Nuevas Hojas de Cernimiento y Diagnóstico de Cáncer de Mama y Cuello Uterino y Preguntas Frecuentes de Proveedores

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Propósito y Metas

Propósito de las hojas de cernimiento y diagnóstico

Recopilar la información clínica de cernimiento y diagnóstico de las participantes del Programa con el propósito de evaluar si cumplen con los protocolos clínicos y las prioridades del Programa, según los requerimientos del CDC.

Nuevas Hojas de Cernimiento y Diagnóstico

Metas

Agilizar y optimizar los requerimientos de reporte de datos al CDC removiendo los elementos subutilizados y colapsando algunos campos

Modificar los códigos/categorías para **mejorar la certeza y validez** de los datos

Añadir campos para **fortalecer la evaluación del Programa que realiza** CDC

Nuevas Hojas de Cernimiento y Diagnóstico

University of Puerto Rico Comprehensive Cancer Center
Puerto Rico Breast and Cervical Cancer Prevention and Early Detection Program
PMB 371 PO Box 70344, San Juan PR 00936-8344
Phone: 787-772-8300 ext. 1116

Program Use Only
Patient ID: ____
Cycle #: ____

Breast Cancer Screening Data Collection Form
(Follow Cancer Screening Guidelines provided)

A. Patient Information

1a. Last Names	1b. First Name	1c. Initial	2. SSN	3. DOB	4. Age
5a. Postal Address	**5b. Municipality**	**5c. State**	**5d. Zip Code**	**6. Phone Number**	
7. Provider #	**8. Record #**		**9. Municipality of Screening**		

B. Breast Screening History

10a. Has the patient had a mammogram before? If Yes,	○Yes ○No	**11. Does the patient have breast implants?**	○Yes ○No
10b. Date of previous mammogram:		**12. The patient reported breast symptoms?**	○Yes ○No

C. Breast Screening Tests

13. CBE Date:

14. CBE Results:

- ○Normal
- ○Benign Finding
- ○Discrete Palpable Mass – Suspicious for Cancer
- ○Discrete Palpable Mass – Previously Diagnosed Benign
- ○Bloody / Serous Nipple Discharge
- ○Nipple / Areolar Scariness
- ○Skin Dimpling / Retraction
- ○Previous normal CBE in past 12 months – CBE not done today
- ○CBE not done today – other / Unknown Reason
- ○CBE refused

15a. Purpose of the Initial Mammogram:

- ○Routine screening mammogram
- ○Evaluate symptoms, positive CBE, or previous abnormal mammogram
- ○Already done by a non-program provider, patient referred in for diagnostic evaluation

15b. Date of Referral:

- ○Not done (Patient proceeded directly for other imaging or diagnostic workout)

15c. Date of Referral:

- ○Not done (Cervical record only)

16. Initial Mammogram Type: ○Conventional ○Digital

17. Bill to PRBCCEDP: ○Yes ○No

18. Date Initial Mammogram:

19. Initial Mammogram Results:

- ○Negative (BI-RADS 1)
- ○Benign (BI-RADS 2)
- ○Probably Benign (Short interval follow-up suggested; BI-RADS 3)
- ○Suspicious Abnormality (Consider Biopsy; BI-RADS 4)
- ○Highly Suggestive of Malignancy (BI-RADS 5)
- ○Assessment is Incomplete (Need additional imaging; BI-RADS 0)
- ○Unsatisfactory (Cycle complete)
- ○Unknown (Presumed Abnormal, mammogram from non-program provider)
- ○Film Comparison Required

D. Diagnostic Procedures:

20. Diagnostic Work-up Plan:	○Planned ○Not Planned
21. Additional Mammography Views:	○Yes ○No
22. Ultrasound:	○Yes ○No
23. Film comparison to evaluate an incomplete assessment:	○Yes ○No
24. Bill to PRBCCEDP:	○Yes ○No
25. Final Imaging Date:	

26. Final Imaging Outcome:

- ○Negative
- ○Benign finding
- ○Probably Benign (*Short interval follow-up suggested*)
- ○Suspicious Abnormality (*Consider Biopsy*)
- ○Highly Suggestive of Malignancy
- ○Unsatisfactory (*Cycle complete*)
- ○Known Biopsy-Proven Malignancy

27. Additional Diagnostic Procedures (Complete the Breast Cancer Diagnosis Data Collection Form):

- ○ Diagnostic Mammography
- ○ Consultant repeat CBE
- ○ Fine Needle Aspiration Biopsy
- ○ Surgical Consultation
- ○ Large Core Needle Biopsy
- ○ Open Surgical Biopsy
- ○ Other procedure (Specify):

28a. Follow-up: ○2 years ○1 year ○Short-Term

28b. Specify Short-Term months

29. Comments:

30. Provider's Name and Signature:

31. Date:

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Program Use Only
Patient ID: ____
Cycle #: ____

Cervical Cancer Screening Data Collection Form
(Follow Cancer Screening Guidelines provided)

A. Patient Information

1a. Last Names	1b. First Name	1c. Initial	2. SSN	3. DOB	4. Age
5a. Postal Address	**5b. Municipality**	**5c. State**	**5d. Zip Code**	**6. Phone Number**	
7. Provider #	**8. Record #**		**9. Municipality of Screening**		

B. Cervical Screening History

10a. Has the patient had a prior Pap Test? If Yes,	○Yes ○No ○Unknown	**12a. Has the patient received an HPV vaccination? If Yes,**	○Yes ○No ○Unknown
10b. Date of prior (last) Pap test:		**15b. Date of first HPV vaccination:**	
11. Is there history of the following conditions? (Mark all that apply)		**15c. Number of doses received:**	○1 ○2 ○3
11a. Dyspiasia/cervical cancer	○Yes ○No ○Unknown	**13. Is the patient post-menopausal?**	○Yes ○No ○Unknown
11b. HPV	○Yes ○No ○Unknown	**14. Is the patient pregnant?**	○Yes ○No ○Unknown
11c. HIV	○Yes ○No ○Unknown	**15a. Has the patient had a hysterectomy? If Yes,**	○Yes ○No ○Unknown
11d. Immune-compromised	○Yes ○No ○Unknown	**15b. Was the hysterectomy performed for either cervical cancer or Neoplasia?**	○Yes ○No ○Unknown

C. Cervical Screening Tests

16. Test(s) Requested (Mark all that apply): Date of test(s)

- ☐ Pelvic exam:
- ☐ Pap test:
- ☐ HPV test:

17. Pelvic exam results:

- ○Normal ○Abnormal pelvic
- ○Abnormal-not suspicious for cancer
- ○Abnormal-suspicious for cancer
- ○Other result (Specify):

18a. Indication for Pap test to be performed on this screening:

- ○Routine Pap Test
- ○Patient under surveillance for a previous abnormal test
- ○Already done by a non-program provider, patient referred in for diagnostic evaluation

18b. Date of referral:

- ○Not done, Patient proceeded directly for diagnostic work-up or HPV test
- ○Not done, Breast record only

19. Type of Pap Test (Specimen Type):

○Conventional Smear ○Liquid Based ○Other ○Unknown

20. Specimen Adequacy: ○Satisfactory ○Unsatisfactory ○Unknown

21. Pap Test results:

- ○Negative ○ASC-US
- ○LSIL ○HSIL
- ○ASC-H ○Squamous Cell Carcinoma
- ○AGC ○Adenocarcinoma
- ○AIS ○Result unknown, presumed abnormal Pap done by a non-program provider
- ○Other result (Specify):

22. HPV Test Result: (If positive, specify type)

- ○Positive: ○LR ○HR ○Unknown
- ○Negative
- ○Unknown
- ○Not done

23. Diagnostic Work-up Plan: ○Planned ○Not Planned

24a. Follow up: ○Short term **24b. Specify Short-Term months**

- ○Pap in 1 year
- ○Pap in 3 years
- ○Pap in 5 years
- ○**Additional Diagnostic Procedures (Complete the Cervical Cancer Diagnosis Data Collection Form):**
  - ☐Gynecologic Consultation
  - ☐Colposcopy w/o Biopsy
  - ☐Colposcopy with Biopsy
  - ☐Colposcopy with ECC
  - ☐ECC (Only) ☐LEEP ☐CKC
  - ☐Laser Conization
  - ☐Other biopsy-not colposcopy
  - ☐Other procedure (Specify):

25. Bill to PRBCCEDP: ○Yes ○No

26. Comments:

27. Provider's Name and Signature:

28. Date:

FORM A: Screening Breast and Cervical

Program Use Only

Pt. ID _____

Patient Last Names: _____ First Name: _____ Birth Date _____ (mm/dd/yy)

Facility/Provider Name: _____

Breast Screening Tests	Cervical Screening Tests	
Clinical Breast Exam Results: ○ Normal/Benign Finding ○ Abnormality Suspicious for Cancer ○ Not Performed	Has the patient had prior Pap Test? If YES,→ ○ Yes ○ No ○ Unknown	Date Previous Pap Test: _____ (mm/dd/yy)
Risk for Breast Cancer: ○ Average ○ High/Increased* ○ Not Assessed ○ Unknown *High Increased Risk- Woman with BRCA mutation, a first-degree relative who is a BRCA carrier, a lifetime risk of 20-25% or greater as defined by risk assessment models, radiation treatment to the chest between ages 10-30, or personal or family history of genetic syndromes like Li-Fraumeni syndrome.	Risk for Cervical Cancer: ○ Average ○ High/Increased* ○ Not Assessed ○ Unknown *High/Increased) should be reported if risk was assessed and determined to be high risk (prior DES exposure and immunocompromised patients).	
Purpose of the Initial Mammogram: ○ Routine screening ○ Diagnostic ○ Non-program mammogram, patient referred in for diagnostic evaluation ○ No mammogram, Direct to diagnosis for short term follow up	Purpose of Pap Test ○ Routine Screening ○ Patient under surveillance for a previous abnormality ○ Non-program Pap, patient referred in for diagnostic evaluation ○ No Pap, Direct to diagnostics for short term follow up	Purpose HPV Test ○ Co-Test/Screening ○ Triage ○ Test not done ○ Unknown
Date Initial Mammogram: _____ (mm/dd/yy)	Date Pap Test: _____ (mm/dd/yy) Date HPV Test: _____ (mm/dd/yy)	
Initial Mammogram Results: ○ Negative (BI-RADS 1) ○ Benign (BI-RADS 2) ○ Probably Benign (Short interval follow-up suggested; BI-RADS 3) ○ Suspicious Abnormality (Consider Biopsy; BI-RADS 4) ○ Highly Suggestive of Malignancy (BI-RADS 5) ○ Assessment is Incomplete, Needs additional Imaging (BI-RADS 0) ○ Film Comparison Required	Pap Test Results: ○ Negative ○ Infection/Inflammation/ Reactive Changes ○ ASC-US ○ Low Grade SIL ○ Atypical squamous cells cannot exclude HSIL ○ HSIL ○ Squamous Cell Carcinoma ○ Atypical Glandular Cells ○ Adenocarcinoma in situ (AIS) ○ Adenocarcinoma ○ Unsatisfactory ○ Result Pending ○ Unknown, presumed abnormal, Pap test from non-program provider ○ Other: _____	
Additional Procedures Ordered? If YES, please go to Form B	HPV Results: ○ Positive ○ Unknown ○ Negative	
Comments:	Additional Procedures Ordered? If YES, please go to Form C Comments:	
Follow-up: ○ 1 year ○ Short term _____ (months) ○ 2 years	Follow-up: ○ Pap 1 year ○ Pap 5 years ○ Pap 3 years ○ Short term _____ (months)	
Provider's Signature:	Date:	

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Program Use Only
Patient ID: ____
Cycle #: ____

Breast Cancer Diagnosis Data Collection Form

A. Patient Information

1a. Last Names	1b. First Name	1c. Initial	2. SSN	3. DOB	4. Age

5a. Postal Address	5b. Municipality	5c. State	5d. Zip Code	6. Phone Number

7. Provider #	8. Record #	9. Municipality of Diagnosis

B. Diagnostic Procedures (Mark all that apply)

10a. Diagnostic Mammography	☐	10b. Date of Procedure	10c. Bill to PRBCCEDP: ◯Yes ◯No
11a. Consultant-Repeat CBE	☐	11b. Date of Procedure	11c. Bill to PRBCCEDP: ◯Yes ◯No
12a. Fine Needle Aspiration Biopsy	☐	12b. Date of Procedure	12c. Bill to PRBCCEDP: ◯Yes ◯No
13a. Surgical Consultation	☐	13b. Date of Procedure	13c. Bill to PRBCCEDP: ◯Yes ◯No
14a. Large Core Needle Biopsy	☐	14b. Date of Procedure	14c. Bill to PRBCCEDP: ◯Yes ◯No
15a. Open Surgical Biopsy	☐	15b. Date of Procedure	15c. Bill to PRBCCEDP: ◯Yes ◯No
16a. Other Breast Procedures:	☐	16b. Date of Procedure	16c. Bill to PRBCCEDP: ◯Yes ◯No

C. Diagnosis Information

17a. Status of Final Diagnosis:
◯Work-up Complete | 17b. Date of Final Diagnosis: | ◯Lost to Follow Up ◯Work-up Refused

18. Final Diagnosis:
◯Breast Cancer not Diagnosed/Normal breast Tissue
◯Invasive Breast Cancer
◯Lobular Carcinoma In Situ (LCIS)-(Stage 0)
◯Ductal Carcinoma In Situ (DCIS)-(Stage 0)
◯Hyperplasia
◯Atypical Ductal Hyperplasia (ADH)
◯Other Final Diagnosis (*Specify*):

D. Treatment Information

19a. Status of Treatment:
◯Treatment Started | 19b. Date of Treatment:
◯Treatment Pending ◯Treatment Refused
◯Treatment not Needed ◯Lost to Follow-up (*includes death*)

20a. Follow-up:
◯2 years ◯1 year ◯Short-Term
20b. Specify Short-Term months

21. Comments:

22. Provider's Name and Signature: | 23. Date:

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Program Use Only
Patient ID: ____
Cycle #: ____

Cervical Cancer Diagnosis Data Collection Form

A. Patient Information

1a. Last Names	1b. First Name	1c. Initial	2. SSN	3. DOB	4. Age

5a. Postal Address	5b. Municipality	5c.State	5d. Zip Code	6. Phone Number

7. Provider #	8. Record #	9. Municipality of Diagnosis

B. Diagnostic Procedures (Mark all that apply)

10a. Gynecologic Consultation	☐	10b. Date of Procedure	10c. Bill to PRBCCEDP: ◉Yes ◯No
11a. Colposcopy w/o Biopsy	☐	11b. Date of Procedure	11c. Bill to PRBCCEDP: ◯Yes ◯No
12a. Colposcopy with Biopsy	☐	12b. Date of Procedure	12c. Bill to PRBCCEDP: ◯Yes ◯No
13a. Colposcopy with ECC	☐	13b. Date of Procedure	13c. Bill to PRBCCEDP: ◯Yes ◯No
14a. Endocervical Curettage Only (ECC)	☐	14b. Date of Procedure	14c. Bill to PRBCCEDP: ◯Yes ◯No
15a. Loop Electrosurgical Excision Procedure (LEEP)	☐	15b. Date of Procedure	15c. Bill to PRBCCEDP: ◯Yes ◯No
16a. Cold-Knife Cone (CKC)	☐	16b. Date of Procedure	16c. Bill to PRBCCEDP: ◯Yes ◯No
17a. Laser Conization	☐	17b. Date of Procedure	17c. Bill to PRBCCEDP: ◯Yes ◯No
18a. Other biopsy-not colposcopy	☐	18b. Date of Procedure	18c. Bill to PRBCCEDP: ◯Yes ◯No
19a. Other Cervical Procedures:	☐	19b. Date of Procedure	19c. Bill to PRBCCEDP: ◯Yes ◯No

C. Diagnosis Information

20a. Status of Final Diagnosis:
◯Work-up Complete | 20b. Date of Final Diagnosis: | ◯Lost to Follow Up ◯Work-up Refused

21. Final Diagnosis:
◯Normal / Benign Reaction / Inflammation
◯HPV / Condylomata / Atypia
◯CIN I / Mild Dysplasia (Biopsy Diagnosis)
◯CIN II / Moderate Dysplasia (Biopsy Diagnosis)
◯CIN III / Severe Dysplasia / Carcinoma in situ (Stage 0) (Biopsy Diagnosis)
◯Invasive Cervical Carcinoma (Biopsy Diagnosis)
◯HSIL ◯LSIL
◯Adenocarcinoma
◯Other Final Diagnosis (*Specify*):

D. Treatment Information

22a. Status of Treatment:
◯Treatment Started | 22b. Date of Treatment:
◯Treatment Pending ◯Treatment Refused
◯Treatment not Needed ◯Lost to Follow-up (*includes death*)

23a. Follow up:
◯5 years ◯3 year ◯1 year ◯Short-term
23b. Specify Short-Term months

24. Comments:

25. Provider's Name and Signature: | 26. Date:

FORM B: Breast Diagnosis

Program Use Only

Pt. ID

Patient Last Name: _____ First Name: _____ Birth Date _____ (mm/dd/yy)

Facility/Provider Name: _____

Diagnostic Procedures (Mark all that apply)	
○ Ultrasound	Date of Procedure
○ Diagnostic Mammography	Date of Procedure
○ Fine Needle Aspiration Biopsy	Date of Procedure
○ Surgical Consultation	Date of Procedure
○ Large Core Needle Biopsy	Date of Procedure
○ Open Surgical Biopsy	Date of Procedure
○ Other Breast Procedures (Specify):	Date of Procedure

Diagnosis Information

Status of Final Diagnosis:

○ Work-up Complete ○ Lost to Follow Up ○ Irreconcilable

○ Work-up Pending ○ Work-up Refused

Final Diagnosis:

○ Breast Cancer Not Diagnosed
○ Carcinoma In Situ
○ Invasive Breast Cancer
○ Lobular Carcinoma In Situ (LCIS)-(Stage 0)
○ Ductal Carcinoma In Situ (DCIS)-(Stage 0)

Date of Final Diagnosis: _____ (mm/dd/yy)

Follow-up:

○ 2 years ○ 1 year ○ Short-Term_____ (months)

Treatment Information (Program Use Only??)

Status of Treatment:

○ Treatment Started ○ Treatment Not Needed

○ Treatment Pending ○ Lost to Follow-up (includes death)

○ Treatment Refused

Date Treatment Started: _____ (mm/dd/yy)

Comments:

Provider's Signature:	Date:

FORM C: Cervical Diagnosis

Program Use Only

Pt. ID _____

Patient Last Name _____ First Name _____ Birth Date _____ (mm/dd/yy)

Facility/Provider Name_____

Diagnostic Procedures (Mark all that apply)	
○ Gynecologic Consultation	Date of Procedure
○ Colposcopy w/o Biopsy	Date of Procedure
○ Colposcopy with Biopsy	Date of Procedure
○ Colposcopy with ECC	Date of Procedure
○ Endocervical Curettage Only (ECC)	Date of Procedure
○ Loop Electrosurgical Excision Procedure (LEEP)	Date of Procedure
○ Cold Knife Cone	Date of Procedure
○ Laser Conization	Date of Procedure
○ Other Type of Biopsy (Specify):	Date of Procedure
○ Other Cervical Procedures (Specify):	Date of Procedure

Diagnosis Information

Status of Final Diagnosis:

○ Work-up Complete ○ Lost to Follow Up ○ Irreconcilable

○ Work-up Pending ○ Work-up Refused

Final Diagnosis:

○ Normal / Benign Reaction / Inflammation ○ LSIL

○ HPV / Condylomata / Atypia ○ HSIL

○ CIN1 / Mild Dysplasia (Biopsy Diagnosis)

○ CIN2 / Moderate Dysplasia (Biopsy Diagnosis)

○ CIN3 / Severe Dysplasia / Carcinoma in situ (Stage 0) or Adenocarcinoma in Situ of the Cervix (Biopsy Diagnosis)

○ Invasive Cervical Carcinoma (Biopsy Diagnosis)

○ Other (Specify)

Date of Final Diagnosis: _____ (mm/dd/yy)

Follow-up:

=5 years =3 year =1 year =Short-Term _____ (months)

Treatment Information (Program Use Only)

Status of Treatment:

○ Treatment Started ○ Treatment Not Needed

○ Treatment Pending ○ Lost to Follow-up (includes death)

○ Treatment Refused

○ Treatment Not Needed

Date Treatment Started: _____ (mm/dd/yy)

Comments:

Provider's Signature:	Date:

Nuevas variables

Variables nuevas

Risk for Breast Cancer {

Documenta el riesgo de cáncer de mama evaluado por el proveedor. Puede ser historial familiar o pruebas genéticas. CDC no reembolsa las pruebas genéticas

- ‘1’ Average
- ‘2’ High/Increased
- ‘3’ Not assessed
- ‘9’ Unknown

Variables nuevas

HPV Indication {

Se incluye para distinguir la prueba de VPH como prueba de cernimiento

- ‘1’ Co-Test/Screening
- ‘2’ Triage
- ‘3’ Test not done

¿Preguntas?

Preguntas/situaciones frecuentes

¿Bajo qué circunstancias el programa puede aprobar un MRI de seno?

- **MRI en conjuto con mamografía- luego de evaluación por el médico que determina que mujer es de alto riesgo para cáncer de mama. Debe existir alguno de los siguientes criterios:**
  - Participante tiene mutación BRCA
  - Participante tiene familiar de primer grado con mutación BRCA
  - Participante tiene familiar de primer grado con **cáncer de mama pre-menopáusico**
  - Participante tiene "lifetime risk" de un 20-25% o mayor, definido por los modelos de evaluación de riesgo.
  - Historial de tratamiento con radiación al área del pecho antes de los 30 años

- **MRI DIAGNÓSTICO**
  - Para evaluar mejor un área sospechosa en un mamograma o para evaluación de una participante con un historial de cáncer de mama luego de haber completado el tratamiento .

Preguntas/situaciones frecuentes

¿Qué procedimientos cubre el Programa y cuales son las tarifas de éstos procedimientos?

- Solo procedimientos de **cernimiento y diagnóstico** de cáncer de mama y cuello uterino
- **No** cubre procedimientos de tratamiento
- Las tarifas: Medicare
  - “Allowable Procedures and Relevant CPT Codes 2017”

Preguntas/situaciones frecuentes

- Tiempo promedio entre la visita de cernimiento y el diagnóstico = **60 dias**.
- Discrepancias en el seguimiento de procedimientos radiológicos/biopsias – debe haber un consenso entre radiólogo y médico (historial clínico), dentro de un tiempo razonable.
- Nunca utilizar ultrasonido como método de cernimiento. Primero se recomienda mamografía, posteriormente y de ser necesario, el ultrasonido.

Preguntas/situaciones frecuentes

- Las Formas del Programa deben estar completadas apropiadamente para poder llevar a cabo la facturación de los servicios.

- Facturas deben ir acompañadas de:
    1. Hojas del Programa (Formas A, B y C)
    2. Resultados de mama (radiológicos, biopsias, etc)
    3. Resultados de cuello uterino (Pap, HPV, biopsia, colposcopía, etc.)
    4. Compromiso(s) de pago
    5. Enviar documentación por correo electrónico: *tdelatorre@cccupr.org* (encriptado), correo regular o mensajero **con atención a Taína De La Torre** (no Centro Comprensivo de Cáncer *solamente*)

Contactos

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¿Preguntas?