Melanoma

Patient Medical History

*This measure is to be reported for all patients, regardless of age, with a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma — a minimum of **once** per reporting period.*

Measure description

Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months

What will you need to report for each patient with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma for this measure?

If you select this measure for reporting, you will report:

- Whether or not you completed a medical history with a review of new or changing moles

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to complete a medical history with a review of new or changing moles, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason) OR
- Patient reasons (eg, patient declined, economic, social, religious, other patient reason) OR
- System reasons (eg, resources to perform the services not available, insurance coverage/payer-related limitations, other reason attributable to health care delivery system)

In these cases, you will need to indicate which reason applies, specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).

Melanoma

Patient Medical History

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender
		/ /	☐ Male ☐ Female

National Provider Identifier (NPI)	Date of Service

Clinical Information

Step 1 Is patient eligible for this measure?

	Yes	No
Any patient regardless of age.	☐	☐
Patient has a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma.	☐	☐
There is a CPT E/M Service Code for this visit.	☐	☐

If **No** is checked for any of the above, STOP. Do not report a CPT category II code.

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Medical History with Review of New or Changing Moles	Yes	No
Completed	☐	☐
Not completed for one of the following reasons:		
• Medical (eg, not indicated, contraindicated, other medical reason)	☐	☐
• Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐
• System (eg, resources to perform the services not available, other reason attributable to health care delivery system)	☐	☐

Document reason here and in medical chart.

_____

_____

Billing Information

Code Required on Claim Form
Verify date of birth on claim form.
Refer to coding specifications document for list of applicable codes.

Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)
1050F
1050F–1P
1050F–2P
1050F–3P

If **No** is checked for **all** of the above, report 1050F–8P
(History was not obtained regarding new or changing moles, reason not otherwise specified.)

Patient Medical History

Coding Specifications

Codes required to document patient has a diagnosis or history of cutaneous melanoma and a visit occurred:

An ICD-9 diagnosis code for cutaneous melanoma and a CPT E/M service code are required to identify patients to be included in this measure.

Cutaneous melanoma ICD-9 diagnosis codes

- 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 (melanoma)

AND

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult)

Quality codes for this measure (one of the following for every eligible patient):

CPT II Code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- ***CPT II 1050F:*** History obtained regarding new or changing moles
- ***CPT II 1050F–1P:*** Documentation of medical reason(s) for not asking about presence of new or changing moles.
- ***CPT II 1050F–2P:*** Documentation of patient reason(s) for not asking about presence of new or changing moles.
- ***CPT II 1050F–3P:*** Documentation of system reason(s) for not asking about presence of new or changing moles.
- ***CPT II 1050F–8P:*** History was not obtained regarding new or changing moles, reason not otherwise specified.