Cervical Cancer Screening (CCS)

Q: What documentation is needed in the medical record?

A:

- ☑ Women 21-64 years of age, and
- ☑ Had a Pap smear (cervical cytology) in **2013, 2014, or 2015**

Or

- ☑ Women 30-64 years of age, and
- ☑ Had cervical cytology/human papillomavirus (HPV) co-testing on the same date of service in **2011, 2012, 2013, 2014, or 2015**

Q: What codes are used?

A: Please reference attached sample codes; reference Value Set Directory for additional codes

Q: What documentation is needed in the medical record?

A: Documentation must include both of the following criteria:

- ☑ a note indicating the date test was performed, ***and***
- ☑ the result or finding

Q: What type of medical record is acceptable?

A: Acceptable document:

- ☑ Cervical cytology report / HPV report
- ☑ Chronic Problem List with documentation of Pap smear with or without HPV, including date and result
- ☑ Any documentation of history of hysterectomy with no residual cervix
- ☑ Progress note or consultation - notation of date and result of Pap smear
- ☑ Documentation of a "vaginal pap smear" in conjunction with documentation of hysterectomy
- ☑ Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening

Q: How to improve score for this HEDIS measure?

A:

- ☑ Use of complete and accurate Value Set Codes.
- ☑ Timely submission of claims and encounter data
- ☑ Ensure proper documentation in medical record
- ☑ Request results of screenings be sent to you if done at OB/GYN visit
- ☑ Hysterectomy with no residual cervix - *documentation will assist in excluding member from the HEDIS sample*

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SAMPLE CODES

ICD-10 codes
Q51.5, Z90.710, Z90.712

CPT codes
87620-87622, 87624, 87625, 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175

HCPCS screening codes
G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

Exclusion ICD-10 code
Q51.5