Health Partners Plans

HEDIS Hints

Cervical Cancer Screening (CCS)

Agenda

- What is NCQA's Cervical Cancer Screening (CCS) Measure?
- What is Acceptable for NCQA's CCS Measure?
- Best Practices for Documentation
- What is Not Acceptable as Documentation?
- Patient Education Practices
- Coding to improve CCS HEDIS Measure
- Questions

What is NCQA's CCS Measure?

- The percentage of female members ages 21-64 years old who were screened for cervical cancer using any one of the following criteria:
  - Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
  - Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
  - Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
- This measure is for the Health Partners Plans Medicaid population.
- This measure is a hybrid measure, meaning it can come from chart review or codes submitted on claims.
- Exclusions include:
  - History of hysterectomy with no residual cervix.
  - Members in hospice or who received palliative care at anytime during the measurement year.
  - Member death in the measurement year.

What is Acceptable for NCQA's CCS Measure?

- Medical record documentation must include the date of testing and the result of testing.
- Generic documentation of "HPV" test is evidence of hrHPV testing.
- Documentation of a hysterectomy alone does not meet as an exclusion. There must be evidence that the cervix has been removed:
  - Complete, total or radical hysterectomy indicates no cervix is present.
  - Vaginal hysterectomy indicates no cervix is present.
- Member reported data is acceptable if there is a date of service and the result of the testing.

Best Practices for Documentation

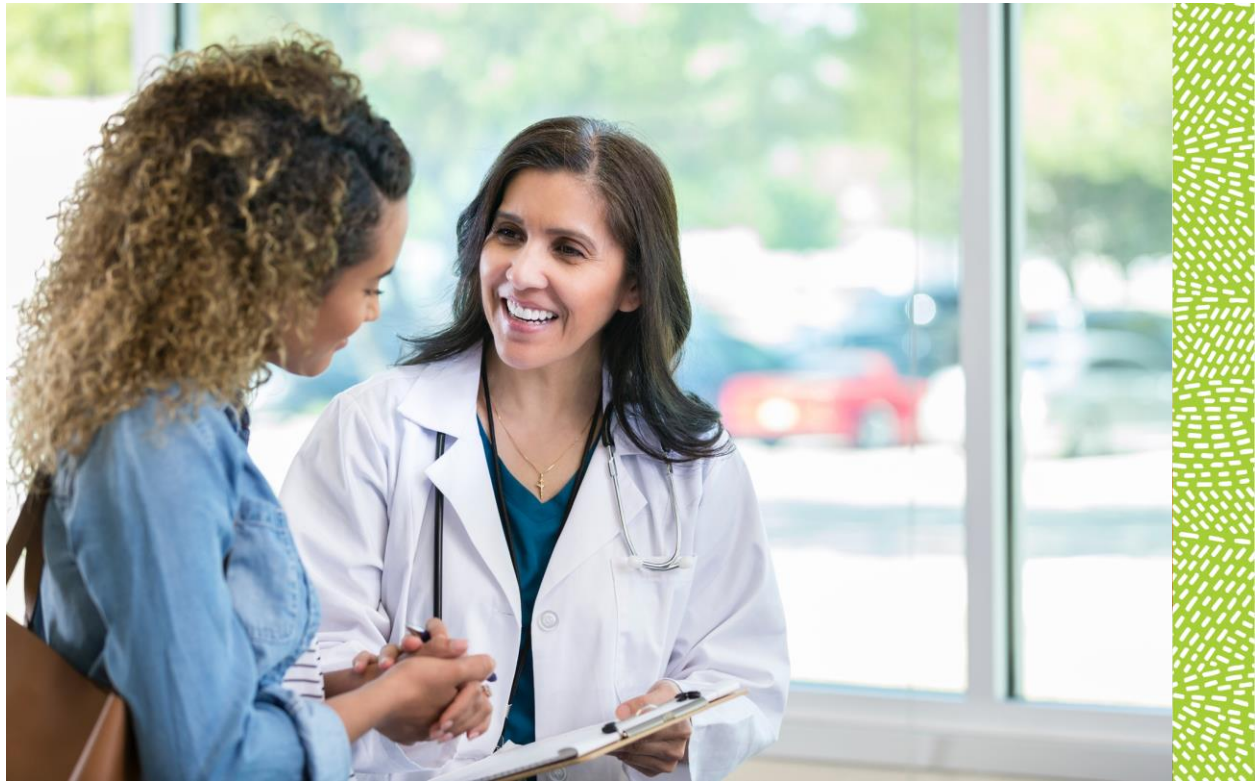
- Review member's level reports in our provider portal to identify noncompliant members.
- If a patient reports that they had a cervical cancer screening in the past but does not recall the date, document the provider/site where the screening was completed.
- Document any screening tests in the patient's medical history with the date of service of the screening and the result.
  - A date can be the exact date, the month and the year, or just the year.
  - Results **must** be documented.
- Save a copy of the screening report with the result in the medical record.
- Do not code for a completed test unless you have the test results.
  - If you ordered the screening, the test must be completed for the care gap to be closed.

What is Not Acceptable as Documentation?

- Lab reports that state that the sample was “insufficient” or that “no cervical cells were present” does not count as a completed screening.
- Biopsies are considered diagnostic and do not meet the measure requirement.
- Documentation for tests that ordered but not completed.

Patient Education Practices

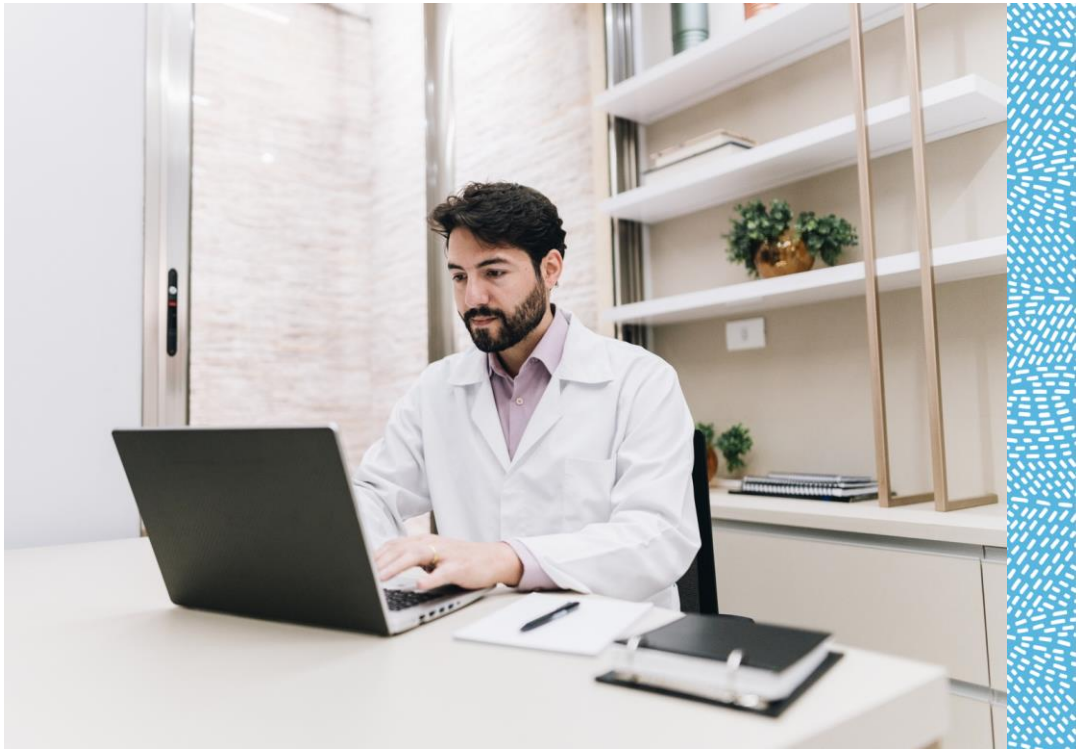
- Explain the purpose of preventive cancer screenings to your patients.
- If you order a screening for the patient, follow up with the patient to make sure the screening was completed.



Coding to Improve this HEDIS Measure

- **HCPCS:**
  - Cervical Cytology Lab Test (only to be used when test has been completed): G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
  - HPV Tests (only to be used when test is completed): G0476

- **CPT:**
  - Cervical Cytology Lab Test (only to be used when test has been completed): 88141-88143, 88147-88148, 88150, 88152, 88153, 88164-88167, 88174-88175
  - HPV Tests (only to be used when test is completed): 87624, 87625



Questions?

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