Cervical Cancer Screening (CCS-E)

Patients 21-64 years of age screened for cervical cancer using any of the following criteria:

Age	Criteria
21-64 years of age	Had cervical cytology performed within the last 3 years
30-64 years of age	• Had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; **OR** • Had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

Exclusions

- Persons with sex assigned at birth of male.
- Persons with a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix.
    - ICD-10 Diagnosis Codes to Report Past Hysterectomy History:
        - Z90.710: acquired absence of both cervix and uterus
        - Z90.712 acquired absence of cervix with remaining uterus

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, & qualifying services—not code submission alone.

88141 (CPT)	Cytopathology, cervical or vaginal
P3000 (HCPCS)	Screening Papanicolaou smear, cervical or vaginal
G0147 (HCPCS)	Screening cytopathology smears, cervical or vaginal
G0476 (HCPCS)	Infectious agent detection by nucleic acid
87624 (CPT)	Infectious agent detection by nucleic acid
87626	Self-collection in office or patient service center, high risk Human Papillomavirus (HPV) with genotyping, vaginal swab
87491, 87591	Self-collection in office or patient service center, Chlamydia/Gonococcus, NAA, swab
87563	Self-collection in office or patient service center, Mycoplasma genitalium, NAA, swab
87661	Self-collection in office or patient service center, Trichomonas vaginalis, NAA, swab

Documentation Requirements

A note in the medical record indicating the date and result of cervical cancer screening.

- For cervical cytology, count any screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present."
- For hrHPV tests, generic documentation of "HPV" tests can be counted.

A note in the medical record indicating the date of the hysterectomy and the following:

- Documentation of a "vaginal Pap smear" with documentation of "hysterectomy."
- Patient attestation is acceptable as long as there is a date and results of the test or a date of the total hysterectomy and acceptable documentation of no residual cervix.
- Documentation of hysterectomy and documentation that a member no longer needs Pap testing/cervical cancer screening.

Common Documentation Insufficiencies

- For hysterectomy exclusion, documentation must indicate that the cervix was removed; documentation of "hysterectomy" alone will NOT meet the intent of the exclusion.
- Failed to include the words "Total", "complete" or "radical" abdominal or vaginal hysterectomy.
- Do not count biopsies as these are diagnostic and therapeutic in nature only.

Best Practices

- Upload lab reports into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify and remind providers of when a patient's next screening is due and to discuss with patients in advance. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of cervical cancer.
- Assess and address member barriers to regular cervical cancer screening (e.g., access to care, transportation, cost, fear/anxiety).
- Identify patients who would benefit from self-collect HPV & STI screening.
    - Patients may be good candidates if they:
        - Have missed recommended STI or cervical cancer screening.
        - Have a history of trauma or anxiety around pelvic exams.
        - Cannot provide a cervical sample from a Pap smear.