Case Management and Patient Navigation

EWC Provider Orientation

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Case Management and Patient Navigation Purpose

Case management involves identifying and resolving recipient barriers to receiving and completing recommended services. This includes the follow-up of a recipient with abnormal results and/or informing a recipient with normal results of appropriate rescreening intervals

- PCP's shall maintain a system of essential support services to ensure EWC patients :
  - receive timely and appropriate screening services
  - return for routine screening, diagnostic and treatment services
  - identify and overcome barriers to achieve screening, definitive diagnosis, and treatment.

Case Management and Patient Navigation

EWC Primary Care Providers are required to:

- Assess an individual patient's barriers to care
- Assist with resolution of identified barriers such as:
  - Transportation
  - Scheduling
  - Childcare or elderly care issues
  - Cultural Beliefs
  - Lack of understanding of value of follow-up procedures
  - Others
- Provide patient education and support as needed
- Document all patient contacts in the medical record including notification of test results.
- Collect and submit required data in DETEC

Case Management and Patient Navigation Recall, Tracking, and Follow Up System

- Implement a tracking system to:
  - Ensure that all screening tests and any necessary diagnostic follow up services are completed
  - Bring patients back in for next routine screening
  - Notify patients of results in a timely manner
  - Refer for further diagnostics and treatment, as necessary
- Must ensure that all patient contacts are recorded in the medical record including notification of test results

Note: EWC has reminder/recall cards for patients to remind them that they are due for screening. You can print them from the EWC website.

Case Management and Patient Navigation

Quality Clinical Standards: Patient Notifications

After receipt of test results, the PCP must notify the patient within these specified timeframes:

Test Result	Number of Calendar Days
Normal	30
Abnormal	14
Cancer	7

All notices must be documented in the medical record

Case Management and Patient Navigation Quality Clinical Standards: Timelines

Diagnostics

- Refer patients for diagnostic evaluation immediately but no longer than 14 calendar days from receipt of abnormal screening results (when indicated)

- Reach final diagnosis within 60 calendar days from receipt of abnormal breast or cervical test results or findings

Case Management and Patient Navigation Quality Clinical Standards: Timelines

» Treatment

- Refer for treatment for patients with breast or cervical cancer or high-grade cervical diagnoses immediately but no more than 7 calendar days from receipt of diagnosis

- Begin treatment within 60 calendar days from receipt of diagnosis of breast or cervical cancer or other high grade cervical diagnoses (HSIL, CIN2, CIN3/CIS)

Case Management and Patient Navigation Treatment

- EWC recipients with cancer or precancerous conditions must be referred to a source of healthcare coverage or enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP)
- More information on the BCCTP website
  - https://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx
  - Patient must be present – wet ink signature required
  - Submit internet-based application form
  - For help with BCCTP enrollment, call 1-800-824-0088
- All BCCTP applicants MUST also apply for full scope Medi-Cal within 30 days of the BCCTP application.

Case Management and Patient Navigation Quality Clinical Standards: Patient Notifications

- PCP should make at least three (3) attempts to contact the recipient either by mail, electronically or by phone; and at least one method of contacting recipients should verify if notification was received
- That can be done via certified mail/first class mail that requires a recipient signature or via electronic communication, such us dedicated secure messaging platforms and applications, encrypted email services, and Electronic Health Record (EHR) chat
- Recipients should provide written consent specifying their preferred method of notification

Case Management and Patient Navigation EWC Definition: Refused Care

Recipient requires immediate diagnostic services but:

- Refuses the procedure
- Gets Medi-Cal or other insurance coverage
- Changes their PCP (for any reason)
- Fails to schedule or keep appointments
- Fails to respond to telephone messages or certified letter, but letter was delivered
- Moves

Note: If a client refuses care, it is important to note this in the medical records, along with the reason

Case Management and Patient Navigation Definition: Lost to follow-up

- This status should be selected for recipients who required immediate diagnostic work-up but providers were unable to reach them after at least three (3) attempts to contact the recipient either by mail, electronically or by phone.
- A PCP shall document all attempts to notify the recipient as specified in this section and retain this documentation in the recipient's records
- Recipients are not considered "lost to follow-up" if they can be located.

Case Management Billing and Payment

- EWC pays PCPs for reporting outcomes of recipients' breast and/or cervical cancer procedures in DETEC
- The only cycles eligible for reimbursement for case management services are those with findings that require immediate work-up and an additional referral together with coordination of services
- EWC does not pay for case management for recipients who require routine or short-term follow-up re-screening
- Payment for case management will be based on submission of complete, accurate data

Case Management Billing and Payment

- Case management is billed using HCPCS code T1017
- T1017 is payable only to providers enrolled as PCPs in EWC and only for recipients enrolled in the EWC program
- Although the T1017 description is in units of 15 minutes, for EWC the quantity of units allowed for reimbursement is only one unit per recipient per provider per calendar year regardless of the time required to complete case management services. The amount reimbursed is $50.
- The date of service for a case management claim is the date the cycle was completed and submitted in DETEC.