



WOMEN'S WAY

A Breast & Cervical Cancer
Early Detection Program

ENROLLED HEALTH CARE PROVIDER HANDBOOK

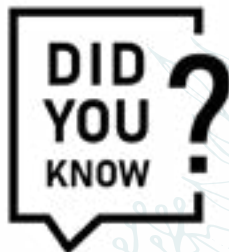


Women's Way

Serving women in North Dakota since 1997

Effective August 2022

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This manual and provider educational resources are available to download or print by visiting the [Provider page](#)

BACKGROUND & HISTORY OVERVIEW

In 1990, Congress passed the Breast and Cervical Cancer Mortality Prevention Act, which launched funding for a national breast and cervical cancer screening program. The Centers for Disease Control and Prevention (CDC) distributes the money and oversees the national program.

In 1993, North Dakota received funding for planning and system development. The North Dakota breast and cervical cancer early detection program was named **Women's Way** and began offering screening services in 1997.

Women's Way is administered through the State Public Health and local public health offices. Together we promote early detection of breast and cervical cancer as a way to reduce breast and cervical cancer morbidity and mortality.

In 2001, the North Dakota state legislature passed and Governor Hoeven signed legislation allowing uninsured **Women's Way** clients diagnosed with breast or cervical cancer to access treatment coverage through Medicaid - **Women's Way** Treatment program.

As of 2022, **Women's Way** is one of 70 funded states, tribes, and territories that provide national breast and cervical cancer early detection program services. As many as 22,000 (or 1 in 17) women in North Dakota could be eligible for **Women's Way** and receive free breast and cervical cancer screenings.

PURPOSE OF HANDBOOK

This handbook is available to enrolled health care providers who offer services for individuals enrolled in **Women's Way**. The handbook includes information on the services that will be reimbursed by **Women's Way** and the responsibilities of enrolled providers.



Approximately 1 in 17 women in North Dakota could be eligible for **Women's Way** and receive free breast and cervical cancer screenings!
Have you made a **Women's Way** referral?

RESPONSIBILITIES AND REIMBURSEMENTS

What are Health Care Provider Responsibilities?

Follow North Dakota Century Code and provide screenings and/or diagnostic services:

1. State Office staff, Contractors, Providers, and Partners shall ensure that procedural safeguards are followed for confidentiality requirements as stated in [North Dakota Century Code 23-01.3](#).
2. Provide breast and cervical cancer screenings and education.
3. Assess breast cancer risk to determine individuals at high risk for breast cancer using risk assessment tool of preference.
 - Individuals at high risk include those who:
 - » Have a known genetic mutation such as BRCA 1 or 2,
 - » Have first-degree relatives with premenopausal breast cancer or known genetic mutations and have not had genetic testing themselves,
 - » Have a history of radiation treatment to the chest area before the age of 30 (typically for Hodgkin's lymphoma), and
 - » Have a lifetime risk of 20% or more for the development of breast cancer according to risk assessment models based mainly on family history.
4. Ensure that adequate and timely diagnostic workup is planned for an abnormal clinical breast exam (CBE), mammogram, Pap test, or HPV test.
5. Notify individuals of their test results.
6. Remind individuals when they are due for future screenings.
7. Advise individuals of services not covered by **Women's Way** before services are provided.

Assess Use of Tobacco using AAR (Ask, Advise, Refer)

The provider will use their best efforts to ensure every **Women's Way** patient is assessed for smoking status and that a referral is made to NDQuits if she is a current smoker.

1. Ask the individual if they smoke or use tobacco.
2. Advise the individual to quit.
3. Refer the individual to NDQuits if the individual is a current smoker. Click here for the [NDQuits referral form](#).

Complete and return forms provided by the **Women's Way** local coordinator. Forms with instructions include:

1. Intake and Visit Summary form (results for clinical breast exam, mammogram, screening MRI, pelvic exam, Pap test, and HPV test). To view the form, see [Appendix A](#).
2. Breast Diagnostic Results form (for a diagnostic mammogram, ultrasound, MRI, surgical consult, fine needle aspiration, biopsy). To view the form, see [Appendix B](#).
3. Cervical Diagnostic Results form (for colposcopy or other procedures). To view the form, see [Appendix C](#).

If the **Women's Way** local coordinator did not provide a form before the appointment for breast or cervical cancer screening or diagnostic services, contact the local coordinator at [800-449-6636](tel:800-449-6636). Instructions are included to ensure accurate completion.

Forms must be completed and returned to the local coordinator within 30 days of screening and/or diagnostic services.

What is the process for Health Care Facilities/Providers to be reimbursed for Women's Way Services?

1. **Women's Way** reimburses for breast and cervical cancer screening and diagnostic services listed in the What's Covered **Women's Way** CPT Code Medicare Part B Rate List. This list is updated each year.
 - To obtain a current What's Covered List **Women's Way** CPT Code Medicare Part B Rate List, call [800-280-5512](tel:800-280-5512) or go to the **Women's Way** website to obtain the [CPT Code List](#).
2. Some of the CPT codes listed in the What's Covered **Women's Way** CPT Code Medicare Part B Rate List may apply to services other than breast or cervical cancer screenings. CPT codes such as those for office visits will be reimbursed by **Women's Way** only if the office visit includes:
 - Reviewing the individual's breast or cervical cancer risk,
 - Advising when the next breast or cervical cancer screening is due,
 - Breast or cervical cancer screenings or diagnostic services, or
 - If the office visit is for a follow-up to breast or cervical cancer screening or diagnostic services.
3. The health care facility/provider agrees to submit requests for reimbursement to Blue Cross Blue Shield of North Dakota, the designated central reimbursement agency for **Women's Way**.
 - The 12-digit ID number assigned to each client needs to be included on all claim forms for services charged to **Women's Way**

Why is a Signed Provider Cooperative Agreement Needed?

1. All health care facilities/providers must enter into a Provider Cooperative Agreement with **Women's Way before** providing care or submitting claims for services because:
 - It indicates the acceptance of current What's Covered **Women's Way** CPT code Medicare Part B rates as full payment for screening and/or diagnostic services.
 - It indicates agreement to offer screening and/or diagnostic services to all enrolled individuals according to guidelines described in this handbook.
 - Services provided **before** the effective date of the Provider Cooperative Agreement are not reimbursable by **Women's Way**.
2. The health care facility/provider must be accredited with Blue Cross Blue Shield of North Dakota, an independent entity.



Health care providers play a vital role on behalf of their patients by recommending and providing breast and cervical cancer screenings and diagnostic services. Have you made a **Women's Way** referral?

SCREENING AND DIAGNOSTIC SERVICES

Breast Cancer Screening and Diagnostic Services

What breast cancer screening and diagnostic services are available for individuals ages 40 through 64?

- Clinical breast exam (optional).
- Mammogram including a 3D mammogram.
- Alternating mammogram and breast MRI every six months for individuals at high risk for breast cancer.
- Diagnostic tests or consultations that are needed for definitive diagnosis as listed in the What's Covered **Women's Way** CPT Code Medicare Part B Rate List.

What breast cancer screening and diagnostic services are available for symptomatic individuals ages 21 through 39?

- Clinical breast exam to determine a breast abnormality, including a palpable lump, bloody nipple discharge, nipple inversion, ulceration, dimpling, or skin inflammation.
- Diagnostic mammogram, including a 3D diagnostic mammogram, only if a health care provider documented a breast abnormality such as a palpable lump, bloody nipple discharge, nipple inversion, ulceration, dimpling, or inflammation of the skin.
- Diagnostic tests or consultations that are needed for definitive diagnosis as listed in the What's Covered **Women's Way** CPT Code Medicare Part B Rate List.

What breast cancer screening and diagnostic services are available for asymptomatic individuals ages 21 through 39 at high risk for breast cancer?

- Annual breast MRI beginning at age 25.
- Alternating mammogram and breast MRI every six months beginning at age 30.
- Diagnostic tests or consultations that are needed for definitive diagnosis as listed in the What's Covered **Women's Way** CPT Code Medicare Part B Rate List.

Cervical Cancer Screening and Diagnostic Services

What cervical cancer screening and diagnostic services are available for individuals ages 40 through 64?

- Pap test every three years with cytology alone, or every five years with a combination of cytology and HPV testing for women who want to lengthen the screening interval or every five years with primary HPV testing. (These guidelines are for general population screening and do not address high-risk populations. High-risk populations include individuals with a history of cervical cancer, exposure in utero to diethylstilbestrol, or those who are immunocompromised. High-risk individuals may require more frequent screening.)

- Repeat Pap tests needed for a follow-up to abnormal cervical cancer screening or diagnostic results.
- Pap tests for individuals with total hysterectomies (including removal of the cervix) due to cervical neoplasia or cervical cancer.
- Individuals older than 65 should not be screened if they have had adequate prior screening and are not otherwise at high risk for cervical cancer.
- HPV test (High-Risk typing) is an adjunctive screening test to the Pap test for individuals age 30 and older. Testing for low-risk genotypes of HPV is not permitted. Follow-up HPV testing as per ASCCP recommendations.
- Diagnostic tests or consultations that are needed for definitive diagnosis as listed in What's Covered **Women's Way** CPT Code Medicare Part B Rate List.
- **Women's Way** does not pay for Pap tests for individuals with total hysterectomies due to noncancerous reasons, uterine cancer, or ovarian cancer. If an individual does not know if they have a cervix, a pelvic exam should be performed to confirm the presence or absence of the cervix. If there is no cervix, **Women's Way** will not pay for a Pap test.
- For information on the Risk-Based Management Consensus Guidelines, go to the American Society for Colposcopy and Cervical Pathology (ASCCP) website: ASCCP.org.

What cervical cancer screening and diagnostic services are available for individuals ages 21 through 39?

Pap test if the individual has never had a Pap test or has not had a Pap test within the last three to five years, or requires a Pap test as a follow-up to an abnormal Pap test result.

Eligible individuals ages 30 through 39 can receive:

- Conventional or Liquid-Based Pap test every three years with Pap test alone.
- Every five years with a combination of Pap test and HPV or Primary HPV testing.
- Diagnostic services or consultations, as listed in **Women's Way** CPT code Medicare Part B Rate list, if needed.

Eligible individuals ages 21 through 29 can receive:

- Conventional or Liquid-Based Pap test every three years.
- HPV testing, only if an individual has had an abnormal Pap test, and HPV testing is recommended according to the ASCCP guidelines.
- Diagnostic services or consultation as listed in **Women's Way** CPT code Medicare Part B Rate List.



Provider recommendations increase the likelihood of patients following through with life-saving cancer screenings! Your recommendations are vital to life-saving cancer screenings!

ELIGIBILITY AND ENROLLMENT

Who is eligible for Women's Way?

Any individuals who:

- Live in North Dakota.
- Are between the ages of 40 and 64.
- Are uninsured or have insurance that does not cover Pap tests and/or mammograms or cannot afford to pay insurance deductible or co-pay.
- Are not currently enrolled or eligible for Medicare Part B, Medicaid, or Medicaid Expansion.
- Meet income guidelines.
- Are between the ages 21 and 39, have breast cancer symptoms or are at high risk for breast cancer, are due for a Pap test, or need breast or cervical diagnostic procedures.

Are Women's Way services available for men?

Men who meet all program eligibility requirements can receive breast cancer screening and diagnostic services through **Women's Way**.

Are Women's Way services available for transgender women?

Transgender women (male to female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through **Women's Way**.

Are Women's Way services available for transgender men?

Transgender men (female to male) who have not undergone a bilateral mastectomy and meet all program eligibility requirements can receive breast cancer screening and diagnostic services through **Women's Way**.

Transgender men (female to male) who have not undergone a total hysterectomy (i.e., still have a cervix) and meet all other eligibility requirements can receive cervical cancer screening and diagnostic screenings through **Women's Way**.

How does an individual enroll?

An individual can enroll by:

- Calling the **Women's Way** local coordinator in their area at [800-449-6636](tel:800-449-6636) or **Women's Way** State Office at [800-280-5512](tel:800-280-5512) or [701-328-3398](tel:701-328-3398). **Women's Way** local coordinators are available to assist individuals; to expedite the process, potential clients should complete the form [Are You Eligible](#).
- Being referred by a health care provider or clinic staff and then contacted by the local coordinator in the area. Click here for the [Referral Form](#).

TREATMENT

Does Women's Way pay for treatment for an individual diagnosed with breast or cervical cancer or pre-cancer?

1. No, if a **Women's Way** client requires treatment, **Women's Way** does not pay for any treatment services.
2. An uninsured individual can apply for Medicaid, and it will be determined if they are eligible for the North Dakota Medicaid Breast or Cervical Cancer Early Detection Program (managed through Medicaid), which will pay for treatment of breast and cervical cancer or precancerous breast (Ductal Carcinoma In Situ) or cervical conditions.

Treatment includes, but is not limited to:

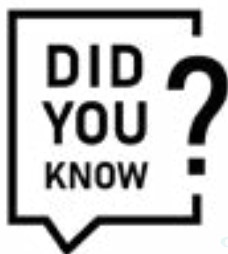
1. Cervical pre-cancer and cancer treatment such as LEEP, cryotherapy, hysterectomy, radiation therapy, and chemotherapy.
2. Breast cancer or pre-cancer treatment, such as surgery, radiation therapy, chemotherapy, and adjunctive therapy such as Tamoxifen or Arimidex.

The following forms are needed for the North Dakota Medicaid Breast or Cervical Cancer Early Detection Program, which will be provided to the health care provider by the **Women's Way** local coordinator. Both forms must be returned to the local coordinator as soon as possible.

- Verification of Diagnosis form (verifies diagnosis and plan of treatment)
- Completion of Treatment form (confirms that treatment has been completed)

Individuals with North Dakota Medicaid Breast or Cervical Cancer Early Detection Program can be verified through the current Medicaid electronic system.

For questions, call North Dakota Medicaid at [877-328-7098](tel:877-328-7098).



Women's Way clients who have been diagnosed with breast or cervical cancer, or cervical abnormalities requiring treatment, and those who have no insurance may be able to enroll in the Medicaid Treatment Program by contacting a Women's Way local coordinator at [800-449-6636](tel:800-449-6636) or Nurse Consultant at [701-328-2389](tel:701-328-2389).

EDUCATION MATERIALS AND RESOURCES

What materials are available from Women's Way at no cost?

- Women's Way program cards
- Breast health palm card
- HPV and Pap tests palm card
- Breast density information for patients and health care providers

Order forms are available online; click here to [Request Women's Way Materials](#).

Order materials by mail, telephone, or fax:

By Mail: **Women's Way**
North Dakota Department of Health and Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, N.D. 58505-0250

By Telephone: [701-328-3398](tel:701-328-3398)

By Fax: [701-328-2036](tel:701-328-2036)

TECHNICAL ASSISTANCE

The **Women's Way** State Office team is available to provide assistance from 8 a.m. - 5 p.m Central Time. Monday through Friday (excluding State-approved holidays). They can be reached by calling 701-328-3398 or emailing womensway@nd.gov or selecting a phone number from the following list:

Billing issues.....	701-328-2389
Covered services or patient-specific questions.....	701-328-2389
General questions.....	701-328-3398 or 800-280-5512
Request program materials or resources.....	701-328-3398 or 800-280-5512



Appendix A - Women's Way Intake and Visit Form

Instructions to complete form:

Page 1

Women's Way local coordinator will complete

- Client information
- Screening Procedures
- Breast Procedures and Screening History

Health care provider will be responsible to complete appropriate areas for the services provided

Clinical Breast Exam

- Results
- Date CBE performed and Date Client Notified of Results (same date)
- Based on CBE results, check appropriate follow-up
- Recommended Procedure if immediate follow-up/diagnostic needed

Mammography/MRI

- Is client at high risk for breast cancer
- Digital Mammogram or Digital Mammogram with Breast Tomosynthesis
- Exam Type – Screening or Diagnostic
- Mammogram or MRI results
- Date Mammogram or Screening MRI Performed and Date Client Notified of Results
- Based on the Mammogram/MRI results, check the appropriate follow-up
- Recommended Procedure if immediate follow-up/diagnostic needed

Page 2

Women's Way local coordinator will complete

- Indication for Cervical Procedure Visit
- Cervical Procedures and Screening History

Health care provider will be responsible to complete appropriate areas for the services provided

Pelvic Exam

- Is client at high risk for cervical cancer?
- Results
- Date Pelvic Exam Performed and Date Client Notified of Results
- Based on the Pelvic Exam results, check the appropriate follow-up
- Recommended Procedure if diagnostic work-up planned

Pap Test

- Specimen Adequacy
- Type Pap test
- Results
- Date Pap Test Performed and Date Client Notified of Results
- HPV Results (if applicable)
- Date HPV Test Performed and Date Client Notified of Results (if applicable)
- Based on the Pap Test/HPV results, check the appropriate follow-up
- Recommended Procedure if immediate follow-up/diagnostic needed



WOMEN'S WAY INTAKE AND SUMMARY VISIT

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH PROMOTION & CHRONIC DISEASE PREVENTION
SFN 51771 (2-2023)

NBCCEDP Paid Patient Navigation Yes No

Navigation Only Yes No

Client Name (Last, First, Middle Initial)		Date of Birth	Alternate ID Number
Enroll / Re-Enroll Date	Enrollment Site	WW Contact Telephone Number	Provider Name
Facility Name		Facility Telephone Number	Appointment Date
Health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former	Interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

SCREENING PROCEDURES (record all procedures, regardless if procedures are paid by Women's Way)

Indication for breast procedure visit: <input type="checkbox"/> Routine screening mammogram <input type="checkbox"/> Surveillance of symptoms, abn CBE or previous abnormal mammogram <input type="checkbox"/> Mammogram not done, CBE only or other diagnostic work-up only	<input type="checkbox"/> Diagnostic referral	Dx referral date
		Dx screening date
		BI-RADs number

BREAST PROCEDURES AND SCREENING HISTORY

Previous mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, date of last mammogram	Implants? <input type="checkbox"/> Yes <input type="checkbox"/> No	Noticed changes in breast? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If Yes, specify changes

Skin different Lump Nipple discharge Nipple inversion Other: _____

The following will be paid for by Women's Way:

CBE Mammogram Screening MRI None 40-49 year old-State paid mammogram Office visit

Office Visit - Provider to Complete

Is client at high risk for breast cancer? Yes No Not assessed

<input type="checkbox"/> Reviewed cancer screening history <input type="checkbox"/> Advised on next screening due	<input type="checkbox"/> * Skin dimpling/retraction <input type="checkbox"/> * Bloody/serous nipple discharge <input type="checkbox"/> * Nipple/areolar scaliness <input type="checkbox"/> * Discrete palp mass - suspicious for cancer	Date of office visit or CBE performed
CBE Results <input type="checkbox"/> Normal <input type="checkbox"/> Benign finding <input type="checkbox"/> Discrete palp mass - (Dx benign)		Date client notified of results

Based on the CBE results, check the appropriate follow-up:

Follow routine screening Short term follow-up ** Number of months: _____
 Immediate follow-up / Diagnostic needed. Cycle is 'Workup Planned' - Must be completed within 60 days

Recommended procedure

MAMMOGRAPHY / MRI - Provider to Complete

Digital mammogram Digital mammogram with breast tomosynthesis (3D) Exam type: Screening Diagnostic

Mammogram Results <input type="checkbox"/> BI-RADS 1 Negative finding <input type="checkbox"/> BI-RADS 2 Benign finding <input type="checkbox"/> BI-RADS 3 Probably benign (Consider short term follow-up) <input type="checkbox"/> * BI-RADS 4 Suspicious abnormality (Biopsy should be considered) <input type="checkbox"/> * BI-RADS 5 Highly suggestive of malignancy (Follow-up needed) <input type="checkbox"/> * BI-RADS 0 Assessment incomplete (Need additional imaging) <input type="checkbox"/> * BI-RADS 0 Assessment incomplete - Film comparison required <input type="checkbox"/> * Result unknown - Presumed abnormal <input type="checkbox"/> Unsatisfactory	Date mammogram performed	Breast Density <input type="checkbox"/> Mostly fatty <input type="checkbox"/> Scattered fibroglandular <input type="checkbox"/> Heterogeneously dense <input type="checkbox"/> Extremely dense
	Date client notified of result	
	Date of Screening MRI	Date client notified of result
	MRI Results <input type="checkbox"/> BI-RADS 1 <input type="checkbox"/> BI-RADS 2 <input type="checkbox"/> BI-RADS 3 <input type="checkbox"/> * BI-RADS 4 <input type="checkbox"/> * BI-RADS 5	<input type="checkbox"/> * BI-RADS 0 <input type="checkbox"/> Not done <input type="checkbox"/> Refused

Based on the mammogram / MRI results, check the appropriate follow-up:

Additional imaging needed Follow routine screening Short term follow-up ** Number of months: _____
 Immediate follow-up / Diagnostic needed. Cycle is 'Workup Planned' - Must be completed within 60 days

Recommended procedure

Client Name	Date of Birth
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Indication for cervical procedure visit:

Routine Pap test
 Surveillance for previous abnormal cervical test result
 Pap test not done, diagnostic work-up or HPV only
 Diagnostic referral
 Pap after primary HPV+ result
 Unknown
 Pelvic exam only

Diagnostic referral date	Pap test date	Result
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CERVICAL PROCEDURES AND SCREENING HISTORY

Previous Pap test? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, date of last Pap test	Have you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If Yes, reason for hysterectomy

Cervical cancer
 Unknown
 Cervical pre-cancer
 Non-cancer
 Other GYN cancer

Do you still have a cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	The following will be paid for by Women's Way: <input type="checkbox"/> Pelvic exam <input type="checkbox"/> Pap test <input type="checkbox"/> HPV <input type="checkbox"/> None <input type="checkbox"/> Office visit
--	--

Office Visit - Provider to Complete **Is client at high risk for cervical cancer?**
 Yes
 No
 Not assessed

<input type="checkbox"/> Reviewed cancer screening history <input type="checkbox"/> Advised on next screening due	Pelvic Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal-not suspicious for cancer <input type="checkbox"/> Abnormal-suspicious for cancer	Date of office visit or pelvic exam <hr/> Date client notified of results
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Based on the Pelvic Exam results, check the appropriate follow-up:

Follow routine screening
 Short term follow-up **
 Number of months: _____
 Diagnostic - 'Workup Planned'

Recommended procedure

PAP TEST (USE 2001 BETHESDA SYSTEM CATEGORIES) / HPV - Provider to Complete

Specimen adequacy <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory	Type of Pap test <input type="checkbox"/> Conventional Pap smear <input type="checkbox"/> Liquid based
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Results

Negative (WNL) or Negative for intra. lesion or malignancy
 ASC-US - atypical squamous cells, undetermined significance
 Low Grade SIL (Including HPV changes/CIN 1)
 * ASC-H - atypical squamous cells, cannot exclude High Grade
 * High Grade SIL - suspicious for invasion (CIN 2 and CIN 3/CIS)
 * AGC - Abnormal glandular cells
 * AIS - Endocervical adenocarcinoma *in situ*
 * Adenocarcinoma
 * Squamous cell carcinoma*
 * Result unknown, presumed abnormal - not paid

Unsatisfactory
 Pending
 Other: _____

Date Pap test performed	Date client notified of results
-------------------------	---------------------------------

HPV results (High risk typing, only) <input type="checkbox"/> Negative <input type="checkbox"/> Positive with genotyping not done/unk <input type="checkbox"/> Positive with positive genotyping <input type="checkbox"/> Positive with negative genotyping	Date HPV test performed <hr/> Date client notified of results
--	--

Based on the Pap test / HPV results, check the appropriate follow-up:

Follow routine screening
 Short term follow-up **
 Number of months: _____
 Immediate follow-up / Diagnostic needed. Cycle is 'Workup Planned' - Must be completed within 90 days

Recommended procedure

Comments:

According to the Privacy Act of 1974, this is to let *Women's Way* clients know that disclosure of a social security number to *Women's Way* is voluntary and it is requested for identification purposes only. Failure to disclose this information will not affect participation in this program.

* Additional diagnostics required - cycle is '**Workup Planned**' and/or if you choose to perform diagnostic tests.
 ** Check "Short Term Follow-up" if diagnostic work-up is not planned but screening tests are recommended before the next routine screening.



Appendix B - Women's Way Breast Diagnostic Results Form

Instructions to complete form:

Page 1

Women's Way local coordinator will complete

- Client Name, Date of Birth, Alternate ID Number, Facility Name, Provider Name, and Appointment Date

Health Care providers will be responsible to complete appropriate areas for the services provided (pages 1 and 2)

Mark the procedure or procedures that were provided

- Results
- Date procedure was performed and Date Client Notified of Results
- Recommended Follow-Up

Page 2

Health Care providers will be responsible to complete the following area under Final Diagnosis

- Final Diagnosis Results
- Date of Final Diagnosis

Women's Way local coordinator will complete the other areas under Final Diagnosis and Breast Cancer Treatment Status



WOMEN'S WAY BREAST DIAGNOSTIC RESULTS

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES

HEALTH PROMOTION & CHRONIC DISEASE PREVENTION

SFN 51772 (2-2023)

Page 1 of 2

For LCU Use Only

Navigation Only

Yes No

Client Name (Last, First)	Date of Birth	Alternate ID Number
Facility Name	Provider Name	Appointment Date

Consultant / Repeat Breast Exam

Result: <input type="checkbox"/> Normal <input type="checkbox"/> Benign Finding <input type="checkbox"/> Bloody /serous nipple discharge* <input type="checkbox"/> Discrete Palp mass - (Dx Benign) <input type="checkbox"/> Nipple/areolar scaliness* <input type="checkbox"/> Discrete Palp mass - Susp for Cancer* <input type="checkbox"/> Skin dimpling /retraction* <input type="checkbox"/> Refused <input type="checkbox"/> Not done-other/unknown reason	Date Repeat CBE Performed	Date Client Notified
Repeat CBE Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Additional Views/Diagnostic Mammogram **Film Comparison**

Results <input type="checkbox"/> BI-RADS 1 Negative Finding <input type="checkbox"/> BI-RADS 2 Benign Finding <input type="checkbox"/> BI-RADS 3 Probably Benign (Consider Short Term Follow-up) <input type="checkbox"/> BI-RADS 4 Suspicious Abnormality (Biopsy should be Considered)* <input type="checkbox"/> BI-RADS 5 Highly Suggestive of Malignancy (Take Appropriate Action)* <input type="checkbox"/> BI-RADS 6 Known Biopsy - Proven Malignancy* <input type="checkbox"/> BI-RADS 0 Assessment Incomplete (Need Additional Imaging)* <input type="checkbox"/> Result Unknown - Presumed Abnormal* <input type="checkbox"/> Unsatisfactory Film <input type="checkbox"/> Result Pending <input type="checkbox"/> Film Comparison Required	Date Mammogram or Film Comparison Performed
Date Client Notified of Result	
Dx Mammogram Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Film Comparison Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Recommended Follow-Up:

<input type="checkbox"/> Follow Routine Screening Schedule	<input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____
<input type="checkbox"/> Additional Mammographic Views	<input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration
<input type="checkbox"/> Repeat Mammogram Immediately	<input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI

Ultrasound **MRI**

Results <input type="checkbox"/> BI-RADS 1 <input type="checkbox"/> BI-RADS 2 <input type="checkbox"/> BI-RADS 3 <input type="checkbox"/> BI-RADS 4 <input type="checkbox"/> BI-RADS 5 <input type="checkbox"/> BI-RADS 0 <input type="checkbox"/> BI-RADS 6 <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date Ultrasound Performed	Results <input type="checkbox"/> BI-RADS 1 <input type="checkbox"/> BI-RADS 2 <input type="checkbox"/> BI-RADS 3 <input type="checkbox"/> BI-RADS 4 <input type="checkbox"/> BI-RADS 5 <input type="checkbox"/> BI-RADS 0 <input type="checkbox"/> BI-RADS 6 <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date MRI Performed
Date Client Notified of Result		Date Client Notified of Result	
US Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No		MRI Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Recommended Follow-Up: <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Surgical Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> Additional Imaging _____ <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Follow Routine Screening Schedule <input type="checkbox"/> Short-Term Follow-up _____ Number of Months: ____	Recommended Follow-Up: <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Surgical Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> Additional Imaging _____ <input type="checkbox"/> Fine Needle Aspiration <input type="checkbox"/> Follow Routine Screening Schedule <input type="checkbox"/> Short-Term Follow-up _____ Number of Months: ____
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Surgical Consultation

Results <input type="checkbox"/> No Intervention, Routine Follow-Up <input type="checkbox"/> Short-Term Follow-Up <input type="checkbox"/> Biopsy/FNA Recommended <input type="checkbox"/> Refused <input type="checkbox"/> Ultrasound Recommended <input type="checkbox"/> Surgery or Treatment Recommended <input type="checkbox"/> Not done--other/unknown reason	Date Consult Performed
Date Client Notified of Result	
Consult Paid by Women's Way? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Client Name (Last, First)	Date of Birth
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Surgical Consultation Recommended Follow-Up:

- | | |
|--|--|
| <input type="checkbox"/> Follow Routine Screening Schedule | <input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____ |
| <input type="checkbox"/> Additional Mammographic Views | <input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration |
| <input type="checkbox"/> Repeat Mammogram Immediately | <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI |

Fine Needle Aspiration

Results <input type="checkbox"/> Inadequate Sample of Fluid or Tissue <input type="checkbox"/> Not Suspicious for Cancer / Benign Carcinoma <input type="checkbox"/> Suspicious for Cancer <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date FNA Performed Date Client Notified of Result FNA Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

- | | |
|--|--|
| <input type="checkbox"/> Follow Routine Screening Schedule | <input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____ |
| <input type="checkbox"/> Additional Mammographic Views | <input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration |
| <input type="checkbox"/> Repeat Mammogram Immediately | <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI |

Biopsy

Results <input type="checkbox"/> Normal Breast Tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other Benign Changes <input type="checkbox"/> Atypical Ductal Hyperplasia (ADH) <input type="checkbox"/> Invasive Breast Cancer <input type="checkbox"/> Lobular CIS <input type="checkbox"/> Ductal CIS <input type="checkbox"/> CIS - Other <input type="checkbox"/> Refused <input type="checkbox"/> Not done--other/unknown reason	Date Biopsy Performed Date Client Notified of Result Biopsy Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

- | | |
|--|--|
| <input type="checkbox"/> Follow Routine Screening Schedule | <input type="checkbox"/> Short-Term Follow-up mammogram: Number of Months: _____ |
| <input type="checkbox"/> Additional Mammographic Views | <input type="checkbox"/> Ultrasound <input type="checkbox"/> Surgical Consultation <input type="checkbox"/> Fine Needle Aspiration |
| <input type="checkbox"/> Repeat Mammogram Immediately | <input type="checkbox"/> CBE by Consult <input type="checkbox"/> Biopsy <input type="checkbox"/> MRI |

FINAL DIAGNOSIS RESULTS

<input type="checkbox"/> Cancer Not Diagnosed <input type="checkbox"/> Cancer Diagnosed* <input type="checkbox"/> Refused <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> Irreconcilable/Incomplete <input type="checkbox"/> Other (specify): _____	Date of Final Diagnosis
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If cancer diagnosed, complete the following:

Cancer Stage <input type="checkbox"/> Ductal Carcinoma in Situ (DCIS) - Stage 0* <input type="checkbox"/> Lobular Carcinoma in Situ (LCIS) - Stage 0* <input type="checkbox"/> Invasive Breast Cancer*
Tumor Stage <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV <input type="checkbox"/> Stage Unknown <input type="checkbox"/> Unstaged <input type="checkbox"/> Summary Local <input type="checkbox"/> Summary Regional <input type="checkbox"/> Summary Distant
Tumor Size in CM (use decimal format and largest measurement; example: 1x2.4 = 2.4 cm)

BREAST CANCER TREATMENT STATUS

Treatment Status Date (date treatment plan developed and started)	Treatment Status <input type="checkbox"/> Started <input type="checkbox"/> Pending/Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Lost to Follow-Up
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If treatment started, complete the following:

Treatment Provided	Date Provided	Treatment Provided	Date Provided
<input type="checkbox"/> Lumpectomy		<input type="checkbox"/> Radiation	
<input type="checkbox"/> Modified Mastectomy		<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Modified Radical Mastectomy		<input type="checkbox"/> Other:	
Treatment Provided By			

* Additional diagnostic tests required



Instructions to Complete *Women's Way* Cervical Diagnostic Results Form

Page 1

***Women's Way* local coordinator will complete**

- Client Name, Date of Birth, Alternate ID Number, Facility Name, Provider Name and Appointment Date

Health Care providers will be responsible to complete appropriate areas for the services provided (pages 1 and 2)

Mark the procedure or procedures that were provided

- Results
- Date procedure was performed and Date Client Notified of Results
- Recommended Follow-Up

Page 2

Health Care providers will be responsible to complete the following area under Final Diagnosis

- Final Diagnosis Results
- Date of Final Diagnosis
- Date Client Notified of Final Diagnosis

***Women's Way* local coordinator will complete**

- Status of Final Diagnosis under Final Diagnosis
- Cervical Cancer Treatment Status



WOMEN'S WAY CERVICAL DIAGNOSTIC RESULTS
 NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
 HEALTH PROMOTION & CHRONIC DISEASE PREVENTION
 SFN 52197 (2-2023)

For LCU Use Only

Navigation Only: Yes No

Client Name (Last, First)	Date of Birth	Alternate ID Number
Facility Name	Provider Name	Appointment Date

Colposcopy with Biopsy **Colposcopy Without Biopsy**

Results: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Other Nonmalignant Abnormality (HPV, condyloma) <input type="checkbox"/> Not done - other/unknown reason <input type="checkbox"/> Refused	<input type="checkbox"/> CIN 1 - Mild Dysplasia <input type="checkbox"/> CIN 2 - Moderate Dysplasia <input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS	Results: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Infect/Inflam/React Changes <input type="checkbox"/> Other Abnormality <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Not done - other/unknown reason <input type="checkbox"/> Refused
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Date Colposcopy Performed	Date Client Notified of Result	Colposcopy Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

Pap in 1 year Pap in 2 years Pap in 3 years
 Repeat Pap Immediately Short-Term Follow-up : Number of Months: _____
 Colposcopy Alone Colposcopy with Biopsy Colposcopy with ECC Other Biopsy
 Cold Knife Cone (CKC) Definitive Treatment Gynecologic Consultation Pelvic Ultrasound
 HPV Test Hysterectomy LEEP

Colposcopy with Biopsy and ECC **Colposcopy with ECC** **Endocervical Curettage (ECC)**

Results: <input type="checkbox"/> Negative (WNL) <input type="checkbox"/> Invasive Squamous Cell Carcinoma <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Other Nonmalignant Abnormality (HPV, condyloma) <input type="checkbox"/> Not done - other/unknown reason <input type="checkbox"/> Refused	<input type="checkbox"/> CIN 1 - Mild Dysplasia <input type="checkbox"/> CIN 2 - Moderate Dysplasia <input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS <input type="checkbox"/> No Tissue Present
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Date Performed	Date Client Notified of Result	Paid by <i>Women's Way</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

Pap in 1 year Pap in 2 years Pap in 3 years
 Repeat Pap Immediately Short-Term Follow-up : Number of Months: _____
 Colposcopy Alone Colposcopy with Biopsy Colposcopy with ECC Other Biopsy
 Cold Knife Cone (CKC) Definitive Treatment Gynecologic Consultation Pelvic Ultrasound
 HPV Test Hysterectomy LEEP

Client Name (Last, First)	Date of Birth
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Other Procedures (NOT REIMBURSABLE WITH WOMEN'S WAY FUNDS):

LEEP
 Cold Knife Cone
 Other Biopsy
 Pelvic Ultrasound
 Hysterectomy

Other (specify): _____
 Complete additional forms if more than one "Other" procedure is done.

Results:

<input type="checkbox"/> Negative (WNL)	<input type="checkbox"/> CIN 1 - Mild Dysplasia	<input type="checkbox"/> Other Nonmalignant Abnormality (HPV, condyloma)
<input type="checkbox"/> Invasive Squamous Cell Carcinoma	<input type="checkbox"/> CIN 2 - Moderate Dysplasia	<input type="checkbox"/> Not done - other/unknown reason
<input type="checkbox"/> Adenocarcinoma	<input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS	<input type="checkbox"/> Refused

Date Procedure Performed	Date Client Notified	Procedure Paid by <i>Women's Way</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Recommended Follow-Up:

Pap in 1 year
 Pap in 2 years
 Pap in 3 years

Repeat Pap Immediately
 Short-Term Follow-up : Number of Months: _____

<input type="checkbox"/> Colposcopy Alone	<input type="checkbox"/> Colposcopy with Biopsy	<input type="checkbox"/> Colposcopy with ECC	<input type="checkbox"/> Other Biopsy
<input type="checkbox"/> Cold Knife Cone (CKC)	<input type="checkbox"/> Definitive Treatment	<input type="checkbox"/> Gynecologic Consultation	<input type="checkbox"/> Pelvic Ultrasound
<input type="checkbox"/> HPV Test	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> LEEP	

FINAL DIAGNOSIS

<p>Final Diagnosis Results:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Normal/Benign/Inflammation</td> <td><input type="checkbox"/> CIN 2 - Moderate Dysplasia *</td> </tr> <tr> <td><input type="checkbox"/> HPV/Condylomata/Atypia</td> <td><input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS *</td> </tr> <tr> <td><input type="checkbox"/> Low Grade SIL</td> <td><input type="checkbox"/> High Grade SIL *</td> </tr> <tr> <td><input type="checkbox"/> CIN 1 - Mild Dysplasia</td> <td><input type="checkbox"/> Invasive Cervical Carcinoma *</td> </tr> <tr> <td><input type="checkbox"/> Other (specify): _____</td> <td></td> </tr> </table> <p>* Treatment is required. Treatment is optional for HPV, CIN I, LSIL, and Other</p>	<input type="checkbox"/> Normal/Benign/Inflammation	<input type="checkbox"/> CIN 2 - Moderate Dysplasia *	<input type="checkbox"/> HPV/Condylomata/Atypia	<input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS *	<input type="checkbox"/> Low Grade SIL	<input type="checkbox"/> High Grade SIL *	<input type="checkbox"/> CIN 1 - Mild Dysplasia	<input type="checkbox"/> Invasive Cervical Carcinoma *	<input type="checkbox"/> Other (specify): _____		<p>Cancer Stage:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Stage I</td> <td><input type="checkbox"/> Summary Local</td> </tr> <tr> <td><input type="checkbox"/> Stage II</td> <td><input type="checkbox"/> Summary Regional</td> </tr> <tr> <td><input type="checkbox"/> Stage III</td> <td><input type="checkbox"/> Summary Distant</td> </tr> <tr> <td><input type="checkbox"/> Stage IV</td> <td><input type="checkbox"/> Unstaged</td> </tr> <tr> <td><input type="checkbox"/> Stage Unknown</td> <td></td> </tr> </table>	<input type="checkbox"/> Stage I	<input type="checkbox"/> Summary Local	<input type="checkbox"/> Stage II	<input type="checkbox"/> Summary Regional	<input type="checkbox"/> Stage III	<input type="checkbox"/> Summary Distant	<input type="checkbox"/> Stage IV	<input type="checkbox"/> Unstaged	<input type="checkbox"/> Stage Unknown	
<input type="checkbox"/> Normal/Benign/Inflammation	<input type="checkbox"/> CIN 2 - Moderate Dysplasia *																				
<input type="checkbox"/> HPV/Condylomata/Atypia	<input type="checkbox"/> CIN 3 - Severe Dysplasia/CIS *																				
<input type="checkbox"/> Low Grade SIL	<input type="checkbox"/> High Grade SIL *																				
<input type="checkbox"/> CIN 1 - Mild Dysplasia	<input type="checkbox"/> Invasive Cervical Carcinoma *																				
<input type="checkbox"/> Other (specify): _____																					
<input type="checkbox"/> Stage I	<input type="checkbox"/> Summary Local																				
<input type="checkbox"/> Stage II	<input type="checkbox"/> Summary Regional																				
<input type="checkbox"/> Stage III	<input type="checkbox"/> Summary Distant																				
<input type="checkbox"/> Stage IV	<input type="checkbox"/> Unstaged																				
<input type="checkbox"/> Stage Unknown																					

Status of Final Diagnosis: <input type="checkbox"/> Complete <input type="checkbox"/> Refused <input type="checkbox"/> Lost to Follow-Up	Date of Final Diagnosis	Date Client Notified of Final Diagnosis
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CERVICAL CANCER TREATMENT STATUS

Date Treatment Plan Developed and Started

Treatment Status:

Started
 Pending
 Tx Not Needed
 Refused
 Lost to Follow-Up

Treatment Provided	Date Performed
Cryotherapy	
LEEP	
Laser Therapy	
Cone Biopsy	
Hysterectomy	
Radiation	
Systemic Chemotherapy	
Other	

Treatment Provided By