

Women's Wellness Connection  
eCaST Frequently Asked Questions  
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1. What is the difference between covered and paid cases? Are all covered cases paid? Are covered follow-up cases paid?
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1. What is the difference between covered and paid cases? Are all covered cases paid? Are covered follow-up cases paid?

A: Covered means a procedure is eligible for WWC payment because the woman met all eligibility criteria and data is correctly entered. Covered does not mean a case/cycle will be paid. WWC pays once per fiscal year per woman at the end of a completed submission (CSR). Once a submission for a woman is paid for in a fiscal year, further payment on more submissions does not always occur. Provided a woman meets eligible criteria, eligible follow-up procedures entered on a new CSR will be marked as covered in eCaST. eCaST then checks to compare the level that was paid on the previous submission to the level calculated on the follow-up CSR (submission). If the submission with covered follow-up procedures results in a higher level than the previously paid submission *and* if it is complete and ready for payment, an adjusted payment in the amount of the difference between the two submissions is generated to the agency on the next billing run. If the follow-up submission results in the same or lower level, no payment will be generated. A check on the Billing History Tab will show the cycle calculating as level 0 and a click of the Test Billing button will show a message that states the cycle is ineligible for payment because there was a payment in a previous cycle. The significance of having procedures marked as covered may have something to do with how the cost per woman is calculated and what data is collected and reported to the Centers for Disease Control and Prevention.

2. Is a patient considered lost to follow-up when she does not return for short-term follow-up?

A: No. A patient is considered lost to follow-up in eCaST only when there is an abnormal screening and she does not complete diagnostics to determine a definitive diagnosis. In terms of data entry, once a CSR is closed with a definitive diagnosis and short-term follow-up is recommended, there are no updates required on the CSR if she does not return later for the recommended short-term follow-up.

Note: Clinically speaking, yes, this patient may be lost to follow-up, but not in terms of data entry in eCaST. Remember that when there is an abnormal screening, a definitive diagnosis must be determined. If it cannot be determined because of a no show, then the patient is lost to follow-up. The patient is lost to the follow-up for diagnostics required to determine whether or not she has cancer; not for the follow-up that's recommended once it was determined that the abnormal screening is not cancer.

3. I have a patient who had an unsatisfactory Pap result. Do I enter the unsatisfactory Pap or should I just wait until the repeat Pap is done to enter it?

A: i) Enter unsatisfactory Pap into eCaST with recommended follow-up of "Pelvic or Pap in 1 year."

ii) Enter re-Pap on a new CSR (with the same Pap reason as on the CSR with the unsatisfactory Pap) along with any diagnostic procedures resulting from the re-Pap.

Note if both Paps are in the same fiscal year, you will be paid on the CSR with the unsatisfactory Pap at a C2 level. If the re-Pap shows additional work-up is needed, then you will be paid an adjustment (difference up to a C3 or C4) for diagnostics performed on the CSR with the satisfactory Pap.

4. When should I use the diagnostic follow-up report? Should I use it for short-term follow-up?

A: Whenever a patient has an abnormal screening (CBE, mammogram, pelvic or Pap), the follow-up for that screening cycle must be indicated as "further immediate follow-up required." (eCaST automatically selects this option for all abnormal screenings. Unless the patient fails to complete follow-up that should not be changed.) Follow-up, or diagnostics, are entered on the Breast or Cervical Diagnostic Follow-up Report screen. These diagnostic follow-up reports can only be accessed through an open CSR cycle. Data entered on these reports will close the accompanying CSR when the bottom of the diagnostic report, the Diagnosis Status section, is complete. Note: whenever there is an abnormal screening, eCaST requires a definitive diagnosis (cancer, non-cancer) to close a case. Once an abnormal screening is connected to a diagnostic procedure that defines the patient's cancer status, (or once you have correctly and completely entered data into the diagnostic follow-up report) you are done entering diagnostic procedures. All short-term follow-up resulting from the diagnostic procedures **must be** entered on a new CSR cycle.

5. Why can't I enter short-term follow-up diagnostics on a CSR?



A: When short-term follow-up is a diagnostic procedure other than a diagnostic mammogram or a consultant CBE (such as an ultrasound, GYN consult, etc.) you will not be able to enter the procedures. Access to diagnostics that must be entered on the Breast or Cervical Diagnostic Follow-up report can only be achieved through an open CSR with screenings. Since you are not entering screenings, you must contact the WWC data specialist to enter your data. Make sure you provide complete procedure details including recommended follow-up. You are able to open a new CSR to enter either a follow-up consultant CBE or a diagnostic mammogram. If neither is covered contact the data specialist to override coverage for you.

6. Should I enter short-term follow-up on an existing CSR?

A: Short term follow-up is never added to an existing closed CSR. When a patient has an abnormal screening she requires follow-up diagnostics. Once diagnostics confirm cancer status, that CSR is considered closed....even if it is not read only. If you add short term follow-up you must also change the final diagnostic date to match the short-term follow-up procedure date. This will add to the time from the abnormal screening to the final diagnostic, which may cause you to fail the 60-day timeliness indicator. This is why short-term follow-up must be on a separate CSR.

7. Why is the recommended follow-up on the CSR "further immediate follow-up required" when the case is complete and cancer was not diagnosed at this time? How do I change the recommended follow-up to "follow routine screening" on the CSR?

A: There is no reason to go back to the screening page of the CSR to enter change the follow-up. First off, we are talking about two things which are recorded in two different places. There is follow-up regarding screening, and there is follow-up regarding diagnostics. The recommended follow-up after screenings is recorded in the Recommended Follow-up section of the screening page of the CSR. Follow-up after diagnostic procedures have occurred is entered in the Diagnosis Status section of the Breast or Cervical Diagnostic Follow-up Report.

Whenever a patient has diagnostic procedures, the recommended follow-up on the CSR, must be "further immediate follow-up required." This recommendation is automatically selected by eCaST whenever breast or cervical screenings are abnormal, and it should not be changed. This is why "further immediate follow-up required" is the recommendation. Exceptions to this would be when the patient is lost to follow-up, refuses follow-up or when short-term follow-up for the abnormal screening is **appropriate and in accordance with clinical algorithms**.



There are times when, because of patient history, normal screenings may require diagnostic follow-up. In these cases, "further immediate follow-up required" is not automatically selected by eCaST. You must choose it. Anytime a patient has diagnostic procedures that are only available on the Breast or Cervical Diagnostic Follow-up Report page, "further immediate follow-up required" must be the recommended follow-up on the screening page of the CSR.

After diagnostics are entered on the Breast or Cervical Diagnostic Follow-up Report, the recommended follow-up section on the CSR screening page becomes grayed out. That is supposed to happen and it should not be changed, because it reflects that the CSR includes diagnostic procedures. After diagnostic procedures are entered on the Breast or Cervical Diagnostic Follow-up Report, you must indicate

what follow-up (to the diagnostics) should occur. This will be different than what was indicated on the screening page of the CSR. Once follow-up is correctly entered in the Diagnosis Status of the Breast or Cervical Diagnostic Follow-up report, the CSR is closed and no other procedures, including short-term follow-up should be entered on this CSR.

8. Why are patients on Report 22? I am attempting to clean up Report 22. There are a lot of our women who have not yet completed their mammograms and are listed as, "Pending, screenings not complete." What should I do for these cases?

A: Patients with covered procedures appear on Report 22 when the case is pending. So, that's not a bad thing. Report 22 lets you know that a procedure will be paid when it is no longer pending. When you indicate that a patient will have a routine screening mammogram, and the mammogram has not yet been entered into eCaST the case is not complete. If a case is pending diagnostics, it is not complete. eCaST waits for the mammogram or diagnostic results to be entered.

When the mammogram results are entered, and if no further diagnostics are required, and if there are no data errors or fiscal holds on the payment, the case is complete and payment will be generated during the next billing run. Or, when the CBE result was normal or benign, 90 days after the CBE when WWC generates a billing run, eCaST will automatically close out pending breast cases. The mammogram reason will be changed to "mam not done" and the recommended follow-up to "routine." These cases are dropped off of Report 22, and as long as there are no data errors payment will be generated. So, you don't need to do anything.

When diagnostics are entered into eCaST and the Diagnosis Section of the Breast or Cervical Diagnostic Follow-up Report is complete, and if there are no data errors or fiscal hold on the payment, the case is complete and payment will be generated on the next billing run.



9. Why are patients on Report 22A?

A: Cases are placed on hold or administrative override for a number of reasons. The three most common are: 1) you were paid for a patient under a duplicated WWC ID and now the procedures have been moved - to avoid double payment we put these patients on hold, 2) multiple agencies performed services for the same patient within a fiscal year - to correct/avoid double payment we put patients on administrative override/hold, and 3) due to a glitch, eCaST is not processing payments on complex cases automatically - to force payment we put patients on administrative override.

You cannot clear clients off this report but you are supposed to review it to make

sure everyone listed on there is as to be expected. This is especially important at the end of the FY as you cannot request payment for a client past the data entry deadline. Also, if you disagree with someone being on the report, please contact either Christen or Amanda