2018 CMS Web Interface

PREV-5 (NQF 2372): Breast Cancer Screening
Measure Steward: NCQA

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INTRODUCTION

There are a total of 15 individual measures (including one composite consisting of two measures) included in the 2018 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The Measure Documents are being provided to allow group practices and Accountable Care Organizations (ACOs) an opportunity to better understand each of the 15 individual measures included in the 2018 CMS Web Interface data submission method. Each Measure Document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION

BENEFICIARY SAMPLING

For more information on the sampling process and methodology please refer to the 2018 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION

DESCRIPTION:
Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer

IMPROVEMENT NOTATION:
Higher score equals better quality

INITIAL POPULATION:
Women 51 - 74 years of age with a visit during the measurement period

DENOMINATOR:
Equals Initial Population

DENOMINATOR NOTE:
The intent of the measure is that starting at age 50 women should have one or more mammograms every 24 months with a 3 month grace period.

DENOMINATOR EXCLUSIONS:
Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy

OR

Patient age 65 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 any time during the measurement period

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
None

GUIDANCE:
This measure evaluates primary screening. Do not count biopsies, breast ultrasounds or MRIs because they are not appropriate methods for primary breast cancer screening.

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for reporting requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR

  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR

  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country or did not have Fee-for-Service (FFS) Medicare as their primary payer select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance Patient Confirmation

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected*, the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.*

If "Not Qualified for Sample" is selected and the date is unknown*, you may enter the last date of the measurement period (i.e., 12/31/2018).*

The Measurement Period is defined *as January 1 – December 31, 2018.*

NOTE:

- ***In Hospice****: Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- ***Moved out of Country:*** *Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- ***Deceased:*** *Select this option if the patient died during the measurement period*
- ***Non-FFS Medicare:*** *Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure
  - If the patient is qualified for the measure select "Yes"

  OR

  - If there is a denominator exclusion for patient disqualification from the measure select "Denominator Exclusion"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Denominator Exclusion codes can be found in the 2018 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

If "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected*, the patient will be "skipped" and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.*

CMS Approved Reason *may only be selected when approved by CMS. To request a CMS Approved Reason, you would need to provide the patient rank, measure, and reason for request in a CMS Quality Payment Program Service Desk inquiry. A CMS decision will be provided in the resolution of the inquiry. Patients for whom a CMS Approved Reason is selected will be "skipped" and another patient must be reported in their place, if available.*

The intent of the exclusion for individuals age 65 and older residing long-term care facilities, including nursing homes, is to exclude individuals who may have limited life expectancy and increased frailty where the benefit of the process may not exceed the risks. This exclusion is not intended as a clinical recommendation regarding whether the measures process is inappropriate for specific populations, instead the exclusions allows clinicians to engage in shared decision making with patients about the benefits and risks of screening when an individual has limited life expectancy.

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if a mammogram to screen for breast cancer was performed during the measurement period or the 15 months prior to the measurement period
  - If a mammogram to screen for breast cancer was not performed during the measurement period or the 15 months prior to the measurement period select "No"

  OR

  - If a mammogram to screen for breast cancer was performed during the measurement period or the 15 months prior to the measurement period select "Yes"

Numerator codes can be found in the 2018 CMS Web Interface PREV Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***Total lookback period for a mammogram*** *includes the measurement year, the year prior to the measurement year, and a 3 month grace period for a total of 27 months*
- ***Documentation in the medical record*** *must include both of the following: A note indicating the date the breast cancer screening was performed AND the result or findings*
- ***Documentation*** *of 'normal' or 'abnormal' is acceptable*
- ***Patient Reported Requirement****: Date and type of test AND result/finding*
- ***Screening includes:*** *screening, diagnostic, film, digital or digital breast tomosynthesis* (3D) mammography
- ***MRI, Ultrasound and Biopsies*** *are not considered breast cancer screening for this measure*
- ***Documentation of screening for breast cancer*** *may be completed during a telehealth encounter*

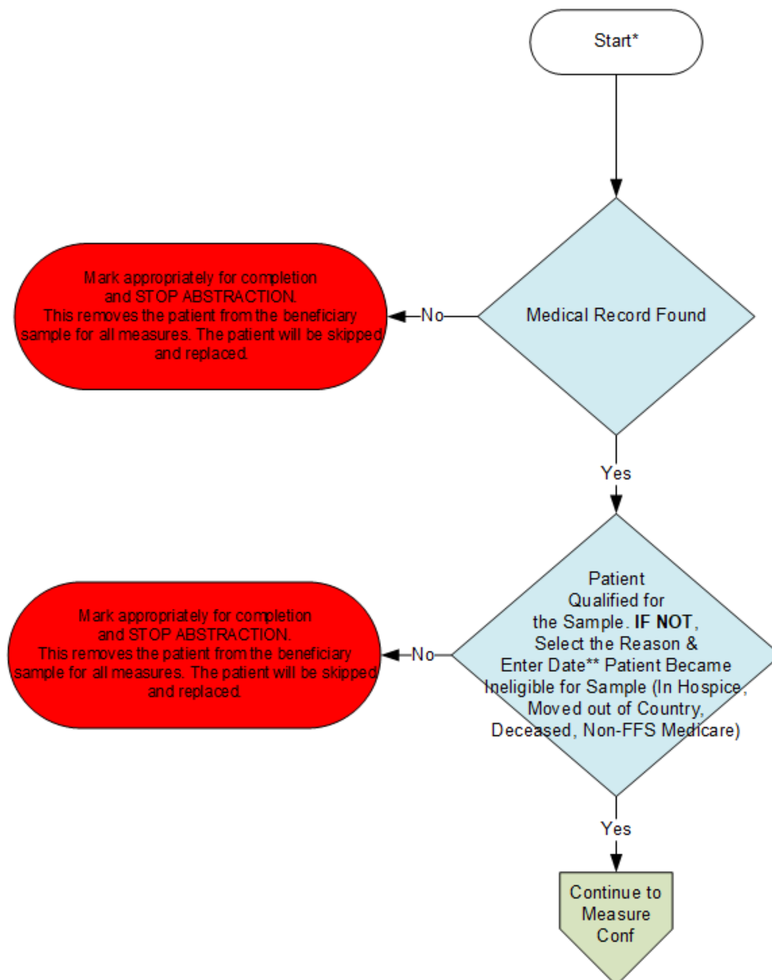
DOCUMENTATION REQUIREMENTS

When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Patient Confirmation Flow

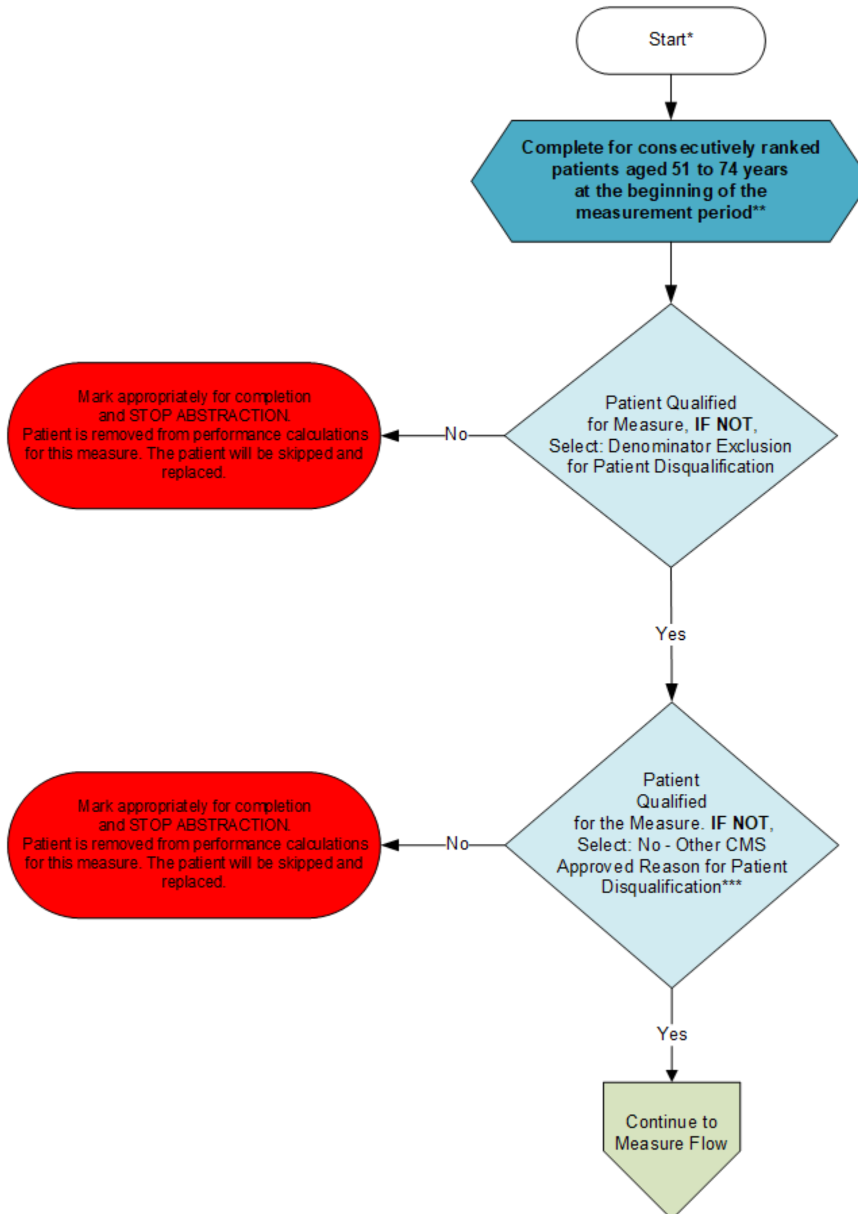
For 2018, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.



*See the Measure Reporting Document for further instructions on how to report this measure
**If date is unknown, enter 12/31/2018

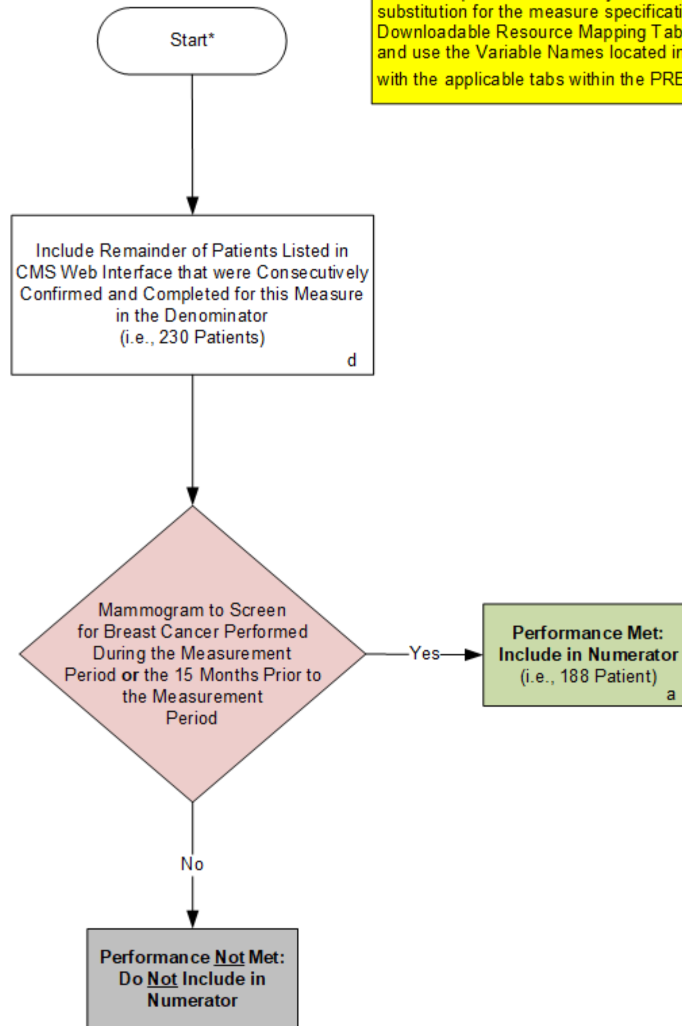
Measure Confirmation Flow for PREV-5

For 2018, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.



*See the Measure Submission Document for further instructions on how to submit this measure
**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect gender or date of birth listed, a change of the gender or patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-5 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
***"Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at qpp@cms.hhs.gov

Measure Flow for PREV-5



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a=188 Patients) / Denominator (d=230 Patients) = 188 Patients / 230 Patients = 81.74%

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

*See the Measure Submission Document for further instructions on how to submit this measure

Patient Confirmation Flow

For 2018, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient. Refer to the Measure Submission Document for further instructions.

1. Start Patient Confirmation Flow.

2. Check to determine if Medical Record can be found.
   a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
   b. If yes, Medical Record found, continue processing.

3. Check to determine if Patient Qualified for the sample.
   a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2018) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
   b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for PREV-5.

Measure Confirmation Flow for PREV-5

For 2018, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears. Refer to the Measure Submission Document for further instructions.

1. Start Measure Confirmation Flow for PREV-5. Complete for consecutively ranked patients aged 51 to 74 years at the beginning of the measurement period. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect gender or date of birth listed, a change of the gender or patient date of birth by the abstractor may result in the patient no longer qualifying for the PREV-5 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

2. Check to determine if the patient qualifies for the measure (Denominator Exclusion).
    a. If no, the patient does not qualify for the measure select: Denominator Exclusion for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. Stop processing.
    b. If yes, the patient does qualify for the measure, continue processing.

3. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).
    a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced. "Other CMS Approved Reason" may only be selected if you have received an approval from CMS in the resolution of a requested Quality Payment Program Service Desk Inquiry at qpp.cms.hhs.gov. Stop processing.
    b. If yes, the patient does qualify for the measure, continue to the PREV-5 measure flow.

Measure Flow for PREV-5

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 as a substitution for the measure specifications. For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the PREV Coding Document.

1. Start processing 2018 PREV-5 (NQF 2372) Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for PREV-5. Note: Include remainder of patients listed in CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (denominator, i.e. 230 patients).

2. Check to determine if the patient had a mammogram to screen for breast cancer performed during the measurement period or the 15 months prior to the measurement period.
    a. If no, the patient did not have a mammogram performed during the measurement period or the 15 months prior to the measurement period; performance is not met and should not be included in the numerator. Stop processing.
    b. If yes, the patient did have a mammogram performed during the measurement period or the 15 months prior to the measurement period, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a' category (numerator, i.e. 188 patients). Stop processing.

Sample Calculation
Performance Rate Equals
Performance Met is category 'a' in the measure flow (188 patients)
Denominator is category 'd' in the measure flow (230 patients)
188 (Performance Met) divided by 230 (Denominator) equals a performance rate of 81.74 percent
Calculation May Change Pending Performance Met

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2018 CMS Web Interface PREV Coding Document.

***PREV-5: Preventive Care and Screening: Breast Cancer Screening**

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator Exclusion/ Denominator Exclusion Codes	Exclusion	BILATERAL_CODE	I10 SNM
		UNILATERAL_CODE	C4 I9 I10 SNM WITH evidence of a right and a left mastectomy
Numerator/ Numerator Codes	Breast Cancer Screening	MAMMO_CODE	C4 HCPCS LN

**For EHR mapping, the coding within PREV-5 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements

RATIONALE:

Breast cancer is one of the most common types of cancers, accounting for a quarter of all new cancer diagnoses for women in the U.S. (BreastCancer.Org, 2011). It ranks as the second leading cause of cancer-related mortality in women, accounting for nearly 40,000 estimated deaths in 2013 (American Cancer Society, 2011).

According to the National Cancer Institute's Surveillance Epidemiology and End Results program, the chance of a woman being diagnosed with breast cancer in a given year increases with age. By age 30, it is one in 2,212. By age 40, the chances increase to one in 235, by age 50, it becomes one in 54, and, by age 60, it is one in 25. From 2004 to 2008, the median age at the time of breast cancer diagnosis was 61 years among adult women (Tangka et al, 2010).

In the U.S., costs associated with a diagnosis of breast cancer range from $451 to $2,520, factoring in continued testing, multiple office visits and varying procedures. The total costs related to breast cancer add up to nearly $7 billion per year in the U.S., including $2 billion spent on late-stage treatment (Lavigne et al, 2008, Boykoff et al, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50-74 years (B recommendation). The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (C recommendation). (USPSTF, 2009) The Task Force concludes the evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years and older (I statement).

U.S. Preventive Services Task Force (2009)

Grade: B recommendation. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.

Grade: C recommendation. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.

Grade: D recommendation. The USPSTF recommends against teaching breast self-examination (BSE).

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.

Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

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