2021 CMS Web Interface

PREV-5 (NQF 2372): Breast Cancer Screening

Measure Steward: NCQA

Contents

INTRODUCTION

There are a total of 10 individual measures included in the 2021 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 organizations an opportunity to better understand each of the 10 individual measures included in the 2021 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 2021 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 in the 27 months prior to the end of the measurement period

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
Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 days during the measurement period

OR
Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period

OR
Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period

Table: Dementia Exclusion Medications

Description	Prescription
Cholinesterase inhibitors	Donepezil Rivastigmine Galantamine
Miscellaneous central nervous system agents	Memantine

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Women with one or more mammograms during the 27 months prior to the end of the measurement period.

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:

Mammography screening is defined by a bilateral screening (both breasts) of breast tissue. If only one breast is present, unilateral screening (one side) must be performed on the remaining breast.

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 submission 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., 12/31/2021).*

The Measurement Period is defined *as January 1 – December 31, 2021.*

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 2021 CMS Web Interface PREV-5 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.*

Other CMS Approved Reason *is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.*

To submit a skip request, follow these steps:

1. *After confirming the beneficiary for the sample, scroll to the measure you would like to skip.*
2. *When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.*
3. *In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary's condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.*

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

The intent of the exclusion *for individuals age 66 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 27 months prior to the end of the measurement period.
  - If a mammogram to screen for breast cancer was performed during the 27 months prior to the end of the measurement period select "Yes"

  OR

  - If a mammogram to screen for breast cancer was not performed during the 27 months prior to the end of the measurement period select "No"

Numerator codes can be found in the 2021 CMS Web Interface PREV-5 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

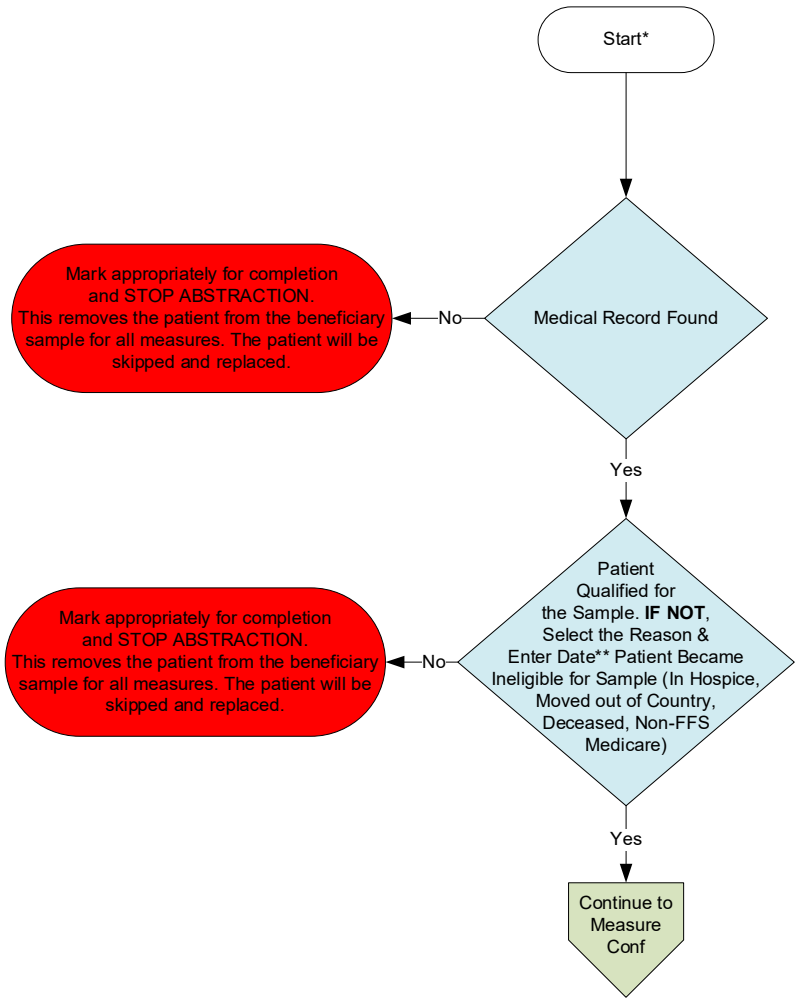
When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

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

Patient Confirmation Flow

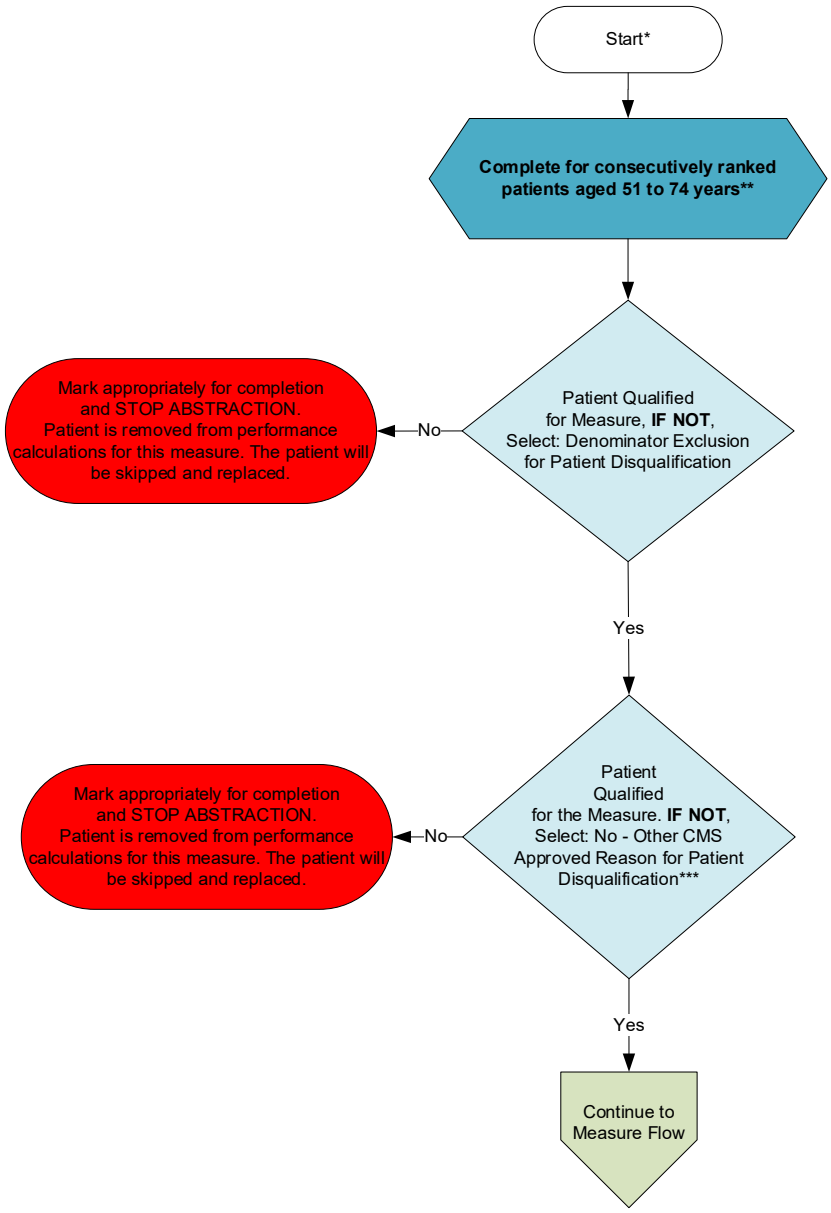
For 2021, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.



*See the posted measure submission document for specific coding and instructions to submit this measure.
**If date is unknown, enter 12/31/2021

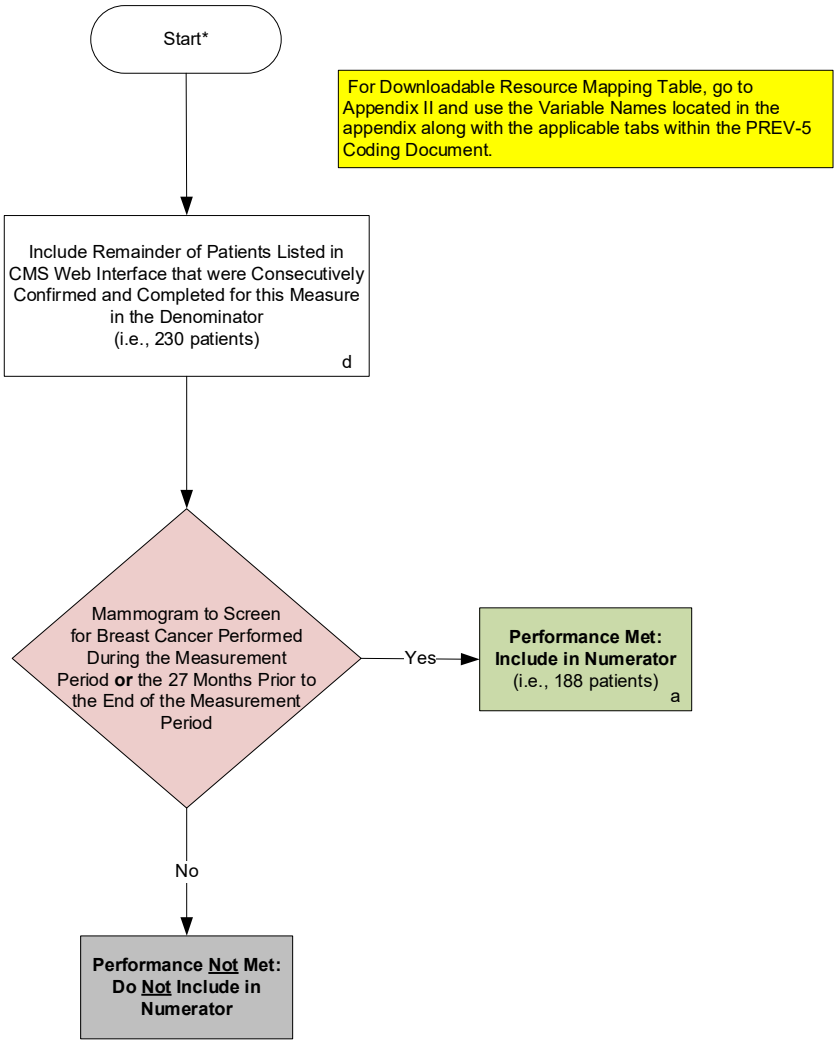
Measure Confirmation Flow for PREV-5

For 2021, 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 posted measure submission document for specific coding and instructions 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 the CMS Web Interface updated the resolution of the skip request to be "Approved".

Measure Flow for PREV-5



SAMPLE CALCULATION:

Performance Rate=

Performance Met (a=188 patients) = 188 patients = **81.74%**

Denominator (d=230 patients) = 230 patients

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

*See the posted measure submission document for specific coding and instructions to submit this measure.

Patient Confirmation Flow

For 2021, 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.

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 12/31/2021) 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 2021, 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.

1. Start Measure Confirmation Flow for PREV-5. Complete for consecutively ranked patients aged 51 to 74 years. 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 the CMS Web Interface updated the resolution of the skip request to be "Approved". Stop processing.

    b. If yes, the patient does qualify for the measure, continue to the PREV-5 measure flow.

Measure Flow for PREV-5

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-5 Coding Document.

1. Start processing 2021 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 27 months prior to the end of the measurement period.

    a. If no, the patient did not have a mammogram performed during the measurement period or the 27 months prior to the end of the measurement period; performance is not met and the patient 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 27 months prior to the end of 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=

Performance Met (a=188 patients)	=	188 patients	=	**81.74%**
Denominator (d=230 patients)	=	230 patients		

CALCULATION MAY CHANGE PENDING PERFORMANCES MET ABOVE

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 2021 CMS Web Interface PREV-5 Coding Document.

***PREV-5: Breast Cancer Screening**

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Denominator Exclusion/ Denominator Exclusion Codes/Denominator Exclusion Drug Codes	Exclusion	BILATERAL_CODE	I9 I10 SNM
		STATUS_POST_LEFT_MAST_CODE OR UNILATERAL_LEFT_CODE AND STATUS_POST_RIGHT_MAST_CODE OR UNILATERAL_RIGHT_CODE OR UNILATERAL_UNSPECIFIED_CODE AND LEFT_QUALIFIER_CODE AND RIGHT_QUALIFIER_CODE	I10 SNM OR I10 SNM AND I10 SNM OR I10 SNM OR I9 I10 SNM AND SNM AND SNM (evidence of a right and a left mastectomy
	Exclusion/66 years and older residing longer than 90 days	CARE_SERVICES_LT_RES_CODE	C4 SNM AND residing longer than 90 days
		NURSING_FACILITY_VISIT_CODE	C4 SNM AND residing longer than 90 days

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
	Exclusion/66 years and older with at least one claim/encounter for frailty AND dispensed dementia medication	FRAILTY_DEVICE_CODE OR FRAILTY_DIAGNOSIS_CODE OR FRAILTY_ENCOUNTER_CODE OR FRAILTY_SYMPTOM_CODE AND DEMENTIA_DRUG_CODE	HCPCS SNM OR I10 SNM OR C4 HCPCS SNM OR I10 SNM AND RxNorm (Drug EX=Y)

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
	Exclusion/66 years and older with at least one claim/encounter for frailty AND EITHER one acute inpatient encounter with advanced illness OR two outpatient, observation, ED or nonacute inpatient encounters on different dates with advanced illness	FRAILTY_DEVICE_CODE OR FRAILTY_DIAGNOSIS_CODE OR FRAILTY_ENCOUNTER_CODE OR FRAILTY_SYMPTOM_CODE AND EITHER ACUTE_INPATIENT_CODE WITH ADVANCED_ILLNESS_CODE OR OUTPATIENT_CODE OR OBSERVATION_CODE OR ED_CODE OR NONACUTE_INPATIENT_CODE WITH ADVANCED_ILLNESS_CODE	HCPCS SNM OR I10 SNM OR C4 HCPCS SNM OR I10 SNM AND EITHER C4 SNM WITH I10 SNM OR C4 HCPCS OR C4 OR C4 SNM OR C4 SNM WITH I10 SNM
Numerator/ Numerator Codes	Breast Cancer Screening	MAMMO_CODE	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 15 percent of all new cancer diagnoses in the U.S. (Howlader et al, 2016). In 2015, over 3 million women were estimated to be living with breast cancer in the U.S. and it is estimated that 12 percent of women will be diagnosed with breast cancer at some point during their lifetime (Howlader et al, 2016).

While there are other factors that affect a woman's risk of developing breast cancer, advancing age is a primary risk factor. Breast cancer is most frequently diagnosed among women ages 55-64; the median age at diagnosis is 62 years (Howlader et al, 2016).

The chance of a woman being diagnosed with breast cancer in a given year increases with age. By age 40, the chances are 1 in 68; by age 50 it becomes 1 in 43; by age 60, it is 1 in 29 (American Cancer Society, 2017).

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 screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years (C recommendation). (USPSTF, 2016)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older (I statement). (USPSTF, 2016)

The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method for breast cancer (I Statement). (USPSTF, 2016)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram (I statement). (USPSTF, 2016)

Appendix V: Use Notices, Copyrights, and Disclaimers

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