Quality ID #225 (NQF 0509): Radiology: Reminder System for Screening Mammograms
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measure Area: Preventive Care

2020 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Structure – High Priority

DESCRIPTION:
Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

INSTRUCTIONS:
This measure is to be submitted each time a screening mammogram is performed during the performance period for patients seen during the performance period. This measure is intended to reflect the quality of services provided for reminding patients when follow-up mammograms are due.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients undergoing a screening mammogram

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Diagnosis for mammogram screening (ICD-10-CM): Z12.31
AND
Patient procedure during the performance period (CPT or HCPCS): 77067

NUMERATOR:
Patients whose information is entered into a reminder system with a target due date for the next mammogram

Numerator Instructions:
The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier, patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram. Use of the reminder system is not required to be documented within the final report to meet performance for this measure.

Numerator Options:
Performance Met: Patient information entered into a reminder system with a target due date for the next mammogram (7025F)

OR

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Denominator Exception:	Documentation of medical reason(s) for not entering patient information into a reminder system (e.g., further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s) (7025F *with* 1P)

OR

Performance Not Met:	Patient Information not entered into a reminder system, reason not otherwise specified (7025F *with* 8P)

RATIONALE:

Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence shows that only 72% of women are receiving mammograms based on current guideline recommendations. The use of patient reminders is associated with an increase in screening mammography.

Encouraging the implementation of a reminder system could lead to an increase in mammography screening at appropriate intervals.

CLINICAL RECOMMENDATION STATEMENTS:

The Community Preventive Services Task Force recommends the use of client reminders to increase screening for breast and cervical cancers on the basis of strong evidence of effectiveness (CPSTF, 2010)

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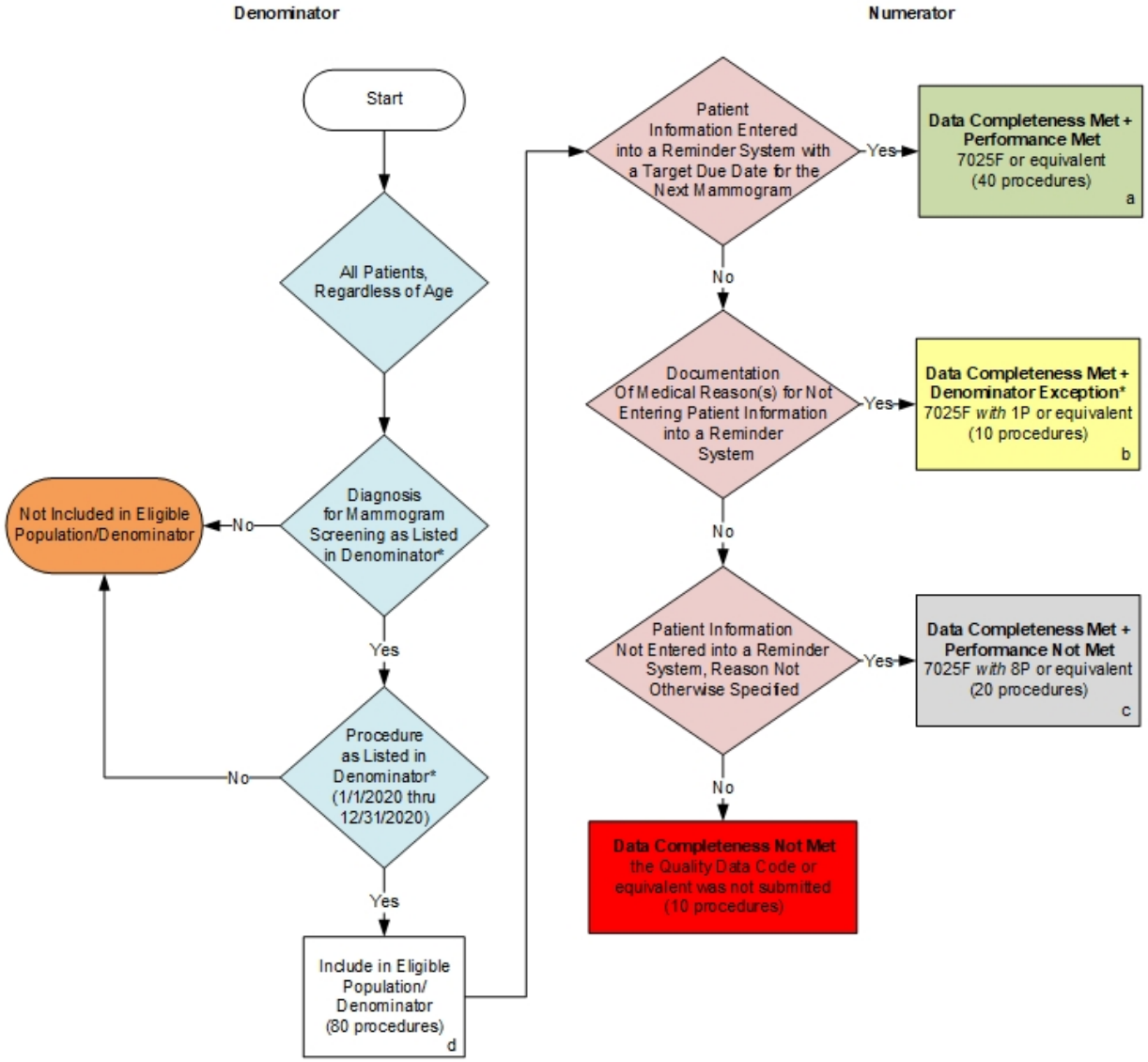
2020 Clinical Quality Measure Flow for Quality ID #225 NQF #0509: Radiology: Reminder System for Screening Mammograms

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS:

Data Completeness=

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) = 70 procedures = **87.50%**

Eligible Population / Denominator (d=80 procedures) = 80 procedures

Performance Rate=

Performance Met (a=40 procedures) = 40 procedures = **66.67%**

Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 60 procedures

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure

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2020 Clinical Quality Measure Flow Narrative for Quality ID #225 NQF #0509: Radiology: Reminder System for Screening Mammograms

Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.

1. Start with Denominator
2. All Patients, Regardless of Age
3. Check Patient Diagnosis:
    a. If Diagnosis for Mammogram Screening as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Diagnosis for Mammogram Screening as Listed in the Denominator equals Yes, proceed to check Procedure Performed.
4. Check Procedure Performed:
    a. If Procedure as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Procedure as Listed in the Denominator equals Yes, include in Eligible Population.
5. Denominator Population:
    a. Denominator Population is all Eligible Procedures in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
6. Start Numerator
7. Check Patient Information Entered into a Reminder System with a Target Due Date for the Next Mammogram:
    a. If Patient Information Entered into a Reminder System with a Target Due Date for the Next Mammogram equals Yes, include in Data Completeness Met and Performance Met.
    b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 procedures in the Sample Calculation.
    c. If Patient Information Entered into a Reminder System with a Target Due Date for the Next Mammogram equals No, proceed to check Documentation of Medical Reason(s) for Not Entering Patient Information into a Reminder System.
8. Check Documentation of Medical Reason(s) for Not Entering Patient Information into a Reminder System:
    a. If Documentation of Medical Reason(s) for Not Entering Patient Information into a Reminder System equals Yes, include in Data Completeness Met and Denominator Exception.
    b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 procedures in the Sample Calculation.

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c. If Documentation of Medical Reason(s) for Not Entering Patient Information into a Reminder System equals No, proceed to check Patient Information Not Entered into a Reminder System, Reason Not Otherwise Specified.

9. Check Patient Information Not Entered into a Reminder System, Reason Not Otherwise Specified:

   a. If Patient Information Not Entered into a Reminder System, Reason Not Otherwise Specified equals Yes, include in Data Completeness Met and Performance Not Met.

   b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 20 procedures in the Sample Calculation.

   c. If Patient Information Not Entered into a Reminder System, Reason Not Otherwise Specified equals No, proceed to check Data Completeness Not Met.

10. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS:

Data Completeness =

Performance Met (a=40 procedures) + Denominator Exception (b=10 procedures) + Performance Not Met (c=20 procedures) / Eligible Population / Denominator (d=80 procedures) = 70 procedures / 80 procedures = **87.50%**

Performance Rate =

Performance Met (a=40 procedures) / Data Completeness Numerator (70 procedures) – Denominator Exception (b=10 procedures) = 40 procedures / 60 procedures = **66.67%**

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