Cervical Cancer Screening (CMS124)

https://ecqi.healthit.gov/ecqm/ep/2022/cms124v10

Measure Details

Measure Description: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed within the last 3 years
- Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

Initial Population: Female Patients 23-64 years of age with a visit during 2022.

Numerator: Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test
- Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are 30 years or older at the time of the test.

Denominator: Equals Initial Population.

Exclusions:

- Women who had a hysterectomy with no residual cervix or a congenital absence of cervix.
- Patients who are in hospice care for any part of the measurement period.
- Patients receiving palliative care during the measurement period.

Documentation Overview

What is Documented	When is it Documented	Where in QMER
Cervical Cytology (PAP) Females 21-64	During 2022 or 2 years prior	History or Orders & Results
Cervical HPV Testing Females (30-64)	During 2022 or 4 years prior	Order & Results Module

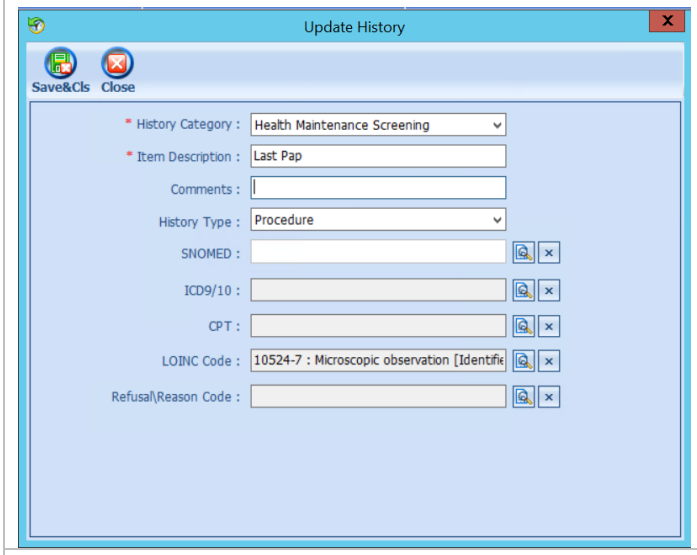
Exclusions/Exceptions	Where in QEMR
Prior Hysterectomy	History Module
Hospice/Palliative Care	History Module

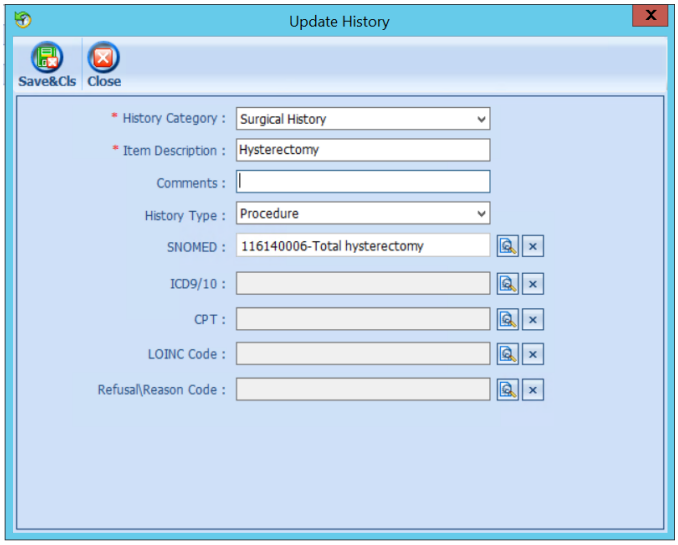
Set Up

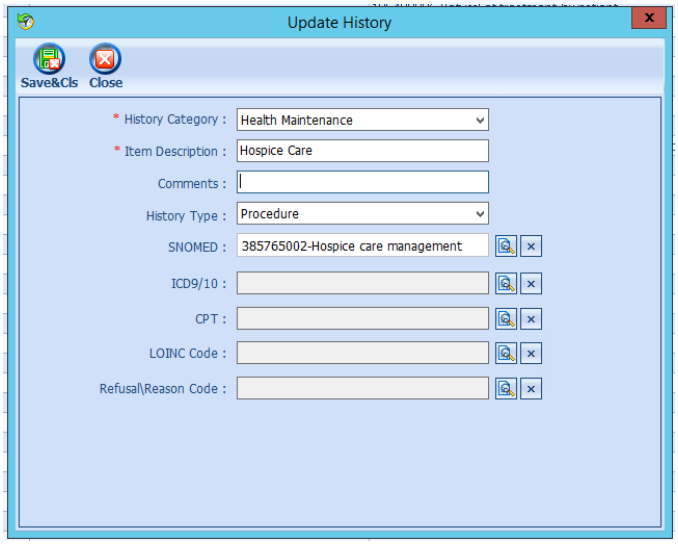
Building History Items

Build the history items seen below:

1. Log into **QEMR** > Navigate to **Edit** > **History**
2. Highlight **APPROPRIATE** Category list on left side bar
3. Click **New** hot button
4. **Complete the Update History** Screen as seen below
5. Click **Save & Close** hot button



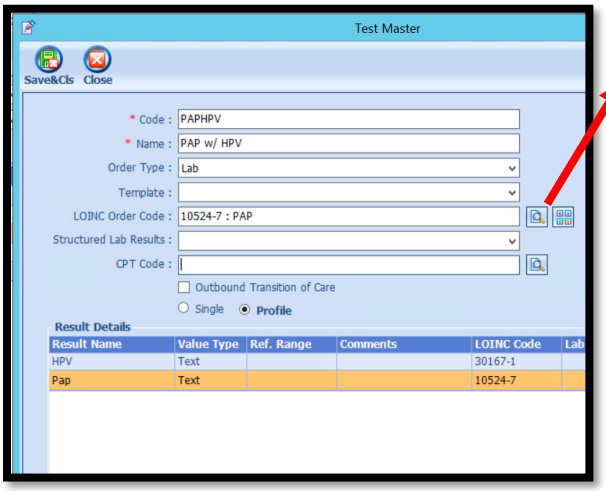




Building Internal Order & Results

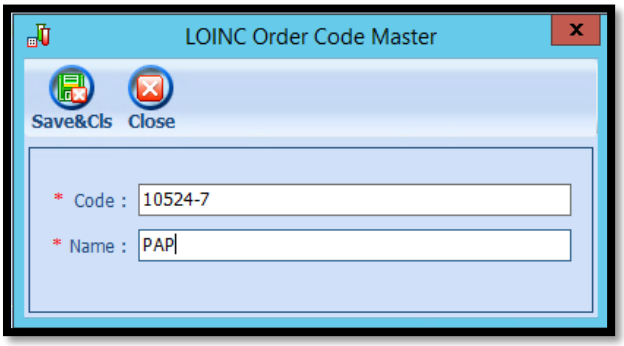
If the test is ordered via Lab Interface, the resulting lab should be sending LOINC in the HL7 message. If resulted internally (in office lab test), build the appropriate result profile in **Edit > Orders & Results**, adding appropriate LOINC (from lab test kit).

1. Log into **QEMR** > Navigate to **Edit** > **Order & Results Setup > New** hot button
2. Complete the Test Master screen as shown below using appropriate LOINC
3. Click **Save & Close**



When searching for the LOINC Order Code if it is not there you will need to create by following the steps listed here:

1. Click the **Add LOINC Order Code** icon
2. Complete the LOINC Order Code Master as shown below
    a. **Code**: 10527-7
    b. **Name**: Pap
3. Click **Save & Close** button



Workflow

Document PAP via History Module

For practices not ordering or performing PAPS in office can document last PAP via the History Module.

To document Last Pap status follow steps below:

1. Navigate to **History** Module > **Health Maintenance** category
    a. Double-click **Last Pap**
    b. Enter **Occur Date**

Ordering Screening Test

For those who order or perform the testing without a lab interface order and results must be done via the **Orders & Results > Order Entry**

1. Navigate to **Orders & Results > Order Entry** hot button
2. Double-click PAP test which was built in Set Up section of this guide
    a. To modify and/or print the prescription for the patient click the ellipsis icon for templates
    b. **Modify** Template if necessary > **Print** > **Save & Close**
3. **Save & close** the order Entry Screen > **Save & Close** the View Orders and Results Screen

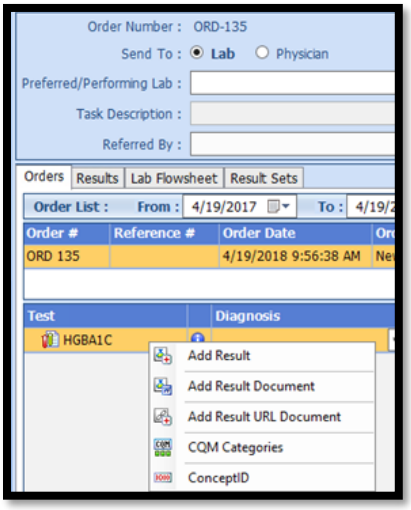
Documenting Test Results

After receiving the test results via scanned documents or received fax you must associate it with the order or manually enter the numerical results if testing was done in-house.

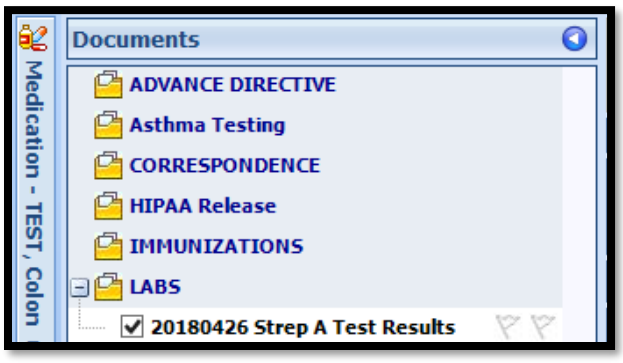
Adding Scanned Test Results

To associate a document to the test results:

1. Navigate to **Orders & Results > Orders Tab**
2. Right-click on the test you would like to add the results to
3. Click **Add Results Document**



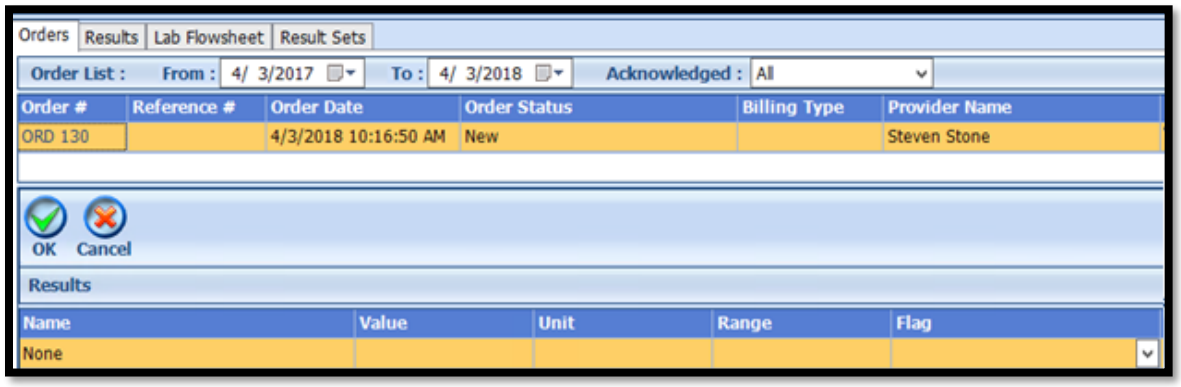
4. You will be brought to the **Scan Documents** screen
    a. Place a **check box** in the document you would like to associate
    b. Click **Save** hot button



Adding Value Results to Order

To manually document the test results:

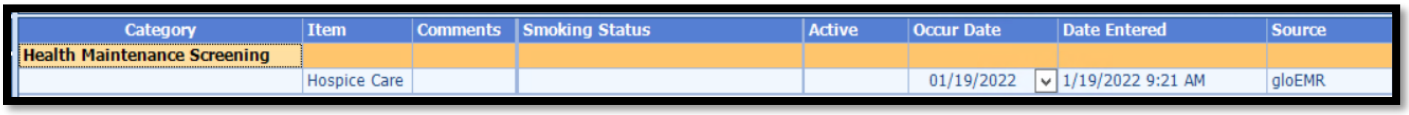
1. Navigate to **Orders & Results > Orders Tab**
2. Right-click on the test you would like to add the results to
3. Click **Add Results**
4. Enter test results in **Value** field **>** Click **Save & Close** hot button



Documenting Exclusions

Patients with a prior total hysterectomy or receiving hospice care are to be excluded by documenting the applicable exclusion via the history module. See steps listed below to document.

1. Navigate to **History Module** > applicable category
    a. Double-click applicable exclusion item
        i. Total Hysterectomy OR
        ii. Hospice Care
    b. Enter **Occur Date**



Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be completed.

Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

Some of the SnoMed, LOINC, ICD10 and CPT Codes list are one of many available for some measures, if you practice would like to use an alternate code than what is listed in the set up section, please reach out to support for additional options.