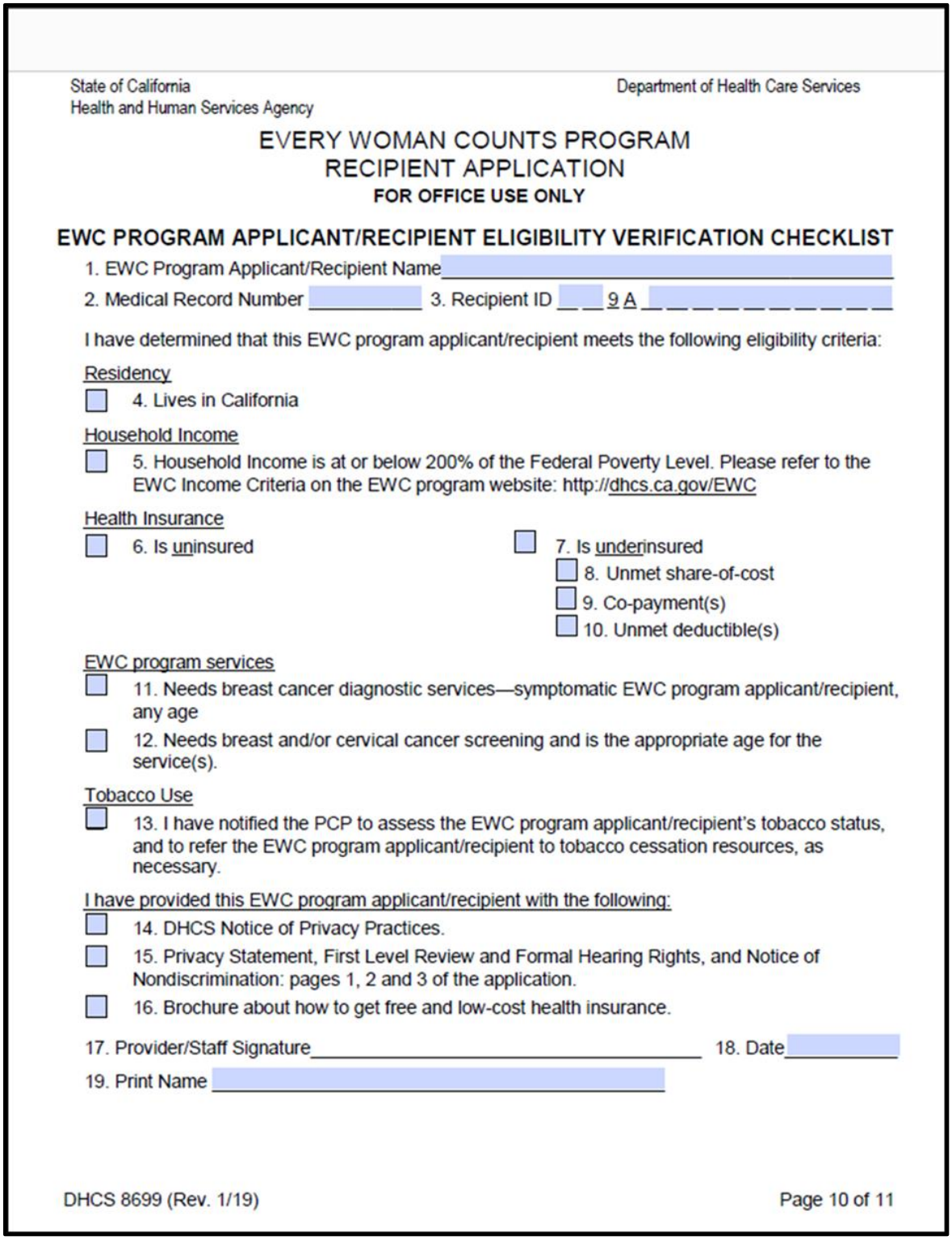
Figure 2.7: Every Woman Counts Program Recipient Application (Page 6 of 11).

EWC Program Applicant/Recipient Eligibility Verification Checklist



State of California
Health and Human Services Agency

Department of Health Care Services

EVERY WOMAN COUNTS PROGRAM
RECIPIENT APPLICATION
FOR OFFICE USE ONLY

EWC PROGRAM APPLICANT/RECIPIENT ELIGIBILITY VERIFICATION CHECKLIST

1. EWC Program Applicant/Recipient Name_____
2. Medical Record Number _____ 3. Recipient ID __ __ 9 A __ __ __ __ __ __ __ __ __

I have determined that this EWC program applicant/recipient meets the following eligibility criteria:

Residency

☐ 4. Lives in California

Household Income

☐ 5. Household Income is at or below 200% of the Federal Poverty Level. Please refer to the EWC Income Criteria on the EWC program website: http://dhcs.ca.gov/EWC

Health Insurance

☐ 6. Is uninsured

☐ 7. Is underinsured
- ☐ 8. Unmet share-of-cost
- ☐ 9. Co-payment(s)
- ☐ 10. Unmet deductible(s)

EWC program services

☐ 11. Needs breast cancer diagnostic services—symptomatic EWC program applicant/recipient, any age

☐ 12. Needs breast and/or cervical cancer screening and is the appropriate age for the service(s).

Tobacco Use

☐ 13. I have notified the PCP to assess the EWC program applicant/recipient's tobacco status, and to refer the EWC program applicant/recipient to tobacco cessation resources, as necessary.

I have provided this EWC program applicant/recipient with the following:

☐ 14. DHCS Notice of Privacy Practices.

☐ 15. Privacy Statement, First Level Review and Formal Hearing Rights, and Notice of Nondiscrimination: pages 1, 2 and 3 of the application.

☐ 16. Brochure about how to get free and low-cost health insurance.

17. Provider/Staff Signature_____ 18. Date_____

19. Print Name _____

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Figure 2.8: Every Woman Counts Program Eligibility Verification Checklist (Page 10 of 11).

Every Woman Counts Consent/Signature Policy

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 the applicant's behalf (Authorized Representative).
2. Complete each field of the EWC Recipient Application, on behalf of the applicant, based on the applicant's verbal response/consent (#1-68, pages 4-6).
3. Read the consent language aloud to the individual/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/Authorized Representative verbally acknowledge their consent.
5. Print the name and relationship to the applicant of the 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" in the signature line 73 of the application and date in line 74.
7. Sign and date page 6 of the EWC Recipient Application to confirm eligibility.
8. Sign and date lines 17-19 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 PCPs may also fax or email a copy of the identification card to the referral provider(s) along with the referral, so the referral providers can verify enrollment.

EWC Approved Procedures

The following CPT and HCPCS codes are benefits of EWC. All the codes are available for EWC primary care and referral providers except for 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.

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

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

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.

Table 1a: Cervical Cancer Screening ICD-10-CM Codes

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 ICD-10-CM Codes

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: Cervical Cancer Screening ICD-10-CM Codes

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

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 Screening Related ICD-10-CM Codes

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

EWC Approved Procedures

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	Not Applicable
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion	see table 2b	Not Applicable
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	see table 2b	Not Applicable
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	see table 2b	Not Applicable
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	see table 2b	Not Applicable
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion	see table 2b	Not Applicable
10011	Fine needle aspiration biopsy, including MR guidance; first lesion	see table 2b	Not Applicable
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion	see table 2b	Not Applicable
10021	Fine needle aspiration; biopsy, without imaging guidance; first lesion	see table 2b	Not Applicable
19000	Puncture aspiration of cyst of breast	see table 2b	Not Applicable
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	Not Applicable
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	Not Applicable
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	see table 2b	Not Applicable
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

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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
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

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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
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	Not Applicable
76641	Ultrasound, complete examination of breast including axilla, unilateral	see tables 2a and 2b	Not Applicable
76642	Ultrasound, limited examination of breast including axilla, unilateral	see tables 2a and 2b	Not Applicable
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	see table 2b	Not Applicable

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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 not covered to assess the extent of disease in a woman who has just been newly diagnosed with breast cancer in order to determine treatment.
77047	Magnetic resonance imaging (MRI), breast, without contrast; bilateral	see tables 2a and 2b	Same as for 77046

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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	Not Applicable
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 ABRCA 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 Restricted to individuals 40 years of age or older
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	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	See table 1c and Z11.51	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 aged 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	Not Applicable
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	Not Applicable
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	see tables 1a and 1b	Not Applicable
88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site;	see table 2b	Not Applicable

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	Not Applicable
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	Not Applicable
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	Not Applicable
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	Not Applicable
88305	Level IV – Surgical pathology, gross and microscopic examination	see tables 1b and 2b	Not Applicable
88307	Level V, gross and microscopic examination, requiring microscopic evaluation of surgical margins	see tables 1b and 2b	Not Applicable
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	See table 2b	Not Applicable
88332	Pathology consultation during surgery; each additional tissue block with frozen section(s)	See table 2b	Not Applicable
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	Not Applicable

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	Not Applicable
88360	Morphometric analysis, tumor immunochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual	see table 2b	Not Applicable
88364	In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure	see tables 1b and 2b	Not Applicable
88365	In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure	see tables 1b and 2b	Not Applicable
88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	see tables 1b and 2b	Not Applicable
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	Not Applicable
88368	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure	see tables 1b and 2b	Not Applicable
88369	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure	see tables 1b and 2b	Not Applicable
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	Not Applicable

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	Not Applicable
88377	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure	see tables 1b and 2b	Not Applicable
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	Not Applicable
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	Not Applicable
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	Not Applicable
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.

Approved Procedures, CPT Codes Key (continued)

CPT Code	Description	ICD-10-CM Code	Additional Information
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	Not Applicable
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	Not Applicable
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	Not Applicable
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
A4217	Sterile water/saline, 500 ml	see tables 1b and 2b
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
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., 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 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.	see tables 2a and 2b

Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code
G2012	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 e/m service provided within the previous 7 days nor leading to an e/m 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
J7030	Infusion, normal saline solution, 1000 cc	see tables 1b and 2b
J7040	Infusion, normal saline solution, sterile (500 ml = 1 unit)	see tables 1b and 2b
J7050	Infusion, normal saline solution, 250 cc	see tables 1b and 2b
J7120	Ringers lactate infusion, up to 1000 cc	see tables 1b and 2b
Q3014	Telehealth originating site facility fee	see tables 1a, 1b, 2a and 2b

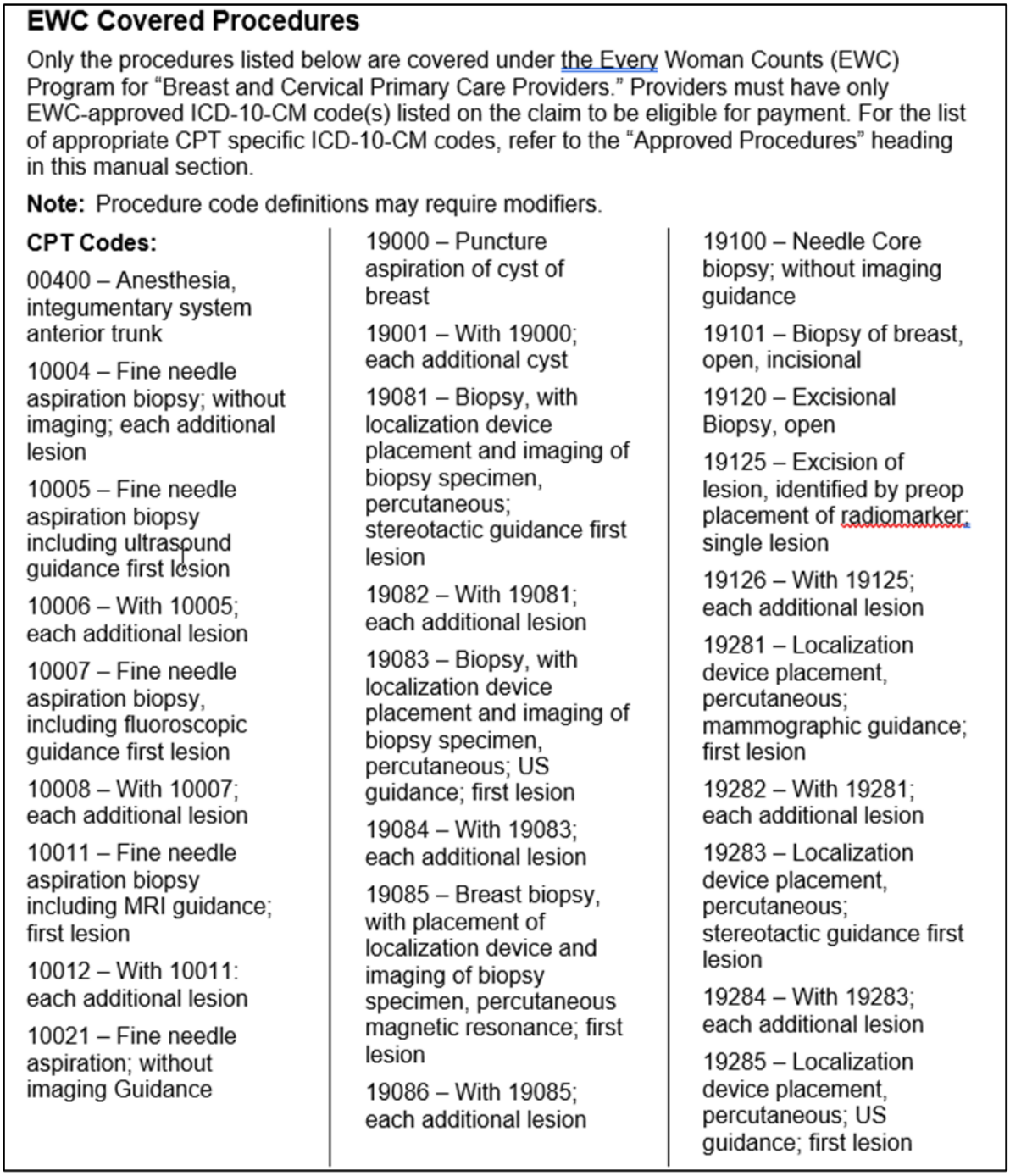
Approved Procedures Key, HCPCS Codes (continued)

HCPCS Code	Description	ICD-10-CM Code
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
T1014	Telehealth transmission, per minute, professional services bill separately	see tables 1a, 1b, 2a and 2b
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
Z7500	Examining or treatment room use	see tables 1a, 1b, 2a and 2b
Z7506	Operating room or cystoscopic room use; first hour	see tables 1b and 2b
Z7508	Operating room or cystoscopic room use; first subsequent half hour	see tables 1b and 2b
Z7510	Operating room or cystoscopic room use; second subsequent half hour	see tables 1b and 2b
Z7512	Recovery room use	see tables 1b and 2b
Z7514	Room and board, general nursing care for stays of less than 24 hours, including ordinary medication	see tables 1b and 2b
Z7610	Miscellaneous drugs and medical supplies	see tables 1a, 1b, 2a and 2b

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

Figure 3.1: EWC Covered Procedures (1 of 3).

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

Figure 3.2: EWC Covered Procedures (2 of 3).

EWC Covered Procedures (continued)

CPT code (continued)

99202 – OV; new pt. 20 min

99203 – OV; new pt. 30 min

99204 – OV; new pt. 45 min

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.

G2012 – Brief tech comm; 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

Figure 3.3: EWC Covered Procedures (3 of 3).

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 Data Requirements

In accordance with the PCPEA and to be eligible for case management payment, PCPs are responsible for reporting screening and outcome data within 30 days of receiving final results of all required information for all recipients served. The PCP must submit complete cancer screening cycle data, including work-up status, referral, final diagnosis and treatment status. Providers who do not submit data are at risk for disenrollment.

The PCP **must** submit the following **breast cancer screening cycle** data via DETEC:

- Risk for breast cancer
- Current breast symptoms
- Clinical breast exam results
- Magnetic Resonance Imaging (MRI) screening result (if at high risk for breast cancer)
- Reason for current mammogram
- Current mammogram results
- Additional breast imaging results
- Other breast diagnostic procedures performed, results must be included
- Work-up status
- Final diagnosis
- Treatment information

The PCP must submit the following **cervical cancer screening cycle** data via DETEC:

- Risk for cervical cancer
- Previous Pap test history
- Reason for current Pap test
- Current Pap test results
- Reason for current HPV test
- Current HPV test results
- Other cervical procedures performed, results must be included
- Work-up status
- Final diagnosis
- Treatment information

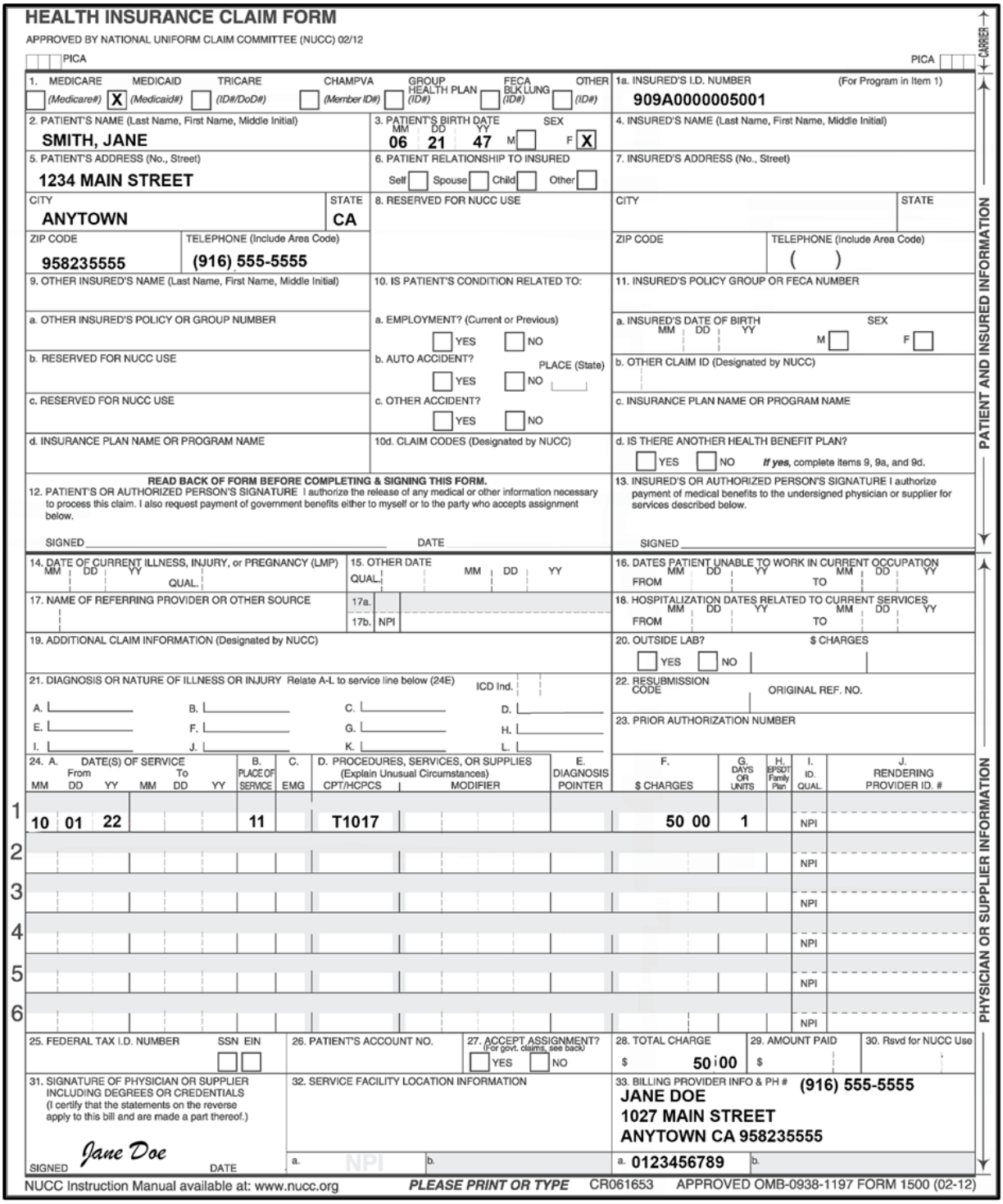
Case Management Billing and Payment

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.

Claim Management Billing Examples

Please adapt to your billing situation.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 909A0000005001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JANE

3. PATIENT'S BIRTH DATE: 06 21 47 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 22		11		T1017			50 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 50 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Jane Doe DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE DOE
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

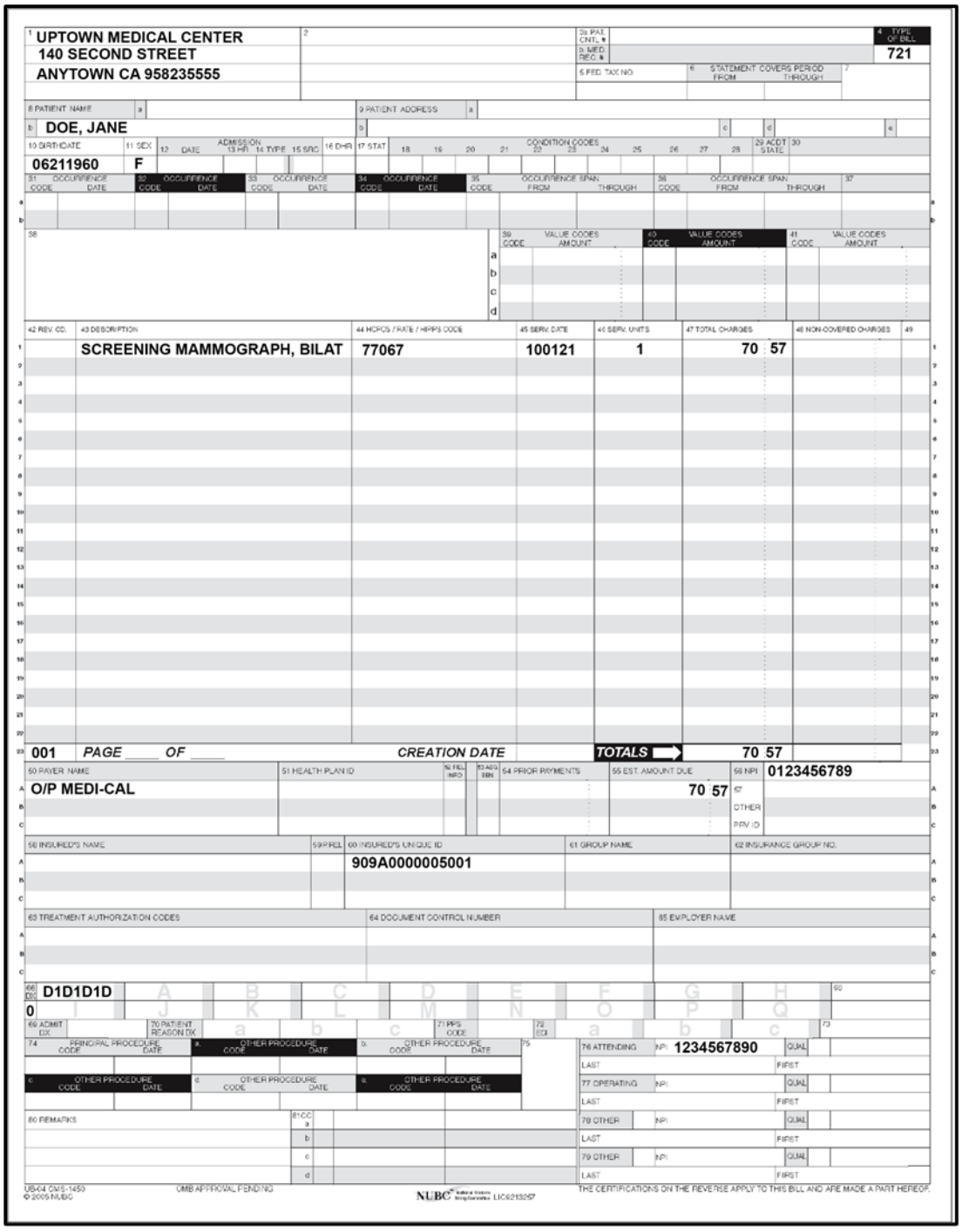
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 4.1: Breast and Cervical Cancer Screening Billed with Annual Case Management – *CMS-1500.*

Hospital Clinic Billing Routine - Mammogram Example

Please adapt to your billing situation.



1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555					4 TYPE OF BILL 721	
8 PATIENT NAME DOE, JANE		9 PATIENT ADDRESS				
10 BIRTHDATE 06211960	11 SEX F	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE	30					
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT				

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	SCREENING MAMMOGRAPH, BILAT	77067	100121	1	70 57		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	70 57		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
O/P MEDI-CAL					70 57	0123456789	57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
		909A0000005001		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67 A	B	C	D	E	F	G	H	68
D1D1D1D									
0	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

76 ATTENDING NPI 1234567890 QUAL	LAST	FIRST
77 OPERATING NPI QUAL	LAST	FIRST
78 OTHER NPI QUAL	LAST	FIRST
79 OTHER NPI QUAL	LAST	FIRST

80 REMARKS	81 CC a	b	c	d

UB-04 CMS-1450 © 2005 NUBC — OMB APPROVAL PENDING — NUBC LIC#213257 — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Figure 4.2: Hospital Clinic Billing for Routine Mammogram – *UB-04.*

EWC Program Reminders

- Program-covered cancer screening and diagnostic services are free.
- Payment for program-covered services is at Medi-Cal rate.
- 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 PCPs can enroll an individual and obtain the individual’s EWC Recipient ID number (14-digit identification number).
- Claims must be submitted with the individual’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 individual can be recertified/re-enrolled.
- All providers must verify current eligibility before rendering services.
- All services and findings must be reported to the PCP.

Where to Submit Claims

Claims can be submitted either by 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 as appropriate, but processing will be delayed. To order free pre-addressed envelopes for claim submission free of charge, contact the Telephone Service Center (TSC) at 1-800-541-5555.

Billing EWC Claims Electronically

Electronic billing is done per Medi-Cal electronic billing instructions.

Submitters can access the website by selecting **"Transaction Center"** or **"Login"** link from the Medi-Cal home page. For more information regarding CMC, you may contact the Telephone Service Center (TSC) at 1-800-541-5555.

Knowledge Review

1. Claims must be submitted with the individual's EWC Recipient ID number (14-digit identification number) after the online *Recipient Information* form is completed and submitted.

   True ☐ False ☐

2. EWC benefits and policies apply to individuals of any gender identity if the procedure is medically necessary.

   True ☐ False ☐

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

   True ☐ False ☐

4. Claims can be submitted either via hard copy or Computer Media Claims (CMC).

   True ☐ False ☐

5. EWC recipient ID numbers will always have the alpha character "A" in the 4th place of the ID number.

   True ☐ False ☐

6. To qualify to bill for the case management fee HCPCS code T1017, the PCP provider is required to have submitted all clinical information using the online DETEC forms.

   True ☐ False ☐

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

   True ☐ False ☐

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

   True ☐ False ☐

9. Referral providers must obtain the recipient's 14-digit identification number from the PCP or the recipient for claims submission.

   True ☐ False ☐

10. All providers must verify current eligibility before rendering services.

    True ☐ False ☐

See the Appendix for the Answer Key.

Resource Information

References

The following reference materials are available in the Medi-Cal provider manual and include program and eligibility information.

Provider Manual References

Part 2

Every Woman Counts (ev woman)

Every Woman Counts Billing Examples – CMS-1500 (ev woman exc)

Every Woman Counts Billing Examples – UB-04 (ev woman exub)

Other References

Every Woman Counts web page

Every Woman Counts Step-by-Step User Guide

Medi-Cal Providers website

EWC Regional Contractors web page

Every Woman Counts DETEC Frequently Asked Questions (FAQs)

Resources

Medi-Cal Providers website (htpps://provider-portal.apps.prd.cammis.medi-cal.ca.gov/)

- Manuals
- Bulletins
- News
- Medi-Cal Subscription Service (MCSS)
- Medi-Cal Learning Portal (MLP)

Telephone Service Center (TSC) (1-916-541-5555)

Provider Field Representatives

Claims Assistance Room (CAR)

Small Provider Billing Assistance and Training (1-916-636-1275)

Appendix

Acronyms

Acronym	Description
BCCTP	Breast and Cervical Cancer Treatment Program
CAR	Claims Assistance Room
CBE	Clinical Breast Exam
CCCCP	California Colon Cancer Control Program
CDC	Centers for Disease Control and Prevention
CDS	Cancer Detection Treatment Branch
CMC	Computer Media Claims
CPPI	Core Program Performance Indicators
CPT	Current Procedural Terminology
DETEC	Detecting Early Cancer
DHCS	Department of Health Care Services
DOB	Date of Birth
EWC	Every Woman Counts
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
FQHC	Federally Qualified Health Centers
HCPCS	Healthcare Common Procedure Coding System
HHS	Health and Human Services
IHS	Indian Health Services
ICD-10-CM	International Classification of Diseases – 10th Revision, Clinical Modification
ID	Identification
IMPACT	IMProving Access, Counseling & Treatment for Californians with Prostate Cancer
MLP	Medi-Cal Learning Portal
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NPI	National Provider Identifier
PCP	Primary Care Provider
PCPEA	Primary Care Provider Enrollment Agreement
PIN	Provider Identification Number
POS	Point of Service
RC	Regional Contractor
RHC	Rural Health Clinic
SOC	Share of Cost

Module A Answer Key

Knowledge Review

1. True
2. True
3. True
4. True
5. True
6. True
7. True
8. True
9. True
10. True

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