641—10.3 (135) Components of the Iowa get screened (IGS): colorectal cancer program. The program shall include the following key components:

10.3(1) Program and fiscal management shall be conducted by ensuring strategic planning, implementation, coordination, integration and evaluation of all programmatic activities and administrative systems, as well as the development of key communication channels and oversight mechanisms to aid in these processes. Program management shall ensure that infrastructure adequately supports service delivery.

10.3(2) Service delivery to screen for colorectal cancer for participants enrolled in the IGS program shall be provided by local program coordinators and enrolled heath care providers through contractual arrangements.

a. The IGS program provides reimbursement for the following screening tests, procedures, preparations and tissue analyses when those services are provided by a participating health care provider who has a provider agreement with the IGS program. Payment is based on Medicare Part B participating provider rates (Title XIX).

(1) Fecal immunochemical tests annually;

(2) Colonoscopy every 10 years from initial screen or as prescribed by a physician for surveillance in accordance with USPSTF recommendations;

(3) Biopsy/polypectomy during a colonoscopy;

(4) Bowel preparation;

(5) Moderate sedation for colonoscopy;

(6) One office visit related to IGS program-covered colorectal cancer tests;

(7) One office visit related to colorectal cancer follow-up diagnostic test results;

(8) Total colon examination with either colonoscopy (preferred) or double contrast barium enema if medically prescribed by doctor;

(9) Pathology services.

b. The IGS program does not provide reimbursement for the following:

(1) Screening tests requested at intervals sooner than recommended by the USPSTF;

(2) CT colonography (or virtual colonoscopy) as a primary screening test;

(3) Computed tomography scans (CT or CAT scans) requested for staging or other purposes;

(4) Surgery or surgical staging, unless specifically required and approved by the IGS program's MAB to provide a histological diagnosis of cancer;

(5) Any treatment related to the diagnosis of colorectal cancer;

(6) Any care or services for complications that result from screening or diagnostic tests provided by the IGS program;

(7) Medical evaluation of symptoms that make individuals at high risk for CRC;

(8) Diagnostic services for participants who had an initial positive screening test performed outside of the program;

(9) Management and testing (e.g., surveillance colonoscopies and medical therapy) for medical conditions, including inflammatory bowel disease, ulcerative colitis or Crohn's disease;

(10) Genetic testing for participants who present with a history suggestive of a hereditary nonpolyposis colorectal cancer (HNPCC) or familial adenomatous polyposis (FAP);

(11) Use of propofol as anesthesia during endoscopy, unless specifically required and approved by the IGS program's MAB in cases where the participant cannot be sedated with standard moderate sedation; and

(12) Treatment for colorectal cancer.

c. A local program that has a signed contract with the IGS program shall be responsible for the following:

(1) Recruitment of participants;

(2) Eligibility determination;

(3) Enrollment;
(4) Patient support services;
(5) Tracking of follow-up care;
(6) Documentation and data reporting; and
(7) Recall of participants who remain eligible for continued services.

d. Local program coordinators must use a case management services approach throughout the screening process to ensure that all participants:

(1) Receive program information and colorectal cancer educational materials;

(2) Are assisted, according to each participant's need, to reduce barriers to screening including, for example, fears, cultural beliefs, language, transportation, understanding of information, and insurance enrollment;

(3) Receive guidance throughout the screening, diagnostic and treatment processes;

(4) Understand colorectal cancer screening procedures and health care provider recommendations;

(5) Receive appropriate services according to diagnosis including follow-up; and

(6) Have the opportunity to get questions answered throughout the process.

e. A health care provider that has a provider agreement with the department shall be subject to the following provisions:

(1) The health care provider agrees that reimbursement of procedures and services provided shall not exceed the amount that would be paid under Medicare Part B participating provider rates of Title XVIII of the Social Security Act.

(2) The health care provider shall provide the participant and local program coordinator timely colorectal cancer screening results and follow-up recommendations.

(3) The gastrointestinal health care provider shall submit pathology specimens to a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory for processing.

(4) The health care provider shall practice according to the current standards of medical care for colorectal cancer early detection, diagnosis and treatment.

(5) The health care provider or entity shall submit universal claim forms, originals of the HCFA 1500 or the UB 92, for reimbursement of IGS program-covered services in accordance with the provider agreement.

(6) The health care provider may deliver services in a variety of settings. Service delivery shall include:

1. Working with local coordinators as they refer IGS program participants to provide follow-up or initial colorectal cancer screening services;
2. Providing a point of contact for program communication with the department to relay information that may include updating data, follow-up information and final diagnosis;
3. Providing screening services for a specific geographic area; and
4. Providing referral and follow-up for participants with abnormal screening results.

(7) The health care provider shall ensure compliance with this chapter and other terms and conditions included in the provider agreement or contract.

10.3(3) IGS program and contracted local program staff shall conduct referral, tracking and follow-up utilizing a Web-based data system to monitor each enrolled participant's receipt of screening, rescreening and diagnostic procedures.

a. The enrolled participant shall be notified within 30 days of the screening service by contracted local program staff or the enrolled health care provider of the results of the service, whether the results are normal, benign or abnormal.

b. The contracted local program shall use the IGS program data system to enter appropriate and timely clinical services, including screening and diagnostic test results, follow-up, and completion of screening services.

c. If the enrolled participant has an abnormal colorectal cancer screening test, the health care provider or local coordinator shall provide to the participant a comprehensive referral directing the participant to appropriate additional diagnostic or treatment services. When the results of a FIT screen are positive, the local coordinator shall work with the participant and enrolled health care provider to schedule a colonoscopy.

d. The local program coordinator shall follow up with the provider to obtain results if not provided in a timely manner.

e. IGS program staff shall follow up with the local program coordinator if results have not been entered in the IGS data system in a timely manner.

10.3(4) If treatment services are needed, the participant's health care provider may perform a consultation in order to educate the participant about treatment options. If more than two office visits are warranted for a participant throughout the screening cycle, subsequent office visits must be authorized by IGS program staff.

10.3(5) IGS program staff shall use quality assurance and process improvement techniques including use of established standards, systems, policies and procedures to monitor, assess and identify practical methods for improvement of the IGS program and its components. Quality assurance and process improvement are integral components of the IGS program and contribute to program success. As part of the vision, to reduce morbidity and mortality from colorectal cancer, high-quality, timely participant services are essential. IGS program requirements and monitoring activities shall include:

a. Professional licensure and accreditation. Health facilities and health care providers must be currently licensed or accredited to practice in the state of Iowa.

b. Reporting standards. Radiological, laboratory and pathology and other results must be reported according to national standards.

c. Standards for adequacy of follow-up. Data reports shall track appropriate and timely short-term, diagnostic and rescreening services.

d. A case management services approach. Local program staff shall follow the participants through the colorectal cancer screening process from the first contact to final diagnosis and as needed for referral to treatment and patient navigation services. Local program staff shall be responsible for documenting these activities as described in paragraph 10.3(2)*"d."*

e. Accurate data collection and documentation.

(1) Colorectal cancer data elements (CCDEs) are reported to CDC semiannually by the department.

(2) Site visits are conducted at local program sites to provide technical assistance, give feedback on program performance, evaluate case management process and if needed conduct a walk-through of current services to provide feedback.

f. Evaluation. Workplans shall be reviewed and surveys conducted in the community and with program partners. Reports on progress and face-to-face meetings shall be conducted routinely and on an as-needed basis to assess how the IGS program is meeting CDC program objectives.

g. Process improvement and systems change activities.

h. Adherence to CDC policies and guidelines.

i. Approval and utilization of additions to the local program allowable procedures list.

10.3(6) Professional development shall be provided by the IGS program and contracted local program staff through a variety of channels including educational activities that enable professionals to perform their jobs competently, to identify needs and resources, and to ensure that health care delivery systems provide appropriate clinical outcomes for colorectal cancer screening services.

10.3(7) The IGS program and contracted local program staff shall provide in-reach education and recruitment that involve the systematic design and delivery of clear and consistent messages about colorectal cancer (CRC) and the benefits of early detection using a variety of methods and strategies. In-reach activities shall focus on men and women who have never or rarely been screened for CRC and shall work toward the removal of barriers to care (e.g., by providing respite care, interpreter services and transportation) through collaborative activities with other community organizations. In-reach shall

be targeted toward the participants already being served through the IA CFY program and patients at FQHCs. Public education and outreach activities for community awareness of CRC are supported and mandatory for the project.

10.3(8) The IGS program may develop coalitions and partnerships to establish a common agreement for sharing resources and responsibilities to achieve the common goal of reducing colorectal cancer mortality.

10.3(9) The IGS program shall conduct surveillance utilizing continuous, proactive, timely and systematic collection, analysis, interpretation and dissemination of colorectal cancer screening prevalence, survival and mortality rates. Studies shall be conducted utilizing minimum data elements and other data sources to establish trends of disease, diagnosis, treatment, and research needs. IGS program planning, implementation and evaluation shall be based on the data.

10.3(10) Evaluation by the IGS program evaluator shall be conducted through documentation of services, operation processes at the state and local program levels and outcomes of the IGS program. The evaluation shall include face-to-face interviews with state and local IGS program staff involved in IGS program delivery. IGS program evaluation shall include suggestions to help IGS and local program staff meet the recommendations as set in the CRCCP program manual. Recommendations shall then be incorporated into the program workplan by the state staff.

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