BREAST AND CERVICAL CANCER MEDICAID (BCCM)

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I. INTRODUCTION

Breast and Cervical Cancer Prevention and Treatment Act of 2000 provides full Medicaid coverage to women diagnosed with and who need treatment for breast or cervical cancer and/or precancerous conditions of the breast or cervix including other medical related services.

This coverage provided under the Breast and Cervical Cancer control Program, a screening service for early detection of breast and cervical cancer. Local health departments, community health centers, and other designated medical facilities provide screening for BCCCP.

To be enrolled and screened for BCCCP the woman must:

A. Be under age 65

B. Have income at or below 250% of the current Federal Poverty Level

C. Not be currently enrolled in any creditable medical insurance coverage.

1. The following types of coverage are considered creditable medical insurance coverage:

   a. Individual or group medical plan,

   b. Medical insurance coverage, which is a benefit consisting of medical care under any hospital or medical service policy or certificate, hospital or medical services plan contract, or HMO organization contract offered by a medical insurance issuer,

   c. Medicare A or B,

   d. Enrolled in a full Medicaid benefit program,

   e. Military-sponsored health care program or

   f. A state health risk pool.

2. In certain situations, a woman with creditable medical insurance coverage may be eligible for BCCM.

   If the applicant meets either criteria listed below the requirement for having no creditable insurance is met:

a. If the coverage consists solely of limited benefits such as accident or limited-scope dental, vision, or long term-care, or Family Planning the individual may be eligible for BCCM, or

b. The applicant has major medical insurance, but coverage does not include treatment of breast or cervical cancer.

D. Women who move to North Carolina:

Women who are screened and approved for BCCCP in another state and relocate to North Carolina do not have to be screened again by NC BCCCP. However, they must have a health care provider located in NC and contact an NC BCCCP Coordinator to complete an application for NC BCCM.

II. BREAST AND CERVICAL CANCER MEDICAID (BCCM) ELIGIBLITY

There is no income or resource test for BCCM. The applicant/beneficiary meets the Medicaid income and resource test based on eligibility for BCCCP.

A. To be eligible for BCCM, the woman must:

1. Be approved by BCCCP.

2. Not be eligible for another full Medicaid benefit. Do not authorize the woman for BCCM if she is eligible for another full Medicaid benefit. If the woman is potentially eligible for MAF-M (medically needy), authorize for MAF-M if medical expenses meet the deductible as of the date of the BCCM application.

3. Be a citizen of the U.S. or be an alien who meets the criteria contained in MA-3332, US Citizenship Requirements and/or MA-3330, Alien Requirements.

   a. If the woman is an alien limited to emergency medical care only, she may still be able to receive Medicaid coverage related to an "emergency condition," other than services related to an organ transplant. Breast or cervical cancers may be identified at various stages.

   b. If the woman is a qualified alien, verify the alien status and date of admission using Systematic Alien Verification for Entitlement Program SAVE.

4. Be a resident of North Carolina as defined in MA-3335, State Residency.

5. Not be an inmate of a public institution. Individuals incarcerated in a NC Department of Public Safety, Division of Prisons (DOP) facility may have their eligibility placed in suspension if they remain otherwise eligible. Refer to MA-2510 or MA-3360, Living Arrangement.

6. Furnish a Social Security number or apply for a number. Refer to MA-3355, Enumeration Procedures.

7. Cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any child who is currently receiving Medicaid. Refer to MA-3365, Child Support.

8. Beneficiary is not required to meet Caretaker/Relative requirements.

B. If the woman states she is disabled, the caseworker will utilize the DHB-5079 to evaluate for Medicaid Aid to the Disabled (MAD). The caseworker should attempt to contact the woman by telephone to complete the disability determination assessment in NCFAST. If the telephone attempt is unsuccessful, the caseworker must mail the DHB-5097, Request for Information, to the woman advising her to contact the caseworker to complete the disability determination assessment.

Refer to MA 2300 Application, for processing requirements.

III. APPLICATION

A. The BCCM application (DHB-5079) is completed by the BCCCP provider. No interview is required by the local agency.

B. The BCCCP provider faxes or mails the DHB-5079 to the local agency.

Local agency must establish and maintain a fax/mail-in log to register and track all BCCM applications.

C. The application is considered complete when received in the local agency and:

1. The DHB-5079 is signed and dated by the applicant and BCCCP coordinator/staff.

2. Section I and Section II (name, home address, social security number, and date of birth) are completed.

The application date is the date the completed DHB-5079 is received in the local agency.

D. The DHB-5081, Verification of Screening, Diagnosis and Treatment is required, and is considered complete when:

1. Signed by a physician

2. Has patient's name

3. Includes date of diagnosis

4. Estimated length of treatment

If the DHB-5081is not received from the BCCCP Coordinator, the worker must request a copy and fax to DHB, Eligibility Services.

E. The local agency faxes the DHB-5081to DHB Eligibility Services for submission to Division of Public Health (DPH). Once DPH determines treatment criteria and establishes needed months of treatment, the DHB-5081 is faxed back to the local agency from DHB.

F. The caseworker evaluates for all Medicaid programs except Family Planning Program (FPP) before approval under BCCM:

1. If incurred medical expenses meet a deductible as of the date of the BCCM application; authorize as MAF-M/medically needy.

2. If applicant claims disability, but has not been determined disabled, evaluate for MAD as noted in II. B above and approve BCCM.

G. Medicaid Classification Codes

1. W - Citizen receiving full coverage benefits

2. T - Qualified alien receiving full coverage benefits

3. U - Qualified alien eligible for emergency services only

4. V - Non-qualified alien eligible for emergency services only

H. Women receiving BCCM are eligible for Non-Emergency Medical Transportation (NEMT). Refer to MA-3550, NEMT.

IV. RETROACTIVE COVERAGE

A. The applicant may request up to 3 months of retroactive coverage under BCCM.

B. Retroactive coverage only applies if, as of the earlier date, the woman met all eligibility requirements. This includes having been screened and found to need treatment for breast or cervical cancer in the retroactive month.

C. The retroactive months are separate from the ongoing certification period.

V. PROCESSING THE APPLICATION

The caseworker must:

A. Check all electronic data sources and other available records – FNS, WFFA, etc. Certain information can only be requested and/or verified post (after) eligibility determination. Refer to MA-3205, Post Eligibility.

B. Only ask the applicant to provide documentation:

1. When unavailable within the local agency or from electronic sources

2. When income is not reasonably compatible with self-attestation

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VI. CERTIFICATION

The certification period is based on the woman's course of treatment as established by a physician and approved by the Division of Public Health (DPH). This information is provided on the DHB-5081.

A. The certification period begins with the first day of the application month the woman is found to meet all eligibility requirements for BCCM, as stated on the DHB-5081.

B. The certification period ends on:

1. The twelfth month, or

2. The last month of the estimated period of treatment stated on the DHB-5081 and, can be less than 12 months.

VII. RECERTIFICATION

A recertification must be completed before the end of the certification period.
Women must be evaluated for all other Medicaid programs prior to being recertified as BCCM.

When a woman is found ineligible for all other Medicaid programs, evaluate for continuing BCCM eligibility:

A. Ex-parte process

1. All recertifications must be completed as ex-parte using electronic data sources and available agency records first to determine continued eligibility.

2. The caseworker is required to:

   a. Conduct all electronic matches, including OVS

   b. Check other available records

   c. Contact beneficiary only if continuing eligibility cannot be determined by available information

B. Mail DHB-5081R, Recertification for Continuing BCCM Eligibility to the BCCCP screening provider.

1. When the BCCCP provider returns the DHB-5081R; fax it to DHB Eligibility Services.

2. Once DPH determines treatment criteria and establishes needed months of continued treatment, the DHB-5081R is faxed to the local agency.

C. Once the local agency receives the DHB-5081R, complete the recertification.

1. If continuing need of treatment is established, recertify for the appropriate months of treatment indicated, not to exceed 12 months.

2. If there is no continuing need of treatment, evaluate for all other programs

VIII. CHANGE IN SITUATION

A. Evaluate for all other Medicaid programs when the woman

1. Turns 65 years old

2. Has obtained creditable medical insurance coverage; including Medicare, See Section I above or,

3. Is no longer receiving treatment for cancer

B. If the beneficiary is no longer eligible, terminate the BCCM and send appropriate notice DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance.

C. Notify the BCCCP Coordinator using the 'authorized representative' field for terminations.

D. Refer to Long-Term Care Budgeting MA-2270, if the woman enters a long-term care facility. Compute a patient monthly liability and enter into NC FAST. Advise the woman to apply for Medicaid for the Disabled (MAD).

IX. APPEALS AND HEARINGS

Follow Appeals section for Medicaid eligibility appeals Refer to MA-2420 or MA-3430, Notice and Hearing Process.