Measure Specifications Quick Reference

This page provides a quick, at-a-glance reference for the **Melanoma Resection** episode-based cost measure specifications. More details and logic for each component will be available in the full Draft Cost Measure Methodology document and the Draft Measure Codes List file, both of which will be posted on the MACRA Feedback page at the beginning of the field testing period.

Episode Window: *During what time period are costs measured?*

Pre-Trigger Window: 30 days

Post-Trigger Window: 90 days

Triggers: *Patients receiving what medical care are included in the measure?*

- CPT/HCPCS procedure code indicating melanoma resection by removal of malignant growth, adjacent tissue transfer or rearrangement procedures, or tissue transfer repairs of wound
- An episode is only triggered when the CPT/HCPCS procedure code is also accompanied by an ICD-10 diagnosis code for either malignant melanoma of skin (C43) or melanoma in situ (D03)

Sub-Groups: *What are the mutually exclusive types of episodes?*

1. Head/Neck Melanoma
2. Trunk/Extremity/Unspecified Melanoma

Service Assignment: *Which clinically related costs are included in the measure?*

Assigned services fall within the following 14 clinical themes:

- Primary resection; secondary excision; secondary reconstruction; lymph node services; infection; wound care
- Other surgical complications; other inpatient hospitalizations; other imaging; other emergency department visits; other post-acute care; other home health services; other pre-operative outpatient services; other post-operative outpatient services

Risk Adjustors: *Which risk factors are accounted for in the risk adjustment model?*

- Standard risk adjustors, including comorbidities captured by 79 Hierarchical Condition Category (HCC) codes that map with over 9,500 ICD-10-CM codes, interaction variables accounting for a range of comorbidities, beneficiary age category, beneficiary disability status, beneficiary ESRD status, and recent use of institutional long-term care.
- Measure-specific risk adjustors including but not limited to melanoma site (e.g., eyelid, lip, nose, ear), resection size and tissue transfer or rearrangement size, presence of flap/graft reconstructive procedures, and patients undergoing chemotherapy/immunotherapy.
- For the full list of standard and measure-specific risk adjustment variables, please reference the “RA” and “RA_Details” tabs of the Draft Measure Codes List file.

Exclusions: *Which populations are excluded from measure calculation?*

- Standard exclusions to ensure data completeness:
  - The beneficiary has a primary payer other than Medicare for any time overlapping the episode window or 120-day lookback period prior to the trigger day.
  - The beneficiary was not enrolled in Medicare Parts A and B for the entirety of the lookback period plus episode window, or was enrolled in Part C for any part of the lookback plus episode window.
  - No main clinician is attributed the episode.
  - The beneficiary’s date of birth is missing.
  - The beneficiary’s death date occurred before the episode ended.
  - The episode trigger claim was not performed in an ambulatory/office-based care, outpatient hospital, or ASC setting based on its place of service.
- Measure-specific exclusions including Mohs surgery performed for melanoma. For the full list of measure-specific exclusions, please reference the “Exclusions” and “Exclusions_Details” tabs of the Draft Measure Codes List file.