

AAD 6: Skin Cancer: Biopsy Reporting Time – Clinician to Patient

Electronic health records (EHRs) collect and organize notes, medication lists, and patient information using various formats. With providers also documenting this information in unique ways, this can potentially cause confusion and an increased timeline for measure mapping with DataDerm. This tip sheet can help you manage reporting requirements for performance measures and streamline standard documentation practices to allow seamless data pull into DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make the process as smooth as possible, it helps to document key elements of patient care. DataDerm cannot read scanned images of any kind, including scanned images for labs, letters to physicians, pathology reports, follow-up plans, and dates. If you have scanned images with information needed for your measures, please add a note in your chart with the date and required patient information for this data to be accurately collected.

This tip sheet can assist paper-based practices in standardizing documentation practices. Keeping notes in the patient's paper chart of all documentation requirements will assist you when reporting for this measure.

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For all patients aged 18 and older, document the following in your notes:

Current diagnosis of basal cell carcinoma or squamous cell carcinoma (to include in situ disease):

- C44.01, C44.02, C44.111, C44.1121, C44.1122, C44.1191, C44.1192, C44.121, C44.1221, C44.1222, C44.1291, C44.1292, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.41, C44.42, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.81, C44.82, C44.91, C44.92, D04.0, D04.10, D04.111, D04.112, D04.121, D04.122, D04.20, D04.21, D04.22, D04.30, D04.39, D04.4, D04.5, D04.60, D04.61, D04.62, D04.70, D04.71, D04.72, D04.8, D04.9

OR

Diagnosis for melanoma (including in situ disease):

- 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, D00.01, 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

For more information, see: aad.org/measures

OR

Other malignant diagnosis:

- C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C44.90, C44.99, C46.0, C46.1, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9

AND

Cutaneous biopsy / biopsies performed during the performance period:

- 11102, 11103, 11104, 11105, 11106, 11107, 11755, 40490, 54100, 56605, 56606, 67810, 69100

If applicable:

- Documentation of the date the patient was informed of their biopsy pathology results
 - Communication must occur before or equal to 12 days from the date the biopsy was performed
- Documentation of the communication method to patient:
 - Directly speaking with the patient or a person designated by the patient to discuss results
 - Documented telephone message or voice mail regarding the availability of lab results
 - Mailer/fax sent to the patient indicating the availability of lab results or discussing the diagnosis itself
 - Any HIPAA secure electronic communication with the patient discussing the diagnosis
- Document if the pathology report for tissue specimens were produced from excision, if applicable (11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646)

Additional Tips:

- Collect **each time** a biopsy is performed during the reporting period that is consistent with a cutaneous BCC, SCC, or melanoma (including in situ disease).
- If a patient has more than one biopsy procedure date during the measurement period (separate procedures on separate days), a procedure-based record would be submitted for each separate date of procedure.
- Pathology reports for tissue specimens produced from excision are exclusions.

Updates:

Number of days in which the patient is notified of their final biopsy report has changed from within 14 days to within 12 days.