Client
HMSA: PQSR 2007

Measure Title
FOLLOW-UP EXAMINATION AFTER DIAGNOSIS AND TREATMENT OF SKIN CANCERS

Disease State
Cancer

Indicator Classification
Disease Management

Strength of Recommendation
C

Clinical Intent
To ensure that all members who have been diagnosed with skin cancer receive the appropriate follow up consultation with a specialist at a clinically appropriate frequency.

Physician Specialties
Refer to PQSR 2007 Specialty Matrix

Clinical Rationale Disease Burden
- The American Cancer Society estimates that 61,290 people will be newly diagnosed with melanoma in 2006, making melanoma the fifth and sixth most common cancer among men and women, respectively.[1] In addition, more than 1 million cases of cutaneous basal cell or squamous cell cancers occur yearly.[1]
- Approximately 10,710 people will die from skin cancer in 2006, and it is estimated that 7,910 of those deaths will be from melanoma.[1]

Reason for Indicated Intervention or Treatment
- Surveys of cancer and melanoma registries demonstrate that patients diagnosed with cutaneous melanoma have a 0.5-5.5% incidence of developing a second primary melanoma after the initial diagnosis [2-8], a risk that is 10-25 times greater than for patients without a history of melanoma.[3, 4] Rates of recurrence are approximately 20%.[9-11]
- The greatest risk of developing a new or recurrent melanoma is in the first or second year after the initial diagnosis.[11-14]
- Patients with cutaneous squamous cell or basal cell carcinomas have at least a 10-fold increase in incidence of developing a subsequent cancer of the same type [15], and almost 50% of patients treated for squamous or basal cell carcinoma have another skin cancer within 5 years.[16-18]
- Approximately 95% of the recurrences and metastases of cutaneous squamous cell carcinoma occur during the first five years after treatment.[19]

Evidence supporting Intervention or Treatment
- Studies are mixed on whether patients or physicians detect more new or recurrent melanomas at follow-up. While some studies show that patients detect recurrences more frequently than their physicians (47-72%) [9-11], others indicate that physicians have a higher rate of detection.[11, 20]
- A prospective intervention study of 9000 patients diagnosed with melanoma from 1971 to 1999 showed that careful patient follow-up (biannually for the first five years and annually thereafter) allowed for earlier diagnosis of a second primary melanoma, since the tumor stage for the second melanoma was significantly lower than for the first.[21]
- However, one audit of 331 melanoma patients with recurrences indicated...
that even though physicians detected recurrences at earlier stages than patients, no changes in survival were seen between the two groups.[10]

- Cancers diagnosed at earlier stages are more likely to be curable, and the evidence suggests that follow-up of patients with skin cancer may be important in detecting new and recurrent cancers. Unfortunately, no studies directly examine the relationship between follow-up intervals for melanoma [11-13], squamous cell carcinoma, or basal cell carcinoma and patient outcomes.

Clinical Recommendations

- Most organizations agree that patients with melanoma and cutaneous squamous cell and basal cell carcinomas need close follow-up, especially in the years immediately after their diagnosis. However, guidelines and recommendations differ in their suggested follow-up interval and duration.
- The American Academy of Dermatology (AAD), based on recommendations from a task force of recognized experts, recognizes that there is no evidence to support a specific follow-up interval for patients with primary cutaneous melanoma. However, the AAD recommends routine interval follow-up physical examinations at least annually.[22]
- The Melanoma Study Group and the British Association of Dermatologists recommend 3-month visits for 3 years for all patients with invasive melanoma. Thereafter, those with melanomas greater than 1.0 mm in depth should be followed every 6 months for another 2 years, while those with melanomas less than 1.0 mm in depth do not require further follow-up. Patients with in situ melanoma need only one follow-up after complete excision of the primary lesion.[9, 23]
- For squamous cell carcinoma, the British Association of Dermatologists, the British Association of Plastic Surgeons and the Faculty of the Clinical Oncology of the royal College of Radiologists recommend that patients be kept under observation for 5 years by a specialist, primary care physician or patient self-examination.
- The American Academy of Dermatology recommends either annual or biannual screening for all patients with a history of nonmelanoma skin cancers.[24]

Source
Health Benchmarks, Inc.

Denominator
Continuously enrolled members ages 19 - 91 years by the end of the measurement year, who had a skin biopsy followed by a diagnosis of skin cancer during the year prior to the measurement year.

Relevant Billings Codes:

ICD-9-CM code(s): 172.xx, 173.xx, 232.xx

CPT-4 codes: 11100-11101, 11600-11606, 11620-11626, 11640-11646, 17260-17266, 17270-17276, 17280-17286, 17304-17310

Exclusion
Members with a diagnosis of malignant neoplasm of the vagina, labia majora, labia minora, vulva unspecified, prepuce, skin of the breast, any carcinoma in situ of breast and genitourinary system, or neoplasm of bone, soft tissue, or skin during the 365 days after the index date.
Relevant Billings Codes:

ICD-9-CM code(s): 184.0x, 184.1x, 184.2x, 184.4x, 187.1x, 198.2x, 233.xx, 239.2x

Numerator
Members who had at least one follow-up visit or a procedure removing a benign or pre-malignant skin lesion within 14 days to 365 days after the index date.

Relevant Billings Codes:

ICD-9 CM code(s): 172.xx, 173.xx, 232.xx, V58.42, V71.1, V76.43
ICD-9 Surgical Procedure codes: 86.3, 18.2, 08.2, 21.3
CPT-4 Codes: 10060-10061, 11200,11201,11300-11313, 11400-11406, 11420-11426, 11440-11446, 11900-11901 or 17000-17004, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275, 99301-99313, 99315, 99316, 99318-99337, 99341-99350, 99354-99355, 99381-99387, 99391-99397, 99401-99429, 99450, 99455-99456,

Interpretation of Score
High score implies better performance

Physician Attribution
Score all physicians (in the selected specialties) who saw the member from 14 to 365 days after the index date.

References
1. American Cancer Society, Cancer Facts and Figures 2006. 2006, American Cancer Society: Atlanta, GA.
**1 Indicator Classification** (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

**Diagnosis**
Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)

**Effectiveness of Care**

**Prevention**
Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).

**Screening**
Measures applicable to asymptomatic patients who have risk factors or preclinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).

**Disease Management**
Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).

**Medication Monitoring**
Measures applicable to patients taking medications with narrow therapeutic windows and/or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy)

**Medication Adherence**
Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).

**Utilization**
Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).
Strength of Recommendation Based on a Body of Evidence

**FIGURE 2.** Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)