

STATE OF NEVADA

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**THE WOMEN'S HEALTH CONNECTION PROGRAM
PROVIDER CORRESPONDENCE FFY 10-01**

July 14, 2009

RE: Payment Rates and Income Guidelines for the Period June 30, 2009, through June 29, 2010
and Program Guideline Changes

Dear Women's Health Connection Program Provider:

The purpose of this correspondence is to announce the Fee for Service Schedule and the new Income Guidelines for the period June 30, 2009, through June 29, 2010, for the Women's Health Connection Program. The 2009-2010 fact sheet, which includes the new guidelines are enclosed. The new rates are available on the program's website at <http://health.nv.gov> by selecting the Bureau of Child, Family and Community Wellness link and then the Women's Health Connection link.

Additionally, this correspondence will serve as notification of important program guideline changes. The Women's Health Connection (WHC) Program funding is solely through a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC). Due to the ongoing difficult economic times, there are more women that qualify for the WHC Program than the CDC funding can support. Therefore, it has become necessary to implement new guidelines to ensure compliance with the CDC guidelines and ensure that the limited resources are used appropriately.

GUIDANCE FOR ALL PROVIDERS

All claims for services provided to eligible clients of the Women's Health Connection Program must be received within 60 days of the date the service was provided. Claims will only be paid if the appropriate medical reports and/or exam forms are on file with the program. Claims received later than 60 days from the date of service will be held in pending status and processed for payment at the close of the grant as long as funds are available. Claims will not be paid if the program has depleted its funding for the current fiscal year. The current fiscal year runs from June 30, 2009, through June 29, 2010.

Please disregard any previous information you may have received indicating that claims should be submitted within 90 days. The 60-day policy applies to all providers and will ensure better budget management for the program.

Terminology Changes in Suspense Report

The WHC Program has enhanced the reporting capabilities to our providers through the use of new terminology in the Suspense Reports. The WHC Program assigned claim number will be identified below the amount to be paid. When inquiring about a specific claim status, the claim number will assist the WHC Program staff's research of the claim. Services that cannot be reimbursed as they are not a covered service will be identified as 'Deny' below the claimed amount with the Suspense Reason as 'Procedure Not Covered'.

Claims that have a payable line item with an item that cannot be paid as the reports are missing will show on the Suspense Report as 'Pay' with a reason code 'Payment of Claim (number) is Suspended. The payable claim will pay when the reports are received for the non-payable item on the same claim. Items that are in suspense due to reports missing will be reported as 'Pend'.

Removal of Cervical Polyps

Effective June 30, 2009, the WHC Program will **not reimburse** for removal of cervical polyps. In accordance with the NBCCEDP and the Medicaid Treatment act neither can reimburse for these procedures. Virtually all cervical polyps are benign, easily removed, and require little or no follow up. The only rare exception would be a large or specifically located polyp may make it impossible to perform a Pap test. In this circumstance **prior authorization must be obtained** prior to referring a client to a specialist for consideration for removal of the polyp. The clinician must fax copies of all of these reports along with the recommended procedure to (702) 486-0403. The WHC clinical staff will review the request and supporting documents and respond, in writing, to the requesting provider within 48 business hours.

Pap test Result ASC-US with HPV Positive

Effective January 1, 2009, a new data element that is required to be reported to the CDC is Pap test with atypical squamous cells of undetermined significance (ASC-US) with Human Papilloma Virus (HPV) 'Positive'. A client with this type of result, please fax, immediately, to the WHC Program Las Vegas office at (702) 486-0403, along with the clinicians follow-up recommendations,.

GUIDANCE FOR PRIMARY CARE PROVIDERS

Each primary care provider is responsible for providing the Program with the original copy of the Presumptive Eligibility Enrollment Form or the Annual Screening Visit Form within two weeks of performing the service. Without this documentation, the program is unable to confirm that a screening service was performed for a client and will be unable to pay other claims that come through as a result of a referral to an imaging facility or specialist provider. Similarly,

separate claims for Pap tests from lab facilities also cannot be paid until the Program has documentation that a screening service was performed by a contracted primary care provider.

To assist with timely processing of payments, it is helpful if the primary care provider also sends the Pap report and the mammogram or ultrasound report as soon as these items are received by the primary care provider. This is not a requirement, but it ensures that the program has complete information about the services provided to eligible clients.

Consultations

Effective June 30, 2009, the WHC Program will pay for consultation under the following circumstances:

- To notify client of an abnormal screening result: **exception;** following an assessment incomplete mammogram result requiring additional imaging,
- Discussion by a specialist to inform client of a diagnostic work-up plan,
- To notify client of results and recommendations of a completed diagnostic work-up plan,
- Client is under surveillance following a previous abnormal Pap test finding including Unsatisfactory Pap test results: **exception;** Pap test result of; Negative for Intraepithelial Lesion or Malignancy, endometrial cells present,
- Client is under appropriate surveillance following treatment for cervical precancerous or cancerous condition, and
- Client is under appropriate surveillance following completed diagnostic work-up for a breast finding that was suspicious for breast cancer.

The WHC Program cannot reimburse for consults under the following circumstances:

- To discuss normal screening results,
- Purpose of the office visit is for treatment,
- To discuss diagnostic or treatment plans for non-covered health conditions,
- To give client a mammography referral form following a recent assessment incomplete mammogram result or a prior follow-up for a BIRADS 3, Probably Benign mammography result,
- To discuss mammogram results which are paid through another payment source other than the WHC Program

Mammograms and Other Referrals

Please ensure that referrals for mammograms are made in accordance with the Program's policies. In addition, any referrals from a contracted primary care provider should be made on a carbon form titled "Women's Health Connection Mammography Reporting Form."

Effective June 30, 2009, clients that have an Assessment Incomplete Mammogram result and additional imaging is recommended, the WHC **Program will not reimburse an office visit to give clients referral forms for the additional imaging.** The ordering clinician should fax the "Women's Health Connection Mammography Reporting Form" ordering the additional imaging

to the imaging facility making the recommendation following verbal notification to the client. This should expedite the client receiving the recommended additional imaging,

The program does not pay for a screening mammogram for women who are between the ages of 40 and 49. Do not use the Women's Health Connection Program's mammography form for women in this age group unless the clinical breast exam is positive suspicious for breast cancer. A suspicion condition includes a "Discrete palp mass-Suspicious for Cancer," "Bloody/serous nipple discharge," "Nipple/areolar scaliness," or "Skin dimpling/retraction." If the screening exam indicates one of these conditions or is suspicious for malignancy, please refer the client for imaging studies to rule out a cancerous or precancerous condition. Further, in accordance with the Program's policies, clients with this screening result also must be referred to a specialist provider, and the exam form must immediately be faxed to the Program's Case Management Unit at (702) 486-0403. **If none of the aforementioned conditions are met, it is not appropriate to use the Program's mammography form to send a client who is between the ages of 40 and 49 for any mammography or ultrasound service.**

The program pays for screening mammograms for women 50 years of age and older. However, a Clinical Breast Exam must be performed on the client prior to referring her for a screening mammogram. The results of the CBE must be recorded on the appropriate form and sent to the Program within two weeks of the exam being performed. Further, this referral also must be made on the "Women's Health Connection Mammography Reporting Form."

Pap test Reimbursement Policy

This is a reminder regarding the reimbursement guidelines for Pap tests. As of June 30, 2007, once a woman has had three consecutive, normal cervical cancer screening tests documented with the same provider within a 60-month period, the WHC Program can only pay for Pap tests once every three years, unless there is an abnormal cervical exam. Please note that, for women who have **not** yet had three consecutive, normal cervical cancer screening tests in a 60-month period, the WHC Program will reimburse every 24 months for cervical cancer screening with liquid-based Pap tests, or every 12 months for cervical cancer screening with conventional Pap tests, for women who have an intact cervix or for women who have had a hysterectomy due to cervical neoplasia.

GUIDANCE FOR IMAGING FACILITIES, LABS, AND SPECIALIST PROVIDERS

Claims for payment for mammograms, ultrasounds, biopsies, Pap tests, office visits for consultations, and other related services should be submitted with the appropriate reports. However, payment for these services is contingent upon the program receiving the appropriate screening exam information from the referring primary care provider. **This policy replaces any existing policy in this regard.**

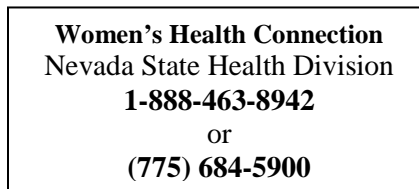
Before billing the Women's Health Connection Program for a service, you must ensure that the client has a proper referral from a contracted primary care provider. For imaging services, this

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referral must be made on the “Women’s Health Connection Mammography Reporting Form.” However, if the client is between the ages of 40 and 49 and does not have a positive suspicious clinical breast exam as outlined in the preceding guidance for primary care providers, the program will be unable to pay for the imaging service. **If you suspect that the primary care provider has made an inappropriate referral, please contact the referring provider and discuss your concerns.** Do not contact the Women’s Health Connection Program because it is likely we will not have the most up to date information concerning the client, and we will not be able to authorize the service.

Please document covered services that are performed in follow-up to abnormal screening results on the appropriate Breast or Cervical Services form. These forms are primarily used by the program’s specialist providers, but they may also be used by primary care providers.

Appropriate Pap test referrals should be made on a form that has the Program’s pink lab sticker, which looks like this:

**CLOSING COMMENTS**

A copy of this correspondence is available on the program’s website at <http://health.nv.gov> by selecting the Bureau of Child, Family and Community Wellness link and then the Women’s Health Connection link.

In addition, scanned copies of the forms referenced in this correspondence also are available for viewing on the website.

The Women’s Health Connection Program is a payer of last resort for women in Nevada who do not have health insurance. Program staff strive to process the paperwork in a timely manner, and adherence to the program’s policies will ensure that all claims get paid.

Questions about these billing guidelines may be directed to Karen Allen, Program Coordinator, at (775) 684-5936 or the toll free number of 1-888-463-8942. Thank you for your cooperation.

Respectfully,

Judith M. Wright
Deputy Bureau Chief
Bureau of Child, Family and Community Wellness