

NQF 0031: Breast Cancer Screening

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

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NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR).

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and denominator exclusion.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and denominator exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu measure
Related to other measures?	<ul style="list-style-type: none"> Not related to other Stage 1 MU clinical quality measures
Data required to identify the denominator (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Gender Outpatient encounter code¹
Data required to identify the denominator exceptions or exclusions	<ul style="list-style-type: none"> Procedure Code unilateral or bilateral mastectomy
Data required to identify the numerator (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Documentation of breast cancer screening¹

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit:

https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth and gender	<ul style="list-style-type: none"> Ensures only patients who are 40-69 years of age during the measurement period are included in the denominator. 	<ul style="list-style-type: none"> Date of birth Gender is female 	
2. Record the type and date of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator. 	<ul style="list-style-type: none"> Date of visit Encounter code² 	
3. Check patient record for a bilateral or unilateral mastectomy	<ul style="list-style-type: none"> Ensures patients who have a mastectomy are captured as exceptions or exclusions. 	<ul style="list-style-type: none"> Mastectomy procedure code³ if applicable 	
4. Check patient record for recent mammogram, or if appropriate, schedule one.	<ul style="list-style-type: none"> Ensure all patients who have mammograms are captured in the numerator. 	<ul style="list-style-type: none"> Mammogram code⁴ Date of mammogram 	

¹ This data element(s) must be documented ≤ 2 years before or simultaneous to the measurement end date

² See Technical Supplement for denominator inclusion criteria (encounter): pp. TS-2

³ See Technical Supplement for exception of exclusion criteria (mastectomy): pp. TS-2

⁴ See Technical Supplement for numerator inclusion criteria (mammogram): pp. TS-3

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure numerator and denominator.

DENOMINATOR INCLUSION CRITERIA

What counts as an encounter? (CPT codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an evaluation, and medical decision making. .
- Observation care discharge day management
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an evaluation, and medical decision making.
- Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a history, an evaluation, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an evaluation, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an evaluation, and medical decision making.
- Initial or periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new or established patient
- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual
- Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)
- Unlisted preventive medicine service
- Work related or medical disability examination by treating physician or other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

EXCLUSION OR EXCEPTION CRITERIA

What counts as a mastectomy? (SNOMED CT codes)

- Bilateral subcutaneous mastectomy (procedure)
- Bilateral mastectomy with excision of bilateral regional lymph nodes (procedure)
- Modified radical mastectomy, bilateral (procedure)
- Other specified total mastectomy (procedure)
- Quadrantectomy of breast (procedure)
- Bilateral simple mastectomy (procedure)
- Segmentectomy of breast (procedure)
- Bilateral mastectomy (procedure)
- Extended simple mastectomy (procedure)
- Halsted mastectomy (procedure)
- Extended radical mastectomy (procedure)
- Segmental excision of breast (procedure)

What counts as a mastectomy? (SNOMED CT codes)

- Radical mastectomy (procedure)
- Re-excision of breast for clearance of tumor margins (procedure)
- Bilateral mastectomy extended simple (procedure)
- Removal of intact mammary implant, bilateral, plus capsulectomies (procedure)
- Bilateral subcutaneous mamnectomy with synchronous implant (procedure)
- Mastectomy with excision of regional lymph nodes (procedure)
- Bilateral radical mastectomy (procedure)
- Simple mastectomy (procedure)
- Subcutaneous mastectomy for gynecomastia (procedure)
- Total mastectomy and division of pectoralis minor muscle (procedure)
- Total mastectomy and excision of part of pectoral muscles and chest wall (procedure)
- Radical mastectomy including axillary lymph nodes (procedure)
- Subcutaneous mastectomy and prosthetic implant (procedure)
- Mastectomy with preservation of skin and nipple with synchronous implant (procedure)
- Radical mastectomy including pectoral muscles and axillary lymph nodes (procedure)
- Urban operation, extended radical mastectomy (procedure)
- Patey total mastectomy (procedure)
- Modified radical mastectomy (procedure)
- Wedge excision of breast (procedure)
- Skin sparing mastectomy (procedure)
- Mastectomy of left breast (procedure)
- Mastectomy of right breast (procedure)
- Subcutaneous mastectomy (procedure)

What counts as a mastectomy? (CPT codes)

- Mastectomy, simple, complete
- Mastectomy, subcutaneous
- Mastectomy, radical, including pectoral muscles, axillary lymph nodes
- Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)
- Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

*Use of CPT modifier 50 with any of the above codes also counts as a mastectomy

NUMERATOR INCLUSION CRITERIA

What counts as a mammogram? (SNOMED CT codes)

- Bilateral mammography (procedure)
- Breast sinogram (procedure)
- Computed tomography of breast (procedure)
- Mammogram - localization (procedure)
- Mammogram - symptomatic (procedure)
- Mammogram coned (procedure)

What counts as a mammogram? (SNOMED CT codes)

- Mammogram in compression view (procedure)
- Mammogram magnification (procedure)
- Mammography (procedure)
- Mammography and aspiration (procedure)
- Mammography and biopsy (procedure)
- Partial mastectomy with axillary lymphadenectomy (procedure)
- Screening mammography (procedure)
- Stereotactic mammography (procedure)
- Xeromammography (procedure)

What counts as a mammogram? (CPT codes)

- Mammography, unilateral
- Mammography, bilateral
- Screening mammography, bilateral (2-view film study of each breast)

What counts as a mammogram? (ICD-9 codes)

- Xerography of breast
- Other mammography
- Screening mammogram for high-risk patient
- Other screening mammogram

What counts as a mammogram? (HCPCS codes)

- Screening mammography, producing direct digital image, bilateral, all views
- Diagnostic mammography, producing direct digital image, bilateral, all views
- Diagnostic mammography, producing direct digital image, unilateral, all views

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0031	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	x			x	x		x	x			x
Denominator ²	x	x		x		x	x				
Exceptions or exclusions ³	x			x			x				x

- (Codes with an asterisk (*) are required from certified EHRs)
- ¹ To identify the numerator in this CQM, the following standard codes are required: a "diagnostic study" code for breast cancer screening from CPT, HCPCS, ICD-9-CM, ICD-10-CM, SNOMED.
- ² To identify the denominator in this CQM, the following standard codes are required: (1) an "individual characteristic" code from HL7, AND (2) an outpatient "encounter" code from CPT, ICD-9-CM
- ³ To identify the exclusions or exceptions in this CQM, the following standard codes are required: "procedure" code(s) for mastectomy from CPT, CPT modifier, ICD-9-CM, SNOMED

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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