Quality ID #138: Melanoma: Coordination of Care

2023 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patient visits, regardless of age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

INSTRUCTIONS:
This measure is to be submitted at **each denominator eligible visit** occurring during the performance period ending November 30th for melanoma patients seen during the performance period. It is anticipated that Merit-based Incentive Payment System (MIPS) eligible clinicians providing care for patients with melanoma will submit this measure.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

THERE ARE TWO SUBMISSION CRITERIA FOR THIS MEASURE:

1) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion

OR

2) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting

SUBMISSION CRITERIA 1: ALL VISITS FOR PATIENTS, REGARDLESS OF AGE, DIAGNOSED WITH A NEW OCCURRENCE OF MELANOMA DURING EXCISION OF MALIGNANT LESION

DENOMINATOR (SUBMISSION CRITERIA 1):
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

DENOMINATOR NOTE: *The diagnosis of melanoma does not need to be present on the date of excision. This diagnosis would need to be attributed to the procedure in order to be considered denominator eligible.*

Denominator Criteria (Eligible Cases) 1:
Diagnosis for melanoma (ICD-10-CM): C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND

Patient encounter for excision of malignant melanoma (CPT): 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 17311, 17313
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 1):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Definition:
Communication – "Communication" may include: documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Instructions:
A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

NUMERATOR NOTE: *For Denominator Exception(s), patients are ineligible for this measure if at the time of encounter there are patient or system reason(s) for not communicating the treatment plan (e.g. patient asks for treatment plan not to be communicated or patient does not have a Primary Care or referring Physician).*

Numerator Options:

Performance Met:	Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**
OR	
Denominator Exception:	Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**
OR	
Performance Not Met:	Treatment plan not communicated, reason not otherwise specified **(5050F *with* 8P)**

OR

SUBMISSION CRITERIA 2: ALL VISITS FOR PATIENTS, REGARDLESS OF AGE, DIAGNOSED WITH A NEW OCCURRENCE OF MELANOMA EVALUATED IN AN OUTPATIENT SETTING

DENOMINATOR (SUBMISSION CRITERIA 2):
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

DENOMINATOR NOTE: *For providers who do surveillance, pathology would have to be completed for melanoma to be diagnosed after the initial visit. The diagnosis of the melanoma can be attributed to the initial encounter in which the biopsy occurred to be eligible for this measure. If outpatient visit and excision occur in the same visit, then it would be expected that the clinician would submit measure data via submission criteria one.*

**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee*

Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.

Denominator Criteria (Eligible Cases) 2:
Diagnosis for melanoma (ICD-10-CM): C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.111, D03.112, D03.121, D03.122, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter during the performance period (CPT): 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242*, 99243*, 99244*, 99245*, 99424, 99426
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 2):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Definition:
Communication – "Communication" may include: documentation in the medical record that the physician(s) treating the melanoma communicated (e.g., verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Instructions:
A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

NUMERATOR NOTE: *Denominator Exception(s), patients are ineligible for this measure if at the time of encounter there are patient or system reason(s) for not communicating the treatment plan (e.g. patient asks for treatment plan not to be communicated or patient does not have a Primary Care or referring Physician.*

Numerator Options:

Performance Met:	Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis **(5050F)**
OR	
Denominator Exception:	Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care) **(5050F *with* 2P)**
OR	
Denominator Exception:	Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician) **(5050F *with* 3P)**
OR	
Performance Not Met:	Treatment plan not communicated, reason not otherwise specified **(5050F *with* 8P)**

RATIONALE:
Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider and clinicians providing continuing care to support, facilitate, and coordinate the care of the patient.

Deficits in communication have clearly been shown to adversely affect post-discharge care transitions. A recent summary of the literature found that direct communication between hospital physicians and primary care physicians occurs infrequently (in 3%-20% of cases studied), the availability of a discharge summary at the first post-discharge visit is low (12%-34%) and did not improve greatly even after 4 weeks (51%-77%), affecting the quality of care in approximately 25% of follow-up visits. This systematic review of the literature also found that discharge summaries often lack important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling, and follow-up plans (Kripalani, 2007).

CLINICAL RECOMMENDATION STATEMENTS:

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE, 2006)

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; e.g., at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient´s clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MD and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The Transitions of Care Consensus Conference (TOCCC) proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

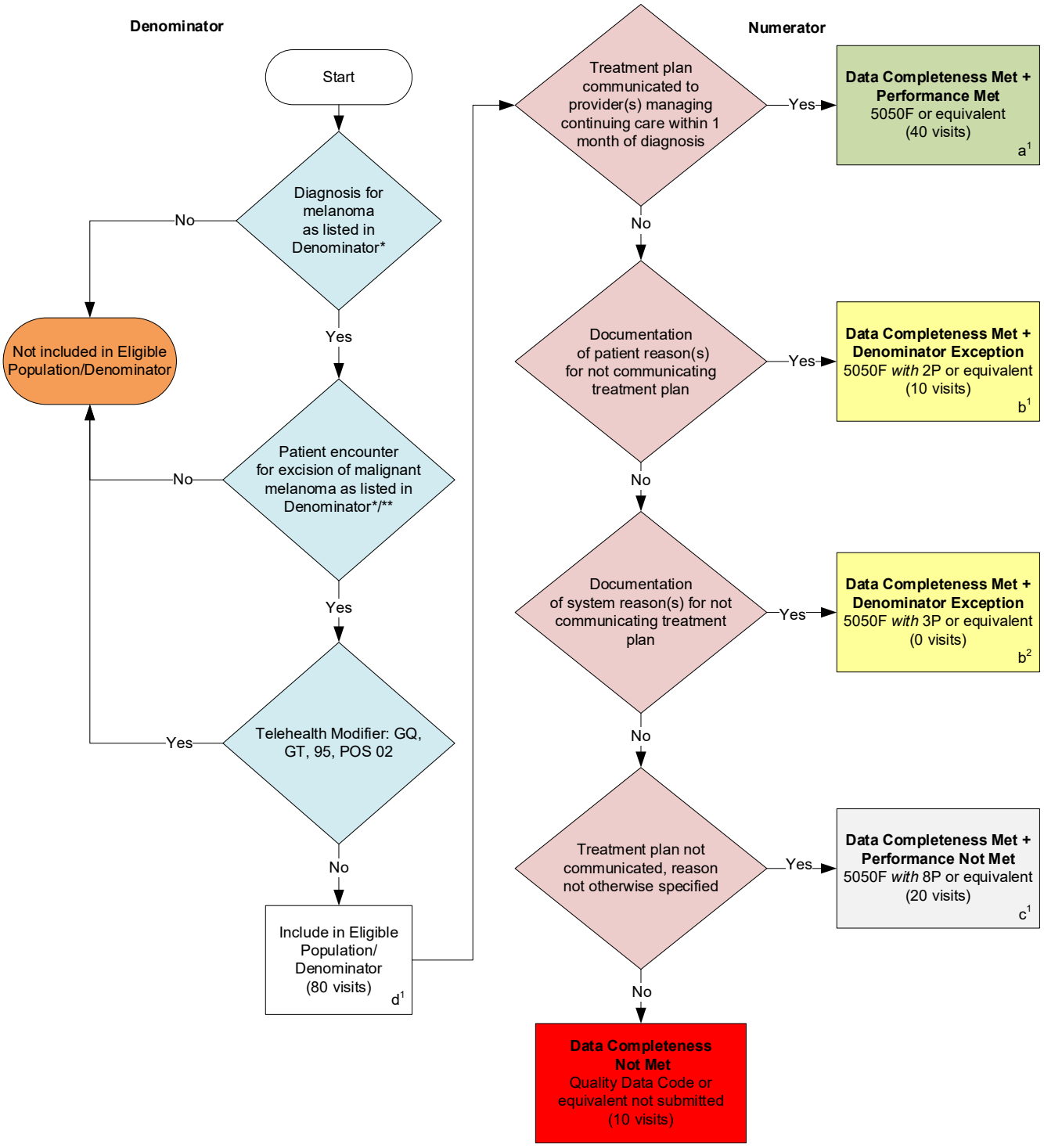
The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care, etc.

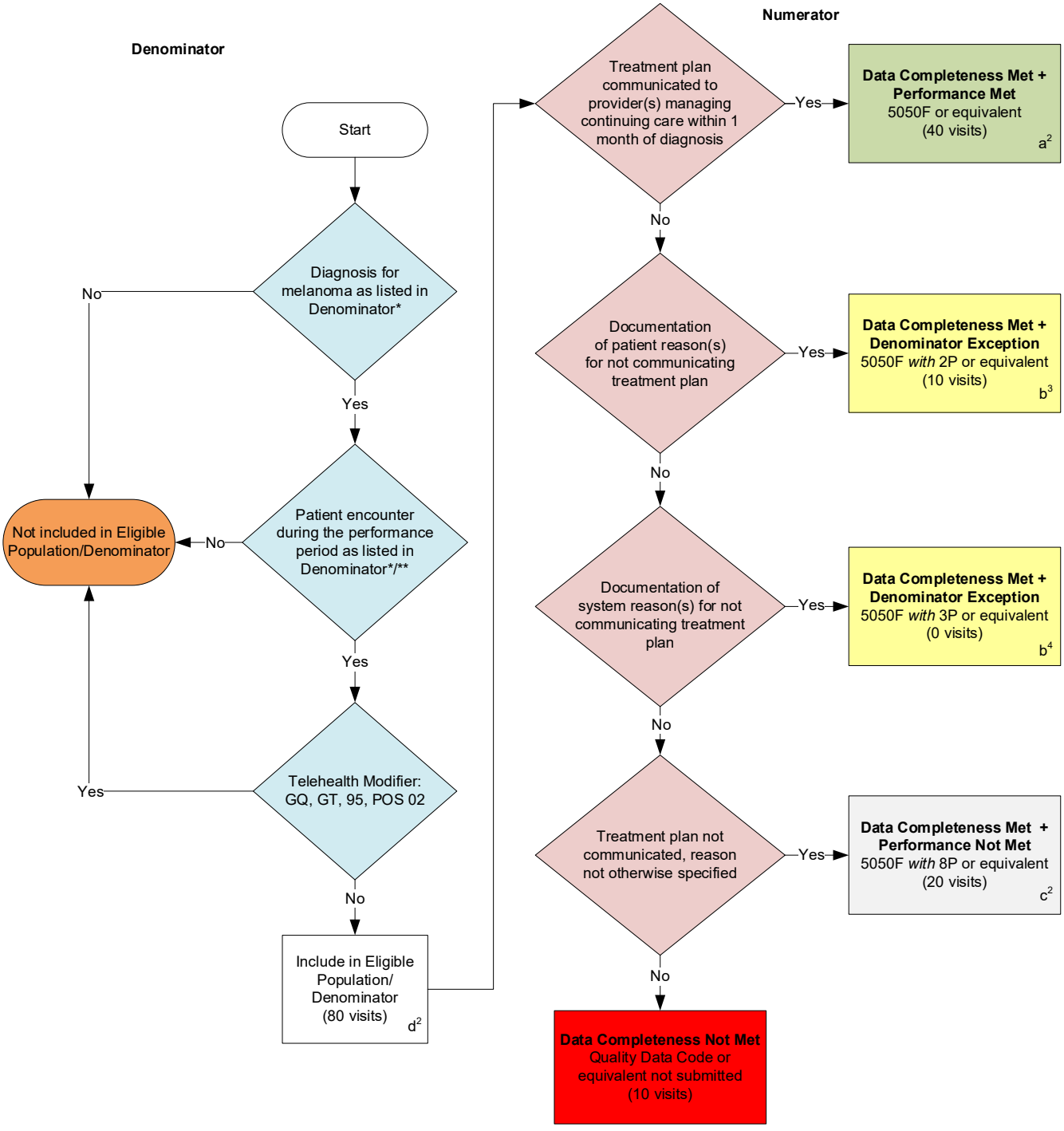
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (ACP, SGIMSHM, AGS, ACEP, SAEM, 2009) (Consensus Policy Statement)

2023 Clinical Quality Measure Flow for Quality ID #138:
Melanoma: Coordination of Care
Submission Criteria One

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



Submission Criteria Two



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a^1+a^2=80 visits) + Denominator Exception ($b^1+b^2+b^3+b^4$=20 visits) + Performance Not Met (c^1+c^2=40 visits) = 140 visits = **87.50%**

Eligible Population / Denominator (d^1+d^2=160 visits) = 160 visits

Performance Rate=

Performance Met (a^1+a^2=80 visits) = 80 visits = **66.67%**

Data Completeness Numerator (140 visits) – Denominator Exception ($b^1+b^2+b^3+b^4$=20 visits) = 120 visits

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

**Eligible cases are determined, and must be submitted, if the visit includes either the CPT codes for excision of malignant melanoma or CPT codes for outpatient setting encounter (as listed in measure specifications).

NOTE: Submission Frequency: Visit

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

2023 Clinical Quality Measure Flow Narrative for Quality ID #138: Melanoma: Coordination of Care

Disclaimer: *Refer to the measure specification for specific coding and instruction to submit this measure.*

Submission Criteria One:

1. Start with Denominator
2. Check *Diagnosis for melanoma as listed in Denominator*:*
    a. If *Diagnosis for melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for melanoma as listed in Denominator** equals Yes, proceed to check *Patient encounter for excision of malignant melanoma as listed in Denominator*/***.
3. Check *Patient encounter for excision of malignant melanoma as listed in Denominator*/***:
    a. If *Patient encounter for excision of malignant melanoma as listed in Denominator*/*** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter for excision of malignant melanoma as listed in Denominator*/*** equals Yes, proceed to check *Telehealth Modifier*.
4. Check *Telehealth Modifier:*
    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier* equals No, include in *Eligible Population/Denominator.*
5. Denominator Population:
    a. Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 80 visits in the Sample Calculation.
6. Start Numerator
7. Check *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis*:
    a. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 40 visits in the Sample Calculation.
    b. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals No, proceed to check *Documentation of patient reason(s) for not communicating treatment plan*.
8. Check *Documentation of patient reason(s) for not communicating treatment plan*:
    a. If *Documentation of patient reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.
        - *Data Completeness Met and Denominator Exception* letter is represented in the Data

Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 visits in the Sample Calculation.

b. If *Documentation of patient reason(s) for not communicating treatment plan* equals No, proceed to check *Documentation of system reason(s) for not communicating treatment plan*.

9. Check *Documentation of system reason(s) for not communicating treatment plan*:

   a. If *Documentation of system reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

      - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 visits in the Sample Calculation.

   b. If *Documentation of system reason(s) for not communicating treatment plan* equals No, proceed to check *Treatment plan not communicated, reason not otherwise specified*.

10. Check *Treatment plan not communicated, reason not otherwise specified*:

    a. If *Treatment plan not communicated, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

       - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 20 visits in the Sample Calculation.

    b. If *Treatment plan not communicated, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

       - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Submission Criteria Two:

1. Start with Denominator

2. Check *Diagnosis for melanoma as listed in Denominator**:

   a. If *Diagnosis for melanoma as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Diagnosis for melanoma as listed in Denominator** equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator*/**.*

3. Check *Patient encounter during the performance period as listed in Denominator*/**:

   a. If *Patient encounter during the performance period as listed in Denominator*/** equals No, do not include in *Eligible Population/Denominator*. Stop processing.

   b. If *Patient encounter during the performance period as listed in Denominator*/** equals Yes, proceed to check *Telehealth Modifier*.

4. Check *Telehealth Modifier*.

    a. If *Telehealth Modifier* equals Yes, do not include in *Eligible Population/Denominator.* Stop processing.

    b. If *Telehealth Modifier* equals No, include in *Eligible Population/Denominator*.

5. Denominator Population:

    a. Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 80 visits in the Sample Calculation.

6. Start Numerator

7. Check *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis*:

    a. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 40 visits in the Sample Calculation.

    b. If *Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis* equals No, proceed to check *Documentation of patient reason(s) for not communicating treatment plan*.

8. Check *Documentation of patient reason(s) for not communicating treatment plan*:

    a. If *Documentation of patient reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^3 equals 10 visits in the Sample Calculation.

    b. If *Documentation of patient reason(s) for not communicating treatment plan* equals No, proceed to check *Documentation of system reason(s) for not communicating treatment plan*.

9. Check *Documentation of system reason(s) for not communicating treatment plan*:

    a. If *Documentation of system reason(s) for not communicating treatment plan* equals Yes, include in *Data Completeness Met and Denominator Exception*.

        - *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^4 equals 0 visits in the Sample Calculation.

    b. If *Documentation of system reason(s) for not communicating treatment plan* equals No, proceed to check *Treatment plan not communicated, reason not otherwise specified*.

10. Check *Treatment plan not communicated, reason not otherwise specified*:

    a. If *Treatment plan not communicated, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented in the Data

Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 20 visits in the Sample Calculation.

b. If *Treatment plan not communicated, reason not otherwise specified* equals No, proceed to check *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations

Data Completeness equals Performance Met (a^1 plus a^2 equals 80 visits) plus Denominator Exception (b^1 plus b^2 plus b^3 plus b^4 equals 20 visits) plus Performance Not Met (c^1 plus c^2 equals 40 visits) divided by Eligible Population/Denominator (d^1 plus d^2 equals 160 visits). All equals 140 visits divided by 160 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 equals 80 visits) divided by Data Completeness Numerator (140 visits) minus Denominator Exception (b^1 plus b^2 plus b^3 plus b^4 equals 20 visits). All equals 80 visits divided by 120 visits. All equals 66.67 percent.

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

**Eligible cases are determined, and must be submitted, if the visit includes either the CPT codes for excision of malignant melanoma or CPT codes for outpatient setting encounter (as listed in measure specifications).

NOTE: Submission Frequency: Visit

NOTE: Telehealth modifiers include **but are not limited to**: GQ, GT, 95, POS 02

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 alone or as a substitution for the measure specification.