

Cervical Cancer Screening (CCS-E)

APPLICABLE LINES OF BUSINESS

- Commercial
- Medicaid

MEASURE DESCRIPTION

The percentage of members 21-64 years of age who were recommended for routine cervical cancer screening and screened for cervical cancer using any of the following criteriaⁱ:

- Members 21-64 years of age who had cervical cytology performed within the last three years.
- Members 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years and who were 30 years or older on the test date.
- Members 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years and who were 30 years or older on the test date.

EXCLUSIONS

Members are excluded if they:

- Had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix. Documentation of "complete", "total", "radical", or "vaginal" hysterectomy must be present.
- Had sex assigned at birth of male at any time during the patient's history.
- Used hospice services or received palliative care during the measurement year.
- Died any time during the measurement year.

MEDICAL RECORDS

Patient medical records should include:

- For members 21-64 years of age: Notation of the date of service when the cervical cytology was performed and the results or findings.
- For members 30-64 years of age: Notation of the date of service when the high-risk human papillomavirus (hrHPV) test was performed and the results or findings.

CODING

Type	Code	Description
CPT ^{®ii}	88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	Cervical cytology
HCPCS ⁱⁱⁱ	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	Cervical cytology
CPT [®]	87624, 87625	HPV test

HCPCS	G0476	HPV test - Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types for cervical cancer screening
ICD-10 ^{iv}	OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ	Hysterectomy with no residual cervix
CPT®	51925, 56308, 57450, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552, -58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135	Hysterectomy with no residual cervix
ICD-10	Q51.5, Z90.710, Z90.712	Absence of cervix

TIPS FOR SUCCESS

Patient Care

- Implement standing orders for screening.
- Request outside medical records for patients who completed screening with their OB-GYN.
- Educate patients regarding the benefit of early detection through cervical cancer screening:
 - Cervical cancer is a disease in which malignant (cancer) cells form in the cervix.
 - Screening can help find precancerous cells and cervical cancer early, when treatment is most effective.
 - The high-risk human papillomavirus (hrHPV) test looks for infection by high-risk types of HPV that are more likely to cause cancers of the cervix.
- Use multi-modal screening reminders, such as mail, phone, or text messages, for patients.
- Use electronic reminders, such as prompts in the EMR, for providers and staff.
- Use telehealth for screening consultations and follow-up of results.
- Offer non-traditional facility hours and/or screening in alternative settings
- Empower appointing staff to review due/overdue care and co-schedule cervical cancer screenings as other appointments are being made.

Documentation and Coding

- Biopsy-only reports do not count for cervical cancer screening.
- Partner with your health plan payers to submit electronic data from your EMR.
- Document medical and surgical history in the medical record with dates in structured fields so your EMR can include these in reporting. This will allow the corresponding code to be included in electronic reporting, including claims, to health plans.
- Code for exclusions.
- NCQA has transitioned this measure to an Electronic Clinical Data Systems (ECDS) reported measure. This means that health plans can only use information submitted *during* the measurement year to qualify for this measure. Information can be submitted electronically (e.g., EMR extracts and FHIR feeds), via claims codes, and in medical record documentation sent to the plan. Plans will no longer perform chart reviews *after* the measurement year for this measure.

ⁱ National Committee for Quality Assurance. HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans (2025), 523-529.

ⁱⁱ CPT Copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

ⁱⁱⁱ HCPCS Level II codes and descriptors are approved and maintained jointly by the alpha-numeric editorial panel (consisting of Centers for Medicare & Medicaid Services, America's Health Insurance Plans, and the Blue Cross Blue Shield Association).

^{iv} ICD-10-CM created by National Center for Health Statistics (NCHS), under authorization by the World Health Organization (WHO). WHO-copyright holder.