AAD 16: Avoidance of Post-operative Systemic Antibiotics for Office-based Closures and Reconstruction After Skin Cancer Resection Procedures

- **National Quality Strategy Domain: Effective Clinical Care**
- **Meaningful Measure Area: Medication Management**

2024 COLLECTION TYPE:
QCDR MEASURE

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of procedures in patients aged 18 and older with a diagnosis of skin cancer who underwent intermediate layer or complex linear closure or reconstruction after skin cancer resection in the office-based* setting who were prescribed post-operative systemic antibiotics tobe taken immediately following reconstruction surgery (inverse measure)

This measure is stratified by intermediate layer or complex linear closure or reconstructive procedures.

High Priority Measure: Yes
Meaningful Measure Area: Medication Management
Risk-Adjusted: No
Inverse Measure: Yes
Proportional Measure: Yes
Continuous Variable Measure: No
Ratio Measure: No
Number of performance rates required for measure: 3rd Performance Rate
Care Setting: Ambulatory Care: Clinician Office/Clinic

INSTRUCTIONS:
This measure may be reported by eligible physicians and allied professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 and older with a diagnosis of skin cancer who underwent intermediate layeror complex linear closure or reconstruction after skin cancer resection in the office-based* setting

Strata 1: Intermediate layer or complex linear closures after skin cancer resection

Strata 2: Reconstruction after skin cancer resection

Strata 3: Intermediate layer and complex linear closures AND reconstruction after skin cancerresection in the

office-based setting (Weighted average of Strata 1 and 2)

*Office based: not billed with an ASC or inpatient facility code

Denominator Criteria (Eligible Cases):
Strata 1:
CPT for Encounter Intermediate layer and complex linear closures
12031, 12032, 12034, 12035, 12036, 12037, 12041, 12042, 12044, 12045, 12046, 12047, 12051, 12052, 12053, 12054, 12055, 12056, 12057, 13100, 13101, 13120, 13121, 13131, 13132, 13151, 13152

OR

Strata 2:
CPT® for Encounter Reconstruction
14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061; 15050, 15100,15120; 15200, 15220, 15240, 15260; 15740

and

ICD-10 Codes for most common skin cancers:
C43-C44
D03-D04

and

Place of Service Code: 11 (office)

Strata 3: FOR REPORTING
Strata 1 + Strata 2; Calculate as (numerator 1 + numerator 2)/(denominator 1 + denominator 2),not the average of the performance rates

Denominator Exclusions:
Surgical sites at intrinsically high risk of infection – lower extremities and intertriginous areas(groin, genitalia, perianal, axilla)

Surgical reconstructions at intrinsically higher risk of infection –

a. Flaps greater than 30 square cm*
b. Full thickness skin grafts greater than 20 square cm*
c. Multistage interpolation flaps*
d. Wedge reconstructions of ear
e. Reconstructions requiring 2 or more repair types (flap and graft)*
f. Cartilage or composite graft*
g. Repair of exposed cartilage or bone

*These exclusions only apply to strata 2 (Reconstruction)

Codes for exclusion of skin cancer on lower legs, for which procedures have a higher risk ofinfection.

ICD-10 Codes:

BCC – C44.711, C44.712, C44.719

SCC – C44.721, C44.722, C44.729

MM – C43.70, C43.71, C43.72

MMIS – D03.70, D03.71, D03.72

SCCIS – D04.70, D04.71, D04.72

Cartilage grafts: 21230, 21235, 20910, 20912

Denominator Exceptions:

Medical reason exceptions include patients with a history of:

1. Lymphedema I89.0, I89.1, I89.8, I89.9
2. History of immunosuppressive medications Z92.24
3. Immunodeficiency syndromes D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9
4. HIV B20
5. Underlying disease with high risk of surgical site infection – chronic inflammatory skin disease (such as psoriasis and atopic dermatitis) or documented staph aureus carrier
6. Clinical evidence of infection at the surgical site at time of reconstruction, defined as:
   - Purulent drainage, with or without laboratory confirmation, from the surgical site
   - Pathogenic organisms isolated from culture of fluid or tissue from the surgical site
   - At least one of the following signs or symptoms of infection at the surgical site: pain or tenderness, localized swelling, redness, or heat.
   - An existing antibiotic prescription from another provider based on the diagnosis of infection at the surgical site.
   - Underlying disease with high risk of surgical site infection – chronic inflammatory skin disease (such as psoriasis and atopic dermatitis) or documented staph aureus carrier status or patient history of 3 or more surgical site infections, presence of lymphedema, history of immunodeficiency or immunosuppression

NUMERATOR:

Patients who were prescribed post-operative systemic antibiotics by the surgeon or assistant to be taken immediately following surgery (inverse measure)

CLINICAL RECOMMENDATION STATEMENT:

The Work Group recommends that clinicians should not routinely administer perioperative systemic antibiotics for adult patients undergoing reconstruction after skin cancer resection in the office-based setting.

Evidence Quality: Moderate

Recommendation Strength: Moderate

Chen et al, ASPS, Reconstruction After Skin Cancer Resection Guideline 2019

RATIONALE:

Based on the preponderance of evidence, in the office setting, it is recommended that clinicians not administer routine perioperative systemic antibiotics. Benefits of avoiding antibiotic prophylaxis include cost savings, absence of antibiotic side effects, prevention of drug-drug interactions, reduced time delay prior to reconstruction, avoidance of complications associated with oral or intravenous administration, and lack of contribution to antibiotic resistance. Potential risks and harms include medicolegal vulnerability if an infection occurs. Patient education on the need for antibiotic stewardship may help convey to patients that antibiotic prophylaxis is not without risk, and avoidance of such may be in their best interest. This measure is limited to procedures in the office-based setting. Procedures done in the hospital or ambulatory surgical center are often

larger operations and are governed by "SCIP" protocol for antibiotic use, the Surgical care Improvement Project which dictates antibiotic selection for surgical patients.

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