EWM Diagnostic Program - Breast -How EWM can help your clients with breast concerns -What your office needs to do EVERY WOMAN MATTERS

EWM Diagnostic Program -Breast

Who can enroll?*

Diagnostic Enrollment is for women with:

-breast concerns (pain, lump, etc.)

-abnormal breast exam

-abnormal screening mammogram

who are in need of further testing to diagnose whether or not breast cancer is present.

*If your client is 40 or over and has no insurance and needs a screening mammogram, please see our EWM Screening Guidelines for instructions.

Who can enroll in the EWM Diagnostic Breast Program?



EWM Breast Die	agnostic Program Eligibility
Gender:	Females only
Age:	18-64 years old
Income:	Must meet income guidelines (see slide 17 for details)
Insurance:	 Women with insurance are eligible for the EWM Diagnostic program (but ineligible for screening). See slide 10. Uninsured women are eligible for the diagnostic program as well.
Citizenship:	Must be US Citizen or <u>Permanent Resident</u> (See slide 16)
Health Status:	Must need services to diagnose breast cancer

What services are covered?

Coverage is determined by the age of the client and the results of screening, following guidelines from the National Comprehensive Cancer Network (NCCN).

Procedures covered for women 18-39:

Screening mammogram **not covered** by EWM for women <40

Age	CBE Findings:	Diagnostic Services Allowable for Reimbursement Based on Findings:
18-29	Suspicious CBE (Consultation by surgeon preferred)	 Surgical Consultation (can only be reimbursed if provider normally brings clients in the office for consultation) Breast Ultrasound Fine Needle Aspiration Breast Biopsy Cytology of breast discharge
30-39	Suspicious CBE (Consultation by surgeon preferred)	Same as list above, can also get diagnostic mammogram

Note: Diagnostic mammogram alone does not meet clinical standards of care for those with a suspicious clinical breast exam

Procedures Covered for women ages 40-64:

- If the client did NOT have a screening mammogram, had a breast lump or other cause for concern, see the first row ("No Screening Mammogram and Suspicious CBE").
- If she had a screening mammogram, see the column to the right of the results of the screening mammogram (BI-RADS 0-5) to determine if services are covered.

Age	Screening N	Aammogram Findings	Diagnostic Servi	ces Allowable for Reimbursement Based on Findings
40-64	CBE (palpable	Mammogram and Suspicious e mass, etc.) agnostic mammogram findings ->	Diagnostic mammogram BI-RADS 0-3 Diagnostic mammogram BI-RADS 4, 5	 Breast Ultrasound is required (diagnostic mammography alone misses 15-20% of translucent tumors) Fine Needle Aspiration Breast Biopsy Consultation
	BI-RADS 0 - Needs additic	onal imaging evaluation	 Comparison of p Diagnostic mam Breast Ultrasour 	mogram
	BI-RADS 1	CBE Negative	Routine Screenir	ng
	–Negative or BI-RADS 2 – Benign finding	CBE Suspicious for malignancy	Breast UltrasouFine Needle Asp	
	BI-RADS 3 – P	Probably Benign	Diagnostic mam	mogram or ultrasound at 6 months, then every 6-12 months for 2-3 years
		uspicious Abnormality or lighly suggestive of malignancy	Consultation (caBreast Biopsy	n only be reimbursed if provider normally brings clients in the office for consultation)

Services EWM does NOT cover

- Breast cancer treatment (more on this later)
- Anything not directly related to diagnosing breast cancer
- <u>Elective</u> excisional biopsies
- Non-cancerous skin lesions on breast or axillary area
- Genetic testing
- Diagnostic mammograms for women under 30
- Office visits for women under 40 who do not need further testing
- Follow-up for women under 40

Enrolling Clients

- Clients never before enrolled in EWM
- Clients already enrolled in EWM



Who can enroll clients into EWM Breast Diagnostic Program?

> You can! We'll show you how!

- We call this process "enrolling clients diagnostically"
- Any EWM contracted provider can enroll clients diagnostically
- Clients do NOT have to be previously enrolled in the program



What if a client comes in with no paperwork?



- Clients do not need to bring in their EWM screening card for diagnostic services
- Clients do not need to bring any paperwork at all – even if they're not enrolled yet
- You the provider can enroll her diagnostically by using <u>Breast Diagnostic Enrollment Form</u>



What if a client has insurance?

Many EWM Diagnostic clients have health insurance but still need our program to cover extra costs:

- Client is still eligible for the <u>EWM Breast Diagnostic Program</u>
- Must meet all other program criteria
- Is not eligible for <u>EWM Screening Program</u> unless insurance does not pay for preventive services
- EWM will cover costs that insurance does not pick up
- ► Enroll her diagnostically

Having Health Insurance is OK!

How do I enroll clients?

- Use the <u>Breast Diagnostic</u> <u>Enrollment Form (BDIA)</u>
- Who/what is this form for? This form is to be used ONLY for women with an abnormal breast exam or abnormal screening mammogram that are in need of further testing to diagnose whether or not breast cancer is present.

Client	First	MI	Last		DOB
	Bre	ast Cancer Refe	erral & Treatment		
Referral:	Client referred to Clinician/Clinic name and o		24	who will	I take over care.
Consultation :	Consultation Date to give client options				
Treatment:	Treatment regimen consists of Treatment Scheduled Date:			(lumpectomy, su	urgery, chemo, radiatior
Refusal:	Cancer treatment refused date Reason for refusal:			Client made infor	med decision: OYes C
	Screen	ning MRI Preau	thorization Request		
 Lifetime risk o <u>www.can</u> Client has O First-degree r Previous Rad 	sonal history of breast cancer of 20-25% or greater based on family histo <u>cer.gov/bcrisktool/</u> (for women under 38 BRCA1 OBRCA2 OOther mutation relative with BRCA1 or BRCA2 (parent, bro iation Therapy to chest, between the ages	5, go to https://ibis. Date of ther, sister, child) R s of 10-30 Age:	<u>.ikonopedia.com/)</u> f genetic testing:/_ elative: Purpose of radiat	Clin Pho Fax Date of gene	
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Where to find our forms

- Forms can be downloaded and printed out from here: <u>www.dhhs.ne.gov/ewmforms</u>
- Bookmark this page!
- Breast Diagnostic forms are available in <u>English</u> and <u>Spanish</u>
- <u>Instructions</u> are no longer printed as part of the form but can be found online

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If you have forms in your office...

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- Please check the date in the top right corner
- ▶ We prefer forms dated 2024
- The newer the better these forms change frequently as our program eligibility evolves
- Always go to the website for most updated version

Enrolling Clients-Part One



CLIENTS THAT ARE NOT CURRENTLY ENROLLED IN EWM

• NEVER BEEN IN EWM BEFORE

OR

 HAVE BEEN ENROLLED IN EWM OVER ONE YEAR AGO AND NEED UPDATED ENROLLMENT INFORMATION

Enrolling Clients Diagnostically

Patients not yet enrolled in EWM

- Your client does not have to be currently enrolled in Every Woman Matters to use the diagnostic form.
- Clients 18-64 with a breast diagnostic issue may be enrolled <u>immediately</u> by using this form as long as they:
 - meet the income guidelines
 - meet citizenship requirements
 - have abnormal screening results within the last 6 months

	REAST DIAGNOSTIC EN ollow Up & Treatment Plan for W			SCREENING	
:	VIDER NOTES: Clients with insurance MAY STILL BE ELIGIBLE for d If client is currently enrolled for screening services on Diagnostic form instructions may now the found onlin Male clients - NOT eligible for screening or diagnostic and pg 81 in the Women's & Men's Health Program P Please answer ea	mplete ONL e at dhhs.ne procedures rovider Parti	f pages 3 and/or 4. . <mark>gov/ewmforms</mark> (see Transgender Policy pg 77	Reasonable accom persons with disabiliti Nebraska DHHS provis at no cost to limited Er	Fax: 402-471-0 1-800-532-2 gov/womenshe modations made for ex mn (2001833-735)
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	2b. Was your hysterectomy to treat cervical cancer? OYes ONo		ONO Ores ODK	When:/	

Enrolling Clients Diagnostically – Clients not yet enrolled in EWM

In order to be eligible, a client must...



Need services to diagnose breast cancer

- Breast lump, pain, or discharge
- Abnormal breast exam
- Abnormal screening results within the last 6 months.



Meet Income Guidelines

Eligible clients must be within 250% of the Federal Poverty Guidelines.

Current income guidelines can be found at https://dhhs.ne.gov/Documents/EWM_Income_Guidelines.pdf



Be a U.S. Citizen or Permanent Resident

Clients must comply with Neb. Rev. Stat. §§4-108 through §§4-114, being either a US citizen or Qualified Alien under the Federal Immigration and Nationality Act.

 Qualified Aliens *must* submit a front *and* back copy of their <u>Permanent Resident Card</u> with their application.

Income guidelines

Women's and Men's Health Programs Income Eligibility Scale Every Woman Matters Effective July 1, 2024-June 30, 2025

	Yearly Incom	е
# of People in Household	FREE	\$5.00 Donation
1	0-\$15,060	\$15,061-37,650
2	0-\$20,440	\$20,441-51,100
3	0-\$25,820	\$25,821-64,550
4	0-\$31,200	\$31,201-78,000
5	0-\$36,580	\$36,581-91,450
6	0-\$41,960	\$41,961-104,900
7	Call 1-800	-532-2227

Women's & Men's Health Program

Every Woman Matter

aska Colon Cancer Screening Program

Monthly Income

	# of People in Household	FREE	\$5.00 Donation
	1	0-\$1,255	\$1,256-3,137
	2	0-\$1,703	\$1,704-4,257
]	3	0-\$2,152	\$2,153-5,380
]	4	0-\$2,600	\$2,601-6,500
1	5	0-\$3,048	\$3,048-7,620
1	6	0-\$3,497	\$3,498-8,742
]	7	Call 1-800	-532-2227

Note: When Screening Cards are sent to clients, they will have an opportunity to make the suggested \$5 donation back to the program to help women receive screening services.

301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817 Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913

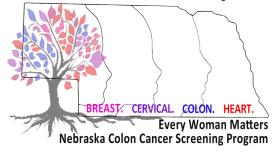
www.dhhs.ne.gov/EWM

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cenvical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services.

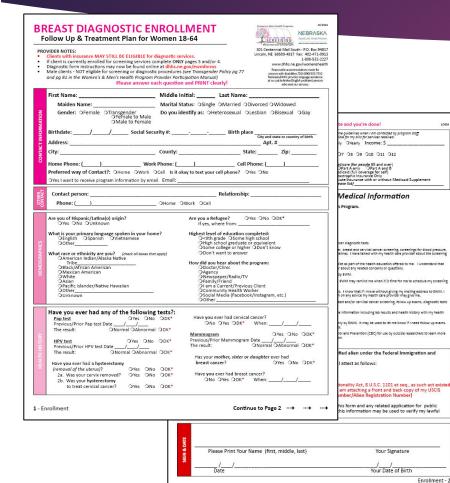


DEPT. OF HEALTH AND HUMAN SERVICES

Women's & Men's Health Programs



Enrolling Clients Diagnostically Patients not yet enrolled in EWM



Clients who have not yet enrolled in the program or who have enrolled over one year ago must complete pages 1-2 of the <u>Breast Diagnostic Enrollment (BDIA)</u> with:

- contact information
- demographics
- breast and cervical history
- income and insurance
- citizenship status
- signature (date of signature should be the date of first diagnostic service in order for it to be reimbursed)

Providers can have clients complete pages 1&2 in their office.

Enrolling Clients – Part Two



CLIENTS THAT **ARE** CURRENTLY ENROLLED IN EWM OR THE STATE PAP PLUS PROGRAM

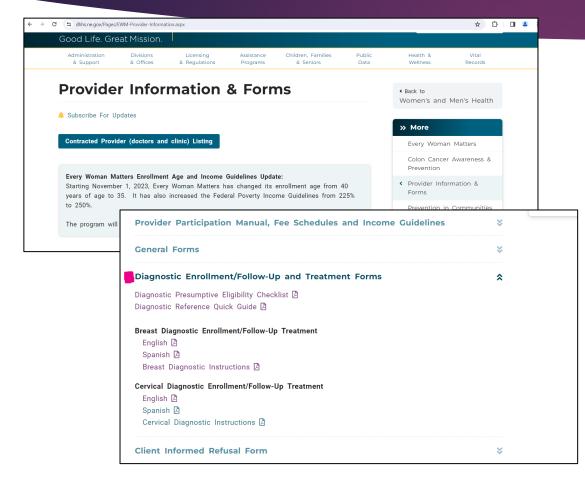
Enrolling Clients Diagnostically – Patients already enrolled in EWM

If your client meets the following criteria, pages 1-2 of the Breast Diagnostic Form (BDIA) <u>do not</u> need to be completed or returned:

- Age 21-64 and has recently completed a Healthy Lifestyle Questionnaire and had a EWM well woman screening visit
- Call EWM at 1-800-532-2227 if you are not sure they are an EWM client



NEW! Quick reference guides online!



When in doubt, check these out!

- Go to <u>www.dhhs.ne.gov/ewmforms</u>
- There is a Checklist and a Reference Guide for eligibility for diagnostic services so you don't need to have all of this memorized
 - <u>Diagnostic Presumptive Eligibility</u>
 <u>Checklist</u>
 - Diagnostic Reference Quick Guide
- Print them off for your clinic

NEW - Quick reference guides



Diagnostic Presumptive Eligibility Checklist



- 1. Clients ages 21 and up for breast cancer diagnostics after abnormal screening results that occured within the last 6 months.
- 2. Clients ages 21 and up for cervical cancer diagnostics after abnormal screening results that occured within the last 6 months.
- Clients ages 25 and over with documented personal history of BRCA1 or BRCA2 would be eligible for annual breast MRI screening.
- Breast or Cervical Cancer Diagnostic Form completed in its entirety
 Incomplete forms will be returned to the provider office
- 5. Income falls within Income Eligibility Scale
 - Eligibility scale is found on the Every Woman Matters website: https://dhhs.ne.gov/Documents/EWM_Income_Guidelines.pdf
- 6. Insurance coverage noted on form
 - Patient may have private insurance and be responsible for co-pays and deductibles
 - Patient cannot have Medicare part B or Medicaid
- 7. Client is a U.S. citizen or qualified alien under the Federal Nationality Act
 - Client has marked the box attesting that they are a US citizen or qualified alien
 - Copy of front and back of USCIS documentation provided with program form (Permanent Resident Card/Green Card)
- 8. Medical Release Form is signed and dated by patient (this includes client listing their date of birth and printing their name).
- 9. Services provided follow program guidelines
 - Guidelines are printed on Diagnostic Forms
 - Program adheres to the current ASCCP Consensus Guidelines for Cervical Abnormalities
 - Program adheres to the NCCN Screening and Diagnostic Guidelines for Breast abnormalities
- 10. The initial visit may be reimbursed by EWM if the provider determines that CBE is suspicious for breast malignancy and additional tests are required to reach a final diagnosis.





301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817 Toll-Free: (800) 532-2227 || In Lincoln: (402) 471-0929 || Fax: (402) 471-0913 EWM F-Mail: <u>dhhs.ewm@nebraska.gov</u> || Version: 10/2024

REFERENCE GUIDE FOR PROVIDERS

Qu	alifying Criteria Quick Guide - DIAGNOSTIC SERVICES
Gender:	Females Only
Age:	18-64* for Breast Diagnostic Services 21-64* for Cervical Diagnostic Services *Clients outside of age parameters who meet program guidelines and do not have Medicar coverage will be reviewed on a case by case basis. Enrollment is based upon review.
Income:	Must meet Income Guidelines
Insurance:	CLIENTS MAY HAVE INSURANCE
Citizenship:	Must be a US Citizen or Permanent Resident* *must provide front and back copy of Permanent Resident Card/Green Card
Health Status:	Must need services to diagnose breast or cervical cancer
Forms:	https://dhhs.ne.gov/EWMForms Only forms printed 2024 are accepted (Date found in upper right-hand corner)
Enrollment:	BREAST can be enrolled as a diagnostic client at the provider's office for diagnostic work up for breast issues or if they have had an abnormal screening mammogram. Breast enrollments must follow the National Comprehensive Cancer Network (NCCN) guidelines. If client has a suspicious clinical breast exam, a diagnostic mammogram alone does not meet clinical standards (shown on the Breast Diagnostic Enrollment Follow Up and Treatment Plan Form (BDIA)). CERVICAL can be enrolled as a diagnostic client at the provider's office for diagnostic work up for abnormal pap tests. Cervical enrollments must follow the current American Society for Colposcopy and Cervical Pathology (ASCCP) Guidelines (shown on the Cervical Diagnostic Enrollment Follow Up and Treatment Plan Form (DDIA).

Please call 800-532-2227 to speak with a program Nurse regarding completion of diagnostic forms or to answer diagnostic questions.



# of People in Household	FREE	\$5.00 Donation	# of People in Household	FREE	\$5.00 Donation
1	0.\$15,060	\$15,061-37,650	1	0-\$1,255	\$1,256-3,137
2	D-\$20,440	\$20,441-51,100	2	0-\$1,705	\$1,704-4,257
3	0-\$25,820	\$25,821-64,550	3	0-\$2,152	\$2,153-5,380
4	0-\$31,200	\$31,201-78,000	4	0-52,600	\$2,601-6,500
5	0-\$36,580	\$36,551-91,450	5	0-53,048	\$3,048-7,620
6	0-\$41,960	\$41,961-104,900	6	0-\$3,497	\$1,490-0,742
7	Call 1-80	0-532-2227	7	Call 1-80	0-532-2227





PO. Box 94817 Lincoln, NE 68509 Toll Free: 800-532-2227 Fax: 402-471-0913 dhhs.ewm@nebraska.gov

10/2024

Completing Breast Diagnostic Enrollment Forms

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First, check to make sure client filled everything out on pages 1 and 2 (for clients not already enrolled in EWM)

	gov/evenforms www.dhit.ne.gov/women/bailth See Transgender Policy pg 77 ipatron Manual) Network (Construction of the person with dutations note to person with dutations the person with dutations and the person with dutation of the person ingregation and the person with dutation of
First Name: Middle In	itial: Last Name:
Maiden Name: Marital Sta	atus: OSingle OMarried ODivorced OWidowed
OFemale to Male OMale to Female	entify as: OHeterosexual OLesbian OBisexual OGay
Birthdate:// Social Security #:	Birth place
Address:	Apt. #
City: County:	
county.	
Home Phone: () Work Phone: (
Preferred way of Contact?: OHome OWork OCell Is it ok	ay to text your cell phone? OYes ONo
OYes I want to receive program information by email. Email:	
	Relationship:
Phone: (OHome O'	Work OCell
Are you of Hispanic/Latina(o) origin? OYes ONo OUnknown	Are you a Refugee? OYes ONo ODK* If yes, where from:
What is your primary language spoken in your home? OEnglish OSpanish OVietnamese Oother	Highest level of education completed: O<5th grade D Some high school O High school graduate or equivalent O Some college or higher O Don't know O Don't want to answer
What race or ethnicity are you? (check all bases that apply) OAmerican Indian/Alaska Native	
Tribe OBlack/African American	How did you hear about the program: ODoctor/Clinic
OMexican American OWhite	ODoctor/Clinic OAgency ONewspaper/Radio/TV
QAsian	O Family/Friend
OPacific Islander/Native Hawaiian Oother	OI am a Current/Previous Client OCommunity Health Worker
OUnknown	OSocial Media (Facebook/Instagram, etc.)
	O0ther
Have you ever had any of the following tests?:	
Papitest OYes ONo ODK*	Have you ever had cervical cancer? ONo OYes ODK* When: / /
Previous/Prior Pap test Date// The result: ONormal OAbnormal ODK*	Give Ones ODK* When://
The result. Onormal OAbnormal ODK*	Mammogram OYes ONo ODK*
HPV test OYes ONo ODK*	Previous/Prior Mammogram Date / /
Previous/Prior HPV test Date	The result: ONormal OAbnormal ODK*
The result: ONormal OAbnormal ODK*	Has your mother, sister or daughter ever had
Have you ever had a hysterectomy	breast cancer? OYes ONo ODK*
(removal of the uterus)? OYes ONo ODK*	
2a. Was your cervix removed? OYes ONo ODK*	Have you ever had breast cancer? ONo OYes ODK* When: / /
2b. Was your hysterectomy to treat cervical cancer? OYes ONo ODK*	UNO UTES UDK- When:

	I may be required to show proof that my income is within the program income guidelines when I am contacted by program staff.
	(f) am found to be over income guidelines, I will be responsible for my bills for services received. What is your household income before taxes? Oweekly OMonthly OYearly Income: \$
	How many people live on this income? O1 O2 O3 O4 O5 O6 O7 O8 O9 O10 O11 O12
	Do you have insurance?* OYes If yes, is it: OMedicare (for people 65 and over)
	*Clients with insurance ONone/No Coverage OPert A only OPert A and B
	MAY STILL BE ELIGIBLE OCatastrophic Insurance Only Health Marketplace
	for diagnostic services. OPrivate Insurance with or without Medicaid Supplement (please list)
	Informed Consent and Release of Medical Information
	You must read and sign this page to be a part of the Every Woman Matters Program.
•	vant to be a part of the Every Woman Matters (EWM) Program. I know: If I am under the age of 40, I can only receive breast diagnostic tests.
:	I cannot be over income guidelines If I have insurance, EWIM will only pay after my insurance pays
•	I must be a female (per Federal Guidelines)
	I will notify EVM if I do not wish to be a part of this program anymore now that if I am 21-64 years of age, I may be eligible for screening services which may include: breast and/or cervical cancer screening, screenings for blood pressure,
ch te:	olesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening t(s) and understand possible side effects or discomforts.
be	nderstand that I may be asked to increase my level of physical activity and make changes to my det as part of the health education offered to me. I understand that fore I make these activity and/or diet changes, I am encouraged to talk to my health care provider about any related concerns or questions.
	ave talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM. nav be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening.
ex	ams and send me mail to help me learn more about my health.
m	sed on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I ay not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
an	y health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and/or cervical cancer screening, follow up exams, diagnostic tests d/or treatment to EVM.
C8	assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health re providers.
m	y name, address, email, phone number (for calling or texting), social security number and/or other personal information will be used only by EVM. It may be used to let know if need follow uses assume or used to remind me when I am due for screening/rescreening/restment. This information may be shared with other organizations as given to receive treatment resources.
	her information may be used for studies approved by EWM and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more out women's and men's health. These studies will not use my name or other personal information.
lin	i need help with food, safe housing, or other items that keep me from taking care of my health, I will be offered a referral to a care network called Unite Us. Unite Us will it me to community agancies close to me who can help me. To use this help, my name address, email, phone, or other personal information will be shared. I can refuse help.
	In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.
	 For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows:
y	
NONE	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Or Iam a citizen of the United States. OR
THE OFF	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a citizen of the United States. OR I am a qualified alien under the federal immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existe
CITECA UNE	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Or Iam a citizen of the United States. OR
CHECK ONE	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a cittern of the United States. OR I am a qualified alien under the federal immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existence on January 1, 2009, and an Javdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card)
CILCH OIL	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a cittzen of the United States. OR I am a qualified alien under the federal immigration and Netionality Act, B U.S.C. 1101 et seq., as such act exister on Januar 1, 2009, and am lawfully present in the United States. I am attaching a front and back copy of my USCS documentation. (for example, Permanent Resident Card/Green Card) Horeby attact that my response and the information provided on this from and any related application for public
CILECK OILE	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a cittern of the United States. OR I am a qualified alien under the federal immigration and Nationality Act, 8 U.S.C. 1101 et seq., as such act existence on January 1, 2009, and an Javdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card)
CHECK UNE	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Iam a citteen of the United States. OR Iam a qualified alien under the federal immigration and Nationality Act, B U.S.C. 1101 et seq., as such act existe on January 1, 2009, and an Javdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card) I hereby attest that my response and the information provided on this form and any related application for public benefits are rue, complete, and accurate and lunderstand that this information may bus used to verify my lawful
	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Iam a citteen of the United States. OR Iam a qualified alien under the federal immigration and Nationality Act, B U.S.C. 1101 et seq., as such act existe on January 1, 2009, and an Javdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card) I hereby attest that my response and the information provided on this form and any related application for public benefits are rue, complete, and accurate and lunderstand that this information may bus used to verify my lawful
	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Iam a citteen of the United States. OR Iam a qualified alien under the federal immigration and Nationality Act, B U.S.C. 1101 et seq., as such act existe on January 1, 2009, and an Javdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card) I hereby attest that my response and the information provided on this form and any related application for public benefits are rue, complete, and accurate and lunderstand that this information may bus used to verify my lawful
	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a cittzen of the United States. I am a cittzen of the United States. I am a cittzen of the United States. I am a cittzen of the Inited States.
	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: Iam a citteen of the United States. OR Iam a qualified alien under the federal immigration and Nationality Act, B U.S.C. 1101 et seq., as such act existee on January 1, 2009, and and Jawdily present in the United States. I am attaching a front and back copy of my USCIS documentation. (for example, Permanent Resident Card/Green Card) I hereby attest that my response and the information provided on this form and any related application for public benefits are rue, complete, and accurate and lunderstand that this information may bused to verify my lawful
	For the purpose of complying with Neb. Rev. Stat. 4-111(1)(b), I attest as follows: I am a citizen of the United States. I am a citizen of the United States. I am a citizen of the United States. I am a citizen of the Inited States. I am a citizen of the Inited States. I am a citizen of the Inited States. I am a citizen of the United States. I am a citizen of the Inited States.

EWM will return the form to you if sections are left blank

Income, attestation, and signature are all required

 <u>Spanish forms</u> available online

	First		м	Last	DOB
	Screening: Clinic that initiated care	Name:		City/Phone Number	
Information:	Diagnostic: Clinic that patient was referred to	Name:		City/Phone Number	
Instructions:	Please send this form to	EWM along with corresp	oonding i	adiology and/or pathology reports when	diagnostic workup is comple
	Ages 18	-39		Ages	40-64
O Clinical Brea	Screening His st Exam Suspicious for Breast			Screening O Clinical Breast Exam Suspicious for Br	
O Breast Ultrasound	ious, EWM encourages surgica	ate:// al consult BEFORE ultrasound Date:/		Results of initial SCREENING mammogra O Screening Mammogram was NOT PERPORN O BI-RADS 0 - Assessment incomplete O BI-RADS 1, 2, and 3 with a suspicious clinics O BI-RADS 4 - Suspicious abnormality O BI-RADS 5 - Highly suspicious	/ED al breast exam
 Acceptable: Bri ODiagnostic Mamn Client must be 	east u/s ordered by Primary C nogram f at least age 30 to have a Diag	and to determine need for u/s are Provider if no surgeon avai Date:/ nostic Mammogram t standard of care if CBE is susp	lable	Physician: OBreast Ultrasound	: Workup: Date:// Date:// Date://
OBreast MRI for susp O Consultation/2nd	e: pected Inflammatory Breast Cancer I opinion Guided Needle Aspiration Initiate: Client Informed Refusal Fo	Date:/ Date:/ rm/Service Provider Document		Diagnostic mammogram alone does not in ORepeat Breast Exam OBreast Biopsy type:	Date: Date: cer Date: Date: Date: Date: Date:
			rvices for	more information at www.dhhs.ne.gov/e	wmforms
★ Final Diagnos This section musi completed befor to EWM	t be OCancer no e sending OCancer di ODuo	ot diagnosed - no treatme agnosed - Please complete Bre tal carcinoma in situ I diagnosis or pathology r	ast Cancer 1 O Lobular	reatment section on Page 4 carcinoma in situ OOther carcinoma	in situ Olnvasive cancer

Complete with the client's name, DOB, and screening provider where her CBE was performed (if applicable)

Fill in your clinic's information under diagnostic provider.

Page 3 - Let's get started!

Page 3 of the Breast Follow-up & Treatment Plan can be filled out by any member of the health care team at a primary care, OB/GYN or surgical provider's office.

Page 3 – Screening history

Screening history section:

- For patients 18-39, fill out the date and findings of her clinical breast exam.
- For patients 40-64, fill out the date and findings of clinical breast exam as well as the results of the SCREENING mammogram
 - If client 40-64 only got diagnostic mammogram, do NOT put that in screening mammogram section. Check the box for Screening Mammogram NOT PERFORMED and then check the box under it for Diagnostic mammogram.

Name: F	irst		м	L	ast	DOB
c	creening: linic that initiated care	Name:		C	ity/Phone Number	
	Diagnostic: linic that patient was referred to	Name:		C	ity/Phone Number	
Instructions: Pl	lease send this form to	EWM along with corresp	oonding	radi	iology and/or pathology reports when diagn	ostic workup is complete.
	Ages 18	-39			Ages 40-6	4
O Clinical Breast I	Screening His Exam Suspicious for Breast	tory: Malignancy Date:/			Screening Histor O Clinical Breast Exam Suspicious for Breast Ma	ry: alignancy Date://_
O Surgical Consultation Physician: If CBE is suspiciou	us, EWM encourages surgica	ate://			Results of initial SCREENING mammogram, if a Screening Mammogram was NOT PERFORMED OBI-RADS 0 - Assessment incomplete OBI-RADS 1, 2, and 3 with a suspicious clinical breas OBI-RADS 4 - Suspicious abnormality OBI-RADS 5 - Highly suspicious	
Preferred: Referra Acceptable: Breas Oliagnostic Mammog Client must be at Diagnostic mammo Repeat Breast Exam Breast Biopsy type: OBreast MRI for suspect Oconsultation/2nd op OFNA OR OU/S-Gui	al to surgeon for evaluation st u/s ordered by Primary C gram E least age 30 to have a Diag logram alone does not mee ted Inflammatory Breast Cancer Dinion I ided Needle Aspiration I nitide: Client Informed Refuel For	and to determine need for u/s are Provider if no surgeon avai Date:/ nostic Mammogram t standard of care if CBE is susp Date:/ Date: Date: Date: Date: Date: Date: Date:	lable	r ma	Diagnostic Work OSurgical Consultation Date: Physician:	andard of care if CBE is suspicio
★ Final Diagnosis This section must b completed before s to EWM	sending OCancer no OCancer no OCancer di ODuc	t diagnosed - no treatme agnosed - Please complete Bre tal carcinoma in situ I diagnosis or pathology r	ast Cancer O Lobula	Treat r ca	rcinoma in situ OOther carcinoma in situ	JINVasive cancer

Page 3 – Diagnostic workup and Final Diagnosis

- The Diagnostic workup sections show all of the procedures allowable for these women. Check the box with the imaging or diagnostic procedure done and fill in the date of service.
 - Send corresponding clinical documentation or form may be returned to you.
 - Submit all clinical documentation including the enrollment within 2 weeks of service.
- Check the final diagnosis and date of diagnosis.
 - If you do not check a final diagnosis, the form may be returned.

Name:	First		MI	b & Treatment Plan	for diagnostic services. DOB
Provider Information:	Screening: Clinic that initiated care Diagnostic:	Name:		City/Phone Number	
	Clinic that patient was referred to				
Instructions:	Please send this form to	EWM along with correspo	nding	radiology and/or pathology reports whe	en diagnostic workup is complete
	Ages 18	-39		Ages	40-64
O Clinical Breas	Screening His t Exam Suspicious for Breast		/	Screeni	ng History: Breast Malignancy Date://
O Breast Ultrasound Preferred: Refe Acceptable: Bre O Diagnostic Mamm Client must be a Diagnostic mam O Repeat Breast Exa O Breast Biopsy type O Breast MRI for susp O Consultation/2nd O FNA OR O U/S-G	rral to surgeon for evaluation east u/s ordered by Primary C logram I at least age 30 to have a Diag imogram alone does not mee m e	t standard of care if CBE is suspic Date: Date: Date: Date: Date: Date: m/Service Provider Document	ious	OBI-RADS 0 - Assessment incomplete OBI-RADS 1, 2, and 3 with a suspicious clim OBI-RADS 4 - Suspicious abnormality OBI-RADS 5 - Highly suspicious Diagnost Osurgical Consultation Physician: OBreast Ultraso und Obiagnostic Mammogram Oiagnostic Mammogram Oicent tereast Ultraso Oicent terfused Initiater Gient Informedite r more information at www.dhhs.ne.go	tic Workup: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date: Date:
★ Final Diagnos This section must completed before to EWM	be OCancer no cancer di OCancer di ODuo	ot diagnosed - no treatment agnosed - Please complete Breas tal carcinoma in situ O I diagnosis or pathology reg	t Cancer Lobula	Treatment section on Page 4 r carcinoma in situ OOther carcinon	na in situ Olnvasive cancer

Page 4 – Breast cancer referral and treatment

If client is diagnosed with breast cancer:

- Mark it on final diagnosis on pg 3
- Indicate type of treatment and where client is being referred (pg 4)
- Fill out <u>Treatment Funds</u> <u>Request Form</u>

		Breast Follow-L				
Client	First	MI	Last		DOB	
Information:						
		Breast Cancer	Referral 8	& Treatment		
	Client referred to	nic name and city/phone			who will take over care.	
Consultation:	Consultation Date to give clie					
Treatment:	Treatment regimen consists	of		(lump	 bectomy, surgery, chemo, radiat	
kefusal:	Cancer treatment refused da Reason for refusal:				made informed decision: OYes	
		Screening MRI Pre	eauthori	zation Request		
www.can	cergov/bcrisktool/ (for wome	an under 35 go to https:/	libis ikonor	ol for women 35+: bedia.com/)	Clinic Name Phone #:	
 Client has O First-degree r Previous Rad Have Li-Fraur 	cer.gov/bcrisktool/ (for wome BRCA1 OBRCA2 OOther mut elative with BRCA1 or BRCA2 (iation Therapy to chest, betwee neni syndrome, Cowden syndro	en under 35, go to <u>https:/</u> ation Da parent, brother, sister, chi en the ages of 10-30 Age pome, or Bannayan-Riley-R	/ibis.ikonop ite of genet Id) Relative : uvalcaba sy	bedia.com/) ic testing:/ D : Durpose of radiation: /ndrome, or have first-degree	Phone #: Fax #: Pate of genetic testing:/ e relatives with one of these syn tion expires one month after date of	/
 Client has O First-degree r Previous Rad Have Li-Fraur 	cer.gov/bcrisktool/ (for wome RCA1 OBRCA2 OOther mut elative with BRCA1 or BRCA2 (lation Therapy to chest, betwee neni syndrome, Cowden syndro Request approved: OYes ONo Pro	en under 35, go to <u>https:/</u> ation Da parent, brother, sister, chi en the ages of 10-30 Age pome, or Bannayan-Riley-R	/ibis.ikonop te of genet Id) Relative : uvalcaba sy	bedia.com/) ic testing: D purpose of radiation: ndrome, or have first-degree Authoriza	Phone #: Fax #: Pate of genetic testing:/ e relatives with one of these syn	/
Client has OD First-degree n Previous Rad D Have Li-Fraur EWM staff use only. Past Results: w does client nee follow-up?	Cer.gov/bcrisktool/ (for wome BRCA1 OBRCA2 OOther mut elative with BRCA1 or BRCA2 (lation Therapy to chest, betwee neni syndrome, Cowden syndro Request approved: OYes ONO Pro Last Clinical Breast Exa Last Screening or Diag Last Screening or Diag Last Breast Ultrasound Last Treatment: Jp: Only for clients 40-64. Wh Client reports symptoms: DATE: Br	en under 35, go to https:// ationDa parent, brother, sister, chi- en the ages of 10-30 Age mme, or Bannayan-Riley-R gram signature: Month Follow-Up of m Result/Finding: ONegr nostic Mammogram Result Result: ONO OYES, list symptor inical Breast Exam Results (ace ammogram Results (ace east Ultrasound Results (ace	/ibis.ikonog te of genet Id) Relative: : uvalcaba sy uvalcaba sy tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F	bedia.com/] ic testing:	Phone #: Pax #: e relatives with one of these syn tion expires one month after date of pate: Date:	/
Client has O' First-degree r Previous Rad Have Li-Fraur WWM staff use only. Past Results: w does client neer follow-up? S Month Follow I Current	Cer.gov/bcrisktool/ (for wome BRCA1 OBRCA2 OOther mut elative with BRCA1 or BRCA2 (lation Therapy to chest, betwee neni syndrome, Cowden syndro Request approved: OYes ONO Pro Last Clinical Breast Exa Last Screening or Diag Last Screening or Diag Last Breast Ultrasound Last Treatment: Jp: Only for clients 40-64. Wh Client reports symptoms: DATE: Br	en under 35, go to https:// ationDa parent, brother, sister, chi- en the ages of 10-30 Age mme, or Bannayan-Riley-R gram signature: Month Follow-Up of m Result/Finding: ONegr nostic Mammogram Result Result: ONO OYES, list symptor inical Breast Exam Results (ace ammogram Results (ace east Ultrasound Results (ace	/ibis.ikonog te of genet Id) Relative: : uvalcaba sy uvalcaba sy tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F tresults? F	<pre>sedia.com/) ic testing: D Purpose of radiation: D Purpose of r</pre>	Phone #: Pax #: e relatives with one of these syn tion expires one month after date of pate: Date:	/ signatu

Women's Cancer Program

- If your client is diagnosed with breast cancer through EWM, by Nebraska state statute she may be eligible for Nebraska Medicaid (for at least 6 months) for cancer treatment through the Women's Cancer Program (WCP)
 - this treatment Medicaid is specific to our program including EWM income guidelines (250% of Federal Poverty Guidelines)
 - clients with a breast cancer diagnosis have access to WCP Medicaid throughout their breast cancer treatment
 - We provide the client with the WCP Medicaid application
 - clients must not have adequate health insurance in order to be eligible for Medicaid through Women's Cancer Program
 - If client has insurance that is limited coverage/benefits, we will work with Medicaid to determine if insurance is considered creditable or not. If insurance is deemed not creditable, client may be eligible for WCP.

Women's Cancer Program

If client is diagnosed with breast cancer:

- Call EWM at 1-800-532-2227 and ask for the nurse if you have any questions or need to discuss next steps.
- ▶ EWM staff will contact client and send out our Medicaid form.
- Although not required, we do appreciate a "heads up" phone call so we can get the process of helping your patient to apply for Medicaid started **as quickly as possible**, as this process takes time.
- Clinic should submit the <u>Treatment Funds Request Form</u> to EWM.

Page 4 – Screening MRI Pre-authorization request

- Screening MRIs must be preauthorized
 - Contact EWM with questions
 - Approval will be given via fax
- EWM covers MRIs for diagnostic purposes on a case-by-case basis
- Screening MRIs are ONLY for women at high risk of breast cancer
 - Guidelines set by CDC (our funder)

Client	First	мі	Last	DOB	
nformation					
		Breast Cancer I	Referral & Treatment		
		name and city/phone		who will take ov	er care.
Consultation	Consultation Date to give client	options:			
Freatment:	Treatment regimen consists of		Treatment Perfo	(lumpectomy, surgery, cl rmed Date:	hemo, radiation, etc
Refusal:	Cancer treatment refused date Reason for refusal:			Client made informed dec	cision: OYes ONo
		Screening MRI Pro	eauthorization Reques	t	
1404/14/ 02	rsonal history of breast cancer < of 20-25% or greater based on fam <u>ncer.gov/bcrisktool/</u> (for women u DBRCA1 OBRCA2 OOther mutatio	inder 25 go to https:/	/ibis ikononedia.com/	: Clinic Name _ Phone #:	rovider information:
www.ca D Client has D First-degree D Previous Ra D Have Li-Fran	of 20-25% or greater based on fam	under 35, go to <u>https://</u> on Da ent, brother, sister, chi the ages of 10-30 Age e, or Bannayan-Riley-R	/ibis.ikonopedia.com/) te of genetic testing:/_ ld) Relative: : Purpose of radia uvalcaba syndrome, or have	: Clinic Name Phone #: Fax #: Date of genetic testi tion: first-degree relatives with one	ing://
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Page 4 – Screening MRI Pre-authorization request eligibility criteria

In order to be eligible, client must have documentation of one of the following risk factors:

- Personal history of breast cancer
- Lifetime risk of developing breast cancer of 20-25% or greater using a breast cancer risk tool
 - Must use credible risk assessment tool:
 - For women 25+ may use https://ibis.ikonopedia.com/
 - ▶ For women 35+ may use <u>https://bcrisktool.cancer.gov/</u>
 - Print off results and send in along with request
- ▶ Known BRCA1 or BRCA2 mutation, or 1st degree relative with it
- Radiation to the chest between the ages of 10-30
- Li-Fraumeni syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome or first degree relative with one of these syndromes

Page 4 – Screening MRI Pre-authorization request

- To request MRI, submit middle section of page 4 along with clinical documentation of the criterion selected
- Pre-Authorization expires 1 month after signature date

Client	First	MI Last		DOB
Information:				
		Breast Cancer Referral & Trea		
	Client referred to	ame and city/phone	V	vho will take over care.
Consultation:	Consultation Date to give client of	options:		
Treatment:	Treatment regimen consists of		(lumpect	omy, surgery, chemo, radiation, etc
	Treatment Scheduled Date:	Treat	ment Performed Date:	
Refusal:	Cancer treatment refused date _ Reason for refusal:		Client mac	de informed decision: OYes ONo
	2	Screening MRI Preauthorization	n Request	
<u>www.cand</u> Client has OE First-degree re	of 20-25% or greater based on fami cer.gov/bcrisktool/ (for women u BRCA1 OBRCA2 OOther mutatio elative with BRCA1 or BRCA2 (pare	nder 35, go to <u>https://ibis.ikonopedia.c</u> n Date of genetic test nt, brother, sister, child) Relative:	:om/) ing:// Date	Clinic Name Phone #: Fax #: of genetic testing://
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<u>www.canc</u> O Client has OE O First-degree ro O Previous Radi O Have Li-Fraum	cer.gov/bcrisktool/ (for women u BRCA1 OBRCA2 OOther mutatio elative with BRCA1 or BRCA2 (pare ation Therapy to chest, between th neni syndrome, Cowden syndrome Request approved: OYes ONo Program	nder 35, go to https://ibis.ikonopedia.c n Date of genetic test nt, brother, sister, child) Relative: e ages of 10-30 Age: Purpo , or Bannayan-Riley-Ruvalcaba syndrom	ing:/ Date presses of radiation: he, or have first-degree rel /Authorization	Phone #: Fax #: of genetic testing:// atives with one of these syndrome
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Screening MRI - FAQ

What if my client needs an MRI and does not have any qualifying criteria, or lifetime risk is less than 20%?

If client does not have any of the conditions listed as criterion, she is not eligible for screening MRI through EWM.

What if I have documentation from a physician that an MRI is strongly recommended?

- Client still has to meet one of the aforementioned qualifying criteria. Physician recommendation absent of these risk factors does not qualify a client for screening MRI.
- ▶ There are other resources outside EWM that may be able to help.

Page 4 – Follow-up of Previous Abnormal Finding

- Only for women who need follow-up after a previous finding on ultrasound or mammogram, for example:
 - Those who had findings of "probably benign" and need 6month follow-up
 - Those who had negative biopsies and need follow-up
- Follow-up is reimbursable ONLY for clients ages 40 64. Client must be enrolled. Call if you are not sure.
- Pre-authorization not needed, but must follow NCCN guidelines
- CBE expected before the follow-up imaging is performed

Client	First		MI	Last		DOB
Information:		Project Con	son Rofe	erral & Treatment		
Referral:	Client referred to				who will t	ako ovor caro
Keterral:	Client referred to	nician/Clinic name and city/phone		A!		ake over care.
Consultation :	Consultation Date to g	give client options:				
Freatment:	Treatment regimen co	onsists of		Treatment Performed	(lumpectomy, sur	gery, chemo, radiation, etc
	Treatment Scheduled	Date:		Treatment Performed	Date:	
				C	lient made inform	ed decision: OYes ONo
	Reason for refusal:					
		Screening MI	RI Preau	thorization Request		
 Lifetime risk on <u>www.can</u> Client has OI First-degree risk Previous Radio 	lation Therapy to chest, I	ed on family history using r women under 35, go to <u>h</u> er mutation RCA2 (parent, brother, siste between the ages of 10-30	Age:	ncer tool for women 35+: .ikonopedia.com/) f genetic testing:// elative: Purpose of radiation:	Clinic Phone Fax #: Date of genet	
 Lifetime risk of www.can Client has OF First-degree risk Previous Radio Have Li-Frauri 	of 20-25% or greater bas cer.gov/bcrisktool/ (for BRCA1 OBRCA2 OOth relative with BRCA1 or Bf lation Therapy to chest, I meni syndrome, Cowden	ed on family history using women under 35, go to <u>h</u> er mutation RCA2 (parent, brother, sist between the ages of 10-3C syndrome, or Bannayan-R No Program signature:	iley-Ruval	cer tool for women 35+: <u>lkonopedia.com/)</u> f genetic testing:/ Purpose of radiation: caba syndrome, or have first-d Date:Aut evious Abnormal Findinj	Clinic Phone Fax #: Date of genet legree relatives wi thorization expires or	Name
 Lifetime risk a <u>www.can</u> Client has OI First-degree r Previous Radi Have Li-Fraur EWM staff use only. 	by Last Clinical Bree Last Screening of Last Screening of Last Screening of Last Screening of Last Screening of Last Breast Ultre Last Treatment: Jp: Only for clients 40-6 Client reports symp DATE:	ed on family history using women under 35, go to h er mutation RCA2 (parent, brother, sist between the ages of 10-30 Syndrome, or Bannayan R PNO Program signature: 6 Month Follow-U ast Exam Result/Finding: or Diagnostic Mammogram assound Result: 54. What are the client's c toms: ONO OYES, list syn Clinical Breast Exam R Mammogram Results Breast Ultrasound Results	Jp of Pro Jp of Pro DNegative n Result: urrent res mptoms: (check one) sults (check	Purpose of radiation: caba syndrome, or have first-d Date: /Aut evious Abnormal Finding (Benign OSuspicious for bre ults? Please note follow-up is ck one): ONegative/Benign O: ONegative/Benign O:	Clinic Phoni Pax #: Date of genet egree relatives wi thorization expires or g ast malignancy Dat Dat Date Date Date Suspicious for bre OProbably Benigr USProbably Benigr USProbably Benigr	Name

Page 4 – Follow-up of Previous Abnormal Finding

- Fill out the previous abnormal finding that your patient needs follow-up from
- Under the 6-month Followup, fill out the date and results of your patient's current findings
- You do NOT have to fill out page 3 if it's a 6-month follow-up, only bottom of page 4.
- Send to EWM along with corresponding clinical documentation within 2 weeks of date of service

Client	First	MI	Last	DOB
	Breas	st Cancer Re	ferral & Treatment	
Referral:	Client referred to Clinician/Clinic name and city			who will take over care.
Consultation:	Consultation Date to give client options:			
Treatment:	Treatment regimen consists of Treatment Scheduled Date:			(lumpectomy, surgery, chemo, radiation, etc Date:
Refusal:	Cancer treatment refused date Reason for refusal:		CI	lient made informed decision: OYes ONo
	Screeni	ng MRI Prea	uthorization Request	
O Client has OE O First-degree n	of 20-25% or greater based on family history <u>cer.gov/bcrisktool/</u> (for women under 35, BRCA1 OBRCA2 OOther mutation elative with BRCA1 or BRCA2 (parent, broth	go to <u>https://ib</u> Date er, sister, child)	is.ikonopedia.com/) of genetic testing://_ Relative:	Clinic Name Phone #: Fax #: Date of genetic testing://
 First-degree n Previous Radi Have Li-Fraun 	elative with BRCA1 or BRCA2 (parent, broth ation Therapy to chest, between the ages o neni syndrome, Cowden syndrome, or Bann Request approved: OYes ONo Program signature	er, sister, child) f 10-30 Age: _ ayan-Riley-Ruv :	Relative:Purpose of radiation: Purpose of radiation: alcaba syndrome, or have first-du	Date of genetic testing:
 First-degree n Previous Radi Have Li-Fraun EWM staff use only. Past Results: w does client neefollow-up?	elative with BRCA1 or BRCA2 (parent, broth ation Therapy to chest, between the ages o neni syndrome, Cowden syndrome, or Bann Request approved: O'Yes O'No Program signature 6 Month Fol Last Clinical Breast Exam Result/Fin Last Screening or Diagnostic Mamn Last Breast Ultrasound Result: Last Treatment: p: Only for clients 40-64, What are the cli Client reports symptoms: O'No O'YES, DATE: Breast Ultrasound DATE: Breast Ultrasound	er, sister, child) f 10-30 Age:_ ayan-Riley-Ruv. :	Relative: Purpose of radiation: Purpose of radiation: pate: Date: Purpose of radiation: Purpose of radiation	Date of genetic testing: egree relatives with one of these syndromes thorization expires one month after date of signature gast malignancy Date: Date: Date: Date: not reimbursable for clients under 40. Suspicious for breast malignancy OProbably Benign OProbably Benign Ust do new workup on Page B
First-degree n Previous Radi Have Li-Fraun EWM staff use only. Past Results: w does client nee follow-up? 6 Month Follow L Current	elative with BRCA1 or BRCA2 (parent, broth ation Therapy to chest, between the ages o neni syndrome, Cowden syndrome, or Bann Request approved: O'Yes ONo Program signature 6 Month Fol Last Clinical Breast Exam Result/Fin Last Screening or Diagnostic Mann Last Breast Ultrasound Result: Last Treatment: Jp: Only for clients 40-64. What are the cli Client reports symptoms: ONO OYES, DATE: Clinical Breast DATE: Kanno State	er, sister, child) f 10-30 Age:_ ayan-Riley-Ruv. :	Relative: Purpose of radiation: Purpose of radiation: pate: Date: Purpose of radiation: Purpose of radiation	Date of genetic testing: egree relatives with one of these syndrome thorization expires one month after date of signatur gast malignancy Date: Date: Date: Date: not reimbursable for clients under 40. Suspicious for breast malignancy OProbably Benign OProbably Benign Ist do new workup on PageB

Hereditary Breast Cancer Screening Protocol (BRCA mutations)

Only on clients with <u>documented</u> <u>personal</u> <u>history</u> of BRCA1 or BRCA2 gene mutations. EWM will need to see clinical documentation of this.

- Clients age 25-39: eligible for annual breast MRI screening (a screening mammogram is not reimbursed by EWM).
 - Initiation of screening would be individualized based on earliest age of onset in family.

Clients age 40 through 64:

- annual screening mammogram at the time of her EWM screening visit or immediately afterward,
- breast MRI screening alternating 6 months after the screening mammogram.

Other forms you will need

MAMMOGRAPHY ORDER FORM

Mammography Order Form

- If you are ordering any imaging on a client, you MUST send her with a <u>Mammography Order Form</u>
- Client presents this form to radiology so they know to bill EWM for services
- These forms are found online at <u>www.dhhs.ne.gov/ewmforms</u>
- If you do not do this, the client will get charged for services

Administration	Divisions	Licensing	Assistance	Children, Families	Public	Health &	Vital				
& Support	& Offices	& Regulations	Programs	& Seniors	Data	Wellness	Records				
	er Inforr	mation	& Forn	ns		 Back to Women's and 	Men's Health				
Subscribe For	opuates					» More					
Contracted Provider (doctors and clinic) Listing						Every Woman Matters					
						Colon Cancer Prevention	Awareness &				
Every Woman Matters Enrollment Age and Income Guidelines Update: Starting November 1, 2023, Every Woman Matters has changed its enrollment age from 40 years of age to 35. It has also increased the Federal Poverty Income Guidelines from 225%					 Provider Info Forms 	rmation &					
to 250%.						Provider Participation Manual, Fee Schedules and Income Guidelines					
to 250%. The program			lanual, Fee	Schedules and	Income	Guidelines	*				
	General Fo			Schedules and	Income	Guidelines	•				
	General Fo Provider Mate	rms	orm 🖻	Schedules and	Income	Guidelines	•				
	General Fo Provider Mate Inflatable Col Healthy Lifes: Women Deem Treatment Fu Claim Status Payment Stat	rms erials Re-Order F on Rental Inform tyle Questionnair tyle Questionnair ned Lost to Follo nds Request For Form 🛆	orm 옵 nation 옵 e 옵 e (Spanish) [ow Up Form M 옵	3	Income	Guidelines	•				

Mammography Order Form

Part 2

Facility: Send a copy of t	he dictated repo	ort to the ordering provid	Date of Birth	Arauka Colon Cancer Screening Program 10/2024
First Name	Initiai	Last Name	Date of Birth	Age
Clinic Site:			City:	
	(Please do not ab	breviate)		
		atient to receive the f	ollowing:	
6	0	ered for women 40 and over)		
		ered for women 30 and over) nogram for clients 30-39 only v	rith suspicious CBE or previous ab	normal
	cessary if ordered	by a surgeon or radiologist follo and no surgeon available.)	owing a diagnostic mammogram i	n clients 30-39.
		DIES MAY BE PERFORMEE en's and Men's Health Program) AS DETERMINED BY THE RA n Provider Contract Manual)	DIOLOGIST
RT		LT Provide	er Remarks:	
		<hr/>		
()	X Y			
rovider's Signature:			Date:	
rovider signature may s	erve as an ordei	if facility allows.		
Toll-F Funds for this project were	ree: 800.532.2227 - In L provided through the Cente	incoln: 402.471.0929 - Fax: 402.471.0 rs for Disease Control and Prevention Breas	al Mail South - P.O. Box 94817 - Lincoln, NE 913 - Web: www.dhhs.ne.gov/EWM 913 Cervical Early Detection Program and the W Nebraska Department of Health and Human Ser	ell integrated
-	-			
illing/Admissions/P	atient Registr	ation for Participating	; EWM Clients	
This form is only used for EWIV	1 clients and should o	nly be accepted by contracted EW	M facilities.	
Part 1 stays with the client to p	present to the Radiolo	gy Department. The Radiology De	partment can use Part 1 for tracking p	urposes.
Part 2 can be torn off and used	I for Billing/Admissior	s/Patient Registration purposes.	Client Name:	
			Date of Birth: /	/

- Fill out client's information
- Select what imaging to order
- Provider signs and dates

Send this form with the client to take with her to get the mammogram or ultrasound done!

Let's talk about processes

What does enrolling a client into the Every Woman Matters Breast Diagnostic Program look like in real life?









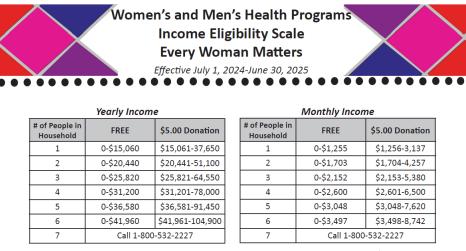


Let's Recap – real life scenario

Hi, I have a breast lump but don't have any insurance. Can you help? We are an Every Woman Matters contracted provider so we may be able to help. Let me ask you a few questions.

What do you need to verify?

- Age: needs to be 18-64
- Income: see chart
- Citizenship: needs to be a US citizen or Permanent Resident (and we need to have copy of front and back of Permanent Resident card to verify)
- Health: needs services to diagnose breast problem (and she already told you she has a breast lump)
- Insurance: does not matter if she has insurance or not, can enroll either way



Note: When Screening Cards are sent to clients, they will have an opportunity to make the suggested \$5 donation back to the program to help women receive screening services.

301 Centennial Mall South ~ P.O. Box 94817 ~ Lincoln, NE 68509-4817 Toll Free: 800-532-2227 ~ Local: 402-471-0929 ~ Fax: 402-471-0913

www.dhhs.ne.gov/EWM



ds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervica Early Detection Program, Well Integrated Screening and Schulabion for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services. **NEBRASKA** Good Life, Great Mission,

PT. OF HEALTH AND HUMAN SERVICE

How to help – starting from the beginning

Can I ask you your age and income level? And are you a US citizen or permanent resident?

Yes, I am 21 and make \$1200 a month. I am a US citizen.



How to help – starting from the beginning

Great! Looks like you are eligible for Every Woman Matters. We can enroll you once you get here. Let's set up an appointment right away.

Great! Thanks!

Later, at the office

Hi, I am here for my Every Woman Matters appointment. OK. Just fill out pages 1 and 2 of the Breast Diagnostic Enrollment form and the doctor will see you soon. Make sure all sections are completed.



During the appointment

Hi there. We're going to need to do an ultrasound on your breast lump.

That sounds expensive. Will Every Woman Matters cover it?

Yes, just make sure you bring this Mammography Order form with you to your appointment.

Great!

After the appointment

What do I do with her Breast Diagnostic Enrollment Form? Do I need to send it to Every Woman Matters right now?

No, you wait until we get the results back of the ultrasound or until we have reached a final diagnosis.

Then you send in the Breast form along with radiology reports.



I knew what services she was eligible for based on the chart on page 3 and the instructions I printed off from the website.

I knew she was eligible for the program because I verified her age, income, and citizenship and knew she needed to diagnose a breast problem. And I was able to get care for my breast problem without having major medical bills!



And that is how it's done!

Reminders

- Forms and instructions can be found online at <u>www.dhhs.ne.gov/ewmforms</u>. We update forms frequently. Please go to the website for the latest versions
- Follow-up is not covered for women under 40
- Diagnostic mammograms not covered for women under 30
- Screening MRI must be pre-authorized and must meet criteria regardless of physician's recommendations
- Forms must be complete including final diagnosis and providers must submit copies of all diagnostic tests
- Call EWM at 1-800-532-2227 if you have questions!

Additional Questions regarding Breast Diagnostic Enrollment?

Contact an Every Woman Matters representative:

Women's & Men's Health Programs

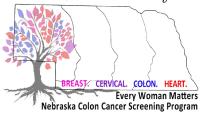
1-800-532-2227 toll free

402-471-0913 fax

www.dhhs.ne.gov/womenshealthweb

dhhs.ewm@nebraska.gov email

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