

# Wyoming

## Breast and Cervical Cancer Screening Program



## Participating Healthcare Provider Manual



Revised July, 2021



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# About the Program

## Background and History Overview

Breast and cervical cancer affects thousands of women each year across the United States (U.S.) with greater impact on those with limited access to care. Early detection and treatment of breast and cervical cancer through screening reduces mortality rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of racial and ethnic minorities and among under- or uninsured women, which creates a wide gap in health outcomes between these women and other women in the U.S.

To address this health inequity, Congress established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in 1991 by enacting the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354). This act authorized the Centers for Disease Control and Prevention (CDC) to partner with state health departments and territorial and tribal health agencies to provide breast and cervical cancer screening and diagnostic services for underserved, uninsured, underinsured, and low-income clients. In addition, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) granted programs permission to provide breast and cervical cancer and cervical pre-cancer treatment services for eligible clients through their state Medicaid programs.

The Wyoming Department of Health's Public Health Division receives funding from the CDC to implement the Wyoming Breast and Cervical Cancer Screening Program (WBCCSP), which is facilitated by the Wyoming Cancer Program. The program also receives state general funds and tobacco settlement funds. The program reimburses participating healthcare providers for qualifying services to enrolled clients, as well as provides navigation services to help clients overcome barriers to screening for breast and cervical cancer. Additionally, the program houses two other components, the Wyoming Colorectal Cancer Screening Program and Wyoming Comprehensive Cancer Control Program.

The goal of the program is to decrease cancer incidence, morbidity, and mortality by focusing on underserved populations, who have increased cancer risk due to health inequities.

## Purpose of the Manual

The purpose of this document is to provide guidance to participating healthcare providers regarding program policies and procedures. Additional information can be found in a copy of the signed provider agreement issued upon enrollment into Wyoming Medicaid. The most recent version of this manual is available on the program website: [health.wyo.gov/cancer](http://health.wyo.gov/cancer).

## Staff Directory

The WCP team is available to provide assistance from 8 a.m. to 5 p.m., Monday through Friday (excluding State-approved holidays). They can be reached by calling 1.800.264.1296, emailing at [wdh.cancerservices@wyo.gov](mailto:wdh.cancerservices@wyo.gov), or selecting a phone number from the following list:

### Team Member

Administrative Assistant and General Questions

Program Materials

Screening Program Supervisor

Program Nurses

### Phone

1.307.777.3699

1.307.777.3480

1.307.777.6006

1.307.777.7461 or 1.307.777.6043

# Provider Information

## Provider Enrollment

Healthcare providers become a participating provider through an enrollment process. This process outlines special provisions in regards to the terms and conditions for participating providers, including payment for services.

All participating providers/facilities are **required** to be a Wyoming Medicaid provider and ensure that up-to-date practice credentials are always on file. Upon enrolling into Medicaid, providers are automatically enrolled into the WBCSP. A current list of participating providers can be found on the Wyoming Medicaid provider portal.

## Assessing Smoking Status and Referral

The program recommends that participating healthcare providers refer program-enrolled clients who are current smokers to the Wyoming Quit Tobacco Program (1.800.QUIT.NOW or [quitwyo.org](http://quitwyo.org)).

## Program Eligibility Criteria

Eligibility for the WBCSP requires that applicants meet criteria in each of the following categories:

- Residency: Must be a Wyoming resident.
- Age/Risk: Applicants must meet the age and risk criteria outlined below (See Age/Risk Criteria on page 4).
- Citizenship: Applicants are not required to be U.S. citizens to enroll in and receive breast and cervical cancer screening and diagnostic services.
  - Citizenship is not required to be enrolled in the screening program but may be required to transition to Medicaid for cancer treatment (See Medicaid Cancer Treatment section on page 11).
- Gender: Applicants must be female, transgender woman who has taken or is currently taking hormone therapy, or transgender man who has not had a bilateral mastectomy and/or total hysterectomy. Men are not eligible.
- Income: Gross household income must be at or below 250% of the Federal Poverty Level.
  - The most current income guidelines can be found on the program's website: [health.wyo.gov/cancer](http://health.wyo.gov/cancer).
    - Federal Poverty Guidelines are updated on an annual basis and are provided by [aspe.hhs.gov/poverty-guidelines](http://aspe.hhs.gov/poverty-guidelines).
- Insurance: Must be uninsured or underinsured. Underinsured means an applicant has an out-of-pocket cost sharing required by their health insurance plan that they cannot afford or their health insurance plan does not cover the services.
  - Applicants with Medicare part A **are** eligible.
  - Applicants with Medicaid or Medicare part B **are not** eligible.





## Provider Information continued

### Age/Risk Criteria

If a client does not meet the criteria listed below, but the healthcare provider considers the client to be at high risk for breast or cervical cancer due to other reasons, the healthcare provider must send documentation of abnormal breast or cervical screening or diagnostic test results to the program indicating the reason(s) they believe an exception should be made. Abnormal screening or diagnostic test results must not be over three months old.



### Breast Cancer Screenings Age/Symptoms:

- Ages 18-39 years: Symptomatic or asymptomatic and high-risk
  - Symptomatic refers to a result that is suspicious or positive for cancer through a breast screening or diagnostic test completed within the past three months. Examples may include a clinical breast exam (CBE), mammogram, ultrasound, or breast biopsy.
  - High-risk refers to applicants who: have a known genetic mutation such as a BRCA 1 or 2, first degree relatives with premenopausal breast cancer or know genetic mutations, a history of radiation treatment to the chest area before the age of 30, and a lifetime risk of 20% or more for development of breast cancer based on risk assessment models that are largely dependent on family history.
    - Providers can choose whichever method they prefer to determine if a woman is at high risk for breast cancer. Women at high risk for breast cancer should be screened with both an annual mammogram and an annual breast MRI.
- Ages 40-64 years: No additional requirements.
- Ages 65 years or older: Applicants without Medicare part B are eligible.
- Women who have a known history of breast cancer: Applicants with a previous diagnosis of breast cancer may be evaluated through the Wyoming Cancer Program for surveillance screenings if they meet program eligibility requirements.

NOTE: If the applicant has a known diagnosis of breast cancer, refer to the Medicaid Cancer Treatment section on page 11.

### Cervical Cancer Screenings Age/Symptoms:

- Ages 21-29 years: Symptomatic or asymptomatic and have not had a Pap test completed within the past three years.
- Ages 30-64 years: Symptomatic or asymptomatic and have not had a Pap test completed within the past three years, or have not had a primary HPV test within the past 5 years, or have not had co-testing with a Pap test and the HPV test within the past 5 years.
- Ages 65 years and older: Applicants without Medicare part B are eligible.

NOTE: If the applicant has a known diagnosis of cervical cancer or cervical pre-cancer, refer to the Medicaid Cancer Treatment section on page 11.



## Provider Information continued

### Covered and Non-Covered Services

The program reimburses for a limited number of covered services. In order to ensure timely reimbursement, only submit claims with allowable current procedural terminology (CPT) codes. A list of reimbursable CPT codes, including allowable modifiers and the current rate of reimbursement, is updated annually and is available on the program website. Use the most recent CPT code list for reimbursement estimates.

**Important Note:** Clients enrolled in the program will be issued an enrollment card. Be sure to ask the client for the card prior to the procedure and make a copy of the card for office records.

### Covered Services

The program recommends that providers refer to the current allowable CPT code list. Expenses are reimbursed by the program at the Medicare allowable rate, and include, but are not limited to:

- Mammograms
- Diagnostic mammograms
- Breast ultrasounds
- Breast biopsies
- Breast ductogram
- Breast galactogram
- Excision of breast cyst or lesion
- Anesthesia
- Placement of breast localization device
- Breast tomosynthesis (77063)
- Clinical breast exams
- Pap tests
- Colposcopies
- Office visits where cancer screenings are discussed and recommended
- Repeat Pap tests, mammograms, breast ultrasounds, and CBE that are approved for short-term follow-up at intervals less than one year
- Repeat Pap tests, when specimen adequacy is deemed “unsatisfactory”
- Short term follow up pap tests after previous abnormal test results
- Follow-up surgical consultations after breast biopsy\*
- Follow-up consultations after a colposcopy, if treatment is needed\*
- HPV testing for clients 30 years and older every 5 years with HPV and cytology (co-testing) or every 5 years with HPV testing alone

\*The program defines consultation as a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another enrolled participating provider. Additional consultations will be approved on a case by case basis.

### 3-D Mammography

The program will reimburse for film, digital, and 3-D mammography up to the Medicare reimbursement rate. All women should be counseled on the benefits and risks of mammography. If a woman has the option of having a 3-D mammography, she should be counseled on the benefits and risks of 3-D mammograms versus 2-D mammograms to make an informed decision. Providers should refer to the program’s CPT code list.





## Provider Information continued

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### Magnetic Resonance Imaging (MRI)

The program will reimburse for screening breast MRI performed in conjunction with a mammogram when a client has been determined to be high risk (e.g., has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20-25% or greater as defined by risk assessment models). Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool.

Breast MRI is not reimbursable when used to assess the extent of disease staging in women who were recently diagnosed with breast cancer and preparing for treatment. Providers should discuss risk factors with all clients to determine if she is at high risk for breast cancer. To be most effective, it is critical that breast MRI is done at facilities with dedicated breast MRI equipment and that can perform MRI-guided breast biopsies.

### Reimbursement of HPV DNA Testing

HPV DNA testing is reimbursable when used for screening or follow-up of abnormal Pap results. HPV genotyping is reimbursable when used for follow-up of abnormal cervical cancer screening results as per ASCCP algorithms. Providers should specify the high-risk HPV DNA panel only. Low-risk HPV DNA panels are not reimbursable.

### Non-Covered Services

Services **not** covered by the WCP include, but are not limited to:

- Telephone consultations
- Removal of polyps
- Blood work
- Pregnancy Tests
- STI testing\*
- Urine analysis
- BRCA gene testing
- Chest X-rays
- EKGs
- Pelvic ultrasounds
- Bone scans
- Uterine biopsies
- D & C
- Nuclear studies
- Prescriptions
- CT scans
- Breast tomosynthesis (77061 unilateral or 77062 bilateral)
- Second office visits, which are made to complete a pelvic examination, Pap test, or CBE (all of these procedures should be completed in one office visit)
- In-patient hospital services
- Evaluations of vaginal or vulvar lesions
- LEEP (Reimbursement allowed only when LEEP is performed for diagnostic reasons)
- Repeat Pap tests performed simultaneously with colposcopy or colposcopy with biopsy (unless more than four months have passed since the initial Pap test was performed)
- Endometrial sampling (reimbursement allowed only after an AGUS Pap result)
- Anything related to other cancers (including the uterus, vagina, vulva, ovaries, etc.)
- Treatment for breast, cervical, and pre-cervical cancer (See Medicaid Cancer Treatment on page 11)
- Missed appointments

\*Clients in need of STI testing may visit [knowyo.org](https://www.knowyo.org) for information and resources.



## Provider Information continued

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The program can only pay for a vaginal smear if the client previously had a hysterectomy due to cervical cancer.

If providing services to a program client that are outlined in the non-covered services section, it is encouraged that the provider discusses the costs of these services with the client prior to completing the service.

### Algorithms for Abnormal Breast and Cervical Cancer Screening Results

The program follows algorithms set forth by the American Society for Colposcopy and Cervical Pathology (ASCCP), the American College of Radiology (ACR) and the Breast Imaging-Reporting and Data System (BI-RADS) to reimburse for claims related to follow up testing after an abnormal screening test. Links to these algorithms are listed below.

[asccp.org/guidelines](https://www.asccp.org/guidelines)

[asccp.org/mobile-app](https://www.asccp.org/mobile-app)

[acr.org/Clinical-Resources/Reporting-and-Data-Systems/Bi-Rads](https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/Bi-Rads)

### Claims and Reimbursements

The Wyoming Cancer Program reimburses breast and cervical cancer screenings at the Medicare rate as required by the CDC. The CPT code list and reimbursement rates are updated annually.

#### Processing Claims

Although the Wyoming Cancer Program is not a Medicaid program, we utilize the Medicaid system to process claims and reimbursements. All billing claims associated with the program must be submitted electronically to Medicaid utilizing either a clearinghouse or Medicaid web portal. The Wyoming Medicaid contractor processes all claims via the web portal. Billing, eligibility, and claim status can be verified by calling 1.800.251.1268 or by utilizing the provider web portal at [wymedicaid.portal.conduent.com/wy/general/home.do](https://wymedicaid.portal.conduent.com/wy/general/home.do).

Participating providers should submit the claim with all required reports attached within three months of the date of service. If the attachment is not received within 30 days of the electronic claim submission, the claim will be denied and it will be necessary to resubmit the claim with the proper attachment. In order to receive reimbursement, the claims must be dated within 12 months of the date of service, and required reports must be attached to the claim. Refer to the Medicaid Provider Manual for further details on submitting a claim with attachments.

To ensure claims are being processed and paid in a timely manner, we highly encourage providers to contact the program for assistance with any claim issues that have not been resolved within 60 days.

The program is the payer of last resort, therefore you must submit a copy of the insurance explanation of benefits (EOB) with the claim for insured clients. If the information is not received, your claim may be denied.

Payments are processed weekly in accordance with policies set by the State Auditor's Office for providers not receiving payment through the electronic process.



## Provider Information continued

### Denied Claims

Claims may be denied for various reasons. Reconsideration of a claim may be made in the following circumstances:

- Timely filing
  - Claims submitted after one year past the date of service will be denied for timely filing. An enrolled client cannot be held responsible for payment if a claim is denied due to the provider failing to submit the claim within one year. Providers should reach out to Medicaid provider services if they are having difficulty submitting a claim.
  - Claims that are denied for timely filing may be appealed through a written appeal. Please send a request and all documentation to [wdh.cancerservices@wyo.gov](mailto:wdh.cancerservices@wyo.gov).
- Invalid CPT codes
  - Providers should reference the CPT code list provided by the program. If a provider has questions regarding which code to use, they may contact the program for guidance.
- Required documentation not attached
  - The program requires supporting documentation with submission of claims. Data from the forms are required by the CDC and reported to CDC twice a year. These data are critically important for program evaluation. Providers are a very important part of the WBCSP and they are required to report accurate and timely data on every client.
  - Providers should contact the program if they experience issues submitting claims and documentation that are not resolved within 60 days.
- For any other claim denials or questions, send a request and any relevant documentation to [wdh.cancerservices@wyo.gov](mailto:wdh.cancerservices@wyo.gov).

Participating providers are prohibited from charging an enrolled client, any member of the client's family, or other sources of supplementation for the services that are covered by the program. The provider may only bill clients enrolled in the program for any services not covered by the program as outlined in the covered and non-covered service section on page 6.

The program encourages providers to reach out to the program to discuss any client prior to forwarding their account for collections.

### Self-Referral Mammograms

If your facility accepts self-referral mammogram screenings, the radiologist or physician that does the mammography reading can be used on the claim form as long as they are an active Wyoming Medicaid provider. If you have any questions, please contact the program for additional instructions.



## Provider Information continued

### Reimbursement Documentation Requirements

Participating providers are required to submit copies of the office visit report, laboratory report, radiology report, and/or pathology report for program-enrolled clients. Provider reimbursement is contingent on submission of these reports. Clinical aggregate outcome data is collected by the program and is available upon request.

As part of the provider agreement, participating healthcare providers agree to provide the following:

- Report of the pelvic examination, Pap test, and CBE
- Laboratory report or radiology report
  - Timely submission of abnormal screening results expedites follow-up services needed.
- When any breast and/or cervical cancer screening test yields a result that is suspicious for cancer, the time from screening to the final diagnosis must be no more than 60 days.
  - If the healthcare provider is having difficulty locating the client or getting a timely response from the client, please contact the program for assistance.



### Diagnosis of Breast or Cervical Cancer or Pre-Cancer

The program realizes that the primary channel for communication is between the provider and their patient. Providers should communicate any cancer diagnosis with the client right away.

- Upon diagnosis of breast cancer, the provider must submit a copy of the breast biopsy pathology report to the program.
- Upon diagnosis of precancerous cells CIN II or CIN III/cervical cancer requiring treatment, the provider will submit a copy of the pathology report to the program.
- Immediate notification is required in order to avoid delay in treatment for the client.

The provider will notify the program nurse of client diagnosis and the program nurse will make the referral to Medicaid coverage. Full Medicaid coverage may be available for clients who qualify for and are enrolled in the program.

## Client Information

### Client Enrollment

To enroll, eligible applicants must complete the most recent version of the application and submit it to the program for review and approval. Previous versions of the application will not be accepted. Applications should be completed to the best of the applicant's ability. Applications take 7 to 10 business days to process.

Electronic applications may be completed and submitted online at [health.wyo.gov/cancer](https://health.wyo.gov/cancer). Applicants can also find a printable version on the website and fax or mail it to the program. Printed copies can also be obtained by calling the program at 1.800.264.1296.

All applicants will be notified of their application approval status. Approved applicants will receive an approval letter with a screening information packet and an enrollment card in the mail to the address they provided on their application.

## Client Information continued

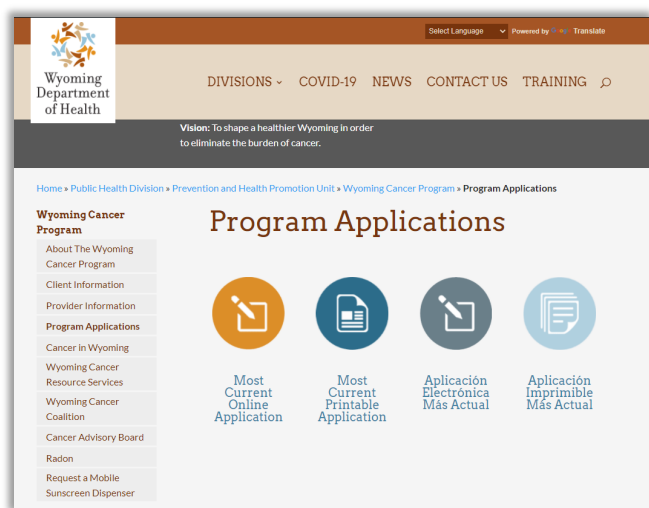
Applicants are covered for up to two years and their eligibility dates will appear on their ID card. Providers are encouraged to contact the program to check eligibility status as applicants may be terminated if there is a change in their eligibility status. The clients will be notified of any changes to their enrollment status via mail.

By signing the application, applicants are certifying that the information they have provided is accurate to the best of their knowledge. They also are agreeing to the requirements of the program and are giving permission to healthcare providers, billing agencies, Wyoming Department of Health, the CDC, and others involved in their care to share medical information obtained.

**The program may reimburse for covered services provided to an applicant up to thirty days prior to the application date.**

## Client Enrollment Application

- The enrollment application must be filled out in its entirety, signed and dated so as not to delay processing of the applicant's enrollment.
  - Social security numbers (SSN) are required for U.S. residents. Applicants may be denied if not provided.
  - If the applicant indicates non-U.S. resident on the application, a SSN is not required.
- Electronic and printable enrollment applications are available on the program website.
- Applicants will be notified by mail if they have been approved or denied for the program. If approved, they will receive an enrollment packet with an ID card (See ID Card section on page 11).
- If the applicant has insurance, they must complete the insurance portion of the application including insurance company name, policy holder name and DOB, and policy ID. A copy of the insurance card should be scanned and emailed or faxed to the program and will assist in the accurate and timely processing of the application.
- If an applicant is denied, they may contact the program for additional available resources.



*Visit [health.wyo.gov/cancer](http://health.wyo.gov/cancer) for program applications*

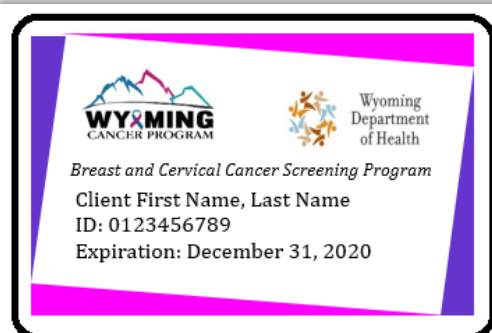
## Client Information continued

### Reconsideration of Denied Applications

If an applicant is denied, they will receive a letter notifying them of why their application has been denied. Reasons for denial may include:

- Incomplete application
  - If the application was missing required information, the applicant must complete the application and resubmit for approval.
- Age or risk factors were not met
  - Providers should ensure that requested documentation is sent to the program. Providers or applicants can provide a request in writing for reconsideration of their application within 30 days of receipt of denial.
  - Program manager will respond with final determination.
- Income exceeds allowed amount
  - Applicants may be contacted by the program for assistance with patient navigation or referral to additional community resources.

Applicants may re-apply for the program at any time if there have been changes to their eligibility.



### Identification Cards

Once approved, clients will receive a welcome packet in the mail that includes a welcome letter with their identification card. The identification cards provide the clients name, identification number, and expiration date.

## Additional Services and Resources

### Medicaid Cancer Treatment

#### Non-Enrolled Clients

Clients who are not already enrolled in the program might qualify for enrollment and be immediately transitioned to Medicaid for cancer treatment if they are under the age of 65, uninsured, low-income (<250% of the Federal Poverty Level), and have a pathology report positive for breast cancer, cervical cancer, or pre-cervical cancer within the last three months.

Providers should contact the program nurses to discuss any woman diagnosed with breast or cervical cancer if the provider believes the woman may be eligible for the program. Supporting documentation and pathology reports may be requested.



## Additional Services and Resources continued

### Enrolled Clients

Clients who are enrolled in the program and receive diagnostic tests indicating they need breast or cervical cancer treatment will have their cases referred to the Division of Healthcare Financing (Medicaid) for determination of benefits. Full Medicaid coverage may be available for clients who qualify for and are enrolled in the program.

The usual criterion for transition to Medicaid for treatment is a breast biopsy result of invasive breast cancer; cervical biopsy result of CIN II, CIN III, CIS, or AGC due to cervical reasons; or cervical cancer. Although the program does not reimburse for breast cancer, cervical cancer, or cervical pre-cancer treatment, program staff can aid in facilitation of enrolled clients' applications to Medicaid for cancer treatment.

Once no longer eligible for Medicaid, a woman may reapply to the program and be considered for re-enrollment for surveillance breast or cervical cancer screenings.

### If a Client is Denied Medicaid Coverage

The client will be directed to LIV Health for evaluation of other available services and may be referred to Wyoming 211 for help with navigating through available market insurance.

### Case Management

Case management is provided when an enrolled client has not completed their screenings within two months of enrollment or when a client is identified as needing short term follow up testing. The case management process is as follows:

- A reminder letter is sent to the client two months after enrolling.
- A reminder email is sent to the client when an email address has been provided, two weeks before a reminder to screen call is made.
- A reminder to screen call is made three months after enrolling.
- When the program receives an abnormal test result for a client and the healthcare provider requests a short-term follow up test, a reminder letter is sent to them one month prior to their follow up testing date.



### Patient Navigation

Patient navigation guides denied clients to other resources to help them get their cancer screenings, as well as assists women who need short term follow up screening. It also assists with transitioning women that are diagnosed with breast, cervical or pre-cervical cancer to Medicaid for cancer treatment.

Patient navigation for screenings:

- The Wyoming Cancer Program has funding through a grant to pay for breast cancer screenings that would not be covered by other funding sources.
- A woman can be navigated to screenings using this funding if she is uninsured or underinsured, regardless of income.
- Women with insurance can also be navigated, but her insurance would cover the cost of her cancer screenings.
- A nurse from the Wyoming Cancer Program will contact women that are eligible for patient navigation and address their barriers to screening.
- The nurse will determine the best available resources for the woman to navigate her through to completing her screening.



## Additional Services and Resources continued

### Communication to the Program

While the program is not a Medicaid program, we encourage providers to utilize the Medicaid provider assistance line for questions relating to claims and attachments. Providers may also utilize the Medicaid portal to determine if a client is enrolled in the program. The program should be contacted if there are additional questions that cannot be answered by these resources.

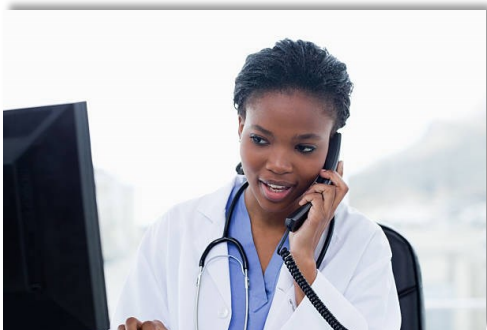
The program is available Monday through Friday from 8 am to 5 pm except for State-approved holidays to address the following:

- Issues with submitting claims or attachments if they have not been resolved after 60 days.
- To address any client bills prior to sending the client to collections.
- Within 60 days for any patients who are diagnosed with breast or cervical cancer or pre cancer.
- Questions related to coverage that have not been outlined in the provider manual or with any questions on complex cases.

### Communication with Providers

The program will periodically send programmatic updates to enrolled providers notifying them of any changes. Providers may find the most recent program information on the program's website at [health.wyo.gov/cancer](http://health.wyo.gov/cancer).

The program may contact a provider to provide technical assistance for any enrollment, claims, or documentation issues that arise.



### Communication with Clients

The program recognizes that the primary channel of communication regarding healthcare issues is between the healthcare provider and the client. It is the responsibility of participating providers to conduct follow-up and notify enrolled clients of test results and the need for further evaluation due to suspicious or abnormal test results.

When referring program clients, it is important to refer to other participating providers or participating laboratories for the services to be covered. The program website is a great resource to access the most current provider listing. Please visit [wymedicaid.portal.conduent.com/](http://wymedicaid.portal.conduent.com/)

[wy/general/home.do](http://wy/general/home.do) with any questions regarding a healthcare provider's enrollment status.

### Health Information Portability and Accountability (HIPAA)

The Wyoming Department of Health is a covered entity. A covered entity may, without the individual's authorization, use or disclose protected health information (PHI) for the purposes of treatment, payment, and healthcare operations activities. The Wyoming Department of Health (WDH) uses and discloses protected health information, as defined by HIPAA, in accordance with State and Federal law and the WDH Notice of Privacy Practices (NoPP). The WDH NoPP can be found on the Wyoming Department of Health's website at [health.wyo.gov](http://health.wyo.gov) or a copy can be requested by calling 1.800.264.1296.

## Additional Services and Resources continued

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### Quality Assurance

To ensure that all participants receive high quality in appropriate care, the CDC and the WBCCSP have established qualifications and quality indicators that enrolled providers must meet in order to participate in the program.

### Quality Indicators

The CDC has established certain indicators of quality. Vigilant in operating within these guidelines is important for the well-being of the women being served. CDC quality performance indicators require that:

- No more than 90 days elapsed between breast and cervical cancer diagnosis and the initiation of cancer treatment.
- 90% of women diagnosed with breast or cervical cancer begin treatment, and 90% of women with abnormal breast and cervical screening results received additional diagnostic services leading to a definitive diagnosis.

Repeated time intervals in excess of these parameters or percentages below them affect their future availability of CDC funds for reimbursement of services for healthcare providers. Healthcare provider vigilance in maintaining these guidelines is important for the women being served.

### Quality Management


Program policies are established in accordance with grant guidelines. Based on information provided on the clinical documentation form, the following aspects of care are reviewed by the WBCCSP and CDC staff to ensure quality and accountability:

- Percentage of women with abnormal breast and cervical screening results that receive additional diagnostic testing for the purpose of yielding a definitive diagnosis.
- Time between abnormal breast and cervical cancer screening results and final diagnosis.
- Percentage of women diagnosed with breast or cervical cancer or cervical pre-cancer that begin treatment.
- Time between a cervical cancer or cervical cancer diagnosis or breast cancer diagnosis and the initiation of treatment.
- Diagnostic procedures used in accordance with guidelines, particularly abnormal clinical breast exam, ultrasounds, and breast biopsies; positive cancer diagnosis rates; or mammogram and Pap test results listed as unsatisfactory or incomplete assessment.

## Thank You

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The Wyoming Cancer Program is focused on decreasing the burden of cancer for Wyoming residents and we would not be able to accomplish this goal if it weren't for the dedication of the healthcare providers on the front lines. Thank you for your commitment to cancer prevention and early detection and utilizing this program as a resource for your community.





# Wyoming Department of Health

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Additional information, copies, and alternative formats may be obtained from:



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