Missouri DHSS Department of Health and Senior Services

# Show Me Healthy Women Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) System Manual

SHOW ME Healthy Women

POWERED BY CDC SCREENOUTCANCER Advancing Cancer Prevention Nationwide

# Contents

# MOHSAIC

Providers are required to manually enter Show Me Healthy Women (SMHW) data in the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) web application. MOHSAIC is a program management and public health surveillance tool. It is not an electronic health record (EHR) and should not be used to gather any information beyond required data elements used for cardiovascular screening surveillance. Based on data entered, agency grant activity statements are generated within the MOHSAIC application, making MOHSAIC data entry the only way WISEWOMAN service delivery providers can access grant funds.

## Data Collected and Reported in MOHSAIC

All SMHW providers must collect and store data on breast and cervical screenings. The program provides a set of paper forms. Information gathered on paper forms represents all data that must be reported via MOHSAIC.

Data must be entered within sixty (60) days of providing cardiovascular services to a SMHW client. If waiting for insurance reimbursement/approval forms, notify the SMHW Regional Program Coordinator (RPC) and document this in the 'Comment' section of the form.

## Accessing MOHSAIC

### MOHSAIC Location and Software Requirements

The MOHSAIC application is located on MDHSS Portal at:
http://webapp01.dhss.mo.gov/SMHW/Default.aspx or
https://webapp02.dhss.mo.gov/SMHW/Default.aspx

Providers do not need to install additional software beyond a web browser. MOHSAIC data entry is a WISEWOMAN contract requirement; therefore, it is important that MOHSAIC users at each provider have access to an MOHSAIC-supported web browser.

## Requesting Access to MOHSAIC

To apply for access to MOHSAIC, applicants will need to follow the instructions below requesting access to Show Me Healthy Women.

### Creating Automated Security Access Processing (A.S.A.P) User Profile

**This step is to be completed only once per user.**

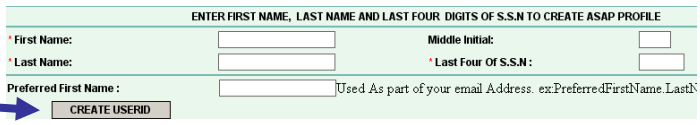
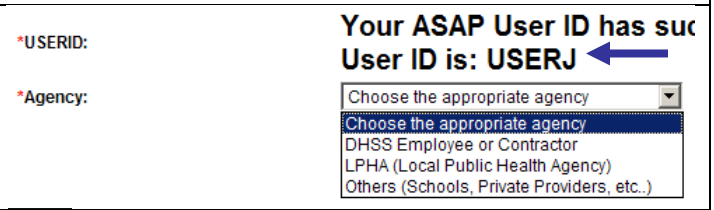
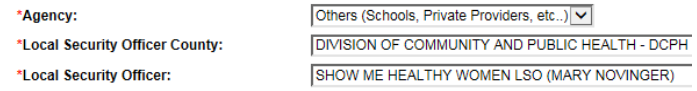
If you have an ASAP profile already and you know your login credentials, please skip to Step 2 (submitting the request).

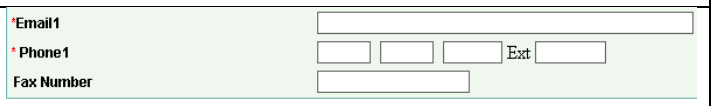
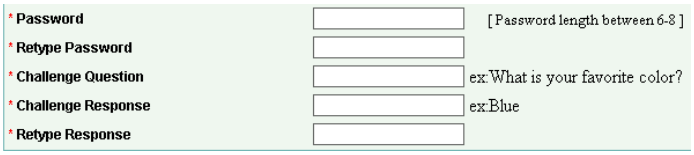
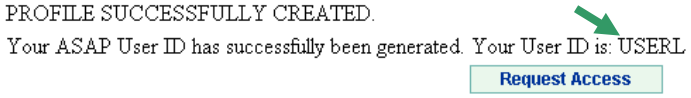
If you are unsure if you have an ASAP profile, follow the following steps to help determine that:

- If you already have an LPHA email account, DHSS health applications and/or DSS prod/mainframe access, you most likely have an ASAP profile.
- If you try to create an ASAP profile and you receive a red message indicating the first and last name are already in use, please contact the ITSD Call Center at 800-347-0887 for assistance. This most likely means you have an ASAP profile and the call center can assist with profile updates, password resets, logging into ASAP, and/or submitting requests.

## STEPS TO CREATING AN A.S.A.P USER PROFILE

- Open Internet Browers and enter address http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx
- Click 'Yes' to any security messages

| Steps | Screen Print |
|---|---|
| 1. Click the NEW USER option |  |
| 2. Enter your first name, last name and last four digits of your SSN.<br>Enter a Preferred First Name, if desired.<br>Click the CREATE USERID button. |  |
| 3. Make note of your UserID. |  |
| 3. Choose 'Others (Schools, Private Providers, etc.)' for the Agency.<br>4. Choose 'DHSS DIVISION OF COMMUNITY HEALTH' for Local Security Officer County.<br>5. Choose 'SHOW ME HEALTHY WOMEN LSO – (Sandy Hentges)' for Local Security Officer. |  |

| | |
|---|---|
| 6. Type your work street number; it will provide a drop-down list. Click your address |  |
| 7. Enter your e-mail address, telephone number, and fax number |  |
| 8. Enter a password<br>Retype your password<br>Enter a challenge question. This should be a question only you know the answer to.<br>Type the response or answer to the challenge question<br>Retype the response or answer to the challenge questions<br><br>**If ASAP did not prompt you to create a password, your password was automatically set to first initial of first name, first initial of last name, and last four digits of your social security number.** |  |
| 9. Click the CREATE PROFILE button |  |
| 10. You should see a message about the profile being successfully created. Make note of your User ID |  |

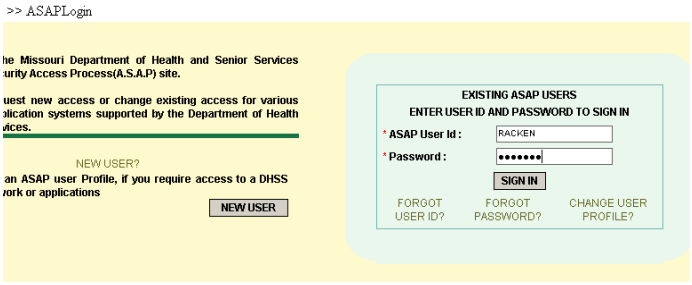
---------- PLEASE CONTINUE TO NEXT PAGE TO REQUEST SMHW ACCESS----------

# REQUEST SMHW ACCESS

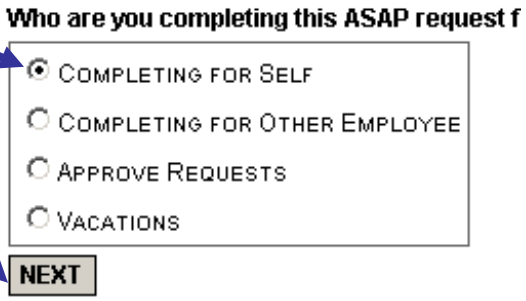
- Open Internet Brower and enter address
http://webapp02.dhss.mo.gov/asap_web/ASAPLogin.aspx
- Click 'Yes' to any security messages

1. Type the **User ID** and **Password** you created in Step A.
2. Click the **SIGN IN** button.

**If ASAP did not prompt you to create a password, your password was automatically set to first letter of first name, first letter of last name, and last four digits of your social security number.**



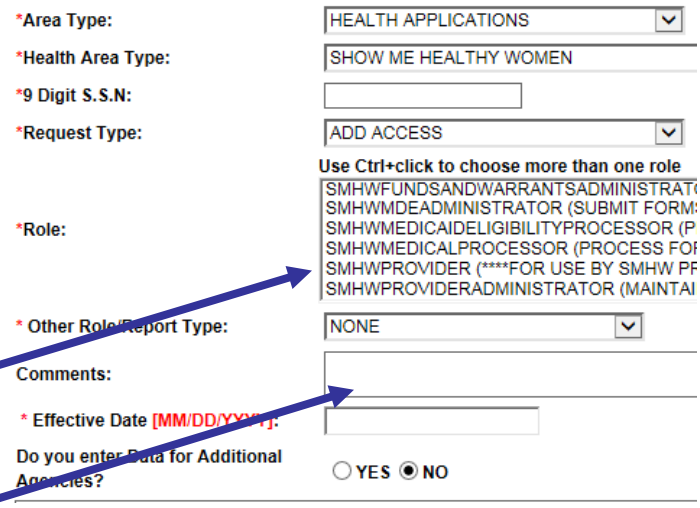

3. Choose the **'Completing for Self'** option.
4. Click the **NEXT** button.

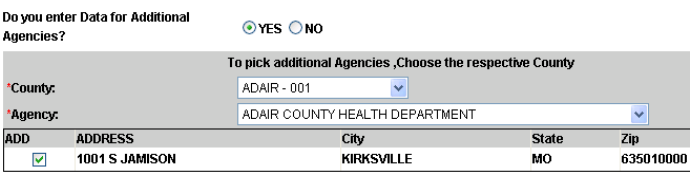
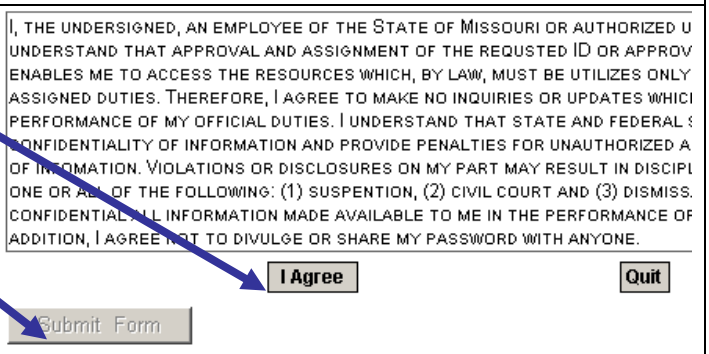
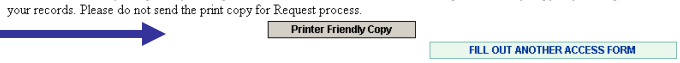



5. Choose '**HEALTH APPLICATIONS**' for Area Type.
6. Choose '**SHOWMEHEALTHYWOMEN'** for Health Area Type.
7. Choose '**ADD ACCESS'** for Request Type.
8. Choose appropriate role from the Role drop down list.

*Hold the Ctrl key to select multiple role(s). As roles are selected, they will become highlighted. (Use the scroll bars to scroll up and down to view the complete list).

9. Choose appropriate role from the Other Role/Report Type dropdown list. **Choose SMHWPROVIDER (****For Use By SMHW Provider) ONLY.**
10. **Optional:** Type in any comments
11. Type in the Effective Date



| | |
|---|---|
| 12. If not entering data for additional Providers, leave defaulted to 'NO'.<br><br>13. To select other Providers, select 'YES' and pick the county and the agency from the the dropdown list |  |
| 14. Click the **'I Agree'** button.<br><br>15. Click the **'Submit Form'** button. |  |
| A message should appear stating the request was successfully completed.<br><br>Print a copy of the completed form for agency records. |  |

**If you experience any problems or have questions while using the ASAP system, please notify the DHSS ITSD Call Center using one of the following methods:**

**Telephone: 573-751-6388 or 1-800-347-0887**
**Email: Support@health.mo.gov**

When an existing MOHSAIC user no longer needs access for WISEWOMAN data entry, an agency must report to WISEWOMAN program staff within 15 days.

# Navigating MOHSAIC

## LESSON 1: THE CLIENT

**MOHSAIC HELPFUL TIPS:**

1. Use Internet Explorer
2. Check Compatibility setting
3. Check text size for screens with overlapping words or adjust zoom setting if needed
4. Turn off Pop-Up Blockers (MOHSAIC uses pop-up screens for data information)

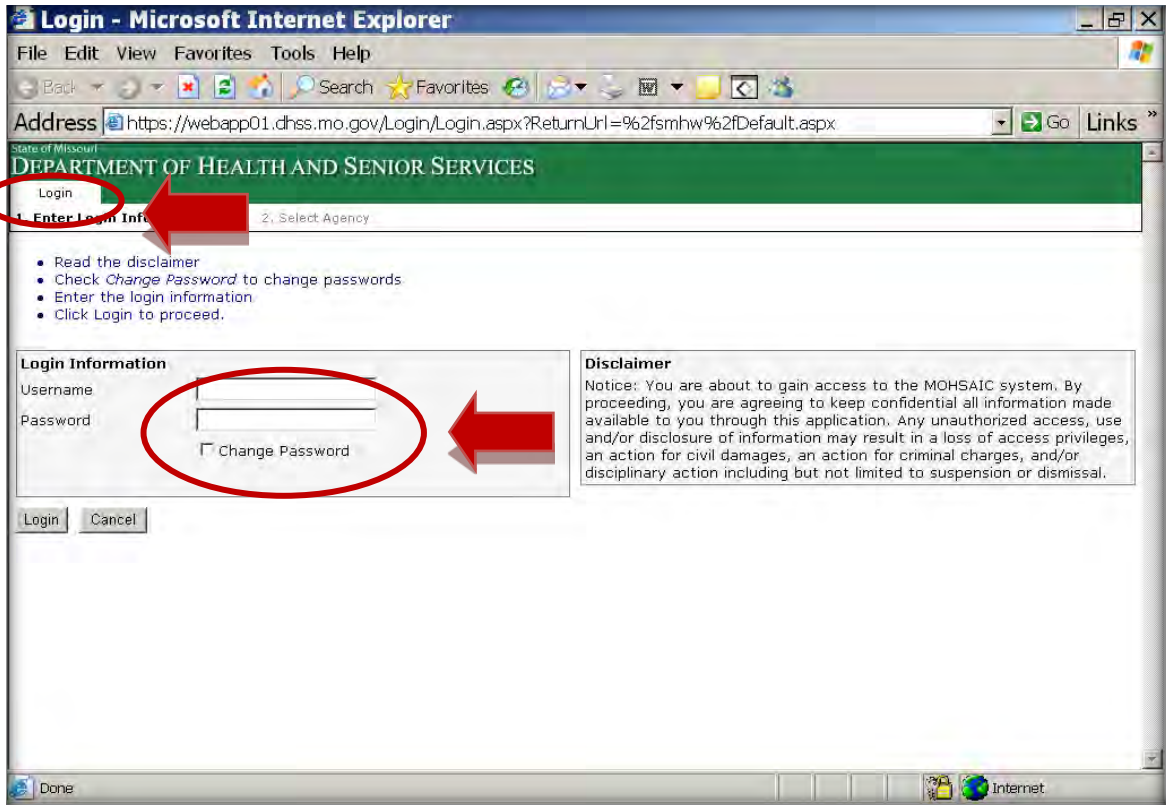
### *Steps to Access the MOHSAIC Application and Log onto the SMHW Application*

#### Log-in Process

Open the Internet browser and enter the Web address on the address line:
https://webapp01.dhss.mo.gov/SMHW/Default.aspx or
https://webapp02.dhss.mo.gov/SMHW/Default.aspx.

- If this is the first time to login, a password must be established:
  - Use the username and assigned password provided to you by e-mail from SMHW, when approved. User name is usually the first five letters of last name and first name initial. Initial password is first and last name initials and last four digits of SSN.
  - Click on 'Change Password.'
  - If you do not login to MOHSAIC for 30 days, the system will 'lock out.' You must call the ITSD Help Desk at 800-347-0887 to unlock and enter new password.
  - After a password is established, the program will ask to change your password every 30 to 60 days. This can be numbers, letters, or a combination, as desired. Password requires six (6) to eight (8) characters and one numeric value.

Once logged in, your agency name will appear and stay constant throughout the application. Click the 'Login' button to proceed.



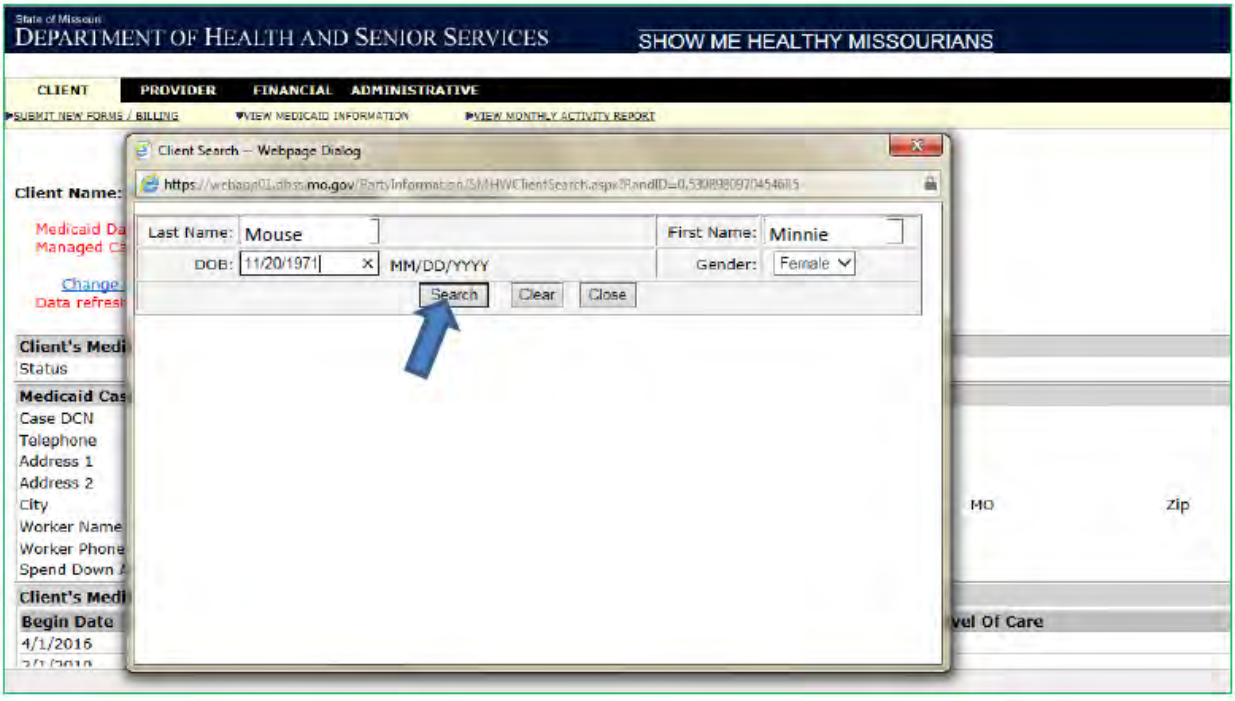

## *How to Look up SMHW Medicaid Status in MOHSAIC*

1) Sign in to MOHSAIC

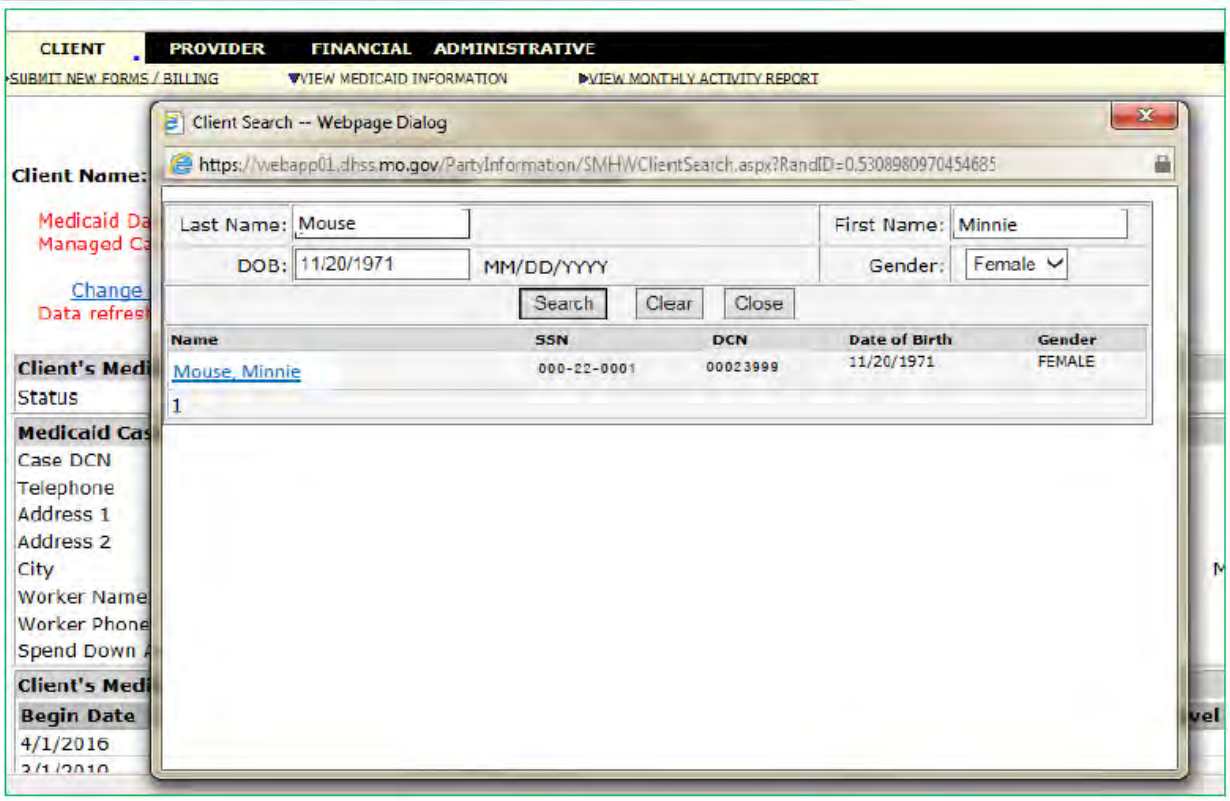
2) Click on the ***Client*** Tab then, click on ***View Medicaid Information***:

3) Click on Change Client:

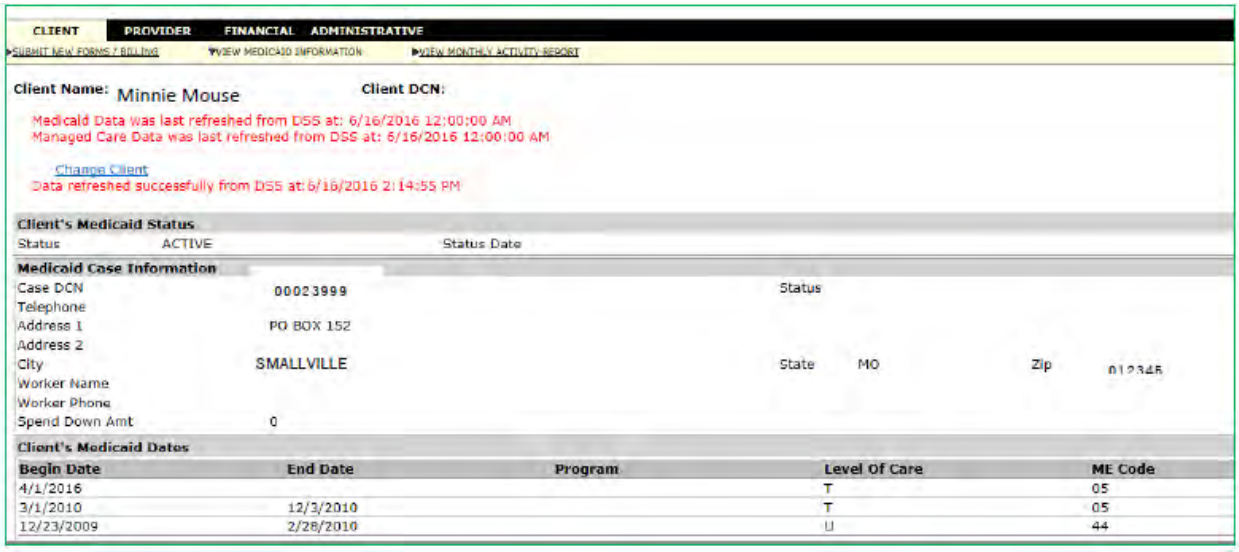

4) The Client Search box will open. Type in Last Name, First Name, DOB and Gender & click on Search. You must complete all boxes or it will not search for names.



5) Click on the Client's name in blue, the box will display *Please wait…* and then should disappear to display the MOHSAIC screen with MEDICAID coverage information.




6) You should be able to view the Client's Medicaid coverage information. This info comes directly from DSS and is usually refreshed daily. This MoHealthnet coverage information is also what providers can access in eMOMED.

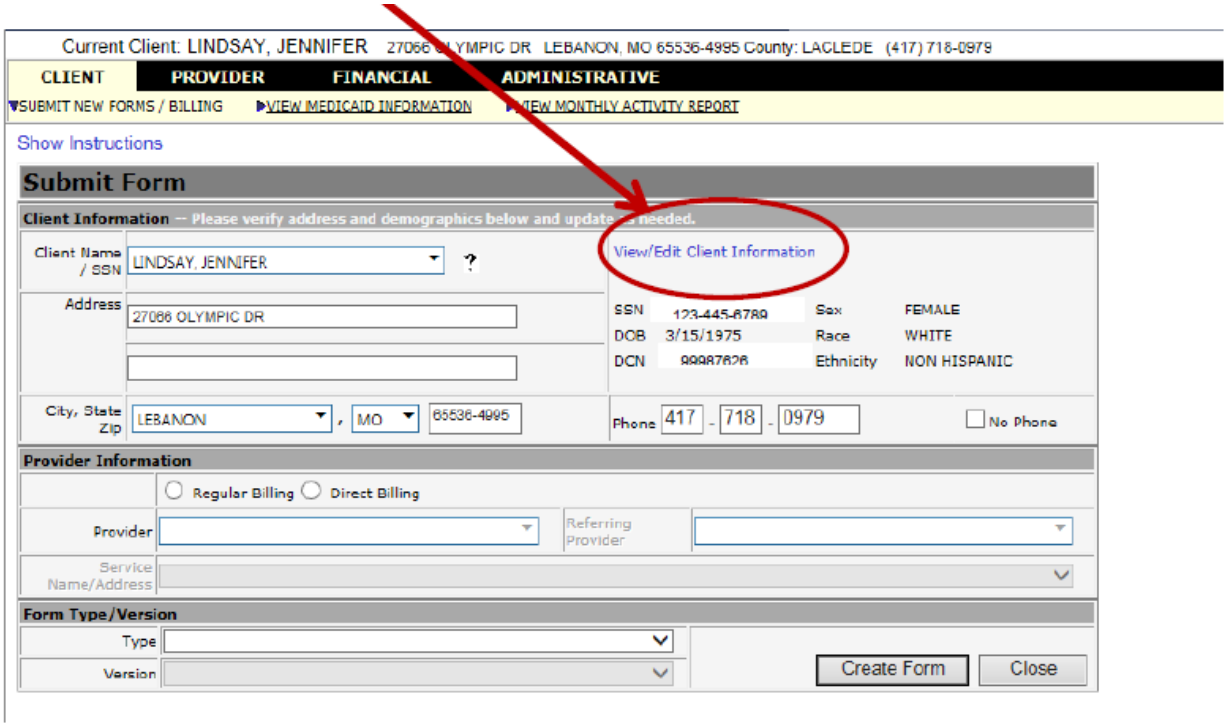


In this example you can see Minnie Mouse has ME Code 05 with a start day of 4/1/16 & no end date. So, as of 4/1/16 her MoHealthnet coverage is active and she is not eligible for SMHW.

What the DHSS SMHW RPC sees on this screen is the same as what the SMHW provider would see in MOHSAIC as well.

## *How to Edit/Change a Client Name in MOHSAIC*

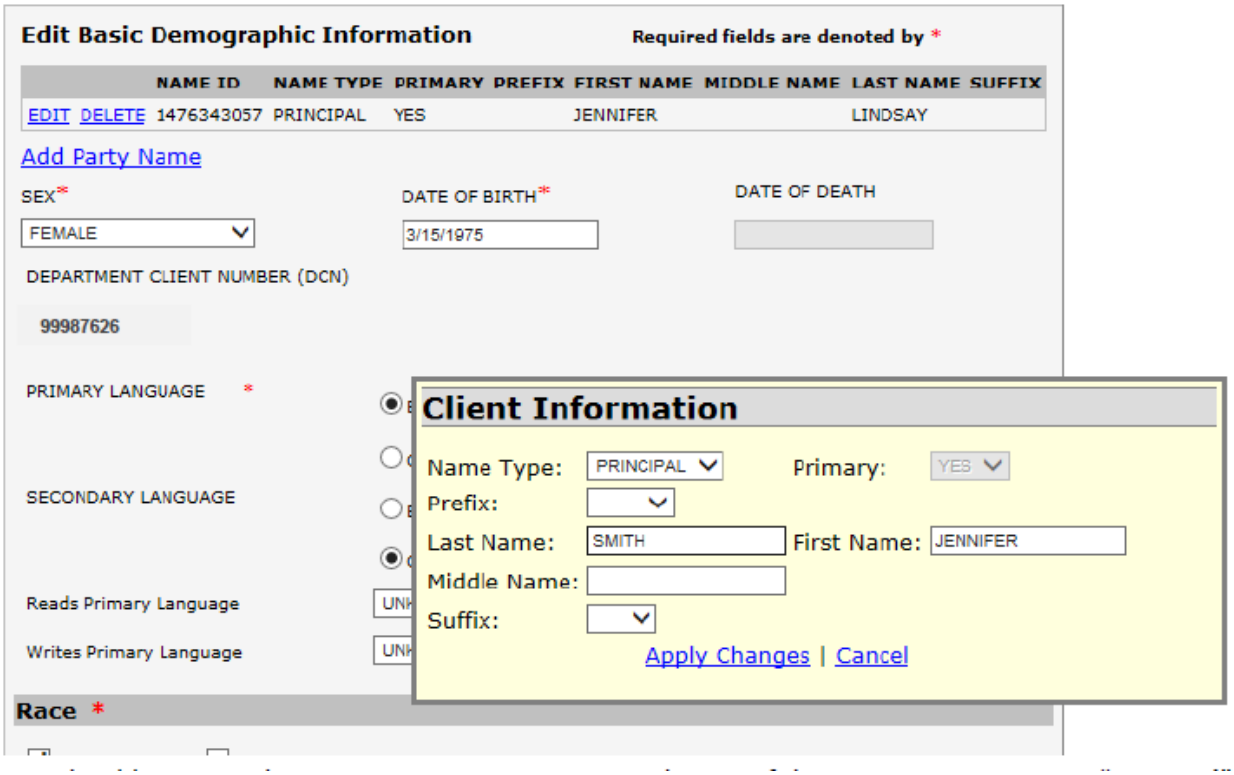
1) Pull up the client in MOHSAIC that needs a name change in the CLIENT-Submit New Forms/Billing Screen.
2) Then, Select View/Edit Client Information



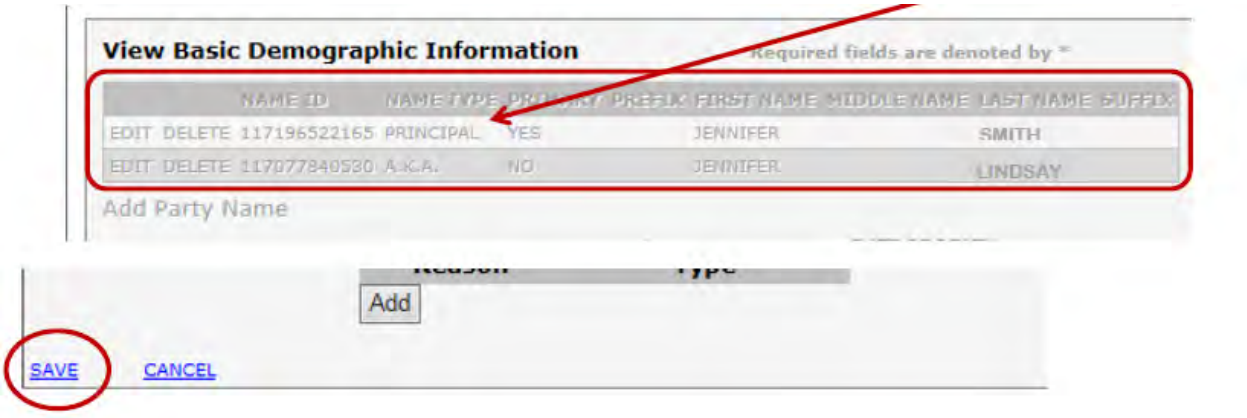
3) When this Screen (also linked to DSS) comes up, scroll to the bottom and Click **EDIT**.


4) Then Click on ADD PARTY NAME (DO NOT try to EDIT/DELETE a Client Name)

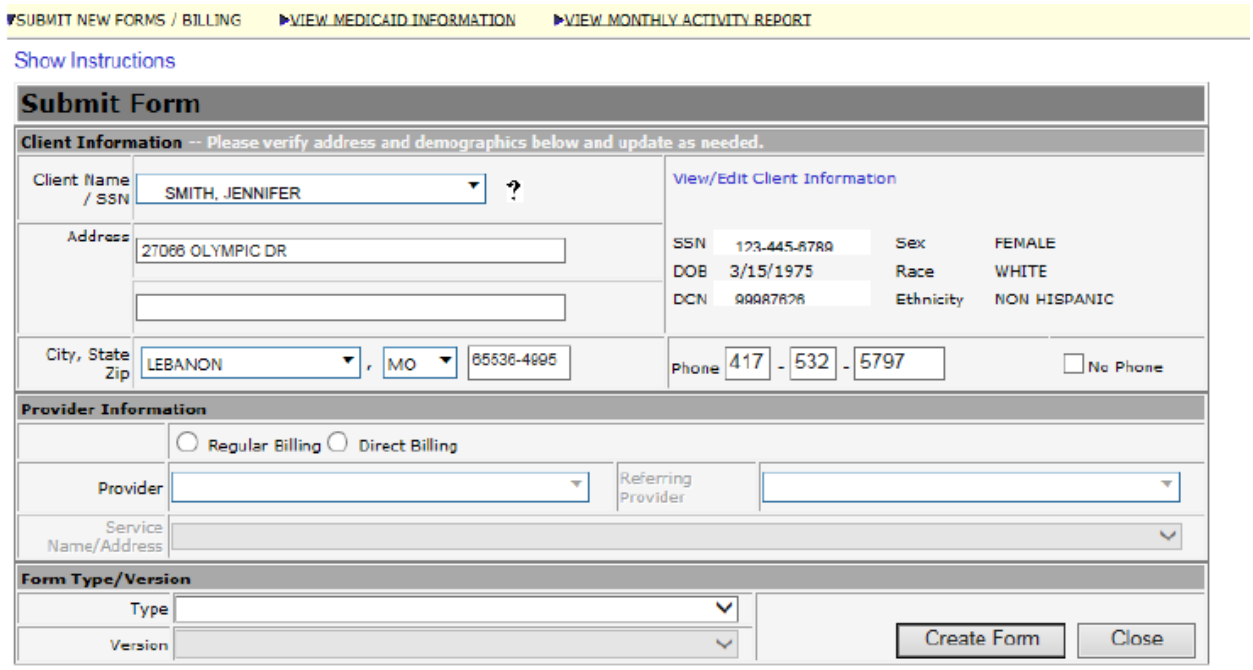
5) In the "**Client Information**" pop up box that appears, select Name Type-PRINCIPAL , enter in the Correct Last Name, First Name, and Middle Name (if applicable), then hit- **Apply Changes**.




6) You should now see the new correct name appear at the top of the Screen as Name Type "**Principal**" along with all previous names used in the system. Then Scroll to the bottom and Click "**SAVE**".



7) You should now see the Correct Last Name in the submit screen Box. This Name will appear on all Future forms entered but will NOT change the name to forms previously entered with a different Name.




8) NOTE: Any forms already entered and viewable in REVIEW PAY STATUS will still show the OLD last Name. When you search for the client forms in REVIEW PAY STATUS- Search by the new Primary/Principal name to pull up all forms associated with that client. If you try to search for forms with the old last name it may not give you any results.
**Client Names/DCN/SSN's are false and for example only**

## LESSON 2: FINANCIAL

### *Provider Contract Information*

When clicking the 'Provider Contract Information' the financial information is automatically displayed. This screen tracks and displays the amount of funding given, amount billed, amount paid, and amount available.

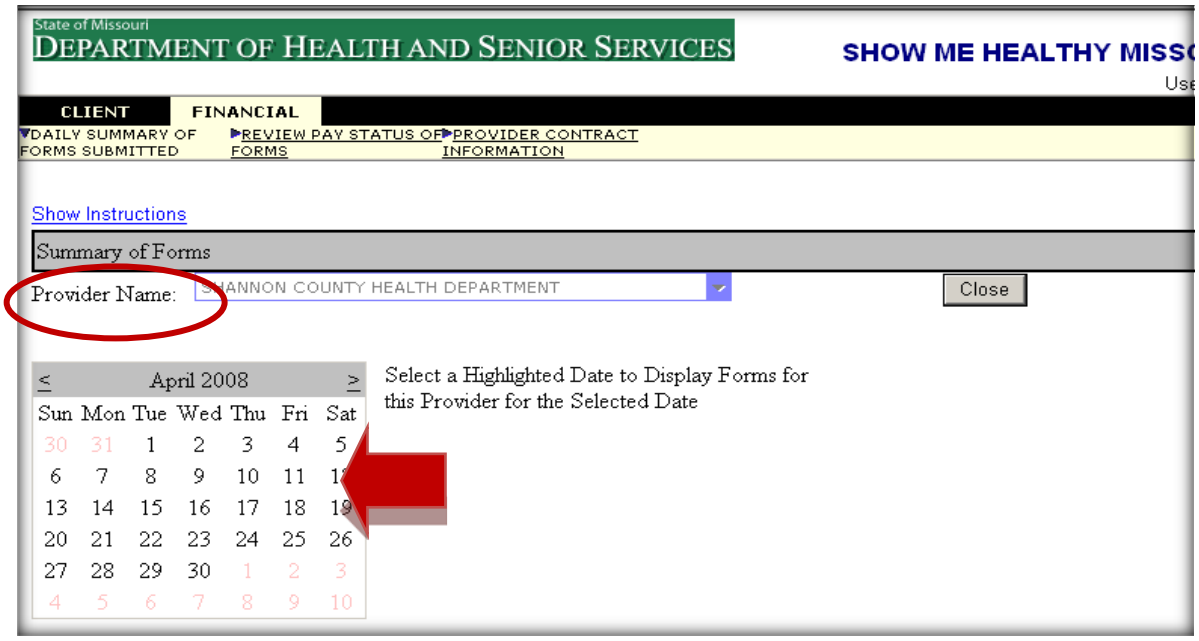
The billed amount subtracts from the amount available upon submission.

If this information does not correspond with your records, contact the SMHW billing coordinator at 866-726-9926. SHMW encourages you to monitor/track your funds through your internal system.

## *Daily Summary of Forms Submitted*

Click on the 'Daily Summary of Forms Submitted' and then click on the month and day to display. Click the arrows on the month bar to change the month and then select the day to display. This will display the client's financial information by type, date and amount.

Clicking on 'Display Full List to Print' will display the screen for sending to the default printer. Clicking on the 'Print Listing' button will generate a print job. Choose the printer on the print screen and click print. If a printout is not needed, click the 'Close' button to return to the main screen.



## REVIEW PAY STATUS OF FORMS

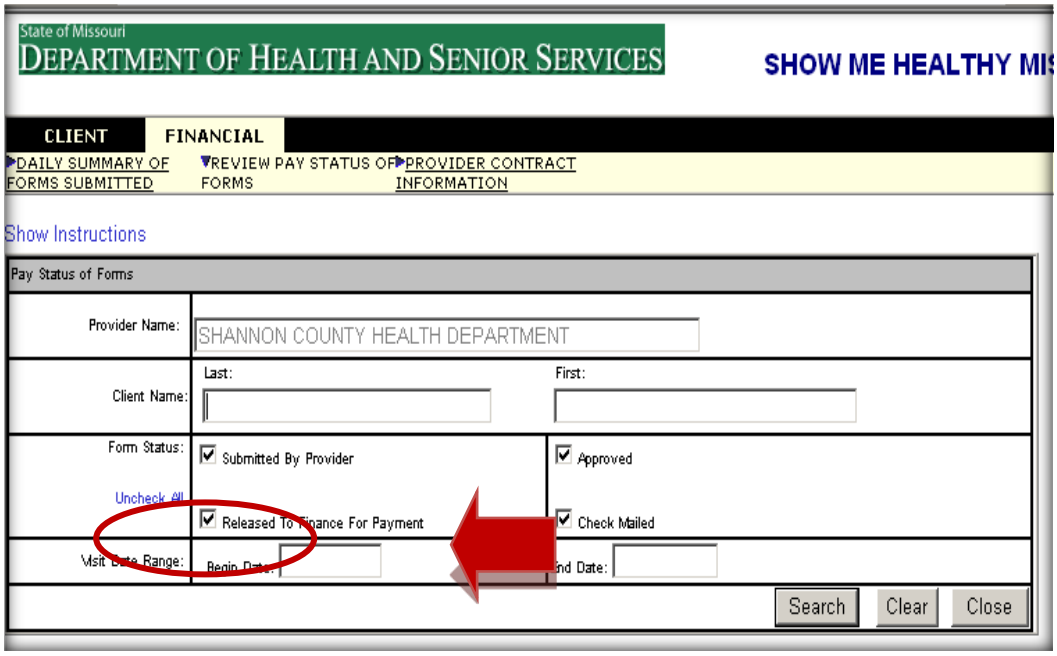
Searching for all records submitted or for a specific client is possible. There are four form status types:

- Submitted by Provider,
- Approved,
- Released to Finance for Payment, and
- Check Mailed

Each indicates a different step in the review and payment process.

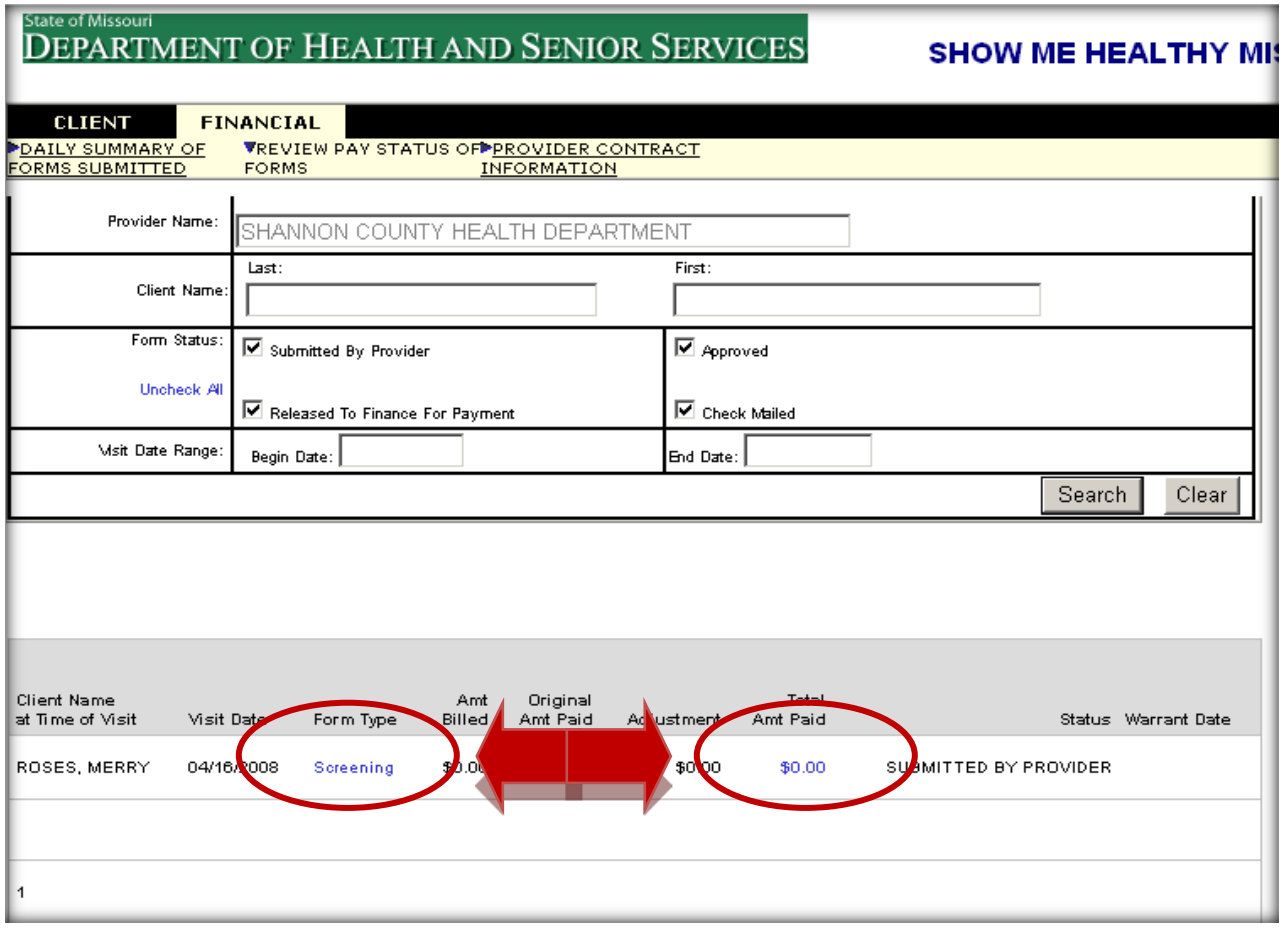
Searching for a client will display all forms submitted for that client and the pay status. Click on 'Form Status' to view all clients under the criteria or click multiple items to display all the selections. (Example: 'Check Mailed')

Entering the date range will display all forms status for the range. Click the 'Search' button to display results.



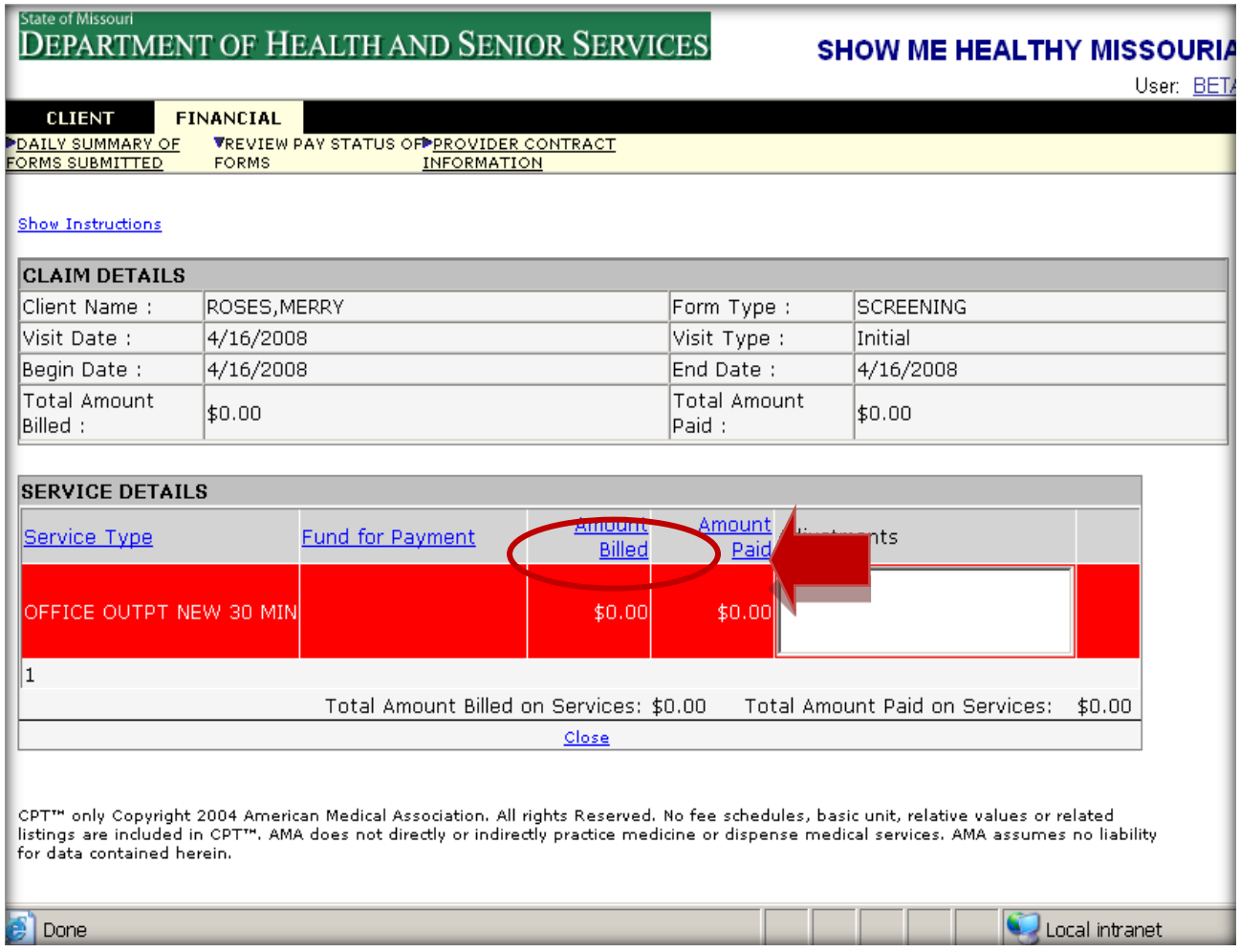
## REVIEW PAY STATUS OF FORMS, CONTINUED

The 'Form Type' and 'Total Amount Paid' columns show in blue. Clicking on either one brings up the form or the claim screen to review. **The claim screen form is 'read only'.**



## REVIEW PAY STATUS OF FORMS, CONTINUED

Clicking on the 'Amount Billed' link will display the detailed information for that client and date. **This form is 'read only'.**




Address questions and general assistance requests to the central office staff by calling SMHW/WISEWOMAN at 866-726-9926.

Direct specific questions or concerns with MOHSAIC to the ITSD Help Desk 800-347-0887 or by e-mail at support@health.mo.gov.

# SHOW ME HEALHTY WOMEN FORMS AND FORM ENTRY IN MOHSAIC

## Show Me Healthy Women Forms Overview

All forms needs to be kept in the patient's file. Other forms that need to be included in the file, not listed below, include: Eligibility form, proof of age-photo ID, and proof of income-tax form/paycheck status.

All forms are available on the web at:
http://www.health.mo.gov/living/healthcondiseases/chronic/showmehealthywomen/forms.php.

Direct any form related questions to the provider's Regional Program Coordinator (RPC).

# SHOW ME HEALTHY WOMEN PATIENT HISTORY FORM (GREEN FORM)

The Patient History Form (green colored form) should be completed by each client at the initial screening visit and at every annual screening thereafter. The provider should enter the green colored form into MOHSAIC when reporting the initial screening visit and update the information each year as needed.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL
SHOW ME HEALTHY MISSOURIANS/SHOW ME HEALTHY WOMEN

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

**PATIENT HISTORY**
(TO BE COMPLETED BY CLIENT AND REVIEWED ANNUALLY)

| ENROLLMENT SITE/SATELLITE CLINIC (IF ANY) | DATE OF VISIT (MM/DD/YYYY) |
|---|---|
| | |

**A. PERSONAL HISTORY**

| NAME (LAST, FIRST, MIDDLE INITIAL) | MAIDEN NAME |
|---|---|
| | |

| E-MAIL ADDRESS | HOME PHONE NO. | WORK PHONE NO. | CELL PHONE NO. |
|---|---|---|---|
| | ( ) | ( ) | ( ) |

| STREET ADDRESS | CITY/STATE | ZIP CODE | COUNTY |
|---|---|---|---|
| | | | |

| DATE OF BIRTH (MM/DD/YYYY) | SOCIAL SECURITY NUMBER (OPTIONAL) | WHAT IS THE PRIMARY LANGUAGE SPOKEN IN YOUR HOME? |
|---|---|---|
| | | ☐ English ☐ Spanish ☐ Other _____ |

| NUMBER OF HOUSEHOLD MEMBERS | INSURANCE COVERAGE: | MEDICAID DCN/MEDICARE NUMBER |
|---|---|---|
| | ☐ None ☐ Mo HealthNet ☐ Medicare ☐ Private | |

Race: (must be answered, choose all that apply)
- ☐ (1) White
- ☐ (2) Black or African American
- ☐ (3) Asian
- ☐ (4) Native Hawaiian or Other Pacific Islander
- ☐ (5) American Indian or Alaskan Native
- ☐ (6) Other_____
- ☐ (7) Unknown (please avoid using)

Ethnicity: (must be answered.)
Are you of Hispanic origin? ☐ Yes ☐ No

Highest grade of school completed (circle one)
(U. S. equivalent if educated in another nation)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

How did you hear about the Show Me Healthy Women program? (please choose only one)
- ☐ (1) Physician
- ☐ (2) Clinic
- ☐ (3) Television
- ☐ (4) Radio
- ☐ (5) Printed Ad
- ☐ (6) Billboard
- ☐ (7) Bus Sign
- ☐ (8) Health Care Provider
- ☐ (9) Health Fair
- ☐ (10) Health Coalition
- ☐ (11) Outreach Worker
- ☐ (12) Relative/Friend
- ☐ (13) Other Location (specify)_____

What type of transportation did you use to get to your clinic appointment? (please choose only one)
- ☐ (1) Bus
- ☐ (2) ACT Van
- ☐ (3) OATS Bus
- ☐ (4) Taxi
- ☐ (5) Personal Vehicle
- ☐ (6) Relative/Friend
- ☐ (7) SMTS
- ☐ (8) Other_____

Date of last Pap Test ____/____/____ (MM DD YYYY)

Date of Last mammogram ____/____/____ (MM DD YYYY)

Do you now smoke cigarettes? ☐ Everyday ☐ Some days ☐ Not at all ☐ Don't know

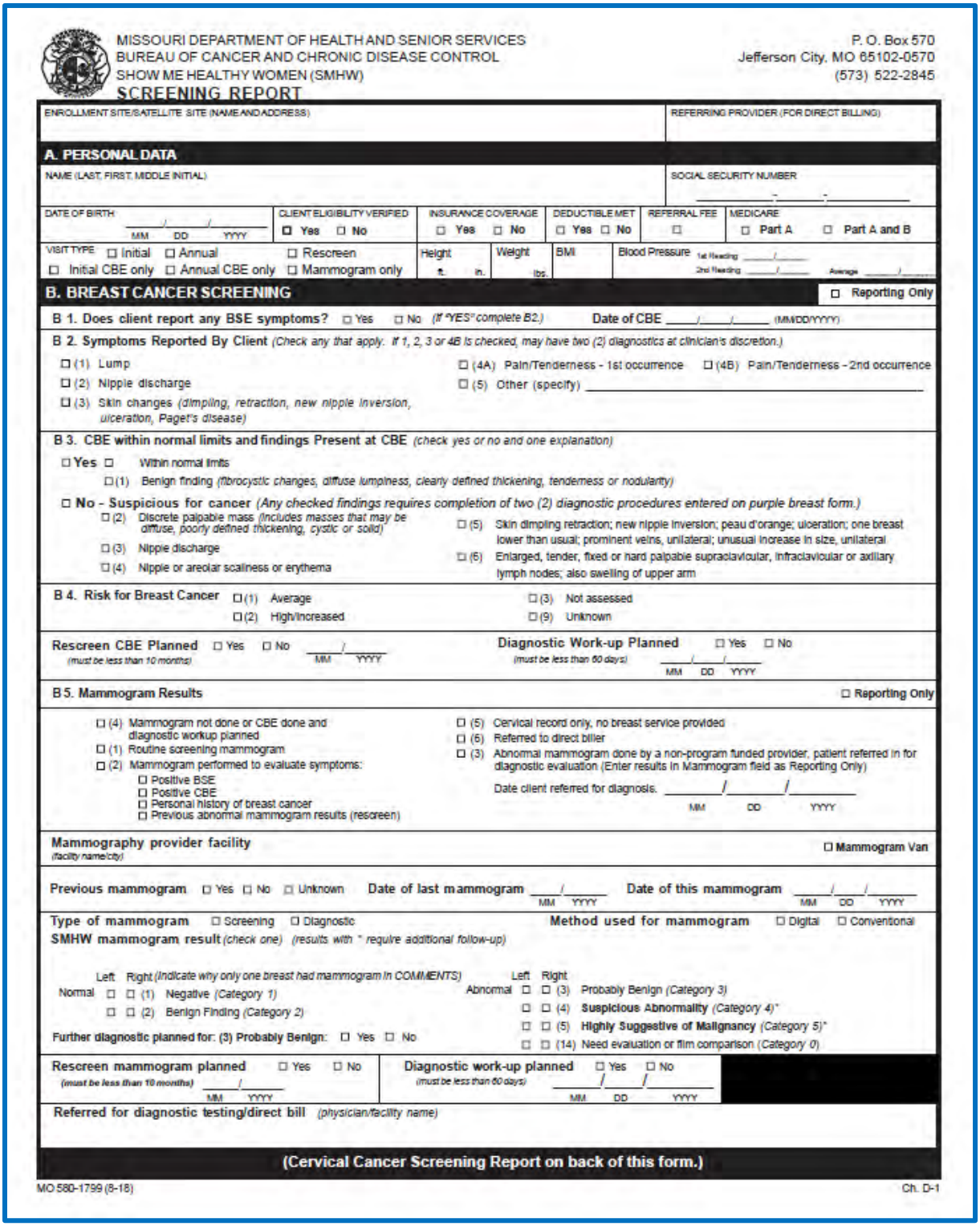
Name and telephone numbers of two people who can always reach you:

| NAME | HOME PHONE WITH AREA CODE | WORK PHONE |
|---|---|---|
| | (_____)_____ | (_____)_____ |
| NAME | HOME PHONE WITH AREA CODE | WORK PHONE |
| | (_____)_____ | (_____)_____ |

MO 580-1800 (12/14) Ch. D-3

## SHOW ME HEALTHY WOMEN SCREENING FORM (BLUE FORM)

The Screening Report Form (blue form) should be submitted at the initial, rescreen, an annual screening for all client's participating in SMHW. Document the first mammogram a client receives on the screening form.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL
SHOW ME HEALTHY WOMEN (SMHW)
**SCREENING REPORT**

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE SITE (NAME AND ADDRESS) | REFERRING PROVIDER (FOR DIRECT BILLING)

**A. PERSONAL DATA**

NAME (LAST, FIRST, MIDDLE INITIAL) | SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM DD YYYY) | CLIENT ELIGIBILITY VERIFIED ☐ Yes ☐ No | INSURANCE COVERAGE ☐ Yes ☐ No | DEDUCTIBLE MET ☐ Yes ☐ No | REFERRAL FEE ☐ | MEDICARE ☐ Part A ☐ Part A and B

VISIT TYPE ☐ Initial ☐ Annual ☐ Rescreen ☐ Initial CBE only ☐ Annual CBE only ☐ Mammogram only | Height ft. in. | Weight lbs. | BMI | Blood Pressure 1st Reading 2nd Reading Average

**B. BREAST CANCER SCREENING** ☐ Reporting Only

**B 1. Does client report any BSE symptoms?** ☐ Yes ☐ No *(If "YES" complete B2.)* Date of CBE ____/____/____ (MM/DD/YYYY)

**B 2. Symptoms Reported By Client** *(Check any that apply. If 1, 2, 3 or 4B is checked, may have two (2) diagnostics at clinician's discretion.)*

☐ (1) Lump
☐ (2) Nipple discharge
☐ (3) Skin changes *(dimpling, retraction, new nipple inversion, ulceration, Paget's disease)*
☐ (4A) Pain/Tenderness - 1st occurrence ☐ (4B) Pain/Tenderness - 2nd occurrence
☐ (5) Other (specify) _____

**B 3. CBE within normal limits and findings Present at CBE** *(check yes or no and one explanation)*

☐ **Yes** ☐ Within normal limits
☐ (1) Benign finding *(fibrocystic changes, diffuse lumpiness, clearly defined thickening, tenderness or nodularity)*

☐ **No - Suspicious for cancer** *(Any checked findings requires completion of two (2) diagnostic procedures entered on purple breast form.)*
☐ (2) Discrete palpable mass *(Includes masses that may be diffuse, poorly defined thickening, cystic or solid)*
☐ (3) Nipple discharge
☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling retraction; new nipple inversion; peau d'orange; ulceration; one breast lower than usual; prominent veins, unilateral; unusual increase in size, unilateral
☐ (6) Enlarged, tender, fixed or hard palpable supraclavicular, infraclavicular or axillary lymph nodes; also swelling of upper arm

**B 4. Risk for Breast Cancer** ☐ (1) Average ☐ (2) High/Increased ☐ (3) Not assessed ☐ (9) Unknown

**Rescreen CBE Planned** ☐ Yes ☐ No *(must be less than 10 months)* ____/____ MM YYYY

**Diagnostic Work-up Planned** ☐ Yes ☐ No *(must be less than 60 days)* ____/____/____ MM DD YYYY

**B 5. Mammogram Results** ☐ Reporting Only

☐ (4) Mammogram not done or CBE done and diagnostic workup planned
☐ (1) Routine screening mammogram
☐ (2) Mammogram performed to evaluate symptoms:
☐ Positive BSE
☐ Positive CBE
☐ Personal history of breast cancer
☐ Previous abnormal mammogram results (rescreen)
☐ (5) Cervical record only, no breast service provided
☐ (6) Referred to direct biller
☐ (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)
Date client referred for diagnosis. ____/____/____ MM DD YYYY

**Mammography provider facility** *(facility name/city)* ☐ Mammogram Van

**Previous mammogram** ☐ Yes ☐ No ☐ Unknown **Date of last mammogram** ____/____ MM YYYY **Date of this mammogram** ____/____/____ MM DD YYYY

**Type of mammogram** ☐ Screening ☐ Diagnostic **Method used for mammogram** ☐ Digital ☐ Conventional

**SMHW mammogram result** *(check one)* *(results with * require additional follow-up)*

| | Left | Right | *(Indicate why only one breast had mammogram in COMMENTS)* |
|---|---|---|---|
| Normal | ☐ | ☐ | (1) Negative *(Category 1)* |
| | ☐ | ☐ | (2) Benign Finding *(Category 2)* |
| Abnormal | ☐ | ☐ | (3) Probably Benign *(Category 3)* |
| | ☐ | ☐ | (4) **Suspicious Abnormality** *(Category 4)** |
| | ☐ | ☐ | (5) **Highly Suggestive of Malignancy** *(Category 5)** |
| | ☐ | ☐ | (14) Need evaluation or film comparison *(Category 0)* |

**Further diagnostic planned for: (3) Probably Benign:** ☐ Yes ☐ No

**Rescreen mammogram planned** ☐ Yes ☐ No *(must be less than 10 months)* ____/____ MM YYYY

**Diagnostic work-up planned** ☐ Yes ☐ No *(must be less than 60 days)* ____/____/____ MM DD YYYY

**Referred for diagnostic testing/direct bill** *(physician/facility name)*

**(Cervical Cancer Screening Report on back of this form.)**

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## C. CERVICAL CANCER SCREENING

☐ (5) Breast and Pelvic exam only

☐ (1) Routine Pap test
☐ (2) Patient under surveillance for previous abnormal (rescreen)
☐ (4) Pap test not done. Patient proceeded directly for diagnostic work-up or HPV testing
☐ (6) Referred to direct biller for Pap and Pelvic
☐ (3) Abnormal Pap test done by non-program provider - reporting only/referral date ____/____/____ MM DD YYYY

**Risk for Cervical Cancer**
☐ (1) Average
☐ (2) High/Increased
☐ (4) Not assessed
☐ (6) Unknown

### C 1. Pelvic Exam Results

**Pelvic Exam WNL?** ☐ Yes ☐ No
(Additional information required in "No" selected, See C 2.)

**Hysterectomy?** ☐ Yes ☐ No
☐ Cervix absent
☐ Cervix absent due to cervical cancer *(needs annual Pap test)*
☐ Cervix present
☐ Reason for hysterectomy unknown

**Date of Pelvic Exam** ____/____/____ MM DD YYYY

**Reproductive Status (check one)**
☐ a) Premenopausal
☐ b) Postmenopausal

### C 2. Pelvic Exam Findings

☐ **Reporting Only**

**Findings Present at Pelvic Exam** (check only one)

☐ **1) Cervix**

☐ a) Polyp
☐ b) Leukoplakia (white lesions)
☐ c) Friable
☐ d) Ulceration
☐ e) Exophytic growth
☐ f) Ectropion
☐ g) Stenotic OS
☐ h) Cervical mass
☐ i) Other: _____

☐ **2) Exam Complicated by Obesity**

Rescreen planned ☐ Yes ☐ No ____/____ MM YYYY

Diagnostic planned ☐ Yes ☐ No ____/____/____ MM DD YYYY
*(must be less than 90 days)*

### C 3. Pap Test Results

☐ **Reporting Only**

**Previous Pap test** ☐ Yes ☐ No ☐ Unknown

**Date of last Pap test** ____/____ MM YYYY

**Date of this Pap test** ____/____/____ MM DD YYYY

**Specimen adequacy**
☐ Satisfactory
☐ Unsatisfactory due to _____
☐ Unknown

**Specimen type**
☐ Conventional Smear
☐ Liquid Based
☐ Annual Pap due to previous treatment for cervical cancer

**Pap test result** *(check one)* *(Results with (*) require additional follow-up)*

Normal
☐ (1) Negative for intraepithelial lesion or malignancy
☐ (2) Infection/Inflamation/Reactive Change

Abnormal
☐ (3) Atypical Squamous Cells of Undetermined Significance (ASC-US)(May have HPV test)
☐ **(4) Lowgrade SIL** *(HPV/Mild Dysplasia/CIN I)**
☐ **(5) Atypical Squamous Cells, cannot exclude HSIL** *(ASC-H)**
☐ **(6) Highgrade SIL** *(with features suspicious for invasion/CIN II-III/CIS)**
☐ **(7) Squamous Cell Cancer***
☐ **(8) Atypical Glandular Cells*** *(including atypicalendocervical adenocarcinoma in situ and adenocarcinoma)*
☐ (9) Adenocarcinoma in situ
☐ (10) Adenocarcinoma
☐ (11) Other _____

**Endocervical Cells** ☐ Yes ☐ No

### C 4. HPV Test Date ____/____/____ MMDDYYYY

☐ **Reporting Only**

**Indication for HPV Test**
☐ (1) Cotesting/Screening
☐ (2) Triage (Reflex)
☐ (3) Not Done
☐ (9) Unknown

**HPV Test Result**
☐ (1) Positive (High Risk)
☐ (2) Negative

**HPV DNA Genotype 16 or 18 Positive** *(Only report if PAP negative and HPV High Risk Group Positive)*
☐ Yes
☐ No
☐ No Test Performed

**Rescreen Pap planned** ☐ Yes ☐ No ____/____ MM YYYY
*(less than 10 months)*

**Diagnostic work-up planned** ☐ Yes ☐ No ____/____/____ MM DD YYYY
*(must be less than 90 days)*

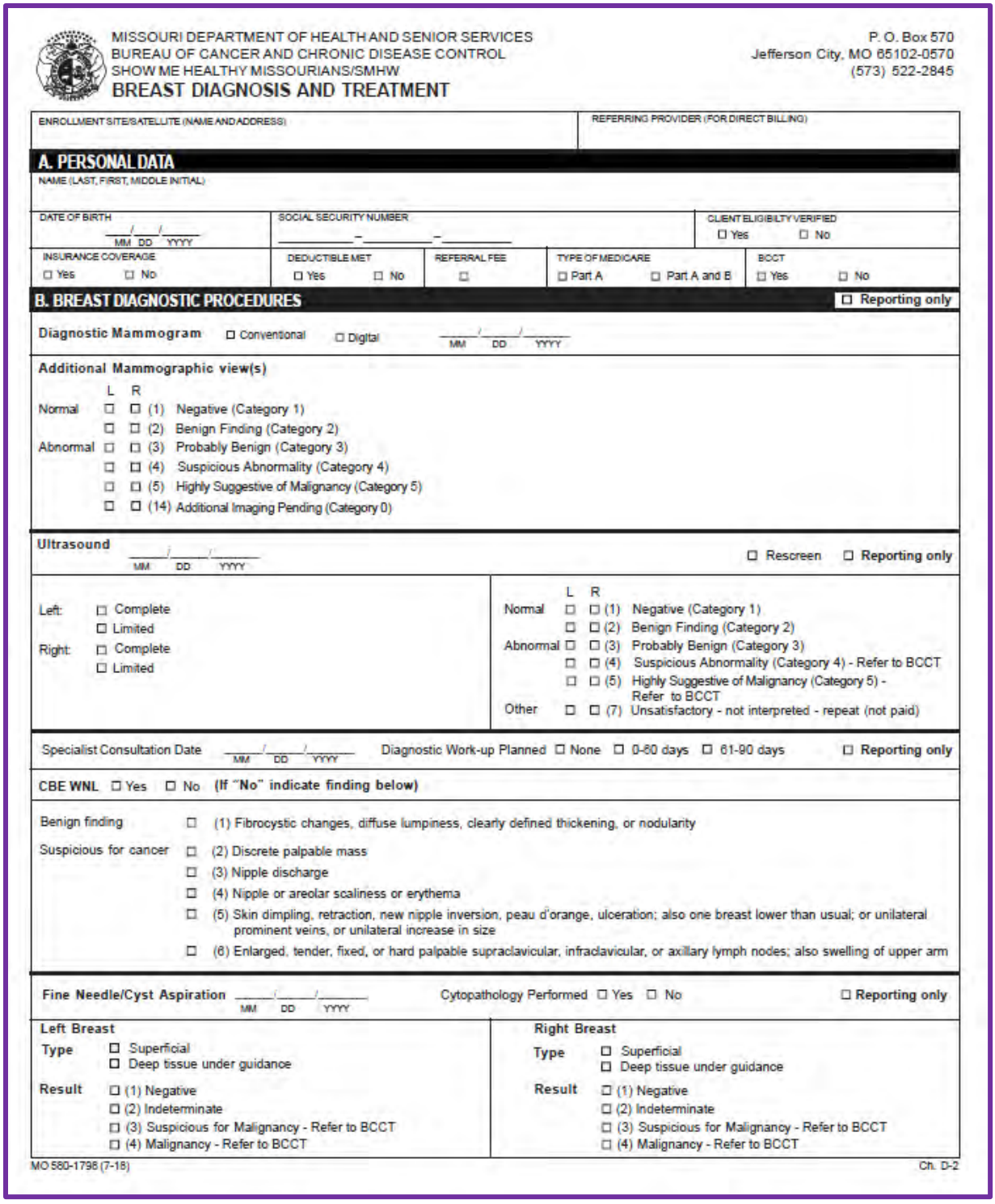
**Referred for diagnostic work-up/direct biller**
(physician/facility name)

**Date of next routine Pap screening** ____/____ MM YYYY

## D. COMMENTS

## SHOW ME HEALTHY WOMEN BREAST FORM (PURPLE FORM)

Breast Diagnosis and Treatment Form (purple form) should be completed for all clients with abnormal breast cancer screening results that require further diagnostic procedures and/or treatment.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL
SHOW ME HEALTHY MISSOURIANS/SMHW
**BREAST DIAGNOSIS AND TREATMENT**

P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS) | REFERRING PROVIDER (FOR DIRECT BILLING)

**A. PERSONAL DATA**

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH ___/___/___ (MM DD YYYY) | SOCIAL SECURITY NUMBER ___-___-___ | CLIENT ELIGIBILITY VERIFIED ☐ Yes ☐ No

INSURANCE COVERAGE ☐ Yes ☐ No | DEDUCTIBLE MET ☐ Yes ☐ No | REFERRAL FEE ☐ | TYPE OF MEDICARE ☐ Part A ☐ Part A and B | BCCT ☐ Yes ☐ No

**B. BREAST DIAGNOSTIC PROCEDURES** ☐ Reporting only

**Diagnostic Mammogram** ☐ Conventional ☐ Digital ___/___/___ (MM DD YYYY)

**Additional Mammographic view(s)**

| | L | R | |
|---|---|---|---|
| Normal | ☐ | ☐ | (1) Negative (Category 1) |
| | ☐ | ☐ | (2) Benign Finding (Category 2) |
| Abnormal | ☐ | ☐ | (3) Probably Benign (Category 3) |
| | ☐ | ☐ | (4) Suspicious Abnormality (Category 4) |
| | ☐ | ☐ | (5) Highly Suggestive of Malignancy (Category 5) |
| | ☐ | ☐ | (14) Additional Imaging Pending (Category 0) |

**Ultrasound** ___/___/___ (MM DD YYYY) ☐ Rescreen ☐ Reporting only

Left: ☐ Complete ☐ Limited
Right: ☐ Complete ☐ Limited

| | L | R | |
|---|---|---|---|
| Normal | ☐ | ☐ | (1) Negative (Category 1) |
| | ☐ | ☐ | (2) Benign Finding (Category 2) |
| Abnormal | ☐ | ☐ | (3) Probably Benign (Category 3) |
| | ☐ | ☐ | (4) Suspicious Abnormality (Category 4) - Refer to BCCT |
| | ☐ | ☐ | (5) Highly Suggestive of Malignancy (Category 5) - Refer to BCCT |
| Other | ☐ | ☐ | (7) Unsatisfactory - not interpreted - repeat (not paid) |

Specialist Consultation Date ___/___/___ (MM DD YYYY) Diagnostic Work-up Planned ☐ None ☐ 0-60 days ☐ 61-90 days ☐ Reporting only

**CBE WNL** ☐ Yes ☐ No **(If "No" indicate finding below)**

Benign finding ☐ (1) Fibrocystic changes, diffuse lumpiness, clearly defined thickening, or nodularity

Suspicious for cancer
☐ (2) Discrete palpable mass
☐ (3) Nipple discharge
☐ (4) Nipple or areolar scaliness or erythema
☐ (5) Skin dimpling, retraction, new nipple inversion, peau d'orange, ulceration; also one breast lower than usual; or unilateral prominent veins, or unilateral increase in size
☐ (6) Enlarged, tender, fixed, or hard palpable supraclavicular, infraclavicular, or axillary lymph nodes; also swelling of upper arm

**Fine Needle/Cyst Aspiration** ___/___/___ (MM DD YYYY) Cytopathology Performed ☐ Yes ☐ No ☐ Reporting only

**Left Breast**
Type ☐ Superficial ☐ Deep tissue under guidance
Result ☐ (1) Negative ☐ (2) Indeterminate ☐ (3) Suspicious for Malignancy - Refer to BCCT ☐ (4) Malignancy - Refer to BCCT

**Right Breast**
Type ☐ Superficial ☐ Deep tissue under guidance
Result ☐ (1) Negative ☐ (2) Indeterminate ☐ (3) Suspicious for Malignancy - Refer to BCCT ☐ (4) Malignancy - Refer to BCCT

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**Biopsy** ____/____/____ (MM DD YYYY) ☐ **Reporting only**

**Location** ☐ Physician Office ☐ Hospital outpatient Facility Fee ☐Yes ☐No Anesthesia ☐

Primary Biopsy Type: Clear

**Breast** ☐ **Left** ☐ **Right**

Percutaneous
☐ Stereotactic Guided (19081)
☐ US Guided (19083)
☐ Needle Core, No Guidance (19100)
☐ Add Lesion

☐ Incisional, No Guidance (19101) ☐ Excisional (19120 or 19125)
☐ Mammogram Guided (19281) Preoperative placement of clip? ☐ Yes ☐ No Radiological exam? ☐ Yes ☐ No
☐ Stereotactic Guided (19283) ☐ US Guided (19285)

Additional Primary Pathology:
☐ No additional pathology
☐ 1 additional pathology
☐ 2 additional pathology
☐ 3 additional pathology

Additional Lesion: Clear

☐ Incisional, No Guidance (19101) ☐ Excisional (19120)
☐ Mammogram Guided Preoperative placement of clip? ☐ Yes ☐ No Radiological exam? ☐ Yes ☐ No
☐ Stereotactic Guided ☐ US Guided

Additional Primary Pathology:
☐ No additional pathology
☐ 1 additional pathology
☐ 2 additional pathology
☐ 3 additional pathology

Additional Facility Fee ☐ Yes ☐ No

**Biopsy Result** (Report only most severe result)
☐ (1) Benign
☐ (2) Benign/Atypical
☐ (3) Indeterminate
☐ (4) Malignancy

**Status of Final Diagnosis**
☐ (1) Work-up Complete (Complete Section C)
☐ (2) Work-up Pending
☐ (3) Lost to Follow-up (Enter Lost to Follow-up Date in Final Diagnosis Date)
☐ (4) Work-up Refused (Describe in coment section/Must have signed waiver)
☐ (9) Irreconcilable (Does not follow typical protocol - Describe)

**Next Breast Cancer Screening Date** ____/____ MM YYYY

**Other Procedure** (specify): _____

**Other Procedure Date:** ____/____/____ (MM DD YYYY)

## C. BREAST DIAGNOSIS

**Final Diagnosis**
☐ (3) Breast Cancer not diagnosed
☐ (4) **Lobular Carcinoma In Situ (LCIS)** *(Stage 0)**
☐ (5) **Ductal Carcinoma In Situ (DCIS)** *(Stage 0)**
☐ (2) **Invasive Breast Cancer***

**Final Diagnosis/Imaging Date** ____/____/____ (MM DD YYYY)

## D. BREAST TREATMENT

**Status of Treatment**
☐ (1) Started
☐ (2) Pending
☐ (3) Lost to F/U (Describe in comment section)
☐ (4) Refused (Describe in comment section/Must have signed waiver)
☐ (5) Not Needed

**Type**
☐ (1) Surgery
☐ (2) Radiation
☐ (3) Chemotherapy
☐ (4) Hormone
☐ (5) Immunotherapy
☐ (6) Other Cancer Therapy
Specify _____

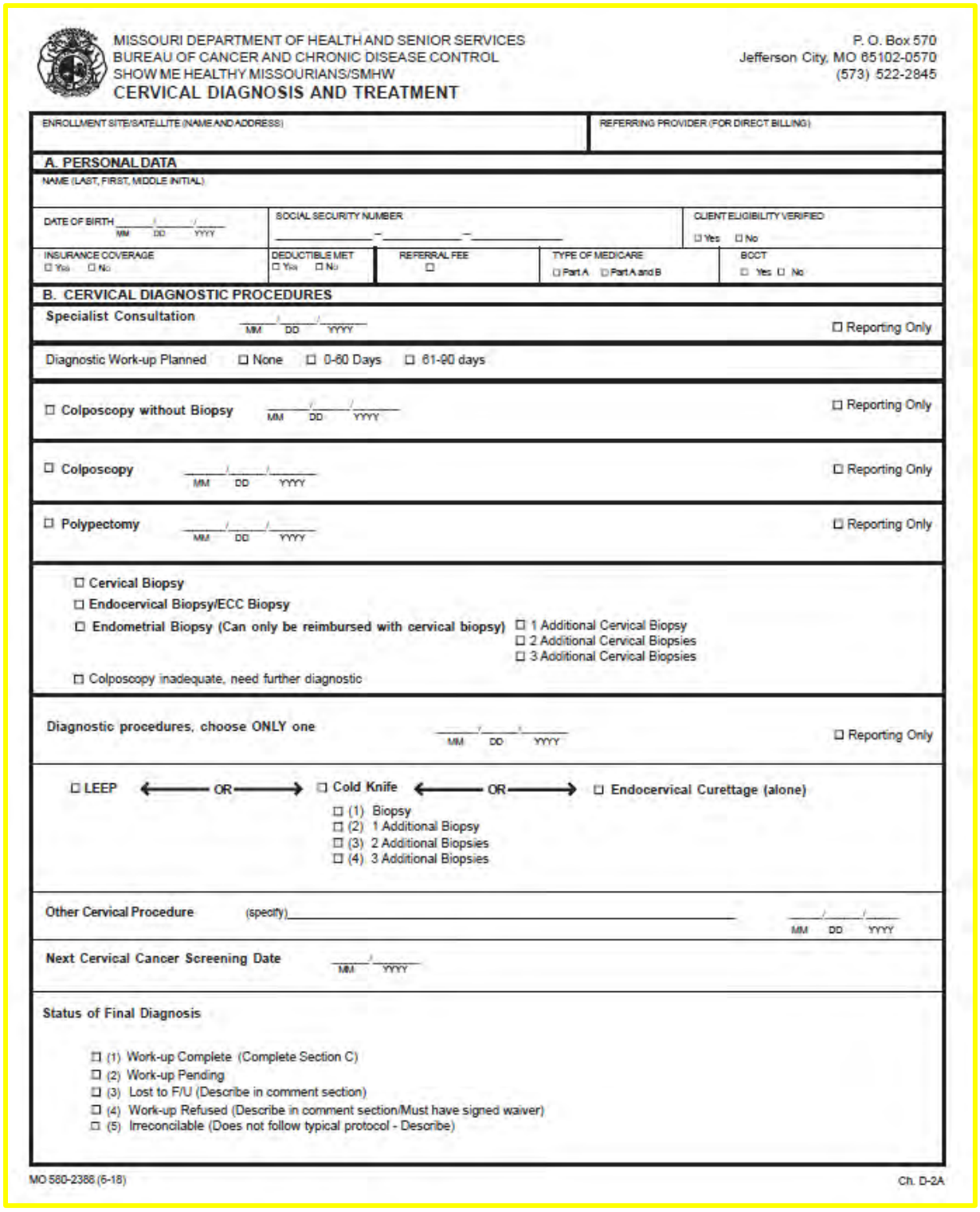
**Treatment Facility**
(Facility Name/City)

**Date Treatment Started** ____/____/____ (MM DD YYYY)

**COMMENTS**

## SHOW ME HEALTHY WOMEN CERVICAL FORM (YELLOW FORM)

Cervical Diagnosis and Treatment Form (yellow form) should be completed for all clients with abnormal cervical cancer screening results that require further diagnostic procedures and/or treatment.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL
SHOW ME HEALTHY MISSOURIANS/SMHW
P. O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

**CERVICAL DIAGNOSIS AND TREATMENT**

ENROLLMENT SITE/SATELLITE (NAME AND ADDRESS) | REFERRING PROVIDER (FOR DIRECT BILLING)

**A. PERSONAL DATA**

NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH ___/___/___ (MM DD YYYY) | SOCIAL SECURITY NUMBER ___-___-___ | CLIENT ELIGIBILITY VERIFIED ☐ Yes ☐ No

INSURANCE COVERAGE ☐ Yes ☐ No | DEDUCTIBLE MET ☐ Yes ☐ No | REFERRAL FEE ☐ | TYPE OF MEDICARE ☐ Part A ☐ Part A and B | BCCT ☐ Yes ☐ No

**B. CERVICAL DIAGNOSTIC PROCEDURES**

**Specialist Consultation** ___/___/___ (MM DD YYYY) ☐ Reporting Only

Diagnostic Work-up Planned ☐ None ☐ 0-60 Days ☐ 61-90 days

☐ **Colposcopy without Biopsy** ___/___/___ (MM DD YYYY) ☐ Reporting Only

☐ **Colposcopy** ___/___/___ (MM DD YYYY) ☐ Reporting Only

☐ **Polypectomy** ___/___/___ (MM DD YYYY) ☐ Reporting Only

☐ **Cervical Biopsy**
☐ **Endocervical Biopsy/ECC Biopsy**
☐ **Endometrial Biopsy (Can only be reimbursed with cervical biopsy)** ☐ 1 Additional Cervical Biopsy ☐ 2 Additional Cervical Biopsies ☐ 3 Additional Cervical Biopsies
☐ Colposcopy inadequate, need further diagnostic

**Diagnostic procedures, choose ONLY one** ___/___/___ (MM DD YYYY) ☐ Reporting Only

☐ **LEEP** ← OR → ☐ **Cold Knife** ← OR → ☐ **Endocervical Curettage (alone)**
☐ (1) Biopsy
☐ (2) 1 Additional Biopsy
☐ (3) 2 Additional Biopsies
☐ (4) 3 Additional Biopsies

**Other Cervical Procedure** (specify)_____ ___/___/___ (MM DD YYYY)

**Next Cervical Cancer Screening Date** ___/___ (MM YYYY)

**Status of Final Diagnosis**

☐ (1) Work-up Complete (Complete Section C)
☐ (2) Work-up Pending
☐ (3) Lost to F/U (Describe in comment section)
☐ (4) Work-up Refused (Describe in comment section/Must have signed waiver)
☐ (5) Irreconcilable (Does not follow typical protocol - Describe)

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## C. CERVICAL DIAGNOSIS

**Final Diagnosis** (RECORD MOST SEVERE RESULT) ***(Diagnostic results with (*) require treatment)***

- ☐ (1) Normal/Benign Reactive/Inflammation
- ☐ (2) HPV/Condylomata/Atypia
- ☐ (3) CIN I/Mild Dysplasia/Low grade SIL (Biopsy Diagnosed)*
- ☐ (4) **CIN II/Moderate Dysplasia (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (5) **CIN III/Severe Dysplasia/High Grade SIL/Carcinoma In Situ (CIS), Stage 0 (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (6) **Invasive (Biopsy Diagnosed)*** (Refer to BCCT)
- ☐ (7) Other _____

**Final Diagnosis Date** _____ / _____ / _____
MM DD YYYY

## D. CERVICAL TREATMENT

**Status of Treatment**
- ☐ Started
- ☐ Pending
- ☐ Lost to F/U (Describe in comment section)
- ☐ Work up refused (Describe in comment section/Must have signed waiver)
- ☐ Not Needed

**Type**
- ☐ Cryotherapy
- ☐ Conization (LEEP, Cold Knife)
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Immunotherapy
- ☐ Other Cancer Therapy - Specify _____

**Treatment Facility**
Facility Name/City

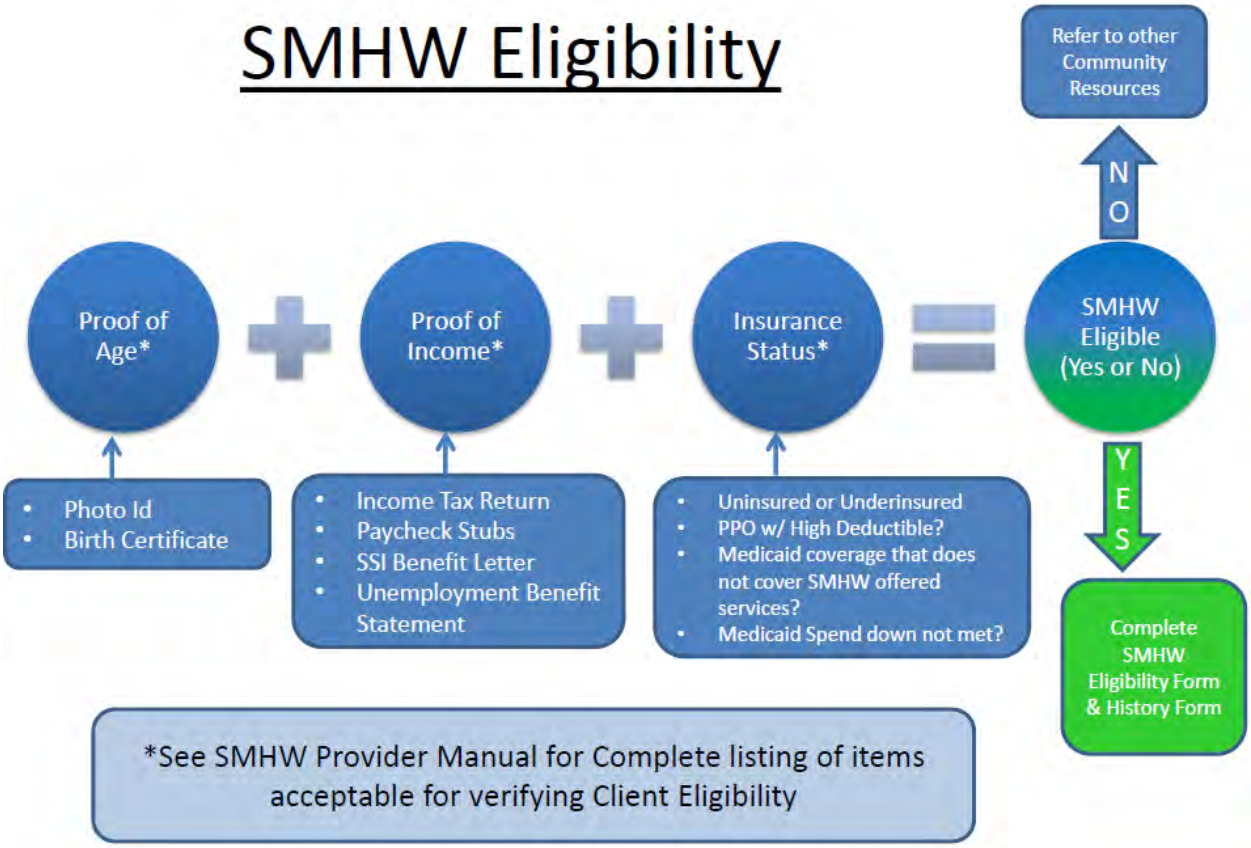
**Date Treatment Started** _____ / _____ / _____
MM DD YYYY

**Comments**

## Show Me Healthy Women Claim Entry

Before submitting any claims, application for access to MOHSAIC must be made. Approval for access will be granted within approximately one week. Please see MOHSAIC section of this manual (starting page 3) for further instructions.

### SHOW ME HEALTHY WOMEN CLIENT ELIGIBILITY

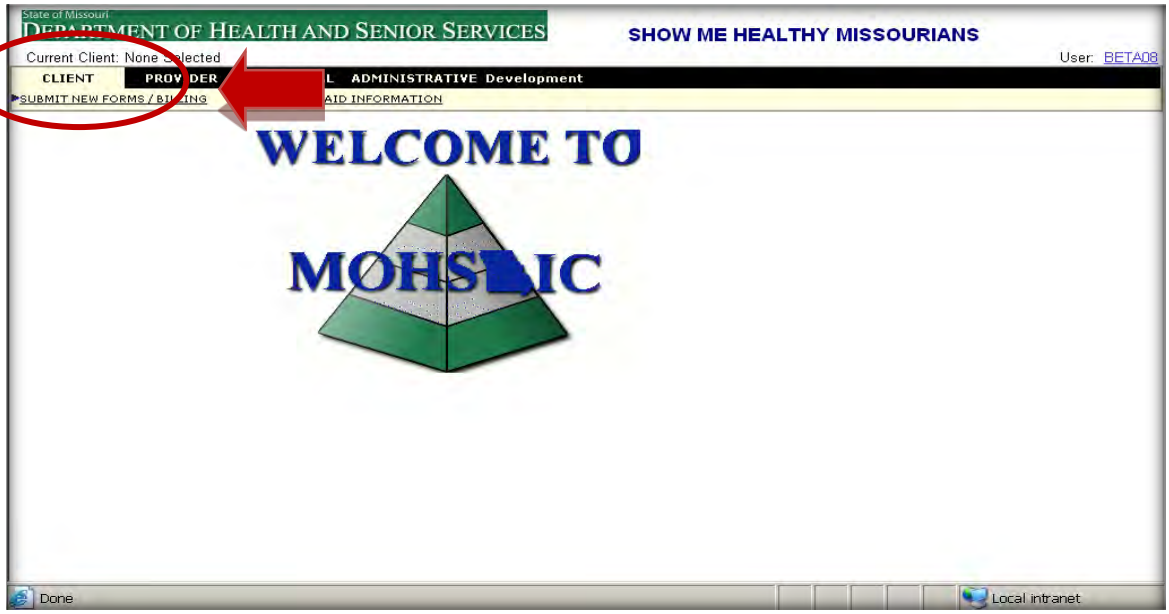


# CLAIM SUBMISSION

## *Entering or Viewing a Client*

The main screen for the SMHW program appears. To enter or view a client:

- Click on the 'Client' link on the menu bar
- Choose 'Submit New Forms/Billing'

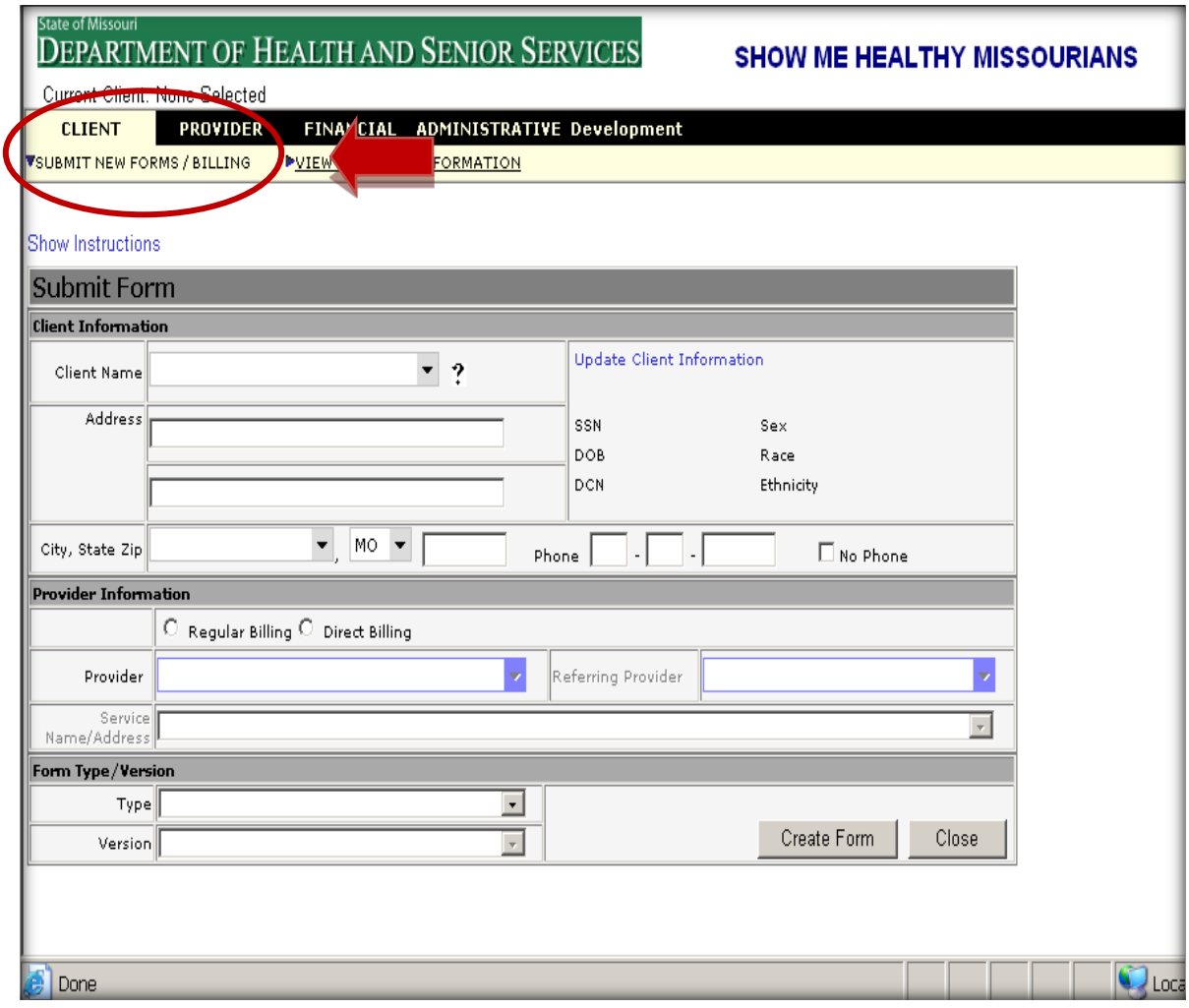


## *Client Search*

In 'Submit New Forms/Billing' screen under the 'Client Information' section, choose either to 'Search and Select' or 'Register a New Client.'

Type the Social Security Number (SSN) with no spaces or hyphens; the Departmental Client Number (DCN) or the last and first name of the client separated by a comma (Example: Doe, Jane). **Do not click return – wait until drop down menu appears.**

If the screen returns more names than the screen will hold, use the scroll down bar to see the full screen. If there are more than 15 names on the screen use the double arrow at the bottom of the screen to proceed to the next search result screen.

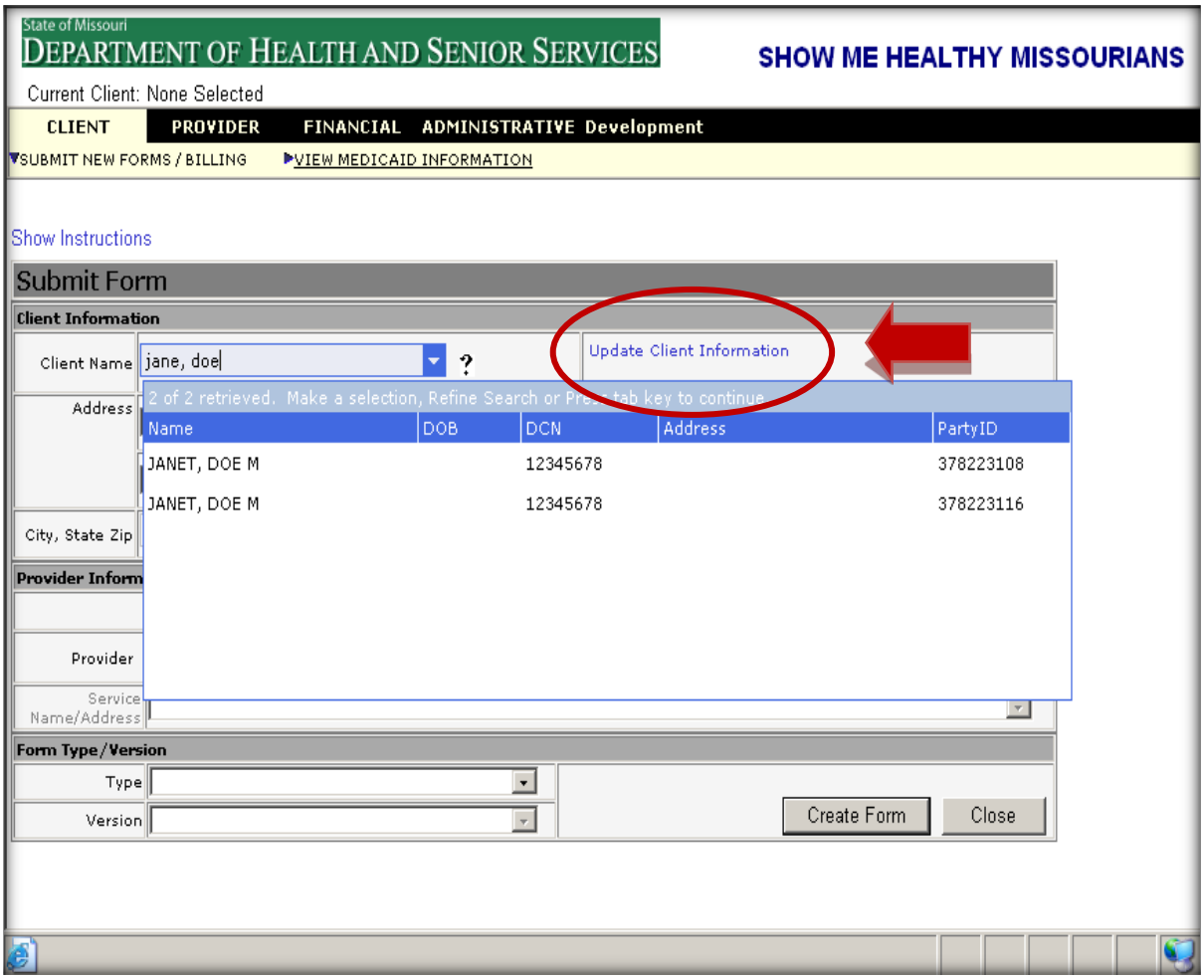


## *Searching for Current Client*

If the client name appears, then select the correct name by clicking on it. Verify the name by checking the date of birth (DOB) and DCN number, if available. The client may be in the system with multiple names. Choose the name of the client as she presents to you. If not available, select one and then correct with 'Update Client Information.'

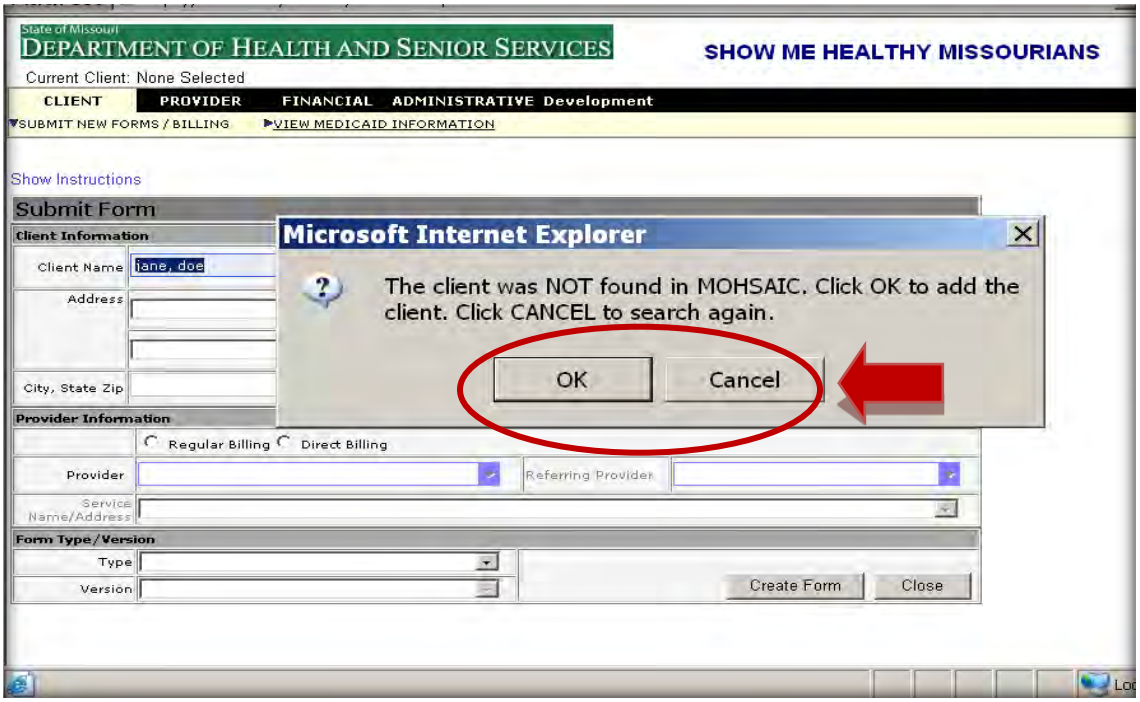
The client information screen will display the client demographic information. If any information is missing, add the correct information in the 'Update Client Information' screen.

If the client name is not in the database, this screen will say 'No Results Found'. Press the tab key to continue.

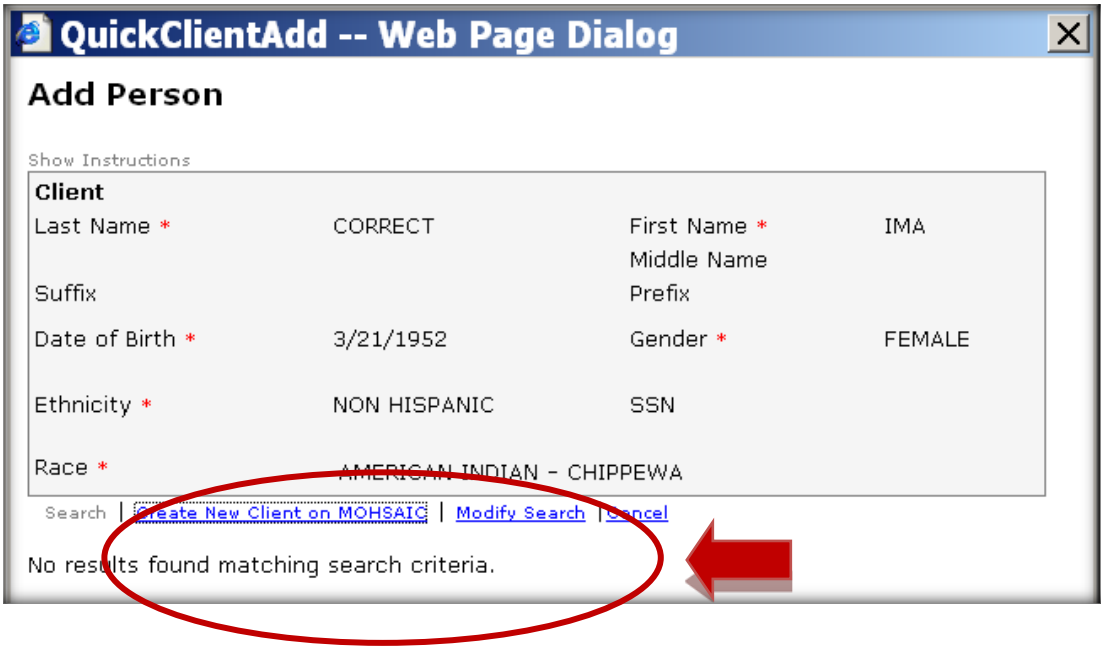


### *Adding a New Client*

If the client name does not appear, then hit the 'enter' or 'tab' key and the message to add a new client appears. Click the 'OK' button and proceed to the 'Add Person' screen.

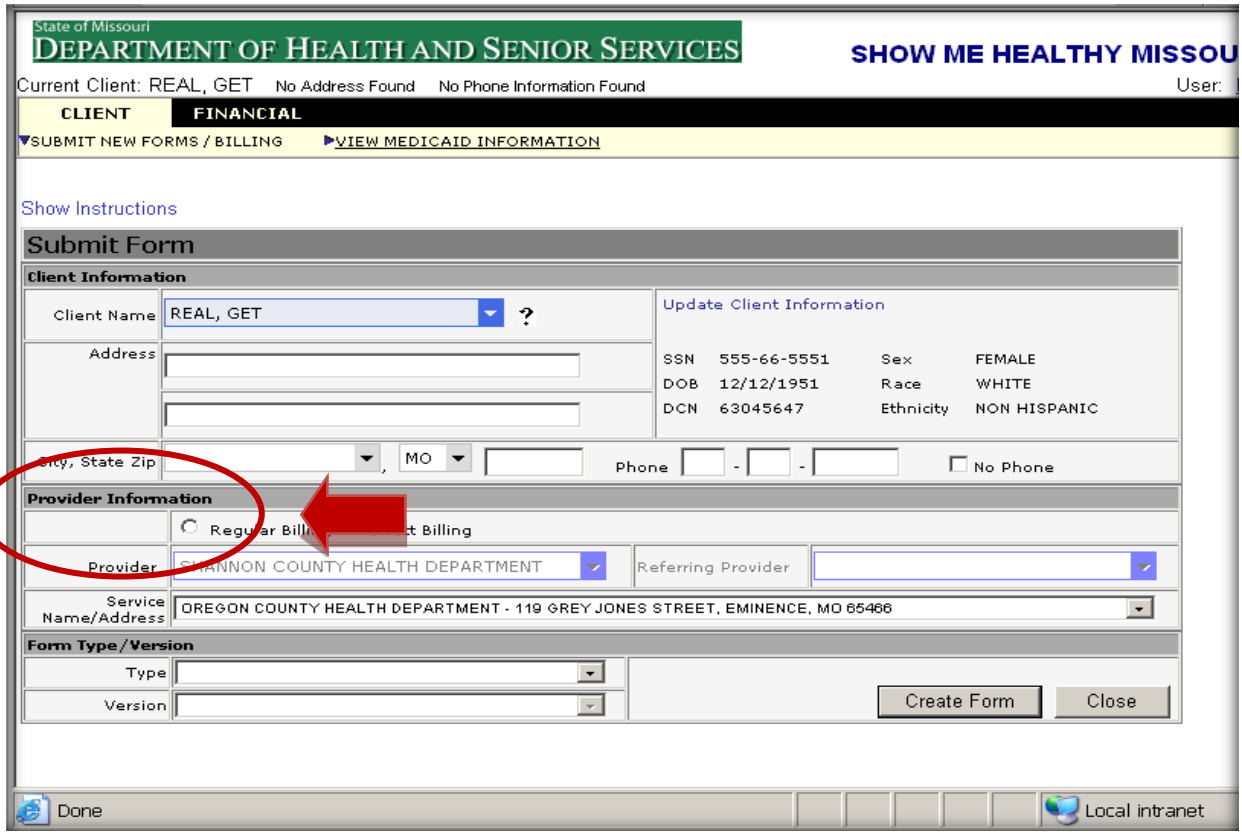



The search will check the MOHSAIC and DSS databases. If the client name is not in the system, the screen appears with the 'No results found matching search criteria.' Click the 'Create New Client on MOHSAIC' link.



## ADDING NEW CLIENT, CONTINUED

The 'Client Information' screen is displayed. The next step is to enter the address and telephone number. Then proceed to the 'Provider Information' section or view Medicaid information.



## *Address Verification*

If the system does not recognize the address, 'Address Verification' will pop up. If the address is correct, enter the county and click "save." Or, change the address to a valid address and click save.

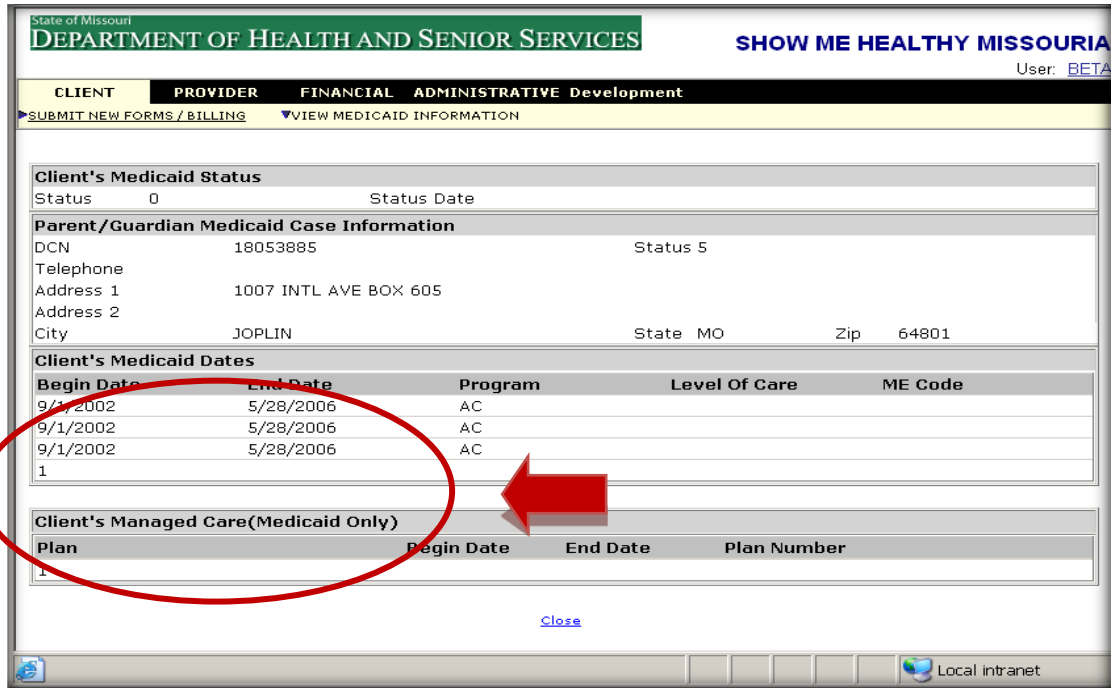
If the county and address match the database, the pop-up box will turn orange. If not, and both fields are correct, call SMHW at 866-726-9926 to request an address fix. Normally this fix will be done overnight.

## *Checking for Medicare/Medicaid*

If the client name is not on Medicaid, the screen will be empty. The 'View Medicaid Information' is transferred from the DSS database. **This screen is 'read only'**. The screen will display the current client at the top of the screen.

If a client name is displayed at the top of the screen and is on Medicaid, the screen will be filled in.

This screen shows all of the client and guardian (if applicable) information as well as the managed care information. If there is an open date but no close date, the client is on some sort of assistance.



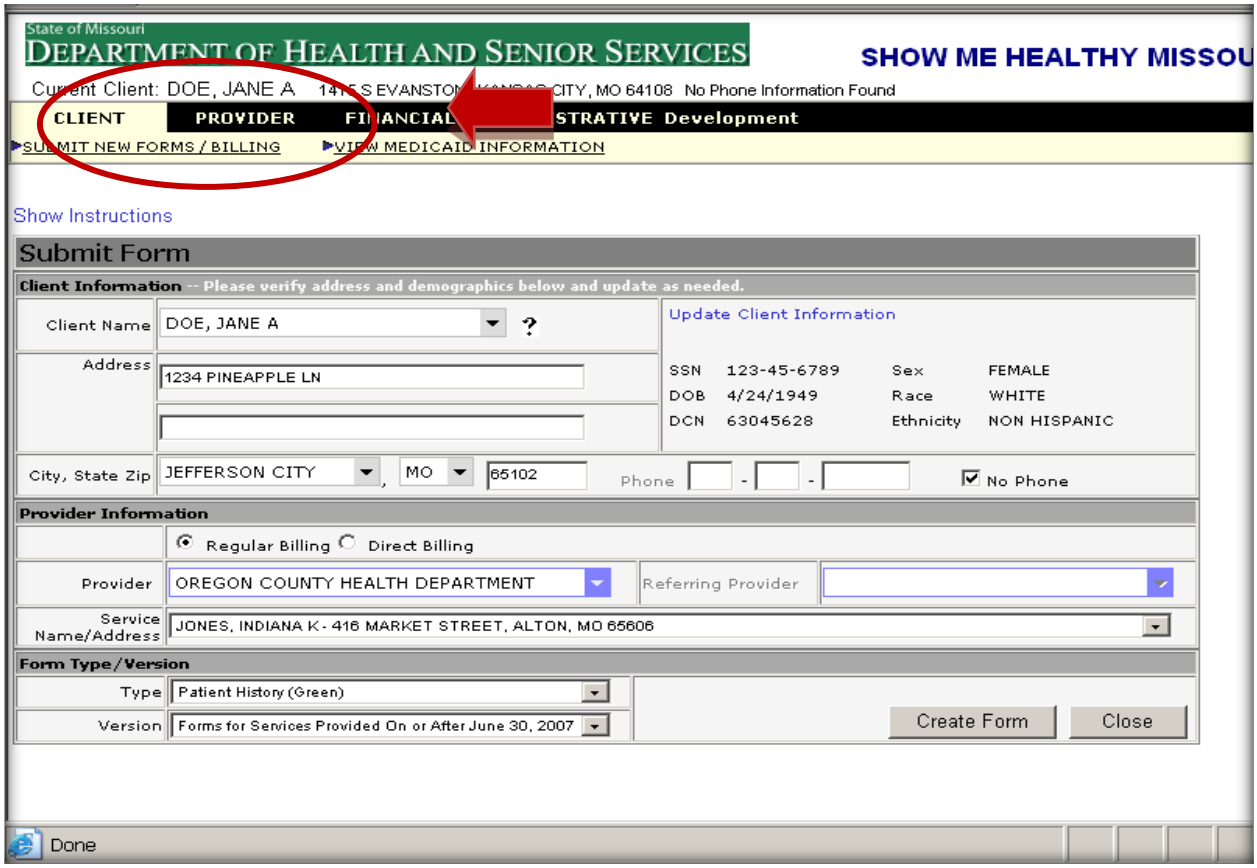

Please remember when pulling up or entering another client under client demographics, **verify** the client address and other personal information is correct. We have encountered several forms that were entered for a different client, but only the client name was changed. This leads to duplicate records in the system and results in errors on the data submitted to CDC. **Until a software programming change is complete, please make sure the date of birth and SSN are correct for the client form being entered.**

## *Entering Provider and Form Type Information*

On the 'Provider Information' section, select either 'Regular' or 'Direct Billing'. If 'Direct Billing' is selected, a referring provider must be entered. Type in the provider's name and select the appropriate provider. If 'Regular Billing' is selected, a referring provider is not necessary.

When entering information in this section is complete, proceed to the next section – 'Form Type/Version.'

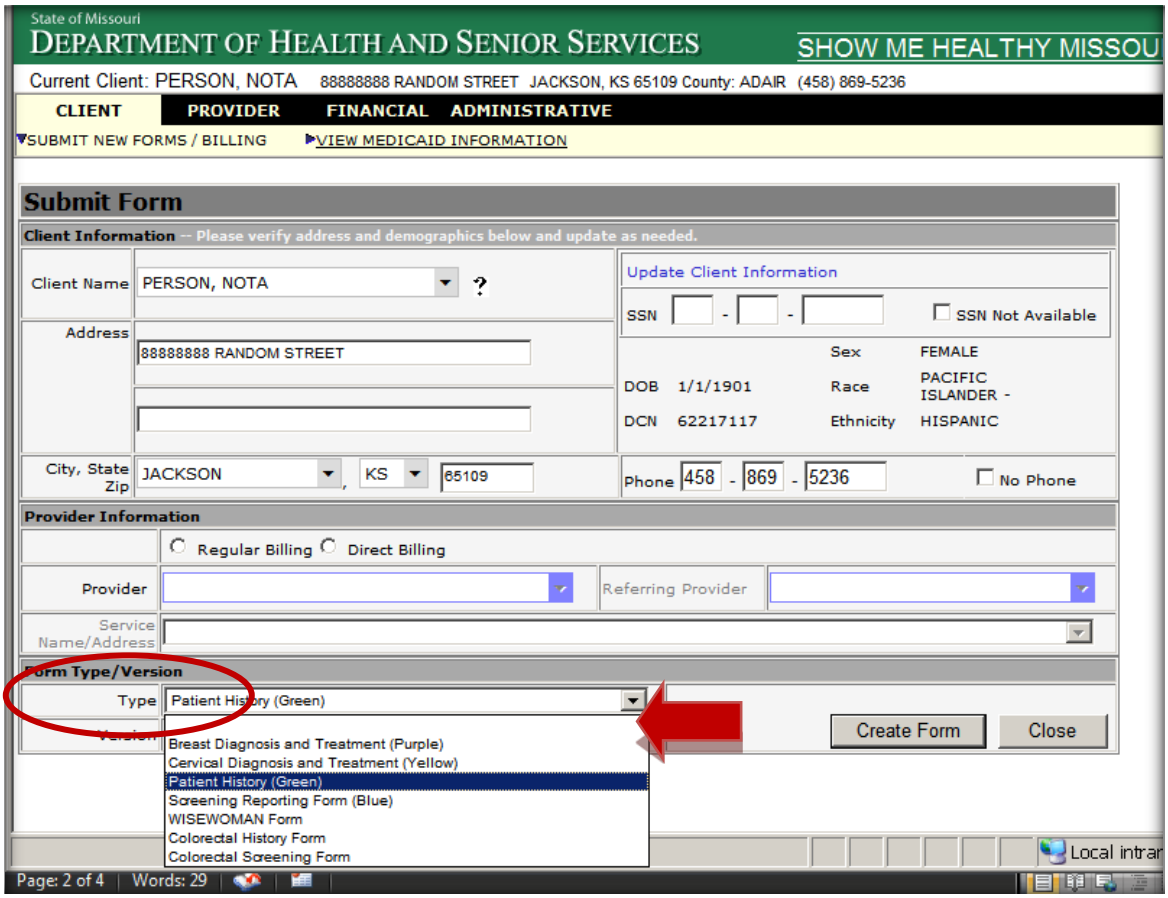
This screenshot has two points to consider. When a form is selected, the version will populate with available demographics. During the first few months of the new grant year, there could be multiple versions (such as current and previous grant year). By default, the software automatically selects the version based on the current date. To enter a form with a date of service from a previous grant year, select a different version from the 'current' version drop down box.



## ENTERING PROVIDER AND FORM TYPE INFORMATION CONTINUED

Under the gray heading, 'Form Type/Version', click on the correct form 'Type' for the submitted information:

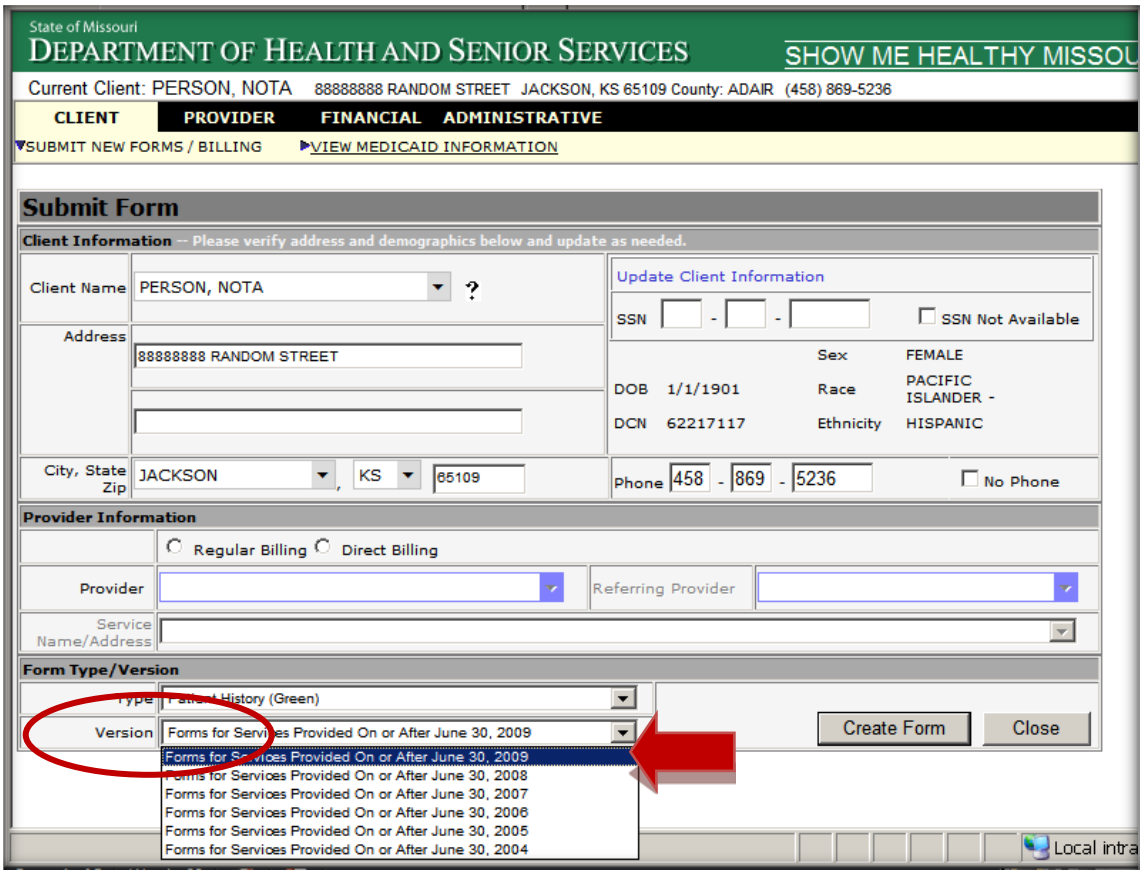
- Breast Diagnosis and Treatment (purple)
- Cervical Diagnosis and Treatment (yellow)
- Patient History (green)
- Screening Reporting Form (blue)
- WISEWOMAN Form (pink)



## ENTERING PROVIDER AND FORM TYPE INFORMATION CONTINUED

Click on the correct form 'Version': ('Forms for Services Provided On or After June 30, 20_ _.'). Dates must correspond with the service dates being submitted. Click on the correct form 'Version' for the submitted information:

Forms for Services Provided On or After June 30, 2018



## *Filling Out a Form*

The name is displayed before entering the data. The form on the screen is the same as the paper form. Fill in the form and click the 'Submit' button at the bottom of the screen to submit/save.

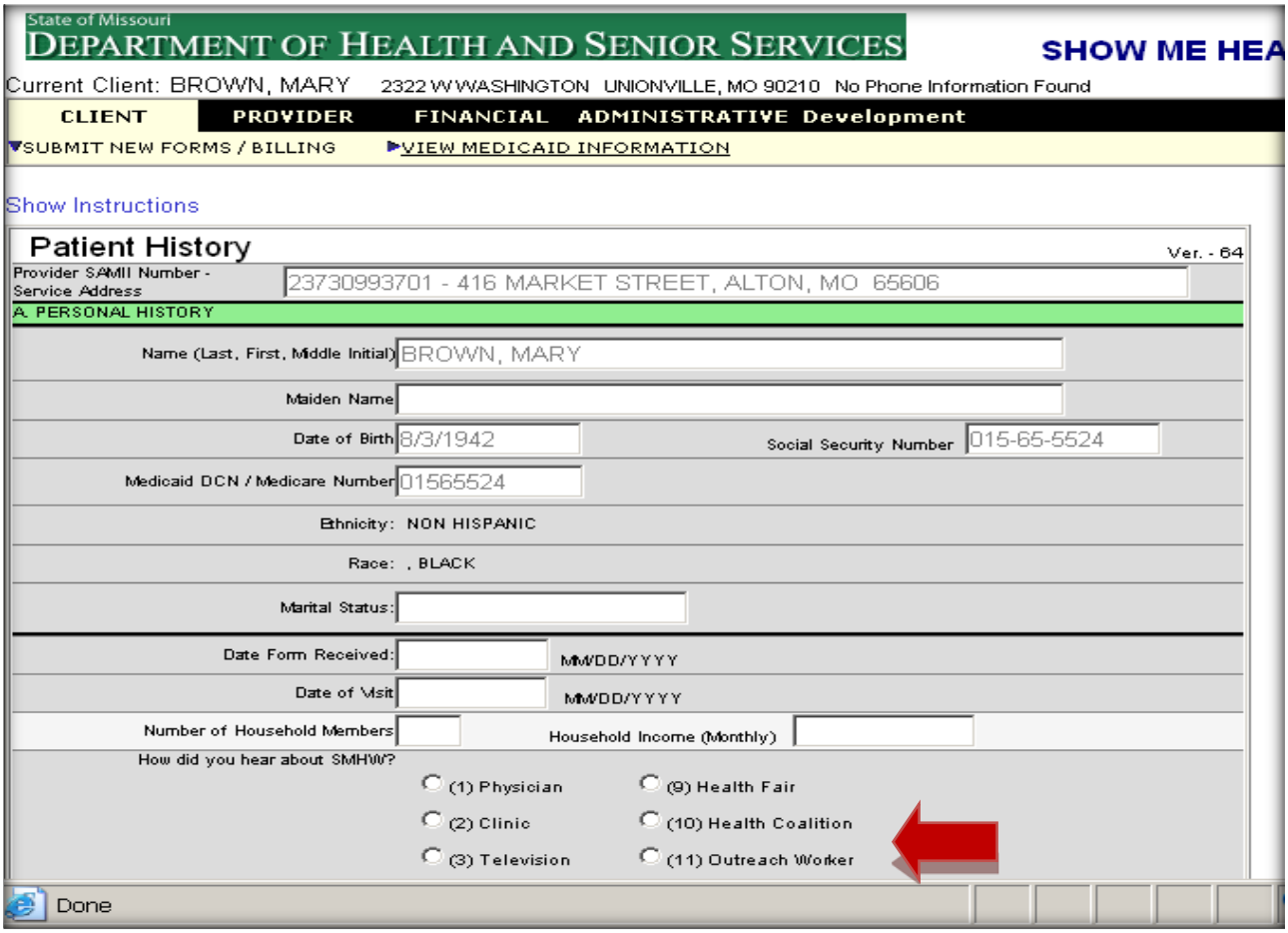
To fill in the forms use the mouse, tab key, or the space bar. To use the mouse, click on the drop down arrow and then select the appropriate choice. If using the mouse for buttons, just click inside the circle. All forms work the same way.

If content of the drop down box is known, then tab to the empty field and type the first letter. The word will appear.

Tab to the next field.

When tabbing and encountering a square radio button, hit the space bar to fill it in.

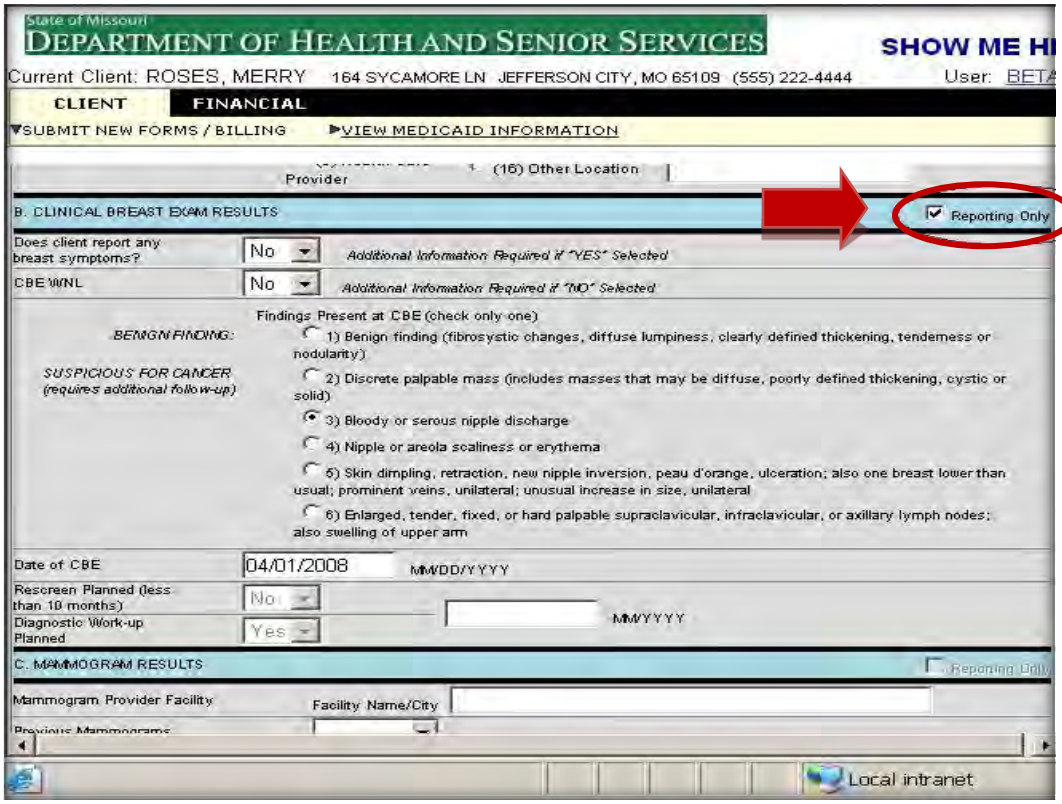
Tabbing to a radio button will automatically fill in the circle when highlighted.



## How to Complete 'Reporting Only' Process

EXAMPLE: A client who is eligible for SMHW diagnostic services is referred from an outside provider. The client has had a breast or cervical screening/diagnostic that is suspicious for cancer. Cancer diagnosis by a tissue biopsy is unconfirmed.

- Verify client eligibility
- Have client sign SMHW Client Eligibility Agreement form
- Complete green History form
- Enter data into MOHSAIC from green History form

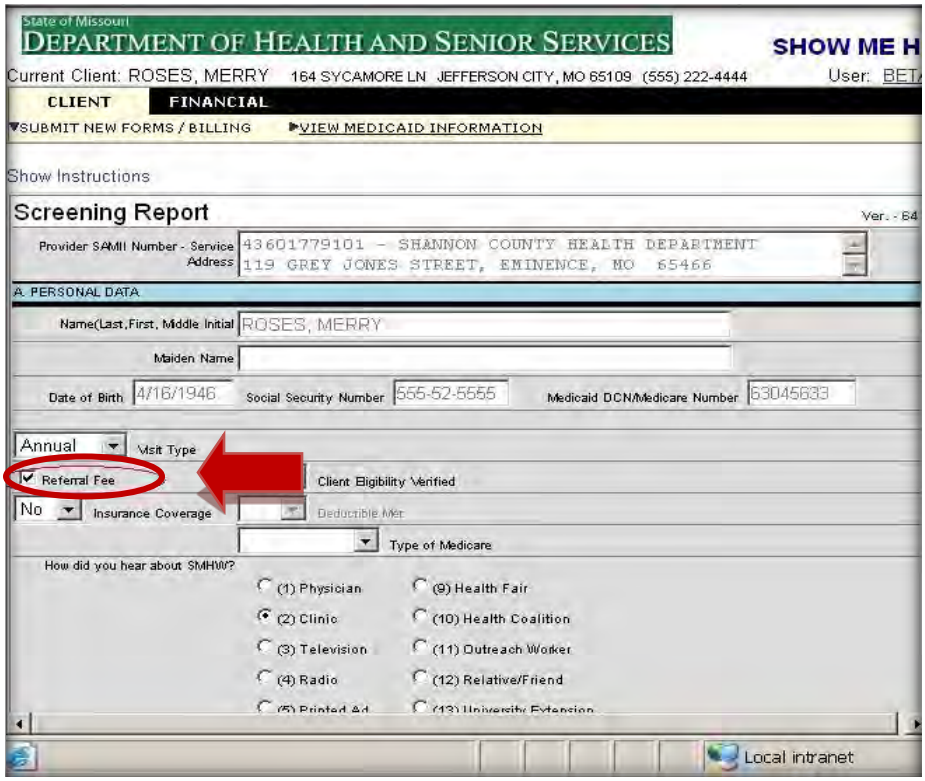


## SHOW ME HEALTHY WOMEN SCREENING REPORT FORM 'REFERRAL FEE'

If a SMHW provider performs additional breast/cervical procedures, enter the data and check the appropriate visit type.

If no SMHW screening services are provided by a SMHW provider, check the appropriate 'Visit Type' and check the 'Referral Fee' box if requesting the $20 referral fee. Provider reimbursement is for the referral fee only, not an office visit.

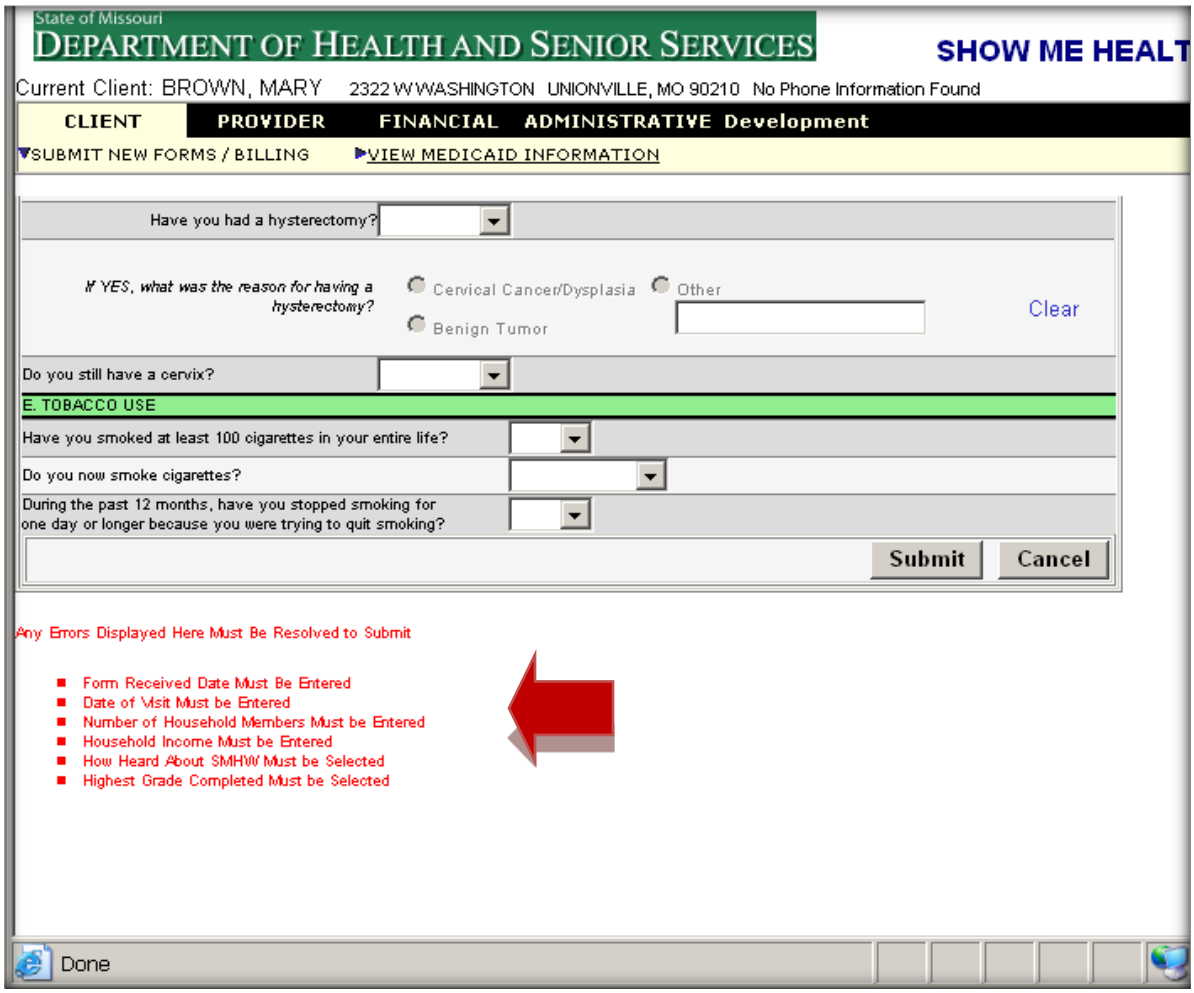
Report any other outside diagnostic procedures completed prior to enrollment on the appropriate diagnostic form as 'Reporting Only' and report SMHW follow-up procedures as usual.



An error message may appear at the bottom of the screen after the 'Submit' button is clicked. If this happens, the system will require form correction before proceeding. Upon form correction, click the 'Submit' button again and the system will proceed to the next screen.

After the successful submission of the form the 'Submit Form' screen will again be displayed. If you wish to continue with this client for additional forms, return to 'Submit New Form/Billing.'

To search for another client, type over the current name and the new search result screen will appear. Select the new SSN and the screen will refresh with the new client name and information.

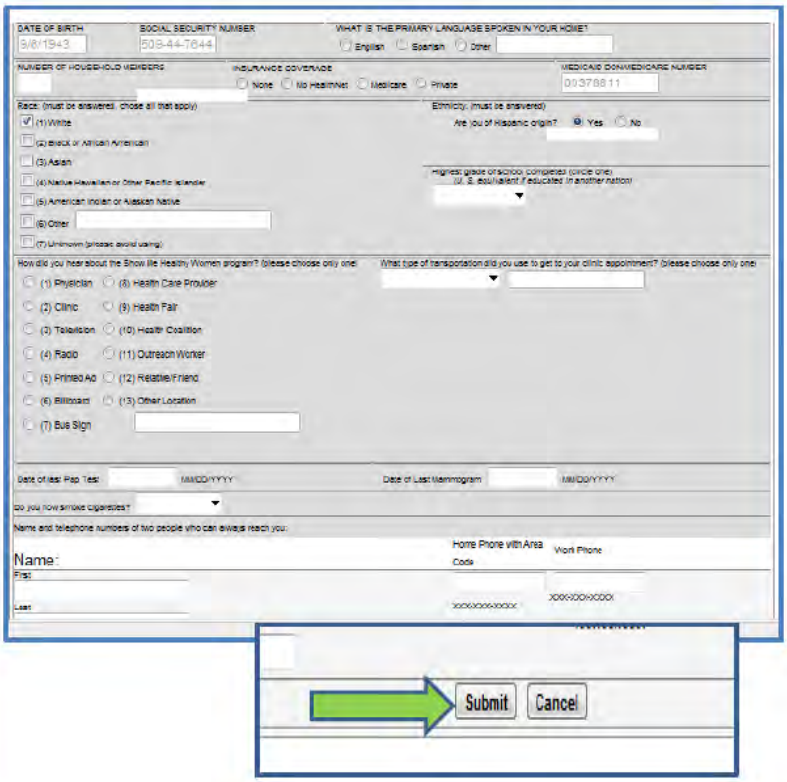


# SHOW ME HEALTHY WOMEN PATIENT HISTORY FORM (GREEN FORM) SUBMISSION

## Green History Form

- **The first form that needs to be entered in MOHSAIC with each annual screening.**
- Includes Demographic information, Ethnicity, Race, and other needed info. All areas of form need to be filled out.
- SSN is recommended but not required. Having a SSN to enter in MOHSAIC will prevent a duplicate record being created on the same client. SSN is required for Full BCCT Medicaid coverage.
- The item: *"Language Spoken in the Home" must be completed*
- *"Date of Last Mammogram" & "Date of Last Pap"* must be completed. An estimated date (month/yr) is fine.

Name, DOB, SSN, DCN, Address, and Phone number auto-populate into form. The rest of the info needs to be completed and then click Submit.

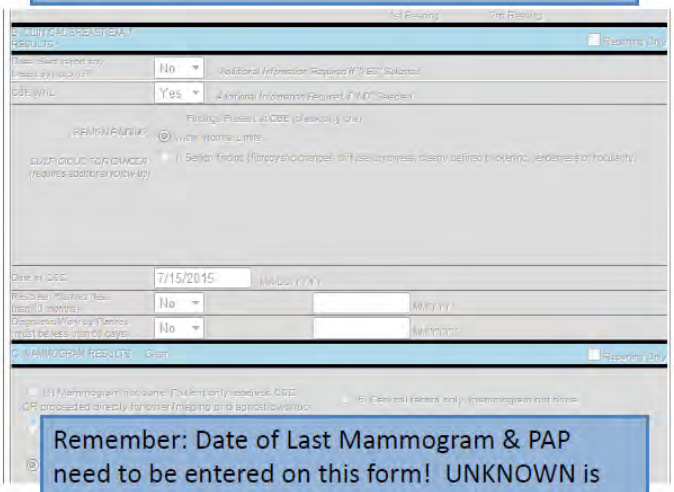


# SHOW ME HEALTHY WOMEN SCREENING FORM (BLUE FORM) SUBMISSION

## Blue Screening Form

- Enter Screening visit information from clinical well woman visit notes.
- Select VISIT TYPE:
  - Initial- (CBE & Pelvic done)
  - Annual-(CBE & Pelvic done)
  - Initial CBE only- (CBE only)
  - Annual CBE only- (CBE only)
- BSE- Client breast concerns
- CBE- clinical breast exam. Normal or Abnormal results
- Screening mammogram completed after the clinical breast exam always goes on Blue form.
- 6 month dx mammogram is entered on Blue Form.
- Pelvic exam results entered , if completed.
- PAP results entered, if client eligible for test per SMHW & ASCCP guidelines.
- A 6 month follow up diagnostic mammogram also goes on Blue form.

Provider name & address, Client name, date of birth, SSN, and DCN auto-populate into form. The rest of the info needs to be completed and then click Submit.

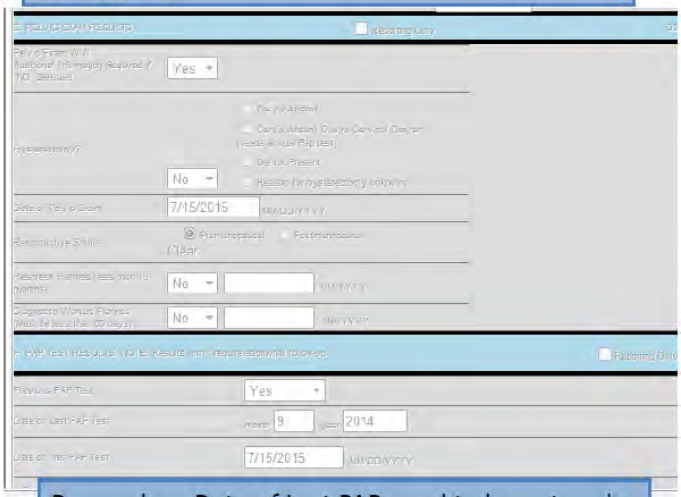


Remember: Date of Last Mammogram & PAP need to be entered on this form! UNKNOWN is NOT a good option. If client has abnormal result , Select YES –Dx Work up Planned. Fill in Mon/Yr (follow up needs to be completed within 60 days of Screening exam.

## Blue Screening Form cont.

- Enter Screening visit information from clinical well woman visit notes (cont.)
- Pelvic exam results entered , if completed.
- If Pelvic exam identifies an abnormal finding on the cervix, client may need further follow up with GYN specialist.
- Note if client is Premenopausal or Postmenopausal.
- PAP results entered, if client eligible for test per SMHW & ASCCP guidelines.

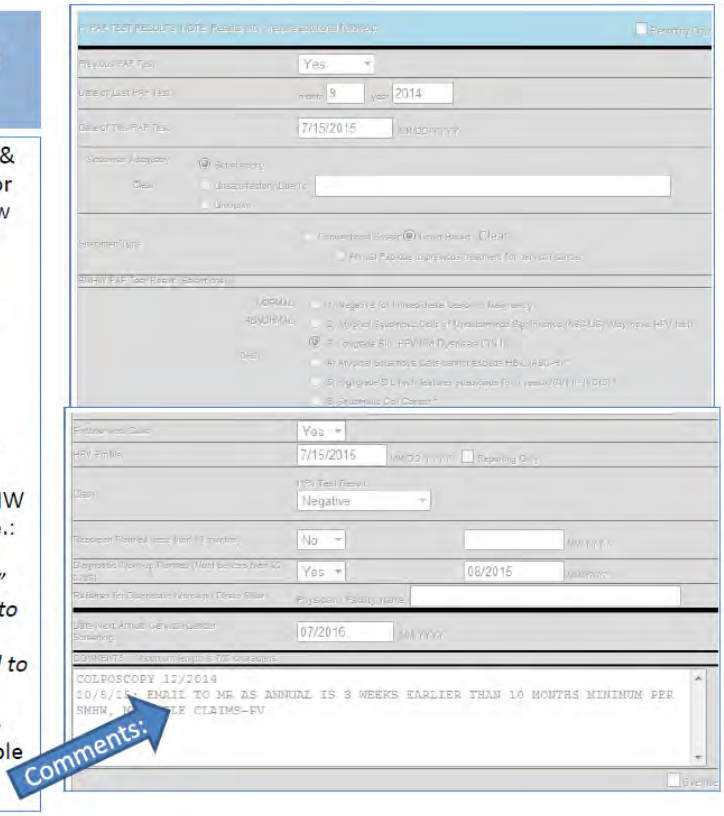
Pelvic section and PAP entered if completed during exam.



Remember: Date of Last PAP need to be entered on this form! UNKNOWN is NOT a good option. If client has abnormal result , Select YES –Dx Work up Planned. Fill in Mon/Yr (follow up needs to be completed within 60 days of Screening exam). Important: if client has had hysterectomy d/t cervical cancer, client is eligible for annual PAP.

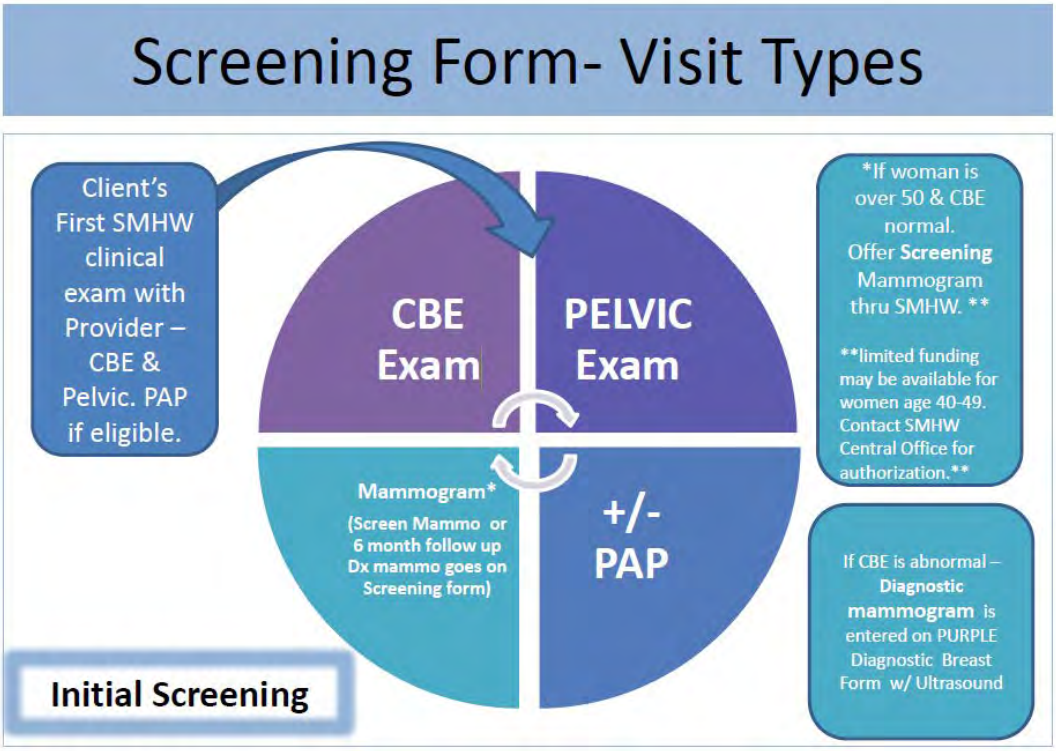
## Blue Screening Form cont.

- PAP - enter from lab results & note if EC cells are present or not. Abnormal results follow up per ASCCP guidelines.
- **An unsatisfactory PAP specimen is not payable by SMHW. **
- Enter HPV results, if completed.
- COMMENTS- type any additional information from screening CBE/Pelvic exam that may be helpful for SMHW program to be aware of. i.e.: *" Reporting only screening mammogram paid by BCFO" or "approved for BCLP fund to pay for screening mammogram" or "Referred to GYN for consult".*
- COMMENTS- also type who entered the form, for example *"entered by MRice".*

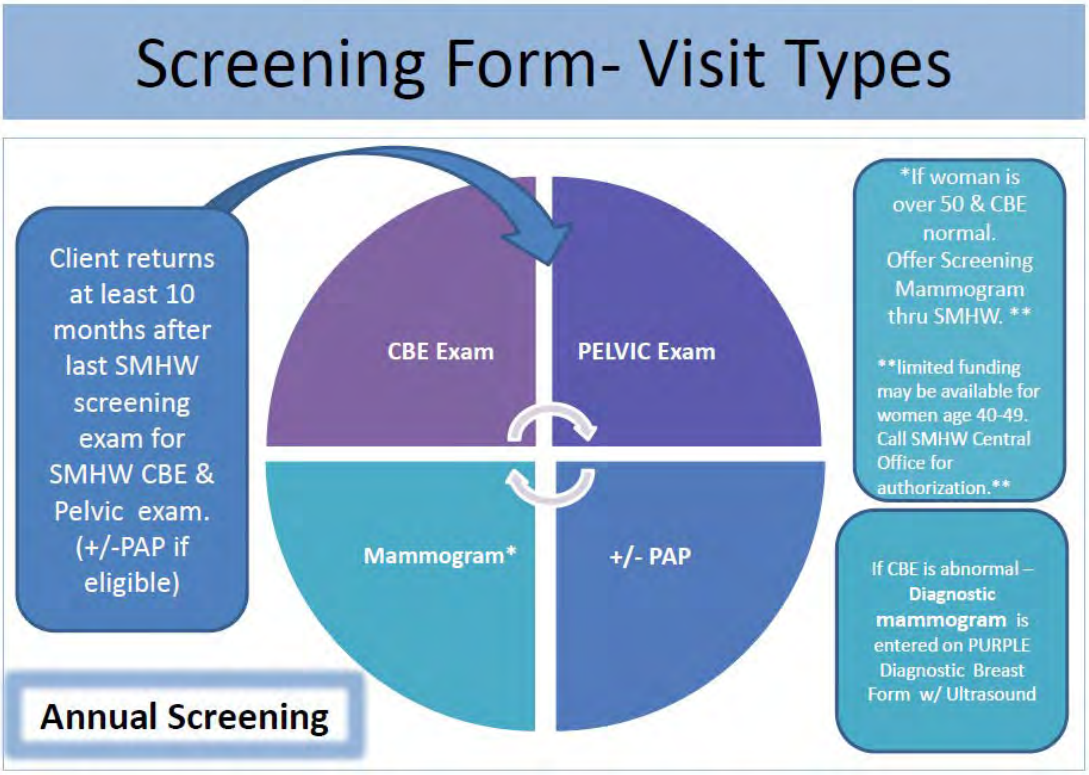



### *Blue Screening Form Visit Types*

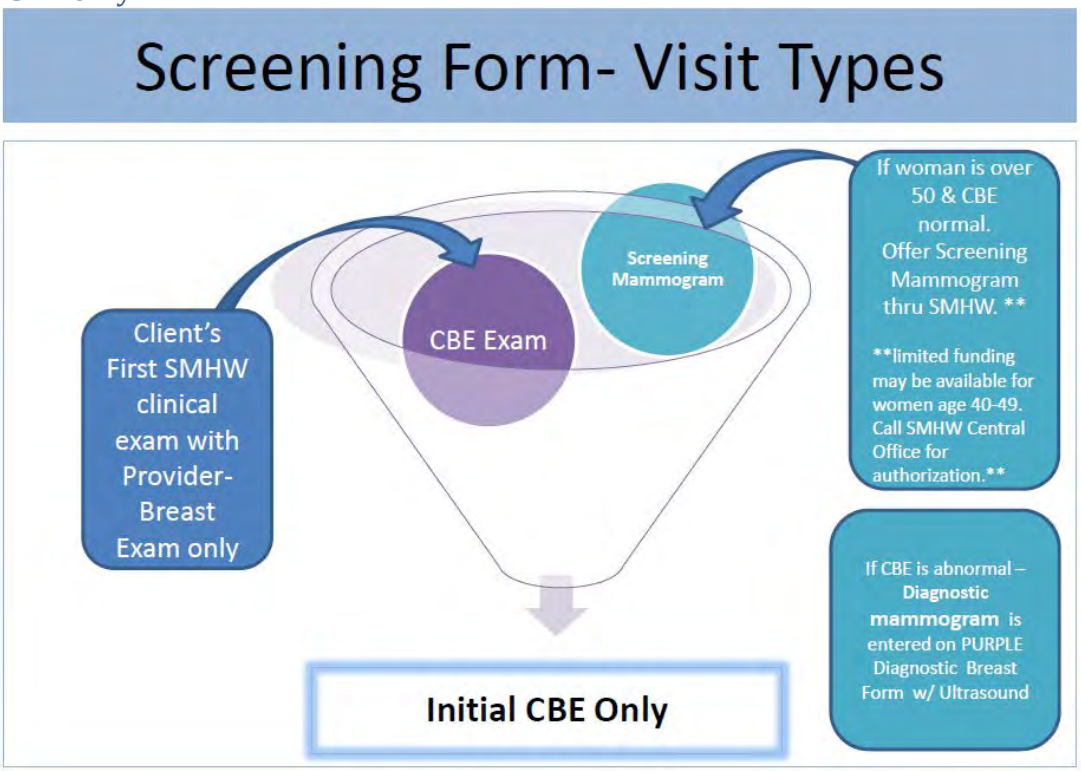
Initial Screening



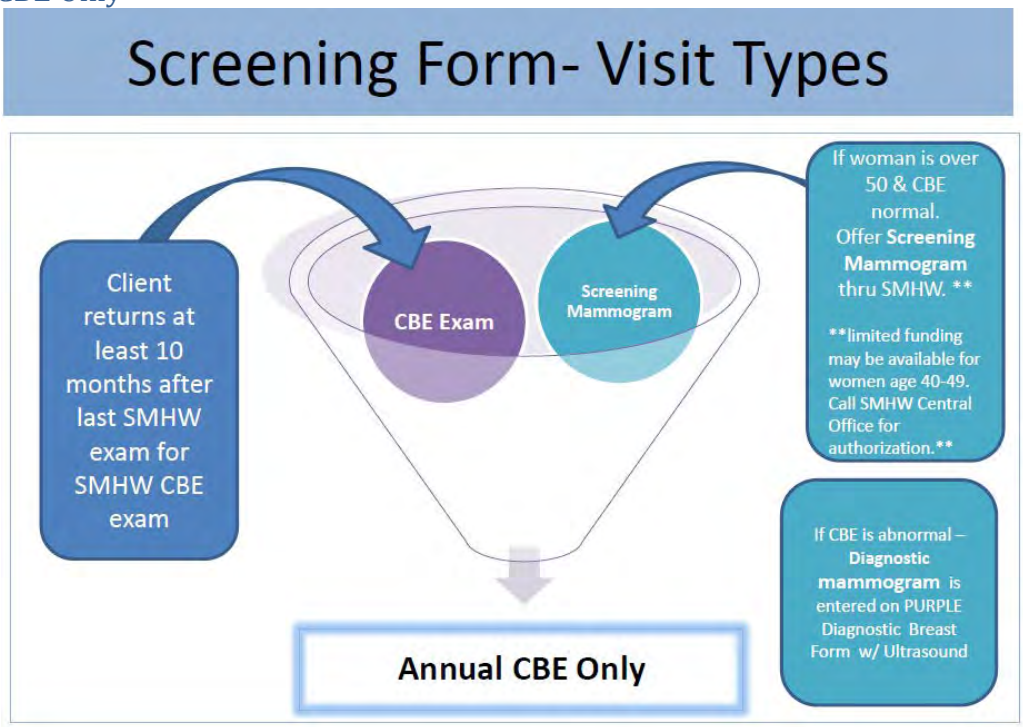
Annual Screening



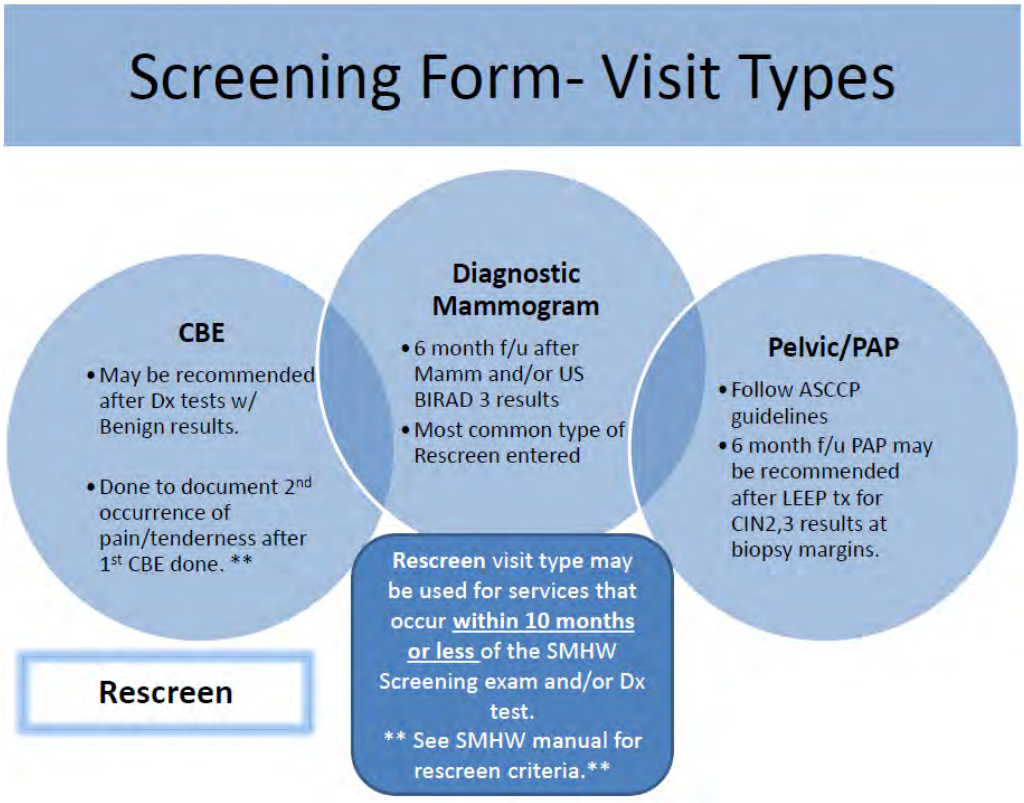

Initial CBE Only



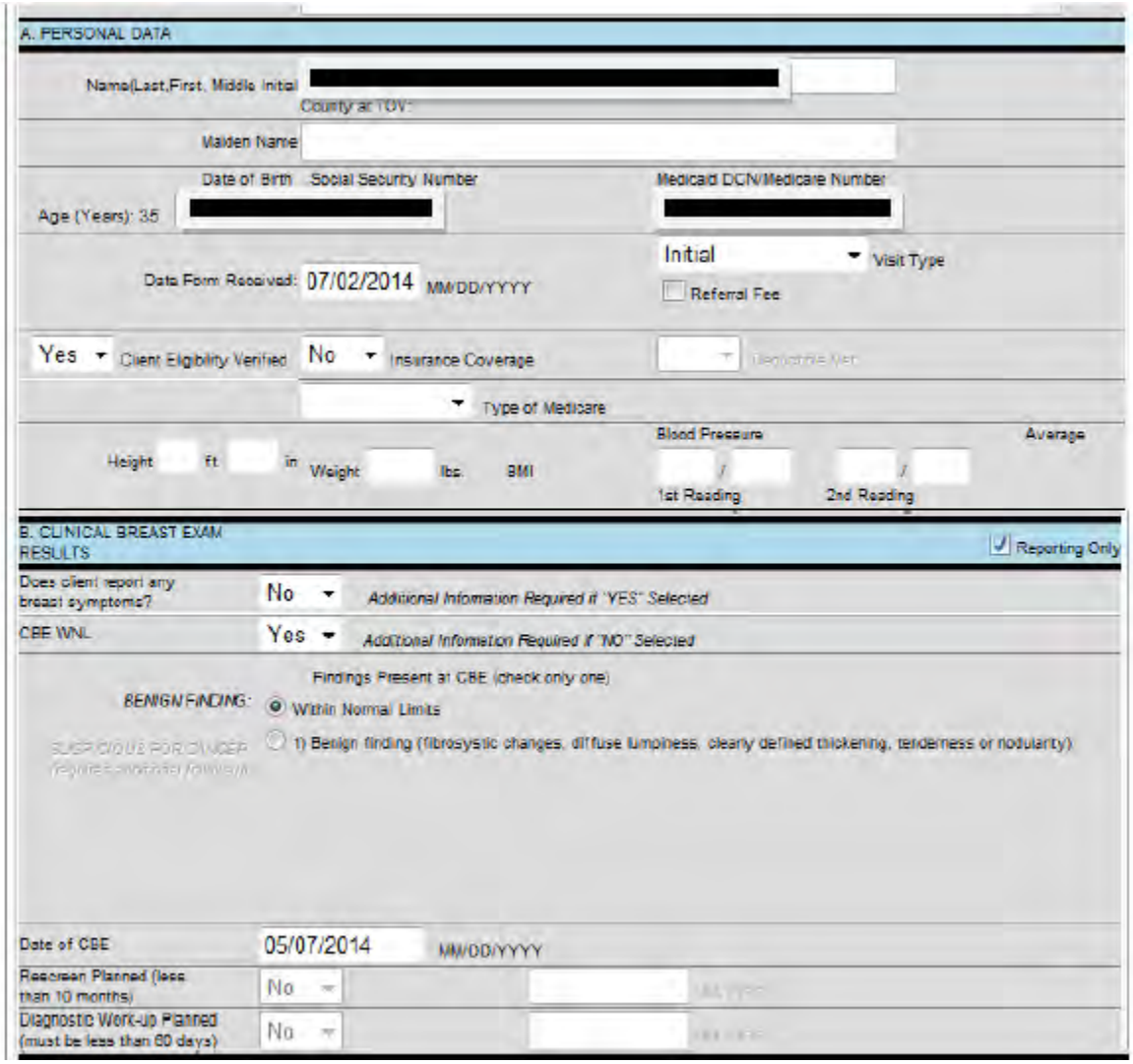
Annual CBE Only




Rescreen Visit



## *Screening Form (Blue Form) Reporting Only- Client with Abnormal PAP Referred to SMHW for Colposcopy*



C. MAMMOGRAM RESULTS Clear ☑ Reporting Only

- (4) Mammogram not done. Patient only received CBE OR proceeded directly for other imaging or diagnostic workup
- (1) Routine screening mammogram
- (2) Mammogram performed to evaluate symptoms:
  - Positive BSE
  - Positive CBE
  - Previous abnormal mammogram results (recorded)
- (5) Cervical record only, mammogram not done
- (6) Referred to Direct Biller for Mammogram
- (3) Abnormal mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation (Enter results in Mammogram field as Reporting Only)

Date Client Referred for diagnosis

Mammogram Provider Facility ☐ Mammogram Ver

Previous Mammograms

Date of Last Mammogram month / year

Date of This Mammogram MM/DD/YYYY

Type of Mammogram Screening / Diagnostic Clear
Gov't (enrolled) / Digital

BMMV Mammogram Result (Check one) LEFT RIGHT Clear

NORMAL
- 1 Negative (Category 1)
- 2 Benign Finding (Category 2)
- 3 Probably Benign (Category 3)

ABNORMAL
- 4 Suspicious Abnormality (Category 4)*
- 5 Highly Suggestive of Malignancy (Category 5)*

OTHER
- 6 Assessment Incomplete - Needs additional imaging evaluation (Category 0)*
- 11 Assessment Incomplete - Film composition required (Category 0)*

NOTE: Results will require additional follow-up

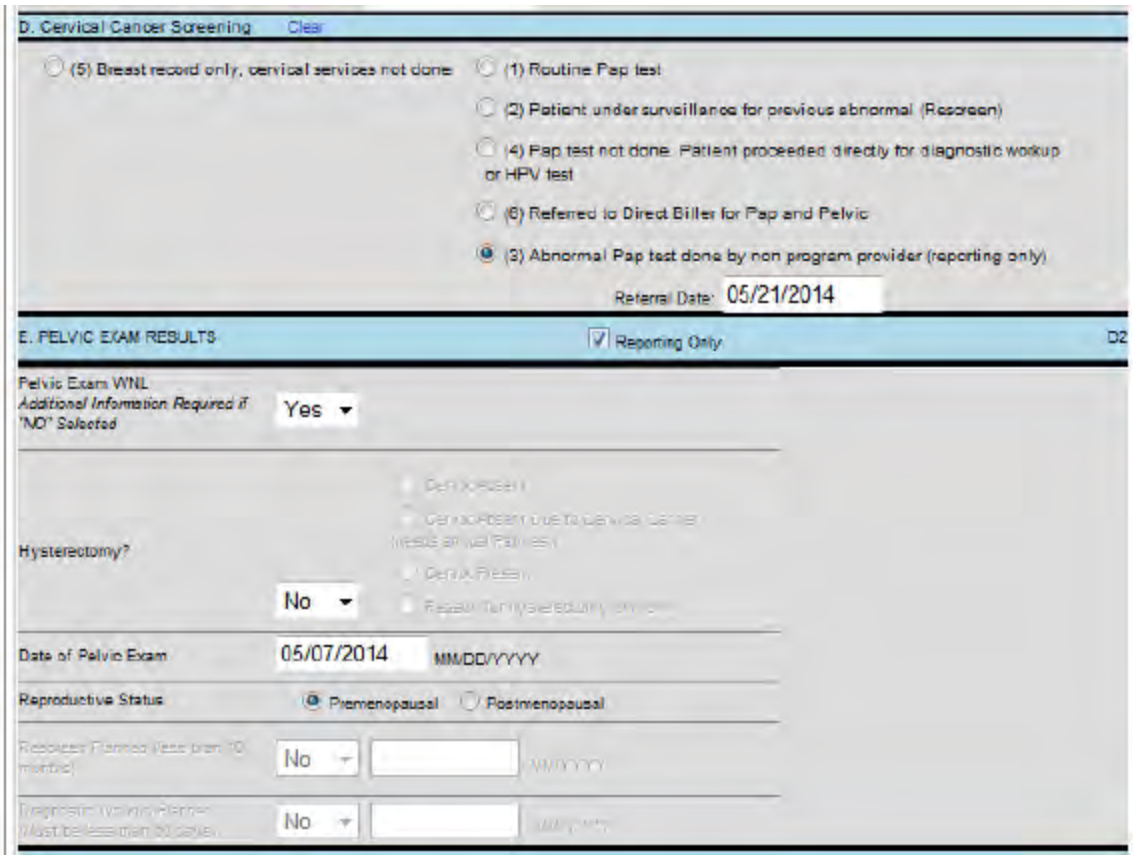
Mammogram Result Comment

Recheck Planned (less than 12 months) No MM/YYYY

Diagnostic Workup Planned (Must be less than 60 days) No MM/YYYY

Referral for Diagnostic Testing / Direct Biller Physician / Facility Name

Date Next Annual Breast Cancer Screening MM/YYYY


D. Cervical Cancer Screening
Clear
(5) Breast record only, cervical services not done
(1) Routine Pap test
(2) Patient under surveillance for previous abnormal (Rescreen)
(4) Pap test not done. Patient proceeded directly for diagnostic workup or HPV test
(6) Referred to Direct Biller for Pap and Pelvic
(3) Abnormal Pap test done by non program provider (reporting only)
Referral Date: 05/21/2014
E. PELVIC EXAM RESULTS
Reporting Only
D2
Pelvic Exam WNL
Additional Information Required if 'NO' Selected
Yes
Hysterectomy?
No
Date of Pelvic Exam
05/07/2014
MM/DD/YYYY
Reproductive Status
Premenopausal
Postmenopausal
No
No

F. PAP TEST RESULTS NOTE: Results with * require additional follow-up. ☑ Reporting Only

Previous PAP Test: Yes

Date of Last PAP Test: month 05 year 2013

Date of This PAP Test: 05/07/2014 MM/DD/YYYY

Specimen Adequacy
- ◉ Satisfactory
- ○ Unsatisfactory Due To:
- ○ Unknown

Clear

Specimen Type: ○ Conventional Smear ◉ Liquid Based Clear
- ○ Annual Pap due to previous treatment for cervical cancer

SMHW PAP Test Result (Select one)

NORMAL
- ○ (1) Negative for Intraepithelial Lesion or Malignancy

ABNORMAL
- ○ (2) Atypical Squamous Cells of Undetermined Significance (ASC-US) (May have HPV test)
- ◉ (3) Lowgrade SIL (HPV/MM Dysplasia/CIN I)
- ○ (4) Atypical Squamous Cells cannot exclude HSIL (ASC-H) *
- ○ (5) Highgrade SIL (with features suspicious for invasion/CIN II-III/CIS) *
- ○ (6) Squamous Cell Cancer *
- ○ (7) Atypical Glandular Cells (including atypical endocervical adenocarcinoma in SITU and adenocarcinoma) *

Clear

OTHER
- ○ (9) Other

Endocervical Cells: Yes

HPV Profile: 05/07/2014 MM/DD/YYYY ☑ Reporting Only

Clear

HPV Test Result: Positive(High Risk)

Rescreen Planned (less than 10 months): No MM/YYYY

Diagnostic Work-up Planned (Must be less than 90 days): Yes 06/2014 MM/YYYY

Referred for Diagnostic Work-up / Direct Biller: Physician / Facility Name

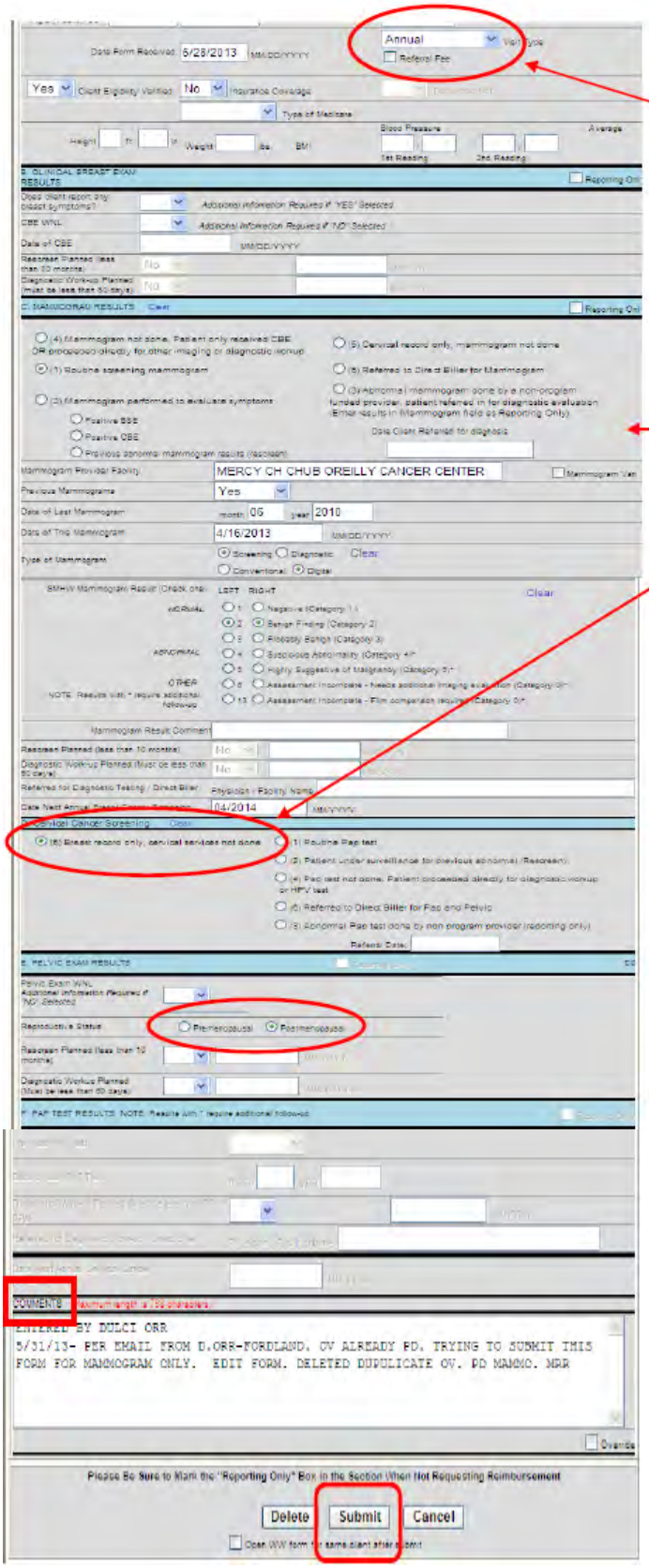
Date Next Annual Cervical Cancer Screening: MM/YYYY

COMMENTS Maximum length is 760 characters.

CLIENT REFERRED TO SMHW FOR COLPO ON 5/21/14 AFTER SHE TURNED 35 YEARS OLD ON 5/11/14. PAP WAS DONE THRU ANOTHER FUNDING SOURCE.

☐ Override

## *Screening From (Blue Form) Mammogram Only*




To enter a Mammogram alone:

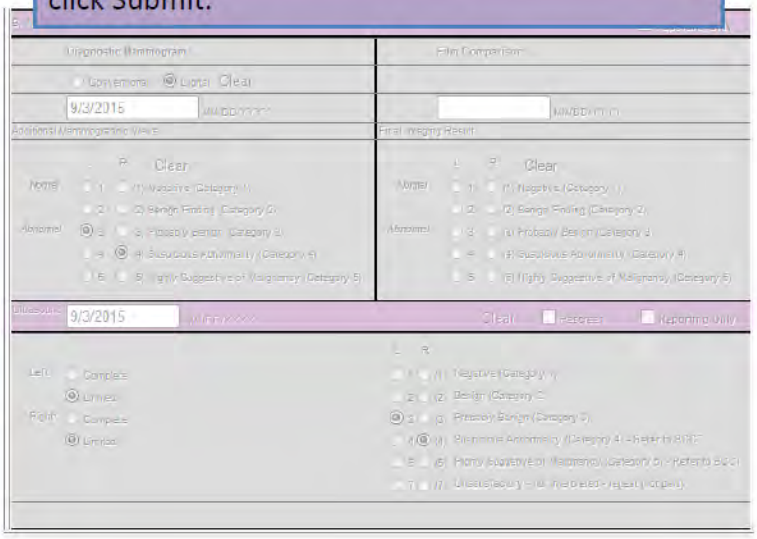
1) Select Visit type: **Annual** (if mammogram follows a SMHW office visit) or **Rescreen** (if mammogram is 6 month follow up.) Complete *Client Eligibility Verified* & *Insurance Coverage* drop down boxes. Leave the rest of the info (ht, wt, etc) blank.
2) Skip section B
3) Go to Section C- Mammogram Results. Enter mammogram info & results.
4) Go to Section D- Select (5) *Breast record only, cervical services not done.*
5) Skip sections E & F
6) You may have to select – Post menopausal in the *Reproductive Status* (Section F) to get the form to submit. Otherwise…
7) Scroll to bottom of the blue form and enter any **Comments** needed.
8) Hit the **Submit** button.

# SHOW ME HEALTHY WOMEN BREAST FORM (PURPLE FORM) SUBMISSION

## Purple Breast Form

- Diagnostic mammogram after abnormal CBE or follow up to BIRAD 0 screening mammogram is entered on this form.
- Ultrasound results entered
- Biopsy results entered, if applicable. (most of the time, biopsy paid by BCCT & entered as "Reporting only").
- Final Dx/Work up Complete entered , or
- If Dx work up not completed- Lost to Follow up entered. ** Need specific contact attempt dates/type.** RPC must be notified after at least 2 attempts to contact client are unsuccessful.
- Treatment start date, type, treatment facility entered if client diagnosed with Breast Cancer.

Provider name & address, Client name, date of birth, SSN, and DCN auto-populate into form. The rest of the info needs to be completed and then click Submit.

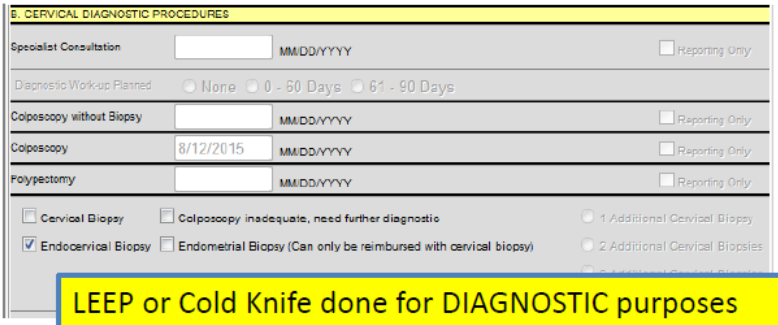



Date of BIRAD 4 or 5 US to Date of Bx must be less than 60 days.
If diagnosed with breast cancer, client should also start treatment within 60 days of biopsy date.
Enter any info regarding BCCT submissions and dx/tx follow up scheduled in COMMENTS.

# SHOW ME HEALTHY WOMEN CERVICAL FORM (YELLOW FORM) SUBMISSION

## Yellow Cervical Form

- GYN Specialist Consult may be completed for abnormal Pelvic exam results noted at screening exam.
- Colpscopy entered for abnormal PAP results (follow ASCCP guidelines)
- Polypectomy (Cervical biopsy) entered for removing suspicious cervical polyp.
- Final Dx/Work up Complete entered & Final Dx date, or
- If Dx work up not completed- Lost to Follow up entered. ** Need specific contact attempt dates/type.** RPC must be notified after at least 2 attempts to contact client are unsuccessful.
- Treatment start date, type, treatment facility entered if client diagnosed with CIN2, CIN3 or Invasive Cervical Cancer.




LEEP or Cold Knife done for DIAGNOSTIC purposes requires Prior Authorization from SMHW- Contact your RPC. LEEP/Cold Knife are typically Treatment after Colposcopy Dx of CIN2,3 results.


If client has biopsy pathology dx of CIN2, CIN3 or Invasive Cervical Cancer- submit BCCT app. Client should also start treatment within 60 days of colposcopy/polypectomy biopsy date. Enter any info regarding BCCT submissions and dx/tx follow up scheduled in COMMENTS.