

Melanoma Resection Episode-Based Cost Measure Q&A

Summary: The Melanoma Resection episode based measure is a new cost measure that will be implemented in 2022. This is the first cost measure that will be relevant to many ACMS Mohs surgeons. The measure seeks to evaluate clinicians' cost to Medicare fee for service patients for standard (non-Mohs) resection of cutaneous melanoma during a 120-day period. Costs include all items and services provided to a patient during an episode of care for cutaneous melanoma management. Episodes are "triggered" when CPT/HCPCS procedure codes for either an excision of malignant lesion code or a tissue transfer code (excision code bundled) are attached to an ICD-10 code for malignant melanoma (C43) or melanoma in situ (D03). CMS uses the ratio of risk-adjusted observed costs to a national risk-adjusted expected cost to generate an "average episode cost ratio," which will allow for calculation of the cost measure score. This process happens automatically, and no data submission is required to CMS. At this time, this is the only episode-based cost measure that we anticipate will be relevant to the majority of Mohs surgeons.

Who is eligible for this new measure?

Clinicians (or groups, if MIPS is being reported as a group) performing 10 or more cutaneous melanoma resections per year. Melanomas treated Mohs surgery are excluded from this measure.

How is an episode defined?

An episode is defined as a 120-day period, 30 days prior to the "triggering" billed event, and 90 days thereafter. The "attributed" clinician is the clinician that bills either an excision of malignant lesion code or tissue transfer codes attached to an ICD-10 code for malignant melanoma (C43) or melanoma in situ (D03), and all related costs in the 120-day period will be assigned to that clinician.

What costs are included in this measure?

Cost of excisions, pathology, reconstruction, lymph node services, infections, wound care, hospitalizations, imaging, ED visits, other post-operative post-acute care services. Costs incurred as a consequence of care (e.g., complications) are included.

Will health care costs that the patient incurs that are unrelated to melanoma resection be attributed to me?

CMS has established methodology to exclude unrelated costs (e.g., costs associated with care for a chronic condition) from the cost calculation.

What adjustments will CMS make to ensure my costs are comparable to my peers?

CMS will run a regression to risk adjust for factors outside of clinician control which might influence costs. Furthermore, cost sub-groups (such as Head/Neck melanoma vs. Trunk/Extremity) will be developed to account for differences in body location.

Do I need to submit any data to CMS for the measure to be applied? No, CMS will automatically compile your cost-specific data for you.

Can I review the specific CMS methodology for developing my average episode cost?

Methodology can be found here ([CMS Melanoma Cost Measure](#)).

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