Cervical Cancer Screening Tip Sheet

CERVICAL CANCER SCREENING (CCS-E) HEDIS MEASURE

Administrative (claims), Supplemental Data and Medical Record Submission.

Description - Members ages 21 to 64 should be screened for cervical cancer using either of the following criteria:

- Members 21-64 years of age receive cervical cytology performed within the last 3 years.
- Members 30-64 years of age receive cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members 30-64 years of age receive cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

LOB - Applies to Marketplace and Medicaid

Claims and Encounter Data - Medical record dates: 1/1/2022-12/31/2024 (for patients 21-64) and medical record dates: 1/1/2020-12/31/2024 (for patients 30-64)

Submission Guidance - This measure accepts claims and/or medical record submission. Acceptable medical record documentation includes a Pap test and/or documentation of PAP smear results, cervical cytology and/or high-risk HPV lab results, progress/encounter notes with medical/surgical history, operative report for a hysterectomy (total, complete, radical or vaginal) or documentation stating pap is no longer needed due to hysterectomy.

Coding

CPT:	HCPCS:	SNOMED:	LOINC:
88141, 88142, 8814, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, 87620, 87621, 87622, 87624, 87625	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091, G0476, G9988, G9999	171149006, 416107004, 417036008, 440623000, 448651000124104, 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 75805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102, 35904009, 448651000124104, 18591004	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0, 95539-3

Not all codes are covered by Medicaid. *To be billed along with cervical cytology codes above; these are not standalone codes.

REQUIRED EXCLUSIONS

Required Exclusions	Timeframe	Additional Notes (if applicable)
Members receiving palliative care	Any time during the MY	
Members in hospice or using hospice services	Any time during the MY	
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix	Any time during the member's history through December 31, MY	
Members who die within the MY	Any time during the MY	Members who are excluded due to death during the MY must be excluded consistently from a measure and indicators within a measure.

Acceptable Documentation	Unacceptable Documentation
The following notations are examples of ***acceptable*** documentation for CCS: • Member reported data is acceptable provided it was collected as part of the member's history by the PCP or specialist who is providing primary care services related to the condition being assessed. This data must include the date AND the results. • Synchronous telehealth documentation is acceptable for abstraction. Be sure the telehealth visit falls within the allowable time frame and meets measure requirements. Member reported information documented within a telehealth visit is acceptable. • Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported (specimen adequate for review) • Documentation in the progress note of a pap test with results or findings and the date of service • List in chart with date of a Pap test and a result of normal or abnormal checkbox with "Y" and "N" boxes • Documentation in the progress note of a HPV test with results or findings and the date of service (The women MUST be ages 30-64 years of age on the date of testing) • Documentation of Pap/HPV cotest: Pap tests with the date of service, results, AND documentation of a HPV test with results which has the same collection date of service as the pap test (The women MUST be ages 30-64 years of age on the date of testing) • Documentation of "simple hysterectomy" is synonymous with "total hysterectomy" and would be acceptable documentation for exclusion. • Documentation of "full hysterectomy" is considered evidence of a complete or total hysterectomy and would be acceptable documentation for the exclusion. • Documentation of "vaginal hysterectomy" and "Laparoscopically Assisted Vaginal Hysterectomy" (LAVH) meet criteria for documentation of hysterectomy with no residual cervix and are acceptable for the exclusion.	The following notations are examples of documentation that is ***not acceptable*** for CCS: • Cervical cancer screening specimens that are noted as vaginal source only. • Medical record documentation that does not specify the date or the result (i.e., PAP up to date). • Lab results that document that the sample was inadequate • Lab results that document "no cervical cells present." • Cervical biopsies are not acceptable because they are diagnostic and therapeutic only • Pap test documentation with results limited to "No Abnormal Pap test" or "Abnormal Pap History" • Documentation of hysterectomy alone • Partial hysterectomy • Supracervical hysterectomy is not acceptable-for this procedure, the uterus is removed, but the cervix is retained. • Hysterectomy with the notation of "pap no longer needed," "patient is no longer a candidate for pap smear" or "vaginal pap smear" no longer meets exclusion criteria for MY 2023 reporting because medical record documentation must match the clinical specificity of the codes in the value sets. • Documentation of "transgender" alone-there must be a notation specifying the type of transgender transition or supporting evidence the member has no cervix.

BEST PRACTICES FOR PHYSICIANS

- Stop screening average-risk members older than age 65 who have had three consecutive negative cytology results or two consecutive negative cytology results plus HPV test results within 10 years, with the most recent test performed within five years.
- Document date and results of completed screening in medical record.
- Medical record must have cervical cytology test results and HPV results documented, even if patient self-reports being previously screened by another provider.
- Submit claims and encounter data in a timely manner. Refer to the coding table above.
- Audit claims for proper codes and provide education to staff on coding as indicated,
- Address financial barriers by informing patients that cervical cancer screening is a covered preventive service,

COMPLIANT CHART EXAMPLES

Date and Result
Documentation of cervical cancer screening can come from any section of the chart if documentation has both a definitive date and a result.
In the following example, the date of the last pap found in the GYN history is acceptable with both a result and a date.

GYN Patient History:
Reviewed GYN History
Current birth control method: Breastfeeding/LAM
Date of LMP: 02/20/MY
Last Pap Smear: **05/24/PY (Notes: neg)**

Member Reported Data

Member reported data is acceptable provided it was collected as part of the member's history by the PCP or specialist who is providing primary care services related to the condition being assessed.

This data must include the date and the results. In this example of an office visit during the MY, the date of two years ago with results is specific enough and would be acceptable. Use the default date rules found in the general guidelines for the appropriate date.

The patient states that her Pap smear was performed two years ago, and the results were normal.

Statement of Adequacy

Lab reports are acceptable if the sample is documented as adequate and has both a date and result. In this example, you would abstract the resulted date of 8/1/PY with a positive result. Statement of adequacy is not required. If documentation is silent on specimen adequacy and a result or finding is documented, then it is assumed that the specimen was adequate to test.

Lab Report:	Collected: 7/1/PY	Resulted: **8/1/PY**
STATEMENT OF ADEQUACY:	**SEE COMMENT** **Satisfactory for evaluation.** Endocervical/transformation zone component present.	N
GENERAL CATEGORIZATION:	**SEE COMMENT** Epithelial cell abnormality	A
INTERPRETATION/RESULT:	**SEE COMMENT**	A

Atypical Squamous Cells of Undetermined Significance (ASC-US)

HPV and Reflex Testing

High-risk HPV Testing or HPV DNA testing documentation can be standalone or noted as reflex testing.

In this example, it lists both the pap and the HPV DNA, but only shows the results for the HPV. The HPV would be acceptable for abstraction. The member must be 30-64 years of age on the date of testing.

LAB: THINPREP PAP AND HR HPV DNA **2/14/19**
HPV DNA (HIGH RISK) **NOT DETECTED**

NON-COMPLIANT CHART EXAMPLES

The following chart examples show unacceptable documentation for the CCS measure:

Inadequate Sample
Lab results that document that the sample was inadequate are not acceptable for abstraction. In this example it is noted that the sample is "unsatisfactory for evaluation" and would not be appropriate for abstraction.

TEST NAME: ThinPrep pap with imager, HPV regardless of result

Statement of adequacy:

Unsatisfactory for evaluation. Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of SCA cellularity.

Specimen forwarded to microbiology for further HPV DNA evaluation.

Missing Date or Result

Medical record documentation that does not specify the date or the result (i.e., PAP up to date) is not acceptable.
In the following example, there is a date of 3/PY but there is not a related result and would not be acceptable for abstraction.
The note of "hx of abnormal PAP" does not have an associated date and it is not acceptable to infer that this is the result for the 3/PY PAP.

GYNHX: Per patient- regular menses, no hx of STDs, hx of abnormal PAP, **last pap 3/PY.**
PLAN: PAP today.

Medical record documentation that does not specify the date of the PAP is not acceptable. In this example, you have the type of test with a result but no date for collection or result. This would be unacceptable.

PAPANICOLAOU SMEAR OF CERVIX WITH LOW GRADE SQUAMOUS INTREPITHELIAL LESION (LGSIL)

Problem Status: Active Problem
Problem Type: Dx of
Problem Code: ICD-795.03

Incorrect Specimen Source
Cervical cancer screening specimens that are noted as vaginal source only are not acceptable. In the example below, the source is noted as vaginal and would not be acceptable for abstraction.

Specimen information:

Specimen adequacy: Satisfactory for evaluation

Source of Specimen: vaginal
Collected: 9/4/PY
Received: 9/5/PY

Interpretation/Result: Negative for intraepithelial lesion or malignancy. **Final Result: 9/6/PY**

Missing Result for Reflex Testing
Pay close attention to reflex testing when noted on lab slips and cytopathology reports. Be sure to validate the reflex test was done. In the example below, the notation indicates that the hrHPV test was not done due to a normal PAP test. This would be acceptable for the PAP only if it was performed in the acceptable time frame.

TEST NAME: ThinPrep pap with reflex hrHPV if ASCUS

Specimen: Cervical, Endocervical
Statement of adequacy: Satisfactory for evaluation

Interpretation: Negative for intraepithelial lesion or malignancy.

NOTE: HPV test not performed. Normal PAP

Hysterectomy with Vaginal Pap

A hysterectomy with the notation of "pap no longer needed", "patient is no longer a candidate for pap smear" or "vaginal pap smear" **no longer meet exclusion criteria for MY 2023** reporting because medical record documentation must match the clinical specificity of the codes in the value sets.

Pap Smear (gyn cases): Result Notes 2/9/PY

Order Providers

Authorizing Provider	Encounter Provider
James, MD	Samantha, LPN

Status: Final result **Visible to patient**: Yes, **Next appt:** None
Dx: Normal gynecologic examination

Component 1 yr. ago

Comment: Kings Medical Center 2201, Department of Cytology
Avenue, xxxxxxx Ky 41101
xxxxxx, xxxxx
MRN: xxxxxxxxxx 809-22-PAP

The information contained in this report is meant to be interpreted by the ordering physician/health care provider in the context of the patient's clinical findings. Please refer to your physician/health care provider for follow up care.

SPECIMEN SUBMITTED: VAGINAL THIN PREP

History: Provided, **history of hysterectomy**-yes

SPECIMEN ADEQUACY

SATISFACTORY FOR EVALUATION - **VAGINAL PAP**

GENERAL CATEGORIZATION

NEGATIVE FOR INTRAEPITHELIAL LESIONS OR MALIGNANCY

INTERPRETATION

BENIGN CELLULAR CHANGES

PREDOMINANCE OF COCCOBACILLI CONSISTENT WITH SHIFT IN VAGINAL FLORA

Cytotechnologist(s) <Sign Out Dr. Signature> Rxxxx Dxxxxxxx, (CT, ASCP)