

# Breast & Cervical Health Check

State of Alaska

Division of Public Health

Women's, Children's & Family Health

3601 C Street, Suite 322

Anchorage, AK 99503

**1-800-410-6266**



# What is BCHC?

- **Part of the NBCCEDP - National Breast & Cervical Cancer Early Detection Program**
- **1 of 68 programs in the U.S.**  
(50 States, District of Columbia, 4 US Territories and 13 Tribes)
- **Funded by the Centers for Disease Control & Prevention (Approximately \$2.5M) and the Alaska**

# What do we do?

We pay BCHC providers for approved breast and cervical health screening services, appropriate to a woman's age and clinical history:

- Clinical Breast Exam
- Pap Test
- Mammogram
- Diagnostic Work Up

# How do we do it?

- **We establish agreements with primary care clinician offices, labs, hospitals, imaging centers and specialist offices state wide**
- **On a fee for service basis, clinicians see eligible women, and bill BCHC**
- **Currently, there are over 150 providers, including Public Health Centers, screening and diagnosing women through BCHC**

# What women are eligible?

- **Any woman age 21-64, with a family income below program limits, income is assessed annually**
- **Uninsured or under-insured women**

# Program Accomplishments

*1995 - 2009*

- **50,000+ Individual Women Screened**
- **76,000+ Cancer Screenings**
- **319 Cases of Breast Cancer Diagnosed**
- **41 Cases of Cervical Cancer Diagnosed**
- **2,900+ Pre-Cancerous Cervical Conditions Diagnosed.**

# Which providers are eligible?

- **Physicians**
- **Osteopathic Physicians**
- **Certified Physician Assistants**
- **Advanced Nurse Practitioners**
- **Certified Nurse Midwives**
- **Diagnostic service providers licensed or certified to perform specific medical tasks (e.g., Mammography, pathology, etc.)**

# What are the benefits of becoming a provider?

- Women diagnosed by a BCHC provider with breast or cervical cancer, or a pre-cancerous condition requiring treatment are eligible to be referred to the Division of Public Assistance to access special “B&C Medicaid” funds.
- Ongoing program support and technical assistance
- Referrals into your practice (if desired)
- Breast and cervical patient education materials for distribution in your clinic (if desired)

# BCHC Operations in Your Clinic

The following sections are designed to provide more detailed information about specific operational matters: Provider Agreements, client enrollment and eligibility, data collection forms and methods, billing and reimbursement, and referral to treatment if a cancer diagnosis is made.

*For the remainder of this presentation, you will need to click your mouse each time you would like a new slide to appear.*

# BCHC Providers

The State of Alaska requires that a written agreement be signed between BCHC and any provider seeking payment for BCHC services

BCHC has two kinds of Provider Agreements:

- Screening Provider Agreement
- Clinical Consultant/Resource Provider Agreement

State of Alaska, Department of Health and Social Services  
Division of Public Health  
Grants & Contracts Support Team  
P.O. Box 110650, Juneau, AK 99811-0650  
**BREAST & CERVICAL HEALTH CHECK  
SCREENING PROVIDER AGREEMENT**

\_\_\_\_\_, (Provider) enters into a Provider Agreement with the State of Alaska, Department of Health & Social Services (DHSS) for the purpose of providing breast and cervical cancer screening and diagnostic services (referred to herein as clinical services) to age and income eligible women for the State of Alaska's Breast & Cervical Health Check (BCHC) program. By entering into this Provider Agreement, the Provider agrees to the following, including all applicable provisions of Appendices A – D and Enclosures:

**APPENDICES:**

- A. 7 AAC 81, Grant Services for Individuals, Revised 6/24/04
- B. Privacy & Security Procedures for Providers
- C. Federal Assurances & Certifications  
Provider Profile

**ENCLOSURES:**

"BCHC Basics" – a Service Delivery Guide  
Clinical Guidelines for Breast Cancer and Cervical Cancer Screening ("Clinical Guidelines")  
BCHC Listing of Approved CPT Codes  
BCHC Screening & Enrollment Forms

**I. PROVIDER ELIGIBILITY**

The Provider agrees to the provisions of 7 AAC 81, Grant Services for Individuals (Appendix A), as well as all other applicable state and federal law; and declares and represents that it meets the eligibility requirements for a Service Provider for this Agreement by meeting the established criteria:

- 1. Has an Employer Identification Number (EIN); and
- 2. Has a current Alaska Business License (please submit copy) or is a

# Screening Providers

Screening Providers are those who routinely do women's annual exams. Screening provider responsibilities include:

- Determining eligibility and ideally serving as the woman's medical home
- Referring women to appropriate BCHC providers (Imaging Centers & specialists) for additional services when necessary
- Providing BCHC with data about women they have screened



*“Good news – those lumps  
were just coal.”*

# Clinical Consultant & Resource Providers

Clinical Consultants are OB-GYN's and/or breast surgeons and specialists. Their responsibilities include:

- **Accepting referrals from BCHC screening providers for further diagnostic testing and consultation**
- **Notifying BCHC and the Screening Provider of results of any consultations, examinations, or diagnostic work done**

# Clinical Consultant & Resource Providers

Resource Providers include laboratories and imaging centers. Their responsibility is to perform necessary tests at the request of a Screening Provider or Clinical Consultant



*I'd like you to have a  
CAT scan."*

# All BCHC Providers...

- **Agree to accept the BCHC Medicare-based reimbursement rate**
- **Agree to write off the difference between what is billed, and what BCHC reimburses, for any procedure that BCHC can pay for**
- **Agree to share with BCHC any requested clinical information about BCHC clients**

# BCHC Provider Agreements

If you wish to become a BCHC Provider, open and print the appropriate agreement form, or download one from:  
[www.hss.state.ak.us/dph/wcfh/BCHC/default.htm](http://www.hss.state.ak.us/dph/wcfh/BCHC/default.htm)

Return the completed agreement & documentation to:  
State of Alaska, BCHC  
3601 C Street, Suite 322  
Anchorage AK 99503

Upon receipt of your signed agreement, someone from BCHC will contact you to arrange a program orientation

Questions about becoming a BCHC provider?  
Call 269-4662

# Client Eligibility & Enrollment

- Eligibility is determined using the BCHC Enrollment Form
- It is the Screening Provider's responsibility to have clients complete this form. Having a completed Enrollment Form at the time of the exam ensures that clients are eligible to receive BCHC services
- Clinical Consultant and Resource Providers can call the Screening Provider or BCHC to verify client eligibility. They can also access the information on-line with a username and password to the BCHC web-based database.

# Client Eligibility & Enrollment

**Age:** Women aged 21 – 64 are eligible for enrollment into BCHC

**Income:** Women with a family income at or below 250% of the federal poverty level are eligible for enrollment. Income eligibility is determined by circling either the client's monthly or yearly income on the grid on the Annual Enrollment Form.

A woman with a family income falling in the "More Than" column on the grid is not eligible for BCHC

## Breast & Cervical Health Check Annual Enrollment Form

Clinic Name:		Medical Record No:				
Last Name:		First Name:	MI:			
Address:		City/State/Zip:				
Soc Sec No:	Date of Birth: - -	Day Phone:				
Latina/Hispanic Origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Phone:				
Race:	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Eskimo <input type="checkbox"/> Other Alaska Native	<input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Aleut <input type="checkbox"/> American Indian				
Most recent P ap test you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never Most recent Mammogram you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never						
Medical Coverage: <i>Check all that apply.</i>						
<input checked="" type="checkbox"/> Medicare Part B – Not eligible for BCHC						
<input type="checkbox"/> None <input type="checkbox"/> Medicaid ID number: _____ (on insurance card)						
<input type="checkbox"/> Insurance Company name: _____						
<b>Household Income:</b>						
1. Circle the number of people living in your household. The number in your household includes yourself, a spouse, relatives and all the children who live with you.						
2. Circle the household income (or range) on the same line where the household size is circled. Household income includes all money from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, and Permanent Fund Dividends.						
Monthly	Household	Less Than	Between	Between	Between	More Than
	1	\$1,064	\$1,065 - \$1,596	\$1,597 - \$2,128	\$2,129 - \$2,660	\$2,660
	2	\$1,427	\$1,428 - \$2,140	\$2,141 - \$2,853	\$2,854 - \$3,567	\$3,567
	3	\$1,789	\$1,790 - \$2,684	\$2,685 - \$3,578	\$3,579 - \$4,473	\$4,473
	4	\$2,152	\$2,153 - \$3,228	\$3,229 - \$4,303	\$4,304 - \$5,379	\$5,379
	5	\$2,514	\$2,515 - \$3,771	\$3,772 - \$5,028	\$5,029 - \$6,285	\$6,285
	6	\$2,877	\$2,878 - \$4,315	\$4,316 - \$5,753	\$5,754 - \$7,192	\$7,192
7	\$3,239	\$3,240 - \$4,859	\$4,860 - \$6,478	\$6,479 - \$8,098	\$8,098	
Yearly	Household	Less Than	Between	Between	Between	More Than
	1	\$12,770	\$12,771 - \$19,155	\$19,156 - \$25,540	\$25,541 - \$31,925	\$31,925
	2	\$17,120	\$17,121 - \$25,680	\$25,681 - \$34,240	\$34,241 - \$42,800	\$42,800
	3	\$21,470	\$21,471 - \$32,208	\$32,209 - \$42,946	\$42,947 - \$53,685	\$53,685
	4	\$25,820	\$25,821 - \$38,730	\$38,731 - \$51,640	\$51,641 - \$64,550	\$64,550
	5	\$30,170	\$30,171 - \$45,255	\$45,256 - \$60,340	\$60,341 - \$75,425	\$75,425
	6	\$34,520	\$34,521 - \$51,780	\$51,781 - \$69,040	\$69,041 - \$86,300	\$86,300
7	\$38,870	\$38,871 - \$58,305	\$58,306 - \$77,740	\$77,741 - \$97,175	\$97,175	
Add \$10,875 for each additional person						
<b>I want to Enroll in BCHC. The information I provided here is correct.</b>						
Client Signature: _____ Date: _____						

This section to be completed only if your organization receives grant funding to do BCHC outreach.  
 Name of organization: \_\_\_\_\_  phone  door to door  block  group  hot  800

IF YELLOW SECTIONS ARE NOT COMPLETE WHEN THE FORM IS SUBMITTED PAYMENT FOR SERVICES WILL BE DELAYED.  
 THIS FORM MUST BE SUBMITTED TO: State of Alaska / BCHC, 4701 Business Park Blvd., Building J, Suite 20, Anchorage, AK 99503  
 FAX: (907) 269-3414 Revised 01/07

# Client Eligibility & Enrollment

Women with insurance are eligible to be enrolled in BCHC, provided they meet age and income guidelines.

Women whose insurance pays for BCHC services at a rate greater than, or equal to, the BCHC (Medicare) reimbursement rate may still be enrolled in BCHC. If necessary, these women are eligible for travel support to access diagnostic services not available in their home community, even if the services themselves are paid for by their other health care coverage.

**Breast & Cervical Health Check  
Annual Enrollment Form**

Clinic Name:		Medical Record No:	
Last Name:		First Name:	MI:
Address:		City/State/Zip:	
Soc Sec No:	Date of Birth: - -	Day Phone:	
Latina/Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No		Night Phone:	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Eskimo <input type="checkbox"/> Other Alaska Native (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Aleut <input type="checkbox"/> American Indian			
Most recent Pap test you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never		Most recent Mammogram you had was: <input type="checkbox"/> less than 5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Never	
Medical Coverage: Check all that apply.			
<input checked="" type="checkbox"/> Medicare Part B – Not eligible for BCHC			
<input type="checkbox"/> None <input type="checkbox"/> Medicaid ID number: _____		<input type="checkbox"/> Insurance Company name: _____ (on insurance card)	

**Household Income:**

- Circle the number of people living in your household. The number in your household includes yourself, a spouse, relatives and all the children who live with you.
- Circle the household income (or range) on the same line where the household size is circled. Household income includes all money from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, and Permanent Fund Dividends.

	Household	Less Than	Between	Between	Between	More Than
<b>Monthly</b>	1	\$1,064	\$1,065 - \$1,596	\$1,597 - \$2,128	\$2,129 - \$2,660	\$2,660
	2	\$1,427	\$1,428 - \$2,140	\$2,141 - \$2,853	\$2,854 - \$3,567	\$3,567
	3	\$1,789	\$1,790 - \$2,684	\$2,685 - \$3,578	\$3,579 - \$4,473	\$4,473
	4	\$2,152	\$2,153 - \$3,226	\$3,227 - \$4,300	\$4,301 - \$5,375	\$5,375
	5	\$2,514	\$2,515 - \$3,771	\$3,772 - \$5,028	\$5,029 - \$6,285	\$6,285
	6	\$2,877	\$2,878 - \$4,315	\$4,316 - \$5,753	\$5,754 - \$7,192	\$7,192
	7	\$3,239	\$3,240 - \$4,859	\$4,860 - \$6,478	\$6,479 - \$8,098	\$8,098
<b>OR</b>	Add \$906 for each additional person					
<b>Yearly</b>	1	\$12,770	\$12,771 - \$19,155	\$19,156 - \$25,540	\$25,541 - \$31,925	\$31,925
	2	\$17,120	\$17,121 - \$25,680	\$25,681 - \$34,240	\$34,241 - \$42,800	\$42,800
	3	\$21,470	\$21,471 - \$32,205	\$32,206 - \$42,940	\$42,941 - \$53,675	\$53,675
	4	\$25,820	\$25,821 - \$38,730	\$38,731 - \$51,640	\$51,641 - \$64,550	\$64,550
	5	\$30,170	\$30,171 - \$45,255	\$45,256 - \$60,340	\$60,341 - \$75,425	\$75,425
	6	\$34,520	\$34,521 - \$51,780	\$51,781 - \$69,040	\$69,041 - \$86,300	\$86,300
	7	\$38,870	\$38,871 - \$58,305	\$58,306 - \$77,740	\$77,741 - \$97,175	\$97,175
	Add \$10,875 for each additional person					

**I want to Enroll in BCHC. The information I provided here is correct.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This section to be completed only if your organization receives grant funding to do BCHC outreach.

Name of organization: \_\_\_\_\_  phone  door to door  block  group  hot  800

IF YELLOW SECTIONS ARE NOT COMPLETE WHEN THE FORM IS SUBMITTED PAYMENT FOR SERVICES WILL BE DELAYED.  
THIS FORM MUST BE SUBMITTED TO: State of Alaska / BCHC, 4701 Business Park Blvd., Building J, Suite 20, Anchorage, AK 99503  
FAX: (907) 299-3414 Form 01/07

# Client Eligibility & Enrollment

Women with Medicare Part B are not eligible to be enrolled, as Medicare pays for these services

All BCHC clients are enrolled in BCHC for one year, following the date the form is signed

Completed forms must be sent to BCHC. Claims submitted by a Clinical Consultant or Resource Provider will be pended until the Screening Provider has sent a completed Enrollment Form to BCHC

**Breast & Cervical Health Check  
Annual Enrollment Form**

Clinic Name:		Medical Record No:				
Last Name:		First Name:	MI:			
Address:		City/State/Zip:				
Soc Sec No:	Date of Birth: - -	Day Phone:				
Latina/Hispanic Origin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Phone:				
Race:	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Eskimo <input type="checkbox"/> Other Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Aleut <input type="checkbox"/> American Indian <i>(Check all that apply)</i>					
Most recent Pap test you had was:	<input type="checkbox"/> less than 5 years ago	<input type="checkbox"/> 5+ years ago	<input type="checkbox"/> Never			
Most recent Mammogram you had was:	<input type="checkbox"/> less than 5 years ago	<input type="checkbox"/> 5+ years ago	<input type="checkbox"/> Never			
Medical Coverage: <i>Check all that apply.</i>						
<input checked="" type="checkbox"/> <b>Medicare Part B – Not eligible for BCHC</b>						
<input type="checkbox"/> None		<input type="checkbox"/> Medicaid ID number: _____				
<input type="checkbox"/> Insurance		Company name: _____ (on insurance card)				
<b>Household Income:</b>						
1. Circle the number of people living in your household. The number in your household includes yourself, a spouse, relatives and all the children who live with you.						
2. Circle the household income (or range) on the same line where the household size is circled. Household income includes all money from jobs, tips, alimony, child support, public assistance, disability, social security, unemployment, and Permanent Fund Dividends.						
<b>Monthly</b>	Household	Less Than	Between	Between	Between	More Than
	1	\$1,064	\$1,065 - \$1,596	\$1,597 - \$2,128	\$2,129 - \$2,660	\$2,660
	2	\$1,427	\$1,428 - \$2,140	\$2,141 - \$2,853	\$2,854 - \$3,567	\$3,567
	3	\$1,789	\$1,790 - \$2,684	\$2,685 - \$3,578	\$3,579 - \$4,473	\$4,473
	4	\$2,152	\$2,153 - \$3,228	\$3,229 - \$4,303	\$4,304 - \$5,379	\$5,379
	5	\$2,514	\$2,515 - \$3,771	\$3,772 - \$5,028	\$5,029 - \$6,295	\$6,295
	6	\$2,877	\$2,878 - \$4,315	\$4,316 - \$5,753	\$5,754 - \$7,192	\$7,192
7	\$3,239	\$3,240 - \$4,859	\$4,860 - \$6,478	\$6,479 - \$8,098	\$8,098	
OR Add \$906 for each additional person						
<b>Yearly</b>	Household	Less Than	Between	Between	Between	More Than
	1	\$12,770	\$12,771 - \$19,155	\$19,156 - \$25,540	\$25,541 - \$31,925	\$31,925
	2	\$17,120	\$17,121 - \$25,680	\$25,681 - \$34,240	\$34,241 - \$42,800	\$42,800
	3	\$21,470	\$21,471 - \$32,205	\$32,206 - \$42,940	\$42,941 - \$53,675	\$53,675
	4	\$25,820	\$25,821 - \$38,730	\$38,731 - \$51,640	\$51,641 - \$64,550	\$64,550
	5	\$30,170	\$30,171 - \$45,255	\$45,256 - \$60,340	\$60,341 - \$75,425	\$75,425
	6	\$34,520	\$34,521 - \$51,700	\$51,701 - \$68,880	\$68,881 - \$86,060	\$86,060
7	\$38,870	\$38,871 - \$58,305	\$58,306 - \$77,740	\$77,741 - \$97,175	\$97,175	
Add \$10,875 for each additional person						
<b>I want to Enroll in BCHC. The information I provided here is correct.</b>						
Client Signature: _____		Date: _____				
<small>This section to be completed <u>only</u> if your organization receives grant funding to do BCHC outreach.</small>						
Name of organization: _____		<input type="checkbox"/> phone <input type="checkbox"/> door to door <input type="checkbox"/> block <input type="checkbox"/> group <input type="checkbox"/> hot <input type="checkbox"/> 800				
<small>IF YELLOW SECTIONS ARE NOT COMPLETE WHEN THE FORM IS SUBMITTED PAYMENT FOR SERVICES WILL BE DELAYED. THIS FORM MUST BE SUBMITTED TO: State of Alaska / BCHC, 4701 Business Park Blvd., Building J, Suite 20, Anchorage, AK 99503 FAX: (907) 269-3414 Revised 01/07</small>						

# Delivery of Clinical Services

- **BCHC coordinates the efforts of a statewide “Clinical Advisory Committee” (CAC). The CAC compiles and distributes “Clinical Guidelines” which describe current, professional organization (e.g., ASCCP, ACS, USPSTF) endorsed approaches to breast and cervical cancer screening and diagnosis. BCHC requires that clinicians follow these standards of care.**
- **Even though described in BCHC’s “Clinical Guidelines,” some limited cancer screening services may not be paid for based on instruction by CDC. For payment limitation please refer to the CPT code list before services are provided or call 269-4662 for more information.**

# Data Forms and Chart Notes

BCHC distributes data reporting forms to providers to help communicate clinical information back to BCHC. These include:

- Annual Screening Form
- Diagnostic Cervical Form
- Diagnostic Breast Form

These forms were designed to collect specific data that BCHC is required to report to the Centers for Disease Control & Prevention.

If preferred, providers can send chart notes or reports in lieu of BCHC Forms.

**Breast & Cervical Health Check  
Annual Screening Data Collection Form**

Clinic: \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Social Secu \_\_\_\_\_

**Breast & Cervical Health Check  
Cervical Cancer Diagnostic Evaluation & Data Collection Form**

Clinic: \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Social Security \_\_\_\_\_

**Breast & Cervical Health Check  
Breast Cancer Diagnostic Evaluation & Data Collection Form**

Clinic: \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DIAGNOSTIC PROCEDURE RESULTS		
Repeat CBE	Diagnostic Mammogram	Breast Ultrasound
Screening Clinician: <input type="checkbox"/> CBE recommended but refused <input type="checkbox"/> CBE performed, date ____-____-____ Results: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable <input type="checkbox"/> CBE abnormal, suspicious for cancer <input type="checkbox"/> Consult only, date ____-____-____	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____-____-____ Results: <input type="checkbox"/> 1 - Normal exam <input type="checkbox"/> 2 - Benign findings <input type="checkbox"/> 3 - Probably benign, short term follow up indicated <input type="checkbox"/> 4 - Suspicious abnormality, biopsy considered <input type="checkbox"/> 5 - Highly suggestive of malignancy, appropriate action should be taken <input type="checkbox"/> 0 - Assessment incomplete, need additional imaging	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____-____-____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Other benign findings <input type="checkbox"/> Cystic <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious for cancer
<b>Surgical Consultation:</b> <input type="checkbox"/> CBE recommended but refused <input type="checkbox"/> CBE performed, date ____-____-____ Results: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable <input type="checkbox"/> CBE abnormal, suspicious for cancer <input type="checkbox"/> Consult only, date ____-____-____		<b>Breast Biopsy</b> <input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____-____-____ Results: <input type="checkbox"/> Normal breast tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other benign changes <input type="checkbox"/> Ductal CIS <input type="checkbox"/> Lobular CIS <input type="checkbox"/> Invasive carcinoma of the breast
<b>DIAGNOSTIC EVALUATION STATUS</b> SCREENING SITE CLINICIAN MUST COMPLETE: Are there other diagnostic procedures to be performed as soon as possible? <input type="checkbox"/> Yes. Procedure: _____ <input type="checkbox"/> No. If no, complete: As of ____-____-____ <input type="checkbox"/> Breast cancer not diagnosed, other benign <input type="checkbox"/> Client refused to complete diagnostic work-up <input type="checkbox"/> Client is lost to follow-up <input type="checkbox"/> Client is deceased		<b>MONITORING/SURVEILLANCE</b> <input type="checkbox"/> Return to screening on: ____-____-____ (mo/yr) <input type="checkbox"/> Short term follow up procedure: ____-____-____ (mo/yr)
<b>TREATMENT STATUS</b> <input type="checkbox"/> As of ____-____-____ client: <input type="checkbox"/> Started treatment <input type="checkbox"/> Is lost to treatment <input type="checkbox"/> Refuses treatment <input type="checkbox"/> Is deceased		

State of Alaska, BCHC Fax (907) 269-3414

# Data Forms and Chart Notes

The Annual Screening & Data Collection Form is for reporting on a woman's annual exam. This form includes CBE, pelvic exam and Pap test information.

➤ The history section of this form is one way BCHC collects information about a client's clinical history

➤ The clinical breast exam result should be reported here. Note that a result of benign finding probable may be worked up at the clinician's discretion

**Breast & Cervical Health Check  
Annual Screening Data Collection Form**

Clinic:		Medical Record #:	
Last Name:		First Name:	MI:
Social Security #:	Date of Birth: - -	Date of Exam: - -	
<b>HISTORY</b>		<b>CERVICAL HISTORY</b>	
Client reports prior mammogram <input type="checkbox"/> No <input type="checkbox"/> Yes, on - - - - <input type="checkbox"/> Client has had breast cancer		Has client had a Pap within the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes last Pap on - - - - <input type="checkbox"/> Client has had cervical cancer <input type="checkbox"/> Client has had a hysterectomy	
<b>BREAST CANCER SCREENING</b>		<b>CERVICAL CANCER SCREENING</b>	
Breast symptoms led to this visit (ie, pain, lump, client concern) <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> CBE done this visit <input type="checkbox"/> CBE not needed – normal exam past 12 months <input type="checkbox"/> CBE refused or needed but not done		<input type="checkbox"/> Pelvic Exam done this visit <input type="checkbox"/> Pelvic not needed, normal exam past 12 months <input type="checkbox"/> Pelvic refused or needed but not done <input type="checkbox"/> Pap test done this visit Type: <input type="checkbox"/> Conventional Smear <input type="checkbox"/> Liquid Based <input type="checkbox"/> Other <input type="checkbox"/> Pap not needed, recent normal or history of normal <input type="checkbox"/> Pap refused or needed but not done <input type="checkbox"/> Pap done by other provider. Submit cytology report	
<b>EXAMINING CLINICIAN MUST COMPLETE:</b>			
CBE Result: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable (e.g. abscess, mastitis and other conditions.) Further evaluation at clinician discretion. <input type="checkbox"/> Suspicious for cancer. (e.g., nipple or areolar scaliness, spontaneous bloody or serous nipple discharge.) Cancer must be ruled out.		For Pap test: Direct the lab to send a copy of the cytology report to BCHC <div style="text-align: center;">OR</div> Send copy of cytology report to BCHC <div style="text-align: center;">OR</div> Record result below: <input type="checkbox"/> Negative <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Includes HPV changes <input type="checkbox"/> HSIL Includes CIS <input type="checkbox"/> Squamous Cell Cancer <input type="checkbox"/> ASC (Atypical Glandular Cells, AIS, and Adenocarcinoma) <input type="checkbox"/> Unsatisfactory for evaluation	
For Screening Mammogram: Direct the Mammography Center to send a copy of the imaging report to BCHC <div style="text-align: center;">OR</div> Send copy of imaging report to BCHC <div style="text-align: center;">OR</div> Record result below: Result of Mammogram performed - - - - <input type="checkbox"/> 0 - Assessment incomplete – needs additional imaging/evaluation <input type="checkbox"/> 1 - Negative <input type="checkbox"/> 2 - Benign findings <input type="checkbox"/> 3 - Probably benign, short interval follow up indicated <input type="checkbox"/> 4 - Suspicious abnormality, biopsy should be considered <input type="checkbox"/> 5 - Highly suggestive of malignancy, appropriate action should be taken <input type="checkbox"/> 6 - Known biopsy-proven malignancy		For HPV test: <input type="checkbox"/> HPV high risk panel test Direct the lab to send a copy of the test result to BCHC <div style="text-align: center;">OR</div> Send copy of cytology report to BCHC <div style="text-align: center;">OR</div> Record result below for test done on - - - - : <input type="checkbox"/> Negative <input type="checkbox"/> Positive	
Next mammogram or CBE due: - - - - (mo/yr)		Next Pap test due: - - - - (mo/yr)	
<b>This form must be completed for each client every year</b>			

# Data Forms and Chart Notes

There are 3 ways to report Pap, HPV and mammogram results:

1. Direct the lab or imaging center to send results directly to BCHC
  - or -
2. Forward the results to BCHC once you receive them
  - or -
3. Report them using this form

**Breast & Cervical Health Check  
Annual Screening Data Collection Form**

Clinic:		Medical Record #:	
Last Name:		First Name:	MI:
Social Security #:	Date of Birth: - -	Date of Exam: - -	
<b>HISTORY</b>		<b>CERVICAL HISTORY</b>	
Client reports prior mammogram <input type="checkbox"/> No <input type="checkbox"/> Yes, on - - - -  <input type="checkbox"/> Client has had breast cancer		Has client had a Pap within the last 5 years? <input type="checkbox"/> No <input type="checkbox"/> Yes last Pap on - - - -  <input type="checkbox"/> Client has had cervical cancer <input type="checkbox"/> Client has had a hysterectomy	
<b>BREAST CANCER SCREENING</b>		<b>CERVICAL CANCER SCREENING</b>	
Breast symptoms led to this visit (ie, pain, lump, client concern) <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> CBE done this visit <input type="checkbox"/> CBE not needed – normal exam past 12 months <input type="checkbox"/> CBE refused or needed but not done		<input type="checkbox"/> Pelvic Exam done this visit <input type="checkbox"/> Pelvic not needed, normal exam past 12 months <input type="checkbox"/> Pelvic refused or needed but not done  <input type="checkbox"/> Pap test done this visit Type: <input type="checkbox"/> Conventional Smear <input type="checkbox"/> Liquid Based <input type="checkbox"/> Other  <input type="checkbox"/> Pap not needed, recent normal or history of normal <input type="checkbox"/> Pap refused or needed but not done <input type="checkbox"/> Pap done by other provider. Submit cytology report	
<b>EXAMINING CLINICIAN MUST COMPLETE:</b>			
CBE Result: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable (e.g. abscess, mastitis and other conditions.) Further evaluation at clinician discretion. <input type="checkbox"/> Suspicious for cancer. (e.g., nipple or areolar scaliness, spontaneous bloody or serous nipple discharge.) <b>Cancer must be ruled out.</b>		For Pap test: Direct the lab to send a copy of the cytology report to BCHC <div style="text-align: center;"><b>OR</b></div> Send copy of cytology report to BCHC <div style="text-align: center;"><b>OR</b></div> Record result below: <input type="checkbox"/> Negative <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Includes HPV changes <input type="checkbox"/> SIL Includes CIS <input type="checkbox"/> Squamous Cell Cancer <input type="checkbox"/> AGC (Atypical Glandular Cells, AIS, and Adenocarcinoma) <input type="checkbox"/> Unsatisfactory for evaluation	
For Screening Mammogram: Direct the Mammography Center to send a copy of the imaging report to BCHC <div style="text-align: center;"><b>OR</b></div> Send copy of imaging report to BCHC <div style="text-align: center;"><b>OR</b></div> Record result below:  Result of Mammogram performed _____ <input type="checkbox"/> 0 - Assessment incomplete – needs additional imaging/evaluation <input type="checkbox"/> 1 - Negative <input type="checkbox"/> 2 - Benign findings <input type="checkbox"/> 3 - Probably benign, short interval follow up indicated <input type="checkbox"/> 4 - Suspicious abnormality, biopsy should be considered <input type="checkbox"/> 5 - Highly suggestive of malignancy, appropriate action should be taken <input type="checkbox"/> 6 - Known biopsy-proven malignancy		For HPV test: <input type="checkbox"/> HPV high risk panel test  Direct the lab to send a copy of the test result to BCHC <div style="text-align: center;"><b>OR</b></div> Send copy of cytology report to BCHC <div style="text-align: center;"><b>OR</b></div> Record result below for test done on _____: <input type="checkbox"/> Negative <input type="checkbox"/> Positive	
Next mammogram or CBE due: _____ (mo/yr)		Next Pap test due: _____ (mo/yr)	
<b>This form must be completed for each client every year</b>			

# Data Forms and Chart Notes

- The Breast Cancer Diagnostic Evaluation Form is used by the Screening Provider to notify BCHC about results of any diagnostic tests or exams that have been performed
- As an alternative to submitting this form, Screening Providers may also notify BCHC of these results by sending a copy of the pathology or radiology report received from the Clinical Consultant or Resource Provider

**Breast & Cervical Health Check**  
Breast Cancer Diagnostic Evaluation & Data Collection Form

Clinic:		Medical Record #:	
Last Name:		First Name:	MI:
Social Security #:		Date of Birth: - -	
DIAGNOSTIC PROCEDURE RESULTS			
Repeat CBE	Diagnostic Mammogram	Breast Ultrasound	Breast Biopsy
Screening Clinician: <input type="checkbox"/> CBE recommended but refused <input type="checkbox"/> CBE performed, date ____ - ____ - ____ Results: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable <input type="checkbox"/> CBE abnormal, suspicious for cancer <input type="checkbox"/> Consult only, date ____ - ____ - ____ Client concerns led to this visit <input type="checkbox"/> Yes <input type="checkbox"/> No Surgical Consultation: <input type="checkbox"/> CBE recommended but refused <input type="checkbox"/> CBE performed, date ____ - ____ - ____ Results: <input type="checkbox"/> Normal exam <input type="checkbox"/> Benign finding probable <input type="checkbox"/> CBE abnormal, suspicious for cancer <input type="checkbox"/> Consult only, date ____ - ____ - ____	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Results: <input type="checkbox"/> 1 - Normal exam <input type="checkbox"/> 2 - Benign findings <input type="checkbox"/> 3 - Probably benign, short term follow up indicated <input type="checkbox"/> 4 - Suspicious abnormality, biopsy considered <input type="checkbox"/> 5 - Highly suggestive of malignancy, appropriate action should be taken <input type="checkbox"/> 0 - Assessment incomplete, need additional imaging Fine Needle Aspiration <input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Results: <input type="checkbox"/> No fluid/tissue obtained <input type="checkbox"/> Not suspicious for cancer <input type="checkbox"/> Suspicious for cancer	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Other benign findings <input type="checkbox"/> Cystic <input type="checkbox"/> Probably benign <input type="checkbox"/> Suspicious for cancer	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Results: <input type="checkbox"/> Normal breast tissue <input type="checkbox"/> Hyperplasia <input type="checkbox"/> Other benign changes <input type="checkbox"/> Ductal CIS <input type="checkbox"/> Lobular CIS <input type="checkbox"/> Invasive carcinoma of the breast
DIAGNOSTIC EVALUATION STATUS		MONITORING/SURVEILLANCE	
SCREENING SITE CLINICIAN MUST COMPLETE: Are there other diagnostic procedures to be performed as soon as possible? <input type="checkbox"/> Yes. Procedure: _____ <input type="checkbox"/> No. If no, complete: As of: ____ - ____ - ____ <input type="checkbox"/> Breast cancer not diagnosed, other benign _____ <input type="checkbox"/> Client refused to complete diagnostic work-up <input type="checkbox"/> Client is lost to follow-up <input type="checkbox"/> Client is deceased <input type="checkbox"/> Breast cancer was diagnosed <input type="checkbox"/> Ductal (DCIS) <input type="checkbox"/> Lobular (LCIS) <input type="checkbox"/> Invasive breast cancer (indicate one): Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV OR Summary: <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown/Unstaged Tumor size: _____ cm		<input type="checkbox"/> Return to screening on: ____ - ____ (mo/yr) <input type="checkbox"/> Short term follow up procedure: on ____ - ____ (mo/yr)	
		TREATMENT STATUS	
		<input type="checkbox"/> As of ____ - ____ - ____, client: <input type="checkbox"/> Started treatment <input type="checkbox"/> Is lost to treatment <input type="checkbox"/> Refuses treatment <input type="checkbox"/> Is deceased	

# Data Forms and Chart Notes

The Cervical Cancer Diagnostic Evaluation Form is used by the Screening Provider to notify BCHC about results of any diagnostic tests or exams that have been performed

As an alternative to submitting this form, Screening Providers may also notify BCHC of these results by sending a copy of the pathology or radiology report received from the Clinical Consultant or Resource Provider

Breast & Cervical Health Check Cervical Cancer Diagnostic Evaluation & Data Collection Form	
Clinic:	Medical Record #:
Last Name:	First Name: MI:
Social Security #:	Date of Birth: - -
DIAGNOSTIC PROCEDURE RESULTS	
Repeat Pap	Colposcopy
<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Type: <input type="checkbox"/> Conventional Smear <input type="checkbox"/> Liquid Based <input type="checkbox"/> Other Direct the lab to send a copy of the cytology report to BCHC <b>OR</b> Send copy of cytology report to BCHC <b>OR</b> Record result below: <input type="checkbox"/> Negative <input type="checkbox"/> ASC-US <input type="checkbox"/> ASC-H <input type="checkbox"/> LSIL Includes HPV changes <input type="checkbox"/> HSIL Includes CIS <input type="checkbox"/> Squamous Cell Cancer <input type="checkbox"/> AGC Includes Atypical, AIS and Adenocarcinoma <input type="checkbox"/> Unsatisfactory for evaluation	<input type="checkbox"/> Recommended but refused <input type="checkbox"/> Performed, date ____ - ____ - ____ Biopsy <u>not</u> taken, results: <input type="checkbox"/> WNL/negative <input type="checkbox"/> Inflammation/HPV changes <input type="checkbox"/> Other abnormality <input type="checkbox"/> Unsatisfactory Biopsy <u>taken</u> , results: <input type="checkbox"/> WNL/negative <input type="checkbox"/> HPV OR <input type="checkbox"/> Other nonmalignant abnormality <input type="checkbox"/> CIN I/mild dysplasia <input type="checkbox"/> CIN II/moderate dysplasia <input type="checkbox"/> CIN III/severe dysplasia/CIS <input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Invasive Carcinoma ECC Results: <input type="checkbox"/> WNL/negative <input type="checkbox"/> CIN I/mild dysplasia <input type="checkbox"/> CIN II/moderate dysplasia <input type="checkbox"/> CIN III/severe dysplasia/CIS <input type="checkbox"/> HPV or other nonmalignant abnormality <input type="checkbox"/> Adenocarcinoma/Glandular Cell Abnormality <input type="checkbox"/> Invasive carcinoma <input type="checkbox"/> No tissue/unsatisfactory
DIAGNOSTIC EVALUATION STATUS	
<b>SCREENING SITE CLINICIAN MUST COMPLETE:</b> Are any other diagnostic procedures to be performed as soon as client can be scheduled? <input type="checkbox"/> Yes - Procedure: _____ <input type="checkbox"/> No - as of ____ - ____ - ____ the final diagnosis is: <input type="checkbox"/> Negative/benign/reactive/inflammation <input type="checkbox"/> HPV OR <input type="checkbox"/> Other nonmalignant abnormality <input type="checkbox"/> CIN I/mild dysplasia <input type="checkbox"/> CIN II/moderate dysplasia <input type="checkbox"/> CIN III/severe dysplasia/CIS <input type="checkbox"/> Invasive cervical cancer - if yes: AJCC Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <b>OR</b> Summary Stage: <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown/Unstaged <b>OR</b> <input type="checkbox"/> Client refused to complete diagnostic work-up <input type="checkbox"/> Client is lost to follow-up <input type="checkbox"/> Client is deceased	
TREATMENT STATUS or OTHER COMPLETED PROCEDURES	
Treatment started: <input type="checkbox"/> LEEP - - - - <input type="checkbox"/> Hysterectomy - - - - <input type="checkbox"/> Cryosurgery - - - - <input type="checkbox"/> Conization - - - - Other procedures: <input type="checkbox"/> GYN Consult - - - - <input type="checkbox"/> Other biopsy - - - - <input type="checkbox"/> HPV (Hybrid Capture II) - - - - (High risk panel only) <input type="checkbox"/> Positive <input type="checkbox"/> Negative No treatment as of ____ - ____ - ____ because client: <input type="checkbox"/> Is lost to treatment <input type="checkbox"/> Refuses treatment <input type="checkbox"/> Is deceased	
MONITORING/SURVEILLANCE	
<input type="checkbox"/> Short term follow up procedure: _____ on ____ - ____ (mo/yr) <input type="checkbox"/> Return to screening on ____ - ____ (mo/yr)	

# Billing and Reimbursement

Each claim received by BCHC must be matched against the following documents or information before it can be paid:

- A signed Provider Agreement
- A current Enrollment Form showing that the woman is eligible
- Chart notes or BCHC forms with results for the date of service being billed
- The claim must also contain a CPT code from the approved BCHC CPT code list
- What happens when a claim comes in that can't be matched to the above?

# Billing and Reimbursement

Providers are given usernames and passwords to BCHC Provider site. This site allows the provider four functions.

- Verify eligibility
- Print pended claims report
- Check claim status
- Or print remittance advice

Providers have 24 hour access to this website.

Alaska Provider Inquiry System - Home Screen - Windows Internet Explorer

https://www.med-itweb.com/ak\_provider/main\_screen.php

File Edit View Favorites Tools Help

Alaska Provider Inquiry System - Home Screen

Back to Home Screen Logout

## Home Screen

Please select an option from below

Patient Eligibility Search Screen	Claim Status Search Screen
Pending Claims Report	Remittance Advice Warrant Search

Welcome to Breast and Cervical Health Check. Please contact Bobbi Unger at 269-4662 if any information you find on this website does not appear correct.  
\*\*We are currently entering data received September 15th, 2010\*\*

start 3 Micros... Windows ... Alaska Pro... Search Desktop 100% 10:51 AM

# A guide to Pended Claims Reports

We received information (e.g., a Pap result from a lab) that this patient was seen in your clinic. We are asking for a current enrollment to verify eligibility.

Pended claims report gives the provider information on claims that we have received but are unable to process due to a lack of information.

The report is generated by the provider through the website.

## Pending Claims Report

Name: Alaska Regional Hospital

Tax ID: 61-1000033

Address: 2801 Debarr Road

Anchorage, AK 99508

907-264-1244

Client's Name	Date of birth	Date of service	Cpt code	Billed	Pending for
	05/08/19	01/21/2009	76645	\$359.64	EOB appr. req.
	05/08/19	01/21/2009	G0206	\$220.32	EOB appr. req.
	09/08/19	06/26/2009	G0202	\$264.60	Scanned Doc.
	09/08/19	06/26/2009	77052	\$12.00	Scanned Doc.
	02/03/19	01/10/2010	G0202	\$97.60	Claim Date
	08/06/19	04/17/2009	77052	\$37.80	EOB appr. req.
	08/06/19	04/17/2009	G0202	\$264.60	EOB appr. req.
	02/09/19	03/01/2010	G0202	\$97.60	Duplicate Claim
	08/03/19	01/10/2010	77055	\$101.29	Claim Date
Total:				\$1,455.45	

### Missing/Note Message Legend

#### EOB appr. req. :

The client appears to have insurance coverage of some type (private or Medicaid). Therefore an administrator must approve payment of this claim after verifying that the appropriate Explanation of Benefits statement has been supplied by the billing provider.

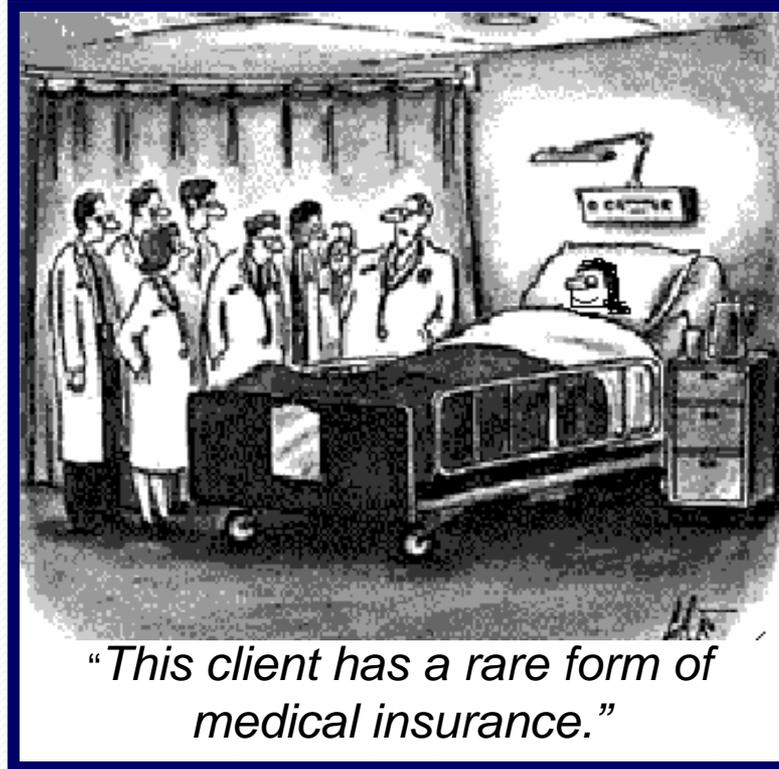
#### Duplicate Claim:

Rejected: A duplicate claim is already in the system for this client.

#### Claim Date:

The claim date entered does not correspond to the client's dates of service.

# Billing and Reimbursement



- **Women with insurance are eligible to be enrolled in BCHC**
- **BCHC collects insurance information from the client's Annual Enrollment Form**

# Billing and Reimbursement

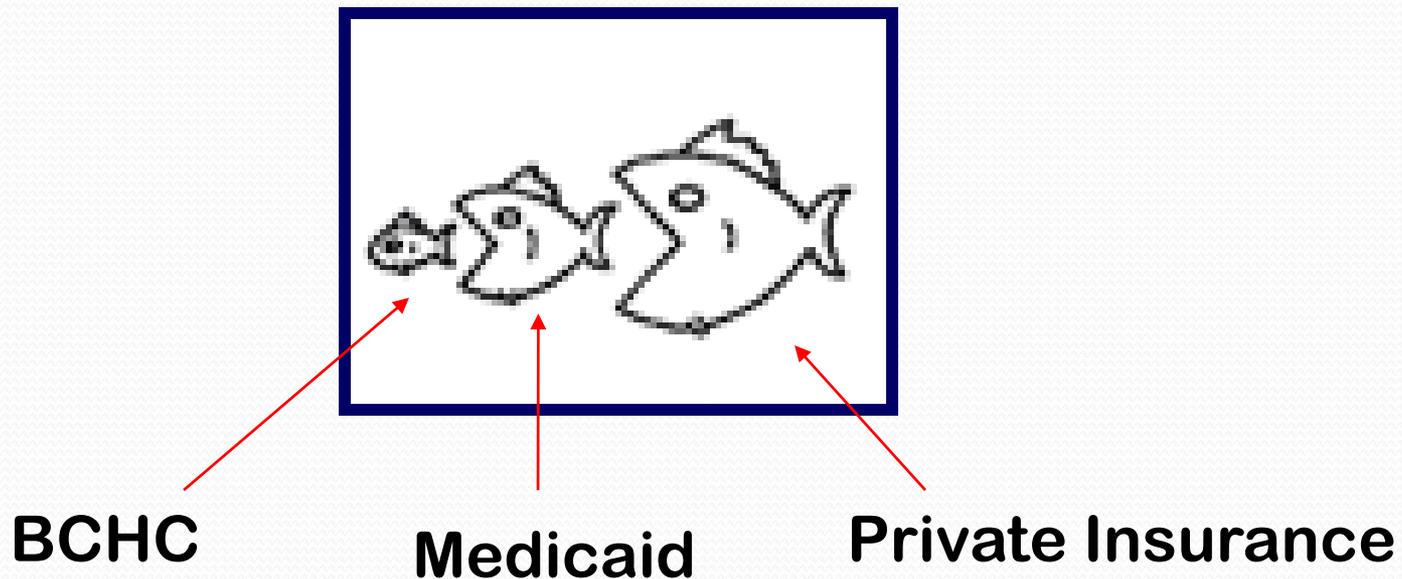
**BCHC must have an EOB on file which shows denial of, or payment for, BCHC approved services before the claim can be processed**

**Claims pending for EOB are listed on the Pended Claims Report. This report is available on the provider website. The Eligibility screen lists any insurance information the client has put on her enrolment form.**

**If insurance has paid the claim, providers can simply mark that on the report and fax it back to BCHC, and it will be removed from any future reports**

# Billing and Reimbursement

BCHC is the payer of last resort!



# Referring Clients for Treatment Coverage

Women diagnosed with breast or cervical cancer, or a precancerous condition<sup>1</sup> requiring treatment are eligible to be referred to the Division of Public Assistance (DPA) for Medicaid treatment coverage.

When treatment is necessary<sup>2</sup>, BCHC staff follow a standard process for referring clients to DPA. Only clients screened by a BCHC provider will be referred using this process.

<sup>1</sup> A CIN I result does not automatically generate a referral to Medicaid. Providers must call (907) 269-4662 and notify BCHC of their intent to treat a CIN I before a referral will be sent.

<sup>2</sup> Clients who require only routine monitoring services for a pre-cancerous breast or cervical condition (e.g., follow up breast examinations or mammograms, 6 month re-Pap) are not considered to need treatment.

# Treatment Coverage

breast or cervical cancer or CIN II or III in a BCHC enrolled client, the following are automatically generated:

1. A Medicaid application packet which is mailed to the woman. The application packet includes a self addressed envelope so the woman can return the application to the Anchorage DPA “Coastal Field Office.” This office is the only one in the state which processes BC Medicaid Applications;
2. A referral to BC Medicaid Eligibility Technicians. They accept this notification as confirmation that the client is income eligible for BC Medicaid;
3. A letter to the Screening Provider notifying them that the Medicaid referral has been made. The letter includes the address that BCHC has on file for that woman. It is helpful to have the provider verify the address on the referral and notify BCHC if they have a more current address for the client.

# Treatment Coverage

- **Screening Providers can call (907) 269-4662 to verify that a Medicaid referral has been made if they don't receive written notification after having sent in a pathology report that would warrant a referral**
- **Application to Medicaid does not guarantee enrollment or coverage. DPA makes all eligibility determinations for Medicaid**
- **Clients who have questions about the application process may call the Coastal Field Office of DPA in Anchorage at 269-8960, or 1-800-478-4364 from outside the Anchorage area**

**We hope this PowerPoint Presentation has been helpful for you.**

**If you have questions about BCHC, our operations or any of the material presented here, please don't hesitate to call our office at 269-4662, or 1-800-410-6266.**

*BCHC Staff*



# Forms

[Appendix A](#)

[Appendix B](#)

[Appendix C](#)

[Appendix D- BCHC Consult](#)

[Appendix D- BCHC Screening](#)

[BCHC Consultant-Resource Provider Agreement](#)

[BCHC Screening Provider Agreement](#)

[CPT Codes 2009](#)