Cervical Cancer Screening (CCS and CCS-E)

New for 2024

Added

- Members who were assigned male at birth is now a required exclusion
- Rates are stratified by race and ethnicity for CCS-E

Updated

- References to women were replaced with members recommended for routine cervical cancer screening

Clarified

- Laboratory claims cannot be used for exclusions related to palliative care, cervical agenesis and acquired absence of cervix

This measure is also an ECDS measure

Yes!
Supplemental Data Accepted

Definition

Percentage of members ages 21-64 who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members recommended for routine cervical cancer screening ages 21–64 who had cervical cytology performed in the measurement year or 2 years prior
- Members recommended for routine cervical cancer screening ages 30–64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed in the measurement year or four years prior. The member must have been at least age 30 on the date of the test.
- Members recommended for routine cervical cancer screening ages 30–64 who had cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or four years prior

Plan(s) Affected	Quality Program(s) Affected	Collection and Reporting Method
• Commercial • Exchange/Marketplace • Medicaid	• CMS Quality Rating System • NCQA Accreditation • NCQA Health Plan Ratings	**Administrative** • Claim/Encounter Data **Hybrid** • Claim/Encounter Data • Medical Record Documentation

Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice. When using SNOMED codes to identify history of procedures, the date of the procedure must be available (do not use the date when the provider documented the procedure as the date of the procedure).

Cervical Cytology	
CPT®/CPT II	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175
HCPCS	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091
LOINC	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
SNOMED	171149006, 416107004 417036008, 440623000, 448651000124104, 168406009, 168407000, 168408005, 168410007, 168414003, 168415002, 168416001, 168424006, 250538001, 269957009, 269958004, 269959007, 269960002, 269961003, 269963000, 275805003, 281101005, 309081009, 310841002, 310842009, 416030007, 416032004, 416033009, 439074000, 439776006, 439888000, 441087007, 441088002, 441094005, 441219009, 441667007, 700399008, 700400001, 1155766001, 62051000119105, 62061000119107, 98791000119102

(Codes continued)

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Codes

The following codes can be used to close HEDIS numerator gaps in care; they are not intended to be a directive of your billing practice.

High Risk HPV Test	
CPT®/CPT II	87624, 87625
HCPCS	G0476
LOINC	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
SNOMED	35904009, 448651000124104, 718591004

Required Exclusion(s)

Exclusion	Timeframe
• Members in hospice or using hospice services • Members receiving palliative care • Members who died	Any time during the measurement year
Members with sex assigned at birth (LOINC code 76689-9) of male (LOINC code LA2-8)	Any time in a member's history through December 31 of the measurement year
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Exclusion codes listed below.	Any time in a member's history through December 31 of the measurement year

ICD10CM/ICD9CM	Q51.5, Z90.710, Z90.712, 752.43, V88.01, V88.03, Q51.5, Z90.710, Z90.712, 752.43, V88.01, V88.03
CPT®/CPT II	57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135
SNOMED	37687000, 248911005, 428078001, 429290001, 429763009, 473171009, 723171001, 10738891000119107, 24293001, 27950001, 31545000, 35955002, 41566006, 46226009, 59750000, 82418001, 86477000, 88144003, 116140006, 116142003, 116143008, 116144002, 176697007, 236888001, 236891001, 287924009, 307771009, 361222003, 361223008, 387626007, 414575003, 440383008, 446446002, 446679008, 708877008, 708878003, 739671004, 739672006, 739673001, 739674007, 740514001, 740515000, 767610009, 767611008, 767612001, 1163275000

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Important notes	Test, Service or Procedure to Close Care Opportunity	Medical Record Detail Including, But Not Limited To
Measurement year or 2 years prior	• Cervical cytology for women ages 21–64 • High Risk HPV test (hrHPV) with results or findings	• Consultation reports • Diagnostic reports • Health history and physical • Lab reports
Measurement year or 4 years prior – test must be performed when the woman is age 30 or older		

Tips and Best Practices to Help Close This Care Opportunity

- **Please check your Patient Care Opportunity Report (PCOR) or Practice Assist often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.
  - Documentation of "HPV Test" can be counted as evidence of hrHPV Test, as long as the result is documented.
- Documentation of a "hysterectomy" alone will **not** meet the intent of the exclusion.
  - The documentation must include the words "total," "complete" or "radical" abdominal or vaginal hysterectomy.
  - Documentation of a "vaginal Pap smear" with documentation of "hysterectomy"
  - Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screeningBiopsies are diagnostic and therapeutic, and not valid for primary cervical cancer screening.
- Member reported information documented in the patient's medical record is acceptable as long as there is a date and result of the test or a date of the hysterectomy and acceptable documentation of no residual cervix. The member reported information must be logged in the patient's chart by a care provider.
- Biopsies are diagnostic and therapeutic, and not valid for primary cervical cancer screening.
- Lab results for cervical cancer screening or procedure codes for hysterectomy can be accepted as supplemental data, reducing the need for some chart review. Please contact your UnitedHealthcare representative to discuss clinical data exchange opportunities.
- Sharing member demographic data is critical to understanding the cultural, linguistic and social needs of those we serve and decreasing health inequities across the care continuum. This data can include, but is not limited to, race, ethnicity, language, sexual orientation, gender identity, pronouns, sex assigned at birth and disability status.
  - As part of UnitedHealthcare's clinical structured data exchange program, we encourage you to include this demographic data with any structured data file or CCD. Your information is confidential. UnitedHealthcare will keep personally identifiable information confidential and won't disclose any information without your written consent.