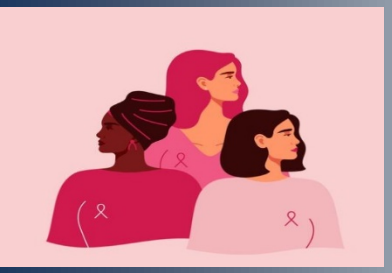
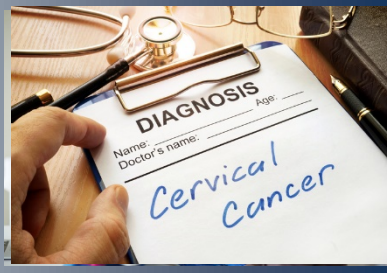


NC Department of Health and Human Services

Breast and Cervical Cancer Medicaid (BCCM)

NC Breast & Cervical Cancer Control Program (NC BCCCP)

September 2020

CNE Credits

- One Nursing Continuing Professional Development (NCPD) Contact Hour and CPH Recertification Credit may be earned upon successful completion.
- For successful completion, participants must attend 100% of educational activity and complete the online course evaluation. There will be no partial credit awarded.
- No conflict of interest exists for anyone in the position to control content for this activity.
- No commercial support has been received for this activity.
- This educational activity is being provided by the Public Health Nursing Institute for Continuing Excellence.
- The Public Health Nursing Institute for Continuing Excellence is approved as a provider of continuing nursing education by the North Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- This training is being recorded.

NC BCCCP Criteria Change!

Women diagnosed outside NC BCCCP

Who meet all other NC BCCCP criteria

May receive patient navigation-only services through local NC BCCCP providers to apply for Breast & Cervical Cancer Medicaid (BCCM)

DSS may grant retroactive coverage up to 90 days prior to application submission to DSS

How will Patient Navigation (PN)-only work?

Newly diagnosed patient
or
Patient's provider

Patient signs BCCCP consent, HIPAA, etc.

PN Needs Assessment/Care Plan completed

BCCM Application (DMA 5079 & DMA 5081)

Report Data to NC BCCCP

Request Reimbursement

How will PN-only work?

Newly diagnosed patient or a patient's provider contacts local NC BCCCP provider:

- Patient consents to services
- Patient provides/ authorizes release of medical records (mini history & pathology results)
- PN Needs Assessment is completed
- BCCM Application Packet (DMA 5079 & DMA 5081) is completed and submitted to local DSS
- Data is reported to NC BCCCP
- Reimbursement is requested for PN-only services

Required Forms – NC BCCCP Consent

(Insert Agency Name Above or Place on Letterhead)

NC Breast and Cervical Cancer Control Program
Consent for Services/Release of Medical Information

The NC Breast and Cervical Cancer Control Program (NC BCCCP) provides screening tests and/or limited diagnostic testing for breast and cervical cancer to eligible women ages 21-64. NC BCCCP may also provide screening and/or limited diagnostic testing **in special circumstances to women who present with symptoms under the age of 40** who meet eligibility criteria and whose diagnostic services are not otherwise covered through another program (for example, Title X Family Planning). In addition, NC BCCCP provides Patient Navigation-Only services for women who are diagnosed with breast or cervical cancer or breast or cervical pre-cancer outside of NC BCCCP. Patient Navigation-Only services are provided to assist with the application for Breast and Cervical Cancer Medicaid (BCCM).

_____ I consent for NC BCCCP Screening/ Diagnostic Services
(Patient initials)

_____ I consent for Patient Navigation-Only Services
(Patient initials)

I understand the screening will include one or more of these tests:

- clinical breast exam.
- pelvic exam with cervical cytology (ages 21-64 every three (3) years; of note, women ages 30 years and above may be screened every three (3) years with cervical cytology alone, every five (5) years with hrHPV testing alone, or every five (5) years with cervical cytology/hrHPV co-testing).
- screening mammogram every 1-2 years after age 50 (or after age 40 if state funds are available).

I understand the program can only provide and pay for tests that are approved by the program. I understand that all results of the screening tests will be explained to me. If any test results are abnormal, I will be referred to another provider for more testing or treatment. All information will be kept private. Only my doctor or nurse and the NC BCCCP staff can see it.

If further tests or surgeries are needed which are not covered by NC BCCCP, I understand I am responsible to work out a payment plan with my medical provider. I am responsible for keeping any appointments made for me. If I choose not to follow the program recommendations, treatment plan, or referrals to other providers, I accept full responsibility for the consequences of my decision.

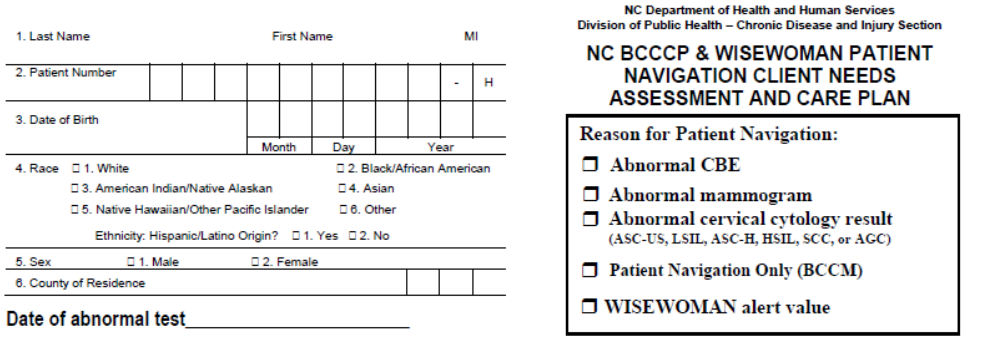
I consent to planning of services to diagnose and treat problems found through NC BCCCP screening.

I authorize _____ (your agency's name) to send NC BCCCP test results to the provider of my choice and to the NC BCCCP. I also authorize my physician or medical facility to release the diagnosis or findings pertaining to any breast and /or cervical cancer screening and /or diagnostic procedures to the _____ (your agency's name). The purpose of sending and receiving this information is to coordinate my care and provide information for statistical purposes.

DATE_____ SIGNATURE_____

WITNESS

Required Forms – PN Needs Assessment



1. Last Name First Name MI

2. Patient Number - H

3. Date of Birth Month Day Year

4. Race ☐ 1. White ☐ 2. Black/African American
☐ 3. American Indian/Native Alaskan ☐ 4. Asian
☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Other

Ethnicity: Hispanic/Latino Origin? ☐ 1. Yes ☐ 2. No

5. Sex ☐ 1. Male ☐ 2. Female

6. County of Residence

NC Department of Health and Human Services
Division of Public Health – Chronic Disease and Injury Section

NC BCCCP & WISEWOMAN PATIENT NAVIGATION CLIENT NEEDS ASSESSMENT AND CARE PLAN

Reason for Patient Navigation:

- ❒ Abnormal CBE
- ❒ Abnormal mammogram
- ❒ Abnormal cervical cytology result (ASC-US, LSIL, ASC-H, HSIL, SCC, or AGC)
- ❒ Patient Navigation Only (BCCM)
- ❒ WISEWOMAN alert value

Date of abnormal test_____

Needs Assessment	
Does patient need additional social support?	❒ Yes ❒ No
Does patient lack access to services needed?	❒ Yes ❒ No
Does patient need help understanding the follow up needed?	❒ Yes ❒ No
Are there other barriers to this patient obtaining the follow up required?	❒ Yes ❒ No If Yes, explain _____

A YES answer in any category requires a plan to assist the patient to overcome barriers to follow-up care. Please list your plan below.

CARE PLAN				
	Problem	Plan	Expectation	Outcome
❒	Needs additional social support			
❒	Lacks access to services			
❒	Needs help understanding of services needed			

Required Forms – DMA-5079

N.C. Department of Health and Human Services
Division of Health Benefits
Breast and Cervical Cancer Medicaid Application

SECTION I. Answer the questions in Section I to determine if application needs to be completed for person needing help with medical bills.

1 Person has been enrolled in the North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) OR has been newly diagnosed outside of NC BCCCP and has received screening and/or diagnostic testing per the guidelines, and needs treatment for breast or cervical cancer including pre-cancerous conditions and early stage cancer.
(Definition of pre-cancerous condition for cervical cancer: High Grade Squamous Intraepithelial Lesion [HSIL]).

☐ *Yes* - Diagnosed in NC BCCCP OR ☐ *Yes*- Diagnosed outside NC BCCCP and meets all other NC BCCCP eligibility criteria

☐ *No* - The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

2. Person has not attained age 65.
   ☐ *Yes* - Continue to question 3.
   ☐ *No* - The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

3. Is this person a U.S. citizen, lawful permanent resident (admitted to the U.S. more than 5 years ago) or a refugee from another country?
   ☐ *Yes* - Make copies of INS documentation and attach with application if person is LPR or refugee. Continue to question 4.
   ☐ *No* - The woman is ineligible for Breast and Cervical Cancer Medicaid. ***STOP!*** **Go no further.**

4. Person has major medical insurance, which is defined as current coverage under a group health plan, including authorized for Medicaid and/or Medicare Part A or B, health insurance coverage (either individual or group), a military-sponsored health care program, a state health risk pool. Check Yes (she has insurance) or No (she does not have insurance.)
   ☐ *Yes* - The woman is ineligible for Breast and Cervical Cancer Medicaid, UNLESS coverage consists solely of limited benefits such as accidents or limited-scope dental, vision, or long-term care insurance. There may also be limited circumstances where a woman has major medical insurance, but she is not actually covered for treatment of breast or cervical cancer. If you have a question about an insurance policy, call the State Medicaid Eligibility Unit at (919) 855-4000.
   - If the woman has limited medical insurance coverage, make a copy of the Insurance Card (front and back). Attach the copy to this application. Continue to question 5.
   - If coverage is not limited, ***STOP!*** **Go no further. This person is ineligible.**

   ☐ *No* - Continue to question 5.

5. **Is this person any of the following: (Check Yes / No)**
   A) Pregnant? ☐ *Yes* ☐ *No*
   B) Blind? ☐ *Yes* ☐ *No*
   C) Disabled (determined by Social Security)? ☐ *Yes* ☐ *No*
   D) Under age 21? ☐ *Yes* ☐ *No*
   E) Former NC Foster Care Child receiving Medicaid at age 18? ☐ *Yes* ☐ *No*
   F) A caretaker relative of a child(ren) in the home under age 18? ☐ *Yes* ☐ *No*

If the answer is "No" to all the questions in 5. A-F, **complete Section II only**, to gather applicant identifying information. Have the applicant and the person completing the form sign and date the application. This application is only for Breast and Cervical Cancer Medicaid Coverage.

If "YES" to any of the questions in 5. A-F, **continue with Section II and Section III** of this application. Person may be eligible for another Medicaid program.

DMA-5079
Revised 07/2020

Required Forms – DMA-5081

VERIFICATION OF SCREENING, DIAGNOSIS, AND TREATMENT

BCCCP Coordinator: By checking (✓) YES you are verifying patient eligibility for BCCM

Yes	
☐	This patient meets eligibility requirements for the NC Breast and Cervical Cancer Control Program (BCCCP). The patient has received screening and/or diagnostic testing per the NC BCCCP guidelines. ☐ Diagnosed in NC BCCCP OR ☐ Diagnosed outside NC BCCCP

Additional certification is required for BCCM coverage to extend beyond the original certification period or beyond 12 months.

Name of Medical Clinic responsible for diagnosis and treatment plan:		**Phone: ( )**
Patient Name:	**DOB: / /**	**SSN: - -**
Patient Address:		**CNDS/MID#:**
Diagnosis:	**Stage: (if known)**	**Diagnosis Date: / /**
Diagnosis Confirmed by: (Pending or unconfirmed diagnoses will result in BCCM denial) ☐ Colposcopy ☐ Biopsy ☐ Other:		
Treatment (describe):		
Treatment to begin (date)_____ **and continue for:** (# of weeks or months of anticipated treatment)		

Physician Signature _____ **Date** _____

Patient County of Residence:	**BCCCP Provider:**
BCCCP Coordinator:	**Phone:**
DSS Representative:	**Date:**
DSS Phone:	**DSS FAX:**

Determination	Date of Determination	Nurse Consultant Signature
☐ Approved for____months		
☐ Denied - Reason:		

THIS IS A REQUIRED ATTACHMENT TO THE APPLICATION FOR BREAST & CERVICAL CANCER MEDICAID (BCCM)

DMA-5081 **Revised 7/2020**

Required Reporting - Data

NC BREAST AND CERVICAL CANCER CONTROL PROGRAM (NC BCCCP)
PATIENT NAVIGATION-ONLY FORM

Patient ID: _____ NC BCCCP Provider Code: _____

First Contact Date: (MM DD YYYY) ____/____/____ | Type of Contact: ☐ Face-to-Face ☐ Telephone ☐ Email ☐ Voicemail ☐ Text ☐ Other

Client Demographics

Name:

Date of Birth: / / | Phone Number: ( ) | Alternative Number: ( )

Street Address | Apt. #

City: | Zip: | County of Residence:

Mailing Address: ☐ Same as Home Address

City: | Zip: | Email:

Race (check all that apply): ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown/Prefer not to Answer

Ethnicity: Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Prefer Not to Answer

Barriers Identified (At Least ONE Must Be Checked)

☐ Trouble scheduling appointment ☐ No healthcare provider ☐ Difficulty getting time off work ☐ Insurance issues
☐ Transportation ☐ Family care issues ☐ Needs education on screening and/or diagnostic procedures
☐ Other_____

SECOND Patient Contact

Second Contact Date: (MM DD YYYY) ____/____/____ | Type of Contact: ☐ Face-to-Face ☐ Telephone ☐ Email ☐ Voicemail ☐ Text ☐ Other

Clinical Services Completed **(*All screening results with an asterisk (*) require diagnostic work-up)**

Mammogram Date: ____/____/____
☐ Screening ☐ Diagnostics
Results:
☐ Negative (BI-RADS 1)
☐ Benign Findings (BI-RADS 2)
☐ Probably Benign; short term follow suggested (BI-RADS 3)
☐ * Suspicious Abnormality, consider biopsy (BI-RADS 4)
☐ * Highly Suggestive of Malignancy (BI-RADS 5)
☐ * Assessment Incomplete; additional imaging req'd (BI-RADS 0)

HPV Test Date: ____/____/____
HPV Results: ☐ Positive ☐ Negative ☐ Positive w/Type 16 or 18 ☐ Positive w/ Negative genotyping ☐ Unknown

Cervical Cytology Test Date: ____/____/____
Cervical Cytology Results:
☐ Negative for Intraepithelial Lesion or Malignancy
☐ * Squamous Cell Carcinoma
☐ Infection/Inflammation/Reactive Changes
☐ * Atypical Glandular Cells
☐ Atypical Squamous Cells of Undetermined Significance (ASC-US)
☐ *Adenocarcinoma in Situ (AIS)
☐ Low Grade SIL (including HPV changes)
☐ Adenocarcinoma
☐ * Atypical Squamous Cells Cannot Exclude HSIL (ASC-H)
☐ * High Grade SIL ☐ Unsatisfactory - Need Re-Pap

Diagnostic Services Completed:

☐ Yes - Breast (Dx Results Date): ____/____/____
☐ Yes - Cervical (Dx Results Date): ____/____/____
☐ No Work-Up Needed
☐ Lost to Follow-Up
☐ Patient Refused

Final Diagnosis:

Breast Cancer Diagnosis:
☐ No Cancer
☐ Invasive ☐ DCIS ☐ LCIS
Diagnosis Date: ____/____/____
Treatment Date: ____/____/____

Cervical Cancer Diagnosis:
☐ No Cancer
☐ Invasive ☐ CIN 3/ CIS
☐ CIN 2 ☐ CIN 1
Diagnosis Date: ____/____/____
Treatment Date: ____/____/____

Patient Navigation Completed? ☐ Yes ☐ No | **Date Completed:** / / | **Provider:**

Patient Navigation-Only Form 09/2020 NC Department of Health and Human Services

Required Reporting – Reimbursement Requests

N.C. Department of Health and Human Services
Division of Public Health
Chronic Disease & Injury/Cancer Prevention: NC BCCCP

Local Health Department Monthly Expenditure Report

Mo/Yr of expenditure

LHD Legal Name

$0.00

NC BCCCP Navigator — Total Expenditure

Screening, diagnostic and follow-up services for breast and cervical cancer on the behalf of BCCCP eligible women.
Purpose

Item Description	Number of Women Served	Rate	
Client Services			
Breast and Cervical Services-Federal		$325.00	$0.00
Breast and Cervical Services-State		$325.00	$0.00
Patient Navigation-Only Services to Apply for BCCM-Federal		$25.00	$0.00
Subtotal			$0.00
	NC BCCCP Federal $ **NC BCCCP State $**		

I hereby certify that the funds requested on the above expenditure report were to the best of my knowledge for women served according to the provisions in the current fiscal year Agreement Addendum. It is also my understanding that this form be completed and faxed before funding is requested from Aid to County, and that required data to support this service and expense will be entered in HIS or compatible data system.

Printed Name & Title of NC BCCCP Navigator — Signature — Date

Required Reporting – Reimbursement Requests

N.C. Department of Health and Human Services
Division of Public Health
Chronic Disease & Injury/Cancer Prevention: BCCCP
Section/Branch

Contract Expenditure Report

06/20	40450
mo/yr of expenditure	Contract ID #:
XYZ Medical Center	
Contractor	NCAS #:
Contract Administrator	**$0.00**
Project Director	Total Expenditure

Screening, diagnostic, and follow up services for breast and cervical cancer on the behalf of BCCCP eligible women
Purpose

Contractor match is REQUIRED by this contract:		X
(Place an "X" in the appropriate box.)	YES	NO

Item Description	Number of Screenings	Contractor Amount	DHHS Amount
Client Services		Do not use this column.	
Breast and Cervical Services-Federal			$0.00
Breast and Cervical Services-State			$0.00
Patient Navigation-Only Services for BCCM Application			

Finance Questions/Concerns?

Tavonyia Thompson, MSAcc
Operations Manager

Tavonyia.Thompson@dhhs.nc.gov

(919) 707-5326

Data Questions/Concerns?

Sarah Duleh, MPH
Data Manager

Sarah.Duleh@dhhs.nc.gov

(919) 707-5327

Additional Questions/Concerns?

Cindy Herndon, PHD, CNE, WHNP, RN
cindy.herndon@dhhs.nc.gov
(919) 218-7660

Angie Moody, BSN, RN
angie.moody@dhhs.nc.gov
(919) 218-4270

Sherry Wright, RN
sherry.wright@dhhs.nc.gov
(919) 218-0183

Earn Professional Development Hours

You may earn continuing education hours for your professional discipline by completing the evaluation for this activity. Your thoughtful responses provide important information that allows the PHNICE to continue its mission of providing quality professional development opportunities at free or reduced cost.

You must **complete the activity evaluation no later than May 31, 2021** to receive your professional development certificate. Everyone should save/print a professional development certificate for their records.

Please Note: This will be your only option to receive evidence of the professional development contact hours and/or CPH Recertification Credits. You will need to save this certificate.

To complete the evaluation, go to

https://www.surveymonkey.com/r/0133A