

**Quality ID #443: Non-Recommended Cervical Cancer Screening in Adolescent Females**

– National Quality Strategy Domain: Patient Safety

– Meaningful Measure Area: Appropriate Use of Healthcare

**2021 COLLECTION TYPE:**

**MIPS CLINICAL QUALITY MEASURES (CQMS)**

**MEASURE TYPE:**

Process – High Priority

**DESCRIPTION:**

The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer

**INSTRUCTIONS:**

This measure is to be submitted **once per performance period** for female patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

**NOTE:** Patient encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

**Measure Submission Type:**

Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are 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:**

Adolescent females 16-20 years of age with a visit during the measurement period

**Denominator Criteria (Eligible Cases):**

Patients aged 16-20 years of age on date of encounter

**AND**

**Patient encounter during the performance period (CPT or HCPCS):**99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402, G0438, G0439

**AND NOT**

**DENOMINATOR EXCLUSIONS:**

**A history of cervical cancer, HIV, or immunodeficiency any time during the patient's history through the end of the measurement period:** B20, B97.35, C53.0, C53.1, C53.8, C53.9, D06.0, D06.1, D06.7, D06.9, Z85.41, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.4, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.81, D84.821, D84.822, D84.89, D84.9, D89.3, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, Z21

**OR**

**Patients who use hospice services any time during the measurement period:** G9805

**NUMERATOR:**

Patients who received cervical cytology or an HPV test during the measurement period

**Numerator Instruction:**

INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures, a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control.

**Numerator Options:**

***Performance Met:***

Patients who received cervical cytology or an HPV test (**G9806**)

**OR**

***Performance Not Met:***

Patients who did not receive cervical cytology or an HPV test (**G9807**)

**RATIONALE:**

This measure assesses the percentage of female adolescents 16–20 years of age who were unnecessarily screened for cervical cancer. A lower rate indicates better performance for this measure.

There are multiple medical societies and evidence-based guidelines which recommend against cervical cancer screening in a general population of females under 21 years of age; however, fewer than 25 percent of clinicians provide care consistent with guidelines (Yabroff 2009). Although screening has been shown to be highly effective in the 21–65 age group, the USPSTF determined there is adequate evidence that screening women younger than 21—regardless of sexual history—does not reduce the incidence and mortality of cervical cancer, compared with beginning screening at 21 (Moyer 2012). The USPSTF found evidence that screening in the younger age group leads to more harm than benefit because abnormal cellular changes are likely to be transient and to resolve on their own, and resulting treatment may have an adverse effect on future child-bearing. Thus, the USPSTF specifically recommends against screening women under 21 years of age (Moyer 2012).

Moyer, V.A., U.S. Preventive Services Task Force. 2012. “Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement.” *Ann Intern Med.* 156(12):880-91.

Yabroff, K.R., M. Saraiya, H.I. Meissner, et al. 2009. “Specialty Differences in Primary Care Physician Reports of Papanicolaou Test Screening Practices: A National Survey, 2006 to 2007.” *Ann Int Med.* 151(9):602-11.

**CLINICAL RECOMMENDATION STATEMENTS:**

The United States Preventive Services Task Force (Moyer 2012):

“The USPSTF recommends against screening for cervical cancer in women younger than age 21 years (D recommendation).”

American College of Obstetricians and Gynecologists (2012):

“Cervical cancer screening should begin at age 21 years. Women younger than age 21 years should not be screened regardless of the age of sexual initiation or the presence of other behavior-related risk factors.”

American Cancer Society, American Society for Colposcopy & Cervical Pathology, American Society for Clinical Pathology (Saslow 2012):

“Cervical cancer screening should begin at age 21 years. Women aged younger than 21 years should not be screened regardless of the age of sexual initiation or other risk factors.”

American College of Obstetricians and Gynecologists. 2012. “Practice Bulletin #131 Screening for Cervical Cancer.” *Obstet Gynecol.* 120:1222-38

Moyer, V.A., U.S. Preventive Services Task Force. 2012. “Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement.” *Ann Intern Med.* 156(12):880-91.

Saslow, D., D. Solomon, H.W. Lawson, et al. 2012. "American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology Screening Guidelines for Prevention and Early Detection of Cervical Cancer." Am J Pathol. 137:516-42.

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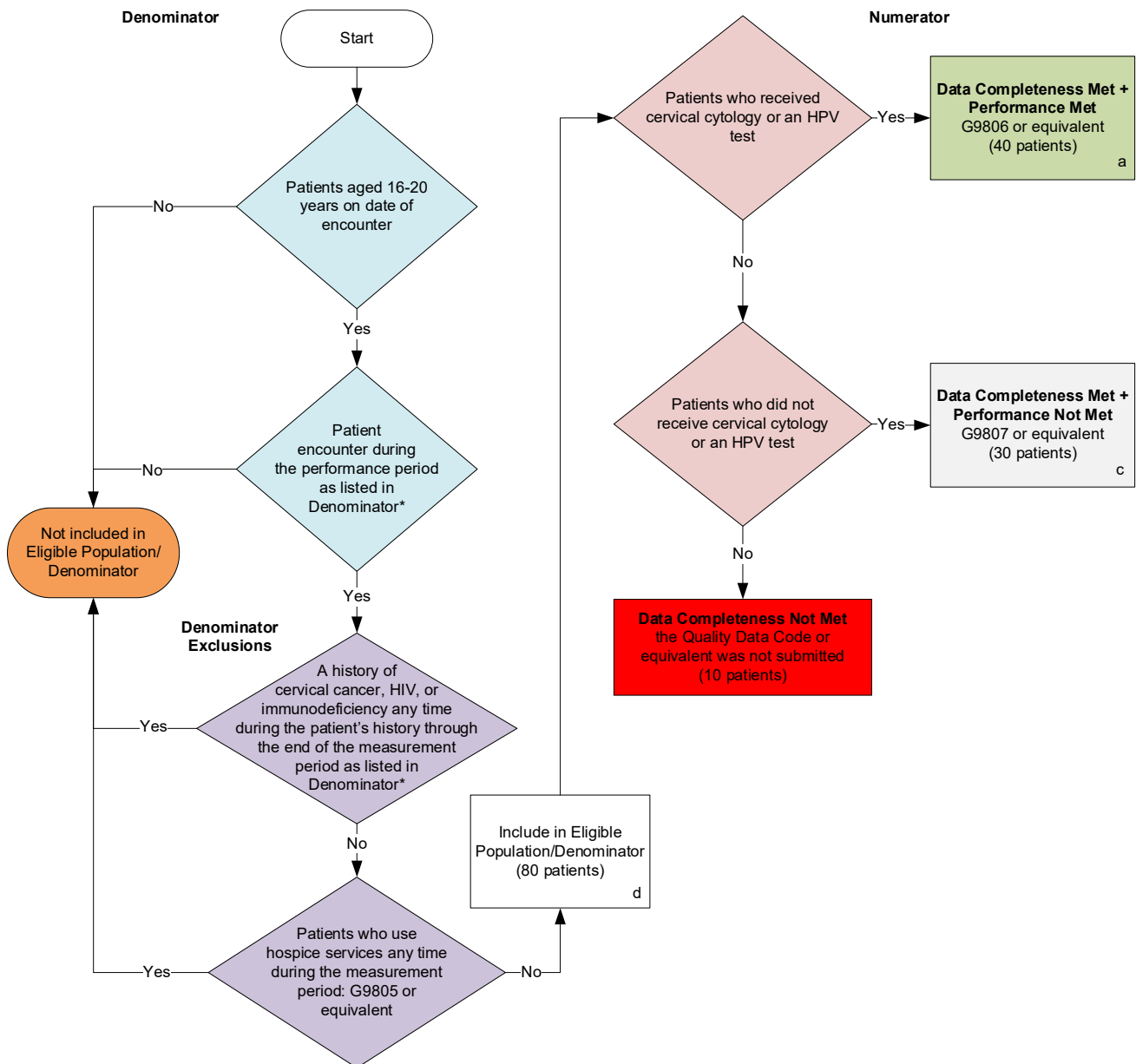
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## 2021 Clinical Quality Measure Flow for Quality ID #443: Non-Recommended Cervical Cancer Screening in Adolescent Females

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



**SAMPLE CALCULATIONS**

**Data Completeness=**  

$$\frac{\text{Performance Met (a=40 patients)} + \text{Performance Not Met (c=30 patients)}}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

**Performance Rate=**  

$$\frac{\text{Performance Met (a=40 patients)}}{\text{Data Completeness Numerator (70 patients)}} = \frac{40 \text{ patients}}{70 \text{ patients}} = 57.14\%$$

\*See the posted measure specification for specific coding and instructions to submit this measure.  
 A lower calculated performance rate for this measure indicates better clinical control and care.  
 NOTE: Submission Frequency: Patient-Process

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 The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

**2021 Clinical Quality Measure Flow Narrative for Quality ID #443:  
Non-Recommended Cervical Cancer Screening in Adolescent Females**

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

1. Start with Denominator
2. Check *Patients aged 16-20 years on date of encounter*:
  - a. If *Patients aged 16-20 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
  - b. If *Patients aged 16-20 years on date of encounter* equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator\**.
3. Check *Patient encounter during the performance period as listed in Denominator\**:
  - a. If *Patient encounter during the performance period as listed in Denominator\** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
  - b. If *Patient encounter during the performance period as listed in Denominator\** equals Yes, proceed to *A history of cervical cancer, HIV, or immunodeficiency any time during the patient's history through the end of the measurement period as listed in Denominator\**.
4. Check *A history of cervical cancer, HIV, or immunodeficiency any time during the patient's history through the end of the measurement period as listed in Denominator\**:
  - a. If *A history of cervical cancer, HIV, or immunodeficiency any time during the patient's history through the end of the measurement period as listed in Denominator\** equals No, proceed to *Patients who use hospice services any time during the measurement period*.
  - b. If *A history of cervical cancer, HIV, or immunodeficiency any time during the patient's history through the end of the measurement period as listed in Denominator\** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
5. Check *Patients who use hospice services any time during the measurement period*:
  - a. If *Patients who use hospice services any time during the measurement period* equals No, include in *Eligible Population/Denominator*.
  - b. If *Patients who use hospice services any time during the measurement period* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
6. Denominator Population:
  - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *Patients who received cervical cytology or an HPV test*:
  - a. If *Patients who received cervical cytology or an HPV test* equals Yes, include in *Data Completeness Met and Performance Met*.

- *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
- b. If *Patients who received cervical cytology or an HPV test* equals No, proceed to *Patients who did not receive cervical cytology or an HPV test*.
9. Check *Patients who did not receive cervical cytology or an HPV test*:
- a. If *Patients who did not receive cervical cytology or an HPV test* equals Yes, include in *Data Completeness Met and Performance Not Met*.
- *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.
- b. If *Patients who did not receive cervical cytology or an HPV test* equals No, proceed to *Data Completeness Not Met*.
10. Check *Data Completeness Not Met*:
- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

### **Sample Calculations**

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population/Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.5 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

\*See the posted measure specification for specific coding and instructions to submit this measure.

A lower calculated performance rate for this measure indicates better clinical control and care.

NOTE: Submission Frequency: Patient-Process

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