Cancer Services Program Operations Manual

07/13

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Chapter 1 - Program Overview

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Chapter 1: CSP Program Overview

The Cancer Services Program (CSP) oversees the delivery of comprehensive breast, cervical and colorectal cancer screening and diagnostic services to eligible uninsured and underinsured individuals in New York State through local cancer screening program contractors. Each individual cancer screening program contractor develops relationships with regional providers (e.g., hospitals, clinics, health care providers) and community-based organizations to collaboratively conduct outreach to priority populations, provide screening, diagnostic and case management services, quality assurance, public education, and data management, as well as other activities outlined in this manual. The contractor and its partners also assist individuals diagnosed with breast, cervical, colorectal or prostate cancer in obtaining prompt, comprehensive treatment through the New York State Medicaid Cancer Treatment Program (MCTP), if eligible. Eligible individuals may receive full Medicaid coverage for the duration of their cancer treatment. NYSDOH does not support routine population-based screening for prostate cancer. However, men screened and/or diagnosed with prostate cancer through participating providers are eligible for treatment coverage through the MCTP.

A. NYSDOH CSP Definitions

CSP Contractor ('contractor')

A contractor is the legal entity with which NYSDOH enters into a contract to coordinate, implement and manage a local CSP across its entire service area. NYSDOH funds contractors across the state to promote evidenced-based cancer screening at the population level and provide appropriate screening services to eligible populations. NYSDOH CSP contractors hold responsibility for all contract activities outlined in Chapter 2 ("Required Activities and Standards"), including those performed by subcontractors. Contractors ensure all required activities and contractual obligations are met in a timely manner and are the primary contact for the NYSDOH. CSP contractors receive a combination of funding from the federal Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and NYS to reimburse health care providers for eligible clinical services. CSP contractors provide services in every county of NYS.

CSP Partners ('partners')

Contractors are expected to accomplish required activities through development of relationships with community organizations and health care providers located throughout the service area. Partners work with the CSP contractor to implement the required contract activities and to provide and promote utilization of cancer screening services at the population level and among eligible populations. Community partners can identify barriers to services for their local population and design effective strategies to overcome these barriers. Community partners are more likely to support interventions they themselves have helped develop.

Partners can help CSP contractors reach their goals by:

- expanding and maximizing resources
- coordinating program activities
- identifying approaches and resources to overcome obstacles to the provision of cancer screening and diagnostic follow-up for the CSP priority populations
- using their relationships to identify, educate and move community members to cancer screening services
- promoting the delivery of breast, cervical and colorectal cancer screening

Partners include:

- community organizations (such as service clubs, senior services programs, libraries, faith-based organizations, community centers, chambers of commerce)
- health care providers in a variety of settings (hospitals, community health centers, local health departments, federally qualified health centers, clinics, family planning providers, primary care providers, specialists)
- local businesses (media representatives, beauty salons and barbershops)
- health-related organizations (American Cancer Society, Avon Foundation, Susan G. Komen for the Cure)
- Public service representatives (elected officials, local health departments)

Partners assist with implementation of required activities as appropriate to the mission and role of their organizations. Partners may provide a valuable source of services, promote the screening programs, and add in-kind resources.

CSP Providers ('providers')

CSP providers are defined as health care providers who have been credentialed and approved by the NYSDOH CSP to provide screening and diagnostic services to CSP clients. CSP contractors are responsible for recruiting providers that adequately address the local CSP's needs for breast, cervical and colorectal cancer screening, diagnostic services, and treatment and referral. To facilitate referral to the MCTP for prostate cancer, contractors should also recruit health care providers and facilities that may screen and/or diagnose men.

Please see CSP Operations Manual, Chapter 2: Required Activities and Standards for additional information about provider credentialing and requirements of CSP providers.

CSP Clients ('clients')

CSP clients are defined as eligible men and women who receive at least one CSP-reimbursed breast, cervical or colorectal cancer screening or diagnostic service.

In general, the eligible populations screened through the local CSP, and for whose clinical services the NYSDOH CSP reimburses, include women ages 40 and over and men ages 50 and over who are uninsured or underinsured. As defined by NYS Public Health Law 2405.1, these are persons who are age-appropriate for breast, cervical and/or colorectal cancer screening and who have inadequate access and/or financial resources to obtain cancer screening and detection services. This includes persons who lack health insurance, persons whose health insurance coverage is inadequate, or those who cannot meet their deductible obligations for purposes of accessing coverage under their health insurance.

Please see CSP Operations Manual, Chapter 3: Eligibility for guidance to determine CSP client eligibility.

CSP Priority Population ('priority population')

"CSP priority population" refers to sub-groups of the eligible population who are disproportionately affected by breast, cervical or colorectal cancers and who, as a result, are of special concern to the NYSDOH CSP. These populations are the focus of outreach, recruitment and screening efforts. Priority populations include:

- uninsured and underinsured persons ages 50-64
- women ages 40 and over who are rarely or never screened for cervical cancer – defined as those who have never had Pap tests or have not had Pap tests within the past five years
- the medically unserved or underserved including, but not limited to, individuals who experience barriers to services due to race, ethnicity, disability, sexual orientation, gender identity, socio-economic status; cultural isolation and/or geographic location

CSP Contractor Staff

Personnel who perform one or more of the key staffing functions under the NYSDOH CSP contract are referred to as CSP contractor staff. CSP contractors are required to hire, train and retain staff to perform or subcontract for provision of the key staffing functions of program coordination, public education and targeted outreach, case management, intake/eligibility, data management and fiscal management. Contractors may subcontract components of the scope of work (e.g., Public Education and Targeted Outreach), but it is required that the contractor at least 51% of the infrastructure contract within the grantee organization. The lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH.

Please see CSP Operations Manual, Chapter 2: Required Activities and Standards for additional information about key staff and functions.

NYSDOH CSP Staff

The NYSDOH CSP staff provides oversight and guidance to CSP contractors through programmatic, administrative, clinical and fiscal monitoring and technical assistance, public and provider education regarding cancer prevention and early detection, and assistance implementing effective outreach to the eligible priority populations. Additionally, NYSDOH CSP staff work with CSP contractor staff to ensure that individuals with abnormal screening results receive follow-up and case management as needed and that quality clinical services are provided by the local CSPs through credentialing activities and a quality assurance program. The NYSDOH Cancer Screening Research and Evaluation Unit (a.k.a. Data Unit) provides data management support and monitors and assesses program data for NYSDOH CSP staff and CSP contractors.

NYSDOH CSP Regional Managers work with the CSP contractors to provide oversight, monitoring and technical assistance regarding all aspects of contract implementation and management. CSP Regional Managers are the first point of contact for all contract questions including billing, vouchers, eligibility, reimbursement, work plans, budgets, reporting requirements and implementation of all required activities. NYSDOH CSP staff is substantially involved in the program activities, above and beyond routine grant monitoring.

NYSDOH Cancer Services Program staff activities include but are not limited to:

- establishing program policies and guidelines
- collaboration with national and statewide partners and organizations to promote and provide comprehensive, guideline-concordant, breast, cervical, and colorectal cancer screening services among age-appropriate populations in the state
- facilitating the exchange of information and coordination, collaboration, and service integration between contractors and chronic disease counterparts
- provision of ongoing guidance, consultation and technical assistance to support planning, implementation, monitoring, and evaluation of the activities listed within the Scope of Work
- monitoring contractor progress in implementation of the program and working with contractors through email, conference calls, and site visits, and review of progress reports and other data reports to support program progress and program improvement
- convening trainings, capacity building exercises, meetings, web forums, conference calls, and site visits with contractors

- providing relevant research findings, scientific research, public health recommendations, and up-to-date clinical guidelines related to the program Scope of Work
- design, implementation, and evaluation of screening promotion and screening provision activities
- provision of strategies to work effectively with health care systems and other organizations to improve the implementation of activities
- use of clinical data submissions to develop regular data monitoring feedback reports that support data use for quality assurance, program improvement, and program monitoring and evaluation
- evaluation, monitoring, and reporting on progress toward meeting performance standards, using interim progress reports, end of year reports, MDE reports, and others

Cancer Survivorship

Due to early detection and improved treatments, it is estimated that nearly 800,000 New Yorkers have survived cancer. A cancer survivor is defined as an individual living with cancer, from the time of diagnosis through the remaining years of life. Numerous organizations offer services for cancer survivors, their caregivers and their families that address a wide range of issues, including medical, emotional, psychosocial, financial and legal needs. These supportive services are offered in a variety of formats across NYS. To learn more, please refer to CSP Operations Manual, Chapter 10: Staff List for contact information for the NYSDOH Coordinator of Survivorship Initiatives.

B. The NYS Medicaid Cancer Treatment Program (MCTP)

In addition to screening services, the local CSP secures provision of diagnostic and case management services, and assists eligible men and women diagnosed with cancer in obtaining Medicaid coverage through the NYS MCTP. Since 2002, the MCTP has provided full Medicaid coverage for the entire period of cancer treatment, for eligible men and women diagnosed with breast cancer and for women diagnosed with cervical cancer, or a pre-cancerous breast or cervical condition. The Federal government and NYS administer funding for the MCTP for women diagnosed with breast or cervical cancer. In 2006, the NYS legislation that created this program was expanded to cover treatment for colorectal and prostate cancers or a pre-cancerous colorectal or prostate condition. Coverage for colorectal cancer began April 1, 2007 and coverage for prostate cancer began October 1, 2007. The NYSDOH CSP does not provide reimbursement for prostate cancer screening or diagnostic services, nor does the NYSDOH CSP support routine population-based prostate cancer screening. However, the local CSP can enroll eligible men, who are screened and/or diagnosed with prostate cancer by a current CSP credentialed provider and who are in need of prostate cancer treatment, in the MCTP. Please see CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program for information about the implementation of the MCTP.

C. Public Health Insurance Programs

The NYSDOH places a high priority on identifying individuals who may be eligible for health insurance through the Health Benefit Exchange so they can have access to a primary care physician and payment source for all of their health care needs. Many CSP clients may be eligible for additional healthcare benefits if they are referred to and enrolled in public and commercial insurance programs. Local CSPs play an essential role in identifying these individuals, providing current information about the health benefit exchange and directing them to navigators and certified application counselors in their areas for possible enrollment.

NYSDOH provides local CSPs with contact information for navigators and certified application counselors. Likewise, uninsured individuals who are not eligible for public and commercial health insurance programs will be directed to local CSPs by navigators and certified application counselors for needed cancer screening services.

D. NYS Tobacco Control Integration

The NYSDOH Tobacco Control Program (TCP) implements evidence-based and promising strategies to prevent and reduce tobacco use. The TCP has worked to effectively increase access to cessation services and motivate smokers to try to quit through the implementation of a multi-pronged cessation approach in NYS.

Effective April 1, 2010, as required by the CDC, the NYSDOH requires local CSPs to implement activities to ensure all CSP clients, at time of intake, are assessed for smoking status, and if applicable, referred to the NYS Smokers' Quitline, 1-866-NY-QUITS (1-866-697-8487). It is recommended that all CSP clients, regardless of smoking status, be sent NYS Quitcards.

NYSDOH provides local CSPs with the contact list for the TCP statewide Cessation Centers, who will work with CSP providers and health-care organizations to implement systems to screen patients for tobacco use and prompt providers to offer advice and assistance to quit.

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Chapter 2 - Required Activities & Standards

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Chapter 2: Required Activities and Standards

A. Scope of Work - Required Activities

The NYSDOH CSP contracts with organizations to coordinate, implement and manage breast, cervical and colorectal cancer screening and diagnostic services to eligible persons, in communities across the state.

Contractors must hire staff and/or enter into subcontract(s), per guidelines, to implement all required activities. The contractor is the primary point of contact with the NYSDOH CSP and is responsible for ensuring implementation of all required activities and program guidelines. Activities specific to the local implementation of the required activities are developed annually through the work plan process. Work plans are routinely reviewed and revised in collaboration with contractor staff and the CSP Regional Manager (see Section H, "Reporting Requirements and Contract Monitoring" of this chapter for more information). Contractors are required to execute and manage the activities listed below under the guidance of the NYSDOH CSP.

1. Program Management and Leadership

The contractor will have overall responsibility for all contract activities and will be the primary contact for the NYSDOH. The contractor will coordinate and administer the program to ensure the implementation of all required activities and timely completion of contractual obligations. The contractor will also ensure that any barriers to implementation of the required activities are promptly addressed to reduce potential adverse effects on program performance. In addition, the contractor will:

- serve as the point of contact with community members, providers, partners and other organizations in the service region
- manage the day-to-day operations of the local screening program
- monitor, review and revise activities according to monthly performance measure reports, budget monitoring tools and other performance indicators
- submit, in a timely manner, complete and accurate annual work plans, budgets, semi-annual reports and other deliverables, as required by the NYSDOH
- ensure a qualified staffing structure, addressing all functions as described in the Required Staff and Key Functions section below. Establish systems to recruit, hire and train staff in a timely manner
- ensure sufficient Designated Qualified Entities (DQEs) in the service area to meet the needs of the client population. DQEs are individuals authorized to complete applications for enrollment in the MCTP
- submit, within one week of start or termination, contact information for key staff as requested by NYSDOH to ensure that the CSP database, public

website and toll-free recruitment phone line database are accurate and up-to-date. NYSDOH maintains this information to facilitate communication with and between contractors, as well as to provide contact information for statewide promotion of the program as conducted by NYSDOH

- ensure that all staff participate in NYSDOH and NYSDOH-sponsored trainings and contractor meetings as directed
- implement reciprocal referral systems whereby clients are directed from CSP contractors to Health Benefit Exchange navigators or certified application counselors for possible enrollment in public and commercial insurance programs; and (for clients not eligible for public or commercial insurance programs) referral from navigators or certified application counselors to the CSP participating providers for needed cancer screening or diagnostic services
- collect and submit, via a performance management tracking system, information and data regarding program implementation and short- and long-term outcomes as required by the NYSDOH. When available, the performance management tracking system will be provided by the NYSDOH
- under the direction of the NYSDOH, participate in and/or coordinate planning and implementation of local sustainability activities aimed at increasing public support for the local screening program. This includes, but is not limited to: media/promotional activities (letters to the editor, newspaper articles, etc.) and educational visits to information community members and decisions makers about the impact of cancer, the unmet need for cancer screening and how the local program addresses the problem in the community
- under the direction of the NYSDOH, oversee the implementation of policy, systems and environmental change strategies to promote cancer screening among age-appropriate populations across the state
- under the direction of the NYSDOH, oversee and coordinate close-out activities at the end of the contract period to ensure smooth transition of clients and continuity of their care, as well as complete final data management and provider reimbursement

2. Partnering, Coordination and Collaboration

The contractor will build and maintain collaborative relationships with health, human service, education and other community organizations to provide and promote utilization of cancer screening services at the population level and among the eligible populations throughout the proposed service region. The contractor will:

- collaborate with and actively engage organizations and individuals, throughout the service region, with the knowledge, skills and resources to reach the eligible and priority populations to assist in implementing all required activities. Such organizations should include key strategic partners (e.g., American Cancer Society, Susan G. Komen for the Cure, local health departments, NYS

Cancer Consortium members, health care systems and providers) and may include public and private businesses, service and social groups, faith-based organizations, non-profit organizations, medical institutions, medical care providers, government agencies, media, Federally Qualified Health Centers, worksites, groups serving individuals with cancer and their families, cancer survivor organizations and others

- develop and implement a plan to regularly communicate with partners and providers about program services and operations. Such communication may be in writing, via phone, webinar and in-person meetings
- engage partners to assess needs, conduct education, and develop, implement and evaluate comprehensive plans for outreach and in-reach recruitment activities to build demand for and provide screening services for eligible priority populations throughout the service region
- ensure that relationships are developed between providers and community organizations to establish referrals for client services not reimbursed through the CSP (e.g., child care, transportation, medical equipment)
- over the course of the grant period and under the guidance of the NYSDOH:
  - collaborate with and actively engage partners to increase awareness of effective policy, systems and environmental (PSE) change intervention approaches, such as those outlined in the Centers for Disease Control and Prevention's Guide to Community Preventive Services (http://www.thecommunityguide.org/index.html),that support cancer screening promotion and provision activities
  - facilitate planning processes to identify, develop and plan PSE interventions which build demand for cancer screening, especially among priority populations, throughout the service region; and,
  - ensure active contractor, partner and provider support for the NYS Comprehensive Cancer Control Plan goals and activities; collaborate with other organizations on common goals regarding cancer prevention and detection. The NYS Cancer Control Plan can be accessed by visiting http://www.nyscancerconsortium.org/

3. Public Education, Targeted Outreach and In-reach

The contractor will engage partners to implement evidence-based or evidence-informed strategies to promote the program, build public demand for cancer screening services, and identify eligible clients in priority populations, throughout the service region. In addition, the contractor will ensure and coordinate implementation of client oriented screening interventions and strategies as outlined in the Centers for Disease Control and Prevention Guide to Community Preventive Services (http://www.thecommunityguide.org/index.html) and the National Cancer Institute's Cancer Control PLANET (http://cancercontrolplanet.cancer.gov/). The contractor will also:

- use data to identify and locate eligible priority populations throughout the service region to target and prioritize public education, outreach and in-reach efforts. It is expected that at least 75% of clients screened through the program will be aged 50 through 64
- ensure implementation of effective strategies for educating members of priority populations about the importance of early detection and screening for breast, cervical and colorectal cancer
- ensure the delivery of clear and consistent messages about breast, cervical and colorectal cancer screening to increase the public demand for cancer screening and promote the availability of the local screening program. Such messages should be written at appropriate reading levels for those with low health literacy skills, with guidance, review and approval from NYSDOH and should include use of traditional and digital media, letters to the editor, etc.
- collaborate with patient navigators, community health workers or other partners to provide one-on-one education to increase knowledge or influence attitudes and beliefs regarding the need for cancer screening
- ensure collaboration with community partners to offer and/or provide group education sessions to community groups and organizations to provide education regarding the need for screening, intention to be screened, risk/benefits of screening and appropriate screening intervals
- ensure strong relationships are built and developed with local media organizations
- coordinate partner participation in promotion and outreach activities (e.g., Main Streets Go Blue, cancer awareness month activities, other community events) as provided and directed by NYSDOH
- coordinate education of local decision makers, community leaders and members of the public. Provide data, facts and client/personal stories for use by partners in these activities
- work with partners to enlist businesses and employers throughout the service region to promote cancer screening
- recruit community programs working with cancer survivors to encourage survivors to be screened
- ensure collaboration with existing chronic disease programs in the service region to conduct joint outreach and recruitment, and to promote clinical preventive services
- ensure implementation of cancer screening and/or mobile mammography (where available) events to increase access to cancer screening, diagnosis and treatment services
- ensure the implementation of in-reach strategies within and among participating health care systems and providers to identify individuals in need of screening for breast, cervical and/or colorectal cancer for potential

enrollment in the program. Examples of in-reach strategies that may be used are listed in #7 below

4. Provision of Health Services: Screening, Diagnostic and Case Management Activities

The contractor will develop a network of medical care providers throughout the service region to provide eligible men and women comprehensive, guideline-concordant breast, cervical and colorectal cancer screening and diagnostic services, and, when necessary, ensure access to treatment services. The contractor will:

- recruit and maintain a comprehensive provider network able to provide high-quality, evidence-based breast, cervical and colorectal cancer screening services to the eligible population throughout the service region
- ensure that written provider agreements are obtained from all network providers within two months of initiation of contract and by April 1 of each grant year thereafter (see Attachment 2 VI and 2 VII). As part of this process, secure assurance and commitment from clinical providers to accept the rates in the Maximum Allowable Reimbursement Schedule (MARS) (See Chapter 6) as payment in full for services rendered
- on an ongoing basis, ensure that there are sufficient numbers and types of providers in the network to meet the needs of the eligible population for comprehensive and timely cancer screening and diagnostic services
- ensure network providers are licensed and appropriately qualified and credentialed, without license restrictions related to providing cancer screening services, as directed by the NYSDOH
- establish and monitor systems for:
    - conducting intake activities and program eligibility assessment for new clients for guideline-concordant breast, cervical and colorectal cancer screening. This may be accomplished through a centralized, decentralized, or combined centralized and decentralized intake model. In a centralized intake model, lead organization staff identify potential clients and act as the first point of contact, assess eligibility, conduct client intake, complete intake forms, schedule appointments and conduct other related administrative tasks. In a decentralized intake model, client identification, eligibility assessment, intake, form completion, scheduling and other administrative tasks take place at many different sites including the lead organization, individual providers, partner organizations, etc. Intake systems will include provisions for ensuring client information and signed consent forms, as required by NYSDOH, are obtained prior to the provision of services. Eligibility assessment systems will include documentation that eligibility criteria have been reviewed for each client. It is expected that at

least 75% of clients screened through the program will be aged 50 through 64

  - recalling existing clients for rescreening at appropriate intervals

- ensure a method for purchase and distribution of fecal test kits for colorectal cancer (either fecal occult blood test [FOBT] or fecal immunochemical test [FIT]) and other program materials; Ensure proper medical oversight for provision of fecal test kits for colorectal cancer. Including the establishment of standing medical orders for fecal test kit distribution, development and follow-up (if applicable). Clients should elect to use one of the available multi-sample fecal tests, i.e., either FOBT or FIT. In instances where the use of the selected test poses a barrier to the participation of a provider or individual patient, consideration will be made for use of the alternative multi-sample test
- report the results of screening and diagnostic testing to the NYSDOH in a timely manner, as outlined in the Program Performance Measures section
- refer clients in need of treatment for breast, cervical or colorectal cancer for enrollment in the Medicaid Cancer Treatment Program (MCTP). Refer men meeting program eligibility criteria and screened and/or diagnosed with prostate cancer by network providers for enrollment in the MCTP. It is expected that 100% of MCTP eligible clients will be enrolled in the MCTP. Note: The NYSDOH does not currently support routine population-based screening for prostate cancer and does not, therefore, reimburse for prostate cancer screening
- ensure men and women with abnormal screening results are assessed for their need for case management services and ensuring such services are provided to those in need. Case management involves working with partners and community resources to assist clients in overcoming barriers to timely diagnostic and treatment services

  Case management may be accomplished through a centralized process (contract organization hiring dedicated case management staff), a decentralized process (contract organization working with staff of network providers) or a combination of both. Case management activities include:

  - ensure men and women in need of follow-up receive comprehensive, coordinated care in a timely manner, as indicated in the Program Performance Measures and based on their individual needs
  - ensure individual written care plans, including periodic reassessment and follow-up of the client's needs throughout the duration of care, are developed, implemented and evaluated for client satisfaction
  - Developing relationships with community organizations that provide resources to address barriers individuals may encounter during diagnosis, evaluation and treatment

- ensure network providers are committed to treat men and women diagnosed with breast, cervical or colorectal cancer, or precancerous cervical lesions, who do not qualify through the MCTP, regardless of the client's ability to pay
- ensure only eligible clients receive program services. Clearly communicate program eligibility guidelines to all providers in the network
- participate in all quality assurance, data collection and reporting requirements set by NYSDOH. Cooperate fully with the NYSDOH quality assurance team to identify providers with potential quality concerns, explore reasons for unusual data patterns, and remediate providers' clinical and/or data reporting deficiencies in a timely manner
- promptly communicate program changes (e.g., eligibility, guidance, practices and policies), professional development opportunities and other issues related to program services and requirements to clinical providers, laboratories, imaging facilities and partners, as directed by NYSDOH
- ensure providers submit all required forms, data and records in a timely manner
- ensure qualified personnel are available to provide clinical oversight for the interpretation of reports and medical records, conduct risk assessment to determine client eligibility, and ensure adherence to guideline-concordant care

5. Data Management

Data management is integral to the monitoring and evaluation of the program. The contractor will oversee the collection of all data required by the NYSDOH. The contractor will:

- ensure all NYSDOH-required data and associated documentation (e.g., client demographics, screening and diagnostic services information, treatment information) for clients screened by participating providers and for whom reimbursement is requested, are collected in a timely manner, using NYSDOH forms and the on-line, secure data system*
- ensure the timely submission of all required client data via the NYSDOH on-line secure data system*, consistent with the NYSDOH 90 day reimbursement policy (as described in Section F of this chapter)
- ensure sufficient staff is trained to enter and manage clinical data on the data system. Participation in NYSDOH sponsored data trainings are required for all new staff and required for experienced staff as necessary or as directed by NYSDOH
- conduct training and follow-up with participating providers, as needed, to ensure the timely and appropriate submission of all required forms and data
- promptly obtain missing or corrected information from providers and forward the information to NYSDOH

**Note: The NYSDOH maintains a secure on-line, real-time data entry system through a contract with Indus Consultancy Services, Inc. (referred to as the Indus system or Indus). Contractors enter screening, diagnostic, treatment and demographic information into this system for men and women who are provided screening services. This internet-based system facilitates timely provider reimbursement and patient tracking and follow-up, improves the quality of data collected, and helps reinforce program procedures. On-line data queries and reports are available for contractors' use to monitor performance.*

6. Fiscal Management

The contractor will be responsible for all fiscal management activities. The contractor will:

- within the funding amounts set by the NYSDOH, establish fiscal and operational systems to ensure that clinical and laboratory services are provided throughout the full program year. This may be done by establishing monthly client volumes for provision of services by participating network providers
- submit the required NYSDOH budget monitoring tool on a monthly basis
- monitor the infrastructure budget to ensure that funds are expended in an appropriate manner. Prepare and submit budget modifications if necessary and in accordance with NYSDOH practices
- on a monthly basis, prepare the budget report of expenditures and submit vouchers to the NYSDOH to ensure prompt reimbursement of subcontractors. Provide back-up documentation for voucher expenditures at the request of NYSDOH. Such documentation may include copies of all receipts, invoices, bills, payroll records, etc. to substantiate all personnel and other than personnel charges
- respond to inquiries from participating providers to reconcile payment for services rendered
- for underinsured clients, ensure that all providers are aware of and conform to client eligibility, data submission, and billing guidelines, in accordance with the CSP Operations Manual Chapter 3: Eligibility
- Component A Grantees Only: On a monthly basis, prepare and submit clinical service vouchers to the NYSDOH and HRI to ensure prompt reimbursement of health care providers and clinical laboratories for clinical services rendered, per the MARS
- Component A Grantees Only: Ensure that systems are in place to receive reimbursement for clinical and laboratory services from the NYSDOH and HRI; process and send checks with appropriate documentation of the eligible services rendered to credentialed providers and clinical laboratories within 14 to 21 business days after receiving payment from NYSDOH and/or HRI

7. Patient Navigation and In-reach*

   **Required* for "Component B" contractors serving Bronx, Brooklyn, Queens, Staten Island, Manhattan and the Hudson Valley (Westchester, Rockland, Putnam, Ulster and Dutchess), *optional* for "Component A" contractors

Component B contractors are required to implement patient navigation strategies to identify individuals in need of screening for breast, cervical and/or colorectal cancer. The Component B contractor will:

- ensure the implementation of in-reach strategies among health care providers to identify individuals in need of screening for breast, cervical and colorectal cancer for potential enrollment in the program. In-reach strategies will include:
  - establishing a system for querying health systems' electronic database to identify current patients in need of guideline-concordant breast, cervical and/or colorectal cancer screening
  - establishing a mechanism for contacting identified patients regarding needed cancer screenings, providing patient education about the importance of cancer screening and assisting them to obtain screening appointments
  - promoting the use of cancer screening reminder and recall systems via telephone, mail or electronic reminders to prompt eligible adults to participate in cancer screening
  - promoting the use of health communications strategies to promote cancer prevention and early detection to their eligible patient populations
  - promote office-based policies and practice-based system changes designed to support comprehensive cancer screening
  - provide assessment and feedback to health care providers to support comprehensive cancer screening to eligible patient populations using program data
- build relationships within the health system, outside the health system and with partners to provide information about the patient navigation function
- maintain ongoing communication with system providers, non-system providers and other partners to identify "at risk" patients due to barriers to care
- identify patient navigation staff who will:
  - help patients understand recommended follow-up of abnormal screening results, treatment referrals and general preventive health behaviors
  - contact patients who are at risk for missing screening, follow-up or treatment appointments

- facilitate access to obtaining insurance coverage or a sliding fee scale for medical appointments
- communicate with providers about unique patient needs, such as language and/or cultural barriers, handicapped access, etc.
- ensure appropriate information is available in the patient's medical record during scheduled appointments
- assist patients in understanding and navigating the health care system

B. Required Staff and Key Functions

Contractors will ensure a staffing plan and infrastructure that fully addresses the lead organization's ability to implement all required activities as defined in the Scope of Work above. The staffing plan should also address staff recruitment, training and retention practices. Contractor staff and subcontractors should have the appropriate education and professional credentials and competencies to effectively carry out the required activities. At the lead organization/contractor, staff should be at a level to affect decision-making related to the contract. Salaries should be commensurate with the level of education and experience required of the positions. *Note: If a vacancy occurs (resignation, maternity leave, medical leave, etc.), it is the responsibility of the lead organization to cover extended absences and to ensure contract work is completed.* Staff fulfilling the roles of the Program Coordinator and other key functions must have the ability to serve and travel to all areas of the service region.

The staffing plan is expected to include the following required Program Coordinator position, as well as positions that fulfill the functions below. One appropriately qualified staff person may be responsible for multiple functions; but all functions should be addressed.

Required Staff

1. Program Coordinator – Required for both Component A and Component B. This individual should have a function within the contractor organization that reflects professional and leadership status. The Program Coordinator will serve as the primary point of contact with the NYSDOH and is expected to attend all trainings and meetings convened by NYSDOH. This individual will also serve as the primary point of contact for all subcontractors, partners, and providers for all contract activities and communications. In addition, the Program Coordinator will ensure that all required activities, as listed in the Scope of Work, are implemented and will have primary responsibility for all activities listed in the Program Management and Leadership, and Partnering, Coordination and Collaborations sections. The Program Coordinator should demonstrate the ability to motivate and inspire others, convey knowledge and enthusiasm for the program to partners, communicate effectively within the community and with regional

and state partners, and plan and implement effective activities to promote and provide breast, cervical and colorectal cancer screening.

a. **For Component A Grantees:** The contractor will employ a professional position, recommended at a minimum .50 FTE, for a Program Coordinator; exceptions to the recommended minimum FTE will be considered with appropriate justification.

b. **For Component B Grantees:** The contractor will employ a professional position, recommended at a 1.0 FTE, for a Program Coordinator; exceptions to the recommended FTE will be considered with appropriate justification.

Key Functions

1. Public Education and Targeted Outreach (PETO) and In-reach – Staff in this capacity serve as the liaison between community members, hard-to-reach members of the priority populations and participating providers. These individuals work to increase the numbers of men and women who seek breast, cervical and colorectal cancer screening by developing and implementing evidence-based and evidence-informed public education programs. Staff should have the ability to communicate clearly and effectively, both orally and in writing, with members of the public and professional audiences about complicated health issues. These individuals should have sufficient knowledge about and experience with the community they serve to identify local resources that address barriers to screening; establish relationships with agencies and organizations to reach priority populations; coordinate culturally appropriate and culturally sensitive events; and conduct other activities needed to reach the eligible and priority populations.

2. Case Management – Case management staff implements protocols and processes to ensure that clients with abnormal screening results receive timely follow-up, as outlined in the Program Performance Measures, for needed diagnostic services. These individuals work with clients, partners, health care providers and other community resources to assist men and women to overcome identified barriers to care. They help clients obtain and keep scheduled diagnostic appointments, access diagnostic evaluation and, if needed, obtain treatment. They may also provide clinical oversight for the interpretation of reports/medical records, conduct risk assessment for eligibility and clinical appropriateness, and ensure adherence to NYSDOH policies and guideline concordant cancer screening. Case management may be conducted by the contractor organization, by network providers or a combination of both.

3. Intake/Eligibility – Staff responsible for intake and eligibility are the first point of contact for potential clients. These individuals determine client eligibility for breast, cervical and colorectal cancer screening and/or diagnostic services. They work with network providers to make appropriate cancer screening appointments for eligible clients and complete required

NYSDOH intake/eligibility forms and may provide initial data management. In addition, Intake/Eligibility staff communicates client information to case management staff to ensure timely follow-up of screening results. They may also contact clients referred by Public Education and Outreach staff, partners and the statewide hotline to determine eligibility for the program. The Intake/Eligibility function may be accomplished through a centralized process (lead organization hiring dedicated staff) or a decentralized process (lead organization working with staff of network providers) or a combination of both processes. Applicants proposing a more centralized intake/eligibility process, where the majority of intake is done at a central location and not primarily dispersed among participating providers, will receive additional consideration.

4. Data Management – Data management staff collects, maintains, and submits data deliverables required by the NYSDOH. These individuals use an on-line, secure database, provided by the NYSDOH, to enter all required client and service-related data. They ensure the security and confidentiality of collected data; establish systems to ensure the timely receipt of client and service data from network providers; review and assess the completeness, accuracy and timeliness of data received; and communicate with network providers to obtain inadequate or missing data. Data management staff also serves as the point of contact for all data-related communication between NYSDOH and the lead organization.

5. Fiscal Management – Fiscal management staff routinely monitor infrastructure and clinical and laboratory services budgets to ensure funds are expended as per contract guidelines, that expenditures do not exceed allocated amounts and conduct oversight of subcontractors. These individuals are responsible for ensuring there are sufficient infrastructure and clinical and laboratory services funds to support the program throughout the entire contract period. Fiscal management staff also prepare and submit vouchers on a monthly basis, ensure that submitted vouchers reflect actual and appropriate costs, and are accompanied by necessary and sufficient back-up documentation to substantiate the costs. These individuals prepare and submit budget modifications as necessary, maintain accounts receivable, prepare the budget statement report of expenditures, and assist the Program Coordinator in monitoring clinical service expenditures through use of the budget monitoring tool provided by NYSDOH. Fiscal management staff also responds to inquiries from providers to reconcile payments for services rendered and communicates with providers to ensure they are aware of services that are eligible for reimbursement. **For Component A grantees only**, fiscal management staff are responsible for ensuring that providers are reimbursed for services rendered in a timely manner and for processing provider payments.

6. Clinical Care Coordinator – *Required for Component B Grantees Only* (optional for Component A). Staff in this capacity hold responsibility for overseeing the clinical work of the case managers. They provide clinical

oversight for interpretation of reports and medical records, provide guidance to intake/eligibility staff for risk assessment, eligibility and clinical appropriateness for screening and ensure adherence to guideline-concordant care. They ensure that systems and processes are in place to ensure the timely follow-up of clients with abnormal screening results, as indicated in the Program Performance Measures. In addition, staff in this capacity may provide training for new case managers, assist in the interpretation of NYDSDOH policies and guidelines, and assist the Program Coordinator with credentialing and quality assurance activities.

7. Patient Navigation – *Required for Component B Grantees Only* (optional for Component A). Patient navigators work within health care systems in collaboration with providers and community organizations to identify individuals in need of breast, cervical and colorectal cancer screening and assist them in receiving such services. These individuals develop and implement in-reach strategies within the health care system to approach members of eligible priority populations and recruit them for program enrollment. They help clients understand the importance of preventive health services, the need for guideline-concordant screening and follow-up of abnormal screening results. Patient navigators also assess clients' barriers to care and coordinate health care system and community resources to address clients' needs. Patient navigation may be conducted by the lead organization, by providers within the health system or a combination of both.

C. Provider Credentialing

All health care providers must be credentialed by the NYSDOH CSP in order to be reimbursed for services provided to CSP clients. All contractors must participate in the credentialing process. Contractors are required to submit to the NYSDOH CSP the names, license numbers, practice locations and other requested information annually to allow for provider credentialing activities by the NYSDOH CSP.

Any new providers added during the contract year must be credentialed by the NYSDOH CSP before a site code is assigned. This process usually takes approximately 10 business days to complete. Site codes are assigned to each CSP provider site to track services provided. The codes are entered into Indus to identify where services took place and to reimburse providers. Contractors must notify the CSP with requests for new site codes, or with changes to existing ones. See Attachments 2-I and 2-II for detailed instructions regarding site codes.

A provider, who has a license restriction, or becomes subject to any disciplinary action taken by a government program, hospital managed care organization, or licensing authority, including but not limited to an active or stayed suspension or restriction of provider's or practitioner's license or certification, will be reviewed by the NYSDOH CSP to determine if the restriction is related to services provided through the CSP or constitutes fraud or malpractice. If the restriction involves one of these areas, the

NYSDOH CSP will send the provider a letter notifying him/her that he/she is prohibited from participation in the CSP. The provider will also be notified of the opportunity to appeal this decision by submitting a request for an appeal to a NYSDOH review panel.

D. Requirements for Clinical Service Providers

The contract with the NYSDOH requires contractors or subcontractors on behalf of the local CSP to obtain annual provider agreements with their providers offering clinical services to CSP clients. Component B contractors are required to use the agreement provided as Attachment 2-VI, the agreement must contain the Participating Provider Requirements for Component B participating providers which are contained in this section. A sample provider agreement (Attachment 2-VII) is also provided for Component A contractors to use with participating providers. Component A provider agreements must also contain the Participating Provider Requirements, referenced in this section.

For CSP Component A Participating Providers

Providers of screening and/or diagnostic services in the New York State Department of Health Cancer Services Program, (PROVIDERS), agree to:

1. Abide by the applicable provisions of the New York State Department of Health Cancer Services Program (STATE) Operations Manual including but not limited to: clinical guidelines, eligibility criteria and case management sections.
2. Provide clients of the CSP (STATE) with the same quality of care as afforded to any other patients in their care.
3. Request reimbursement for clinical services ONLY for clients who meet the eligibility criteria as defined in the (STATE) CSP Operations Manual.
4. Treat the STATE as the payor of last resort. All Providers agree to first bill client's other insurance and/or third party payor for services provided through the STATE. Provider further agrees that it must submit accurate information of services performed to the CONTRACTOR for the STATE and may not submit claims for reimbursement directly to the State.
5. Accept reimbursement rates established by the STATE as payment in full for all services that are covered by the STATE. Providers agree not to charge clients for the difference between the STATE reimbursement rate and the Provider's usual fees. Under no circumstances shall Providers bill CSP clients for services that are covered by the STATE.
6. Promptly refer CSP clients for all needed and appropriate diagnostic and treatment services without consideration of their ability to pay. This assurance includes any and all necessary services NOT covered by the STATE.
7. Obtain signed written consent from all CSP clients for the provision of clinical services and release of their medical information to the relevant other entities participating in their care and the New York State Department of Health for the purposes of case management, tracking and reimbursement, in addition to any other consents or authorizations the Providers may obtain or which may be required by law to obtain.
8. Submit accurate demographic, screening, diagnostic treatment and any other data required by the STATE in a timely manner to the STATE contractor and in the format required by the STATE. The Provider agrees that the reimbursement for clinical services will not be provided by the STATE to the STATE contractor for reimbursement to the Provider until data have been accepted and approved on the CSP data system.
9. The State CONTACTOR agrees to pay providers for clinical services accepted and approved on the CSP data system in accordance with the approved reimbursement schedule.
10. Maintain adequate medical, business, financial, personnel, and other records, which may be applicable to the CSP (STATE). Providers agree to provide the

(STATE) CSP access to medical, including original mammograms, consents, business, and personnel, financial and other records, which may be relevant to the Cancer Services Program for purposes of inspection, auditing and copying.

11. Ensure that all licensed health care professionals are appropriately licensed to practice their profession in the State of New York, and maintain the appropriate credentials for the services that they are providing. Maintain all applicable provider, office based surgery and/or facility credentials, certifications, licenses, operating certificates, and/or approvals required by law and necessary to perform and bill for CSP services and facility fees, including but not limited to approvals for laboratory, mammography, office based surgery and diagnostic and treatment center services.

12. Immediately notify the CSP (i) if Provider's or Practitioner's license to practice or certification to operate in any state, certification(s) to prescribe medication, if applicable, or staff privileges at any hospital, if applicable, are voluntarily surrendered, restricted temporarily or permanently reclassified, suspended or revoked for any reason; and (ii) if Provider or Practitioner is indicted or convicted of a criminal offense, regardless of the nature of the offense, or if the Provider or Practitioner becomes subject to any disciplinary action taken by a government program, hospital, managed care organization, or licensing authority, including, but not limited to an active or stayed suspension or restriction of Provider's or Practitioner's license or certification.

13. Provide all information necessary to comply with the credentialing and re-credentialing activities, and further, to provide such information within a reasonable time period.

14. Cooperate fully with CSP quality assurance efforts, including, participating in discussions to explore reasons for unusual data patterns, and agree to undertake any proposed remediation plans to any clinical and/or data reporting deficiencies in a timely manner.

15. The CSP (STATE) reserves the right to discontinue any service Providers from participation in the CSP for any reason.

16. Paragraphs ten and fourteen of these Participating Provider Requirements shall survive termination of the AGREEMENT.

May 2013

For CSP Component B Participating Providers

Providers of screening and/or diagnostic services in the New York State Department of Health Cancer Services Program, (PROVIDERS), agree to:

1. Abide by the applicable provisions of the New York State Department of Health Cancer Services Program (STATE) Operations Manual including but not limited to: clinical guidelines, eligibility criteria and case management sections.
2. Provide clients of the CSP (STATE) with the same quality of care as afforded to any other patients in their care.
3. Request reimbursement for clinical services ONLY for clients who meet the eligibility criteria as defined in the (STATE) CSP Operations Manual.
4. Treat the STATE as the payor of last resort. All Providers agree to first bill client's other insurance and/or third party payor for services provided through the STATE. Provider further agrees that it must submit accurate information of services performed to the Contractor for the STATE and may not submit claims for reimbursement directly to the STATE.
5. Accept reimbursement rates established by the STATE as payment in full for all services that are covered by the STATE. Providers agree not to charge clients for the difference between the STATE reimbursement rate and the Provider's usual fees. Under no circumstances shall Providers bill CSP clients for services that are covered by the STATE.
6. Promptly refer CSP clients for all needed and appropriate diagnostic and treatment services without consideration of their ability to pay. This assurance includes any and all necessary services NOT covered by the STATE.
7. Obtain signed written consent from all CSP clients for the provision of clinical services and release of their medical information to the relevant other entities participating in their care and the New York State Department of Health for the purposes of case management, tracking and reimbursement, in addition to any other consents or authorizations the Providers may obtain or which may be required by law to obtain.
8. Submit accurate demographic, screening, diagnostic treatment and any other data required by the STATE in a timely manner to the STATE contractor and in the format required by the STATE. The Provider agrees that the reimbursement for clinical services will not be provided by the STATE to Provider until data have been accepted and approved on the CSP data system.
9. The STATE or its fiscal agent thereof, agrees to pay providers for clinical services accepted and approved on the CSP Data system in accordance with the approved reimbursement schedule.
10. Maintain adequate medical, business, financial, personnel, and other records, which may be applicable to the CSP (STATE). Providers agree to provide the (STATE) CSP access to medical, including original mammograms, consents,

business, and personnel, financial and other records, which may be relevant to the Cancer Services Program for purposes of inspection, auditing and copying.

11. Ensure that all licensed health care professionals are appropriately licensed to practice their profession in the State of New York, and maintain the appropriate credentials for the services that they are providing. Maintain all applicable provider, office based surgery and/or facility credentials, certifications, licenses, operating certificates, and/or approvals required by law and necessary to perform and bill for CSP services and facility fees, including but not limited to approvals for laboratory, mammography, office based surgery and diagnostic and treatment center services.

12. Immediately notify the CSP (i) if Provider's or Practitioner's license to practice or certification to operate in any state, certification(s) to prescribe medication, if applicable, or staff privileges at any hospital, if applicable, are voluntarily surrendered, restricted temporarily or permanently reclassified, suspended or revoked for any reason; and (ii) if Provider or Practitioner is indicted or convicted of a criminal offense, regardless of the nature of the offense, or if the Provider or Practitioner becomes subject to any disciplinary action taken by a government program, hospital, managed care organization, or licensing authority, including, but not limited to an active or stayed suspension or restriction of Provider's or Practitioner's license or certification.

13. Provide all information necessary to comply with the credentialing and re-credentialing activities, and further, to provide such information within a reasonable time period.

14. Cooperate fully with CSP quality assurance efforts, including, participating in discussions to explore reasons for unusual data patterns, and agree to undertake any proposed remediation plans to any clinical and/or data reporting deficiencies in a timely manner.

15. The CSP (STATE) reserves the right to discontinue any service Providers from participation in the CSP for any reason.

16. Paragraphs ten and fourteen of these Participating Provider Requirements shall survive termination of the AGREEMENT.

Revised May 2013

E. Confidentiality

1. Health Insurance Portability and Accountability Act (HIPAA)

The first federal privacy standards to protect patients' medical records and individually identifiable health information provided to health plans, doctors, hospitals and other health care providers that were issued as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 took effect on April 14, 2003. These standards, which were developed by the U.S. Department of Health and Human Services, provide patients with access to their medical records and more control over how their personal health information is used and disclosed. Additionally, HIPAA includes provisions designed to encourage electronic transactions and requires safeguards to protect the security and confidentiality of health information. In order for medical information to be released, patients need to sign a specific authorization, unless a specific exception in the law applies.

The federal privacy standards generally do not affect state laws that already provide additional protections for patients. The NYSDOH CSP is exempt from being a covered entity/program itself as it is a government grant. Therefore, covered entities sharing data with the CSP must follow the detailed requirements of HIPAA, but the CSP may disclose data pursuant only to state law requirements, not federal. However, in all cases, reasonable efforts must be made to limit the amount of information disclosed to the minimum amount necessary to accomplish the intended purpose.

2. Confidentiality requirements

- It is the responsibility of the contractor to ensure that all program staff sign written confidentiality agreements to maintain the confidentiality of all CSP clients' information.
- Program staff must treat all information pertaining to CSP clients as confidential information.
- Written or electronic evidence of client participation must not be left unattended on desks or in other open-access areas.
- Staff must maintain and use such information only for the purposes intended for the CSP and only to the extent necessary to fulfill CSP objectives.
- Limited access to fax machines, computer terminals (e.g., password protection), voicemail, cabinets, and workspace areas should be observed by all program staff.
- Client information and ancillary records (e.g., laboratory results, radiology results, and pharmacy records) should be maintained in secure data storage areas, which can include, but are not limited to, files in locked rooms or limited access areas, and password encoded desktop and laptop computer systems.

- Access to data files, both paper forms and computer files, is restricted to program staff who needs such information to perform their work responsibilities.
- Any discarded information containing client information must be shredded.
- CSP client information is confidential and may only be given to authorized individuals after consent has been obtained from the client.
- Any proposed research regarding any CSP client(s) or the CSP must first be approved by the NYSDOH Institutional Review Board. Please forward all such requests to the appropriate CSP Regional Manager (see CSP Operations Manual, Chapter 10: Staff List).
- All responsible persons and entities will be held accountable for breaches of confidentiality and for misuse of confidential data such that job suspensions, terminations, or legal proceedings may be instituted against them.
- Staff permitted to work from home by the contractor must be able to demonstrate appropriate safeguards to prevent the inadvertent sharing or loss of patient information including, but not limited to, firewalls that do not allow outside access to a wireless network and a level of encryption that ensures security.

F. Indus Data Submission and Form Retention

The NYSDOH CSP maintains a secure on-line, real-time, internet-based data entry system through a contract with Indus Consultancy Services, Inc. (commonly referred to as the Indus system, or Indus). Contractors are responsible for entering screening, diagnostic, treatment, and demographic information into this data system for CSP clients. The use of data available through Indus facilitates timely provider reimbursement, patient tracking and follow-up, improves the quality of data collected, and helps reinforce CSP procedures. On-line data queries and reports are available for contractors and NYSDOH CSP staff to monitor performance.

Contractors should establish efficient notification systems with CSP providers in order to receive information from them to ensure that services are reported in a timely manner. These systems are needed to ensure that the following occur:

- positive screening findings are followed-up quickly and appropriately
- timely case management services can be provided
- clients eligible for the NYS MCTP can receive coverage for treatment
- quality clinical care is provided to CSP clients
- rescreening can occur at the appropriate interval and
- CSP providers are reimbursed as soon as possible

Detailed instructions regarding form completion and Indus data entry can be found in the CSP Data Dictionary. Current versions of data entry forms and the CSP Data

Dictionary are available on the "Resources" page of the Indus data system or by contacting the NYSDOH CSP Data Unit at CSPdata@health.state.ny.us.

1. Timely submission of Screening Intake Forms (SIFs) and Follow-up Forms (FFs) on the Indus data system

The Indus data system only allows for the reimbursement of CSP funds for services that are submitted and accepted onto the data system within 90 days of the date of service.

Exceptions to this 90-day rule can be made for services processed with Insurance Denial Conversion Forms, for contractor errors corrected through Revision Forms, and for other special circumstances that justify a longer period of time for data submission. CSP Data Unit administrators have override capability on the Indus data system for the 90-day rule. Requests for overrides should be submitted by email to CSPData@health.state.ny.us.

The 90-day rule for data submission on the SIF and FF is outlined below.

SIF: The Indus data system assesses the submission date for each individual service on the SIF and determines whether the service was submitted and accepted onto the system within 90 days of the service date.

For example, if a mammogram is provided on May 15, 2013 and submitted and accepted onto the data system on August 20, 2013, the system will NOT allow program funds for this service.

It is not prudent to delay entry of SIFs until all screenings are complete. The Indus data system allows contractors to submit services on the SIF, have the form accepted, and then add additional services as they are provided.

FF: The Indus data system starts counting the 90 days with the LAST service date on the FF.

For example, if a FF with a surgical consult on May 15, 2013 and a colonoscopy on July 15, 2013 is submitted and accepted onto the system on September 20, 2013, the data system would allow reimbursement for both of the services on this FF even though the submission is greater than 90 days after the surgical consult in May. The data system begins counting the 90 days with the LAST service date on the form (in this case, July 15, 2013).

Given these rules, situations like cancellations of appointments, delays in scheduling colonoscopies, and extended periods of time between follow-up services should not affect whether services can be reimbursed. FFs should not be submitted onto the data system until they are complete.

Contractors are expected to ensure data are submitted in accordance with the 90-day rule, so that services can be reimbursed.

2. Revisions to SIFs and FFs on the Indus data system

Once SIFs and FFs have been submitted and accepted on the Indus data system, there are several types of revisions that can be made by CSP contractor staff.

The following fields can be modified directly by the CSP contractor staff on an accepted form:

Screening Intake Form:

- Field 1 - Name
- Fields 4-6 - Address
- Field 9 - Sex
- Field 11- Spanish, Hispanic or Latino
- Field 12 - Race
- Field 16 - Monthly Household Income
- Field 17 - Family Size
- Field 18 - Health Insurance
- ALL SITE CODES (all site codes except the intake site)

Follow-up Form:

- ALL SITE CODES

The following types of revisions to an accepted Screening Intake Form (SIF) can be made directly by contractor staff:

a. If SIF has been entered and accepted on the Indus data system with the cervical portion of the form completed (and the breast portion blank), the contractor staff can directly edit the form to add breast cancer screening services that occur within 90 days of the cervical screening services.
b. If SIF has been entered and accepted on the Indus data system with the breast portion of the form completed (and the cervical portion blank), the contractor staff can directly edit the form to add cervical cancer screening services that occur within 90 days of the breast screening services.
c. If SIF has been entered and accepted on the Indus data system with a CBE and no mammogram, the contractor staff can directly edit the form to add a screening mammogram that occurred within 90 days of the CBE. This also works if the form was accepted with a mammogram and no CBE, the contractor staff can directly edit the form to add a CBE that occurred within 90 days of the mammogram.
d. If SIF has been entered and accepted on the Indus data system with breast and/or cervical cancer screening services, the contractor staff can directly edit

the form to add colorectal cancer screening services that occur within 6 months of the breast and cervical screenings.

For all other changes, corrections, or additions to data on SIFs or FFs that have already been submitted and accepted on the Indus data system, CSP contractor staff must submit either a **Screening Intake Revision Form** or a **Follow-Up Revision Form**. Copies of these forms and detailed instructions regarding completion of these forms are available on the "Resources" page of the Indus data system or by contacting the NYSDOH CSP Data Unit at CSPdata@health.state.ny.us.

3. Submitting SIFs and FFs on the Indus data system for NYS MCTP clients

When submitting SIFs and FFs for potential NYS MCTP clients, it is important to consider the Medicaid enrollment date to avoid double payment of services by both Medicaid and the CSP. Enrollment in the MCTP starts on the first day of the month of diagnosis (e.g., for a biopsy done on 1/18/13 with a positive finding, enrollment would start 1/1/13) **OR** 90 days prior to the application date, whichever is later. The CSP should be the payor of last resort.

NYS MCTP clients can enter the CSP at several points during the process of their diagnosis and treatment. The guidance for submission of SIFs and FFs on the Indus data system depends on when the client enters the program. The following scenarios represent different types of clients and the appropriate way to submit the SIFs and FFs for these clients.

a. **CSP Enrolled Clients:** If a client enrolled in the CSP who received screening and/or follow-up procedures through the program is believed to be eligible for the MCTP, contractor staff should submit SIFs and FFs onto the Indus data system as if Medicaid will be paying for some services. Any procedures that occurred within the month of diagnosis should be entered on the SIF and FF as being paid with "other" funds because Medicaid will enroll the client and pay for services rendered back to the first day of the month in which the client was diagnosed. Remember, the client will be insured by Medicaid for all Medicaid approved procedures that occurred during that month as long as they were performed by a provider that accepts Medicaid reimbursement. Services that are not Medicaid approved or that are rendered by providers that do NOT accept Medicaid reimbursement should be entered on the SIF and FF as being paid with "program" funds.

   - If the client is approved for the MCTP, the acceptance letter will include an enrollment date. The contractor staff should compare this enrollment date to the already accepted SIF and FF and confirm that any services that occurred prior to the client's MCTP enrollment date are paid for with "program" funds and services that occurred on or after the enrollment date and were rendered by a provider that accepts Medicaid reimbursement are entered as "other" funds. Revision forms should be submitted to the CSP

Data Unit to change funds as needed. Please list "MCTP" as the reason for the revision on the form.

- If the client is NOT approved for MCTP, submit a revision form to the CSP Data Unit to change procedures listed as "paid with *other* funds" to "paid with *program* funds". Please list "Denied MCTP" as the reason for the revision on the form.

b. **Clients NOT enrolled in the CSP**: For all applicants to the MCTP who were not enrolled in the CSP at the time they received screening and follow-up procedures, the SIFs and FFs should NOT be entered on the Indus data system. Hard copies of SIFs and FFs should be submitted with the MCTP applications.

Please see CSP Operations Manual, Chapter 7: Medicaid Cancer Treatment Program and the Medicaid Cancer Treatment Program Application manual for more information about eligibility criteria and the application process for the MCTP.

4. Form retention recommendations

The NYSDOH CSP does not have any formal requirements for retention of SIFs, FFs, or monthly billing reports. Accepted forms and monthly billing reports are available electronically on the Indus data system. Contractors are required to follow their agency's policies about retention of screening intake forms, follow-up forms, and monthly billing reports, as well as consent forms, clinical or medical records and case management notes. If a contractor disposes of forms with confidential client information, these forms must be shredded.

The NYSDOH CSP does recommend that contractors retain SIFs and FFs until the services on these forms appear on the monthly billing report to verify that the information was accurately entered on the Indus data system and appears correctly on the monthly billing report. The NYSDOH CSP also recommends that monthly billing reports be retained until the voucher is submitted and processed.

Clients who receive case management services should have all case management notes, documentation, forms, etc. retained within their individual charts. Clinical documentation related to case management needs should be retained for a minimum of two (2) years following the conclusion of that client's diagnostic follow-up. For questions or guidance about case management issues, please contact the CSP Case Management Coordinator at (518) 474-1222.

G. CSP Performance Measures Reports

The CSP Data Unit prepares performance measure (PM) reports for contractors and the NYSDOH CSP staff to monitor program services and other issues relevant to quality assurance, as well as to identify contractors in need of assistance or intervention. The CSP distributes the PM reports to all contractors, summarizing key

indicators of performance such as the ability to reach the priority populations, timeliness and appropriateness of follow-up, timely submission of data forms, and the ability to expend clinical services funds. Contractors are expected to meet or exceed CSP PM goals. The PMs are included as objectives in contractor work plans and are used to measure effectiveness related to required activities. The NYSDOH CSP PMs are primarily modeled after those used by the CDC to measure statewide performance. Contractors that meet or exceed the PM goals, as well as other contract requirements, are best positioned to receive the maximum available funding for subsequent contract years. See next page for a list of CSP PMs.

NYSDOH Cancer Services Program
Program Performance Measures
Program Year 2013-2014

No.	Performance Measure Description	Goal
1	Percent of screening mammogram clients age 50 and older	≥75%
2	Percent of initial program-funded Pap tests for women rarely or never screened for cervical cancer	≥20%
3	Percent of women rescreened by mammogram within 24 months	≥60%
4	Percent of clients who are male	≥20%
5	Percent of clients rescreened by fecal test within 10-14 months	≥60%
6	Percent of clients age 50 to 64	≥75%
7	Percent of women age 50 and older with comprehensive cancer screening	≥50%
8	*PM removed*	
9	Percent of eligible population screened in each county	≥20%
10	Percent of abnormal cervical screenings with timely follow-up	≥75%
11	Percent of abnormal breast screenings with timely follow-up	≥75%
12	Percent of abnormal colorectal screenings with timely follow-up	≥75%
13	Percent of eligible clients enrolled in the Medicaid Cancer Treatment Program	≥90%
14	Percent of Screening Intake Forms with timely submission	≥85%
15	Percent of Follow-Up Forms with timely submission	≥85%
16a	Percent of federal clinical service funds expended	≥95%
16b	Percent of state clinical service funds expended	≥95%

H. Reporting Requirements and Contract Monitoring

1. Annual work plan and budget development

The annual work plan and budget should be prepared by the Program Coordinator with participation and input from other contractor staff and partners as appropriate. The NYSDOH CSP provides required goals and objectives that focus on the implementation and evaluation of required CSP deliverables and that are consistent with PMs. Work plans should include detailed activities that will be implemented to fulfill each of the required objectives. A detailed budget and budget justification is required to justify proposed expenditure of infrastructure funding. The work plan and budget format is in a Microsoft Word document provided to contractors by the NYSDOH CSP. Please contact your Regional Manager to access the most current work plan and budget forms.

2. Semiannual reports

NYSDOH CSP requires contractors to complete and submit semi-annual reports that address the contractor's progress and strategies to implement the work plan activities, to meet, exceed and improve on PMs, and evaluate outreach and public education activities. Reports include comments on barriers and solutions to overcome barriers. Semiannual reports are submitted to Regional Managers and will describe activities for the periods from April 1 through September 30 and October 1 through March 31, respectively. Semiannual reports should be prepared by Program Coordinators with participation and input from other contractor staff and partners as appropriate, using data from the most recent PM reports. Instructions and report format will be sent by the NYSDOH CSP to all contractors.

Please contact your Regional Manager to access the most current semiannual report forms.

3. Annual Comprehensive site visit

Regional Managers will assess contractor performance related to implementation of required program goals and activities utilizing the Annual Comprehensive Site Visit Review Tool. Contractors will be required to provide documentation and demonstrate implementation of key required activities for all goals (e.g., produce samples of provider agreements used and communications to providers regarding program policies, guidelines, etc.). A formal, written summary and contractor action plan outlining all required action steps will be provided to the contractor following the annual site visit. Regional Managers will assess contractor progress in responding to required actions steps and adhering to action plans on a pre-determined schedule as indicated in the timeline within the contractor action plan.

4. Annual equipment inventory

Contractors are required to complete and submit an annual Equipment Inventory Form (consistent with approved budget items) to their Regional Manager within 30 days of the end of the annual contract period.

Equipment items purchased by the contracting agency using NYSDOH funds are to be listed in the inventory with identifying information such as tag number (number assigned by contracting agency), serial number (manufacturer's serial number), location, and any relevant remarks. See Attachment 2-III for a copy of the Equipment Inventory Form.

Regional Managers will review the contractor Equipment Inventory Forms at the time of submission and at the annual comprehensive site visits to inventory all equipment, furniture supplies or other property purchased through the contract with the NYSDOH. Equipment for the purposes of the inventory is defined as any item costing five hundred dollars ($500.00) or more and having a life expectancy of greater than three (3) years.

5. Monthly contract monitoring

On a monthly basis, Regional Managers will:

- review contractor vouchers and budget monitoring tools submitted by contractors to ensure all clinical services and infrastructure budget lines are expended and that expenditures are related and appropriate to activities detailed in approved work plans. In addition, Regional Managers will review contractors' clinical services allocations in comparison with key PMs to determine success reaching eligible priority populations
- review contractor PMs to identify challenges and barriers and provide assistance to contractors to meet or exceed measures
- review the Public Education and Targeted Outreach chart, which reflects all public education and targeted outreach activities implemented by each contractor on a monthly basis. Regional Managers will review and use this tool on a monthly basis to assess effective outreach activities, ensure appropriate use of funds, and to monitor performance goals and objectives
- review the contractor Incentive Tracking Tool used to track each incentive distributed to CSP clients (e.g., a $5 gas card for returning FIT kit). Regional Managers will require use of this tool to ensure contractor accountability for program incentives. See Attachment 2-IV for the Incentive Tracking Form
- track and monitor whether contractors have responded to requests from the NYSDOH CSP in a timely and accurate manner (e.g., status of outstanding FFs and medical record requests)

6. Clinical services reimbursement budget management

The clinical service allocations given to each contractor are limited to a fixed dollar amount that cannot be exceeded. Work plan activities will maximize the number of individuals screened within the eligibility criteria and the clinical services allocation. These will include careful monitoring of screening and diagnostic expenditures to ensure that screening services occur throughout the program year and careful assessment of CSP eligibility to maximize services to the priority population and align with the federal clinical practice guidelines for cancer screening services. Contractors must implement plans to closely monitor clinical services funding to stay within the allocation, ensure that services are provided throughout the contract year, and maximize the services provided to the priority population. A budget monitoring tool is provided to all contractors to assist with the tracking of clinical service expenditures. The tool provides estimated monthly screening capacities based on individual contractor annual allocated screening dollars. The tool also assists contractors to track PMs; calculations to meet the performance measures are included in the screening projections. The budget monitoring tool should be used in conjunction with PM reports to assess the provision of services to the eligible priority populations and to revise activities to better target these populations as indicated by the reports. Please contact your Regional Manager to access the most current budget monitoring tool.

I. Communications

The NYSDOH CSP provides information, support, training and technical assistance to contractors in a variety of ways. Contractor staff should ensure that they refer to and participate in the following, as appropriate.

1. Contact Information Form

Contractors must update the contact information form when they add new staff, when staff leaves and when there are changes to staff contact information such as e-mail, address or phone number. The completed form should be sent to the Regional Manager as soon as staff changes occur. See Attachment 2-V for the CSP Contact Update Form.

2. Program updates and communication databases

The CSP distributes general information, periodic updates, programmatic changes, training announcements and opportunities via the CSP BML; contractors should forward information provided by the CSP to their participating clinical services providers as appropriate. The communication target audience will be identified in the salutation (e.g.: "Coordinators"). The recipient should share information with other staff as deemed appropriate based on content. Providers can be added to the CSP Provider Database, which will be used to distribute CSP information directly to providers by sending an e-mail to cspcredentialing@health.state.ny.us.

3. Naming conventions and use of logo

The CSP developed contractor guidelines specifying the program name, use of the CSP logo and the review and development of educational and promotional materials.

Strategies and tools for materials development at the local level are also included in the guidelines. The CSP requires contractors to use the name *Cancer Services Program of X County/Counties* to build name awareness and consistency for clients, partners, and health care providers across the state. The name reflects the integration of the three screening services and acknowledges that the programs serve both men and women. The CSP developed a logo with the selected tagline, "Your partner for cancer screening, support and information," to offer contractors a common symbol and tagline that has the potential to become universally recognized and understood. See CSP Operations Manual, Chapter 9: Promotional Materials Guidelines for more information.

4. Data Unit inquires

For questions about data inquires, Indus access, SIFs, data dictionary copies, data corrections, and insurance denial conversions please contact the CSP Data Unit at CSPdata@health.state.ny.us.

5. Case management conference calls

Case management conference calls are held bi-monthly to discuss common case management challenges and to identify and share solutions and strategies, to discuss the implementation of new policies, and to review case management protocol. Contractors are expected to share this information with their providers who offer case management services to CSP clients. For questions or guidance about case management conference calls, please contact the CSP Case Management Coordinator at (518) 474-1222.

6. Public Education and Targeted Outreach (PETO) conference calls and webinars

The PETO team holds bi-monthly conference calls and webinars to discuss common public education, targeted outreach and recruitment challenges, and evidence- and population-based strategies to increase cancer screening, partner relations and communications. The calls provide an opportunity to network with and learn from others across the state. Contractors are expected to actively participate and implement shared strategies as appropriate. The calls and webinars are open to CSP Program Coordinators, staff fulfilling the public education and targeted outreach functions and community partners. For questions about PETO conference calls, please contact the CSP Outreach and Recruitment Coordinator at (518) 474-1222.

7. Data Unit Conference Calls

Data conference calls are held monthly to provide a way for the Data Unit and all contractors to discuss pertinent topics related to data collection, completion of CSP forms or the use of the Indus Data System, and to provide clarification for any data- or Indus-related questions. This call also acts as a forum for contractors to share best practices or successes. The calls are open to CSP Coordinators, Data Managers or any other CSP staff member who uses the Indus Data System on a regular basis. For questions or guidance about the Data conference calls, please contact the CSP Data Unit at CSPData@health.state.ny.us or at (518) 474-1222.

8. New staff orientation

All new contractor staff must participate in training offered by the NYSDOH CSP. These training sessions provide new staff with an overview of all aspects of the CSP. Some sessions are available 24/7 via webinar or the Learning Management System (LMS); others are offered in-person periodically throughout the year. All are announced via the Canserv BML (canserv@health.state.ny.us).

Attachment 2-I – Credentialing Packet Instructions

(Form updated 5-2013)

Application Submission and Review Process

Please complete each field and submit all required documentation when requesting a new site or reactivating a site. The CSP reviews each of the fields in the application for accuracy and validity. This information is necessary to ensure the quality and credibility of CSP providers. For all other requests please complete the information as requested on page 1 of the credentialing packet.

Type of Request	Select the type of request you need and complete the corresponding pages as indicated in parentheses.
Provider Agreement	In accordance with contract Attachment A-1 Part B, provision F. contractors are responsible for establishing provider agreements. Please indicate if an agreement has been obtained. If it has not, contractors are given up to 30 days to obtain the agreement before the site is closed.
Practice/ Facility Name	Please provide the legal name of the practice or the corporation. The CSP will verify legal names of incorporated practices with the Department of State. For practices that are not incorporated (sole proprietorships or general partnerships) the contractor must supply the CSP with a copy of a W-9 or Assumed Name Certificate for legal name verification.
Doing Business As (DBA) Name	Provide if applicable.
CSP Name & Contact Information	Enter the name of the CSP this application is being submitted for. Also include the name of the CSP contractor staff submitting the credentialing packet and the associated phone, fax and e-mail address information. Application are not accepted directly from providers.
Correspondence Address	Enter the address where all correspondence will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person.
Pay to Address	Enter the address where the payments will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If payments are sent to the Correspondence Address check the Same as Correspondence Address box.
Service Address	Enter the service site address. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If the service address is the same as the correspondence check the Same as Correspondence Address box. If services are provided at more than one location, complete a new credentialing packet for each service address.
Place of Service	Check the box from the list which describes the service site. ***Hospital***- Services are provided within a hospital setting, this may include clinics located within the hospital or hospital departments. ***Hospital Extension Clinic***- Off site or satellite extension clinic affiliated with a hospital. ***Private Office***- Services are provided in a physician's office or in an office owned by a group that is not licensed by the NYS DOH. ***Diagnosis & Treatment Center/ Free Standing Clinic***- Services are provided in a clinic setting that is not connected to a hospital. The clinic is licensed under Article 28 of public health law. ***Mobile Van-*** Services are provided on a mobile van. ***Free Standing Imaging Center-*** Services are provided in a free standing imaging center that is not connected to another facility. ***Laboratory***- Facility that examines specimens for the purpose of providing information on

	diagnosis, prognosis, or treatment of disease. ***Other***- Services are provided in a setting not described in this list. Please provide the type of service setting.
Family Planning Provider &/or Federally Qualified Health Center	Please indicate if the practice is a NYS DOH supported Family Planning Provider, Title X Provider or a Federally Qualified Health Center (FQHC). A FQHC is a non-for profit organization that receives grant funds under Section 330 of the Public Health Services Act.
Organizational Structure	Check the box from the list that indicates how the practice or facility is organized. A copy of a W-9 or Assumed Name Certificate must be included for sole proprietorships or general partnerships.
Licensed Under Article 28	Article 28 refers to all facilities licensed under Article 28 of the Public Health Law. For example: hospitals, extension clinics, diagnostic and treatment centers, or health clinics, such as Planned Parenthood are licensed as an Article 28. They have a facility license that lists the services they can provide. Laboratories would only be considered Article 28 facilities if they are the hospital's lab. Non-Article 28 refers to provider practices which include individual professional corporations (PCs), limited liability partnerships (LLPs), sole proprietors and non-hospital laboratories among others. The CSP requires license information for health care providers practicing at non-article 28 facilities with the exception of laboratories, RNs and LPNs. See Provider List section for additional details.
Facility National Provider Identifier (NPI)	Please list the facility or practice NPI. The NPI is a unique identification number for health care providers; it is an intelligence-free numeric identifier (10-digit number). Contractor staff can search the NPI registry for organizational and individual NPI numbers. Searches can be done by provider/facility name, city, state or zip.
Federal Employer ID No	Please list the facility tax identification number.
Services	Providers can submit for the services for which they are authorized to perform and have indicated so on the application.
Breast Services	Please check all breast services that will be provided to CSP clients. For facilities that are FDA approved for mammography please indicate if the facility is approved for analog and/or digital mammography units. Please submit a copy of the FDA certificate. For facilities that provide CBE, please indicate if they use the CSP CBE form. If they use an alternative form, please submit a copy of their CBE form for review.
Cervical Services	Please check all cervical services that will be provided to CSP clients.
Colorectal Services	Please check all colorectal services that will be provided to CSP clients.
Prostate Services	Clients must access the Medicaid Cancer Treatment Program (MCTP) for prostate cancer treatment through a CSP credentialed provider. You will not need to obtain a provider agreement since there is no reimbursement for screening or diagnostic procedures at this time.
Laboratory Services	Please check the box for the corresponding level of laboratory services. Please provide a copy of the facility's most recent Clinical Laboratories Improvement Amendment (CLIA)

	certificate. • **CLIA Approved/ Compliance** means that the provider is certified to provide specific, more complex testing, such as cytology, pathology, blood bank, clinical testing, etc. • **CLIA Waived** means that a provider received a waiver from CLIA to perform low-level complexity testing. For the purposes of CSP reimbursement the only tests would be the FOBT kits and limited FIT kits (not the Insure test). • **No CSP Laboratory Services Provided**- Please choose this option if the facility or practice does not perform any CSP reimbursable laboratory services.
Pre-Op Testing Services Only	Please check all pre-op testing services that will be provided to CSP clients. • CBC can only be checked if the provider is CLIA Approved.
Other	**Office Based Surgery** • Please identify practices performing Office Based Procedures (OBS) and their accrediting organization. Non-article 28 practices that perform OBS are required by NYS Public Health Law to be accredited. Any surgical or other invasive procedure requiring general anesthesia, moderate sedation, or deep sedation performed in a private office setting requires accreditation. Practices must be accredited by one of the following three organizations: Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or The Joint Commission. **Intake Site Only** • Please indicate if the provider site is an intake site only. **Anesthesia** • Please indicate if practice provides anesthesia. **Facility Fees** • Please indicate if site is reimbursed for facility fees. Site must be an article 28 that provides services the CSP reimbursed facility fees for (See Reimbursement Schedule).
Service Notes	Please add any notes regarding the provision of services that may assist the CSP in understanding the set-up of this practice or facility.
Provider List	List all provider names, medical license numbers, NPIs, and profession information for providers that will see CSP clients at non-Article 28 facilities excluding laboratories. The CSP only requires information on physicians, physicians' assistants, nurse practitioners, and nurse midwives. Provider license information is not required for Article 28 facilities.
Websites:	Below is a list of websites that may assist contractor staff with completing their enrollment packets. New York State Department of State http://appext9.dos.ny.gov/corp_public/corpsearch.entity_search_entry National Provider Identifier https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do Food and Drug Administration – Mammography Database

	http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm New York State- Office Based Surgery http://www.health.ny.gov/professionals/office-based_surgery/practices/ New York State- Office of the Professions http://www.op.nysed.gov/opsearches.htm

Please make sure you have included the following documents with your completed application (if applicable):

- W9 Tax Form or Assumed Name Certificate
- Mammography Certificate
- CLIA Certificate

Attachment 2-II – Credentialing Form
(form revised 5-2013)

TYPE OF REQUEST:

☐ REQUEST NEW SITE CODE (complete entire packet)
☐ RE-ACTIVATE SITE CODE (complete entire packet)

PROVIDER AGREEMENT ON FILE FOR CURRENT PROGRAM YEAR (July 1 – MAR 31): YES ☐ NO ☐ PENDING ☐

Make changes to site code: (Please check appropriate box below).

☐ ADD ADDITIONAL PROVIDERS TO ACTIVE SITE CODE (complete page 1 and 4)
☐ ADD SERVICES PROVIDED TO ACTIVE SITE CODE (complete page 1 and 3)
☐ CHANGE ADDRESS OR CONTACT INFORMATION TO ACTIVE SITE CODE (complete page 1 and 2)
☐ INACTIVATE PROVIDER(S) (complete page 1 and 4)
☐ INACTIVATE SITE CODE (complete page 1 only- Indicate reason(s) why you are closing this code:

☐ Provider does not see the priority population ☐ Delay in receiving payment ☐ Reduction in reimbursement rates
☐ Not willing to sign provider agreement ☐ Screening cap ☐ Other

PRACTICE/FACILITY NAME:
DBA (IF APPILCABLE):
PARTNERSHIP NAME:
SUBMITTED BY:
PHONE NO:
FAX NO:
E-MAIL ADDRESS:

DOH ADMINISTRATIVE USE ONLY

SITE CODE:

APPROVED ☐ DENIED ☐ PROVIDER AGREEMENT DUE DATE IF 'NO' OR' PENDING'
REASON DENIED: Component B requires NYS Required Provider Agreement

DATE: REVIEWED BY:

Please e-mail Enrollment Packet and required documents to: cspcredentialing@health.state.ny.us

ENROLLMENT PACKET MUST BE COMPLETED BY CSP CONTRACTOR STAFF
PACKETS WILL NOT BE ACCEPTED DIRECTLY FROM PROVIDERS
ALL FILEDS MUST BE COMPLETELY FILLED OUT AND REQURIED DOCUMENTS INCLUDED FOR PACKET TO BE PROCESSED
DETAILED INSTRUCTIONS FOR COMPLETNG CREDENTIALING PACKET ARE AVAILABLE
PLEASE ALLOW UP TO 2 WEEKS FOR NEW SITE CODE REQUESTS TO BE PROCESSED

CORRESPONDENCE ADDRESS

ATTENTION (FIRST AND LAST NAME):

STREET:

CITY: STATE: ZIP CODE:

COUNTY:

TELEPHONE (INCLUDING AREA CODE): FAX:

E-MAIL:

PAY TO ADDRESS *Component B Providers must have contact to receive, sign and return State Claim for Payment forms*

☐ **Same as Correspondence Address**

ATTENTION (FIRST AND LAST NAME):

STREET:

CITY: STATE: ZIP CODE:

TELEPHONE (INCLUDING AREA CODE): FAX:

E-MAIL: **Component B Providers **require an email address

SERVICE SITE ADDRESS

☐ **Same as Correspondence Address**

ATTENTION (FIRST AND LAST NAME):

STREET:

CITY: STATE: ZIP CODE: COUNTY:

TELEPHONE (INCLUDING AREA CODE): FAX:

EMAIL:

ADDITIONAL SERVICE SITE ADDRESSES

If services are provided at multiple locations please complete an enrollment packet for each service site that sees CSP clients.

PLACE OF SERVICE (CHECK ONE)

☐ HOSPITAL ☐ HOSPITAL EXTENSION CLINIC ☐ PRIVATE OFFICE ☐ DTC/FREE STANDING CLINIC

☐ MOBILE VAN ☐ FREE STANDING IMAGING CENTER ☐ LABORATORY ☐ OTHER

Please indicate if this site is a Family Planning Provider, Title X Provider and/or a Federally Qualified Health Center

☐ Family Planning Provider ☐ Title X Provider ☐ Federally Qualified Health Center

ORGANIZATIONAL STRUCTURE

Please check the box that described the organizational structure of the business.

☐ CORPORATION (e.g. PC, PLLC, LLC, LLP, INC) ☐ GOVERNMENTAL (local, state, federal)

☐ SOLE PROPRIETORSHIP* ☐ GENERAL PARTNERSHIP*

**Please submit a copy of a W9 or Assumed Name Certificate for Sole Proprietors or General Partnerships*

LICENSED UNDER ARTICLE 28: ☐ YES ☐ NO

FACILITY/PRACTICE NPI: FEDERAL EMPLOYER ID NO:

NYS Vendor ID #:

Attachment 2-III Inventory Report

Annual Office Technology and Equipment Inventory

Any equipment, furniture supplies or other property purchased through your contract with the Department of Health is the property of New York State.

Equipment, for the purposes of the inventory, is defined as any item costing five hundred dollars ($500.00) or more and having a life expectancy of greater than three (3) years.

Equipment items purchased by the contracting agency using State Health Department funds are to be listed in the inventory with identifying information such as tag number (number assigned by contracting agency), serial (manufacturer's serial number), location, and any relevant remarks.

Disposition of the inventoried property will be made in accordance with applicable provisions of the law at the end of the contract.

ANNUAL OFFICE TECHNOLOGY AND EQUIPMENT INVENTORY

Contractor Name: _____

Contract Number: _____

Contract Period: _____

Item	Serial No.	Location

Date_____ Signature_____

(04/2011)

Attachment 2-IV – Incentive Tracking Form

Incentive Tracking Form Contract Period_____

	Vendor	Card #	Amount	Given to (Client ID#)	Program Staff Member sending/giving card	Program Staff Member Authorizing Signature
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

(04/2011)

Attachment 2-V – CSP Contact Update Form

CSP Staff/Contact Update Form

Use this form to notify CSP and Regional Manager of all new/departing staff or changes in current staff member's function or contact information.

Please complete **ALL** information for *each* staff person. Email completed form to dxs20@health.ny.gov and your Regional Manager. If staff member is no longer with CSP, provide contact information for interim staff.

CSP of ____ Person Completing Form: ____ Date: ____

Staff Member/Contact Information	Function(s) Performed
*Check **all** that apply in each section. For updates, include **only** new/updated information.*	
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff ____ & contact information if new) Name: ____ Address: ____ City: ____ State: NY ZIP: ____ Phone#: ____ Ext: ____ Fax#: ____ Email: ____ Effective Date: ____ Termination Date: ____	☐ *Contract Signatory** ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) Select ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) **the person authorized to sign contract documents* ☐ Coordinator ☐ Public Contact* ☐ Other (specify) ____ **Indus access? Select** **Must indicate yes or no, CSP will follow up re: access type** **Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff ____ & contact information if new) Name: ____ Address: ____ City: ____ State: NY ZIP: ____ Phone#: ____ Ext: ____ Fax#: ____ Email: ____ Effective Date: ____ Termination Date: ____	☐ *Contract Signatory** ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) Select ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) **the person authorized to sign contract documents* ☐ Coordinator ☐ Public Contact* ☐ Other (specify) ____ **Indus access? Select** **Must indicate yes or no, CSP will follow up re: access type** **Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff ____ & contact information if new) Name: ____ Address: ____ City: ____ State: NY ZIP: ____ Phone#: ____ Ext: ____ Fax#: ____ Email: ____ Effective Date: ____ Termination Date: ____	☐ *Contract Signatory** ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) Select ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) **the person authorized to sign contract documents* ☐ Coordinator ☐ Public Contact* ☐ Other (specify) ____ **Indus access? Select** **Must indicate yes or no, CSP will follow up re: access type** **Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator

New York State Department of Health Cancer Services Program — Your partner for cancer screening, support and information

* **Public Contact**: This number will be listed on the NYSDOH website and will be the contact number the toll-free referral line provides to callers for information about the program and screening services. **You must identify one public contact.**

12-13

Attachment 2-VI Required Provider Agreement for Contractors and Providers with Direct Reimbursement (Component B)

New York State Department of Health Cancer Services Program
PROVIDER AGREEMENT with STATE CSP CONTRACTOR

I/We agree to participate as a provider in the Cancer Services Program of _____ (name of CSP) and agree to provide cancer screening and/or diagnostic services as outlined in the New York State Department of Health Cancer Services Program (CSP) Operations manual to CSP-eligible clients and will abide by the provisions as defined in the attached Participating Provider Requirements. This agreement shall be in effect for the period of ___/___/___.

Additionally, as a participating provider of the CSP:

- I agree to treat all information regarding patients and the business of the other partners in the strictest confidence and, consequently, to abide by all local, state, and federal laws and regulations, as well as the policies of other partners regarding such confidentiality.

- I acknowledge receipt of, and agreement with, the CSP Operations Manual, the CSP Reimbursement Schedule, and Participating Provider Requirements, which are integral to this agreement and are hereby incorporated into, and made part of, this Agreement.

_____
Print Name of Provider/Facility

_____
Print Name/Title of CSP Contractor

_____
Provider/Facility Address

_____/_____
Provider Authorized Signature/Date

_____/_____
CSP Contractor Authorized Signature/Date

_____/_____
NYS Authorized Signature/Date

Attachment 2-VII Sample NYSDOH CSP Provider Agreement (Component A)

New York State Department of Health Cancer Services Program
PROVIDER AGREEMENT with STATE CSP CONTRACTOR

SAMPLE

I/We agree to participate as a provider in the Cancer Services Program of _____ (name of CSP) and agree to provide cancer screening and/or diagnostic services as outlined in the New York State Department of Health Cancer Services Program (CSP) Operations manual to CSP-eligible clients and will abide by the provisions as defined in the Participating Provider Requirements. This agreement shall be in effect for the period of ___/___/___.

Additionally, as a participating provider of the CSP:

- I agree to treat all information regarding patients and the business of the other partners in the strictest confidence and, consequently, to abide by all local, state, and federal laws and regulations, as well as the policies of other partners regarding such confidentiality.
- I acknowledge receipt of, and agreement with, the CSP Operations Manual, the CSP Reimbursement Schedule, and Participating Provider Requirements, which are integral to this agreement and are hereby incorporated into, and made part of, this Agreement.

_____
Print Name of Provider/Facility

_____
Print Name/Title of CSP Contractor

_____
Provider/Facility Address

_____/_____
Provider Authorized Signature/Date

_____/_____
CSP Contractor Authorized Signature/Date

Chapter 3 - Eligibility

CSP Operations Manual 07/13

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Chapter 3: Eligibility

This section provides guidance for determining which screening services individuals are eligible to receive through the CSP. The section includes definitions to determine individual eligibility based on gender, age, income, health insurance status, and other clinical assessment, as well as an algorithm and script for use with clients at initial contact. Clients determined to be eligible for one or more CSP screening services are then enrolled in the program. Clients can be enrolled by CSP contractor staff or by provider staff, depending on where they access services.

A. Eligibility Assessment and Triage

Contractors should use the intake script and algorithm (Attachments 3-I and 3-II) when first speaking with potential clients. Use of these tools ensures that all clients receive the same information about CSP eligibility. Please note that these are scripts for use at initial client contact and are not meant for use to determine final client eligibility and subsequent enrollment in the CSP. Any staff conducting initial client intake should refer clients to those people in the program who have the ultimate responsibility for determining client eligibility.

B. Eligibility Criteria

The following section describes eligibility for screening services in the CSP. CSP contractor staff should be familiar with screening eligibility and communicate eligibility guidance and intake processes to all providers and partners engaging in client intake, eligibility assessment, program enrollment and provision of clinical services to CSP clients. The CSP will only provide reimbursement for services provided to eligible CSP clients. (Please see CSP Operations Manual, Chapter 6: Reimbursement for a description of all screening and diagnostic services that are reimbursed by the CSP.) Staff responsible for enrolling clients will review eligibility criteria with all clients prior to obtaining client consent. The consent form includes an attestation by the client that he or she meets CSP eligibility guidelines for income and insurance status (see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I). Staff responsible for enrolling clients must review eligibility, acquire the attestation from the client and maintain documentation of the client consent.

Eligibility Criteria

Eligibility Categories ⇒	**Residency**	**Gender**		**Age**			**Income** (See C.4 for income definitions)		**Health Insurance**			**Other**		
Screening and Prevention Services ⇓	**New York State Resident**	**Female**	**Male**	**18-39***	**40-49**	**50-64****	**<250 % FPG**	**>250% FPG (See C.5 for expanded income eligibility definitions)**	**Uninsured (See C.6 for definitions)**	**Underinsured (See C.7 for definitions)**	**Insured**	**Post Hysterectomy (See C.8 for definitions)**	**No FOBT or FIT kit in 10 months**	**Not Undergoing Treatment (See C.11 for definitions)**
Clinical Breast Exam	√	√	See C.2	See C.3	√	√	√	See C.7	√	√	Not Eligible	N/A	N/A	√
Pap Test & Pelvic Exam	√	√	Not Eligible	Not Eligible	√	√	√	See C.7	√	√	Not Eligible	√	N/A	√
Screening Mammogram	√	√	Not Eligible	See C.3	√	√	√	See C.7	√	√	Not Eligible	N/A	N/A	√
FOBT/FIT Kit	√	√	√	Not Eligible	Not Eligible	√	√	See C.7	√	√	Not Eligible	N/A	√	√
Colonoscopy Screening/Diagnostic	√	**ALL CLIENTS MUST MEET Prior Approval SEE SECTION C.9**									Not Eligible	N/A	N/A	√
Medical Consultation for Symptoms of CRC only	√	See C.10	See C.10	Not Eligible	Not Eligible	√	See C.10	See C.10	See C.9	See C.9	Not Eligible	N/A	N/A	N/A

* Persons under age 40 are generally not eligible for the CSP
** Age >64 are not eligible unless uninsured or underinsured for screening service
√= Eligible for program reimbursement N/A = Not Applicable

C. Eligibility Criteria Definitions

1. Residency

Women and men whose permanent or principal home is in New York State are eligible for the program. A person who is visiting New York is not **considered a New York resident. There is no length of residency** requirement.

2. Male Clinical Breast Examination (CBE) Criteria

Men who are at higher risk for breast cancer based on a personal or family history of breast cancer or men who are currently experiencing symptoms of breast cancer and who also meet all other eligibility criteria may be enrolled in the CSP for associated diagnostic testing. A licensed health care provider should provide documentation that attests to the need for diagnostic services for breast cancer evaluation.

3. Breast Cancer Screening/Diagnostics for Women Ages 18-39

Women ages 18-39 who are found to be at high risk for or who have clinically significant findings for breast cancer may be eligible for CSP services. These findings must be assessed by a NYS-licensed health care provider and documented on the *CSP Provider Attestation of Client Eligibility for Women less than 40 Years of Age form* (CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-VI). Women who are ages 18-39 who present with self-reported symptoms are not eligible for clinical breast exams (CBEs) through the CSP; they must first be assessed by a NYS-licensed health care provider as described above. Please refer to CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Section H for more information.

4. Income

Persons living at or below 250% of the current Federal Poverty Guidelines (FPG) meet the income criteria for CSP enrollment (see Table 1). Calculations should be based on self-reported, gross household income from all non-public sources. Child support and sources of public support (i.e. food stamps and housing subsidy) should not be included.

The CSP client consent form (see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I: *Informed Consent/Release of Medical Information/Provision of Case Management*) includes an attestation of income eligibility by the client. Staff responsible for enrolling clients must confirm the attestation by signing and dating the form. The form must be maintained in appropriate program files.

Household income is the sum of income received in the previous calendar year by all household members, including household members not related to the client, people living alone, and others in non-family households.

Table 1: 2014 Federal Poverty Guidelines			
Size of Family Unit	**Poverty Guideline**	**250 % of Guideline**	**Total Monthly Household Income**
1	$11,670	$29,175	$2,431
2	$15,730	$39,325	$3,277
3	$19,790	$49,475	$4,123
4	$23,850	$59,625	$4,969
5	$27,910	$69,775	$5,815
6	$31,970	$79,925	$6,660
7	$36,030	$90,075	$7,506
8	$40,090	$100,225	$8,352
For families with more than 8 persons, add the following amount for each additional person		$4,060	

Source: Department of Health and Human Services 2014 Federal Poverty Guidelines

For more information on poverty guidelines, access the U.S. Department of Health and Human Services website at: http://aspe.hhs.gov/poverty/

5. Expanded Income Eligibility

A client living above 250% of the FPG who meets all other eligibility criteria may be enrolled in the CSP if s/he meets the criteria for uninsured or underinsured outlined below.

6. Uninsured Criteria

A client is "uninsured" if s/he has no health insurance of *any type.*

7. Underinsured Criteria

A client is underinsured if s/he has:

- health insurance that does not cover clinically appropriate cancer screening or diagnostic services
- health insurance with an annual deductible, monthly spend down, or co-payment that is high enough to prevent him/her from obtaining cancer screening services

Staff responsible for enrolling clients will review eligibility criteria with all clients prior to obtaining client consent. The consent form includes an attestation by the client that he or she meets CSP eligibility guidelines for income and insurance status, as noted above. The client's insurance will be billed first and the CSP will reimburse for services based on the CSP maximum allowable reimbursement rates after the insurance has either denied the claim or made partial payment. Both client and CSP provider must be aware that there is no CSP reimbursement if the insurance payment is equal to, or greater than, the CSP maximum allowed reimbursement.

Clients with high deductibles must be enrolled in the CSP prior to receiving services and only after the client has identified the deductible to be a barrier to obtaining screening services. Data submission for services does not occur until information is obtained from billing the insurance first. It is not appropriate to enroll clients after the service has already occurred as a means to pay a bill.

Clients who meet these eligibility criteria must attest that they are "underinsured" on the CSP client consent form (see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I: Informed Consent/Release of Medical Information/Provision of Case Management). Staff responsible for enrolling clients must confirm the attestation by signing and dating the consent form and all insurance billing information, all of which must be maintained in appropriate program files.

As always, contractors should focus client recruitment activities on the uninsured populations in their communities.

8. Post Hysterectomy

Clients with a hysterectomy (surgical removal of a woman's uterus) must meet one of the following criteria to be eligible for a Pap test and pelvic exam:

- had a "supracervical or partial hysterectomy" and therefore have an intact cervix
    - Note: The presence of a cervix can be determined by physical exam if the client is not sure if they have a cervix and medical records are unavailable to assess the presence of a cervix. Clients are eligible for an initial pelvic exam for this determination.
- had a hysterectomy due to cervical cancer or because of a history of in-utero diethylstilbestrol (DES) exposure

9. Colonoscopy; Screening or Diagnostic Eligibility

Uninsured and underinsured clients of any age who are found to be at increased or high risk for colorectal cancer (CRC) may be eligible for colonoscopy through the CSP after undergoing prior approval for colonoscopy. Please refer to CSP

Operations Manual, Chapter 4: Cancer Screening Guidance, Section E. Clients ages 50-64 who are symptomatic for colorectal cancer may be eligible for a diagnostic colonoscopy. For more information, see Section C-10 below.

Please note that clients who are at increased risk, high risk or have clinically significant signs and symptoms of CRC should NOT receive a fecal test (FOBT or FIT kit).

10. Medical Consultation

Clients aged 50 to 64 who present with one or more of the signs and symptoms of CRC listed below may be eligible for the CSP. These signs and symptoms must be assessed by a NYS-licensed health care provider to aid in the determination of CSP eligibility. A client may be referred directly for medical consultation for this evaluation.

Signs and Symptoms of CRC:

- definite, palpable, right sided, abdominal mass
- definite, palpable, rectal (not pelvic) mass
- prolonged rectal bleeding with change in bowel habit to more frequent defecation or looser stools
- persistent rectal bleeding without anal symptoms (soreness, discomfort itching, lumps, prolapse, pain)
- nonspecific signs or symptoms strongly suggestive of colorectal cancer: melena (black, tarry stools), penciling of stools (thin stools difficult to pass) or iron deficiency anemia of undefined origin

11. Not Undergoing Treatment

Clients with a personal history of breast, cervical, colorectal cancer or dysplasia must complete treatment and have no evidence of residual or recurrent disease, must not be currently receiving coverage through the NYS Medicaid Cancer Treatment Program (Operations Manual, Chapter 7) and must be released to routine screening to be eligible for screening services through the CSP. Women receiving long-term hormonal therapy (e.g. Tamoxifen) have completed treatment for the purposes of this definition.

New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Instructions for Use: This phone script is to be used to triage potentially eligible clients and will provide a consistent message to clients across all contractors. This is **not** the final eligibility determination and as such, contractors should train staff to refer clients to those people in your program who have the ultimate responsibility for determining client eligibility.

1. **Do you have any insurance (or have you or your spouse served in the military and could be eligible for Veteran's benefits)?**

- Yes → Go to 1.a.
- No → "Have you applied for some type of public or commercial health insurance?
  - Yes → did not qualify - Go to Question 2. (back of this page)
  - Yes → it is pending. "In that case, we recommend that you call the public health insurance carrier/ company so you can get the names and phone #s of providers in your area who accept your type of insurance. However, if you find out you did not qualify, then please call us back and we will ask you a few additional questions for eligibility for our program." <Collect follow up contact information.>
  - No: "You might be eligible for some type of public or commercial health insurance or subsidy for full health insurance that could pay for your cancer screenings and other health needs. I'll give you the phone # of someone who can help you in determining which type of insurance is appropriate for you. In case you are not eligible for public or commercial health insurance, I would like to ask you a couple additional questions for eligibility for our program." <Give the caller the contact for the NYS Navigator or Certified Application Counselor and then proceed to question #2.>

1. a. Does it cover cancer screenings?

- Yes: but caller indicates they cannot have screening because of co pay, deductible or spend down amount→ Go to Question 2.
- Yes: Caller does not indicate they cannot have screening because of co- pay, deductible or spend down amount. "I'm sorry but you don't meet the eligibility criteria for the cancer screening program. You should call your insurance company (or nearest office of Veteran's affairs) so you can get the names and phone #s of providers in your area who accept your type of insurance."
- No: Go to Question 2.

2. How old are you?

a) Under age 40:

1)<u>Seeking breast cancer screening</u> → proceed to **"A"** response (below)

2)Seeking cervical cancer screening →"The CSP does not offer cervical cancer screening to those under age 40. Let me give the names and phone #s of providers in the community** who offer this service at low cost or on a sliding fee scale."

** Use individual providers, FQHCs, or Family Planning Clinics/Title X providers

3)Seeking colorectal cancer screening →"The CSP does not offer colorectal cancer screening to those average risk under age 40, because there is no recommended screening under age 40." If thinks high risk→ proceed to "A" response

b) Ages 40 to 49 → proceed to **"B"** response

c) Ages 50 and older→ proceed to **"C"** response

"A" The client meets insurance eligibility, but is under age 40 and is seeking a breast or CRC cancer screening: "You might be eligible for a cancer screening. I'm going to give your information to our program coordinator who will (talk to you now) or (call you back within 24hrs.). Her/His name is _____."

"B" The client meets insurance eligibility, and is 40-49 years old: "You may be eligible for a breast and cervical cancer screening. → *proceed to refer for income eligibility and completion of INTAKE, or if INTAKE done by provider* → "Let me give you the names and phone #s of participating providers in your area that offer breast and cervical cancer screenings."

"C" The client meets insurance eligibility, and is 50 or older: "You may be eligible for a breast, cervical and colorectal cancer screening → *proceed to refer for income eligibility and completion of INTAKE, or if INTAKE done by provider*→ "Let me give you the names and phone #s of providers in your area that offer breast, cervical and CRC screening."

Attachment 3-II:

Instructions for Use: This phone script is to be used to triage potentially eligible clients and will provide a consistent message to clients across all contractors. This is **not** the final eligibility determination and as such, contractors should train staff to refer clients to those people in your partnership who have the ultimate responsibility for determining client eligibility.

1. Do you have any insurance (or have you or your spouse served in the military and could be eligible for Veteran's

YE

1a. Does it cover cancer screenings?

YES

Yes: Caller does not indicate they cannot have screening because of co pay, deductible or spend down amount. "I'm sorry but you don't meet the eligibility criteria for the cancer screening program. You should call your insurance company (or nearest office of Veteran's affairs) so you can get the names and phone #s of providers in your area who accept your type

OR

YE

Yes: but caller indicates they cannot have screening because of co-pay, deductible or spend down amount – Go to Question **2**

NO

NO

"Have you applied for some type of public health insurance like Family Health Plus or

NO

No: "You might be eligible for some type of public health insurance that could pay for your cancer screenings and other health needs. I'll give you the phone # of someone who can help you in determining which type of insurance is appropriate for you. In case you are not eligible for public health insurance, I would like to ask you a couple additional questions for eligibility for our program." <Give the caller the Health Benefit Exchange Navigator information and

OR

Yes: But did not Qualify- Go to Question

YES

Yes: it is pending. "In that case, we recommend that you call the public health insurance carrier/ company so you can get the names and phone #s of providers in your area who accept your type of insurance." "However, if you find out you did not qualify, then please call us back and we will ask you a couple additional questions for eligibility for our program." <Collect follow up contact

2. How old are you?

a) Under 40 y.o.:
   1) Seeking breast cancer screening? → proceed to **"A"** response (at left)
   2) Seeking cervical cancer screening? →"The CSP does not offer cervical cancer screening to those under age 40. Let me give the names and phone #'s of providers in the community** who offer this service at low cost or on a sliding fee scale."

   ** Use individual providers, FQHCs, or Family Planning Clinics/Title X providers

   3) Seeking colorectal cancer screening? →"The CSP does not offer colorectal cancer screening to those average risk under age 40, because there is no recommended screening under age 40." If thinks high risk→ proceed to **"A"** response
b) Age 40 to 49 years old → proceed to **"B"** response

"A" The client meets insurance eligibility, but is under age 40 and is seeking a breast or CRC cancer screening: "You might be eligible for a cancer screening. I'm going to give your information to our program coordinator who will (talk to you now) or (call you back within 24hrs.). Her/His name is _____."

"B" The client meets insurance eligibility, and is 40-49 y.o.: "You may be eligible for a breast and cervical cancer screening→ proceed to refer for income eligibility and completion of INTAKE, or if INTAKE done by provider → "Let me give you the names and phone #'s of participating providers in your area that offer breast and cervical cancer screenings."

"C" The client meets insurance eligibility, and is 50 or older: "You may be eligible for a breast, cervical and colorectal cancer screening→ proceed to refer for income eligibility and completion of INTAKE, or if INTAKE done by provider→"Let me give you the names and phone #'s

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Chapter 4 - Cancer Screening Guidance

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Chapter 4: Cancer Screening Guidance

This chapter provides Cancer Services Program (CSP) contractors with background information about the screening tests reimbursed by the CSP. This chapter describes the use of the client informed consent document, a description of tests for each of the three cancers screened for in the CSP, and a review of screening intervals for each of these cancers as they relate to the CSP data reporting on the CSP Screening Intake Form (SIF) and Follow-Up Form (FF). The chapter also includes important information regarding diagnostic evaluation of abnormal screening results and reporting. Additionally, this section addresses the definition of high risk and clinically significant findings related to breast and colorectal cancer. This section reviews only those clinical services for which the CSP provides reimbursement.

The CSP is a population-based, average-risk screening program, which bases its recommendations and reimbursement policies on evidenced-based guidelines published by reputable organizations. Some of these organizations include Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality, United States Preventive Services Task Force (USPSTF), the National Comprehensive Cancer Network (NCCN), the National Cancer Institute (NCI), the American Cancer Society (ACS), the American College of Obstetricians and Gynecologists (ACOG), and the American Society for Colposcopy and Cervical Pathology (ASCCP). When evidence-based guidelines are not available, the CSP relies on developing consensus through internal and external NYSDOH clinician review.

A. Client Consent for Participation in the CSP

Staff responsible for enrolling clients must obtain a signed CSP consent form from each client at the time of his or her enrollment, prior to the provision of services by a CSP provider. The consent form informs the client about CSP reimbursed services and CSP income and insurance eligibility guidelines, as well as requires clients to attest to their eligibility for CSP services. The consent form also serves as permission to release information regarding provided services and gives permission for a case manager to contact clients with an abnormal screening result. The required consent form to be used by all contractors and their participating providers is included as Attachment 4-I. This consent form is available in English, Spanish, Russian, Chinese, French, Korean and Haitian Creole; please contact your CSP Regional Manager to request copies of the required consent forms.

B. Cancer Screening

1. Breast Cancer Screening

Breast cancer screening tests reimbursed by the CSP include:

- mammography (either screen film or digital) and
- Clinical Breast Examination (CBE)

According to program guidance from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), a combination of CBE and mammography can generally detect an abnormality at an early stage of the disease. Mammography is recommended to detect breast cancer in its earliest, most treatable stage. Research from clinical trials demonstrates that mammography can reduce breast cancer mortality by more than 30 percent. Additionally, several studies have evaluated the proportion of cancers (4.6%-5.9%) identified by CBE that were not detected by mammography. CSP providers must offer access to CBE and mammography for breast cancer screening for eligible women.

Breast self-examination (BSE) is the regular practice of observation and palpation of one's own breasts for the purpose of identifying changes. Although BSE is frequently advocated, evidence for its effectiveness to date has not been shown to decrease breast cancer mortality. BSE is not reimbursed by the CSP. Many organizations indicate that it is important for women to know how their breasts usually look and feel and to talk to a health care provider if any lumps or other changes in the breasts are noticed. The CSP recommends BSE be taught only in the context of a CBE by an examining clinician.

a. Mammography

A mammogram is an X-ray examination of the breast. A screening mammogram is performed in women who do not have symptoms of breast cancer (i.e., the woman is asymptomatic). A diagnostic mammogram is performed in women presenting with symptoms. A standard screening mammogram takes four views of the breasts and may locate abnormalities before they can be felt on physical examination. Screening mammography in the United States uses screen-film technology; however, there is growing use of digital mammography across the country, including NYS. The ability of a mammogram to find breast cancer may depend on the size of the tumor, the density of the breast tissue, and the skill of the radiologist.

The results of screening mammograms provided to CSP clients must be reported using the Breast Imaging Reporting and Data System (BIRADS) categories developed by the American College of Radiology (ACR). Mammography providers are also required by the Mammography Quality Standards Act (MQSA) to include a BIRADS result on each mammogram report. The mammography result reported to the CSP on the SIF should be the same as the result indicated by the radiologist on the mammography report. While it is important for clinicians to correlate the results of both a mammogram and a CBE (described below), the results of each test should be determined and reported independently (i.e., the mammography result should NOT be changed because of a CBE finding). For additional questions about BIRADS categories please visit: www.acr.org.

Under the MQSA enacted by Congress in 1992, only facilities that are fully certified by the U.S. Food and Drug Administration (FDA) may provide mammography. Only those facilities that meet this standard are, therefore, eligible to participate in the CSP. Additional information about MQSA can be accessed on-line at the FDA website. This site can also be accessed to locate FDA-certified mammography facilities. Please note that new mammography equipment used by a provider with full certification for other equipment is allowed during the provisional phase of the certification process for the new equipment. Questions about mammography certification should be referred to the Bureau of Environmental Radiation Protection, at (518) 402-7550.

A new NYS law requires mammographers to notify women if they have dense breast tissue. Dense breast tissue may make it more difficult for cancers to be spotted and may also be associated with an increased risk of breast cancer. The law recommends that women discuss this issue with their physicians.

The legislation was signed in July 2012 and went into effect in January 2013.

Under the Federal Mammography Quality Standards Act, the provider of mammography services is required to give each patient a lay summary report of her mammography findings. The new law expands that report to include information on the density of breast tissue.

Mammography providers must now include the following notification in the summary of the mammography report provided to patients who are found to have dense tissue:

"Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with an increased risk of breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your results was sent to your physician."

This legislation was meant to inform and educate. It is not a mandate for additional diagnostic testing. There is no current guideline that recommend screening breast ultrasound and there current reimbursement code for a screening breast ultrasound. NBCCEDP only supports guideline recommended screening. Use of ultrasound as a tool for breast cancer screening is still in an investigation phase.

b. Clinical Breast Examination (CBE)

A CBE is a thorough examination of the breast and related structures by a trained health care professional. The exam includes inspection and palpation of the breast and

surrounding tissue, including axilla (under the arms), above and below the clavicle and nipple.

The CSP recommends and reimburses for the provision of a comprehensive CBE and documentation as described in the November/December 2004 CA: A Cancer Journal for Clinicians *Clinical Breast Examination: Practical Recommendations for Optimizing Performance and Reporting.* Reprints are available by contacting the CSP Professional Development staff at (518) 474-1222.

It is optimal for the CBE to precede a screening mammogram so that the doctor reading the X-ray (radiologist) has the knowledge of any CBE findings when interpreting the mammogram. A CBE should be scheduled 7-10 days after the onset of the menstrual cycle, when the breasts are often less tender. For lactating women, the breasts should be empty.

CBE results, whether normal or abnormal, must be documented by the clinician who performed the examination on the approved CSP CBE Documentation Form (Attachment 4-II). The recommended care plan (immediate follow-up, short-term re-screening or annual screening) should be indicated on the documentation form as well. With prior approval from the CSP, CSP providers may use an alternate form or Electronic Medical Record (EMR) screenshot. The alternative form must contain, at a minimum, the same information required on the CSP CBE Documentation Form in Attachment 4-II. Alternative forms must be sent to the CSP for approval:

Clinical Care Unit
Cancer Services Program
150 Broadway, Suite 350
Albany, NY 12204

Providers will be notified in writing within 30 days if the alternate forms are acceptable.

Minimum Qualifications for CBE Providers:

In accordance with New York State Education Law, CBEs must be performed by a practitioner who is licensed by the State of New York, or another state, as a Registered Nurse (RN), Nurse Practitioner (NP), Physician's Assistant (PA), Doctor of Medicine (MD), or Doctor of Osteopathy (DO) (NYS Education Law, Title VIII, Article 130, 131, 131-B, 139, 140). A licensed radiologic technologist (RT) may perform CBEs in the CSP, under the supervision of a licensed physician, provided that:

8. the licensed RT meets the personnel requirements for performing mammography as defined by the MQSA administered by the FDA. The licensee must maintain MQSA status through continuing medical education as required under MQSA;

9. the licensed RT is certified in mammography and maintains registration in this specialty through the American Registry of Radiologic Technologists; and

10. the licensed RT successfully completes a training course in the performance of CBEs.

It is recommended that providers who perform CBEs attend a skills update once every two years.

2. Cervical Cancer Screening

Cervical cancer screening tests reimbursed by the CSP include:

- Papanicolaou (Pap) test (either conventional or liquid-based) and pelvic examination
- high-risk HPV DNA test, Hybrid Capture II, Cervista HR or cobas® HPV

a. Pap test (Pap Smear) and Pelvic Examination

A Pap test is a procedure performed to collect cells from the surface of the cervix (ectocervix) and from the endocervical canal to check for abnormalities. Cells are gently scraped from the cervix and endocervix using a spatula, broom, or endocervical brush. Conventional Pap tests are done by placing the scraped cells onto a glass microscope slide and then applying a fixative. Liquid-based Pap tests are done by vigorously dispersing the scraped cells into a liquid solution. In either test type, the cells are later examined for the presence or absence of abnormalities.

A Pap test is completed during the visual part of a pelvic examination. The CSP reimburses for a bi-manual pelvic examination. A bi-manual examination occurs when a clinician uses both hands to feel the inside of the vagina, the uterus and the ovaries for any problems. Bi-manual exams are not specific tests for cervical cancer and may be done without also performing a Pap test. Bi-manual pelvic exams performed in conjunction with a Pap test at appropriate intervals are reimbursable through the CSP.

Contractors must utilize cytology laboratories certified under the Clinical Laboratory Improvement Amendments (CLIA) of 1998 to evaluate Pap tests.

b. High-Risk HPV DNA Test

The high-risk HPV DNA test (HPV DNA test) tests for high-risk types of the HPV virus that cause abnormal cervical cell changes. HPV infection is a major risk factor for the development of cervical cancer. An HPV DNA test can be done after abnormalities are seen on a Pap test to determine if the cell changes are being caused by any of the

types of HPV known to cause cervical cancer. The results of this test can help health care providers on the best course of treatment for a patient. The high-risk HPV test can be performed from the same sample obtained in a liquid-based Pap test. An HPV DNA test may also be done in women over the age of 30 at the same time as a Pap test to screen for HPV infection. There is also an HPV test that will provide information regarding the specific genotyping of the high-risk types when risk stratification is necessary, however this is not currently reimbursable in the NBCCEDP program.

3. Colorectal Cancer (CRC) Screening

CRC screening tests reimbursed by the CSP include:

- *fecal tests*: high-sensitivity immunochemical FOBT (iFOBT, also known as fecal immunochemical tests, or "FIT") OR high-sensitivity guaiac fecal occult blood test (gFOBT) – referred to in this manual as gFOBT or FIT
- *colonoscopy* (under special circumstances, see below)
- *double contrast barium enema* (when a colonoscopy is medically contraindicated, see below)
- *flexible sigmoidoscopy* (when a colonoscopy is medically contraindicated, see below)

a. Fecal Tests

Fecal tests check for blood in the stool. Individuals perform these tests at home by using small stool samples placed on special cards, which are then returned to the doctor or laboratory for testing. Microscopic blood in the stool may be a sign of polyps (abnormal growths) within the colon, which may mean an increased risk of CRC or cancer. See Attachment 4-III for more information on laboratory and physician ordering requirements.

The CSP prefers the use of multi-sample FIT, however will reimburses for the use of either gFOBT or FIT (must be multi-sample) for individuals at average risk (no known risk factors) for CRC; fecal tests have been proven to reduce the risk of mortality due to CRC. FOBT and FIT both require annual screening and a complete diagnostic evaluation when positive results are found. Individual manufacturer instructions must be used for the completion of the kits. Test kits are returned to a physician or lab for development.

Differences between FOBT and FIT include the following:

- FOBT tests for peroxidase which is nonspecific for human blood (certain foods in a person's diet can make FOBT tests appear abnormal), while FIT tests for human globin which is specific for human blood.

- FOBT requires patients to adhere to certain dietary and medicinal restrictions while FIT does not have dietary or medicinal restrictions. An exception is the brand MonoHaem™.
- The sampling method for FOBTs and some FITs are different.
- FOBT costs less than FIT.

Scientific studies have found that the FIT provides improved specificity and slightly better sensitivity than FOBT. Studies have also found that the elimination of dietary and medicinal restriction, and the simplified stool sampling of some FIT brands, significantly improve patient participation rates in CRC screening and annual re-screening. For these reasons, the CSP highly recommends the use of multi-sample FIT over gFOBT.

A single test of a stool sample in the clinical setting, as is often collected during a digital rectal exam, is not an adequate substitute for the recommended fecal test procedure of collecting multiple samples. Multiple samples increase the likelihood that the test will detect bleeding abnormalities that might go unnoticed on a single-sample test. *An in-office, single-sample test done in conjunction with a digital rectal exam is NOT recommended for CRC screening and is NOT reimbursed by the CSP. Additionally, any client who receives an in-office, single-sample fecal test and has a positive or abnormal result cannot be enrolled in the CSP for a screening or diagnostic colonoscopy. While these clients will need to be referred for gastrointestinal (GI) evaluation, they are ineligible for CSP-funded services.*

b. Screening Colonoscopy

A colonoscopy involves the examination of the entire colon and rectum using a long, flexible tubular instrument, called a colonoscope. The colonoscope contains a light source and a camera lens. If polyps or suspicious areas are seen, these areas can be removed during the procedure. Most colonoscopies are performed in a hospital or diagnostic and treatment center by a gastroenterologist. Because the procedure is uncomfortable, conscious sedation or anesthesia is typically provided during the exam.

The colon must be flushed before a colonoscopy is performed so that the doctor can clearly see the lining. This preparation includes dietary restrictions one week prior to the colonoscopy. The day before the colonoscopy, only clear liquids can be consumed and a prescribed laxative, which can cause loose and frequent bowel movements, must be taken.

The CSP provides reimbursement for the use of colonoscopy as a first-line CRC screening test only for those individuals determined to be at high or increased risk for CRC. The use of colonoscopy in average-risk clients is limited to diagnostic colonoscopies if an abnormality is found during a fecal test. Approximately 15% to 20% of CRC cases occur among people who are at increased risk and approximately 5% to

10% of CRC cases occur among people who are at high risk. If a colonoscopy is determined to be medically contraindicated by a physician, individuals at increased or high risk should be screened with a double contrast barium enema alone or in combination with a flexible sigmoidoscopy (see below).

c. Double Contrast Barium Enema (DCBE) and Flexible Sigmoidoscopy

The CSP provides reimbursement for DCBE and flexible sigmoidoscopy only for individuals at increased or high risk for CRC when colonoscopy is medically contraindicated.

During a DCBE, the colon is first filled with a chalky white solution containing barium and is then drained, leaving behind a thin layer of barium along the colon's surface. The colon is filled with air to provide a detailed view of the inner surface of the colon, and an X-ray is taken. If any polyps or suspicious areas are seen during the DCBE, a diagnostic colonoscopy should be performed.

A flexible sigmoidoscopy involves the examination of the first third of the colon by a flexible, tubular instrument that is shorter than the colonoscope. The tubular instrument contains a light source and camera to view this portion of the colon. Cleansing of the bowel, similar to preparation for colonoscopy, is required. Sedation may be used; however, many sigmoidoscopies are performed in an office by general internists and family practice doctors without sedation. A diagnostic colonoscopy should be performed if any polyps or suspicious areas are detected during the sigmoidoscopy.

C. Cancer Screening Intervals

1. Breast Cancer

The CSP recommends and reimburses for breast cancer screening tests at the following intervals:

- mammogram every one to two years beginning at age 40 and continuing for as long as a woman is in good health
- CBE annually for women ages 40 and over in conjunction with a gynecological health assessment or just prior to their screening mammogram

Women at increased risk for breast cancer should discuss screening options with their medical providers. While the CSP does not provide reimbursement for all advanced testing for women at high risk for breast cancer, the local CSP may assist women to obtain alternate funds, either through referral to public health insurance programs for which they qualify, or to other available sources.

2. Cervical Cancer

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has adopted United States Prevention Services Task Force (USPSTF) updated screening recommendations effective July 1, 2012. The CSP screening policies are intended to reach the population of women age 40-65, with a continued emphasis on reaching the priority population for cervical cancer screening of women who have never or rarely been screened (screened in the last 5 years). The CSP recommends and reimburses for cervical cancer screening tests at the following intervals:

- screening for cervical cancer in women age 40-65 years of age with cytology (Pap test) every 3 years or screening with a combination of cytology and high risk human papillomavirus (HPV) testing every 5 years for women age 40-65
- no screening for cervical cancer among women older than 65 who have had adequate screening (3 negative cytology alone or 2 negative HR HPV) in the 10 years preceding their 65th birthday, regardless of sexual history and if they are not high risk
- women who are considered high risk (e.g., HIV positive, immunocompromised and exposed in utero to diethylstilbestrol <DES>) should undergo annual cytology testing
- no cervical cancer screening for women who have had a hysterectomy with the removal of a cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia <CIN> grade 2 or 3) or cervical cancer
- women who have hysterectomy for CIN disease (CIN 2 or 3) should undergo routine cervical cancer screening for 20 years even if it goes past the age 65 and women who had cervical cancer should continue routine screening for as long as they are in reasonable health. Routine screening is recommended every three years with cytology after initial post-surgery surveillance

Cervical cancer screening in women who have had a hysterectomy (removal of the uterus) is addressed in CSP Operations Manual, Chapter 3: Eligibility, Section C-8.

3. Colorectal Cancer

The CSP recommends and reimburses for CRC screening tests at the following intervals:

- multi-sample fecal tests (either FOBT or FIT) annually in average-risk men and women ages 50 and older
- colonoscopy in men and women at increased or high risk for CRC to begin at varying ages depending on the individual's risk criteria

The CSP initiated a pilot program for colonoscopy in average-risk individuals who undergo "Informed Decision Making" (IDM) at specific contractor/providers in 2010.

Following a screening colonoscopy for a CSP client, CSP providers should recommend the date of the next screening or surveillance visit. Refer to CSP Operations Manual, Chapter 6: Reimbursement to determine when the subsequent CRC screening or diagnostic services can be reimbursed through the CSP.

D. Diagnostic Follow-up of Abnormal Screening Test Results

1. Breast Cancer

Diagnostic follow-up is performed when a breast cancer screening test (mammogram and/or CBE) indicates that additional evaluation is required to assess an abnormal finding. A self-reported abnormal finding (i.e., a finding reported by a client) is not considered an abnormal finding. CSP contractors and providers must follow the required timeframes for diagnostic follow-up per program guidance from the NBCCEDP.

Diagnostic follow-up for an abnormal finding on a breast screening test must be completed as soon as possible, but no later than 60 days from the initial screening date. The CSP will reimburse for breast cancer diagnostic services for clients only under the following circumstances:

- a mass or other suspicious finding is noted on a CBE. For the purposes of follow-up a repeat CBE, surgical consultation and/or ultrasound must be performed. A mammogram alone cannot rule out breast cancer after an abnormal CBE
- a screening mammogram is interpreted with a BIRADS result of "suspicious abnormality," "highly suggestive of malignancy," or "assessment incomplete." In the CSP, a BIRADS 0 or "assessment incomplete" mammogram that requires additional mammographic or special views is reported as diagnostic mammogram on the Follow-up Form, not as a diagnostic mammogram on the Screening Intake Form. For further information related to the reporting of information on CSP data forms, please refer to the CSP Data Dictionary located on the "Resource" tab of the Indus Data system.

The CSP provides reimbursement for diagnostic follow-up for abnormal breast findings that are related to breast cancer. The CSP does not reimburse for surveillance of benign breast conditions. The CSP does not reimburse for screening breast ultrasound for a finding of dense breast tissue alone. If there is a clinically significant change to a previously confirmed benign breast finding, a new diagnostic evaluation may be initiated.

Clients of any age diagnosed with breast cancer or pre-cancerous breast conditions should be appropriately referred for treatment and may be eligible for Medicaid coverage for this treatment. See CSP Operations Manual, Chapter 7: NYS Medicaid

Cancer Treatment Program for information about Medicaid coverage for breast cancer treatment.

2. Cervical Cancer

Diagnostic follow-up is performed when a cervical cancer screening test indicates that additional evaluation is required to assess the abnormality. CSP contractors and providers must follow the required timeframes for diagnostic follow-up per program guidance from the NBCCEDP.

Diagnostic follow-up for an abnormal finding on a cervical cancer screening test should be completed as soon as possible, but no later than 90 days after the date from the initial screening.

The CSP only provides reimbursement for diagnostic follow-up for abnormal Pap test results and pelvic exam findings that are potentially related to cervical cancer or pre-cancerous cervical changes. The local CSP should assist women with Pap test and pelvic examination results indicative of another type of gynecologic cancer (vaginal, vulvar, endometrial or ovarian) to obtain alternate funds through referral to public health insurance programs for eligible women or through other sources. Clients with non-cancerous conditions (such as infections or sexually transmitted diseases [STDs]) may be referred to Title X Family Planning Clinics, Federally Qualified Health Centers, or STD clinics for diagnosis and treatment of these conditions.

Clients of any age diagnosed with pre-cancerous cervical changes or cervical cancer should be appropriately referred for treatment and may be eligible for Medicaid coverage for this treatment. See CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program for information about Medicaid coverage for cervical cancer treatment.

3. Colorectal Cancer

Diagnostic follow-up is performed when a CRC screening test indicates that additional evaluation is required to assess the abnormality that is present. CSP contractors and providers must follow required timeframes for diagnostic follow-up per program guidance.

Diagnostic follow-up for all positive fecal tests must be completed as soon as possible, but no later than 90 days from the fecal test development date. Providers should conduct proper follow-up for all positive fecal tests with a complete examination of the colon.

Abnormal results on a colonoscopy may be indicative of different conditions, including some not related to CRC or polyps. Clients found to have a condition other than polyps

or CRC (such as hemorrhoids, upper gastrointestinal bleeding, or inflammatory bowel disease) should be appropriately managed by a health care provider. The CSP does not reimburse for treatment services for diagnoses other than those related to CRC. The local CSP may assist such men or women to obtain alternate funds through referral to public health insurance programs, or other sources.

Clients found to have adenomatous polyps, hyperplastic polyps, hereditary non-polyposis colon cancer (HNPCC), or familial adenomatous polyposis (FAP) should be appropriately followed-up according to clinical guidelines.

Clients diagnosed with CRC should be appropriately referred for treatment and may be eligible for Medicaid coverage for this treatment. See CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program for information about Medicaid coverage for CRC treatment.

E. Prior Approval Process for Colonoscopy for Individuals at Increased Risk, High Risk and Symptomatic for CRC

The CSP supports screening for asymptomatic, average-risk people age 50 and older by multi-slide high sensitivity, take-home fecal tests. CSP clients with abnormalities found on multi-slide, take-home fecal tests should be scheduled for a colonoscopy. Individuals aged 50 to 64 with specific symptoms of CRC and those individuals determined to be at elevated risk due to personal or family medical history or current medical or genetic conditions may be screened directly by colonoscopy. To be screened directly by colonoscopy, clients must receive prior approval through the CSP contractor. CSP contractors are responsible for communicating this policy to their clients and providers.

CSP providers will need to submit clear documentation of the individual's risk status in accordance with eligibility criteria to the CSP contractor. See CSP Operations Manual, Chapter 3: Eligibility for more information. The designated CSP contractor staff will review the medical record documentation and complete a *CSP Colonoscopy Prior Approval Request Form* (Attachment 4-IV). A signed copy of this form shall be maintained in the CSP client record and a copy returned to the provider for inclusion in the client's medical record.

F. CSP Reimbursement for Anesthesia with Colonoscopy

The CSP reimburses for monitored anesthesia care only when medically indicated and administered by an anesthesiologist or certified registered nurse anesthetist (CRNA). If a medical provider or hospital chooses to use monitored anesthesia care when it is not medically necessary, the CSP will not reimburse for this service and the provider must find an alternate means to pay for these services.

The routine assistance of an anesthesiologist or CRNA for average-risk adult patients undergoing lower GI endoscopic procedures is not considered medically necessary. Thus, the CSP will not reimburse for anesthesia services unless there is a determined medical necessity and accompanying documentation is provided. This position is supported by the March 2004 consensus statement issued by the American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy. This guidance is not intended to dictate to providers how to practice medicine; providers are expected to exercise their medical judgment in providing the most appropriate care. However, reimbursement by the CSP will require documentation of the medical necessity and verification by the contractor on a *Request for Program Funded Anesthesia with Colonoscopy form* (Attachment 4-V). This information should be included in the client clinical record or documented in the colonoscopy consultation or procedure report. Documenting the reason on the CSP reporting form alone is not appropriate documentation of medical necessity.

The contractor will review supporting clinical documentation. If approved, this form should be completed by the designated contractor staff and forwarded to the CSP Data Unit after the services are entered on the CSP data system. The CSP staff will, in turn, make an override to allow for reimbursement. CSP contractors are required to communicate this policy and procedure with their credentialed providers.

The CSP does not reimburse for conscious sedation as a separate reimbursement fee. Conscious sedation is included in the fee for colonoscopy, regardless of who administers the conscious sedation.

Clients who are scheduled for an upper endoscopy evaluation at the same time as the CSP-reimbursed colonoscopy do not qualify for CSP-funded monitored anesthesia care (MAC), under the medically necessary criteria category of a "prolonged procedure."

G. Identification and Reporting of Colorectal Cancer Screening Complications

Any complications resulting from a CSP-funded colonoscopy MUST be identified and reported. This includes colonoscopy performed in an outpatient setting, such as a diagnostic and treatment center credentialed under Article 28 PHL, ambulatory surgical center, or an accredited office-based surgery practice. The CSP Case Manager is responsible for the identification of clients who have experienced complications and reporting to the CSP on the CSP data system (INDUS). See CSP Operations Manual, Chapter 5: Case Management for more information.

H. CSP Policy for Breast Cancer Screening for Women below the Age of 40

Beginning April 1, 2009, women under the age of 40 were no longer eligible for breast cancer screening through the CSP, with the exception of women in that age group who are at high risk for breast cancer or have clinically significant findings for breast cancer.

The CSP established criteria and the implementation of an evaluation of women under 40 who may be high-risk for breast cancer that is consistent with the National Cancer Institute recommendation that women who are at higher than average risk for breast cancer talk with a health care provider about whether to have breast cancer screening before the age of 40. The decision to screen for breast cancer should be based on an informed decision-making process between a woman and her health care provider.

Please note that mammography may not be indicated for women younger than age 35 who meet one or more of the high-risk criteria on a risk assessment. Clinically accepted guidelines from the National Comprehensive Cancer Network (NCCN) should be utilized when determining whether breast cancer screening is necessary in younger women.

1. Evaluation

There are multiple factors that determine a woman's risk for breast cancer including, but not limited to, a personal and/or family history of breast, ovarian, and other cancers, the age at which the person(s) was diagnosed with a particular cancer, or a history of chest irradiation for treatment of lymphoma during adolescence or young adulthood. These individuals are considered to have an "undetermined" risk for breast cancer and should be referred to an appropriate health care provider for a full clinical assessment, which can include an evaluation of lifetime risk of breast cancer using clinically recognized risk assessment tools. Where appropriate, individuals can be referred for zero-based sliding fee scale genetic counseling for assessment of risk. The CSP toll-free referral line (1-866-442-2262) can link individuals with genetic counseling services in their area. It is not the role of local CSP staff to provide clinical risk assessments.

Women younger than the age of 40 who meet CSP financial eligibility and present to a local CSP with a concern of being at high risk for breast cancer should undergo risk evaluation by an appropriate health care provider before being referred for breast cancer screening services in the CSP. The CSP will reimburse for breast cancer screening services (CBE and screening mammography) and any necessary CSP-reimbursable diagnostic services for individuals under the age of 40 when one of the following criteria are met and screening has been recommended and documented by a NYS-licensed health care provider on a *Provider Attestation of Client Eligibility for Women less than 40 years of Age* form (Attachment 4-VI):

High Risk for Breast Cancer Criteria

- a woman is determined to have a 5-year risk of invasive breast cancer greater than or equal to 1.7%, or a lifetime risk greater than or equal to 20%
- a woman is determined to have a known genetic predisposition for breast cancer by genetic testing (i.e., a BRCA 1 or 2 mutation)

- a woman has a personal history of breast cancer (and is not in active treatment)
- a woman has a personal history of receiving thoracic (chest) irradiation in her teens or 20s

These high-risk criteria have been adapted from those identified by the National Comprehensive Cancer Network (NCCN).

2. Clinically Significant Findings Criteria

Women younger than the age of 40 presenting with a self-reported symptom concerning for breast cancer should undergo an evaluation with a NYS-licensed health care provider. The CSP will not reimburse for CBE in 18-39 year old individuals with self-reported symptoms. The CSP will reimburse for diagnostic evaluation of one or more of the following clinically significant findings after such a finding has been evaluated by a NYS-licensed health care provider who determines whether diagnostic evaluation is necessary AND that provider documents the request on a *Provider Attestation of Client Eligibility for Women less than 40 Years of Age* form (Attachment 4-VI). The following clinically significant findings have been identified by the NBCCEDP and the NCCN and are endorsed by the CSP:

- discrete, dominant mass in breast
- spontaneous nipple discharge without a discrete, dominant mass in breast
- asymmetric thickening or nodularity
- skin or nipple changes

The following diagnostic services, where appropriate, are reimbursable through the CSP:

- diagnostic ultrasound
- breast fluid cytology
- diagnostic mammography and/or
- referral for surgical consultation and biopsy if necessary

I. Use of Magnetic Resonance Imaging (MRI) as an Adjunct Screening Tool in Women at High Risk for Breast Cancer (for women of all ages):

The CSP acknowledges recent literature regarding the use of MRI as an adjunct screening tool in women at high risk for breast cancer. The level of evidence for these recommendations, however, is based on nonrandomized screening trials, observational

studies and expert opinion. In 2005, the NBCCEDP released a white paper on technologies for the early detection of breast cancer. At that time, it was recommended that MRI not be reimbursed as a screening examination for women of any age at either high or average risk for breast cancer. The rationale for this decision was based on concerns about program operations, accuracy, reproducibility and access. The NBCCEDP has not changed its position on this topic since that time. Additionally, in 2007, a Hayes technology review looked at MRI for breast cancer screening in women at high risk. Although moderate evidence was found to suggest that MRI was more sensitive than mammography for the detection of breast cancers, there was a lack of randomized trials comparing mammography screening programs with programs that combine mammography with MRI. Based on this information, the relative impact of MRI on the breast cancer mortality of high-risk women is currently unknown. Therefore, the CSP does not reimburse for the use of MRI as an adjunct screening tool in women of any age including those at high risk for breast cancer.

Attachment 4-I Consent for CSP Participation

Client ID Number: _____
Cancer Services Program of: _____
Fax Number: _____

CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program that works with contract administrators, and with doctors, nurses and other health care providers to offer free, age-appropriate, risk-based screening for breast cancer, cervical (opening of the womb) cancer, and colorectal (the colon and rectum) cancer. Screening tests can help find these cancers in early stages when they may be easier to treat. Sometimes, when these cancers are found and treated early, they can be cured. Contract administrators work with you, health care providers and the NYSDOH to provide the services described in this consent.

The Age-Appropriate, Risk-Based Screenings Offered by the CSP are:

- Mammograms and clinical breast exams for breast cancer
- Pap tests and pelvic exams for cervical cancer
- Take home fecal tests (FIT or FOBT) for colorectal cancer
- Screening colonoscopy for men and women at increased risk for colorectal cancer (this means they have a greater chance of getting colorectal cancer)

People Who Have Abnormal Screening Tests (the screening tests show they may have one of these cancers) May Also Have the Following Services from the CSP:
Diagnostic tests: These are tests and exams that check to see if cancer is there.

- Case management: People help you get to the diagnostic tests by helping make appointments, finding a way to appointments, finding childcare, and many other ways to make it easier to get to the important diagnostic test appointments.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program eligibility (rules). The Medicaid Cancer Treatment Program offers full Medicaid insurance for people with breast, cervical, colorectal or prostate cancer who meet the program eligibility (rules).

Income and Insurance Eligibility
Free cancer screening by the CSP is only offered to women and men who meet income and health insurance eligibility (rules). Income eligibility means that the total amount of money earned by people living in your house must be below a certain amount for you to get free CSP services. CSP services are also offered to women and men who do not have health insurance (including Medicaid or other public insurance) or whose health insurance does not pay for cancer screenings. CSP services may also be offered to women and men who have health insurance, but cannot afford to pay the insurance co-pay, deductible, or spend down. The CSP partnership staff or health care provider will give you information about income and health insurance and talk to you about whether or not you meet these program rules.

Client Initials _____ Page 1 of 2

Signing this consent means that:

- I have read the program information on page 1 and have talked to a CSP staff or provider and understand the services being offered to me by the CSP.
- I agree to be in this program and understand that by agreeing to be in this program, I give permission to the New York State Department of Health, contract administrators and health care providers, including doctors, clinics and/or hospitals to release (share) information about me. I understand this information includes financial and insurance information and medical information about me and related to my breast, cervical and/or colorectal cancer screening and any related diagnostic and treatment care I receive. I understand this information will be released (shared) to other health care providers, contract administrators, other staff, health care providers or agencies participating in the CSP and the New York State Department of Health for my health care, treatment and follow-up, and for case management, tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by this consent or as allowed or required by law.
- I understand that this consent is for CSP cancer screening and related diagnostic and treatment services and case management, as needed and as provided under the CSP.
- I understand that I may choose not to have the services that are offered to me at any time.
- I understand that someone will contact me if I am found to have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me to get the recommended diagnostic follow-up testing and treatment, if needed. I understand that case management services are provided at no cost to me and that I can choose not to have the service at any time.
- I understand that my healthcare provider may recommend tests or procedures that may not be paid for under this program.

Attestation of Eligibility
A CSP staff or provider told me about the program services and eligibility requirements and answered any questions I had. By signing this consent, I attest that to the best of my knowledge, I understand this information and by checking the boxes below, the following is true. I understand that the CSP and the New York State Department of Health may verify (check) the information I have provided herein.

I meet the following income eligibility requirements (choose one):
□ My household income is at or below 250% of the Federal Poverty Guideline (FPG).
□ My household income is above 250% of the FPG, but I cannot afford cancer screening/s.

I meet the following insurance eligibility requirements (choose one):
□ I do not have health insurance of any type (this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance).
□ My health insurance deductible, monthly spend down, or co-payment is too high and prevents me from getting cancer screening services or my health insurance does not provide coverage for cancer screening and/or diagnostics.

☐ I authorize information about my services to be left on my answering machine.

Client Information and Signature
Client Name (Print) _____ DOB _____
Client Signature _____ Date _____
CSP Witness (Signature) _____ Date _____
Client Initials _____ Page 2 of 2
(04/2011)

Attachment 4-II CBE Form

CANCER SERVICES PROGRAM CLINICAL BREAST EXAM FORM

Name: _____ DOB: _____ Date: _____
Last First MI MM/DD/YR MM/DD/YR

Review of Patient History
Patient noticed changes in breasts since last visit? Site code ☐☐☐☐☐☐
No ___ Yes ___ Describe _____
Patient has a personal or family history of breast cancer?
No ___ Yes ___ Who? _____ What age? _____
Patient noted spontaneous nipple discharge?
No ___ Yes ___ Describe _____

Visual Exam:
Skin: ☐ Normal/Benign ☐ Scar(s) ☐ Dimpling ☐ Other: _____
Nipples: ☐ Everted ☐ Inverted ☐ Retraction

Physical Exam:

	Right		Left	
Lymph Nodes (Axillary/Clavicular)	☐ +	☐ -	☐ +	☐ -

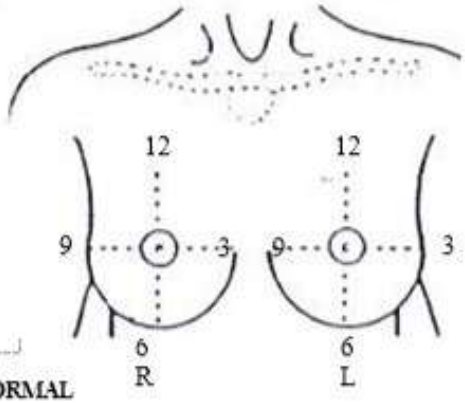

Diagram Documentation Codes

Scar +++	Nodularity ≡	Mole *
Fibrocystic Area ⁂	Node ○	Dimpling ◿
Mass ●		

Describe all clinical exam findings, including NORMAL and ABNORMAL (indicate size, shape, mobility, location of palpable findings).
Findings: _____

_____

Plan: _____

Referral: No _____ Yes _____ (explain) _____

Breast Findings: Check one box only
☐ 1. Normal, Benign, Fibrocystic – Rescreen in 1-2 Years
☐ 2. Probably Benign – Repeat Exam in 3-6 months
☐ **3. Mass or Other Findings – Immediate Testing**

_____
Name of Examiner (please print)

_____
Signature of Examiner Date

This report should be maintained as part of the patient medical record.

(04/2011)

Attachment 4-III Regulations regarding fecal tests

New York State Department of Health Regulations Regarding Laboratory Testing Fecal Tests

In accordance with 10 NYCRR Section 58, all fecal tests (FOBT and FIT) must be ordered by a licensed physician or other health care provider authorized by law (nurse practitioner, physician assistant or certified nurse midwife) and developed by a clinical laboratory holding a permit, as designated in Section 58-1.1. The laboratory must provide a report to the ordering provider who, in turn, is responsible for ensuring that the patient is notified of the test results and that those patients with abnormal/at-risk results are counseled appropriately and/or referred to appropriate follow-up care.

Often local CSPs distribute fecal test kits outside of a clinical setting such as health fairs, educational sessions, and door-to-door campaigns. Due to the nature of this program, a "blanket order" from an ordering provider, which is kept on file with the laboratory used to process the fecal kit (or other tests offered), may be necessary. A blanket order outlines the ordering provider's responsibility as well as the policies and procedures for ordering the test, release of test results and the follow-up of abnormal results. There is no standard format or template for a blanket order, but usually providers work with the laboratory to create one that is satisfactory to both parties. This is a typical agreement between laboratories and ordering providers when testing occurs in health fair settings.

When kits are distributed outside of a clinical setting, the program falls within the "health fair" category. In this case, the laboratory your CSP uses to develop fecal kits must apply for a Health Fair Permit. Your laboratory is probably already familiar with the process and may have this permit or may only need to add health fairs to an existing permit. This is a simple process, is offered at no cost and approval is usually swift. For more information, or to get an application form, go to http://www.wadsworth.org/labcert/regaffairs/RAindex.htm.

In summary, the NYSDOH regulations do not "require" a blanket order, as such, but rather require that fecal tests be ordered and followed up by a physician. How this is handled is left up to the ordering provider and the laboratory. Testing that takes place outside of a clinical setting requires that a laboratory obtain a Health Fair Permit. These requirements can be found in the NYSDOH Clinical Laboratory Statute and Regulations, also located at the above web address.

For additional information, contact your CSP Regional Manager.

Attachment 4-IV CSP Colonoscopy Prior Approval Request Form

Cancer Service Program Colonoscopy Prior Approval Request Form

Client #_____ Initials _____ Project # _____ Site Code_____

Colonoscopy Screening for Individuals at Increased Risk for CRC

Documentation has been provided and this client is eligible for a colonoscopy:

- ☐ Un/underinsured individuals with a single, small (<1 cm) adenoma, eligible 3-6 years after original polypectomy
- ☐ Un/underinsured individuals with a large (1 cm+) adenoma, multiple adenomas, or adenomas with high-grade dysplasia or villous change, eligible within 3 years after the initial polypectomy
- ☐ Un/underinsured individuals history of curative-intent resection of colorectal cancer, eligible 1 year after cancer resection
- ☐ Un/underinsured individuals with either colorectal cancer or adenomatous polyps, in any first-degree relative before age 60, or in two or more first-degree relatives at any age, eligible at age 40, or 10 years before youngest case in the family, whichever comes first

Colonoscopy Screening for Individuals at High-Risk for CRC

Documentation has been provided and this client is eligible for a colonoscopy:

- ☐ Un/underinsured individuals with a family history of familial adenomatous polyposis (FAP), eligible at puberty
- ☐ Un/underinsured individuals with a family history of hereditary non-polyposis colon cancer (HNPCC), eligible at age 21
- ☐ Un/underinsured individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis or Crohn's disease, 8 years after onset of symptoms.

Diagnostic Colonoscopy for Symptomatic Clients (Age 50-64 only)

Documentation has been provided and the client is eligible for a diagnostic colonoscopy:

- ☐ Un/underinsured individuals age 50 to 64 with a definite, palpable, right sided, abdominal mass
- ☐ Un/underinsured individuals age 50 to 64 with a definite, palpable, rectal (not pelvic or anal) mass
- ☐ Un/underinsured individuals age 50 to 64 with prolonged rectal bleeding with change in bowel habit
- ☐ Un/underinsured individuals age 50 to 64 with rectal bleeding persistently without anal symptoms (soreness, discomfort, itching, lumps, prolapse, pain)
- ☐ Un/underinsured individuals age 50 to 64 with nonspecific signs or symptoms strongly suggestive of colorectal cancer: melena (black, tarry stools), penciling of stools (thin stools difficult to pass) or iron deficiency anemia of undefined origin

☐ ***Documentation provided does not meet criteria for a CSP funded colonoscopy***

I have reviewed the documentation provided and confirm eligibility of a CSP reimbursed colonoscopy.

Date_____ Print Name _____

Signature of CSP Designee _____

(Form revised January 2010)

Attachment 4-V Request for Program-funded Anesthesia with Colonoscopy

Cancer Services Program
Request for Program Funded Anesthesia with Colonoscopy

Cancer Services Program of: _____
Provider Name: _____
CSP Site Code: _____

Client Name: _____
CSP client #: _____
Client Date of Birth: _____

Client requires program-funded anesthesia and **documentation of medical necessity is included in the clinical records reviewed by the CSP staff.** (Please check at least one):

☐ Client has an unstable medical condition: Please state condition:
_____

☐ Client has respiratory complications such as emphysema, shortness of breath, or asthma

☐ Client has a psychiatric or developmental diagnosis that prevents him/her from cooperating during the procedure (acute confusion state, senile dementia, anxiety, panic attacks)

☐ Client is or becomes uncooperative or combative during procedure (requiring anesthesia to be called in)

Client's airway is in danger of compromise
☐ Client has dysmorphic facial features
☐ Client has oral, neck or jaw abnormalities
☐ Client is morbidly obese (BMI > 41 or BMI > 35 with comorbid medical conditions)
☐ Client has a diagnosis of clinically significant sleep apnea, stridor, or tracheal stenosis

Clients with intolerance to standard sedatives
☐ Client has had previous problems with or allergies to anesthesia or sedation
☐ Client is anticipated to be poorly responsive to sedation. This includes patients who have long-term use of narcotics, benzodiazepines, alcohol, or neuropsychiatric medications or prior history of poor response to standard sedatives
☐ Drug or alcohol withdrawal or intoxication

Other
☐ Complicated or prolonged procedures (standard colonoscopies do not fit into this category) requiring anesthesia to be called in.

Print name of program staff requesting program funds, then provide Signature and Date

Name: (print) _____ Signature: _____ Date: _____

FAX completed form to CSP Data Unit @ 518-486-6860 <u>after</u> entering services on CSP data system

*Date received in CSP*_____ *Date entered in Indus*_____
*CSP Data Unit staff*_____ *(form revised January 2010)*

New York State Department of Health Cancer Services Program

Provider Attestation of Eligibility of Women less than 40 Years of Age

_____
(Print name of provider and CSP designated site code)
and
_____
(Print name of CSP)

Print Client Name: _____
CSP client #: _____
Client Date of Birth: _____

☐ **High Risk for Breast Cancer**
This client meets the criteria outlined in the New York State Department of Health Cancer Services Program (CSP) Operations Manual for breast cancer screening for high-risk women less than 40 years of age.

High Risk for Breast Cancer Criteria (Choose all that apply)

☐ Client 5-year risk =_____. (A woman of any age is determined to have a 5-year risk of invasive breast cancer greater than or equal to 1.7 %, as determined by a clinically recognized risk assessment tool.)

☐ Client lifetime risk =_____. (A woman age 35 or older with a lifetime risk greater than or equal to 20%, as determined by a clinically recognized risk assessment tool.)

☐ A known genetic predisposition for breast cancer by genetic testing (e.g., BRCA 1 or 2 mutation)

☐ A personal history of breast cancer (and is not in active treatment)

☐ A personal history of receiving thoracic (chest) irradiation in teens or 20s.

OR

☐**Clinically Significant Finding(s) for Breast Cancer**
I have performed a clinical breast exam on the above named client and have determined that she meets the criteria outlined in the New York State Department of Health Cancer Services Program (CSP) Operations Manual for clinically significant finding(s) of breast cancer in women less than 40 years of age.

Clinically Significant Findings Criteria (Choose all that apply)

☐ Discrete, dominant mass in breast
☐ Spontaneous nipple discharge without a discrete, dominant mass in breast
☐ Asymmetric thickening or nodularity
☐ Skin or nipple changes

_____
Provider Signature and Date

(Form revised January 2011)

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Chapter 5 - Case Management

CSP Operations Manual 07/13

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Chapter 5: Case Management

A. Case Management Definitions and Implementation Guidance

Case management begins at the point of an abnormal screening finding, and is defined as activities that increase client adherence to diagnostic and treatment recommendations. Case management services must be available to clients to address any barriers that could prevent or delay their seeking care. The key components of case management are assessment, planning, coordination, resource development, monitoring and evaluation.

1. **Assessment** is the process of gathering critical information from the client and examining the client's need for re-screening, diagnostic, treatment, and support services. Some CSPs may choose to utilize the Barrier Assessment checklist b (Attachment 5-I) to expedite the assessment process. During the initial assessment, it is important to ascertain whether an Informed Consent/Release of Medical Information/Case Management Form has been signed by the client. If not, one will need to be obtained (see Section B-2 of this chapter for more information).

2. **Planning** involves addressing barriers found during the client's assessment and documenting them in an individual written Client Care Plan. The Client Care Plan (Attachment 5-II) outlines identified issues and the steps being taken to overcome barriers. The plan to address the barriers to care requires contact with the client to ensure his/her needs are being met. See Section B-10 of this chapter for more information about documentation requirements.

3. **Coordination** is the provision of active assistance by the case manager to ensure that the client receives the services identified on his/her Client Care Plan. This is a collaborative process: the case manager works to encourage self-sufficiency and supports client/family autonomy through provision of information, resources, skills and other tools. Any steps taken to coordinate service needs should be documented in the client's CSP record. Development of and consistent updates to the local Community Resource Guide are imperative for this phase of case management to be successful in assisting a client to overcome identified barriers. See Section B-6 of this chapter for more information about the Community Resource Guide.

4. **Monitoring** refers to the ongoing reassessment of the client's needs throughout the duration of care to ensure that the quality of care and the provided services are meeting the client's current needs and to ensure that new needs are identified and met. Any new identified barriers should be documented in the client's CSP record noting the steps necessary to address these barriers (the Client Care Plan). If a client decides that case management services are no longer needed, s/he should be informed that this service is available at any time

during the diagnostic follow-up process and s/he can call the local CSP should s/he decide to resume case management services. As with other elements of case management, this should be documented in the client's record.

5. **Resource Development** involves the establishment of formal and informal agreements to maximize availability and access to essential diagnostic, treatment and support services. This step is accomplished through contracts and agreements with providers and community organizations. These resources should be included in the Community Resource Guide developed by the local CSP (see Section B-6 of this chapter).

6. **Evaluation** refers to the process of assessing client satisfaction, access and timeliness of referral services, and the quality of individual case management plans. Once case management ends, the *Case Management Satisfaction Survey* (Attachment 5-III) must be sent to the client with a self-addressed stamped envelope for its return at no cost to him/her (see Section B-7 of this chapter for more information).

B. Expectations of Case Managers

1. Meet with providers to discuss the CSP case management services available to CSP clients. If the provider is performing case management activities, inform him/her that the contractor case manager is available to assist with locating clients who cancel or miss appointments. Explain the importance of receiving results of abnormal findings within three business days of the provider having reviewed those results, and discuss how those results will be communicated to the contractor case manager (e.g., fax, email, telephone call and/or select a specific day during the week that the providers could communicate the results to the CSP case manager).

2. Obtain an Informed Consent/Release of Medical Information/Consent for Case Management Services from the provider or client; keep a copy in the client's CSP record (CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I). A verbal consent from the client is acceptable; however, it must be followed by an attempt to get a signed consent. Send the consent to the client with a cover letter requesting their signature, and include a self-addressed stamped envelope. Before calling the client, refer to the CSP Consent to Participate and note whether or not a message may be left; strictly adhere to the client's request.

3. After verifying with the provider that the client is aware of his/her abnormal finding, contact the client to offer case management services; explain the role of the case manager and that case management services are free. If the client states that case management services are not needed at this time, give the client

the local CSP telephone number and assure the client that this service is available, if needed, in the future.

4. If the client consents to case management, perform a Barrier Assessment (Attachment 5-I). Document identified barriers and the steps to resolve them as part of the written Client Care Plan (Attachment 5-II). All communication with the client or pertaining to the client (e.g., clinical providers, community resources, etc.) is to be documented in the client record. This documentation can be done by anyone within the local CSP, not just the case manager.

5. Contact the client 1-2 days prior to an appointment as a reminder; perform a barrier assessment at that time. The call allows the client an opportunity to verify whether or not he/she will be able to make his/her scheduled appointment. If the client cannot make his/her appointment and a barrier is identified, implement a care plan that addresses and resolves the barrier. Use of a tickler/reminder system may be helpful as a way to trigger client contact. Although providers may make reminder calls to clients, the expectation remains that the contract case manager will also make reminder calls, as this is an effective way to ensure compliance with scheduled appointments.

6. Develop a Community Resource Guide and routinely review and update it to ensure clients are provided with accurate and current resources to address potential barriers to diagnostic follow-up. The Community Resource Guide should include the names of community-based organizations, transportation, translation and financial services, and other local, state, and national resources with contact names, addresses and telephone numbers. This guide may be updated by anyone within the local CSP.

7. Send the *Case Management Satisfaction Survey* (Attachment 5-III) with a self-addressed stamped envelope within 30 days of the end of case management services. Review the survey results to identify issues that can be addressed immediately. Complete a quarterly review of surveys to identify possible trends (e.g., a particular provider billing CSP clients, lengthy wait times at a particular provider, etc.). Although the survey does not need to be kept in the client's record, the case management notes must include documentation that the survey was sent. All returned surveys should be kept in a central, easily accessed location to facilitate the quarterly review process.

8. Review and assess the quality of case management services offered to clients within the local CSP using the CSP Case Management Evaluation Tool (Attachment 5-IV).

9. All contractor Case Managers are required to be trained as Designated Qualified Entities (DQE) so clients with a pre-cancerous or cancer diagnosis can be immediately referred to begin the application process for the NYS Medicaid

Cancer Treatment Program (MCTP). In some instances, there may be other CSP providers trained as DQEs who can also assist the client in completing the MCTP application. Those DQEs may request assistance from the case manager to obtain required documentation or assist the client with transportation for the face-to-face interview with the DQE. Although case management through the CSP ends once a client begins treatment, the CSP recommends that case managers maintain occasional contact (every 4-6 months) with the cancer treatment center case manager and the client to ensure the client is following through on the treatment recommendations. Please see CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program for more information about this program.

10. Document all client contact, or contact pertaining to the client, completely and comprehensively. Document the date and time, a summary of the discussion that occurred, newly identified barriers, newly identified care plan activity, follow-up activities to be carried out by CSP staff or the client, and the CSP staff member's signature documenting the entry. Documentation can be completed by anyone dealing with the client or the client's needs; it is not necessary to have case management activities documented solely by the case manager. If case management is initiated at the provider's office and transferred to the local CSP, include all case management activities conducted by the provider's office in the CSPs case management notes as well. This ensures continuity of care for the client.

11. Ensure every client with an abnormal finding has a CSP client record. This record will contain all clinical documentation related to the abnormal screening, diagnostic procedures, case management notes (including the Barrier Assessment and Client Care Plan), case management notes from the provider, and the signed informed consent.

12. Use the CSP Client Contact Protocol to reach clients to reach clients where case management has been initiated, but who then become difficult to reach or non-compliant with appointments. See Attachment 5-V for more information.

13. The CSP case manager is responsible for the identification of clients who have experienced complications following a CSP-funded colonoscopy. See Attachments 5-VI, 5-VII, and 5-VIII for more information.

Attachment 5-I Barrier Assessment

Barrier Assessment

1	Do you understand what follow-up appointments have been recommended by the doctor?	☐ Yes	☐ No
2	Do you need help scheduling these appointments? If so, what type of help? (i.e., is there a language barrier, difficulty navigating a provider's phone system, no phone access, etc.)? _____ _____	☐ Yes	☐ No
3	Do you work outside the home? If so, what type of work? _____	☐ Yes	☐ No
	Are appointments scheduled during work hours a problem?	☐ Yes	☐ No
	Do you receive paid time off at work? (clients may not want to take time off from work to go to appointments if they will not be paid for that time)	☐ Yes	☐ No
4	Is transportation or distance to the appointment(s) a problem? If so, why (e.g., gas money, lack of transportation, too far away, etc.) _____	☐ Yes	☐ No
5	Do you need someone to go with you to the appointment(s), either for physical assistance (wheelchair, poor eyesight, etc.) or to provide emotional support?	☐ Yes	☐ No
	If so, do you have someone to go with you? If for physical assistance, what type is needed? _____	☐ Yes	☐ No
6	Do you need child or elder care in order to make it to your appointment(s)?	☐ Yes	☐ No
7	There may be some services that will not be paid for by the CSP. Will this cause a problem for you or prevent you from following up?	☐ Yes	☐ No
8	Do you need help filling out paperwork or forms (i.e., due to literacy, language, education, etc.)?	☐ Yes	☐ No
9	Do you have questions for your doctor? If so, what questions do you have (e.g., about the tests and what the results might mean, what's involved in the test or procedure, what exactly is being done, etc.)? _____ _____ _____ _____	☐ Yes	☐ No

_____

_____

_____

_____

10 Did the doctor's office tell you that you needed someone to drive you to and from the appointment(s) (e.g., due to medication the client might have to take or the procedure the client will undergo)? ☐ Yes ☐ No

If so, do you have someone to drive you? ☐ Yes ☐ No

11 For colonoscopy only – Was the preparation for this test explained to you? ☐ Yes ☐ No

12 During the course of your conversation with the client, you will need to determine whether there are any religious or cultural beliefs that might prevent him/her from following up or going to the appointment(s). Please document any such barriers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(04/2011)

Attachment 5-II Client Care Plan

Client Name:_____
Phone Number: _____
DOB: _____

Client Care Plan

Identified Barrier(s)	Plan
1) Provider recommended follow-up appointments	
2) Needs help to schedule appointments	
3) Works outside the home Does not get paid time off Unable to schedule appointments during work hours	
4) Transportation issues	
5) Needs someone to go with her/him to the appointment Physical/emotional support To drive	
6) Needs child/elder care	
7) Money issues	

8) Needs help completing paperwork	
9) Needs referral for MCTP	
10) Client questions for Provider/MD	
11) Needs further instruction regarding preparation for a colonoscopy	
12) Religious/cultural barriers	
13) Other	

(04/2011)

Attachment 5-III Case Management Satisfaction Survey

Case Management Satisfaction Survey

	Very Satisfied	Satisfied	No Opinion	Dissatisfied	Very Dissatisfied	Not Applicable
Case management services were explained to me.						
The case manager listened to my concerns and answered my questions.						
The case manager returned my calls within 1-2 business days.						
I received information in a language I understood.						
I received help from the case manager to get the services I needed.						
I feel I was referred to specialists/others in a timely manner.						
I was treated with respect.						
The case manager asked me about any problems I might have being able to make my appointment(s).						
If treatment was required please answer the following questions: The case manager called me occasionally to see how I was doing. 2) The case manager helped me, or referred me to someone, to complete a Medicaid application that would pay for my treatment.						

Overall rating of case manager						
Overall rating of medical providers						

Did you receive a bill for any of the medical services you received? _____Yes _____No If so, what bills did you receive and did the case manager help you to resolve them?
Do you think you will need further assistance from the case manager? _____Yes _____No If so, what type of assistance will you need?
Would you recommend our program to other women/men? _____Yes _____No If not, why?
What suggestions do you have that might help us improve our program:
Other comments:

(04/2011)

Attachment 5-IV Partnership Case Management Evaluation Tool

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM
CSP Case Management (CM) Evaluation Tool

Client Name: _____ Abnormal Screening: Breast Cervical Colorectal
Client ID#: _____
CSP of: _____ Date of Abnormal Screening _____
Provider Site: _____ Abnormal Results: _____
CM Done By: CSP Provider Date CM Notified of Abnormal Finding _____
Case Manager: _____ Date CM initially contacted client _____
Date of Review: _____

CSP Case Management Questions	Yes	No	N/A	Comments
Did the client receive all diagnostic services within 60 days for breast or 90 days for cervical/colorectal from the date of the initial screening? ****If no, explain reason for delay. If reason for delay is not known, state this as well.**				
Is there a signed CSP informed consent in the client record? Eligibility questions checked? Witness signature present? Adherence to leaving a message?				Date consent signed:
Is the client under 40 years old? If so, is there a breast attestation present?				
Is clinical documentation of the abnormal screening in the chart?				
Is clinical documentation of the diagnostic follow-up procedures/testing in the chart?				
If applicable, were attempts made to contact the client during non-working hours/days?				
Was a barrier assessment completed?				
Is there a plan to address each barrier that is documented?				
Is there documentation/evidence of ongoing monitoring for other barriers?				
Was the client contacted 1-2 days prior to their appointment?				
Was the client contacted after the appointment?				
If applicable, were the 7 & 30 days calls made after the client's colonoscopy?				
Is the client aware of the provider's rescreening recommendation (after the final diagnosis has been made)?				
Did the client receive all of the appropriate referrals?				
If applicable, was the protocol for "lost to follow-up" or "work-up refused" followed?				
If applicable, was the client referred to a DQE?				
Is there evidence of initial contact with the treatment provider?				
Was a client satisfaction survey sent?				
Is there evidence of adequate communication between the client, provider, and CM?				

Comments:_____
_____
_____
_____

(Revised 3/23/12)

Attachment 5-V Client Contact Protocol

New York State Department of Health
Cancer Services Program
Case Management Client Contact Protocol

The following protocol provides suggestions on how to contact clients. This applies to clients where case management has been initiated but who then become difficult to reach or non-compliant with appointments.

- Make three attempts to contact the client by telephone at different times of the day and days of the week (e.g. early morning, late afternoon, evening, weekends, etc.).
- Try calling "other contact" provided on the SIF to ask if the client is away or out of the country, or ask if there is another telephone number where the client can be reached.
- If attempts at contacting the client by telephone fail, send three letters over a period of three weeks to the client, detailing why you are attempting to contact them and the availability of case management services. The last letter should be mailed certified with return receipt. If the letter is returned with a new forwarding address, re-send the letter.* If the letters are not returned or are returned as "unclaimed", this generally means the address was correct. You can then disposition the client as "lost to follow up" or "work refused".
- If the telephone number is incorrect or the client has moved, contact directory assistance (area code+555+1222). Give the operator the last name and the last known address. If the number is non-published, confirm you have the correct address. Directory assistance will confirm/deny the information; however, they will not give out any new information.
- If the client is reached, explain the importance of following through with the diagnostic services and if assistance is needed now or in the future, case management is available.
- If the client refuses follow-up services, explain that a letter of refusal for diagnostic services will be mailed.*

*Once confirmation that the certified letter has been received or the refusal letter has been sent further case management attempts can be discontinued.

Attachment 5-VI CM Procedure for Identification of Complications Following a CSP Funded Colonoscopy

Case Management Procedure for Identification of Complications Following a CSP Funded Colonoscopy

(See Attachment 5-VII for algorithm and Attachment 5-VIII for definitions of colonoscopy complications):

1. Any client who meets eligibility for a CSP-funded colonoscopy must have follow-up by the CSP case manager to identify potential complications resulting from the colonoscopy. The results of that follow-up must be reported on the CSP data system, Indus.

2. The case manager calls the client to offer case management services. At this time, the case manager will complete a barrier assessment and assist the client in scheduling his/her consult or colonoscopy procedure, if needed.
   - If the client is able to schedule his/her own appointment, the case manager will remind him/her to call back with the date and time.
   - The case manager will follow-up with the client within three days to ensure he/she has been able to make the appointment. If he/she has not, the case manager will offer to schedule it for them. If the case manager is unable to reach the client by phone, he/she will contact the provider's office to ask whether the client has made an appointment.
   - The case manager will continue this process until an appointment has been made for the consult and/or the colonoscopy.
3. If the client has a consult done prior to the colonoscopy, the case manager will call him/her 1-2 days following the consult to see if there are any tests that need to be completed before a colonoscopy can be scheduled. Any required pre-testing should be confirmed with the consulting provider. If needed, the case manager will assist the client in completing these tests.

4. The case manager will call the client 1-2 days prior to his/her appointment(s) as a reminder. The case manager will also complete another barrier assessment to ensure the client will be able to make the appointment.

5. The case manager will call the client 7 days after colonoscopy to ask him/her about the procedure and about any experienced complications.*
   - If no complications are reported, the case manager will inform the client to expect a call in a few weeks to "check up" and make sure everything is still going well.
   - If a complication is reported, the case manager will ask the client what it was. The case manager will then ascertain where care was provided and will

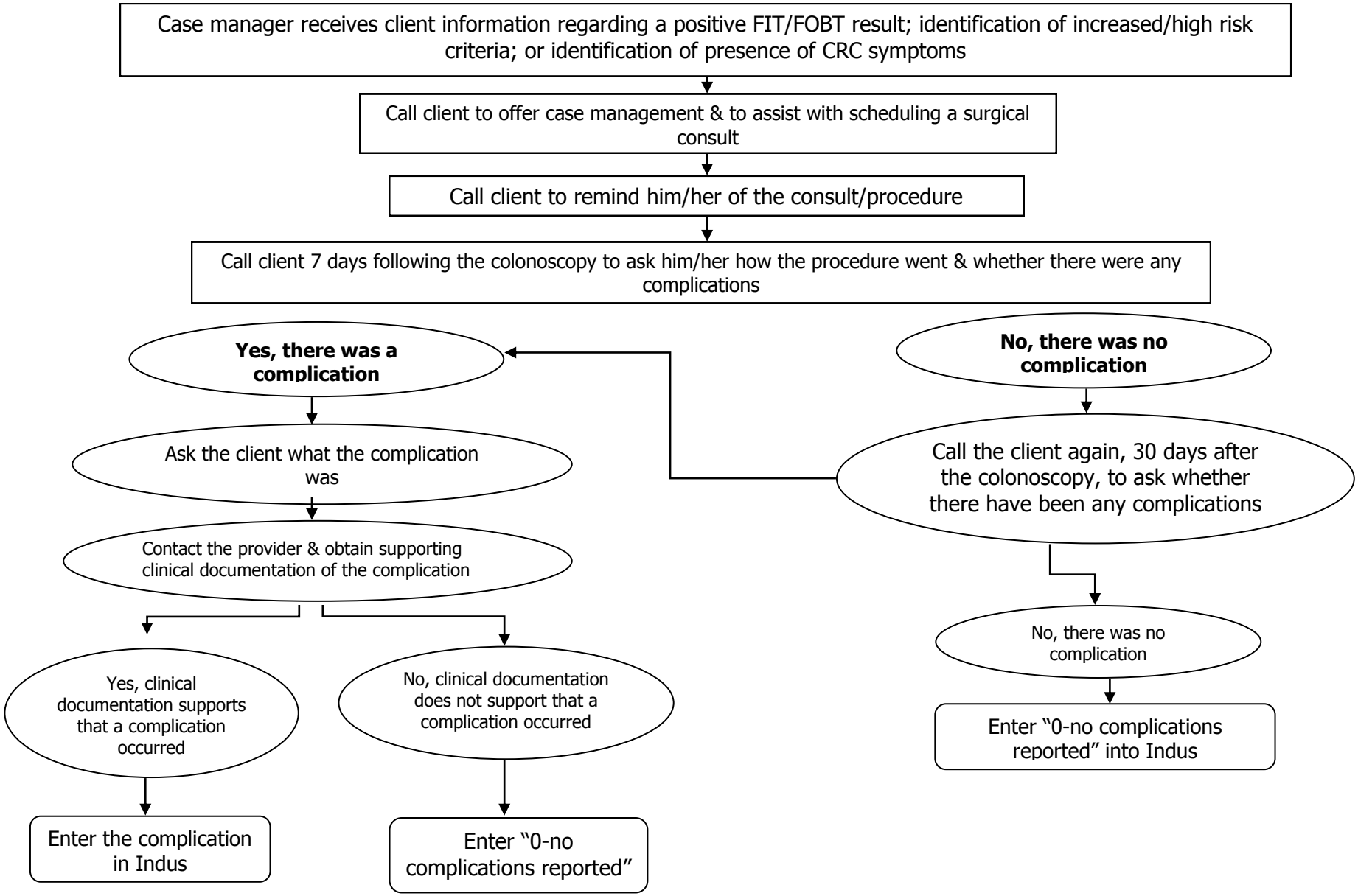
contact the hospital/provider to request the report and clinical documentation to verify the complication. If the documentation does not support evidence of a complication, the case manager will indicate this when reporting on the Indus data system. If the documentation does indicate that a complication occurred, the case manager will indicate the complication on the Indus data system.

6. If no complications are reported, the case manager will call the patient again 30 days after the procedure to inquire about any complications up this point.
   - If no complications are reported, the case manager will indicate this on the Indus data system.
   - If a complication is reported, the case manager will ask the client what it was. The case manager will then ascertain where care was provided and will contact the hospital/provider to request the report and clinical documentation to verify the complication. If the documentation does not support evidence of a complication, the case manager will indicate this when reporting on the Indus data system. If the documentation does indicate that a complication occurred, the case manager will indicate the complication on the Indus data system.

**See Attachment 5-VIII for definitions of these complications*

Attachment 5-VII Case Management CRC Complications Algorithm

Case Management Colorectal Cancer Complications Algorithm



Attachment 5-VIII Definitions of Colonoscopy Complications

Definitions of Colonoscopy Complications

0 = No complication reported: self-explanatory

1= Bleeding requiring transfusion: if a transfusion has occurred, clinical documentation will state one of the following examples – "transfused with packed red blood cells;" "transfused with packed cells;" "transfused with red cells;" or "transfused with RBCs."

2= Bleeding not requiring transfusion: clinical documentation will have a description of the bleeding, including the amount ("scant," "small," or a measured amount), with a description of what steps were taken to stop the bleeding. The documentation samples in #1 will NOT appear on the report.

3= Cardiopulmonary events (e.g., hypotension, hypoxia, arrhythmia, etc.): hypotension (low blood pressure), hypoxia (lack of oxygen), arrhythmia (irregular heartbeat accompanied by heart palpitations, dizziness, fainting, shortness of breath, and/or chest pains). These symptoms will typically occur during or immediately after the colonoscopy procedure.

4= Complications related to anesthesia: these include allergic reactions (the medical term is anaphylaxis) which usually are described as difficulty breathing, swelling of the face & mouth, appearance of a red rash, increased heart rate, and/or low blood pressure (the medical term is hypotension). Non-allergic reactions that might occur are nausea, vomiting, low blood pressure (hypotension), and respiratory depression (poor breathing).

5= Bowel perforation*: clinical documentation might state that the client complained of persistent abdominal pain and distention; or that the client presented with peritonitis, fever, and an elevated white blood cell count (the medical term is leukocytosis). Documentation will state that a perforation occurred and where it is located; how the perforation was treated will also be included.

6= Post polypectomy syndrome/excessive abdominal pain*: clinical documentation will reveal client complaints of abdominal pain, fever, and an elevated white blood cell count (the medical term is leukocytosis). This complication will occur if a polyp is removed.

7= Death: self-explanatory

8= Other: other possible complications include rupture of the spleen, appendicitis, excessive bleeding related to reasons other than polyp removal or bowel perforation, and problems related to improper disinfection of the colonoscope (the lighted tube used to view the colon).

*Although #5 & #6 have similar symptoms, the complications are a result of different issues. Symptoms for #5 occur from a bowel perforation and symptoms for #6 occur from the removal of a polyp.

Chapter 6 - Reimbursement

CSP Operations Manual 04/14

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Chapter 6: Reimbursement

A. Guidelines

Clinical services are paid for by the CSP contractor (Component A grantees) or the State, Health Research Inc. (HRI) and/or its Fiscal Agent (Component B grantees) to the CSP-credentialed provider after the contractor has submitted all required data to the NYSDOH CSP. Monthly billing reports generated from the data system are used to create vouchers, which are then used to bill the State and HRI for reimbursable clinical services provided to eligible clients.

Component A contractors receive payment from the State and HRI and subsequently reimburse the providers with whom they have agreements for provision of services to eligible CSP clients and invoices for services in accordance with the CSP maximum allowable reimbursement rates.

All contractors must have written agreements with participating providers that include consent to provide services as outlined by the CSP Operations Manual and provisions of the contract described in Participating Provider Requirements (see CSP Operations Manual, Chapter 2: Required Activities and Standards, Section D). For reimbursement of clinical services, contractors and providers must:

1. request reimbursement for clinical services only for clients who meet the eligibility criteria as defined in the CSP Operations Manual, Chapter 3: Eligibility
2. treat the CSP as the Payor of last resort. All providers agree to first bill client's other insurance and/or third party payor(s) for services provided through the CSP. Providers further agree that they may not submit claims for reimbursement directly to New York State (NYS) but will provide information to the CSP contractors for submission on the CSP Data system for reimbursement.
3. accept reimbursement rates established by the CSP as payment in full for all services that are covered by the CSP. Maximum Allowable Reimbursement Schedule (MARS) rates are issued annually by the CSP and are included in the *New York State Department of Health Cancer Services Program Reimbursement Schedule* (Attachment 6-I). *The New York State Department of Health Cancer Services Program Reimbursement Schedule* represents reimbursement in full for specific services.

   The CSP does not reimburse for services billed by Current Procedural Terminology (CPT) code or on Health Care Financing Administration (HCFA) billing forms. Providers agree not to charge clients for the difference between the CSP reimbursement rate and the provider's usual fees or the amount allowed by the clients' insurance plan. The CSP reimbursement rate is based on Medicare regional global rates, which include the technical and professional component of the service to be reimbursed. Under no circumstance shall providers bill CSP clients for the services that are reimbursed by the CSP.

4. submit reimbursable services in a timely manner on a completed Screening Intake Form (SIF) and, where applicable, a Follow-up Form (FF)
5. submit accurate demographic, screening, diagnostic, treatment and any other data required by NYS in a timely manner and in the format required by NYS
6. the provider agrees that the reimbursement for clinical services will not be provided by NYS for reimbursement to the provider until appropriate data have been submitted and accepted in the CSP data system

B. Maximum Allowable Reimbursement for Clinical Services

The CSP is the Payor of last resort. The CSP will pay for services according to the *New York State Department of Health Cancer Services Program Reimbursement Schedule* (Attachment 6-I) ONLY if the client meets all eligibility criteria and no other sources of payment are available for the services. Other sources include private insurance, managed care plans, Medicare, Medicaid, and Title X Family Planning Services.

Payor of last resort as it applies to Indian Health Service (IHS) Clinics and Tribally Operated Clinics: IHS is designated as the Payor of last resort, meaning that all other available alternative resources, including IHS facilities, must first be used before payment is expected. According to 42 CFR 136.61 (2002), IHS is the Payor of last resort for persons who have an alternate resource, notwithstanding any State or local law or regulation to the contrary. Accordingly, IHS will not be responsible for or authorize payment for medical services to the extent that an alternate resource is available (Reference: CDC, NBCCEDP Program Guidance Manual, Policies and Procedures, Attachment C-1, April 2007). Therefore, the CSP may be billed for eligible services rendered outside of the IHS provider or facility to persons qualifying under the IHS who have no additional health insurance coverage or source of payment.

Refer to the *New York State Department of Health Cancer Services Program Reimbursement Schedule* (Attachment 6-I).

The reimbursement criteria are not clinical guidelines. These criteria address reimbursement of services through the CSP only. Alternate funds must be identified to reimburse for services that are recommended by providers, but are not reimbursed by the CSP.

NOTE: For reimbursement policies related to Family Planning Programs, refer to Attachment 6-II *Guidance for Cancer Services Program Contractors and Title X Family Planning Providers, July 2009*.

1. Breast Cancer Screening Services

    a. Clinical Breast Exam (CBE)

The CSP will reimburse for:

- a screening CBE annually for women aged 40 years and older

  - a screening CBE for a women under age 40 who has been determined to be high-risk for breast cancer in accordance with CSP high-risk criteria and has a signed attestation. See CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Section H
- a short-term CBE (i.e.: performed sooner than one year) for women aged 40 years and older, if ordered by a clinician at least 30 days after an initial CBE to assess a probably benign CBE finding. This should be submitted on a new SIF.
- a repeat CBE performed as follow-up to a CBE finding initially reported as suspicious for breast cancer. This should be submitted on the FF.
- more than one CBE in a year if a woman aged 40 years or older presents with an interval finding within the year (e.g., a woman finds a lump in her breast after having a negative CBE within the past year)

The CSP does not reimburse for screening CBE in women under age 40 who have clinically significant findings for breast cancer or for men at any age. The CSP will, however, reimburse for a repeat CBE reported on the FF as part of diagnostic evaluation for a woman under age 40 and for men 18 years of age and older for clinical correlation of diagnostic testing and when it is performed within 30 days of the diagnostic testing.

b. Screening Mammogram

The CSP will reimburse for:

- a screening mammogram annually for women ages 40 years and older
- a short-term repeat mammogram (i.e., a mammogram performed sooner than one year) following a reported BI-RAD 3 probably benign short-term mammogram recommended. This should be submitted on a new SIF.

The CSP does not reimburse for screening mammography in average-risk women under age 40. Women ages 18-39 who are determined to be at high risk for breast cancer or who have clinically significant findings for breast cancer may be eligible for some CSP-reimbursed services (see CSP Operations Manual, Chapter 3: Eligibility, Section C-3).

The CSP reimburses for film-screen and digital mammography at the same rate. The CSP will not reimburse for computer-assisted detection (CAD). *The CSP will not reimburse for a screening mammogram for men.*

2. Cervical Cancer Screening Services

a. Pelvic Exam

The CSP will reimburse for:

- a pelvic exam for women ages 40 years and older, when performed at the same time as an appropriate cervical cancer screening test

- a short-term repeat pelvic exam (i.e., a pelvic exam performed sooner than one year) in women ages 40 years and older based on abnormal findings of a previous cervical cancer screening or a cervical cancer screening performed for surveillance purposes following recommended treatment when performed at the same time as an appropriate cervical cancer screening test. This should be submitted on a new SIF.

- a short-term pelvic exam (i.e., pelvic exam performed sooner than one year) in women ages 40 years and older who present with an interval finding that may be suspicious for cervical cancer. This should be documented in the medical record and submitted on a new SIF.

- an initial pelvic exam for women ages 40 and older who have had a hysterectomy and who are not sure if their cervix is intact for the purpose of determining if the client still has a cervix. For further explanation, see CSP Operations Manual, Chapter 3: Eligibility, Section C-8.

The CSP will not reimburse for pelvic exams performed during the years in between cervical cancer screenings for women who are receiving cervical cancer screening according to an appropriately lengthened interval.

b. Cervical Cytology (Pap Test)

The CSP will reimburse for:

- a liquid-based Pap test every three years for women ages 40 years and older with an intact cervix and a prior negative test. Once there are three consecutive negative Pap tests in a 60-month period, the CSP will reimburse for Pap test and pelvic exam once every three years for cervical cancer screening, except in those for whom there is medical exemption from the every three year screening interval (see below)
- a conventional Pap test every three years for women ages 40 years and older with an intact cervix and a prior negative test; a liquid based Pap test every five years when performed in combination with a high risk HPV test and when both tests are negative
- a short-term repeat Pap test (i.e.: a Pap test performed sooner than one year) in women ages 40 years and older based on the prior Pap test was unsatisfactory. This should be submitted on a new SIF.
- a conventional or liquid-based Pap test every three years (after initial surveillance at the appropriate prescribed intervals with negative results) for women ages 40 years and older who have had a hysterectomy due to cervical cancer or pre-cancerous cervical dysplasia. See CSP Operations Manual, Chapter 3: Eligibility, Section C-8 for more information.
- a conventional or liquid-based Pap test annually for women 40 years and older who have a documented medical exception of being immunocompromised, are infected with HIV, or were exposed in utero (as a fetus) to diethylstilbestrol (DES).

The CSP provides reimbursement for conventional and liquid-based cytology at different reimbursement rates. The CSP reimburses one reimbursement rate for conventional and another rate for liquid-based cytology, regardless of the methodology, level of interpretation, or the CPT code billed for reimbursement.

The CSP will reimburse for cervical cancer screening at intervals prescribed by the updated Cervical Cancer Screening CSP Reimbursement Guidelines (Attachment 6-IV).

The CSP will not reimburse for a Pap test for a client who has had a total hysterectomy and whose cervix was removed for reasons other than those listed above (see CSP Operations Manual, Chapter 3:Eligibility, Section C-8).

c. Human Papillomavirus (HPV) DNA Testing (High-Risk Only)

The CSP will reimburse for High-Risk (HR) HPV DNA (Hybrid Capture II), Cervista HR HPV or cobas® HPV test for women ages 40 and older for screening:

- in conjunction with cytology for cervical cancer screening performed at the appropriate interval
- when performed as surveillance 12 months after biopsy has confirmed CIN 1 or less with index Pap test for colposcopy of ASC-US, ASC-H, or LGSIL
- when performed in 12 months, as follow-up to a prior negative Pap test and a positive HR HPV DNA test
- when performed as surveillance co-testing 12 months and 24 months after treatment of CIN 2 or greater.

3. Colorectal Cancer Screening Services

a. Fecal Tests

i. Fecal Occult Blood Test (FOBT) Kit

The CSP will reimburse for an annual multi-slide, take-home FOBT kit:

- only for men and women ages 50 years and older at average risk for colorectal cancer who have not completed an FOBT or FIT kit in the past ten months

The CSP will not reimburse for an in-office, single-slide fecal test.

Please note: diagnostic services based on a positive in-office, single-slide fecal test will not be reimbursed.

ii. Fecal Immunochemical Test (FIT) Kit

The CSP will reimburse for an annual multi-slide, take-home FIT kit:

- only for men and women ages 50 years and older at average risk for colorectal cancer who have not completed a FIT or FOBT kit in the past ten months

b. Screening Colonoscopy

The CSP will reimburse for:

- screening colonoscopy for clients who are at increased or high risk for colorectal cancer (see CSP Operations Manual, Chapter 3: Eligibility, Section C-9)

The CSP will not reimburse for screening colonoscopy in clients who are at average risk for colorectal cancer. An exception is those clients who have undergone screening in the selected CSP pilot programs.

4. Breast Cancer Diagnostic Services

The reimbursement policies below apply to women ages 40 and older, women under the age of 40 who are deemed high-risk for or with clinically significant findings for breast cancer, and men deemed at high risk for or with clinically significant findings for breast cancer who are otherwise eligible for the CSP. The following diagnostic procedures can be reimbursed only following an abnormal CBE or a screening mammogram with a finding of BI-RAD 4, 5, or 6/0. The CSP will reimburse for the following services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS Medicaid Cancer Treatment Program (MCTP) (see CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below represent the codes for each procedure on the Follow-up Form and Indus.

(01) Unilateral Diagnostic Mammogram, (90) Bilateral Diagnostic Mammogram (Special Views ONLY)

The CSP will reimburse for:

- a diagnostic mammogram, either bilateral or unilateral. In the CSP, a diagnostic mammogram is defined as one or more special views such as a cone view, magnification view, or compressed view which is performed in addition to the four standard views - medial, lateral, oblique [MLO] and craniocaudal [CC] of the left and right breasts
- a specimen radiograph (post-operative mammogram of the removed area of concern), if not included in an all-inclusive procedure fee.
- a post-procedure mammogram to examine the site of biopsy, if not included in an all-inclusive procedure fee.
- A 6 month short term follow up after the biopsy for a mammographic finding to ascertain stability.

Note: procedure (16) and (84) Stereotactic breast biopsy and procedure (25) and (86) are all inclusive codes and already include specimen radiograph and post-procedure film. The CSP does not reimburse for additional implant displaced views as a diagnostic mammogram. The CSP does not reimburse for tomography as special views.

(02) Repeat Clinical Breast Exam

The CSP will reimburse for:

- a repeat CBE following a finding on a screening CBE
- a repeat CBE if done at the time of a surgical consult or second opinion for a clinically palpable finding.
- a repeat CBE for clinical correlation of imaging findings within 30 days of the original abnormal screening CBE

(03) Surgical Consult/Second Opinion

The CSP will reimburse for:

- a surgical consult prior to a biopsy OR on the same day of the biopsy
- a second opinion when performed prior to the biopsy
- the CSP does not reimburse for a surgical consult or a second opinion once a diagnosis has been determined (i.e., post-diagnosis)
- a second opinion/surgical consult, (1): when performed by a different provider and (2) following a biopsy that is discordant with imaging findings, pathology findings or physical examination and (3) that requires a second biopsy for a definitive diagnosis to rule out breast cancer. Example: A client has stereotactic breast biopsy in which atypical micropapillomas are present in pathology specimen and the recommendation is a surgical consult for excisional biopsy. This second surgical consult, if performed by a different provider after the initial biopsy, would be reimbursed.

(04) Diagnostic Breast Ultrasound (Sonogram)

The CSP will reimburse for:

- a breast ultrasound only after a clinically significant finding has been determined by a NYS-licensed health care provider on a CBE or mammogram
- bilateral ultrasounds (i.e., ultrasounds performed on both breasts) is reimbursed at the same rate as a unilateral ultrasound and should only be performed if there are bilateral findings that require diagnostic ultrasound
- one short-term, repeat ultrasound when clinically indicated based on the findings from a previous probable benign short-term study. In order to receive reimbursement for this procedure, the provider must submit the procedure on a Revision Form for inclusion on the follow up form that contains the initial Probable Benign short-term ultrasound .
- a diagnostic ultrasound when performed as image guidance to a biopsy

- a diagnostic ultrasound when performed as image guidance to a biopsy procedure that does not result in biopsy, because the lesion/area to be biopsied is not located

The CSP reimbursement for a diagnostic breast ultrasound is for a unilateral OR a bilateral ultrasound. The CSP will not reimburse for screening breast ultrasounds or survey ultrasounds for dense breast tissue alone. The CSP will not reimburse for ultrasounds when performed as follow-up on mammography findings of benign dense breast tissue alone or to follow benign breast conditions post-diagnosis; this includes routine 6 month US following a breast biopsy with a benign finding. The CSP will reimburse for only one ultrasound on the same day by the same provider.

(07) Fine Needle Aspiration Breast Biopsy (FNAB) with ultrasound guidance

The CSP will reimburse for:

- FNAB with image guidance only when performed to rule out breast cancer, not when performed to drain a cyst or performed to reduce pain from simple cysts
- one FNAB with image guidance per lesion if there are multiple lesions
- only one FNAB with image guidance if there are multiple samples taken from a single lesion

Please note that the reimbursement rate includes reimbursement for ultrasound guidance used during the FNAB. If the ultrasound does not locate the lesion at the time of FNAB and the biopsy is not performed, then the ultrasound can be reimbursed as (04) Diagnostic Ultrasound, and the FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining or when performed to relieve mastalgia.

(08) Core Breast Biopsy

The CSP will reimburse for:

- core biopsy taken from a lesion to rule out breast cancer

(09) Incisional Breast Biopsy

The CSP will reimburse for:

- an incisional biopsy taken from a lesion to rule out breast cancer

(10) Excisional Breast Biopsy

The CSP will reimburse for:

- an excisional breast biopsy that removes the entire lesion to rule out breast cancer
- one excisional biopsy per lesion if there are multiple lesions
- only one excisional biopsy if there are multiple samples taken from a single lesion

The CSP does not reimburse for an excisional breast biopsy (lumpectomy) if performed after a diagnosis of cancer has already been determined.

(11) Cytology, Breast Fluids

The CSP will reimburse for:

- cytology of breast fluids, only when submitted to a lab for diagnosis following an FNAB
- one cytology per lesion if there are multiple samples

(12) Histology, Breast Tissue

The CSP will reimburse for:

- histology, breast tissue following a core, incisional, excisional or stereotactic biopsy
- only one histology per lesion for all biopsies. Multiple samples from the same lesion will be reimbursed as one histology.

(82) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. It is not used for examination of benign specimens.

(14) Cytology, Nipple Smear

The CSP will reimburse for:

- cytology, nipple smear when done to rule out breast cancer

The reimbursement fee includes both the collection and reading of the sample.

(15) Pre-operative Mammographic Needle Localization and Wire Placement all inclusive procedure reimbursement.

The CSP will reimburse for:

- mammographic needle localization when performed pre-operatively to a biopsy to locate a lesion and place a wire to localize the lesion prior to biopsy

When a mammographic needle localization is attempted and the area of concern is not found and, therefore, no needle/wire is advanced and the biopsy is cancelled, a (01) Diagnostic Mammogram and (03) Surgical Consult can be reimbursed and the (15) Pre-operative Mammographic Needle Localization and wire placement is not reported on the FF.

(83) Additional pre-operative Mammographic Needle Localization and Wire Placement second lesion

- when a second lesion requires mammographic needle localization and wire placement on the same day.

(16) Stereotactic Biopsy Procedures (regardless of biopsy apparatus employed) all inclusive procedure; placement of breast localization device(s),(eg, clip, metallic pellet) imaging of the biopsy specimen, percutaneous biopsy; first lesion, including stereo guidance

The CSP will reimburse for:

- a stereotactic biopsy when performed to rule out breast cancer

When a stereotactic procedure is performed utilizing standard core biopsy(s), the all-inclusive rate for stereotactic procedures includes payment for mammographic localization, core biopsy(s), image-guided clip placement and post procedure imaging of placement and the post-procedure specimen radiograph. Procedure code (16) Stereotactic Biopsy Procedures with standard core(s) must be reported.

(84) Second lesion Stereotactic Procedure all inclusive (as above.)

When a second stereotactic procedure is performed on a second lesion (same breast or opposite breast) on the same day, Procedure code (**84)** is reported for the second lesion and any additional lesions where Stereotactic biopsy procedure is employed

For pathology reimbursement associated with the stereotactic biopsy procedure, see (12) Histology, Breast Tissue, above.

If a stereotactic breast biopsy is attempted and the lesion cannot be identified and, subsequently, the biopsy cannot be performed, (01) Diagnostic Mammogram view(s) taken to locate the lesion and the (03) Surgical Consult can be reimbursed; the all-inclusive stereotactic procedure should not be reported on the FF.

(18) Anesthesiologist Services

The CSP will reimburse for:

- anesthesiologist services only when an anesthesiologist or nurse anesthetist administers IV-monitored anesthesia care

An anesthesiologist fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

(19) Chest X-Ray

The CSP will reimburse for:

- a pre-operative chest X-ray only prior to an incisional or excisional breast biopsy

(20) Electrocardiogram (ECG/EKG)

The CSP will reimburse for:

- a pre-operative ECG/EKG only prior to an incisional or excisional breast biopsy

(21) Complete Blood Count (CBC)

The CSP will reimburse for:

- a pre-operative CBC only prior to an incisional or excisional breast biopsy

(22) Pre-operative Ultrasonic Needle Localization and Wire Placement- all inclusive procedure reimbursement.

The CSP will reimburse for:

- ultrasonic needle localization when performed pre-operatively to locate a lesion and place a wire to localize the lesion prior to excisional biopsy

When ultrasonic needle localization is attempted and the area of concern is not found and, subsequently, the needle/wire is not advanced and the biopsy is cancelled, a (04) Diagnostic Ultrasound and (03) Surgical Consult can be reimbursed and the (22) Pre-operative Ultrasonic Needle Localization and Wire Placement is not reported.

(85) Additional pre-operative Ultrasonic Needle Localization and Wire Placement second lesion

- when a second lesion requires US needle localization and wire placement on the same day.

(23) Facility Fee – Core Biopsy

The CSP will reimburse for:

- a facility fee for a core biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. Only one facility fee per day, regardless of the number of biopsies performed.

(24) Facility Fee – Excisional/Incisional Biopsy

The CSP will reimburse for:

- a facility fee for an excisional or an incisional biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. Only one facility fee per day, regardless of the number of biopsies performed.

(25) Ultrasound-Guided Core Needle Biopsy with Vacuum-Assisted Device all inclusive procedure; placement of breast localization device(s),(eg, clip, metallic pellet) imaging of the biopsy specimen, percutaneous biopsy (s); first lesion, including US guidance

The CSP will reimburse for:

- ultrasound-guided core needle biopsy using a vacuum-assisted rotating biopsy device only when performed to rule out breast cancer

Please note that the reporting of this procedure code is all-inclusive

(86) Second lesion US guided vacuum assisted breast biopsy procedure - all inclusive (as above.)

When a second US guided vacuum assisted breast biopsy procedure is performed on a second lesion (same breast or opposite breast) on the same day, Procedure code (**86)** is reported for the second lesion and any additional lesions where Stereotactic biopsy procedure is employed

(29) Fine Needle Aspiration Breast Biopsy (FNAB) without image guidance

The CSP will reimburse for:

- FNAB without image guidance only when performed to rule out breast cancer, not when performed to drain a cyst or performed to reduce pain from simple cysts
- one FNAB without image guidance per lesion if there are multiple lesions
- only one FNAB without image guidance if there are multiple samples taken from a single lesion

Please note that if the lesion is not palpable at the time of the biopsy and the biopsy is not performed, then the FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining or when performed to relieve mastalgia.

Cervical Cancer Diagnostic Services

The reimbursement policies below apply to women ages 40 years and over who are otherwise eligible for the CSP.

The following procedures can be reimbursed only after one or more of the following conditions have been met:

- a screening pelvic exam with an exam finding that is reported as suspicious for cervical cancer
- a Pap test with a finding of:
  - 2nd Atypical Squamous Cells of Undetermined Significance (ASC-US) @12 months(03)
  - Low-grade Squamous Intraepithelial Lesion (LSIL) (04) no HPV performed , or + HR HPV Co-test

- High-grade Squamous Intraepithelial Lesion (HSIL) (05)
- Squamous Cell Cancer (06)
- Atypical Squamous Cells: Cannot Exclude HSIL (ASC-H) (08),
- Atypical Glandular Cells (AGC); all subtypes including adenocarcinoma in situ, but excluding atypical endometrial cells only (12).
- 2nd Negative Pap cytology with a +HR HPV @ 12 months

The CSP will reimburse for services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS Medicaid Cancer Treatment Program (MCTP) (see CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below are the codes that should be reported for each procedure on the CSP Follow-up Form and on Indus.

(52) Colposcopy without Biopsy

The CSP will reimburse for:

- a colposcopy without biopsy when a colposcopy is performed and no lesion is visualized or biopsied

According to the American Society for Colposcopy and Cervical Pathology (ASCCP), colposcopy with endocervical sampling is preferred in women with no lesions observed and/or with unsatisfactory colposcopy (incomplete visualization of entire squamocolumnar junction and margin of any visible lesion).

The CSP will not reimburse for the colposcopy if a Pap test and a colposcopy are performed on the same day.

The CSP will reimburse for a short-term repeat colposcopy without biopsy only as active surveillance at 6-month intervals to a biopsy confirmed Cervical Intraepithelial Neoplasia - Grade 2 or 2,3 (CIN2 or 2,3) that is not being actively treated when the client is not eligible for MCTP Active Surveillance.

The CSP will not pay for surveillance or repeat colposcopy when a diagnosis of Cervical Intraepithelial Neoplasia- Grade 1 is obtained, unless the client has a new abnormal Pap test that initiates colposcopy follow-up.

(53) Colposcopy-Directed Biopsy

The CSP will reimburse for:

- a colposcopy-directed biopsy when a colposcopy is performed, lesions are visualized, and a biopsy is taken from one or more lesions

Only one colposcopy fee will be reimbursed regardless of the number of tissue samples taken during biopsy.

(54) Gynecologic Consultation (Cervical)

The CSP will reimburse for:

- a gynecologic consultation prior to a colposcopy in order to discuss the risks and benefits with the client and/or the procedure that is about to be performed
- a gynecologic consultation after a colposcopy but prior to a diagnostic excisional procedure in order to discuss the options available to the client and/or the procedure that is about to be performed

Only one gynecologic consult will be reimbursed, unless it is a second opinion by a participating provider prior to the colposcopy. The CSP will not reimburse for a surgical consult or a second opinion that is completed post-diagnosis. The gynecologic consultation is not intended to be the appointment to discuss results of a Pap test.

(56) Diagnostic Loop Electrosurgical Excision Procedure (LEEP) or Loop Electrical Excision of the Transformation Zone (LEETZ) Biopsy (the process of obtaining a specimen from the transformation zone and endocervical canal for histological evaluation)

The CSP will reimburse for:

- a LEEP or LEETZ biopsy that is performed as a diagnostic procedure and meets the criteria below:
  - the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
  - the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

(57) Diagnostic Cold Knife Cone Biopsy

The CSP will reimburse for:

- a diagnostic cold knife cone biopsy which is performed as a diagnostic procedure and meets the following criteria:
  - the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
  - the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

(58) Diagnostic Laser Cone Biopsy

The CSP will reimburse for:

- a diagnostic laser cone biopsy which is performed as a diagnostic procedure and meets the following criteria:

- the initial Pap test finding was AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
- the initial Pap test finding was HSIL or ASC-H and the colposcopy was unsatisfactory or if HSIL is found on surveillance co-testing at 12 and 24 months

(59) Cervical Pathology Tissue

The CSP will reimburse for:

- one pathology charge when the tissue samples are submitted in one container (in toto)
- multiple pathology charges if the tissue samples are submitted in separate containers
- ECC pathology when the procedure is performed on the same day as the colposcopy

(88) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. (e.g. +LEEP, + cone) It is not used for examination benign specimens.

(61) Conventional Cytology

The CSP will reimburse for:

- conventional cytology when required to be performed at the time of surveillance colposcopy or when the colposcopy for a HSIL or AGC Pap test occurs greater than 5 months after the initial (index) cytology. These are the only instance a Pap test is submitted on the Follow-up Form.

(62) Chest X-Ray

The CSP will reimburse for:

- a pre-operative chest X-ray only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

(63) Electrocardiogram (ECG/EKG)

The CSP will reimburse for:

- a pre-operative ECG/EKG only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

(64) Complete Blood Count (CBC)

The CSP will reimburse for:

- a pre-operative CBC only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

(65) High-Risk Human Papillomavirus DNA Test (HR HPV)

The CSP will reimburse for:

- HR HPV DNA Hybrid Capture 2 high-risk types only or Cervista HR HPV test immediately following a finding of ASCUS (03) on a screening Pap test (reflex testing)
    - when performed at the time as a colposcopy for evaluation of an AGC pap, when HPV testing was not done as part of screening with a Pap test

The CSP will not reimburse for HR HPV testing performed on a Pap test finding greater than ASC, as those clients will be referred to diagnostic evaluation with colposcopy/ECC.

The CSP will not reimburse for HR HPV DNA test performed on the same day as a colposcopy, except in the case of a woman aged 40 and older with a diagnosis of AGC as indicated above.

(66) Colposcopy with Cervical Biopsy and Endocervical Curettage (ECC)

The CSP will reimburse for:

- a colposcopy with cervical biopsy and ECC when a colposcopy is performed, lesions are visualized, a biopsy is taken from one or more lesions and an ECC is performed

(67) Colposcopy with ECC

The CSP will reimburse for:

- a colposcopy without cervical biopsy and an ECC is performed

(68) Endometrial Biopsy

The CSP will reimburse for:

- endometrial biopsy after a Pap test result of AGC (all subcategories except endometrial only) AND the client is either aged 40 years or older with a clinical history of abnormal bleeding or a condition consistent with chronic anovulation (a condition whereby an egg is not released from a woman's ovary)

(69) Article 28 – Facility Fee for Diagnostic LEEP, LEETZ, Cold Knife or Laser Cone Biopsy

The CSP will reimburse for:

- a facility fee for diagnostic LEEP, LEETZ, cold knife or laser cone biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms, personnel and medical-surgical supplies.

(70) Anesthesiologist Services

The CSP will reimburse for:

- anesthesiologist services during diagnostic LEEP, LEETZ, cold knife or laser cone biopsy only when an anesthesiologist or nurse anesthetist administers IV-monitored anesthesia care

An anesthesiologist fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

(71) Liquid-based Cytology

The CSP will reimburse for:

- liquid-based cytology when required to be performed at the time of surveillance colposcopy, or when the colposcopy for a HSIL or AGC Pap test occurs greater than 5 months after the index cytology. These are the only instance a Pap test is submitted on the Follow-up Form.

Colorectal Cancer Diagnostic Services

The following diagnostic procedures will be reimbursed only after a positive multi-slide, take-home fecal test result or if the client is assessed to be at increased or high risk for colorectal cancer or symptomatic for colorectal cancer (see CSP Operations Manual, Chapter 3: Eligibility, Section C-9). The CSP will reimburse for services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the NYS MCTP (see CSP Operations Manual, Chapter 7: NYS Medicaid Cancer Treatment Program).

The numbers in parentheses below are the codes for each procedure that should be indicated on the CSP Follow-up Form and on Indus.

(32) Flexible Sigmoidoscopy

The CSP will reimburse for:

- a flexible sigmoidoscopy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(33) Flexible Sigmoidoscopy with Polypectomy by Hot Biopsy Forceps or Cautery

The CSP will reimburse for:

- a flexible sigmoidoscopy with polypectomy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy with polypectomy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(34) Flexible Sigmoidoscopy with Biopsy (Single or Multiple)

The CSP will reimburse for:

- a flexible sigmoidoscopy with biopsy when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a flexible sigmoidoscopy with biopsy when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(35) Radiologic Exam; Colon, Barium Enema

The CSP will reimburse for:

- a double contrast barium enema (DCBE) when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's medical record
- a DCBE when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(36) Colonoscopy

The CSP will reimburse for:

- a diagnostic colonoscopy following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer, according to CSP eligibility and guidance for prior approval. See CSP Operations Manual Chapter 3: Eligibility, Section C-9 and Chapter 4: Cancer Screening Guidance, Section E for more information.
- a repeat colonoscopy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(37) Colonoscopy with Biopsy (Single or Multiple)

The CSP will reimburse for:

- a diagnostic colonoscopy with biopsy following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy with biopsy for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (see CSP Operations Manual, Chapter 3: Eligibility, Section C-9)
- a repeat colonoscopy with biopsy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(38) Colonoscopy with Removal of Tumor(s), Polyp(s), by Hot Biopsy Forceps or Bipolar Cautery

The CSP will reimburse for:

- a diagnostic colonoscopy with hot biopsy or bipolar cautery following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy with hot biopsy or bipolar cautery for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (See Chapter 3: Eligibility, Section C-10)
- a repeat colonoscopy with biopsy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(39) Colonoscopy with Removal of Tumor(s), Polyp(s) By Snare Technique

The CSP will reimburse for:

- a diagnostic colonoscopy by snare technique following a positive multi-slide, take-home fecal test kit or following the identification of symptoms of colorectal cancer
- a screening colonoscopy by snare technique for any client at increased or high risk for colorectal cancer according to CSP eligibility guidelines (see CSP Operations Manual Chapter 3: Eligibility, Section C-9)
- a repeat colonoscopy by snare technique if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(41) Anesthesiologist Services

The CSP will reimburse for:

- monitored anesthesia care (MAC) only when medically indicated and administered by an anesthesiologist/anesthetist

The CSP will not reimburse for the administration of medication and monitoring of the patient performed by the endoscopy team. The presence of an anesthesiologist/anesthetist will not be

deemed medically necessary, except in those rare instances when a client has a pre-existing unstable medical condition. For more information, see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Section F.

Conscious sedation (such as with Versed and Demerol) is included in the reimbursement fee for colonoscopy.

(42) Surgical Pathology, Gross and Microscopic Examination

The CSP will reimburse for:

- surgical pathology of tissue removed during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)
- multiple pathologies of tissue samples if removed and analyzed separately during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)

(87) Surgical Pathology, Gross and Microscopic, needing examination of surgical margins.

- This code is only used in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. It is not used for examination benign specimens.

(43) Medical or Surgical Consultation

The CSP will reimburse for:

- a consultation following a positive multi-slide, take-home fecal test kit result and prior to a colonoscopy, sigmoidoscopy, or barium enema or following the identification of symptoms of colorectal cancer
- a medical consultation for a client who is determined at increased or high risk for colorectal cancer according to CSP guidance prior to a colonoscopy, sigmoidoscopy, or barium enema. For more information, see CSP Operations Manual, Chapters 3 and 4
- a medical consultation for a client age 50-64 who presents with symptoms as outlined in CSP Operation Manual, Chapter 3: Eligibility, Sections C-9 and C-10. If the GI consult does not result in a colonoscopy at this time, the CSP Data Unit must be contacted to provide an override for this service
- a second opinion by another program provider occurring prior to a colonoscopy, sigmoidoscopy, or barium enema
- a medical consultation provided for an increased- or high-risk client at an eligible interval determined by prior colonoscopy (see Attachment 6-III) where the GI consult does not result in a colonoscopy at this time. Contact the CSP Data Unit to provide an override to allow for this service

The CSP will not reimburse for a medical consultation that is completed post-diagnosis. The CSP will not reimburse for a medical or surgical consultation to determine if a client is increased or high-risk.

(45) Chest X-Ray

The CSP will reimburse for:

- a pre-operative chest x-ray provided only prior to a colonoscopy,

(46) Electrocardiogram (EKG/ECG)

The CSP will reimburse for:

- a pre-operative EKG provided only prior to a colonoscopy,

(47) Complete Blood Count (CBC)

The CSP will reimburse for:

- a pre-operative CBC provided only prior to a colonoscopy,

(48) Facility Fee – Sigmoidoscopy

The CSP will reimburse for:

- a facility fee for a sigmoidoscopy performed at an Article 28 facility
- a facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies

(49) Facility Fee – Colonoscopy

The CSP will reimburse for:

- a facility fee for a colonoscopy performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms and medical-surgical supplies. The facility fee does not apply to non-Article 28 accredited office-based surgery practices.

(50) Second Technique – Colonoscopy Biopsy Procedure

The CSP will reimburse for:

- a second biopsy technique performed during a colonoscopy.

This reimbursement addresses the additional expense associated with performing a second biopsy technique. For example, one polypectomy may be performed using the snare technique (procedure code 39), while another polypectomy may be performed using hot biopsy forceps (procedure code 38) during the same colonoscopy procedure. In this example, the more expensive procedure (snare technique) should be entered on the Follow-up Form using

procedure code 39. The second technique by hot biopsy forceps should be entered on the Follow-up Form using procedure code 50.

A second technique will not be reimbursed if more than one polyp is removed using the same technique.

5. Re-screening after a CSP-funded Colonoscopy

- Refer to Attachment 6-III for detailed reimbursement criteria about what colorectal cancer screening and diagnostic services can be reimbursed and when those services can be reimbursed after a CSP-funded colonoscopy has been completed

These reimbursement criteria are not eligibility guidelines for an initial screening through the CSP. For eligibility guidelines, refer to CSP Operations Manual Chapter 3: Eligibility, Section C-9.

Attachment 6-I NYSDOH CSP Reimbursement Schedule

New York State Department of Health Reimbursement Schedule 4/1/2014 - 3/31/2015							
	INDUS Procedure Codes	Guiding CPT Code(s)***	<----------Medicare Regions ---------->				
			Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
Breast/Cervical Procedures							
Screening mammogram - bilateral (film or digital) **	SIF	77057	$87.58*	$94.33	$97.23	$87.58*	$96.69
Screening mammogram - bilateral diagnostic (film or digital) **	SIF	77056	$110.54	$132.61	$136.80	$122.81	$135.94
Screening mammogram - unilateral diagnostic (film or digital) **	SIF	77055	$87.20*	$103.09	$106.34	$95.49	$105.69
Assessment, education and CBE	SIF	99201	$41.43	$49.15	$50.57	$45.65	$50.39
Assessment, education and pelvic exam with Pap test	SIF	99201	$41.43	$49.15	$50.57	$45.65	$50.39
Repeat CBE	2	**1/2** of 99201	$20.72	$24.58	$25.29	$22.88	$25.20
Diagnostic mammogram - unilateral (film or digital) **	1	77055	$87.20*	$103.09	$106.34	$95.49	$105.69
Diagnostic mammogram bilateral	90	77056	$110.54	$132.61	$136.80	$122.81	$135.94
Diagnostic breast US **(unilateral or bilateral)** w/image documentation	4	76645	$94.77	$114.98	$118.99	$106.18	$118.07
Fine needle aspiration biopsy without image guidance	29	10021	$142.25	$173.09	$179.43	$159.91	$178.53
Fine needle aspiration biopsy with image guidance	7	10022	$134.29	$161.16	$166.38	$149.33	$165.55
Core biopsy	8	19100	$142.53	$ 74.36	$181.18	$160.98	$180.31
Incisional biopsy	9	19101	$321.86	$393.32	$408.71	$363.35	$407.10
Pre-operative ultrasonic needle localization and wire placement	22	19285	$446.68	$545.49	$565.38	$502.82	$560.29
Additional US needle loc and wire placement for second lesion	85	19286	$374.35	$458.25	$475.06	$421.98	$470.25
Pre-operative mammographic needle localization and wire placement	15	19281	$233.73	$280.96	$290.12	$260.17	$288.47
Additional mammographic needle loc and wire placement second lesion	83	19282	$162.40	$195.16	$201.32	$180.57	$199.78

Excisional biopsy	10	19120	$468.26	$571.12	$593.66	$528.29	$592.52
Stereotactic biopsy procedure-breast - **all inclusive** of placement of breast localization device(s), (e.g., clip, metallic pellet), imaging of the biopsy specimen, percutaneous bx; first lesion, including stereotactic guidance	16	19081	$641.99	$791.11	$822.91	$728.43	$816.64
Each additional lesion, including stereotactic guidance	84	19082	$520.01	$638.51	$662.88	$587.87	$656.71
US guided vacuum-assisted biopsy breast - **all inclusive** of placement of breast localization device(s) (e.g., clip, metallic pellet)imaging of the biopsy specimen, percutaneous bx; first lesion, including ultrasound guidance	25	19083	$637.92	$785.53	$816.83	$723.31	$810.42
Each additional lesion, including US guidance	86	19084	$512.92	$629.88	$653.91	$579.87	$647.75
Article 28 facility fee - Core Biopsy	23	APC 0005	$702.08	$702.08	$702.08	$702.08	$702.08
Article 28 facility fee - incisional/excisional biopsy	24	APC 0028	$1,974.26	$1,974.26	$1,974.26	$1,974.26	$1,974.26
Cervical Diagnostics							
Colposcopy without biopsy	52	57452	$106.09	$127.31	$131.67	$118.18	$131.53
Colposcopy with cervical biopsy and ECC	66	57454	$150.03	$179.58	$185.66	$166.86	$165.66
Colposcopy with one or more cervical biopsies	53	57455	$139.27	$167.46	$173.32	$155.39	$173.15
Colposcopy with ECC	67	57456	$131.75	$158.56	$164.15	$147.10	$163.96
Endometrial biopsy	68	58100	$106.62	$128.29	$132.89	$119.03	$132.69
High-risk HPV DNA hybrid capture 2 or Cervista HR	65	87621	$47.87	$47.87	$47.87	$47.87	$47.87
Pap smear cytology, conventional	SIF, 61	88164	$14.42	$14.42	$14.42	$14.42	$14.42
Pap smear cytology, liquid based prep	SIF, 71	88142	$27.64	$27.64	$27.64	$27.64	$27.64
Fluid cytology, breast and nipple, (not vaginal / cervical)	11,14	88173	$140.74	$166.36	$170.85	$154.60	$169.88
Diagnostic LEEP/LEETZ	56	57461	$309.58	$374.84	$388.42	$346.98	$387.11

Diagnostic cone biopsy- cold knife or laser	CKC 57, LC 58	57520	$297.27	$357.49	$369.96	$331.66	$369.47
Article 28 facility fee - diagnostic LEEP/LEETZ, etc.	69	APC 0193	$1,375.00	$1,375.00	$1,375.00	$1,375.00	$1,375.00
Colorectal Procedures							
FOBT kit processing	SIF	82270	$4.44	$4.44	$4.44	$4.44	$4.44
FIT	SIF	82274	$16.99	$21.70	$21.70	$21.70	$21.70
Colonoscopy	36	45378 or G0121 or G0105	$374.24	$453.13	$469.33	$419.26	$467.28
Colonoscopy w/biopsy single or multiple	37	45380	$445.83	$538.92	$ 557.88	$498.80	$555.45
Colonoscopy w/removal of tumor(s), polyp(s) by hot biopsy	38	45384	$446.11	$539.09	$558.12	$499.09	$555.94
Colonoscopy w/removal of tumor(s), polyp(s) by snare technique	39	45385	$503.36	$607.72	$628.98	$562.73	$626.53
Sigmoidoscopy	32	45330	$130.94	$159.02	$164.72	$146.92	$163.68
Sigmoidoscopy with polypectomy	33	45333	$284.70	$347.59	$360.57	$320.71	$358.05
Flexible sigmoidoscopy with biopsy	34	45331	$156.58	$190.51	$197.46	$175.95	$196.23
Radiological exam; colon, barium enema	35	74270	$153.12	$186.18	$192.73	$171.79	$191.07
2nd Technique- colonoscopy dir bx	50	n/a	$90.86	$108.78	$112.33	$100.95	$112.03
Article 28 facility fee - colonoscopy	49	APC 0158	$ 645.73	$646.73	$646.73	$646.73	$646.73
Article 28 facility fee - sigmoidoscopy	48	APC 0146	$461.00	$461.00	$461.00	$461.00	$461.00
Other Procedures							
Surgical consultation	3, 54, 43	99203	$103.55	$122.19	$125.59	$113.75	$125.35
Anesthesiologist fee	18, 70, 41	n/a	$150.00	$150.00	$150.00	$150.00	$150.00
Chest X-ray	19, 62, 45	71020	$29.61	$35.71	$36.90	$33.04	$36.66
CBC - complete blood count pre-operative testing	21, 64, 47	85025	$10.55	$10.61	$10.61	$10.61	$10.61
EKG	20, 63, 46	93000	$16.01	$19.21	$19.84	$17.81	$19.76
Surgical pathology - level IV-gross and microscopic	12, 59, 42	88305	$67.8	$79.57	$81.52	$74.08	$81.17

Surgical pathology - level IV- needing examination of surgical margins; some excisional, LEEP, cone, and some polyps	82, 87, 88	88307	$274.45	$330.44	$341.04	$305.58	$338.35
*Reimbursement rates are the higher of either the NY regional Medicare rate or the NYS Medicaid fee.							
**NYS provides reimbursement for digital mammography and or mammography with CAD at the conventional film rate							
***These CPT codes are for reference only. Reimbursement is not limited to these CPT codes. Other CPT codes that fulfill the service/procedure as listed may also be reimbursed at these rates.							

Attachment 6-II Guidance for CSP Contractors & Title X Family Planning Providers

Guidance for Cancer Services Program Contractors and Title X Family Planning Providers July 2009

This information is being provided to assist CSPs and providers with understanding client eligibility for CSP reimbursable services when clients are referred to Title X family planning providers. As of April 1, 2009, the CSP eligibility for reimbursable services changed to serve women ages 40 years and older. There are a few exceptions to this, which are outlined in the CSP policy. See CSP Operations Manual Chapter 4: Cancer Screening Guidance, Section H (*CSP Policy for Breast Cancer Screening for Women below the Age of 40*.

However, clients 40 years of age and older who are referred to a Title X family planning provider should not automatically be assured that the visit will qualify for submission to the CSP for reimbursement.

The NYS Department of Health recommends that clients receive, as appropriate, the full range of services for which they are eligible. Therefore, if a woman 40 years of age or older presents to a Title X family planning provider for a visit (annual exam) for breast cancer screening (CBE) and cervical cancer screening (pelvic exam, Pap test and /or HR HPV DNA) and is also in need of contraceptive services, the full range of services are to be provided.

Therefore, when a client aged 40 years or older requires information and a service to regulate fertility, the visit becomes a Title X family planning visit; the breast and/or cervical cancer screening performed at this family planning visit are not eligible for CSP reimbursement. Clients who receive Title X eligible services will be assessed and assigned to a sliding fee scale for the Title X family planning visit.

A woman 40 years of age and older who has breast and/or cervical cancer screening at a family planning provider and who meets CSP eligibility will still qualify for a CSP-reimbursable mammogram at a CSP-participating provider, whether or not she is a Title X client. Title X does not cover breast imaging services.

It is recommended that clients referred by CSP contractors to Title X family planning providers be informed at the time of referral, that if, at the time of the visit for breast and/or cervical cancer screening, they need or require any services related to birth control or family planning, the visit will not be eligible for CSP reimbursement and that they will be responsible for the fee-scaled cost of the visit. CSP contractor staff members are not required to triage or ask women questions about their methods of contraception. However, CSP contractor staff must communicate to a woman referred to a Title X family planning provider that the cancer screening services at this visit may not be reimbursable by the CSP.

Some examples of this include:

- *A 40-year-old woman is referred by CSP contractor staff to a Title X family planning provider for breast and cervical cancer screening. During the visit, the woman indicates that she needs either a new prescription or renewal for birth control (oral contraceptives, NuvaRing, Evra, Depo-Provera, etc.).* The visit becomes a Title X family planning visit and is not eligible to be billed to the CSP.
- *A 40-year-old woman is referred by CSP contractor staff to a Title X family planning provider for breast and cervical cancer screening and she has an IUD.* If at the visit there is a need to

discuss a problem with her IUD or the need to change the method, then it is not a CSP-eligible visit: this constitutes a Title X family planning visit, which is not eligible for CSP reimbursement. If however, she has an IUD, but there is no required counseling or method change for this client, and all that is performed is her routine breast and cervical cancer screening, then it is a CSP eligible visit.

- *A 40-year-old woman had a tubal ligation at age 37 and is not in need of any services for birth control or regulation of her fertility; she requests breast and cervical cancer screening*. This woman is CSP-eligible. If however, at the time of the visit, she requests counseling and information regarding reversal of her tubal ligation so that she might achieve another pregnancy, the visit would then be a Title X family planning visit and is not reimbursable by the CSP.
- *A 40-year-old woman is relying on her male partner's vasectomy as her method of birth control*. This woman is eligible for breast and cervical cancer screening. However, if this same woman indicates at the time of the visit that while one of her partners has a vasectomy, she has another partner, who does not and needs to discuss the use of other methods of birth control, including the use of condoms, that visit now becomes a Title X family planning visit and is not reimbursable by the CSP.
- *A 40-year-old woman has a same sex partner and is not in need of contraception or a 40-year-old woman is not sexually active and requires no information or services related to birth control or the regulation of her fertility.* This woman is eligible for a CSP-reimbursed visit for breast and cervical cancer screening. If, in either of these situations, the woman indicated at the visit that she needed information regarding planning a pregnancy, then the visit is not eligible for CSP reimbursement. This example would include the client with a same sex partner who is interested in information regarding her and her partner attempting a pregnancy with a donor. This is not a CSP eligible visit

Attachment 6-III Rescreening Reimbursement Criteria Following Program-Funded Colonoscopy

New York State Department of Health Cancer Services Program
Re-screening Reimbursement Criteria Following a Program-Funded Colonoscopy

This document outlines CSP criteria for the reimbursement of re-screening after a CSP-funded colonoscopy. These criteria are based on the updated recommendations of the American Cancer Society (ACS)[1], the American College of Gastroenterology (ACG)[2]. These criteria are not eligibility guidelines for an initial screening through the CSP. Furthermore, these criteria are not clinical guidelines. These criteria pertain only to the reimbursement of services through the CSP. Alternate funds must be identified to reimburse for services that are recommended by providers, but are not covered through the CSP.

Information about the client's risk status and findings from the previously funded colonoscopy must be taken into account to determine what subsequent services will be reimbursed and when those services will be reimbursed after a CSP-funded colonoscopy. The following are three examples of situations that might occur:

1. A client enrolled in the CSP had a positive fecal test and a subsequent diagnostic colonoscopy. The final diagnosis was hemorrhoids. This client would now be eligible for reimbursement for a fecal test no sooner than five years after that previously funded colonoscopy. Please note: An annual fecal test is not recommended for five years after a colonoscopy has been performed.[3] The CSP will not reimburse for annual fecal tests for five years following a program-funded colonoscopy.
2. A client enrolled in the CSP is determined to be at increased risk due to a family history of colorectal cancer in a first-degree relative. During the colonoscopy, the client was found to have 2 small (<10mm) adenomatous polyps. This client would now be eligible for reimbursement for a colonoscopy no sooner than three years after that last colonoscopy. Please note: If the physician recommends that the next colonoscopy be scheduled five years later, then the client should be recalled for the next colonoscopy in five years. These reimbursement criteria represent the minimum time interval between reimbursable services.
3. A client enrolled in the CSP (regardless of risk status) was referred for a colonoscopy, which was unable to be completed. Reasons why a colonoscopy could not be completed include, but are not limited to, poor bowel preparation, client's inability to tolerate the procedure, or incomplete polypectomy or biopsy. In this case, the client would be eligible for another colonoscopy within one year of that incomplete colonoscopy. Ideally, the client should be scheduled for another colonoscopy as soon as possible.

The table below outlines the combination of scenarios when an enrolled client would be eligible for reimbursement for a subsequent colonoscopy or fecal test based on risk status and findings of the previously funded colonoscopy.

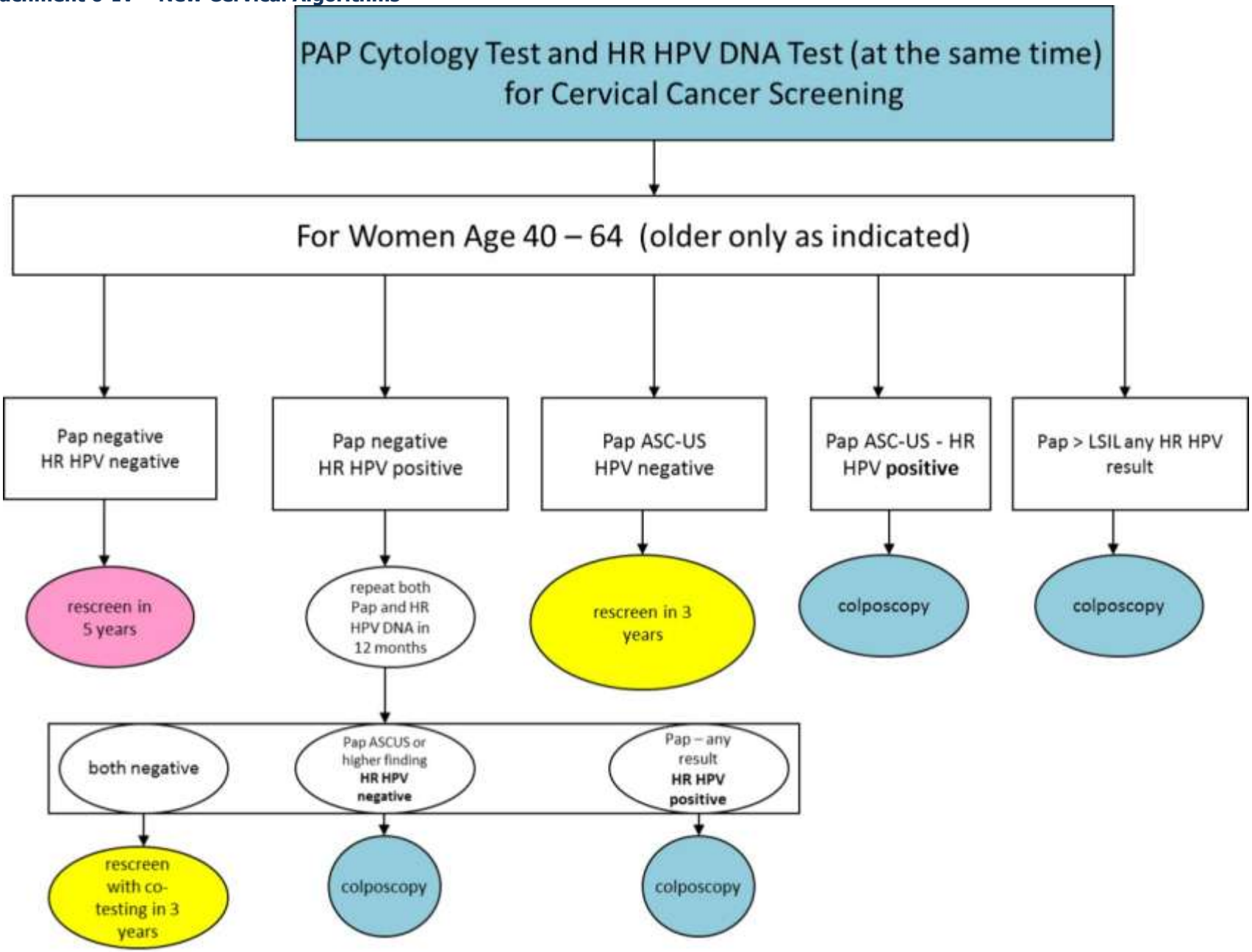
While these criteria address the majority of situations that may occur, individual cases may still warrant consultation with CSP staff. Should you have any questions, please feel free to contact your regional manager or NYSDOH CSP Clinical Care Unit staff at (518) 474-1222.

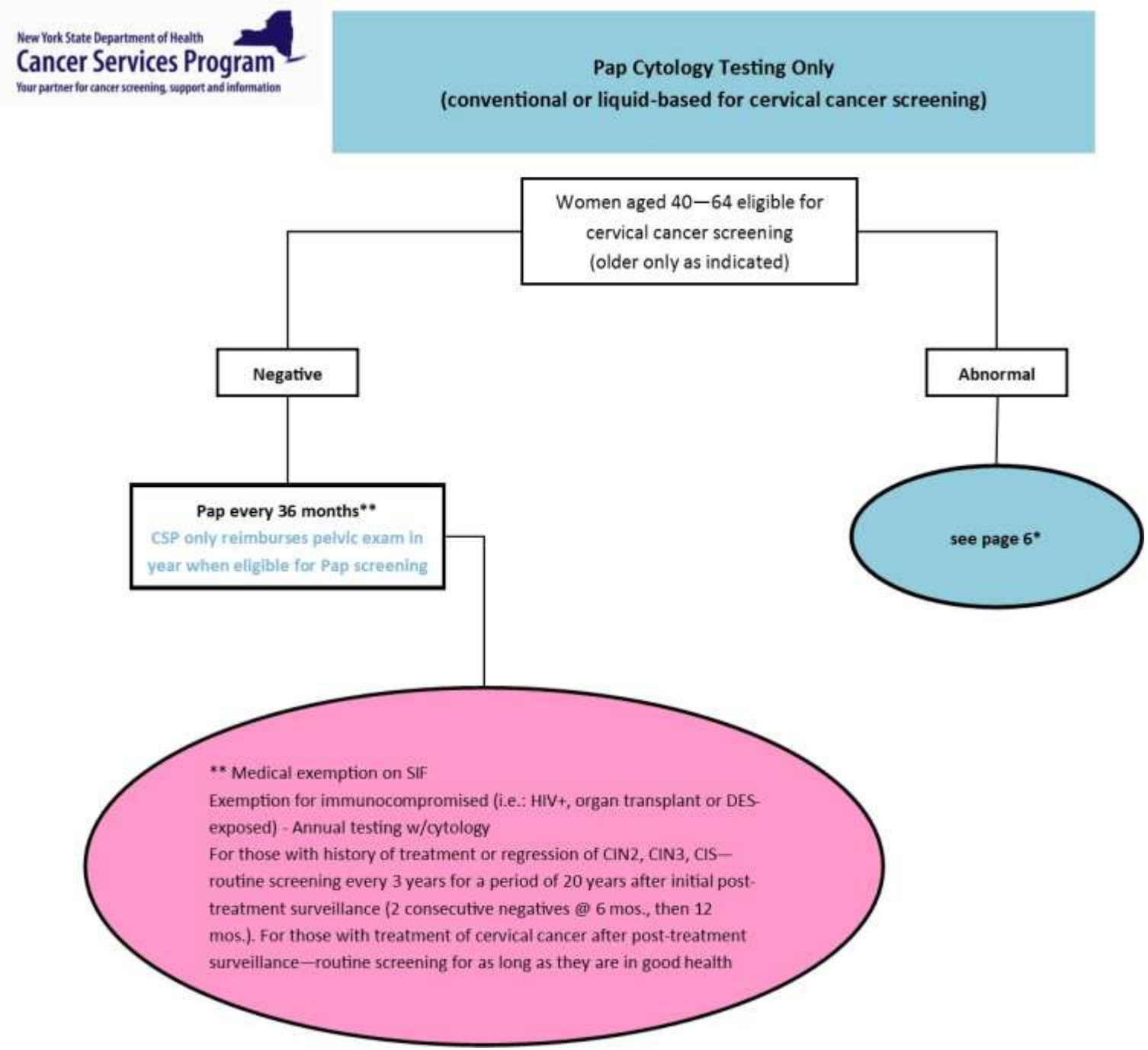
References:

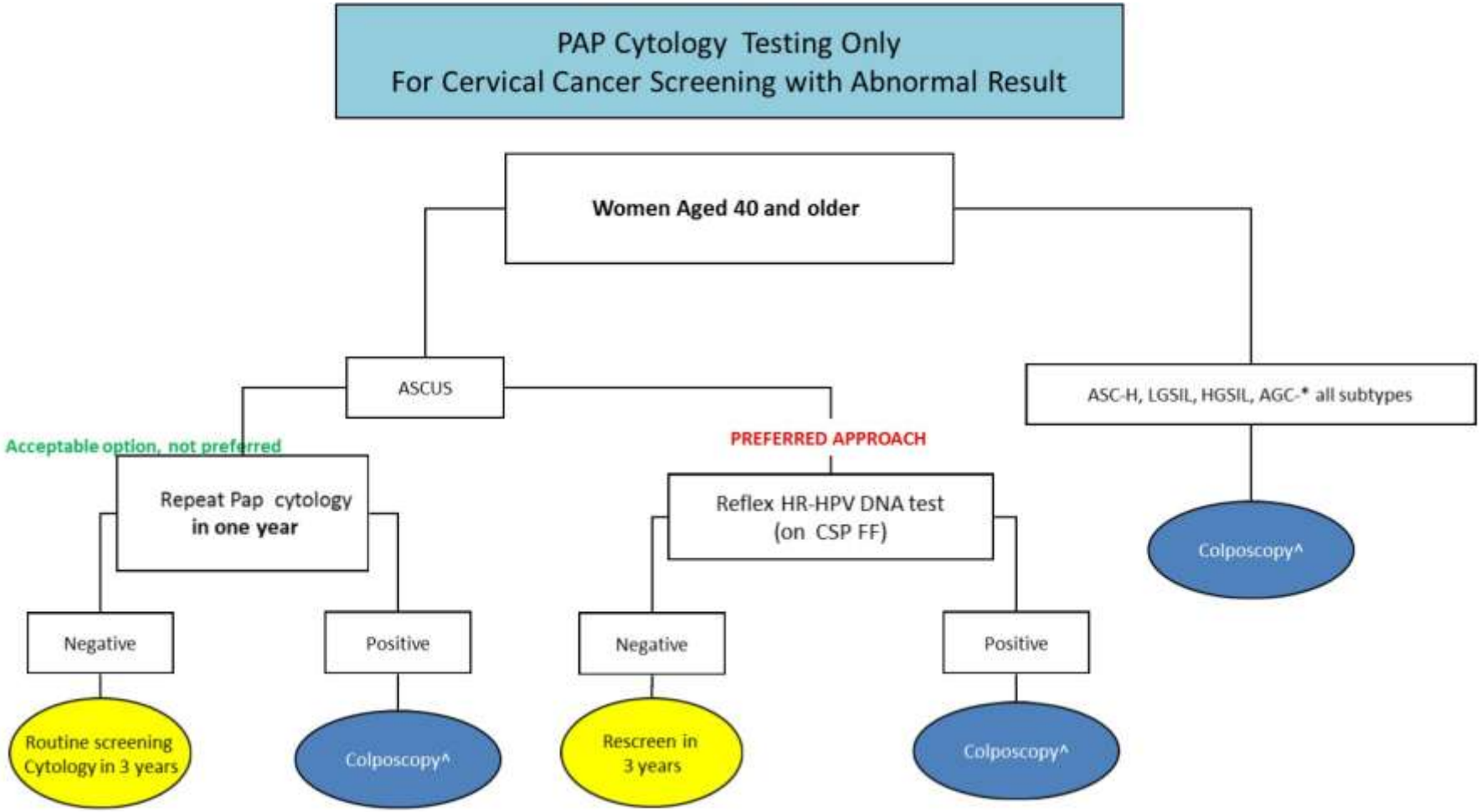
1. Lieberman D, Rex D, Winawer S, Giardiello F, Johnson D, Levin T, Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology 2012; 143:844-857.*
2. Winawer S, Zauber A, Fletcher R, Stillman J, et al. American Cancer Society Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. CA A Cancer Journal for Clinicians. On line at http://onlinelibrary.wiley.com/doi/10.3322/canjclin.56.3.143/abstract

	Eligible for Reimbursement for:			
	Colonoscopy			Fecal Test
Finding on Most Recent Colonoscopy	**< 1 Year**	**≥ 1 Year**	**≥ 3 Years**	**≥ 5 Years**
During the previous CSP screening visit, the client completed a program-funded diagnostic colonoscopy, because the client was either 1) average risk, asymptomatic, age 50 or older and had a positive fecal test or 2) average risk, symptomatic, age 50 to 64.[2]				
1st Colonoscopy was unable to be completed with no final diagnosis determined (this is a repeat colonoscopy) or incomplete removal of sessile serrated polyp/removed piecemeal with retention	√			
Colorectal Cancer diagnosed and cancer treatment completed		√		
Adenomatous polyposis syndrome (>10 adenomas) or serrated polyposis syndrome		√		
Inflammatory Bowel Disease			√	
Crohn's Disease			√	
Chronic Ulcerative Colitis			√	
Adenomatous Polyp			√	
Other Polyps				√
Hemorrhoids				√
Diverticulitis				√
Other Diagnosis				√
No Abnormality At This Time				√
During the previous CSP screening visit, the client completed a program-funded screening colonoscopy, because the client was at increased or high risk for colorectal cancer, regardless of whether symptoms were present. [2]				
1st Colonoscopy was unable to be completed with no final diagnosis determined (this is a repeat colonoscopy) or incomplete removal of sessile serrated polyp/ removed piecemeal with retention	√			
Colorectal Cancer diagnosed and cancer treatment completed		√		
Adenomatous polyposis syndrome (>10 adenomas) or Serrated polyposis syndrome		√		
Inflammatory Bowel Disease			√	
Crohn's Disease			√	
Chronic Ulcerative Colitis			√	
Adenomatous Polyp			√	
Other Polyps			√	
Hemorrhoids			√	
Diverticulitis			√	
Other Diagnosis			√	
No Abnormality At This Time			√	

Attachment 6-IV – New Cervical Algorithms



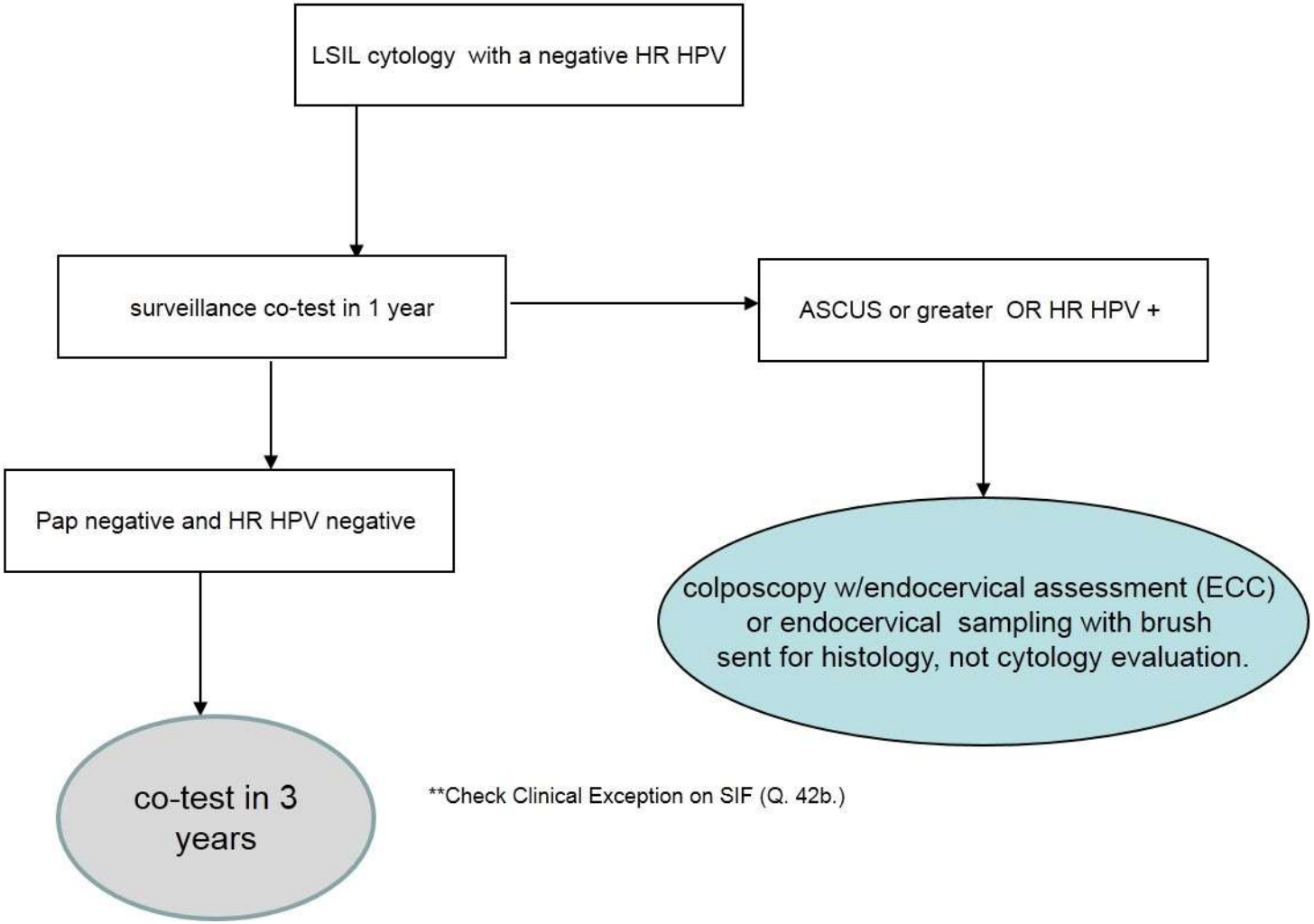

New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information
Pap Cytology Testing Only
(conventional or liquid-based for cervical cancer screening)
Women aged 40—64 eligible for cervical cancer screening (older only as indicated)
Negative
Abnormal
Pap every 36 months**
CSP only reimburses pelvic exam in year when eligible for Pap screening
see page 6*
** Medical exemption on SIF
Exemption for immunocompromised (i.e.: HIV+, organ transplant or DES-exposed) - Annual testing w/cytology
For those with history of treatment or regression of CIN2, CIN3, CIS—routine screening every 3 years for a period of 20 years after initial post-treatment surveillance (2 consecutive negatives @ 6 mos., then 12 mos.). For those with treatment of cervical cancer after post-treatment surveillance—routine screening for as long as they are in good health



*The CSP will reimburse for HR HPV DNA test at time of colposcopy for AGC- all subtypes if not part of screening (except when specified "atypical endometrial" only)
^See CSP Diagnostic Algorithms Reimbursement .

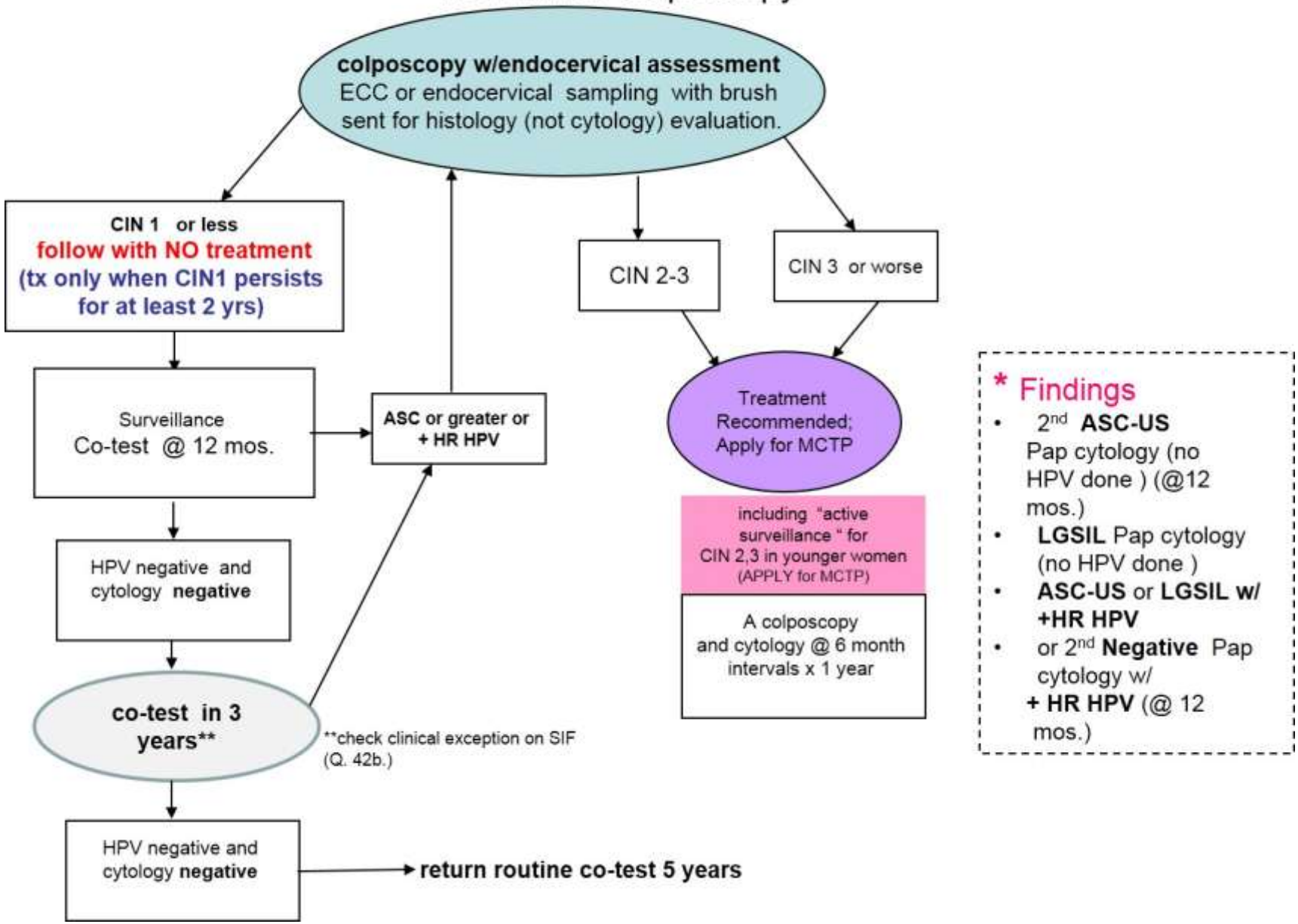
Attachment 6-V: Reimbursement Guidelines Algorithms for Cervical Cancer Diagnostic Follow-up Procedures

LSIL Pap cytology with negative HR HPV as co-test

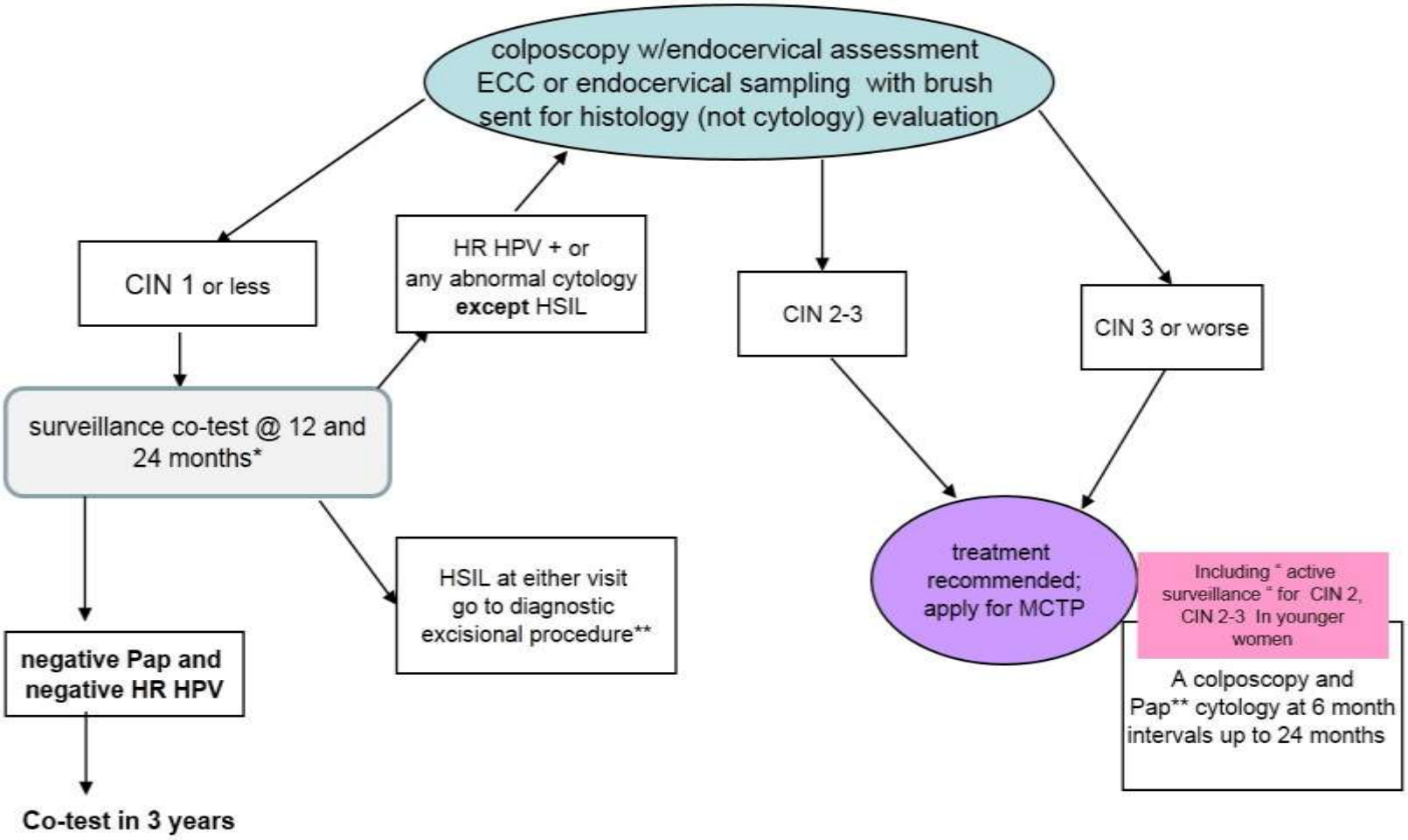


**Check Clinical Exception on SIF (Q. 42b.)

Minor Grade Cytology or HR HPV+ Findings* That Refer a CSP-eligible Woman for Colposcopy



ASC-H or **HSIL** Cytology That Refers a Woman Age 40 or Older for Colposcopy (regardless of HR HPV status)



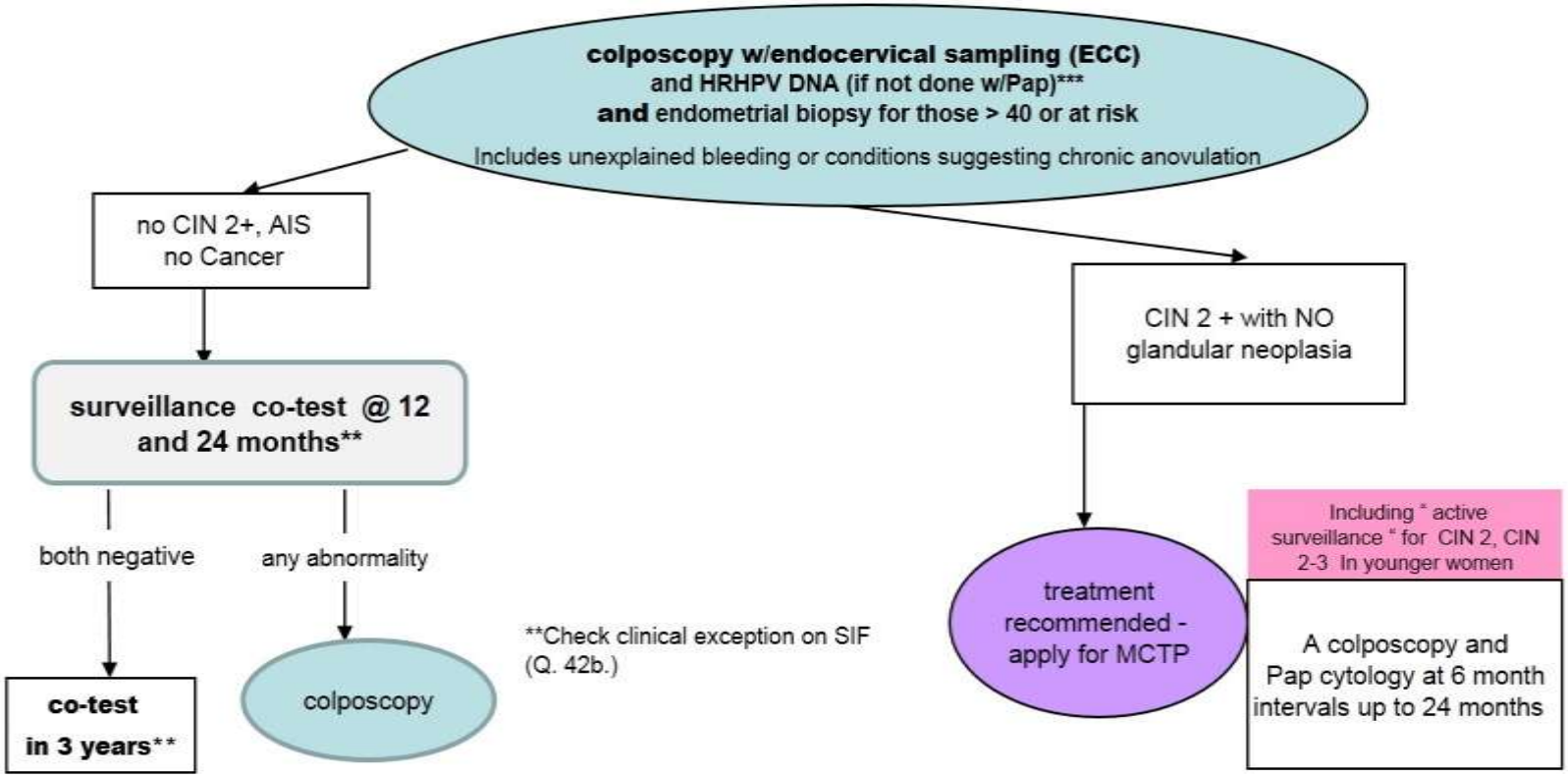
* provided colposcopy is satisfactory (Check clinical exception for 24 mo. pap and co test in 3 years on SIF (Q. 42b.))

**diagnostic excisional procedure (LEEP) (on CSP FF) is only reimbursed when the colposcopy is inadequate or if HSIL is found on surveillance testing. Should be an intact specimen with interpretable margins. ECC performed after excision /post procedure on same day is preferred.

Cytology That Referred a Woman Age 40 or Older for Colposcopy

Atypical Glandular Cells NOS (not otherwise specified)

All sub-types-**except atypical endometrial ∞**

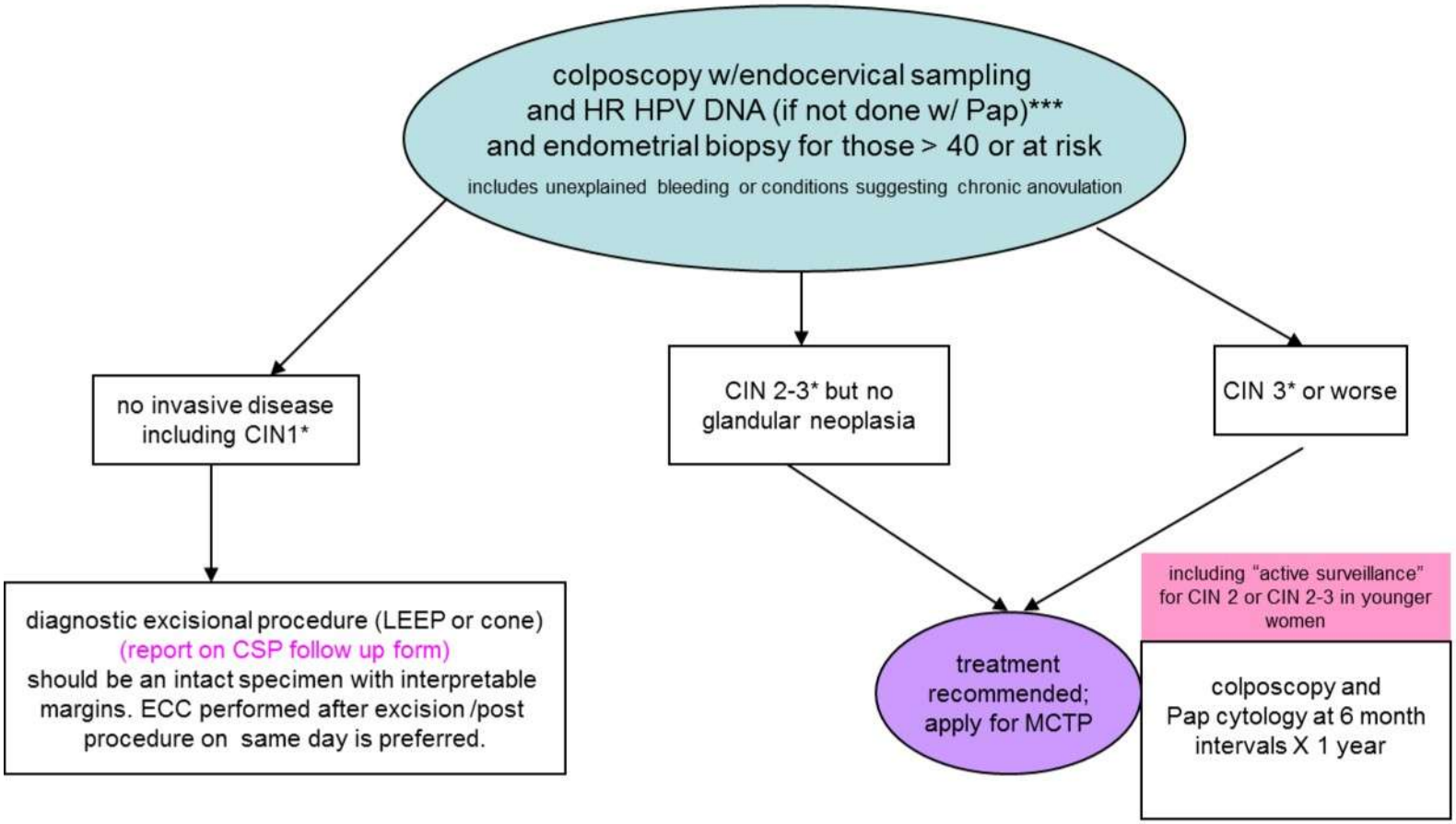


∞The CSP does not reimburse for services to evaluate a finding of atypical endometrial cells (only) in the cervical cancer screening program as the evaluation that is required is for endometrial conditions, not cervical. (i.e., endometrial biopsy/ECC) . However, if there is no endometrial pathology and client continues to colposcopy, the endo biopsy gets reported as "other funds" and the CSP will reimburse for colposcopy evaluation of cervical abnormality.

*** Repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap until colposcopy is performed. (Report on CSP Follow up form)

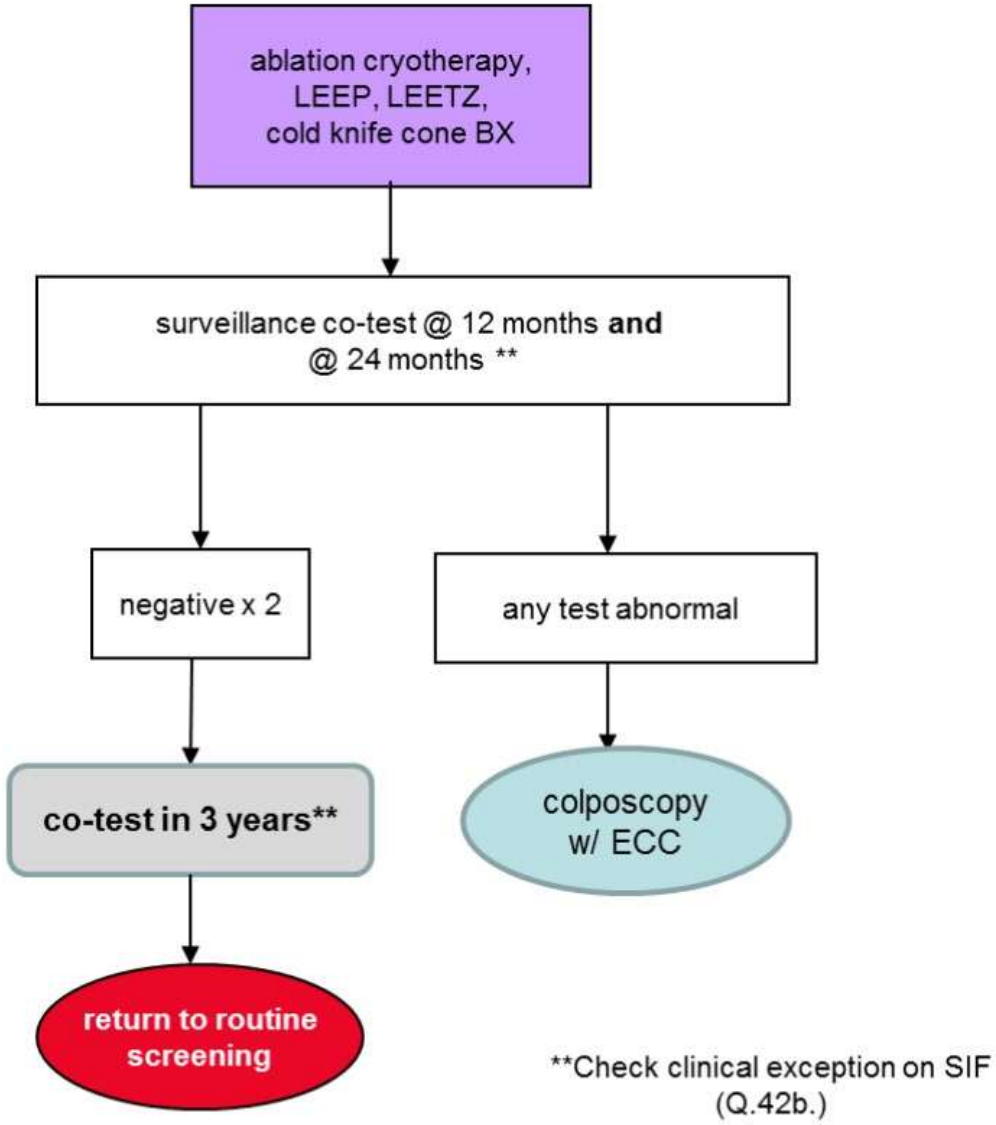
Cytology That Referred a Woman Age 40 or Older to Colposcopy

AGC favors neoplasia or adenocarcinoma in situ



*** A repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap, until colposcopy is performed (report on CSP Follow up form)

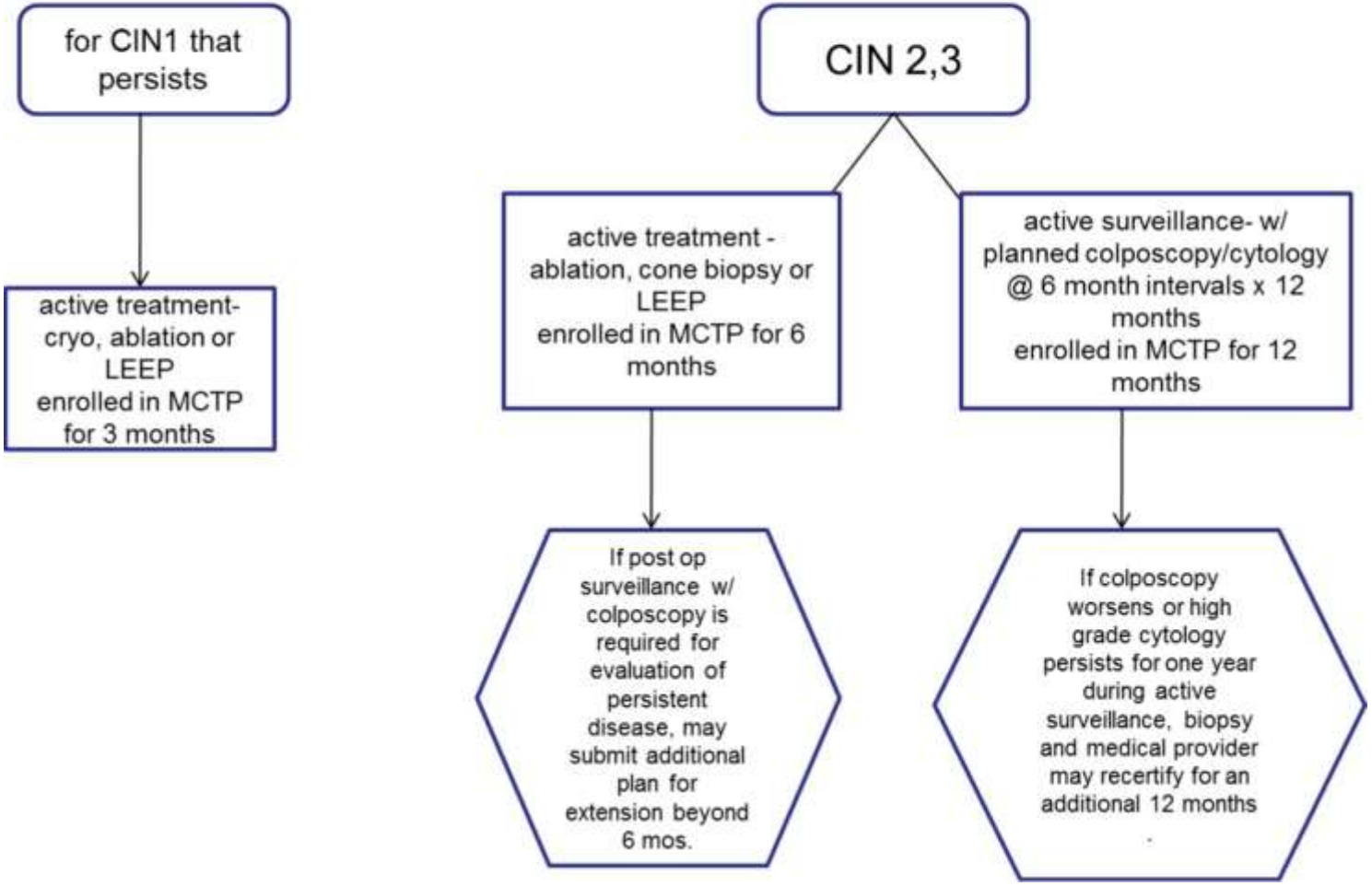
CSP Reimbursement of Follow-up After Active Treatment of **CIN 2, CIN 3 or Greater** (diagnosis by histology)



Attachment 6-VI: MCTP Enrollment for Cervical Dysplasia

Enrollment in MCTP for Cervical Dysplasia

The Medicaid Cancer Treatment Program (MCTP) is available for treatment of CIN 1, CIN2, CIN 3 for all eligible women in NYS. The CSP does not provide screening/diagnostic testing for women ages 18-39. However, for eligible women 18 years of age and older for whom treatment, including active surveillance for CIN 2,3 is recommended, an application to the MCTP should be made.



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Chapter 7 - NYS Medicaid Cancer Treatment Program (MCTP)

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Chapter 7: NYS Medicaid Cancer Treatment Program (MCTP)

A. Medicaid Cancer Treatment Program (MCTP)

The Medicaid Cancer Treatment Program (MCTP) is a Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer (and in some cases, pre-cancerous conditions of these cancers). To be enrolled in the MCTP, an individual must complete an application with a New York State Department of Health Cancer Services Program (CSP) trained designee, referred to as a Designated Qualified Entity (DQE). A DQE is a person designated and trained by the New York State Department of Health as a "Qualified" entity, for the purpose of assisting individuals to complete the MCTP application.

Once an individual is enrolled in the MCTP, full Medicaid coverage is provided for an initial period of enrollment as determined by the type of cancer being treated. Recertification is required yearly, if the individual is still in need of treatment, at which time eligibility is reassessed. Enrollees must receive services from a Medicaid enrolled provider in order to have their services covered. MCTP coverage is limited to the individual enrollee and cannot be extended to family members or dependents.

When an application is processed by the State Medicaid office and an applicant appears to be eligible for regular Medicaid in any of the mandatory Medicaid categories, the individual will be authorized for a limited time period on MCTP and will be notified by mail that an application for regular Medicaid must be submitted to their local Department of Social Services.

This chapter of the Operations Manual describes eligibility requirements for the MCTP as they relate to each cancer type and provides additional clarification regarding MCTP eligibility criteria.

B. Eligibility Requirements

This section describes eligibility requirements for each of the four cancer types covered by the MCTP. Differences in eligibility requirements reflect differences in both state and federal legislation and subsequent New York State Department of Health policies. Section C provides additional clarification regarding the below listed eligibility requirements.

1. Breast cancer treatment (Legislation enacted 10/1/2002, Expanded 11/1/2008)

To be eligible for treatment coverage for breast cancer, or pre-cancerous breast conditions, individuals must be:

- screened for and diagnosed with breast cancer, or a pre-cancerous breast condition, by a New York State licensed health care provider, **OR**, if diagnosed with such in another state, were screened and/or diagnosed by that state's National Breast and Cervical Cancer Early Detection Program
- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for breast cancer or a pre-cancerous breast condition
- a resident of New York State (NYS) **and**
- a United States (US) citizen or an alien with satisfactory immigration status

If an individual who meets the above requirements appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

2. CERVICAL CANCER TREATMENT (Legislation enacted 10/1/2002, Expanded 11/1/2008)

To be eligible for treatment coverage for cervical cancer, or pre-cancerous cervical conditions, individuals must be:

Screened for and diagnosed with cervical cancer, or a pre-cancerous cervical condition, by a New York State licensed health care provider, **OR**, if diagnosed with such in another state, were screened and/or diagnosed by that state's National Breast and Cervical Cancer Early Detection Program ;

- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for cervical cancer or a pre-cancerous cervical condition
- a resident of New York State (NYS) **and**
- a United States (US) citizen or an alien with satisfactory immigration status

If an individual who meets the above requirements appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

3. COLORECTAL CANCER TREATMENT (NYS Legislation enacted 4/1/2007)

To be eligible for treatment coverage for colorectal cancer, or pre-cancerous colorectal conditions, individuals must be:

- Cancer Services Program (CSP) eligible at the time of screening or diagnosis
- screened and/or diagnosed with colorectal cancer by a current CSP credentialed provider

- under 65 years of age
- income eligible (income at or below 250% Federal Poverty Guidelines (FPG) at the time of MCTP application)
- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for colorectal cancer or a pre-cancerous colorectal condition
- a resident of New York State (NYS) **and**
- a United States (US) citizen or an alien with satisfactory immigration status

If an individual who meets the above requirements appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

4. PROSTATE CANCER TREATMENT (NYS legislation enacted 10/1/2007)

To be eligible for treatment coverage for prostate cancer, or pre-cancerous prostate conditions, individuals must be:

Screened and/or diagnosed with prostate cancer by a current CSP credentialed provider*;

- under 65 years of age
- income eligible (income at or below 250% Federal Poverty Guidelines (FPG) at the time of MCTP application)
- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for prostate cancer or a pre-cancerous prostate condition
- a resident of New York State (NYS) **and**
- a United States (US) citizen or an alien with satisfactory immigration status

*For the purposes of program implementation, screened or diagnosed with prostate cancer through a current CSP-credentialed provider is interpreted as a man having received screening or diagnostic testing by a health care provider or facility currently credentialed as a provider in the CSP. Please note that this eligibility criterion reflects the fact that the CSP does not currently provide reimbursement for prostate cancer screening or diagnostic services.

If an individual who meets the above requirements appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

C. Additional Guidance/Clarification regarding MCTP Eligibility Requirements

This section provides additional detail regarding each of the listed eligibility criteria. Questions about eligibility criteria should be directed to the Cancer Services Program.

Please note that this information, as well as additional detail regarding the MCTP application components and completion process, is provided within a separate manual developed for DQEs.

1. Income at or Below 250% Federal Poverty Guideline (FPG) at the Time of MCTP Application (Colorectal and Prostate Cancer treatment only)
   a) Individuals diagnosed with colorectal or prostate cancer, who are in need of treatment and who meet all other eligibility criteria, must have a household income at or below 250% of the FPG at the time of MCTP application submission in order to be eligible for the MCTP. The following information should be considered in assessing this eligibility criterion:
      i) Definition of a household: Anyone applying, their spouse and their children under the age of 21. Medicaid staff will look at legal lines of responsibility in determining who can be included in the Medicaid household and the programs for which the applicant may be eligible.
      ii) Definition of income: Any payment received by the applicant from any source. Income may be recurring, a one-time payment, earned or unearned.
         (1) earned income is income received as a result of work activity. This includes wages, salaries, tips, commissions and income received from self-employment.
         (2) unearned income is income that is paid because of a legal or moral obligation rather than for current services performed. It includes pension, government benefits, dividends, interest, insurance compensation and other types of payments.

If an individual receives Social Security Disability Insurance (SSDI) benefits (i.e., dependent benefits, disability benefits, survivor benefits), this is counted in the household income. Note: Dependent benefits for children under the age of 21 are not counted if the child is not applying for Medicaid.

2. Not covered under any creditable insurance at the time of MCTP application
   a) Individuals with the following types of coverage would be considered to have creditable coverage and would not be eligible for the MCTP:
      i) a group health plan or
      ii) health insurance coverage benefits consisting of medical care (provided directly through insurance or reimbursement, or otherwise and including

items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer or

iii) Medicare; or

iv) Medicaid; or

v) Armed Forces Insurance; or

vi) a state health risk pool

b) *Insurance* (lost coverage or treatment not covered):

i) all individuals who are in need of treatment for breast, cervical, colorectal or prostate cancer or a pre-cancerous condition (and who otherwise meet all other eligibility criteria) and who have either lost their health insurance or their insurance does not cover the cost of treatment for breast, cervical, colorectal or prostate cancer or pre-cancerous conditions, are eligible to apply for the MCTP.

3. <u>In need of treatment for cancer</u>

a) *Individuals diagnosed* with breast, cervical, colorectal or prostate cancer, or pre-cancerous conditions, must be recommended for treatment in order to meet this eligibility requirement. The following cancer-specific treatment modalities, although not an exhaustive list, reflect treatments that are recognized as meeting the MCTP eligibility criteria for an individual in need of treatment.

i) treatment for breast cancer:

(1) surgery

(2) chemotherapy

(3) radiation therapy

(4) hormonal therapy (tamoxifen, Femara©, etc.)

ii) treatment for cervical cancer:

(1) LEEP/LEETZ

(2) cryotherapy

(3) chemotherapy

(4) radiation therapy

(5) hysterectomy

(6) active surveillance with colposcopy/cytology

iii) treatment for colorectal cancer:

(1) surgery

(2) chemotherapy

(3) radiation therapy

iv) treatment for prostate cancer:

(1) surgery

(2) chemotherapy

(3) radiation therapy

(4) expectant management/active surveillance

(5) hormonal therapy

4. Out of country residents

a) Individuals who have been diagnosed with breast, cervical, colorectal or prostate cancer or a pre-cancerous condition in another country and later move to NYS are not eligible to apply for the MCTP.

5. Undocumented immigrants

a) Individuals must be United States citizens, Nationals, Native Americans or aliens with satisfactory immigration status to complete an MCTP application.

Chapter 8 - Sustainability

CSP Operations Manual 07/13

THIS SECTION IS UNDER REVIEW
(SUMMER 2013)
WE WILL RELEASE THE UPDATED
CHAPTER AS SOON AS IT IS
AVAILABLE

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Chapter 9 - Promotional Materials Guidelines

CSP Operations Manual 07/13

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Chapter 9: Guidelines for Contractor Use of the CSP Logo and Review and Development of Educational and Promotional Materials

This section provides CSP contractors with guidelines for use of the CSP logo and review and development of educational and promotional materials. Strategies and tools for materials development at the local level are also provided.

A. CSP Logo

1. Rationale for use of logo
   Using a visual symbol consistently over time helps build public awareness. The CSP developed a logo with the selected tagline, "*Your partner for cancer screening, support and information*" to offer contractors a common symbol and tagline that has the potential to become universally recognized and understood. Over time, with consistent use, the logo will help strengthen the identity of the CSP by making it more recognizable to clients as well as providers, partners, and community-based organizations who work together to ensure access to services throughout the continuum of cancer care. **Contractors are required to place the logo on all promotional and educational materials and communications that are hard copy or electronic.**

2. Use of CSP name
   The CSP requires contractors to use the name **Cancer Services Program of X County/Counties** to build name awareness and consistency for clients, partners and health care providers across the state.

3. Logo options
   We have developed two logos. The first (**A**) is the local CSP logo. The second (**B**) is the New York State Department of Health (NYSDOH) version, primarily for use by the Cancer Services Program on statewide reports and materials for use promoting the program on a statewide level. Contractors may want to use the NYSDOH version in instances where multiple contractors collaborate to develop a regional campaign, etc.

A

Albany and Rensselaer
Cancer Services Program
Your partner for cancer screening, support and information

4. General Rules for Use of Contractor Logo (A)

Contractors must adhere to the following guidelines when using logo A. The logo should appear on all materials funded in whole or in part by the CSP, such as letterhead, business cards, brochures, posters, billboards and promotional products. The logo cannot be used by anyone except CSP contractors UNLESS the NYSDOH CSP Public Education and Promotions Coordinator has provided specific approval. See CSP Operations Manual, Chapter 10: Staff List, for contact information.

a. *Logo MAY NOT be altered*
   - The size and position of the graphics have been designed to achieve balance with the words and should not be changed.
   - Do not use other figures, graphics, photos or clip art as part of the logo.
   - Do not print the logo as a fainter, less opaque version or use shadows.
   - Do not position the logo on a diagonal.
   - Do not place the logo on a dark or textured surface. Do not cut and paste the logo from previously printed materials, which can distort the image and will affect its legibility.
   - The logo can only be used in the original color as provided to the contractor but may also be reproduced/printed in black and white.
b. *Logo placement*
   - The logo should not be used in ways that reduce or block its readability.
   - The logo can be used as a stand-alone image on materials or in conjunction with a contractor's logo.
   - The logo should always be surrounded by sufficient "white space".
c. *Use of Logo on billboards*
   - When preparing billboards or posters, it is recommended that the logo, if not used as part of the poster, be placed in a lower corner of the poster.
d. *Use of Logo on letterhead and business cards*

- The logo may be used on letterhead alone or in conjunction with contractor letterhead and, in plain text, as part of a signature on a letter, e.g., Coordinator, Cancer Services Program of X County.
- The logo may be used on business cards. It is recommended that it be placed in the upper left corner.

B

New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

e. Use of the NYSDOH Logo (B)

1. The NYSDOH Logo may only be used by contractors with the express, written permission of the NYSDOH as provided by the CSP Regional **Manager**. Contractors are encouraged to use the local/contractor logos (A) in most instances.

2. To request use of Logo B, send an email request to the CSP Regional Manager and the CSP Public Education and Promotions Coordinator and attach a copy of the document for which you are seeking Departmental approval. Please provide sufficient time for review and approval of the request to use Logo B, generally, eight weeks. The email should very briefly describe:
   - rationale for use of logo OR for the publication or promotional material
   - brief summary of the development process
   - purpose and intended audience
   - type of medium/manner in which the document will be distributed (e.g., newspaper ad, billboard, TV/radio, mailing, etc.)
   - date you plan to distribute/promote
3. You will be notified by your Regional Manager if use of the NYSDOH logo is approved or denied.

f. Requesting your logo

The CSP will provide contractors with electronic versions of personalized logos for use on contractor materials. Logos are available in .jpg or .eps file formats. Please email your Regional Manager to request a personalized logo and provide the following information:

- county(ies) name
- file format(s) requested

B. Ownership of Products Developed with NYSDOH Funds

When NYSDOH funds are used to develop media campaigns and messages, brochures, tool kits or any materials or products, those materials or products belong to the people of New York. Contractors should be aware of the following conditions, as per contract language:

1. The CONTRACTOR shall obtain written approval of the CSP prior to publication or use of all materials, articles, documents, forms, papers, and similar materials whether electronic or paper form (Materials) developed under or in the course of performing this AGREEMENT. Any Materials developed by the CONTRACTOR under or in the course of performing this AGREEMENT must contain the following acknowledgement: "Funded by a grant from the New York State Department of Health, Bureau of Chronic Disease Control" and such Materials must include the Cancer Services Program logo. CONTRACTOR shall obtain prior written approval of the STATE for any publication or use of the Cancer Services Program logo, as per the Program's Operations Manual (herein referred to as the CSP Operations Manual).

2. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.

C. Materials Review Process

1. **All materials that are developed or purchased with NYSDOH CSP funds and/or contain the CSP logo MUST BE APPROVED prior to expenditure of NYSDOH CSP funds or publishing of material to include logo.** Please provide sufficient time for review; submissions should be made at least 4 weeks prior to the need to expend funds. Submissions requesting use of the NYSDOH Logo should be submitted at least 8 weeks

prior to the need to expend funds. See Section C-3 of this chapter, "Materials Review Timeline," for more information.

As with materials developed by contractors, written approval is required for materials purchased with NYSDOH CSP funds, such as brochures, posters, billboards, gear, ads, etc.

The goal of reviews is to ensure materials are: accurate and up-to-date; consistent with all funder requirements and applicable state laws, rules, regulations and policies; consistent with recommended clinical guidelines; and appropriate for the intended audience.

Tip: It is recommended that all materials developed or purchased with NYSDOH CSP funds be pretested by three (3) to five (5) members of the intended audience. Pretesting helps ensure that the message you send is the message your audience receives. Use the results of the pretest to revise your materials. A sample review tool is included as Attachment 9-I.

2. **Materials Requiring CSP Review and Approval**

   a. **Examples of the types of materials requiring review are listed below, consistent with funding requirements.**

Types of Materials Requiring Review	
• pamphlet/brochure/booklet	• poster
• television public service announcement	• billboard or transit poster
• radio public service announcement	• CD-ROM/DVD
• wallet card/palm card	• web page(s) and social media

   b. **Any educational material that includes the CSP logo or is to be purchased or developed by a NYSDOH CSP contractor requires review.**

      Review of reprints that have received prior approval is recommended but not required (except as noted in "c)", below) before reprinting in order to ensure the material is scientifically and technically accurate. Contractors should ensure that materials purchased from vendors are up-to-date and are the most current versions available. A sample content review tool, included as Attachment 9-II, may be used for this purpose.

   c. **Review of reprints that have received prior approval IS REQUIRED in the following instances**:

- **when documentation of the prior review and approval is unavailable.** Prior to reprinting, contractors must provide the Regional Manager with documentation of prior approval or verify that such documentation is already on file with the Regional Manager.
- **laws, rules, regulations or policy changes require such revisions**
- **the intended target audience for the material has changed**

d. **All web pages and social media sites providing educational information must be reviewed and approved of as per these guidelines prior to posting on the web or social media site.** Please note that NYSDOH CSP review and approval for revised web pages or revised materials posted to the website need only be done when information changes require review for scientific and technical accuracy; when laws, rules, regulations or policy changes require revisions; or when the intended target audience of the website or material on the site changes. Contractors should establish a system for routine review and website maintenance to ensure that information is accurate and up-to-date.

e. **Materials that have been reviewed and approved in one format (e.g. pamphlet) do not need to be reviewed again for reproduction in another format (e.g. website posting) if there is no change in content.**

f. **Materials developed by the agencies and organizations listed in the box below, promotional materials that do not contain any educational messages, and materials developed or purchased using funding from other sources DO NOT require review.** Promotional materials are, for example, a pen or palm card promoting a hotline number that includes hours of operation and the agency phone number. However, if the card also includes an educational message promoting cancer screening and prevention, review is required, as per this guidance. Please note that while promotional items do not require review per these guidelines, the purchases must be reflected in the approved contractor work plans and budgets.

Materials that do <u>NOT</u> Require Review

- those developed or distributed by the following organizations:
  - New York State Department of Health (NYSDOH)
  - Centers for Disease Control and Prevention (CDC)
- materials that do not contain any educational messages

3. **Materials Review Timeline**

All reviews and approvals must be acquired PRIOR TO DEVELOPMENT AND RELEASE OF MATERIALS AND EXPENDITURE OF FUNDS. The CSP Regional Manager is responsible for approval of funds prior to material development, purchase, printing, posting or airing.

a. **For materials to be DEVELOPED:**
Contractors should seek **initial conceptual approval from the Regional Manager** before proceeding with development of new materials and/or campaigns. When submitting an initial conceptual proposal for the development of a new material/campaign, the contractor should submit a proposal to their Regional Manager that includes the purpose of material, intended audience, specific key messages, planned distribution points and the type of medium to be used (e.g., billboard, brochure, radio, etc.). After concept approval, the CSP Regional Manager is responsible for working with CSP contractors to ensure ALL media messages:

- are clearly understood
- use language that is appropriate for the intended audience
- are developed at a 6th – 8th grade reading level
- use current and correct terminology
- use medically accurate text and drawings
- do not discriminate (e.g., based upon sexual orientation, race, gender or ethnicity)

i. Please allow sufficient time for conceptual review, generally no less than two (2) weeks. Conceptual approval does not imply complete approval for purchase and dissemination of materials.

ii. Once the Regional Manager approves the conceptual development, the contractor coordinates development of the new material. Once ready, the developed material and the Material/Campaign Review Tool should be submitted to the Regional Manager for review prior to printing, posting, airing, etc. It is strongly recommended that the contractors allow sufficient time for review, generally no less than four (4) weeks for review. Printing, posting, etc. should not be completed prior to receiving approvals.

iii. CSP will return the Material/Campaign Review Tool to the Contractor indicating one of the following outcomes of the review process:

- **Approved** (for development completion, purchase and/or printing/distribution with NYSDOH CSP funds): This indicates that the material is approved as submitted.

  - The Regional Manager provides written approval to the contractor as notification that NYSDOH CSP funds may be expended for the requested purpose.
  - The Regional Manager maintains the written approval in the contractor files along with a copy of the material.

- OR -

- **Approved with Revisions:** This indicates that the material will be approved if required revisions are made.

  - The material may be re-submitted for review and approval after required revisions have been incorporated.
  - The Regional Manager maintains documentation in the contractor files along with a copy of the material.

- **Not approved:** This indicates that the material does not meet the goals of the review.

  - The Regional Manager will send written notification to the contractor justifying the reason for this disposition.
  - The Regional Manager maintains documentation in the contractor files along with a copy of the material.

b. **For educational materials to be PURCHASED:**

The contractor submits the materials to the Regional Manager for review. Please allow sufficient time for this review, generally no less than four (4) weeks.

Once the contractor acquires written approval for the new material, two (2) copies of the material should be submitted to the Regional Manager for the contractor's file.

c. **For educational materials to be REPRINTED:**

Please see Section C-2 of this chapter, "Materials Requiring CSP Review and Approval," items III-V to determine when review of reprinted materials is required.

Once the contractor acquires written approval for the material, two (2) copies of the proposed material should be submitted to the Regional Manager for the contractor's file.

D. Materials Development Strategies and Resources

The following are strategies for writing simply, using language and visuals that your audience may relate to and understand, and organizing information so it is clear and easy to act on and recall. (Source: Simply Put, CDC, Office of Communication)

1. Message Content

   a) Limit the number of messages

   - Present readers with no more than three or four main ideas per document or section of document.
   - Tell readers only what they need to know and skip details that are "nice to know".
   - Stick to one idea at a time.
   - Avoid lengthy lists – limit lists to five or six items.

   b) Tell readers what you want them to do

   - Clearly state what actions you want readers to take.
   - Accentuate the positive.

   c) Tell readers what they will gain from reading the material

   - Readers want to know what they'll gain from the material. Answer the question, "What's in it for me?"

   d) Choose words carefully

   - Keep it short.
   - Write as if you were talking to a friend.
   - Avoid talking down to your readers.
   - Be consistent with word use.
   - Avoid abbreviations or acronyms when you can.
   - Instead of statistics, use general words like most, many, and half.

   e) Be sensitive to cultural differences

- Use terms with which your audience is familiar and comfortable.
- If you need to identify a group of people by race or ethnicity, use a term preferred by that group.
- Tailor messages to each cultural or ethnic group or subgroup.

2. Text Appearance

   a. Use font sizes between **12 points** and **14 points.**

   b. For the body of text, use fonts with serifs, like the one used in this line.

   c. Do not use fancy or *script* lettering.

   d. Mix upper and lower case letters. ALL CAPS IS HARD TO READ**.**

   e. **Use boldface** or underlining to emphasize words or phrases; limit the use of italics.

   f. Use dark letters on a light background.

3. Visuals

   a. Use visuals to help communicate your message
      - Present one message per visual.
      - Use visuals that explain the text, but stay away from visuals that decorate your material.

   b. Choose the best type of visual for your materials and audience
      - Photographs may work best for depicting "real life" events, showing people and conveying emotions.
      - Cartoons may be good to convey humor or to set a more casual tone.

   c. Make visuals culturally relevant and sensitive**.**
      - Use images and symbols familiar to your audience
      - If you show people in your visuals, make them of the same racial or ethnic group as your intended audience

   d. Use only professional, adult-looking visuals.
      - Avoid poor quality visuals.
      - Adults may not pick up materials that have "cute" images.

4. Layout and Design

   a. Design an effective cover.

- Make the cover attractive to your audience.
- Show the main message and the intended audience on the cover.

b. Organize your messages so they are easy to act on and recall.

- Place the most important information at the beginning and end.
- Use headings and sub-headings.

c. Leave plenty of white space.

- Leave a lot of white space around the edges and between columns.
- Limit the amount of text and visuals on one page.

d. Make the text easy for the eye to follow.

- Break up text with bullets.
- Do not justify the right margin.
- Use columns.
- Place key information in a text box.

5. Tips on Translation
   a. Messages that work well with an English-speaking audience may not work for audiences who speak another language.
   b. Design materials appropriate for your intended audience.
   c. Get advice from community organizations in the areas you wish to reach.
   d. Carefully select and instruct your translator.
   e. Avoid literal translation.
   f. Field test draft materials with members of your intended audience.

6. Testing for Readability
   a. Testing for readability allows you to make sure the reading level of your material matches the reading skills of your intended audience.
   b. Aim for 6th – 8th grade reading level (See *Simply Put* website reference in the next section about readability testing).

E. Additional Resources

1. *Pfizer Principles for Clear Health Communication*, available on-line at: http://www.pfizerhealthliteracy.com/Default.aspx

2. *CDCynergy*, an interactive CD-ROM about health communication planning. Available on-line at: http://www.orau.gov/cdcynergy/soc2web/default.htm

3. *Simply Put*; a guide to developing low-literacy health information; contains information about testing for readability. Available on-line at:

   http://www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf

4. *Making Health Communication Programs Work: A Planner's Guide*; available on-line at: http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook

5. *HealthComm Works* is a free, online communication development system with three components: MessageWorks, SocialMediaWorks and ProofWorks. You can access this resource at https://www.healthcommworks.org.

Attachment 9-I Sample Print Material Review Tool

Publication and Review Information

Material Title: _____

Format:_____ Language(s): _____

Author/Publisher/Developer: _____

Reviewer: _____ Date: _____

Directions for Completing Checklist

The following set of review criteria have been adapted from: Guidelines for Health Education and Risk Reduction Activities, April 1995, Centers for Disease Control and Prevention, Atlanta, Georgia. To complete the checklist, each reviewer indicates his/her assessment of the degree to which the author/publisher/developer met the review criteria by placing a check mark in the appropriate box after each item.

- Excellent: Indicates that the material exceeds the review criteria for the material to be "fully successful."
- Fully Successful: Indicates that the material met the review criteria successfully.
- Needs Attention: Indicates that the material needs improvement to meet review criteria.
- N/A: Indicates that these criteria did not apply to this situation.
- If undecided, use "Comments" section below to clarify.

Review Criteria

1. **Material provides a call for action.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

2. **The text provides reasons for changing behavior.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

3. **Material provides current and accurate medical information.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

4. **The format of the text is visually appealing: typeface is no smaller than a 12-point font, sentences are not too long and the page is not too text dense.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

5. **Graphics and photos are immediately identifiable, relevant and simple. They reinforce the text.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

6. **Material is clearly introduced and states the purpose of the text to the reader.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

7. **Major points of the text are summarized at the end.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

8. **Material is brief, concise and in the language or dialect of the intended audience.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

9. **Material is written at the educational and reading level of the target audience and avoids jargon and technical phrases.**
   ☐ Excellent ☐ Needs Attention
   ☐ Fully Successful ☐ N/A

10. **Material avoids or defines difficult words or concepts.**
    ☐ Excellent ☐ Needs Attention
    ☐ Fully Successful ☐ N/A

11. **Material uses terms consistently (e.g., uses either "colorectal" or "colon" rather than using these terms interchangeably.**
    ☐ Excellent ☐ Needs Attention
    ☐ Fully Successful ☐ N/A

12. **Material is straightforward and clear. It does not use abbreviations, acronyms, euphemisms, unclear statistics or anything else that could cause confusion.**
    ☐ Excellent ☐ Needs Attention
    ☐ Fully Successful ☐ N/A

13. **Text uses lists, bullets or illustrations instead of long discussions. Graphics are used to emphasize key points.**
    ☐ Excellent ☐ Needs Attention
    ☐ Fully Successful ☐ N/A

14. **Text is underlined, boldfaced or "boxed" for reinforcement**
    ☐ Excellent ☐ Needs Attention
    ☐ Fully Successful ☐ N/A

Comments:_____
_____
_____
_____
_____

(04/2011)

Attachment 9-II Sample Print Material Content Review Tool

Material/Campaign Review Tool

This section MUST be completed by contractor. Attach a copy of the proposed material in its original format (e.g.: Word, Publisher, etc.) – **do not send PDFs.**

Name: **Title**:
CSP of:
Material Title: or **Campaign Title**:
Format (Newspaper, Poster, Radio, TV, website):
Location (*Name* of newspaper, radio station, TV station, placement in CBOs or provider offices, etc.):

Date (s) Material or Campaign will be posted, aired or running:
(to)
Target Audience (Men, Women, Amish, African American, LGBT, etc.):
Additional Information:
Photo Price: or **N/A:** ☐
Funding Source and Percentage (e.g., CSP 100% or CSP 50%/Komen 50%, other):

Source 1:	%		Source 2:	%	
Source 3:	%		Source 4:	%	
Source 5:	%		TOTAL:		0

All sources combined must total 100%

Date of Submission to RM:

This section MUST be completed by Regional Managers.

1. **Consistent with objectives identified in workplan?** Select

   Comment:
2. **Is funding is available?** Select

   a. **Is a budget modification required?** Select

   Comment:
3. **Suggested Revisions/Comments?**

Date sent to Central Office:

form revised 05-2011

This section will completed by Central Office staff.

1. **Is the information scientifically accurate?** Select
   Comment:
2. **Is the information current and up to date?** Select

   Comment:
3. **Strengths:**

4. **Weaknesses:**

   Disposition:
   ☐ Approved #
   ☐ Accept with minor revisions:
   ☐ Reject:
   Name of Reviewer: **Date**:

Year_____Code _____No_____

form revised 05-2011

Chapter 10 - Staff Listing

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Chapter 10: CSP Staff List

NYSDOH CSP Staff Content Area

The NYSDOH CSP staff directs the activities of the CSP and is available to contractors as a resource. The CSP Regional Manager is the first level of support for contractor staff and providers. Email general questions about the CSP to the CanServ BML at canserv@health.state.ny.us.

Regional Managers are the first point of contact for all contractor questions, including, billing, vouchers, eligibility, reimbursement, work plans, budgets, reporting requirements and implementation of all required activities.	
Regional Manager	**Counties**
Michele Benedict	Albany/Rensselaer, Clinton, Delaware/Otsego/Schoharie, Franklin/Essex, Warren/Washington/Hamilton, Saratoga, Schenectady/Fulton/Montgomery
Linda Garner	Chautauqua, Erie, Genesee/Orleans, Livingston/Wyoming, Monroe, Niagara
Lloyd James	Bronx, Brooklyn, Richmond (Staten Island)
Tammy Nazarko	Columbia/Greene, Hudson Valley (Dutchess, Putnam, Rockland, Ulster, Westchester), Ontario/Seneca/Yates, Orange, Wayne
Anita Pedulla	Manhattan, Nassau, Queens, Suffolk
Janet Roach	Allegany/Cattaraugus, Cortland/Tompkins, Southern Tier (Broome, Tioga, Chemung, Chenango, Schuyler), Steuben, Sullivan
Erica Wade-Loop	Cayuga, Jefferson/Lewis, Onondaga, Oneida/Madison/Herkimer, Oswego, St. Lawrence

Alphabetical Staff Listing

☎ Phone: (518) 474-1222* 🖷 Fax: (518) 473-0642*
***Unless otherwise listed**

Name	Title	E-mail
LeBlanc, Heather	**Director**, Cancer Prevention and Services	hsl04@health.ny.gov
Avery, Sallie Ann	Bureau Health Program Aide	saa05@health.ny.gov
Vacant	Coordinator, CSP Outreach and Recruitment	
Benedict, Michèle	Regional Manager, CSP Capital Region	mmz01@health.ny.gov
Bisner, Sharon	Director, CSP CCU	sab14@health.ny.gov
Bradt, Ellen	Coordinator, CSP Professional Development	ekb02@health.ny.gov
Brady, Roxanne	Coordinator, Bureau Special Projects	rnj02@health.ny.gov
Chytilo, Jan	Coordinator, Field Operations/Community Clinical Linkages Unit	jcc07@health.state.ny.gov
Collins, Elisè	Coordinator, CSP Colorectal Cancer Initiatives	eac10@health.ny.gov
Daniels, Mary Catherine	Coordinator, Support & Survivorship Initiatives	mcd10@health.ny.gov
DeFlumer, John	Coordinator, CSP Medicaid Cancer Treatment Program	jdd07@health.ny.gov
Fusco, Suzanne	Fiscal Officer Aide	smf07@health.ny.gov ☎ (518) 474-3050
Garner, Linda	Regional Manager, CSP Western NY	lmg16@health.ny.gov ☎ (585) 423-8094
James, Lloyd	Regional Manager, CSP Metro NY	laj02@health.ny.gov ☎ (212) 417-4957

Name	Title	E-mail
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Kim, Dongsul	CSP Data Analyst	dxk07@health.ny.gov
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Mathews, Stan	CSP Fiscal Officer Aide	sxm23@health.ny.gov ☎ (518) 474-3050
McClenaghan, Michele	Case Management Coordinator	mxm58@health.ny.gov
McGee, Deborah	CSP Case Management Specialist	dxm25@health.ny.gov
McGovern, Erin	Support, Bureau of Chronic Disease Control	ebm03@health.ny.gov
Nazarko, Tammy	Regional Manager, CSP Hudson Valley	tnn02@health.ny.gov
Pedulla, Anita	Regional Manager, CSP Metro NY	amp04@health.ny.gov ☎ (631) 851-3092
Roach, Janet	Regional Manager, CSP Southern Tier	jmr04@health.ny.gov ☎ (607) 687-8620
Romanzo-Smith, Antoinette (Nettie)	Coordinator, CSP Data Management and Technical Support	axr20@health.ny.gov
Spencer, Diana	CSP Asst. Health Program Administrator	dxs20@health.ny.gov
Wade, James	CSP Quality Assurance Assistant,	jjw05@health.ny.gov
Wade-Loop, Erica	Regional Manager, CSP Central NY	elw03@health.ny.gov ☎ (315) 477-8120

Program website and email addresses	
CSP (CanServ)	CanServ@health.state.ny.us
Credentialing	CSPCredentialing@health.state.ny.us
Data Unit**	CSPData@health.state.ny.us
Fiscal Unit	CSPFiscal@health.state.ny.us
Web Address	http://www.health.ny.gov/cancerservicesprogram

****The following requests and questions should be submitted via the Data Unit email address:**

- All data requests (using the electronic Data Request Form)
- Addition or inactivation of Indus users
- Problems with the Indus system
- How to use the Indus system
- Screening intake form (SIF) questions
- Requests for copies of the Data Manual
- Site code questions
- Data correction questions
- Insurance denial form questions

Chapter 11 - Abbreviations and Acronyms

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Chapter 11: Abbreviations and Acronyms

ACG	American College of Gastroenterology
ACOG	American College of Obstetricians and Gynecologists
ACIP	Advisory Committee on Immunization Practices
ACS	American Cancer Society
AGC	Atypical glandular cells
AGCUS	Atypical glandular cells of undetermined significance
ASCCP	American Society for Colposcopy and Cervical Pathology
ASC-H	Atypical squamous cells, cannot rule out high-grade squamous intraepithelial lesion
ASCUS	Atypical squamous cells of undetermined significance
BI-RADS	Breast Imaging Reporting and Data System
BSE	Breast self-examination
BSROE	Budget statement and report of expenditures
CBC	Complete blood count
CBE	Clinical breast examination
CCU	Clinical care unit
CDC	Centers for Disease Control and Prevention
CIN	Cervical intraepithelial neoplasia
CLIA	Clinical Laboratory Improvement Act
COLA	Cost of living adjustment
CRC	Colorectal cancer
CSSI	Cancer Support and Survivorship Initiatives
CSP	Cancer Services Program
DCBE	Double contrast barium enema
DOH or NYSDOH	Department of Health (or New York State Department of Health)
DQE	Designated Qualified Entity
DSS	Department of Social Services

ECC	Endocervical curettage
ECG/EKG	Electrocardiogram
EHR	Electronic Health Record
E&R	Report of Expenditure and Revenue
FAP	Familial adenomatous polyposis
FDA	Food and Drug Administration
FF	Follow up forms
FIT/FOBT	Fecal Immunochemical Test / Fecal Occult Blood Test
FNAB	Fine needle aspirate biopsy
FOPD	Field Operations and Partner Development
FPG	Federal Poverty Guidelines
FPP	Family planning program
FQHC	Federally Qualified Health Center
HGSIL	High-grade squamous intraepithelial lesion
HIPAA	Health Insurance Portability and Accountability Act
HNPCC	Hereditary non-polyposis colon cancer
HRI	Health Research, Inc.
HPV	Human papilloma virus
IHS	Indian Health Services
LEEP	Loop electrosurgical excision procedure
LEETZ	Large loop excision of the transformation zone
LGSIL	Low-grade squamous intraepithelial lesion
MAC	Monitored anesthesia care
MARS	Maximum Allowable Reimbursement Schedule
MBR	Monthly billing report
MCTP	Medicaid Cancer Treatment Program
MQSA	Federal Mammography Quality Standards Act
MRI	Magnetic Resonance Imaging

NBCCEDP	National Breast and Cervical Cancer and Early Detection Program
NCCN	National Comprehensive Cancer Network
NCI	National Cancer Institute
NYS	New York State
OHIP	Office of Health Insurance Programs
PaRC	Partner Relations and Communications Unit
PM	Performance measure
QA	Quality assurance
RT	Radiologic technologist
RM	Regional Manager
SIF	Screening Intake Form
SIL	Squamous intraepithelial lesion
STD	Sexually transmitted disease
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children

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Revision History

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Revision History:

Date	**Revision**	**Chapter/Page(s) updated**
July 2013	Document Creation	N/A
10/22/13	Corrected Cervical Algorithm	6-32
12-2013	Updated staffing info, added new staff, removed staff no longer with program	10-1 –> 10-3
1/23/14	Added missing arrow from cervical algorithm	6-30
1/23/14	Updated Regional Manager assignments	10-1
1/28/14	Inserted new Contact Update Form	2-40
	Chart updated to reflect 2014 Federal Poverty Guidelines (FPG)	3-4
	Cervical Screening Algorithm updated : *Pap > **ASC-US** any HR HPV result* **changed to** *:Pap >LSIL HR HPV any result*	6-30

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New York State Department of Health

Cancer Services Program

Your partner for cancer screening, support and information