



AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Breast Cancer Screening Quick Reference Guide

2026

Table of Contents

MEASURE SNAPSHOT	3
How The Years Line Up	4
In One Sentence	5
CMS Cut Points	5
2026 Industry Performance (2025 → 2026 Trend)	5
WHAT THE MEASURE IS ASKING	5
In Plain Language	6
Why it Exists	6
What a Care Team Actually Controls	7
MEASURE SPECIFICATION	9
HEDIS Breast Cancer Screening (BCS) Measure	9
Measure-Defined Exclusions	9
Commonly Misunderstood	10
HOW PERFORMANCE IS MEASURED	11
Official Star-Scoring Pathway	11
Internal Performance is not the Official Star Result	11
Adjustment and Comparability	11
HIGH-YIELD INTERVENTIONS	11
COMMON PITFALLS AND PRACTICAL FIXES	13
BARRIERS AND EVIDENCE-BASED SOLUTIONS	14
Patient-side	14
System and Workflow	15
Disparity Gaps Requiring Targeted Action	16
CLINICAL CONTEXTS AND APPLICATIONS	17
Clinical Contexts	17
Patient Journey	17
Companion Guides – Making Connections	18
DOCUMENTATION THAT SUPPORTS CARE	18
Documentation that Reflects the Care	18
Clinical Documentation Optimization – SOAP Example	19
Documentation Examples	20
One Status, Clearly Stated	21
KEY TAKEAWAYS	22
Changes to Monitor	23
REFERENCES	24

MEASURE SNAPSHOT

CMS Part C Star Measure: C01 - Breast Cancer Screening

CMS Definition: Percent of female plan patients aged 50–74 who had a mammogram.¹

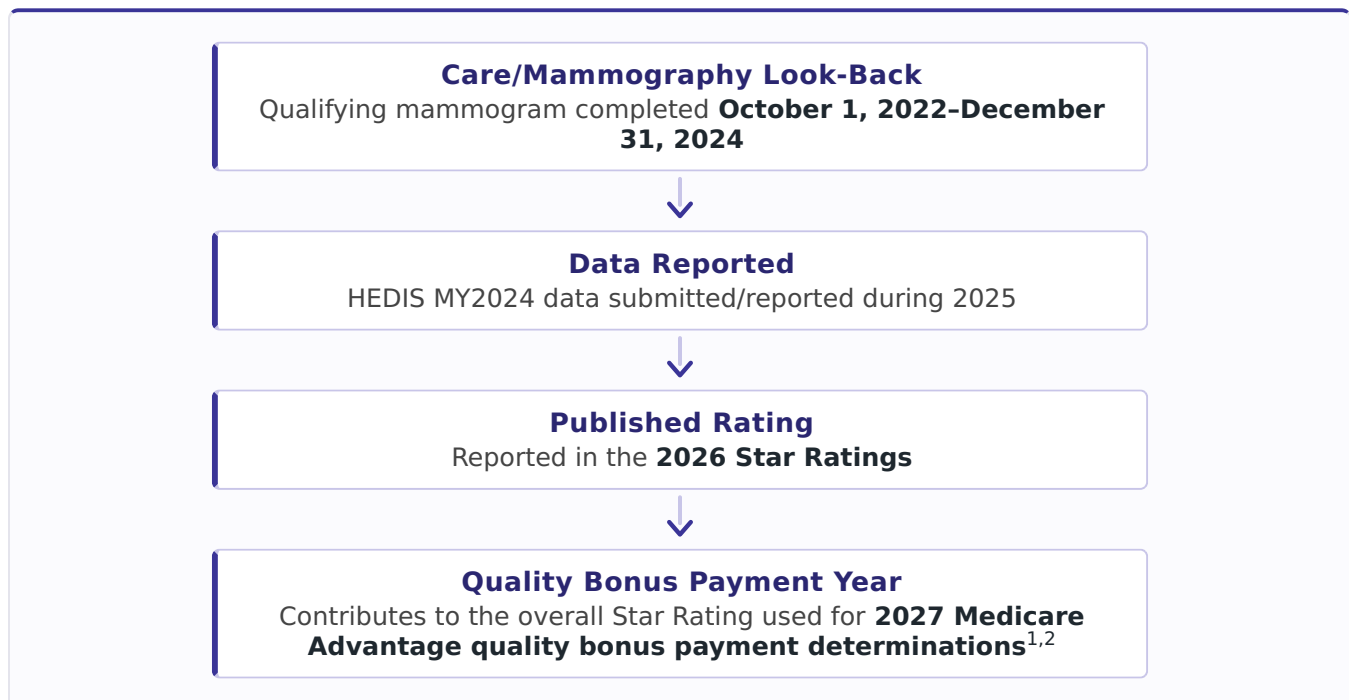
CMS Metric: Percentage of women MA patients **aged 52-74 as of December 31 of the measurement year** who had a mammogram to screen for breast cancer in the past two years.¹

FIELD	ENTRY
CMS measure name	Breast Cancer Screening, BCS
Domain	Staying Healthy: Screenings, Tests and Vaccines
CMS weighting category	Process Measure
Weight	1 — standard-weighted
Primary data source	HEDIS
HEDIS reporting method	ECDS (Electronic Clinical Data Systems) — BCS-E is ECDS-only for MY2024. Qualifying structured data may come from administrative claims, clinical registries, EHRs, and case-management systems
External mammography data	Outside mammography may contribute when the qualifying study is verified and incorporated into an allowable structured ECDS data source . Patient-reported history may guide record retrieval but does not by itself establish verified completion
Unit of measurement	CMS health plan-level measure — individual clinicians and practices do not receive a C01 Star Rating
Trend direction	Higher is better
Case-mix adjusted	No¹
Measurement period	January 1, 2024–December 31, 2024 ^{1,2}
Numerator look-back	October 1, 2022–December 31, 2024 (27 months)
Star measure credit	At least one qualifying mammogram completed within the applicable look-back window and captured through an allowable HEDIS data pathway. An order, referral, or scheduled appointment alone does not satisfy the numerator

FIELD	ENTRY
Qualifying mammography	Mammography included in the applicable HEDIS Mammography Value Set may satisfy the numerator, including screening mammography, diagnostic mammography, and digital breast tomosynthesis (DBT) Breast ultrasound, MRI, clinical breast examination, and biopsy alone do not satisfy the numerator^{1,2}
Statistical method	Clustering ; cut points are recalculated annually and should not be interpreted as prospective guarantees
Reporting/Claims codes (support administrative capture)	CPT 77061-77063, 77065-77067 — mammography and digital breast tomosynthesis codes used in HEDIS-aligned mammography documentation. ICD-10-CM Z12.31 — encounter for screening mammogram for malignant neoplasm of breast^{2,3}

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; I-SNP = Institutional Special Needs Plan; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification; NCQA = National Committee for Quality Assurance

How The Years Line Up



In One Sentence

For the **2026 Star Ratings**, C01 measures the percentage of women MA patients **aged 52-74 as of December 31, 2024** who had at least one qualifying mammogram during the applicable look-back window.

CMS Cut Points

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<58%	≥58% to <71%	≥71% to <76%	≥76% to <84%	≥84%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance (2025 → 2026 Trend)

- **National Numeric Average:** C01 performance increased slightly from **73% in the 2025 Star Ratings to 74% in the 2026 Star Ratings**
- **Average Measure Rating:** Despite the slight increase in the numeric rate, the average C01 measure rating declined from **3.4 Stars to 3.2 Stars**^{1,4}
- **Higher 2026 Base-Group Cut Points:** For the 2025 Star Ratings, the 4-Star range was **≥75% to <82%** and 5-Star performance was **≥82%**. For the 2026 Star Ratings, the corresponding thresholds increased to **≥76% to <84%** and **≥84%**, respectively. These cut points are **rating-year specific and represent data collected during the measurement period; they may be used prospectively only as directional benchmarks**⁵

WHAT THE MEASURE IS ASKING



AAVBC PERSPECTIVE — C01 IS ONE PART OF BREAST CARE

C01 documents **mammography screening completion; it does not represent the full breast-evaluation pathway**. New breast symptoms, abnormal examination findings, or an abnormal/incomplete mammogram may require **diagnostic mammography and/or additional imaging or tissue evaluation based on the clinical situation**. For PCPs, the goal is to keep routine screening on track while also ensuring that **symptoms and abnormal findings move promptly into the appropriate diagnostic pathway**. **Screening frequency varies across major guidelines**. For average-risk women, the

USPSTF recommends **biennial mammography from ages 40-74**, while ACOG recommends **screening every 1-2 years beginning at age 40**. The American Cancer Society recommends **annual screening at ages 45-54** (with the option to begin annually at 40-44) and, at age ≥ 55 , either biennial screening or continued annual screening. The American College of Radiology recommends **annual mammography beginning at age 40**.

AAVBC favors annual mammography beginning at age 40 for women appropriate for routine screening, consistent with the ACR approach and prioritizing the greater modeled mortality reduction, deaths averted, and life-years gained associated with annual screening. Screening should remain individualized according to breast-cancer risk, prior findings, comorbidity, life expectancy, and patient preference.

In Plain Language

C01 asks whether an eligible woman completed a qualifying mammogram during the applicable HEDIS look-back window. Official measure credit depends on completed mammography captured through an allowable HEDIS data pathway. For care teams, the priority is to **identify women who are due, recommend screening, facilitate completion, reconcile outside mammograms, and close abnormal-result follow-up.**

Why it Exists

Breast cancer remains a major cause of cancer morbidity and mortality among women, making timely screening an important part of preventive primary care. For PCPs, the goal is to **identify appropriate patients, address barriers to mammography, and help convert a screening recommendation into completed care.**^{6,7}



QUALITY OUTCOME — WHY BREAST CANCER SCREENING MATTERS

Screening can identify breast cancer **before symptoms develop and at an earlier, more treatable stage**, supporting timely diagnosis and treatment.^{6,7}

Screening: Recommend and facilitate mammography for appropriate patients while addressing barriers such as **discomfort, transportation, cost, language, disability, scheduling, and site of care**.

Follow-through: Confirm completion, reconcile the final report, communicate results, and **track abnormal or incomplete findings to diagnostic resolution**.

Annual vs Biennial Screening — What the Evidence Shows

The screening interval debate reflects a trade-off between **maximizing deaths prevented and life years gained** and limiting cumulative screening burden of additional screening, false-positive evaluations, benign biopsies, and overdiagnosis.

Annual screening maximizes modeled benefit.⁸ In 2023 CISNET modeling, annual screening from ages **40-79** produced the greatest estimated mortality reduction (**41.7%**), breast-cancer deaths averted (**11.5 per 1,000 women screened**), and life-years gained (**230 per 1,000**). When the same **40-74 age range** was compared, annual screening was associated with an estimated **37% mortality reduction versus 30% with biennial screening**.

Biennial screening emphasizes the overall benefit-to-harm balance.⁶ The USPSTF recommends mammography **every 2 years from ages 40-74**, concluding that biennial screening provides a moderate net benefit while limiting the cumulative burden of additional screening, false-positive evaluations, benign biopsies, and overdiagnosis. Modeling reviewed by the USPSTF found that **annual screening increases benefits but also increases false-positive recalls and overdiagnosis compared with biennial strategies**.

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the **clinical care, access, completion, data continuity, and follow-through** that contribute to C01 performance.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Use Annual Wellness Visits and other appropriate encounters to assess screening status and identify women who are due or whose prior mammography remains unverified • Recommend and facilitate a qualifying mammogram when clinically appropriate. Do not stop at an order or referral; provide a direct scheduling pathway and track the patient toward completed screening • Address barriers before the patient leaves when possible, including transportation, cost concerns, prior discomfort, language needs, disability/ accessibility, and scheduling difficulty • Reconcile outside mammograms with the date, facility/source, and available final report so completed screening is not left as an apparent open gap • Document valid measure-defined exclusions accurately with the specific evidence needed to support the exclusion • Close abnormal-result loops and document the next action, follow-up owner, timeframe, and outcome until diagnostic resolution is reached	• Imaging-facility access and completion for routine screening, including timely availability of appropriate in-network and, when clinically appropriate, freestanding breast imaging options • External mammography record exchange and reconciliation when prior screening was completed outside the practice, so the date, source, and available report can be verified and captured • Transportation and community-access resources that help patients reach and complete imaging • Radiology report and BI-RADS return to the practice so current screening completion, results, and required next steps can be confirmed • Abnormal-result communication and diagnostic follow-through across radiology, primary care, and specialty care, including facilitation and tracking of recommended next steps to resolution	• CMS/NCQA measure specifications and value sets, including denominator, numerator, exclusions, and qualifying data pathways • CMS cut points and clustering methodology, which are recalculated and applied at the contract level • Contract-level Star calculations and adjustments, which are outside the control of an individual practice

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; HIE = health information exchange

MEASURE SPECIFICATION

HEDIS Breast Cancer Screening (BCS) Measure

C01 is a HEDIS-based screening measure. The denominator is defined by **age, enrollment, and measure-defined exclusions**; numerator credit requires a **qualifying mammogram during the applicable look-back period**.

ELEMENT	SPECIFICATION
Denominator	Women Medicare Advantage enrollees 52-74 years of age as of December 31 of the measurement year who meet applicable HEDIS eligibility requirements and do not meet a measure-defined exclusion ^{1,2}
Numerator	At least one qualifying mammogram during the applicable HEDIS look-back period. Breast ultrasound, MRI, clinical breast examination, and biopsy do not substitute for qualifying mammography ^{2,3}
Measurement year	January 1-December 31, 2024 for the 2026 Star Ratings
Data collection	HEDIS ; qualifying data are reported through the applicable HEDIS ECDS data pathway
Case-mix adjustment	Not case-mix adjusted

ABBREVIATIONS: I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage; NCQA = National Committee for Quality Assurance

Measure-Defined Exclusions

ELEMENT	SPECIFICATION
Hospice	Patient was in hospice or using hospice services at any time during the measurement period ¹
Death	Patient died at any time during the measurement period
Bilateral mastectomy/absence of both breasts	Bilateral mastectomy , history of bilateral mastectomy, or qualifying evidence showing mastectomy/absence involving both the left and right breast . A single unilateral mastectomy does not qualify
Age ≥66 — institutional status	Patient was enrolled in an Institutional SNP (I-SNP) or living long-term in an institution at any time during the measurement year ¹

ELEMENT	SPECIFICATION
Age ≥66 — frailty + advanced illness	Patient must meet BOTH criteria: frailty —at least 2 indications on different dates during the measurement period; and advanced illness —qualifying advanced-illness evidence on at least 2 different dates during the measurement period or prior year, or a dispensed dementia medication
Palliative care	Patient received palliative care or had a qualifying palliative-care encounter at any time during the measurement period

ABBREVIATIONS: I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage; NCQA = National Committee for Quality Assurance



RED FLAG — DEMENTIA ALONE IS NOT AN EXCLUSION

A dementia diagnosis by itself does **not** automatically exclude a patient from C01. A **dispensed dementia medication may satisfy the advanced-illness component** of the age ≥66 frailty + advanced-illness exclusion, but the patient must still meet the required **frailty criteria**.



RED FLAG — AN ORDER IS NOT A COMPLETED SCREENING

Placing a mammography order or documenting “screening recommended” does not by itself satisfy C01. The patient must complete mammography that meets the applicable HEDIS specification and the completed care must be captured through the appropriate reporting pathway. **Do not mark ordered, scheduled, or unverified mammography as completed.**^{1,3}

Commonly Misunderstood

- **Any breast imaging is assumed to qualify → it does not**

Ultrasound, MRI, biopsy, and clinical breast examination may be clinically appropriate but **do not substitute for qualifying mammography** under C01.

- **Other clinical factors are assumed to automatically create an exclusion → they do not**

Frailty alone, one unilateral mastectomy, patient refusal, or a clinician decision not to screen **does not automatically remove the patient from the measure**. Apply only measure-defined exclusions.

HOW PERFORMANCE IS MEASURED

Official Star-Scoring Pathway

C01 is a HEDIS-based measure reported at the Medicare Advantage contract (health plan) level. Breast Cancer Screening is reported through the HEDIS **ECDS** method, which incorporates structured data from sources such as **administrative claims, EHRs, clinical registries, and case management systems**. Individual clinicians and practices **do not receive a C01 Star Rating**; their care and data capture contribute to health-plan performance.

Internal Performance is not the Official Star Result

CALL IT THIS	WHICH MEANS
Official result	CMS contract-level C01 result calculated from the applicable HEDIS data and methodology
Internal proxy	Practice estimate of eligible patients with a completed qualifying mammogram
Documentation completeness	Whether completed care and valid exclusions are captured in structured, reportable data
Care-gap status	Whether the patient is due, scheduled, completed, awaiting external reconciliation, or requires follow-up

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services

Adjustment and Comparability

C01 is not case-mix adjusted. As a result, differences across contracts may reflect not only screening workflows, but also differences in **access, transportation, rurality, language, socioeconomic barriers, prior screening patterns, and availability of mammography services**. Care teams should stratify internal data to identify inequities and tailor outreach, scheduling, and access support to patient needs.

HIGH-YIELD INTERVENTIONS

Screening performance is commonly lost at three points: **a completed outside mammogram is missed, an eligible patient is not converted from due to scheduled, or a scheduled mammogram is not completed.**³

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Use pre-visit planning to verify screening status before outreach or the encounter. Review available claims, imaging-facility, and external records for a qualifying mammogram or valid exclusion	Pre-visit/care-gap review—MA, quality staff	A missing mammogram in the EHR may be a data gap rather than a care gap . Verification prevents duplicate outreach and unnecessary repeat imaging ^{2,3}
Give a clear screening recommendation and address the patient's specific barrier. Ask about discomfort, cost, transportation, language/accessibility needs, prior experiences, or competing priorities	During the encounter —PCP/clinical staff	A generic reminder may not change behavior. A specific recommendation tied to the patient's actual barrier makes the next step more feasible ¹²
Before the encounter closes, facilitate mammography scheduling when screening is appropriate and the patient agrees. Provide a direct scheduling pathway and help identify an accessible in-network imaging site when appropriate	Encounter/checkout —clinical staff or scheduler	An order is not completion. Scheduling turns the recommendation into a concrete next step and reduces loss to follow-up ¹²
Track scheduled mammography to completion. Re-contact patients after cancellations or no-shows and address unresolved barriers rather than repeating the same reminder	After scheduling—care coordinator/outreach team	Scheduled is not completed. Closed-loop follow-up helps identify appointments that did not occur and gives the team another opportunity to solve the barrier ¹³
Reconcile outside mammograms promptly. Document the date, facility/source, and available final report through the appropriate structured workflow	When external care is identified— MA/records/quality team	Prevents completed screening from remaining an apparent open gap and reduces duplicate outreach or unnecessary repeat mammography ¹⁴
Review and communicate the final result, and close abnormal or incomplete-result follow-up. Update screening status; when additional evaluation is required, facilitate the next diagnostic step, assign an owner, and track the outcome to resolution	After report receipt — PCP/clinical staff	Screening completion and clinical resolution are not the same thing . Abnormal or incomplete findings require timely diagnostic follow-through

ABBREVIATIONS: MA = medical assistant; PCP = primary care provider



AAVBC PERSPECTIVE — OPTIMIZE THE SITE OF CARE

For routine screening, **favor an in-network freestanding breast imaging center when clinically appropriate and available rather than defaulting to a hospital outpatient setting.** Freestanding centers may offer **more scheduling flexibility, greater appointment availability, lower cost, easier parking or physical access, and a more streamlined breast-imaging workflow** with staff who perform mammography routinely. These features can reduce practical barriers and help move the patient from **recommended→ scheduled→ completed screening.**

Site selection should still account for the patient's **accessibility, transportation, prior imaging availability, and whether diagnostic or speciality services may be needed.**

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
"Ordered" treated as "done"	The mammography order is placed and the care gap may disappear from the immediate workflow, even though the mammogram was never completed	Track order → scheduled → completed. Keep the gap open until completion is verified, and follow up after cancellations or no-shows ^{3,12}
Outside mammography is not reconciled	The patient completed screening elsewhere, but the practice lacks a verified date, facility/source, or report, so the screening still appears overdue	Verify external completion before repeating outreach. Search available claims, HIE, imaging-facility, or outside records and reconcile the confirmed study through the appropriate workflow ^{2,3}
Exclusion recorded without supporting evidence	Incomplete documentation (e.g., "history of mastectomy"), limited prior records, or a new-patient history is treated as an exclusion without the specific evidence required by the measure	Apply only valid measure-defined exclusions and document the supporting evidence in the appropriate structured field/workflow ^{1,3}

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Supplemental imaging counted as screening	Breast MRI or ultrasound is clinically appropriate in some patients but is assumed to substitute for a qualifying mammogram	Do not treat supplemental imaging alone as qualifying mammography. Verify that the completed study meets the applicable HEDIS Mammography Value Set before closing the gap Use qualifying mammography: screening or diagnostic mammography, including digital mammography/DBT (3-D) ; CPT 77061-77063, 77065-77067 ^{2,3}
The screening loop closed, the diagnostic loop forgotten	Screening was completed, so the care gap appears closed even though an abnormal result still requires diagnostic follow-up ^{14,15}	Maintain separate diagnostic follow-up ownership for abnormal findings. Track recommended imaging/biopsy or specialist follow-up to a documented outcome ^{3,15}
ABBREVIATIONS: BI-RADS = Breast Imaging Reporting and Data System		

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	RECOMMENDED ACTIONS
Concern about follow-up costs	The patient worries that screening may lead to additional imaging or procedures with unexpected cost ³	Separate screening from possible diagnostic follow-up. Clarify what is known about screening coverage and help the patient identify benefit/cost resources for additional testing if needed ¹¹
Site-of-care barriers	The selected imaging site may create scheduling, transportation, parking, accessibility, or patient-experience barriers that make screening difficult to complete	Optimize the site of care. When clinically appropriate and available, consider an in-network freestanding breast imaging center that offers convenient scheduling, appropriate accessibility, and a dedicated breast-imaging workflow. Match the site to the patient's transportation, mobility, prior imaging, network, and follow-up needs

BARRIER	HOW IT SHOWS UP	RECOMMENDED ACTIONS
Discomfort and a bad prior experience	A previous painful or stressful mammogram leads the patient to avoid repeating the experience	Acknowledge the prior experience rather than minimizing it. Explain positioning and compression, encourage the patient to communicate discomfort during the exam, and help identify a different facility when appropriate ³

ABBREVIATIONS: none

System and Workflow

BARRIER	HOW IT SHOWS UP	RECOMMENDED ACTIONS
Imaging results that never return	Freestanding imaging centers sit outside the practice EHR; reports may arrive as faxes or scanned documents that do not reliably flow into reporting or care-gap workflows	Build a closed-loop imaging workflow. Use imaging portals and named staff ownership to obtain the report, reconcile completion, and route abnormal findings for follow-up ^{2,3}
Orders that depend on patient self-scheduling	The order is placed, but scheduling is left entirely to the patient and the mammogram may never occur	Facilitate scheduling before the patient leaves when possible. Give a direct scheduling pathway and track cancellations/no-shows ^{3,12}
No owner for exclusion verification	Mastectomy, frailty/advanced illness, hospice, or other exclusion evidence is scattered across free text, old records, or problem lists	Create an exclusion-verification workflow. Confirm the exact evidence required by the measure and capture it in the appropriate structured field ^{1,3}
Alerts at the wrong moment	A screening prompt appears after the visit is nearly complete or when the clinician cannot reasonably act on it	Use pre-visit planning and rooming workflows so screening status is known before the PCP enters the encounter. Pair point-of-care prompts with periodic provider assessment and feedback on screening performance ^{3,16}

ABBREVIATIONS: EHR = electronic health record

Disparity Gaps Requiring Targeted Action

Some patients face barriers that make mammography **harder to schedule, access, or complete**. Stratify internal screening and completion data to identify gaps, then tailor outreach and access support to the barrier.

POPULATION SEGMENT	PATIENT IMPACT	RECOMMENDED ACTIONS
Patients facing financial and access barriers	Cost concerns, transportation, inflexible work schedules, and competing priorities may delay screening completion ^{3,17}	Discuss cost/access before ordering. Connect patients with available coverage, transportation, scheduling, or community screening resources ¹⁸
Women with disabilities	Equipment accessibility, positioning, communication barriers, or transportation may make mammography difficult to complete ¹⁹	Confirm accessibility before referral and identify a facility that can accommodate the patient's mobility, positioning, or communication needs ¹⁹
Rural and LEP populations	Distance to imaging, plus language-discordant reminders and self-scheduling systems, produce drop-off between referral and completion ³	Use the closest feasible imaging option , qualified interpreters/bilingual staff, translated instructions, and active follow-up ^{3,12}

ABBREVIATIONS: CDC = Centers for Disease Control and Prevention; LEP = limited English proficiency



CLINICAL PEARL — MATCH SCREENING TO THE PATIENT'S RISK

Dense breasts should prompt an **individualized risk discussion**, not automatic supplemental imaging. When a patient's overall risk warrants screening MRI, use MRI **in addition to, not instead of, mammography**. Dense breasts alone do not universally require MRI, and supplemental imaging does **not replace qualifying mammography for C01**.^{14,20}

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
The Annual Wellness Visit	The AWW is a practical opportunity to verify mammography status, identify unresolved outside records, and address barriers	Review the screening gap before the visit; reconcile outside mammograms or facilitate scheduling when screening is due ³
Multiple chronic conditions	Diabetes, cardiovascular disease, and other competing priorities may push preventive screening down the visit agenda ³	Use pre-visit planning and team workflows so mammography status is addressed without displacing management of urgent chronic conditions
Elevated-risk women	Family history or other elevated-risk features may require a screening strategy beyond routine mammography alone	Separate the C01 mammography requirement from individualized high-risk care. Follow the appropriate clinical pathway for additional imaging/genetic or specialty evaluation when indicated ²⁰
Adults beyond the measure age range and patients with frailty	The Star-measure denominator ends at the applicable age boundary, but clinical decisions about screening may continue beyond it	Do not let the measure boundary substitute for clinical judgment. Continue or stop screening based on health status, goals, anticipated benefit, and current clinical guidance ^{1,6}

ABBREVIATIONS: MRI = magnetic resonance imaging

Patient Journey

BEAT	CONTENT
Presents as	A woman completed a screening mammogram, but the final report identified a finding requiring additional diagnostic evaluation . No completed follow-up is documented, and the patient believes the screening process is finished

BEAT	CONTENT
PCP Action	During pre-visit review, the care team identifies the unresolved result. The PCP explains the finding and recommended next step , confirms the patient's understanding, and assigns a care-team member to facilitate diagnostic scheduling and address any access barriers
Outcome	Recommended diagnostic evaluation is completed and the final report is returned, reviewed, and reconciled into the record. Any additional recommended care is assigned a clear follow-up owner
Follow-up	Confirm that the patient received and understood the result, document the next clinical plan and responsible owner , and continue tracking until the abnormal or incomplete finding reaches a documented resolution

Note: Case is illustrative and is not a reported individual case

Companion Guides - Making Connections

GUIDE	WHEN TO REACH FOR IT
Breast Cancer QRG	When screening identifies a suspicious or confirmed breast finding and care progresses to diagnostic evaluation, treatment, or oncology management
Osteoporosis Management in Women QRG	When breast-health care overlaps with bone-health risk , particularly in older women or patients whose breast-cancer history or treatment may affect osteoporosis risk
Cervical Cancer QRG	When the patient also needs cervical cancer screening or coordinated women's preventive screening and follow-up

ABBREVIATIONS: QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- **Documentation does not replace completed mammography; it supports care, reconciliation, and follow-up^{2,3}**
- For outside care, distinguish **patient-reported history from verified completion^{2,3}**
- For abnormal results or exclusions, document the **specific evidence, clinical interpretation, next action, follow-up owner, timeframe, and outcome^{14,20}**

What Belongs in the Record

ELEMENT	WHAT TO RECORD
Completed screening	Qualifying mammogram date, facility/source, available report/result, structured screening status ^{2,3}
Result	BI-RADS/final assessment when available, date received/reviewed and patient notification ^{16,20}
Exclusion	Specific measure-defined exclusion evidence, including laterality/date when relevant ¹
Barrier and action taken	Transportation, cost, fear, language, accessibility, scheduling, or other barrier plus what the care team did about it ³
One clear status	Due; external record requested; ordered-unscheduled; scheduled; completed-report pending; completed-reviewed; abnormal/incomplete follow-up pending; valid exclusion; declined after discussion ³
Follow-up ownership	Named owner, next step, timeframe, and escalation plan for unresolved or abnormal findings ^{3,14}
Mammography procedure code, when available	CPT 77061-77063, 77065-77067 — mammography/digital breast tomosynthesis codes. Record the actual code performed/billed when available; do not infer a procedure code from patient-reported history alone

ABBREVIATIONS: BI-RADS = Breast Imaging Reporting and Data System

Clinical Documentation Optimization - SOAP Example

SOAP documentation should clearly show the **screening status, relevant history and barriers, clinical assessment, action taken, and follow-up plan.**

S — Subjective

Patient presents for an Annual Wellness Visit and is unsure when her last mammogram was, believing it may have been completed approximately 2 years ago at an outside facility. Reports prior mammography discomfort and difficulty arranging transportation. Denies current breast symptoms, including **new breast lump, nipple discharge or other nipple changes, and skin changes.** Patient is willing to proceed with screening if an accessible imaging option and transportation plan can be arranged

O — Objective

Available **EHR, claims, and external-record sources reviewed; no qualifying mammogram identified.** No verified outside mammography report is available at the time of the visit. No documented measure-defined exclusion identified. Prior imaging date/facility remains unconfirmed. Transportation and access barriers reviewed

A — Assessment

Breast cancer screening appears **overdue pending verification of outside records**. No current breast symptoms identified that would prompt a diagnostic rather than routine screening pathway. Primary barriers are **transportation and prior negative mammography experience**

P — Plan

Screening mammogram recommended, ordered, and facilitated based on currently available information. Outside-record request initiated to verify the prior mammography **date, facility, and report**. Prior discomfort discussed; imaging-site options and transportation support reviewed, and scheduling assistance provided.

Care team assigned to **confirm scheduling and completion, obtain and reconcile the final mammography report, update screening status, and communicate results to the patient**. If the result is abnormal or incomplete, assign an owner for the recommended diagnostic next step and **track follow-up to resolution**. If a qualifying outside mammogram is verified before repeat imaging occurs, reconcile the record and reassess whether repeat screening is needed

Documentation Examples

Screening Completed

"Screening mammogram completed [date] at [facility]. Final report received and reviewed; final assessment documented. **Result communicated to patient and structured screening record updated**. Next screening interval is documented as clinically appropriate. No additional diagnostic follow-up required at this time."

External Screening Verified

"Patient reported mammography at [facility] on approximately [date]. External report obtained and **screening completion verified**. Date, facility/source, and available result entered into the structured screening record. Report reviewed and patient notified as appropriate. Care-gap status updated to reflect verified completion."

Abnormal Result/Diagnostic Follow-up

"Screening mammogram completed [date]; final report identifies finding requiring additional diagnostic evaluation. Result reviewed with patient. Diagnostic imaging/follow-up ordered and scheduling initiated. Named care-team owner assigned to track completion and final disposition."

Measure-Defined Exclusion

"Prior bilateral mastectomy confirmed through operative/history documentation with applicable laterality/date evidence. **Supporting exclusion evidence entered in the structured record and screening care-gap status updated**. No screening mammogram ordered based on the applicable measure-defined exclusion."

Patient Declines/Follow-up Plan

"Breast cancer screening recommended. Patient declines today because of prior painful mammography experience after risks, benefits, and alternatives were discussed. Concern documented; available facility options and strategies to address discomfort reviewed. **Patient agrees to revisit screening at the next encounter; named care-team owner assigned for follow-up**."

Not enough — Incomplete

"Mammogram ordered" → **No evidence of completion**

"Mammogram up to date" → **No date/source/report**

“History of mastectomy” → **Insufficient exclusion detail**

“Abnormal mammogram—follow up” → **No next action, owner, or timeframe^{2,3}**

“Patient declined.” → **No specific concern, counseling, or plan to revisit.**



DOCUMENTATION REMINDER — DO NOT TURN “UNKNOWN” INTO “DONE”

If prior mammography cannot be verified, **search available external sources before assuming completion.** Record the actual source and date when found; if it remains unverified, keep the care gap open and address screening prospectively.

One Status, Clearly Stated

Use one clear status so the care team knows what remains to happen next.

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Due	No qualifying mammogram or valid exclusion identified after available record review. Recommend screening and facilitate the next step
External record requested	Patient-reported or claims-suggested outside mammography is being verified. Keep the gap open until completion is confirmed
Ordered — unscheduled	Mammography has been ordered but no appointment is documented. Facilitate scheduling and address access barriers
Scheduled	Facility, date, and time are known. Confirm transportation/access needs and track to completion
Completed — report pending	Mammography occurred, but the final report has not yet been received/reviewed. Obtain and reconcile the report
Completed — reviewed	Final result reviewed, patient notified as appropriate, and screening status updated. Routine screening loop closed
Abnormal or incomplete — follow-up pending	Screening identified a finding requiring additional evaluation. Assign an owner and track diagnostic follow-up to resolution¹⁴
Valid exclusion	Official measure-defined exclusion criteria are supported by appropriate evidence. Document the evidence and update the structured status
Declined after discussion	Patient declines after counseling. Document the specific concern, counseling provided, and plan to revisit when appropriate. This patient remains in the measure

ABBREVIATIONS: none

KEY TAKEAWAYS

1 **The Annual Wellness Visit is a key opportunity to address breast cancer screening**

Use the AWW to verify screening status, address unresolved outside records or barriers, and facilitate scheduling when appropriate.

2 **C01 requires a completed qualifying mammogram—not an order, referral, or a scheduled appointment**

Official measure performance depends on a qualifying mammogram completed within the applicable HEDIS look-back window and captured through an allowable HEDIS data pathway. Orders, outreach attempts, and appointments support care but do not independently satisfy the numerator.

3 **The clinical objective is timely, appropriate breast cancer screening**

Care teams should identify women who are due, provide a clear recommendation, facilitate mammography when appropriate, and address barriers that may prevent completion.

4 **A missing mammogram in the EHR does not necessarily mean the patient was not screened**

Women may complete mammography at outside imaging centers, hospitals, or other facilities. Verify before reordering by reviewing available claims, imaging-facility, and external-record sources, then reconcile the verified date, source, and report to avoid duplicate outreach or unnecessary repeat imaging.

5 **Measure exclusions require specific supporting evidence**

Do not treat vague mastectomy history, frailty, advanced illness, or a clinician decision not to screen as an automatic exclusion. Apply only the measure-defined exclusion criteria and document the evidence needed to support the exclusion.

6 Screening completion is not the clinical endpoint when the result is abnormal or incomplete

A completed mammogram may close the screening gap while still creating a new clinical responsibility. Assign a care team, communicate the result, facilitate the recommended diagnostic next step, and track follow-up to resolution.

7 Clinical vulnerability and access barriers should guide outreach and inform follow-through

Transportation, cost concerns, disability, rural access, language, work schedules, prior painful experiences, and fear of additional testing can prevent screening from occurring. Identify the specific barrier and match the intervention to it rather than repeating generic reminders.

8 Clear patient communication can turn a recommendation into completed screening

Explain why mammography is recommended, address the patient's specific concern, and pair counseling with a clear next step—scheduling, access support, or follow-up.

Changes to Monitor

KIND OF CHANGE	GOOD PRACTICE
Measure status and specification	Confirm that C01 Breast Cancer Screening remains an active Part C Star measure and recheck the official measure name, weight, denominator, numerator, age criteria, exclusions, data source, and look-back window. Do not assume a newer HEDIS specification applies to an earlier Star-rating year ^{1,2,21}
Rating-year methodology	Revalidate CMS cut points, clustering/statistical methodology, Categorical Adjustment Index treatment, Improvement Measure inclusion, and applicable disaster adjustments when CMS publishes each new Star Ratings cycle. Do not carry prior-year thresholds forward ^{1,4}
MQSA requirements	Verify current breast-density notification, reporting, patient-communication, and urgent-result requirements and update workflows as needed ¹⁴
Codes and value sets	Verify current NCQA/HEDIS mammography value sets and applicable CPT/HCPCS/ICD-10-CM coding before each measurement year. Coding examples support workflow and administrative capture but do not replace the current licensed measure specification ^{2,3}

KIND OF CHANGE	GOOD PRACTICE
Internal tools	Review care-gap logic, pre-visit prompts, scheduling workflows, external-record reconciliation, exclusion verification, abnormal-result follow-up, outreach logic, and patient education materials. Remove outdated dates, cut points, age ranges, or screening recommendations
Current clinical guidance	Recheck current breast-cancer screening guidance for screening age, interval, risk-based screening, and supplemental imaging. Keep clinical recommendations separate from C01 measure specifications

ABBREVIATIONS: CPT = Current Procedural Terminology; MQSA = Mammography Quality Standards Act; NCQA = National Committee for Quality Assurance

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