QUALITY MEASURE GUIDE

Cervical Cancer Screening

Learn how to improve your Healthcare Effectiveness Data and Information Set (HEDIS®) rates by using this tip sheet about the Cervical Cancer Screening measure, best practices and more resources.

The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer

LOB	CMS Weight	HEDIS
Commercial Medicaid	N/A	2024

Compliance (any one of the following)

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

Exclusions

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year
- Received hospice services anytime during the measurement year
- Deceased during the measurement year
- Received palliative care or who had an encounter during the measurement year
- Members with Sex Assigned at Birth of Male at any time in the patient's history

Best Practices

- Assess existing barriers to regular cervical cancer screening (i.e. access to care, cost)
- Educate the members about the importance of early detection and encourage screening
- Request to have cervical cytology results sent to you if done at an OB/GYN office
- Engage patients to discuss their fears
- Set care gap "alerts" in your electronic medical record
- Document the month, year and results of most recent cervical cancer screening in the medical record
- Set care gap "alerts" in your electronic medical record

Cervical cancer can be detected in its early stages by regular screening. Due to the success of cervical cancer screening in the U.S., dramatic decreases have been observed in both mortality and incidence of invasive cervical cancer.

Reminder

The CCS measure is hybrid. Any care not received via claims will be captured through chart audits.

Tips on How to Code using ICD-10 Codes

Best Practice Documentation for Cancer Diagnosis

Current Cancer:

- Documentation must show clear evidence of current disease
- Active treatment for cancer
- Watchful Waiting to determine if or when treatment should begin
- No treatment (e.g., palliative or hospice care)
- Requires detailed MEAT

History of Cancer:

- When malignancy has been excised and no further treatment is directed at that site (i.e., radiation, chemotherapy, additional surgery)
- Only routine follow-up care (surveillance) with oncology is required
- Use a history of cancer code when no evidence of disease is present (Z85)

Exclusion Codes, not limited to:

- Z85.41- Personal history of malignant neoplasm of cervix uteri
- Z51.5- Encounter for palliative/hospice care
- Z90.710 -Acquired absence of both cervix and uterus

For additional best practices regarding

https://www.cancer.org/cancer/types/cervical-cancer.html
https://www.cdc.gov/cancer/cervical/l
https://www.aafp.org/pubs/afp/issues/2015/1215/p1107.html

Send feedback to: Tia Palko at Tia.Corder-Palko@Uhhospitals.org.