Quality ID #138: Melanoma: Coordination of Care
– National Quality Strategy Domain: Communication and Care Coordination
– Meaningful Measures Area: Transfer of Health Information and Interoperability

2019 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

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 to the patient's Primary Care Physician (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 to the Primary Care Physician(s) (PCP) (s) (eg, 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 to the PCP(s) (eg, 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. The denominator eligible encounter, after confirmation of melanoma, would be considered denominator eligible. 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): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241*, 99242*, 99243*, 99244*, 99245*
WITHOUT
Telehealth Modifier: 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 to the patient's Primary Care Physician (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 to the Primary Care Physician(s) (PCP)(s) (eg, 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 to the PCP(s) (eg, 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 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.

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 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)

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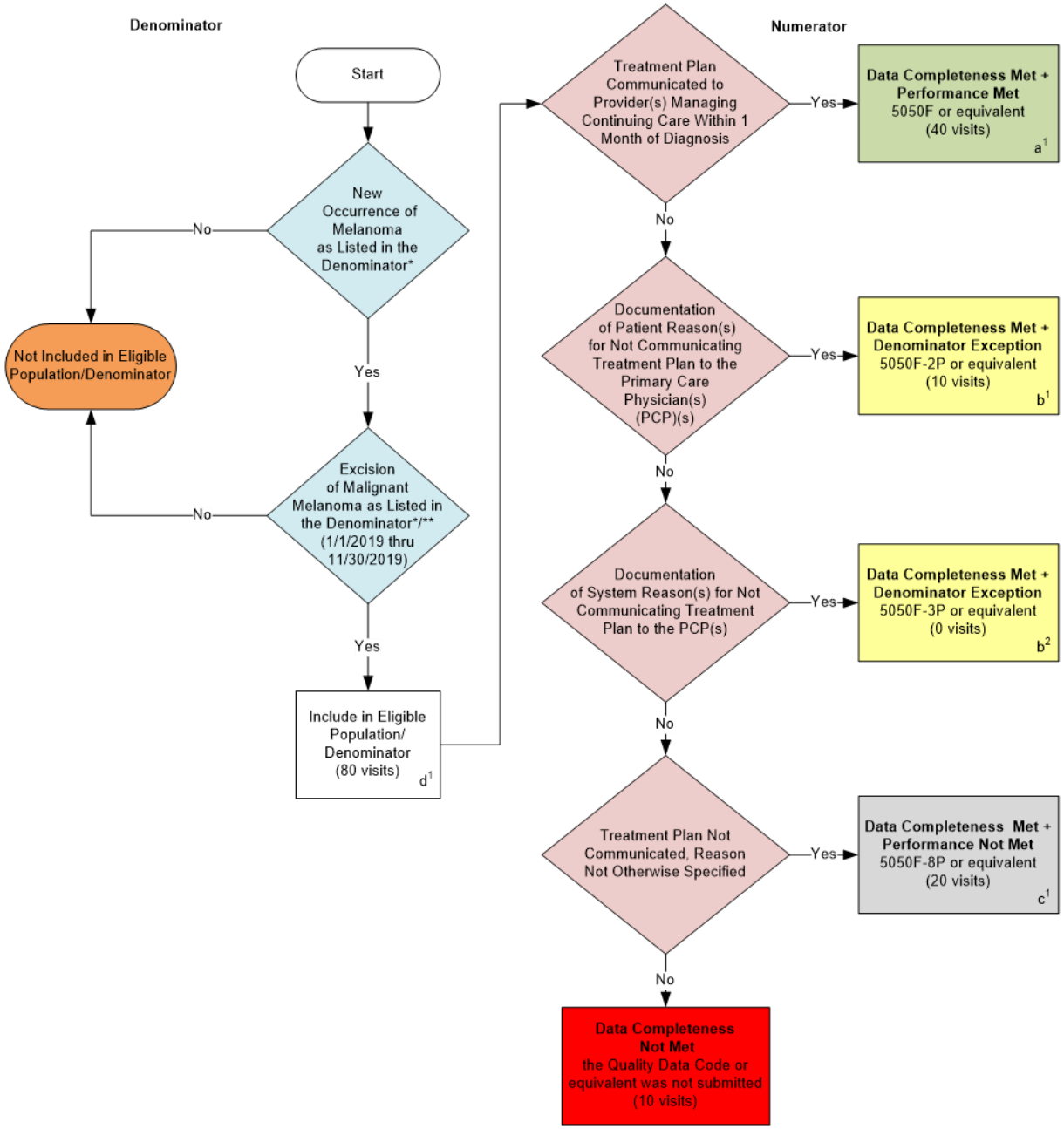
2019 Registry Flow for Quality ID #138: Melanoma: Coordination of Care Submission Criteria One



*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

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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.

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2019 Registry Flow for Quality ID #138: Melanoma: Coordination of Care Submission Criteria Two

*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

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2019 Registry Flow for Quality ID #138:
Melanoma: Coordination of Care

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.
This measure contains 2 Submission Criteria, although as the Sample Calculation indicates, there is **ONLY** one data completeness and one performance rate for this measure.
NOTE: Submission Frequency – Visit

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2019 Clinical Quality Measure Flow for Quality ID #138: Melanoma: Coordination of Care

Please refer to the specific section of the specification to identify the denominator and numerator information for use in submitting this Individual Specification.

Submission Criteria One

1. Start with Denominator
2. Check Patient Diagnosis:
    a. If New Occurrence of Melanoma as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If New Occurrence of Melanoma as Listed in the Denominator equals Yes, proceed to check Excision of Malignant Melanoma as Listed in the Denominator.
3. Check Excision of Malignant Melanoma as Listed in the Denominator:
    a. If Excision of Malignant Melanoma as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Excision of Malignant Melanoma in the Denominator equals Yes, include in Eligible Population.
4. 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.
5. Start Numerator
6. 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.
    b. 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.
    c. 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 to the Primary Care Physician(s) (PCP)(s).
7. Check Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s):
    a. If Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s) equals Yes, include in Data Completeness Met and Denominator Exception.
    b. 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.

c. If Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s) equals No, proceed to check Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s).

8. Check Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s):

    a. If Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s) equals Yes, include in Data Completeness Met and Denominator Exception.

    b. 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.

    c. If Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s) equals No, proceed to check Treatment Plan Not Communicated, Reason Not Otherwise Specified.

9. Check Treatment Plan Not Communicated, Reason Not Otherwise Specified:

    a. If Treatment Plan Not Communicated, Reason Not Otherwise Specified equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. 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.

    c. If Treatment Plan Not Communicated, Reason Not Otherwise Specified equals No, proceed to check Data Completeness Not Met.

10. Check Data Completeness Not Met:

    a. 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.

2019 Clinical Quality Measure Flow Narrative Flow for Quality ID #138: Melanoma: Coordination of Care

Please refer to the specific section of the specification to identify the denominator and numerator information for use in submitting this Individual Specification.

Submission Criteria Two

1. Start with Denominator
2. Check Patient Diagnosis:
    a. If New Occurrence of Melanoma as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If New Occurrence of Melanoma as Listed in the Denominator equals Yes, proceed to check Excision of Malignant Melanoma.
3. Check Excision of Malignant Melanoma:
    a. If Excision of Malignant Melanoma as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Excision of Malignant Melanoma as Listed in the Denominator equals Yes, check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, include in Eligible Population.
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.
    b. 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.
    c. 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 to the Primary Care Physician(s) (PCP)(s).
8. Check Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s):
    a. If Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s) equals Yes, include in Data Completeness Met and Denominator Exception.

b. 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.

c. If Documentation of Patient Reason(s) for Not Communicating Treatment Plan to the Primary Care Physician(s) (PCP)(s) equals No, proceed to check Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s).

9. Check Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s):

   a. If Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s) equals Yes, include in Data Completeness Met and Denominator Exception.

   b. 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.

   c. If Documentation of System Reason(s) for Not Communicating Treatment Plan to the PCP(s) 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 the Data Completeness Met and Performance Not Met.

    b. 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.

    c. If Treatment Plan Not Communicated, Reason Not Otherwise Specified equals No, proceed to check Data Completeness Not Met.

11. Check Data Completeness Not Met:

    a. 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=

$$\frac{\text{Performance Met } (a^1+a^2=80 \text{ visits}) + \text{ Denominator Exception } (b^1+b^2+b^3+b^4=20 \text{ visits}) + \text{Performance Not Met } (c^1+c^2=40 \text{ visits})}{\text{Eligible Population / Denominator } (d^1+d^2=160 \text{ visits})} = \frac{140 \text{ visits}}{160 \text{ visits}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=80 \text{ visits})}{\text{Data Completeness Numerator (140 visits)} - \text{Denominator Exception } (b^1+b^2+b^3+b^4=20 \text{ visits})} = \frac{80 \text{ visits}}{120 \text{ visits}} = \mathbf{66.67\%}$$