



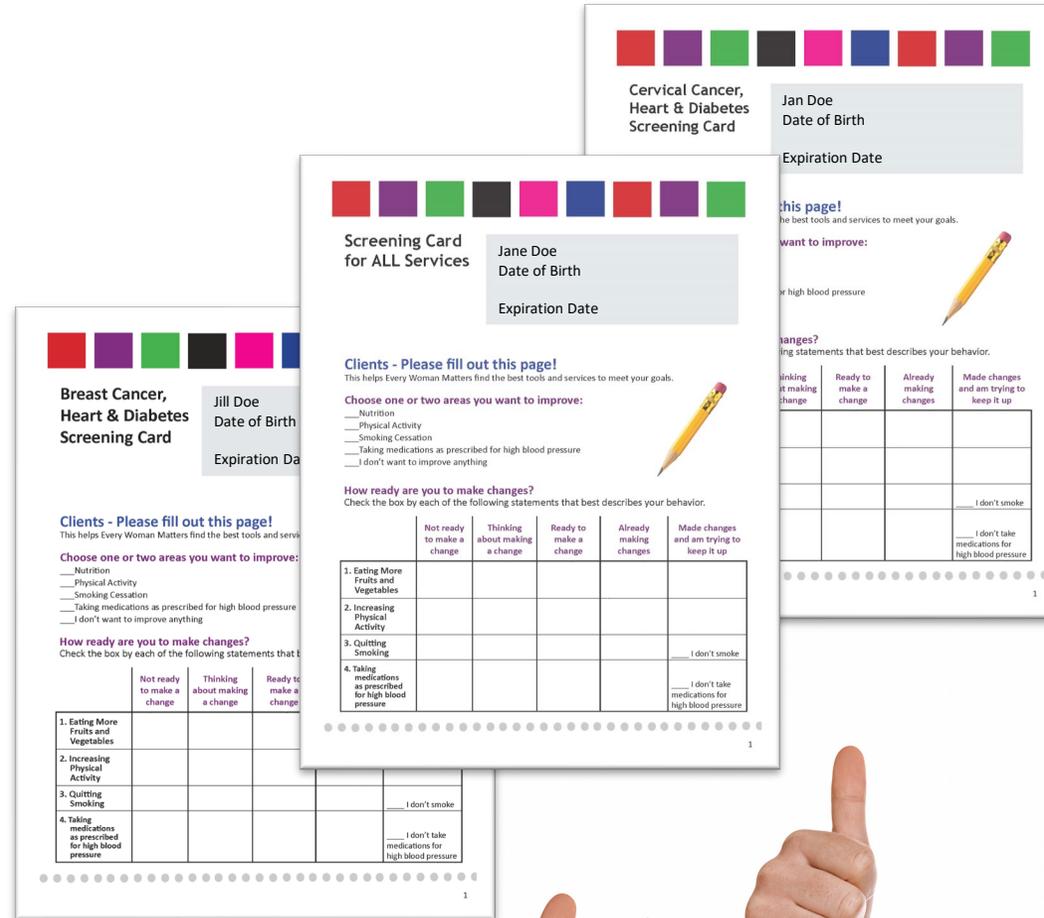
# SCREENING CARDS

and what to do with them

EVERY WOMAN MATTERS

# A client comes in to the office with her screening card...

- ▶ Clients that bring in their screening card have been approved to receive services that can be reimbursed through the Every Woman Matters Program
- ▶ Each client's card is tailored to the services they are eligible for at the time of their enrollment
- ▶ It is the provider's responsibility to fill out the card and return it to the program



# How Eligibility for Services is Determined

USPSTF Screening Guidelines	
<b>Cervical Cancer</b>	<b>Breast Cancer</b>
<b>Women 21-29</b> <b>Grade: A</b> Screen with cytology (Pap smear) every 3 years.	<b>Women aged 50 to 74 years</b> <b>Grade: B</b> Biennial screening mammography for women aged 50 to 74 years.
<b>Women 30-65</b> <b>Grade: A</b> Screen with cytology every 3 years or co-testing (cytology/HR-HPV testing) every 5 years or screen every 5 years with HR-HPV alone.	<b>Women aged 40 to 49 years</b> <b>Grade: C</b> The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.
<b>Colon Cancer</b>	
<b>Men and Women 45-74</b> <b>Grade: B</b> Screening for Colon Cancer with any of the following tests: <ul style="list-style-type: none"> <li>• FOBT/FIT Annually*</li> <li>• Colonoscopy every 10 years *</li> </ul>	
<i>Other approved tests by USPSTF: <a href="https://www.uspreventiveservicestaskforce.org/Page/Document/Recommendation-StatementFinal/colorectal-cancer-screening2">https://www.uspreventiveservicestaskforce.org/Page/Document/Recommendation-StatementFinal/colorectal-cancer-screening2</a></i>	
<i>*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.</i>	

## Eligibility criteria to receive services allowed through EWM is based on:

- ✓ Age
- ✓ Personal and Family Health History
- ✓ Client Self-Reported Screening History
- ✓ Previous screening history documented through EWM
- ✓ U.S. Preventive Services Screening Task Force (USPSTF) Guidelines  
[www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org)

In the event that the client incorrectly self-reported or the provider believes that they are at increased risk and should be screened for a service deemed ineligible, please contact EWM at 1-800-532-2227

# General Rules

## All Services Screening Card

PROVIDER NOTE: In order to receive reimbursement, all sections must be completed.

<p><b>General Clinical Services</b></p> <p>Height: (with shoes off) _____ / _____ ft./in.          Weight: _____ lbs.          Waist Circumference: _____ inches          Hip Circumference: _____ inches</p> <p><b>Note-2 blood pressure readings are required for this visit.</b>          Blood Pressure (1): _____ / _____ mm Hg          Blood Pressure (2): _____ / _____ mm Hg</p> <p>1. Is the client taking blood pressure medication? <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>2. Are you ordering or changing blood pressure medication today? <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <p>3. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227          *Counsel client on medication adherence for hypertension and check the last box in the section below.</p> <p><b>Cardiovascular Risk Reduction Counseling</b></p> <p>Refer to the questions on the front of this card. Check if counseling completed.</p> <p><input type="checkbox"/> Nutrition Counseling  <input type="checkbox"/> Physical Activity Counseling  <input type="checkbox"/> Tobacco Cessation Counseling  <input type="checkbox"/> Client Referred to Statewide Quitline at 1-800-QUIT-NOW  <input type="checkbox"/> Fax Referral to Statewide Quitline at 1-800-QUIT-NOW  <input type="checkbox"/> Client Refused</p> <p><input checked="" type="checkbox"/> Medication Adherence for Hypertension Counseling</p> <p><i>Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.</i></p>	<p><b>CVD/Diabetes Screening</b></p> <p><i>Labs can only be done in conjunction with breast and/or cervical screening services.</i></p> <p>Bloodwork Ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No          Blood Draw Date: _____ / _____ / _____  <i>Blood draw needs to be within 30 days of today's visit</i></p> <p><i>Cholesterol does NOT need to be fasting.</i>          Total Cholesterol: _____ mg/dl          HDL (value not ratio): _____ mg/dl          LDL (value not ratio): _____ mg/dl          Triglycerides: _____ mg/dl</p> <p><b>ALL clients are now eligible for A1c!</b>          A1c (preferred): _____</p> <p>OR</p> <p>Blood Glucose: _____ mg/dl          Client fasted 9 hrs <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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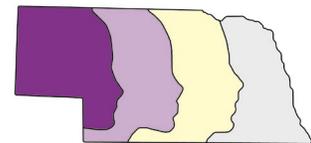
PROVIDERS: Please check the appropriate box in the screening pap and mammography section.

<p><b>Screening Pap</b></p> <p>Pap test performed (place red &amp; white EWM sticker on lab requisition)  <input type="checkbox"/> Co-testing with HPV performed  <input type="checkbox"/> No co-testing performed</p> <p>Pap test not ordered (if not performed, mark or list reason)  <input type="checkbox"/> Hysterectomy (with cervix removed) not due to cervical cancer  <input type="checkbox"/> _____</p> <p><b>Pelvic Exam</b></p> <p>Finding:  <input type="checkbox"/> Negative/Benign  <input type="checkbox"/> Visible Suspicious CERVICAL lesion  <input type="checkbox"/> Not Performed</p>	<p><b>Mammography</b></p> <p><input type="checkbox"/> Mammogram ordered (Give client Mammography Order Form)  <input type="checkbox"/> Mammogram not ordered (if not performed, mark or list reason:  <input type="checkbox"/> Not age appropriate  <input type="checkbox"/> Client not at risk (client 40-49)  <input type="checkbox"/> Other _____</p> <p><b>Clinical Breast Exam</b></p> <p><input type="checkbox"/> Client reports breast symptoms</p> <p>Finding:  <input type="checkbox"/> Negative/Benign  <input type="checkbox"/> Suspicious for BREAST Malignancy (Immediate follow up is required beyond mammogram)  <input type="checkbox"/> Not Performed</p>
<p><b>Colon Cancer Screening</b></p> <p>The client has already been screened through the NCP:  <input type="checkbox"/> Client is 50-74 and was sent a FOBT kit with this card  <input type="checkbox"/> Client is 50-74 and NCP is working with client to schedule a colonoscopy  <input type="checkbox"/> NCP is requesting additional information.  <input type="checkbox"/> Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.</p> <p><b>CLINICIAN:</b>          Discussed with client the importance of:  <input type="checkbox"/> Completing the FOBT kit at home  <input type="checkbox"/> Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"</p> <p><b>Reminders to Clinician:</b></p> <ul style="list-style-type: none"> <li>Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.</li> <li>NCP is a screening program NOT a diagnostic program.</li> </ul>	<p><b>**MUST be an approved contracted provider to receive reimbursement.</b></p> <p>Date of Service for Office Visit _____</p> <p>Clinician Name (PRINT full name-do not abbreviate) _____</p> <p>Clinic Name (PRINT full name-do not abbreviate) _____</p> <p>City _____</p>

- Clients are eligible to receive services listed on pages 2 – 3
- Pages 2 – 3 are tailored to the eligibility of each client
- In order to receive reimbursement for the screening, all sections must be completed
- You must complete the *Cardiovascular Risk Reduction Counseling* section in the bottom half of the *General Clinical Services* section in addition to recording height, weight and **two** blood pressure readings to be reimbursed for risk-reduction counseling

# Screening Cards Explained

*Every Woman Matters*





### Screening Card for ALL Services

Jane Doe  
Date of Birth \_\_\_\_\_  
Expiration Date \_\_\_\_\_

#### Clients - Please fill out this page!

This helps Every Woman Matters find the best tools and services to meet your goals.

#### Choose one or two areas you want to improve:

- Nutrition
- Physical Activity
- Smoking Cessation
- Taking medications as prescribed for high blood pressure
- I don't want to improve anything



#### How ready are you to make changes?

Check the box by each of the following statements that best describes your behavior.

	Not ready to make a change	Thinking about making a change	Ready to make a change	Already making changes	Made changes and am trying to keep it up
1. Eating More Fruits and Vegetables					
2. Increasing Physical Activity					
3. Quitting Smoking					<input type="checkbox"/> I don't smoke
4. Taking medications as prescribed for high blood pressure					<input type="checkbox"/> I don't take medications for high blood pressure

## All Services Screening Card

PROVIDER NOTE: In order to receive reimbursement, all sections must be completed.

### General Clinical Services

Height: (with shoes off) \_\_\_\_\_ / \_\_\_\_\_ ft./in.  
Weight: \_\_\_\_\_ lbs.  
Waist Circumference: \_\_\_\_\_ inches  
Hip Circumference: \_\_\_\_\_ inches

**Note—2 blood pressure readings are required for this visit.**

Blood Pressure (1): \_\_\_\_\_ / \_\_\_\_\_ mm Hg  
Blood Pressure (2): \_\_\_\_\_ / \_\_\_\_\_ mm Hg

- Is the client taking blood pressure medication today?  Yes\*  No
- Are you ordering or changing blood pressure medication today?  Yes\*  No
- Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227

\*Counsel client on medication adherence for hypertension and check the last box in the section below.

### Cardiovascular Risk Reduction Counseling

Refer to the questions on the front of this card. Check if counseling completed.

- Nutrition Counseling
- Physical Activity Counseling
- Tobacco Cessation Counseling
  - Client Referred to Statewide Quitline at 1-800-QUIT-NOW
  - Fax Referral to Statewide Quitline at 1-800-QUIT-NOW
  - Client Refused
- Medication Adherence for Hypertension Counseling

Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.

### CVD/Diabetes Screening

Labs can only be done in conjunction with breast and/or cervical screening services.

Bloodwork Ordered:  Yes  No  
Blood Draw Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Blood draw needs to be within 30 days of today's visit

Cholesterol does NOT need to be fasting.

Total Cholesterol: \_\_\_\_\_ mg/dl  
HDL (value not ratio): \_\_\_\_\_ mg/dl  
LDL (value not ratio): \_\_\_\_\_ mg/dl  
Triglycerides: \_\_\_\_\_ mg/dl

**ALL clients are now eligible for A1c!**

A1c (preferred): \_\_\_\_\_

OR  
Blood Glucose: \_\_\_\_\_ mg/dl (acceptable)

Client fasted 9 hrs  Yes  No

PROVIDERS: Please check the appropriate box in the screening pap and mammography section.

### Screening Pap

- Pap test performed (place red & white EWM sticker on lab requisition)
- Co-testing with HPV performed
  - No co-testing performed

- Pap test not ordered (if not performed, mark or list reason)
- Hysterectomy (with cervix removed) not due to cervical cancer
  -

### Pelvic Exam

- Finding:
- Negative/Benign
  - Visible Suspicious CERVICAL lesion
  - Not Performed

### Colon Cancer Screening

- The client has already been screened through the NCP:
- Client is 50-74 and was sent a FOBT kit with this card
  - Client is 50-74 and NCP is working with client to schedule a colonoscopy
  - NCP is requesting additional information.
  - Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.

- CLINICIAN:
- Discussed with client the importance of:
  - Completing the FOBT kit at home
  - Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"

- Reminders to Clinician:
- Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.
  - NCP is a screening program NOT a diagnostic program.

### Mammography

- Mammogram ordered  
Give client Mammography Order Form
- Mammogram not ordered  
If not performed, mark or list reason:
  - Not age appropriate
  - Client not at risk (client 40-49)
  - Other \_\_\_\_\_

### Clinical Breast Exam

- Client reports breast symptoms
- Finding:
- Negative/Benign
  - Suspicious for BREAST Malignancy  
Immediate follow up is required beyond mammogram
  - Not Performed

**\*\*MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit \_\_\_\_\_

Clinician Name (PRINT full name-do not abbreviate) \_\_\_\_\_

Clinic Name (PRINT full name-do not abbreviate) \_\_\_\_\_

City \_\_\_\_\_



EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

USPSTF Screening Guidelines		
Cervical Cancer	Breast Cancer	
<b>Women 21-29</b> Screen with cytology (Pap smear) every 3 years.	<b>Grade: A</b> <b>Women aged 50 to 74 years</b> Biennial screening mammography for women aged 50 to 74 years.	<b>Grade: B</b>
<b>Women 30-65</b> Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years.	<b>Grade: A</b> <b>Women aged 40 to 49 years</b> The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.	<b>Grade: C</b>
<b>Colon Cancer</b>		
<b>Men and Women 50-74</b> Screening for Colon Cancer with any of the following tests:	<b>Grade: A</b>	
<ul style="list-style-type: none"> <li>• FOBT/FIT Annually*</li> <li>• Colonoscopy every 10 years*</li> </ul>		
Other approved tests by USPSTF: <a href="https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2">https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2</a>		
*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.		

If you have questions, please contact the Nebraska Women's & Men's Health Programs:

Nebraska Women's & Men's Health Programs  
301 Centennial Mall South - P.O. Box 94817  
Lincoln, NE 68509-4817

Toll Free: 800-532-2227  
In Lincoln: 402-471-0929  
Fax: 402-471-0913

Websites: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)  
[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc) or [www.StayintheGameNE.com](http://www.StayintheGameNE.com)

Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov) (Every Woman Matters)  
[dhhs.ncpp@nebraska.gov](mailto:dhhs.ncpp@nebraska.gov) (Nebraska Colon Program)



# All Services Screening Cards

Client is eligible for all EWM services!



### Breast Cancer, Heart & Diabetes Screening Card

Jane Doe  
Date of Birth \_\_\_\_\_  
Expiration Date \_\_\_\_\_

**Clients - Please fill out this page!**  
This helps Every Woman Matters find the best tools and services to meet your goals.

Choose one or two areas you want to improve:

- Nutrition
- Physical Activity
- Smoking Cessation
- Taking medications as prescribed for high blood pressure
- I don't want to improve anything



**How ready are you to make changes?**

Check the box by each of the following statements that best describes your behavior.

	Not ready to make a change	Thinking about making a change	Ready to make a change	Already making changes	Made changes and am trying to keep it up
1. Eating More Fruits and Vegetables					
2. Increasing Physical Activity					
3. Quitting Smoking					<input type="checkbox"/> I don't smoke
4. Taking medications as prescribed for high blood pressure					<input type="checkbox"/> I don't take medications for high blood pressure

### Breast Cancer, Heart & Diabetes Screening Card

PROVIDER NOTE: In order to receive reimbursement, all sections must be completed.

#### General Clinical Services

Height: (with shoes off) \_\_\_\_\_ / \_\_\_\_\_ ft./in.

Weight: \_\_\_\_\_ lbs.

Waist Circumference: \_\_\_\_\_ inches

Hip Circumference: \_\_\_\_\_ inches

**Note - 2 blood pressure readings are required for this visit.**

Blood Pressure (1): \_\_\_\_\_ / \_\_\_\_\_ mm Hg

Blood Pressure (2): \_\_\_\_\_ / \_\_\_\_\_ mm Hg

1. Is the client taking blood pressure medication?  Yes\*  No

2. Are you ordering or changing blood pressure medication today?  Yes\*  No

3. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227

\*Counsel client on medication adherence for hypertension and check the last box in the section below.

OR

Blood Glucose: \_\_\_\_\_ mg/dl (acceptable)

Client fasted 9 hrs  Yes  No

#### Cardiovascular Risk Reduction Counseling

Refer to the questions on the front of this card. Check if counseling completed.

Nutrition Counseling

Physical Activity Counseling

Tobacco Cessation Counseling

Client Referred to Statewide Quitline at 1-800-QUIT-NOW

Fax Referral to Statewide Quitline at 1-800-QUIT-NOW

Client Refused

Medication Adherence for Hypertension Counseling

Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.

#### CVD/Diabetes Screening

**Labs can only be done in conjunction with breast and/or cervical screening services.**

Bloodwork Ordered:  Yes  No

Blood Draw Date: \_\_\_\_\_

Blood draw needs to be within 30 days of today's visit

Cholesterol does NOT need to be fasting.

Total Cholesterol: \_\_\_\_\_ mg/dl

HDL (value not ratio): \_\_\_\_\_ mg/dl

LDL (value not ratio): \_\_\_\_\_ mg/dl

Triglycerides: \_\_\_\_\_ mg/dl

**ALL clients are now eligible for A1c!**

A1c (preferred): \_\_\_\_\_

OR

Blood Glucose: \_\_\_\_\_ mg/dl (acceptable)

Client fasted 9 hrs  Yes  No

Client is **NOT** eligible for a screening Pap

PROVIDERS: Please check the appropriate box in the screening pap and mammography section.

#### Screening Pap

Client NOT eligible for Screening Pap this year

See back of screening card for USPSTF guidelines

#### Colon Cancer Screening

The client has already been screened through the NCP

Client is 50-74 and was sent a FOBT kit with this card

Client is 50-74 and NCP is working with client to schedule a colonoscopy

NCP is requesting additional information.

Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.

CLINICIAN: Discussed with client the importance of:

Completing the FOBT kit at home

Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"

Reminders to Clinician:

• Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.

• NCP is a screening program NOT a diagnostic program.

#### Mammography

Mammogram ordered Give client Mammography Order Form

Mammogram not ordered

If not performed, mark or list reason:

Not age appropriate

Client not at risk (client 40-49)

Other \_\_\_\_\_

#### Clinical Breast Exam

Client reports breast symptoms

Suspicious for BREAST Malignancy Immediate follow up is required beyond mammogram

Not Performed

Finding:  Negative/Benign

Suspicious for BREAST Malignancy Immediate follow up is required beyond mammogram

Not Performed

**\*\*MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit \_\_\_\_\_

Clinician Name (PRINT full name-do not abbreviate) \_\_\_\_\_

Clinic Name (PRINT full name-do not abbreviate) \_\_\_\_\_

City \_\_\_\_\_



EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

USPSTF Screening Guidelines		
Cervical Cancer	Breast Cancer	
<b>Women 21-29</b> Screen with cytology (Pap smear) every 3 years.	<b>Women aged 50 to 74 years</b> Biennial screening mammography for women aged 50 to 74 years.	<b>Grade: A</b>
<b>Women 30-65</b> Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years.	<b>Women aged 40 to 49 years</b> The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.	<b>Grade: B</b>
<b>Men and Women 50-74</b> Screening for Colon Cancer with any of the following tests: • FOBT/FIT Annually* • Colonoscopy every 10 years*	<b>Other approved tests by USPSTF:</b> <a href="https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2">https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2</a>	<b>Grade: A</b>
<b>*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.</b>		

If you have questions, please contact the Nebraska Women's & Men's Health Programs:  
Nebraska Women's & Men's Health Programs  
301 Centennial Mall South - P.O. Box 94817  
Lincoln, NE 68509-4817  
Toll Free: 800-532-2227  
In Lincoln: 402-471-0929  
Fax: 402-471-0913  
Websites: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)  
[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc) or [www.StayintheGameNE.com](http://www.StayintheGameNE.com)  
Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov) (Every Woman Matters)  
[dhhs.ncpp@nebraska.gov](mailto:dhhs.ncpp@nebraska.gov) (Nebraska Colon Program)



# Breast Cancer, Heart & Diabetes Screening Cards

Client is **NOT** eligible for all EWM services.  
A Pap Test is **not approved** for this visit.

Client is **NOT** eligible for a screening Mammography



**Cervical Cancer, Heart & Diabetes Screening Card**

Jane Doe  
Date of Birth \_\_\_\_\_  
Expiration Date \_\_\_\_\_

**Clients - Please fill out this page!**  
This helps Every Woman Matters find the best tools and services to meet your goals.

**Choose one or two areas you want to improve:**

- Nutrition
- Physical Activity
- Smoking Cessation
- Taking medications as prescribed for high blood pressure
- I don't want to improve anything



**How ready are you to make changes?**  
Check the box by each of the following statements that best describes your behavior.

	Not ready to make a change	Thinking about making a change	Ready to make a change	Already making changes	Made changes and am trying to keep it up
1. Eating More Fruits and Vegetables					
2. Increasing Physical Activity					
3. Quitting Smoking					<input type="checkbox"/> I don't smoke
4. Taking medications as prescribed for high blood pressure					<input type="checkbox"/> I don't take medications for high blood pressure

**Cervical Cancer, Heart & Diabetes Screening Card**

PROVIDER NOTE: In order to receive reimbursement, all sections must be completed.

**General Clinical Services**

Height: (with shoes off) \_\_\_\_\_ ft./in.  
Weight: \_\_\_\_\_ lbs.  
Waist Circumference: \_\_\_\_\_ inches  
Hip Circumference: \_\_\_\_\_ inches

**Note—2 blood pressure readings are required for this visit.**

Blood Pressure (1): \_\_\_\_\_ mm Hg  
Blood Pressure (2): \_\_\_\_\_ mm Hg

1. Is the client taking blood pressure medication?  Yes\*  No

2. Are you ordering or changing blood pressure medication today?  Yes\*  No

3. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227  
\*Counsel client on medication adherence for hypertension and check the last box in the section below.

**Cardiovascular Risk Reduction Counseling**  
Refer to the questions on the front of this card. Check if counseling completed.

Nutrition Counseling  
 Physical Activity Counseling  
 Tobacco Cessation Counseling

Client Referred to Statewide Quitline at 1-800-QUIT-NOW  
 Fax Referral to Statewide Quitline at 1-800-QUIT-NOW  
 Client Refused

Medication Adherence for Hypertension Counseling

*Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.*

**CVD/Diabetes Screening**

*Labs can only be done in conjunction with breast and/or cervical screening services.*

Bloodwork Ordered:  Yes  No

Blood Draw Date: \_\_\_\_\_

*Blood draw needs to be within 30 days of today's visit*

**Cholesterol does NOT need to be fasting.**

Total Cholesterol: \_\_\_\_\_ mg/dl  
HDL (value not ratio): \_\_\_\_\_ mg/dl  
LDL (value not ratio): \_\_\_\_\_ mg/dl  
Triglycerides: \_\_\_\_\_ mg/dl

**ALL clients are now eligible for A1c!**  
A1c (preferred): \_\_\_\_\_

Blood Glucose: \_\_\_\_\_ mg/dl  
Client fasted 9 hrs  Yes  No

PROVIDERS: Please check the appropriate box in the screening panel.

**Screening Pap**

Pap test performed (place red & white EWM sticker on lab requisition)

Co-testing with HPV performed  
 No co-testing performed

Pap test not ordered (if not performed, mark or list reason)

Hysterectomy (with cervix removed) not due to cervical cancer  
 \_\_\_\_\_

**Pelvic Exam**

Finding:

Negative/Benign  
 Visible Suspicious CERVICAL lesion  
 Not Performed

**Colon Cancer Screening**

The client has already been screened through the NCP:

Client is 50-74 and was sent a FOBT kit with this card  
 Client is 50-74 and NCP is working with client to schedule a colonoscopy  
 NCP is requesting additional information.  
 Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.

**CLINICIAN:**  
Discussed with client the importance of:

Completing the FOBT kit at home  
 Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"

**Reminders to Clinician:**

- Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.
- NCP is a screening program NOT a diagnostic program.

**Mammography**

Client NOT eligible for Mammography this year

See back of screening card for USPSTF guidelines

**Clinical Breast Exam**

Client reports breast symptoms

Finding:

Negative/Benign  
 Suspicious for BREAST Malignancy (immediate follow up is required beyond mammogram)  
 Not Performed

**\*\* MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit \_\_\_\_\_

Clinician Name (PRINT full name-do not abbreviate) \_\_\_\_\_

Clinic Name (PRINT full name-do not abbreviate) \_\_\_\_\_

City \_\_\_\_\_



EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

USPSTF Screening Guidelines		
Cervical Cancer	Breast Cancer	
<b>Women 21-29</b> Screen with cytology (Pap smear) every 3 years.	<b>Women aged 50 to 74 years</b> Biennial screening mammography for women aged 50 to 74 years.	<b>Grade: B</b>
<b>Women 30-65</b> Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years.	<b>Women aged 40 to 49 years</b> The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.	<b>Grade: C</b>
Colon Cancer		
<b>Men and Women 50-74</b> Screening for Colon Cancer with any of the following tests:		<b>Grade: A</b>
	<ul style="list-style-type: none"> <li>• FOBT/FIT Annually*</li> <li>• Colonoscopy every 10 years*</li> </ul>	
Other approved tests by USPSTF: <a href="https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2">https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2</a>		
*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.		

If you have questions, please contact the Nebraska Women's & Men's Health Programs:  
Nebraska Women's & Men's Health Programs  
301 Centennial Mall South • P.O. Box 94817  
Lincoln, NE 68509-4817

Toll Free: 800-532-2227  
In Lincoln: 402-471-0929  
Fax: 402-471-0913

Websites: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)  
[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc) or [www.StayintheGameNE.com](http://www.StayintheGameNE.com)

Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov) (Every Woman Matters)  
[dhhs.ncpsp@nebraska.gov](mailto:dhhs.ncpsp@nebraska.gov) (Nebraska Colon Program)



# Cervical Cancer, Heart & Diabetes Screening Cards

Client is **NOT** eligible for all EWM services.  
A screening mammogram is **not approved** for this visit.

### Cervical Cancer Screening Card

Jane Doe  
Date of Birth \_\_\_\_\_  
Expiration Date \_\_\_\_\_

**Clients - Please fill out this page!**  
This helps Every Woman Matters find the best tools and services to meet your goals.

**Choose one or two areas you want to improve:**

- Nutrition
- Physical Activity
- Smoking Cessation
- Taking medications as prescribed for high blood pressure
- I don't want to improve anything

**How ready are you to make changes?**  
Check the box by each of the following statements that best describes your behavior.

	Not ready to make a change	Thinking about making a change	Ready to make a change	Already making changes	Made changes and am trying to keep it up
1. Eating More Fruits and Vegetables					
2. Increasing Physical Activity					
3. Quitting Smoking					<input type="checkbox"/> I don't smoke
4. Taking medications as prescribed for high blood pressure					<input type="checkbox"/> I don't take medications for high blood pressure

### Cervical Cancer Screening Card

**PROVIDER NOTE:** In order to receive reimbursement, all sections must be completed.

**General Clinical Services**

Height: (with shoes off) \_\_\_\_\_ / \_\_\_\_\_ ft./in.  
Weight: \_\_\_\_\_ lbs.  
Waist Circumference: \_\_\_\_\_ inches  
Hip Circumference: \_\_\_\_\_ inches

**Note-2 blood pressure readings are required for this visit.**

Blood Pressure (1): \_\_\_\_\_ / \_\_\_\_\_ mm Hg  
Blood Pressure (2): \_\_\_\_\_ / \_\_\_\_\_ mm Hg

1. Is the client taking blood pressure medication?  Yes\*  No

2. Are you ordering or changing blood pressure medication today?  Yes\*  No

3. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227  
\*Counsel client on medication adherence for hypertension and check the last box in the section below.

**Cardiovascular Risk Reduction Counseling**  
Refer to the questions on the front of this card. Check if counseling completed.

- Nutrition Counseling
- Physical Activity Counseling
- Tobacco Cessation Counseling
- Client Referred to Statewide Quitline at 1-800-QUIT-NOW
- Fax Referral to Statewide Quitline at 1-800-QUIT-NOW
- Client Refused
- Medication Adherence for Hypertension Counseling

Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.

**CVD/Diabetes Screening**  
Labs can only be done in conjunction with breast and/or cervical screening services.

Bloodwork Ordered:  Yes  No

Blood D \_\_\_\_\_

Chol \_\_\_\_\_

Total Ch \_\_\_\_\_ mg/dl

HDL (va) \_\_\_\_\_ mg/dl

LDL (va) \_\_\_\_\_ mg/dl

Triglyce \_\_\_\_\_ mg/dl

ALL clients are now required for A1c!

A1c (preferred): \_\_\_\_\_

OR

Blood Glucose (acceptable) \_\_\_\_\_ mg/dl

Client fast?  No

**Client is NOT eligible for a screening Pap**

**PROVIDERS:** Please check appropriate box in the screening pap section.

**Screening Pap**

Pap test performed (place red & white EWM sticker on lab requisition)

- Co-testing with HPV performed
- No co-testing performed

Pap test not ordered (if not performed, mark or list reason)

- Hysterectomy (with cervix removed) not due to cervical cancer

**Pelvic Exam**

Finding:

- Negative/Benign
- Visible Suspicious CERVICAL lesion
- Not Performed

**Colon Cancer Screening**

The client has already been screened through the NCP:

- Client is 50-74 and was sent a FOBT kit with this card
- Client is 50-74 and NCP is working with client to schedule a colonoscopy
- NCP is requesting additional information.
- Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.

**CLINICIAN:** Discussed with client the importance of:

- Completing the FOBT kit at home
- Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"

**Reminders to Clinician:**

- Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.
- NCP is a screening program NOT a diagnostic program.

**Mammography**

**Client NOT eligible for Mammography this year**

See back of screening card for USPSTF guidelines

**Clinical Breast Exam**

- Client reports breast symptoms

Finding:

- Negative/Benign
- Suspicious for BREAST Malignancy
- Immediate follow up is required beyond mammogram
- Not Performed

**\*\*MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit \_\_\_\_\_

Clinician Name (PRINT full name-do not abbreviate) \_\_\_\_\_

Clinic Name (PRINT full name-do not abbreviate) \_\_\_\_\_

City \_\_\_\_\_

EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

**USPSTF Screening Guidelines**

Cervical Cancer	Breast Cancer
<b>Women 21-29</b> Grade: A Screen with cytology (Pap smear) every 3 years.	<b>Women aged 50 to 74 years</b> Grade: B Biennial screening mammography for women aged 50 to 74 years.
<b>Women 30-65</b> Grade: A Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years.	<b>Women aged 40 to 49 years</b> Grade: C The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.

**Colon Cancer**

**Men and Women 50-74** Grade: A  
Screening for Colon Cancer with any of the following tests:

- FOBT/FIT Annually\*
- Colonoscopy every 10 years\*

Other approved tests by USPSTF: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2>

\*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.

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301 Centennial Mall South - P.O. Box 94817  
Lincoln, NE 68509-4817

Toll Free: 800-532-2227  
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Websites: [www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth)  
[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc) or [www.StayintheGameNE.com](http://www.StayintheGameNE.com)

Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov) (Every Woman Matters)  
[dhhs.ncpp@nebraska.gov](mailto:dhhs.ncpp@nebraska.gov) (Nebraska Colon Program)

#SUS8/DP001421-05; #SUS8/DP002043-04

NEBRASKA  
Good Life. Great Reason.  
NEBRASKA  
Good Life. Great Reason.  
Nov. July 2017

# Breast Cancer Screening Cards

Client is **NOT** eligible for all EWM services.  
Labwork and a screening Pap test is **not approved** for this visit.



### Cervical Cancer Screening Card

Jane Doe  
Date of Birth  
Expiration Date

Clients - Please fill out this page!  
This helps Every Woman Matters find the best tools and services to meet your goals.

- Choose one or two areas you want to improve:
- Nutrition
  - Physical Activity
  - Smoking Cessation
  - Taking medications as prescribed for high blood pressure
  - I don't want to improve anything



How ready are you to make changes?  
Check the box by each of the following statements that best describes your behavior.

	Not ready to make a change	Thinking about making a change	Ready to make a change	Already making changes	Made changes and am trying to keep it up
1. Eating More Fruits and Vegetables					
2. Increasing Physical Activity					
3. Quitting Smoking					<input type="checkbox"/> I don't smoke
4. Taking medications as prescribed for high blood pressure					<input type="checkbox"/> I don't take medications for high blood pressure

### Cervical Cancer Screening Card

PROVIDER NOTE: In order to receive reimbursement, all sections must be completed.

**General Clinical Services**

Height: (with shoes off) \_\_\_ / \_\_\_ ft./in.  
Weight: \_\_\_ lbs.  
Waist Circumference: \_\_\_ inches  
Hip Circumference: \_\_\_ inches

**Note-2 blood pressure readings are required for this visit.**

Blood Pressure (1): \_\_\_ / \_\_\_ mm Hg  
Blood Pressure (2): \_\_\_ / \_\_\_ mm Hg

1. Is the client taking blood pressure medication?  Yes\*  No

2. Are you ordering or changing blood pressure medication today?  Yes\*  No

3. Contact us if you would like your client to get a follow-up visit for a blood pressure re-check (needs prior approval) 1-800-532-2227

\*Counsel client on medication adherence for hypertension and check the last box in the section below.

**CVD/Diabetes Screening**

*Lab tests can only be done in conjunction with breast and/or cervical screening services.*

Bloodwork Ordered:  Yes  No

Blood D

Choleste

Total Ch

HDL (va

LDL (va

Triglyce

*ALL clients are now required to get A1c!*

A1c (preferred):

OR

Blood Glucose (acceptable)

Client fo

Client NOT eligible this year

**Cardiovascular Risk Reduction Counseling**

Refer to the questions on the front of this card. Check if counseling completed.

Nutrition Counseling

Physical Activity Counseling

Tobacco Cessation Counseling

Client Referred to Statewide Quitline at 1-800-QUIT-NOW

Fax Referral to Statewide Quitline at 1-800-QUIT-NOW

Client Refused

Medication Adherence for Hypertension Counseling

*Completion of this section is equivalent to submitting a claim for Risk Reduction Counseling.*

PROVIDERS: Please check the appropriate box in the screening panel.

**Screening Pap**

Pap test performed (place red & white EWM sticker on lab requisition)

Co-testing with HPV performed

No co-testing performed

Pap test not ordered (if not performed, mark or list reason)

Hysterectomy (with cervix removed) not due to cervical cancer

**Pelvic Exam**

Finding:

Negative/Benign

Visible Suspicious CERVICAL lesion

Not Performed

**Colon Cancer Screening**

The client has already been screened through the NCP:

Client is 50-74 and was sent a FOBT kit with this card

Client is 50-74 and NCP is working with client to schedule a colonoscopy

NCP is requesting additional information.

Client is not eligible for any NCP services due to either being under age 50 or over age 74 OR are not eligible based on personal and/or family history OR have been recently screened.

**CLINICIAN:**

Discussed with client the importance of:

Completing the FOBT kit at home

Returning the FOBT kit in the envelope provided that is marked "Physicians Lab"

**Reminders to Clinician:**

- Do NOT give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.
- NCP is a screening program NOT a diagnostic program.

Client is **NOT** eligible for a screening Mammography

**Mammography**

Client NOT eligible for Mammography this year

See back of screening card for USPSTF guidelines

**Clinical Breast Exam**

Client reports breast symptoms

Finding:

Negative/Benign

Suspicious for BREAST Malignancy

Not Performed

**\*\*MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit

Clinician Name (PRINT full name-do not abbreviate)

Clinic Name (PRINT full name-do not abbreviate)

City



EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>

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<b>Colon Cancer</b>			
<b>Men and Women 50-74</b> Screening for Colon Cancer with any of the following tests:			Grade: A
<ul style="list-style-type: none"> <li>• FOBT/FIT Annually*</li> <li>• Colonoscopy every 10 years*</li> </ul>			
Other approved tests by USPSTF: <a href="https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2">https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/colorectal-cancer-screening2</a>			
*Only Colon Cancer Screening Tests are covered by the Program. See Provider Manual for screening algorithms and pre-approval.			

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[www.dhhs.ne.gov/crc](http://www.dhhs.ne.gov/crc) or [www.StayintheGameNE.com](http://www.StayintheGameNE.com)

Email: [dhhs.ewm@nebraska.gov](mailto:dhhs.ewm@nebraska.gov) (Every Woman Matters)  
[dhhs.nccsp@nebraska.gov](mailto:dhhs.nccsp@nebraska.gov) (Nebraska Colon Program)

#SUS8/DP001421-05; #SUS8/DP002043-04

Nov. July 2017



# Cervical Cancer Cards

Client is NOT eligible for all EWM services.  
Labwork and screening mammogram is not approved for this visit.

# Program Guidance



Mammography  
Order Forms



Submitting  
Screening Cards  
to EWM



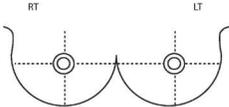
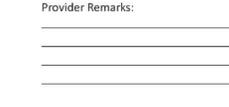
Abnormal Results

# Mammography Order Form

**Every Woman Matters Mammography Order** 

Clinic: This form must be completed prior to receiving services  
 Facility: Send a copy of the dictated report to the ordering provider and EWM

April 2017

First Name	Initial	Last Name	Date of Birth	Age
Clinic Site: _____ City: _____ <small>(Please do not abbreviate)</small>				
<b>This is an order for the above patient to receive the following:</b> <ul style="list-style-type: none"> <li><input type="radio"/> Screening Mammogram <i>(only covered for women 40 and over)</i></li> <li><input type="radio"/> Diagnostic Mammogram <i>(only covered for women 30 and over)</i>            Reimbursement for a diagnostic mammogram for clients 30-39 only with suspicious CBE or previous abnormal mammogram</li> <li><input type="radio"/> Breast Ultrasound  <small>(No pre-approval necessary if ordered by a surgeon or radiologist following a diagnostic mammogram in clients 30-39. Please call 1-800-532-2227 if rural area and no surgeon available.)</small></li> <li><input type="radio"/> CHECK HERE IF ADDITIONAL STUDIES MAY BE PERFORMED AS DETERMINED BY THE RADIOLOGIST  <small>(Per program policies as stated in Women's and Men's Health Program 2017 Provider Contract Manual)</small></li> </ul>				
RT 		LT 		Provider Remarks: _____ _____ _____
Provider's Signature: _____ <small>Provider signature may serve as an order if facility allows.</small>			Date: _____	
<small>Women's and Men's Health Programs - Every Woman Matters Program - 301 Centennial Mall South - P.O. Box 94817 - Lincoln, NE 68509-4817            Toll Free: 800.532.2227 In Lincoln: 402.471.0929 Fax: 402.471.0913 Web: www.dhhs.ne.gov/EWM            #1NUSRDPO06278-01-00 #6NUSRDPO06863-04-02</small>				
Part 1				
<b>Billing/Admissions/Patient Registration for Participating EWM Clients</b>				
1. This form is only used for EWM clients and should only be accepted by contracted EWM facilities. 2. Part 1 stays with the client to present to the Radiology Department. The Radiology Department can use Part 1 for tracking purposes. 3. Part 2 can be torn off and used for Billing/Admissions/Patient Registration purposes.				
			Client Name: _____ Date of Birth: ____/____/____	
Part 2				

Clients who have received an All Services Screening Card or any of the Breast Cancer Screening cards should be issued a Mammography Order Form upon completion of their office visit.

Forms can be downloaded at [dhhs.ne.gov/ewmforms](http://dhhs.ne.gov/ewmforms)

## The referring healthcare provider should:

- ✓ Fill out the client's name, date of birth and age
- ✓ Complete their clinic information
- ✓ Designate the type of service being ordered
- ✓ Sign and Date

Mammography Order Forms are the client's proof to the radiologist that they are eligible for payment. If the client does not take it with her, she will get billed. This creates a ripple effect of problems for everyone.

**Please make sure eligible clients receive their Mammography Order Form!**

# Submitting Screening Cards

The image shows three overlapping screening cards. The top card is the 'All Services Screening Card' with handwritten values: Height 5'5", Weight 155, Hip Circumference 32, Blood Pressure 80/70. The middle card is the 'Screening Pap' card with checkboxes for 'Pap test performed' (checked), 'Co-testing with HPV performed' (checked), and 'Pap test not ordered' (checked). The bottom card is the 'Mammography' card with checkboxes for 'Mammogram ordered' (checked), 'Mammogram not ordered' (checked), and 'Clinical Breast Exam' (checked).

In order to be reimbursed for the screening visit, providers must submit the client's screening card back to EWM within 2 weeks of the service.

## Before Submitting:

- ✓ Check to make sure all sections are complete
- ✓ Include any Pap/HPV reports and/or Lab Reports (if applicable)

## Acceptable Methods of Submission:

- ✓ Mail – P.O. Box 94817, Lincoln NE 68509
- ✓ Fax – 402.471.0913
- ✓ Secure e-mail – [dhhs.everywomanmatters@Nebraska.gov](mailto:dhhs.everywomanmatters@Nebraska.gov)

# Abnormal Results

If a client had an abnormal exam, EWM needs to gather documentation showing the client has been followed through to diagnosis and treatment. The Centers for Disease Prevention and Control requires the information as a condition for continued funding.

**EWM requests additional paperwork to be completed by the Primary Care Provider, OB-GYN, or surgeons office for the following:**

## **Pap test findings of:**

- ▶ Atypical cells of Undetermined Significance (ASC-US) with +HPV  $\geq$  30 \*
- ▶ Low Grade LSIL  $\geq$  25 \*
- ▶ Atypical Squamous Cells: Cannot Exclude High Grade SIL (ASC-H)
- ▶ High Grade SIL (HSIL)
- ▶ Squamous cell carcinoma
- ▶ Atypical Glandular Cells (AGC)

## **Pelvic Exam finding:**

- ▶ Suspicious for cervical malignancy

## **Mammogram findings of:**

- ▶ Suspicious abnormality (SAB) - BIRADS category 4
- ▶ Highly suggestive of malignancy (MAL) - BIRADS category 5
- ▶ Assessment incomplete (NAE)

## **Clinical Breast Exam finding:**

- ▶ Suspicious for malignancy

# Abnormal Results - Forms

Paperwork required for follow up of abnormal results can be found at [dhhs.ne.gov/ewmforms](http://dhhs.ne.gov/ewmforms)

- ▶ **Breast Diagnostic Enrollment/ Follow Up and Treatment Plan**
- ▶ **Cervical Diagnostic Enrollment/ Follow Up and Treatment Plan**

Check out the Breast and Cervical Diagnostic e-learning modules for more information on how to navigate follow-up and treatment!

### Breast Follow-Up & Treatment Plan

<b>Client information:</b>	First Name _____ MI _____ Last Name _____ DOB _____
<b>Breast Cancer Referral &amp; Treatment</b> (see page 5 bottom right)	
<b>Referral:</b>	Client referred to _____ <small>Clinician and clinic name and city and phone</small>
<b>Consultation:</b>	Consultation Date to give client options _____
<b>Treatment:</b>	Treatment regimen consists of _____ Treatment date _____
<b>Refusal:</b>	Cancer treatment refused date _____ Reason for refusal: _____
<b>Screening MRI Pre-</b>	
EWM reimburses for screening MRI as an adjunct to screening mammography. Check one or more that apply to the client, and provide: <input type="checkbox"/> Previous personal history of breast cancer <input type="checkbox"/> Lifetime risk of 20-25% or greater based on family history using the breast cancer <small>For women under 35, go to <a href="http://www.crahhealth.com/risk-express">www.crahhealth.com/risk-express</a>; or call us to request a genetic testing.</small> <input type="checkbox"/> Known BRCA1 or BRCA2 mutation <input type="checkbox"/> First-degree relative with BRCA1 or BRCA2 (parent, brother, sister, child) Relative Date of genetic testing: ____/____/____ <input type="checkbox"/> Previous Radiation Therapy to chest, between the ages of 10-30 Age: ____ P <input type="checkbox"/> Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome <small>EWM staff use only. Request approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Program signature: _____</small>	
<b>Follow-up of Previous</b>	
Past results: why does client need follow-up? →	Last Clinical Breast Exam Result/Finding: <input type="checkbox"/> Negative/Benign Last Screening or Diagnostic Mammogram Result: ____/____/____ Last Breast Ultrasound Result: ____/____/____ Last Treatment: _____
<b>6 Month Follow Up: Only for clients 40-74.</b> What are the client's current results: <input type="checkbox"/> Client reports symptoms: <input type="checkbox"/> NO <input type="checkbox"/> YES, list symptoms: _____ <input type="checkbox"/> DATE: ____/____/____ Clinical Breast Exam Results (check one): <input type="checkbox"/> Benign <input type="checkbox"/> Mammogram Results (check one): <input type="checkbox"/> Assessment incomplete <input type="checkbox"/> Negative <input type="checkbox"/> Benign <input type="checkbox"/> DATE: ____/____/____ Breast Ultrasound Results (check one): <input type="checkbox"/> Assessment incomplete <input type="checkbox"/> Negative <input type="checkbox"/> Benign <input type="checkbox"/> DATE: ____/____/____ Consultation by _____ <input type="checkbox"/> DATE: ____/____/____ Biopsy: Type _____ Results: _____	
Name of Clinic: _____	

### Cervical Follow-Up and Treatment Plan

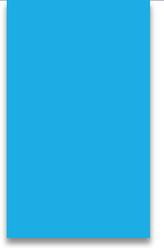
<b>Name:</b>	First _____ MI _____ Last _____ DOB _____						
<b>Provider information:</b>	Screening: _____ Name _____ City and Phone # _____ <small>Clinic that initiated care</small> Diagnostic: _____ Name _____ City and Phone # _____ <small>Clinic that patient was referred to</small>						
<small>Instructions: Please send EWM this form along with Pap test and colposcopy results when diagnostic workup is complete. Must follow current ASCCP guidelines. If your client's procedure is NOT listed directly underneath their Pap result, it may not be reimbursable by our program. Call us to discuss.</small>							
<b>Pap results: Find the client's Pap test result below and mark the date of service for the Pap and procedure listed directly underneath.</b>							
<small>If your client's procedure is NOT listed directly underneath their Pap result, it may not be reimbursable by our program. Call us to discuss.</small>							
Negative	Unsatisfactory	ASC-US	LSIL	ASC-H	HSIL	AGC	Sq. Cell Carcinoma
Date _____	Date _____	Date _____	Date _____	Date _____	Date _____	Date _____	Date _____
With cervical lesion <input type="checkbox"/> Colposcopy with biopsy Date of service: ____/____/____	HPV unknown or HPV- Repeat cytology in 2-4 months. Not eligible for colposcopy. Date of service: ____/____/____	Ages 21-24: Repeat Cytology in 12 months. Must re-enroll in the State Pap Program. Not eligible for colposcopy. Date of service: ____/____/____	Ages 21-24: Repeat Cytology in 12 months. Must re-enroll in the State Pap Program. Not eligible for colposcopy. Date of service: ____/____/____	<input type="checkbox"/> Colposcopy with biopsy Date of service: ____/____/____	Ages 21-24: <input type="checkbox"/> Colposcopy with biopsy Date of service: ____/____/____	All Subcategories: <input type="checkbox"/> Colposcopy with biopsy + ECC and Endometrial biopsy* Both to be done on the same day. Date of service: ____/____/____ Ages 25-74: <input type="checkbox"/> Colposcopy with biopsy OR <input type="checkbox"/> Immediate LEEP Date of service: ____/____/____	Treatment referral to OB/GYN  Complete page 4 - cervical cancer treatment section.
HPV+ ages 30+ <input type="checkbox"/> Repeat co-testing @ 1 year (must re-enroll in State Pap Program if under 40) <input type="checkbox"/> Colposcopy with biopsy IF HPV 16 or 18 positive Date of service: ____/____/____	HPV+ Repeat cytology in 2-4 months, no HBV test allowed per guidelines. <input type="checkbox"/> Colposcopy with biopsy Date of service: ____/____/____	Ages 25-74: HPV unknown; Preferred: do HPV testing Acceptable: Repeat cytology at 1 year HPV negative; Repeat co-testing in 3 years Date of service: ____/____/____	Ages 25-74: HPV negative; Preferred: Repeat co-testing in 1 year Acceptable: <input type="checkbox"/> Colposcopy Date of service: ____/____/____	HPV positive or no HPV: <input type="checkbox"/> Colposcopy with biopsy Date of service: ____/____/____	HPV: <input type="checkbox"/> Colposcopy Date of service: ____/____/____	If no endometrial pathology: <input type="checkbox"/> Colposcopy Date of service: ____/____/____	

Consultation or second opinion: Physician: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Date of service: \_\_\_\_\_

<b>Final Diagnosis:</b> <small>This section must be completed before sending in.</small>	Date of final diagnosis or pathology report: ____/____/____	Check one: <input type="checkbox"/> Inconclusive Results <input type="checkbox"/> Normal/Benign Inflammation <input type="checkbox"/> HPV/Condylomata/Atypia <input type="checkbox"/> CIN I → <input type="checkbox"/> Treatment not indicated	<input type="checkbox"/> CIN II <input type="checkbox"/> CIN III carcinoma in situ <input type="checkbox"/> Invasive Cancer For CIN II and greater, complete pg 4: Cervical Cancer Treatment and Referral	<b>Refusal:</b> <input type="checkbox"/> Client refused diagnostic workup <input type="checkbox"/> Did client make informed decision? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Initiate Client Informed Refusal Form
Clinic Name: _____		Date: _____		

\* ≥ 35 years or at risk for endometrial neoplasia. Includes unexplained vaginal bleeding or conditions suggesting chronic anovulation.  
 Fax to 402-471-0913 or mail to Every Woman Matters, PO Box 94817 Lincoln, NE 68509-4817  
 Call us with any questions at 1-800-532-2227. Print out forms online at [www.dhhs.ne.gov/ewmforms](http://www.dhhs.ne.gov/ewmforms)  
 Instructions are no longer being printed along with the form. They are now posted online at [www.dhhs.ne.gov/ewmforms](http://www.dhhs.ne.gov/ewmforms)

# Frequently Asked Questions



# EWM FAQ

▶ **If a client comes to the clinic without their screening card can we call you to fax us one?**

If the client has completed an HLQ and is eligible for services, a screening card may be faxed to the clinic.

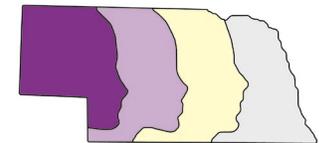
▶ **Does the lab draw have to be done the same day as their office visit?**

The patient needs to receive their labs in conjunction with an office visit in which they received breast and/or cervical cancer screening. It must be done within 30 days of the office visit. There is no reimbursement for a separate office visit. We will pay for venipuncture in which cholesterol and/or glucose/A1c was drawn.

▶ **Does Every Woman Matters help women who are diagnosed with breast or cervical cancer while enrolled?**

Clients may be eligible for Nebraska Medicaid to pay for their cancer treatment through a special program called the Women's Cancer Program. Only those with no other health insurance are eligible. EWM nurses will contact them to assist with this process.

*Every Woman Matters*



# Additional questions regarding the Screening Card process?

Contact an Every Woman Matters representative:

## Women's & Men's Health Programs

1-800-532-2227 toll free

402-471-0913 fax

[www.dhhs.ne.gov/womenshealth](http://www.dhhs.ne.gov/womenshealth) web

[dhhs.everywomanmatters@nebraska.gov](mailto:dhhs.everywomanmatters@nebraska.gov) email

*Every Woman Matters*



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DEPT. OF HEALTH AND HUMAN SERVICES