

NQF 0032: Cervical 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)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

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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NQF 0032: Cervical Cancer Screening

The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu set 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 exceptions or exclusions	<ul style="list-style-type: none"> Procedure code for hysterectomy
Data required to identify the numerator (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Documentation of cervical cancer screening²

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/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

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 21-64 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 code³ 	
3. Check patient record for a hysterectomy	<ul style="list-style-type: none"> Ensures patients who have a hysterectomy are captured as exceptions or exclusions. 	<ul style="list-style-type: none"> Hysterectomy procedure code⁴ if applicable 	
4. Check patient record for recent Pap test, 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"> Pap test code⁵ Date of Pap test 	

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

² This data element(s) must be documented ≤ 3 years before or simultaneous to the measurement end date

³ See Technical Supplement for denominator inclusion criteria (encounter): pp. TS-2

⁴ See Technical Supplement for exception of exclusion criteria (hysterectomy): pp. TS-3

⁵ See Technical Supplement for numerator inclusion criteria (Pap test): pp. TS-5

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, performance of an examination, formulation of a diagnosis, assessment of capabilities and stability, calculation of impairment, development of future medical treatment plan, and completion of necessary documentation/certificates and report.

What counts as an encounter? (ICD-9 codes)

- Postpartum care and examination
- Encounter for contraceptive management
- Procreative management
- Outcome of delivery
- Encounter for antenatal screening of mother
- Presence of contraceptive device
- Multiparity
- Illegitimacy or illegitimate pregnancy
- Other unwanted pregnancy
- High-risk sexual behavior
- Gynecological examination
- Pregnancy examination or test
- Routine general medical examination at a health care facility
- Other general medical examination for administrative purposes

What counts as an encounter? (ICD-9 codes)

- Health examination of defined subpopulations
- Health examination in population surveys
- Other specified general medical examinations
- Unspecified general medical examinations

EXCLUSION OR EXCEPTION CRITERIA

What counts as a hysterectomy? (SNOMED CT codes)

- Total hysterectomy (procedure)
- Radical hysterectomy (procedure)
- Total abdominal hysterectomy (procedure)
- Total abdominal hysterectomy with bilateral salpingo-oophorectomy (procedure)
- Hysterectomy (procedure)
- Total laparoscopic hysterectomy (procedure)
- Radical laparoscopic hysterectomy (procedure)
- Total hysterectomy with unilateral removal of ovary (procedure)
- Radical abdominal hysterectomy (procedure)
- Total hysterectomy with unilateral removal of tube (procedure)
- Radical vaginal hysterectomy (procedure)
- Wertheim-Meigs abdominal hysterectomy (procedure)
- Wertheim operation (procedure)
- Laparoscopic total abdominal hysterectomy and bilateral salpingo-oophorectomy (procedure)
- Total hysterectomy with unilateral removal of tube and ovary (procedure)
- Complete excision of organ (procedure)
- Total hysterectomy with removal of both tubes and ovaries (procedure)
- Removal of ectopic interstitial uterine pregnancy requiring total hysterectomy (procedure)
- Total hysterectomy (procedure)
- Radical hysterectomy (procedure)
- Total abdominal hysterectomy (procedure)
- Total abdominal hysterectomy with bilateral salpingo-oophorectomy (procedure)
- Hysterectomy (procedure)
- Total laparoscopic hysterectomy (procedure)
- Radical laparoscopic hysterectomy (procedure)
- Total hysterectomy with unilateral removal of ovary (procedure)
- Radical abdominal hysterectomy (procedure)
- Total hysterectomy with unilateral removal of tube (procedure)
- Radical vaginal hysterectomy (procedure)
- Wertheim-Meigs abdominal hysterectomy (procedure)
- Wertheim operation (procedure)
- Laparoscopic total abdominal hysterectomy and bilateral salpingo-oophorectomy (procedure)
- Total hysterectomy with unilateral removal of tube and ovary (procedure)
- Complete excision of organ (procedure)

What counts as a hysterectomy? (SNOMED CT codes)

- Total hysterectomy with removal of both tubes and ovaries (procedure)
- Removal of ectopic interstitial uterine pregnancy requiring total hysterectomy (procedure)

What counts as a hysterectomy? (CPT codes)

- Closure of vesicouterine fistula; with hysterectomy
- Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
- Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (e.g., Marshall-Marchetti-Krantz, Burch)
- Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
- Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
- Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
- Vaginal hysterectomy, for uterus 250 g or less;
- Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
- Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
- Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
- Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
- Vaginal hysterectomy, with total or partial vaginectomy
- Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
- Vaginal hysterectomy, radical (Schauta type operation)
- Vaginal hysterectomy, for uterus greater than 250 g;
- Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
- Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
- Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
- Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
- Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
- Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
- Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g
- Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
- Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
- Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
- Laparoscopy, surgical, with totally hysterectomy, for uterus greater than 250 g;
- Laparoscopy, surgical, with totally hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
- Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
- Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
- Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy

What counts as a hysterectomy? (CPT codes)

- Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
- Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy

NUMERATOR INCLUSION CRITERIA

What counts as a Pap test? (CPT codes)

- Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
- Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
- Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
- Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
- Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
- Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
- Cytopathology, slides, cervical or vaginal, defective hormonal evaluation (eg, maturation index, karyopknotic index, estrogenic index)
- Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
- Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

What counts as a Pap test? (HCPCS codes)

- Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
- Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
- Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
- Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision
- Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision
- Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
- Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
- Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening

What counts as a Pap test? (HCPCS codes)

- Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision
- Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician
- Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

What counts as a Pap test? (ICD-10 codes)

- Encounter for screening for malignant neoplasm of cervix
- Encounter for screening for malignant neoplasm of vagina

What counts as a Pap test? (ICD-9 codes)

- Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear

What counts as a Pap test? (LOINC codes)

- Microscopic observation [Identifier] in Cervix by Cyto stain
- Microscopic observation [Identifier] in Cervix by Cyto stain.thin prep
- General categories [interpretation] of Cervical or vaginal smear or scraping by Cyto stain
- Statement of adequacy [interpretation] of Cervical or vaginal smear or scraping by Cyto stain
- Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain
- Microscopic observation [Identifier] in Cervical or vaginal smear or scraping by Cyto stain
- Cytology study comment Cervical or vaginal smear or scraping Cyto stain
- Cytology Cervical or vaginal smear or scraping study
- Cytology report of Cervical or vaginal smear or scraping Cyto stain.thin prep
- Cytology report of Cervical or vaginal smear or scraping Cyto stain

What counts as a Pap test? (SNOMED CT codes)

- Microscopic examination of vaginal Papanicolaou smear (procedure)
- Microscopic examination of cervical Papanicolaou smear (procedure)

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

NQF0032	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹	×			×	×		×	×	×		×
Denominator ²	×			×		×	×				
Exceptions or exclusions ³	×			×			×	×			×

- (Codes with an asterisk (*) are required from certified EHRs)
- ¹ To identify the numerator in this CQM, the following standard codes are required: (1) a "laboratory" code for Pap test from CPT, HCPCS, LOINC, SNOMED; OR (2) an "encounter" code for Pap test from ICD-9-CM, ICD-10-CM.

- 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 or OB/GYN "encounter" code from CPT, ICD-9-CM
- ³ To identify the exclusions or exceptions in this CQM, the following standard codes are required: a "procedure" code for hysterectomy from CPT, ICD-9-CM, ICD-10-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)

Abbreviation	Long Name	Definition/Description
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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