



QPP 397: Melanoma Reporting

For several recent cases of D03.62, the pathology report records pT category, and thickness, ulceration, mitotic rate, peripheral/Deep margin status, and presence/absence of microsatellitosis. These cases should be coded as Performance Met, G9428, correct?

No, these cases are not Performance Met even with the pT category and other statements in the pathology report. Cases coded as D03.* are melanoma in situ, which is excluded from this measure. Any cases of melanoma in situ, even if the pathology report contains all the appropriate information, should be coded as Denominator Exclusions: G9430.

This pathology report is residual invasive melanoma that was previously scored for pT, mitotic rate, thickness, ulceration, peripheral and deep margins, and microsatellitosis. The new pathology report states “pT category unchanged.” Is this sufficient to meet the measure for this new specimen?

No, not quite. If the report stated that pT, mitotic rate, thickness and ulceration were unchanged, this would be satisfactory. However, there is no evidence in this statement that mitotic rate, thickness or ulceration, peripheral and deep margins, and microsatellitosis were evaluated again, so this would not be accepted as Met. Code this case as Performance Not Met: G9431.

This pathology report is for several shave biopsies from the right upper limb, simple nevus with mild atypia and rare, atypical cells. Since the pathologist coded the examination as 88305, would this be considered part of the denominator for this measure?

No. Evidence suggests this case is not primary malignant melanoma and would not be coded with any of the C43 codes. This case would not be part of this measure.

Some of our cases of melanoma in transit are coded as C43 cases, but I know the measure is intended for primary neoplasms, not metastases. Is melanoma in transit considered a primary neoplasm?

No. Even coded as C43, melanoma in transit is considered a metastasis not a primary neoplasm. If a practice has cases of melanoma in transit coded such that they fall into the denominator, these would be considered Denominator Exclusions: specimen site other than anatomic cutaneous location. Code these with G9430.



As a hospital-based practicing pathologist, I receive some melanoma excision cases. In the past, these cases were performed at commercial labs like LabCorp or Quest. Do we need to report these cases with correlation to previous cases?

Cases where there is no residual tumor (negative skin biopsies in a patient with a history of melanoma), and it is documented in the report as such, are considered a measure exception for medical reasons. There is no need to correlate with the previous case, documentation of ypT0, indicating posttreatment, will suffice. In these cases, for the question: “If the pT category, a statement on thickness and ulceration, mitotic rate, peripheral and deep margin status, and/or microsatellitosis for pT1 were not documented in the pathology report, was it due to a documented reason? (E.g. No residual cancer in a patient with a history of melanoma). Then, select “Yes” if is appropriately documented in the report.

The AJCC no longer lists mitotic rate as a valid or significant, prognostic characteristic and has omitted its use in the recently published 8th edition of staging guidelines. CMS, to my knowledge, however, still requires it to be included in reports as a quality measure. Or, has that changed?

Although though AJCC no longer requires mitotic rate for staging, the latest version of the Melanoma Cancer Protocol (November 2021) still recommends its use. Tumor mitotic rate (of the invasive component of a melanoma) is a strong independent predictor of outcome across its dynamic range in all thickness categories and should be assessed and recorded in all primary melanomas including in both initial and excision biopsies (the highest value in any specimen should be used for prognostic purposes). The mitotic rate will likely remain an important parameter in prognostic models developed in the future that will provide a personalized prediction of prognosis for individual patients.

The Melanoma Cancer Protocol can be found here:

https://documents.cap.org/protocols/Skin.Melanoma_4.3.0.2.REL_CAPCP.pdf

If a patient was previously diagnosed with melanoma through a biopsy and the lesion is excised and no melanoma is evident on the re-excision, is this a qualified case for reporting on the measure?

Cases where there is no residual melanoma is evident following an excision in a patient with a history of melanoma will fall into the Denominator Exception and are not counted toward the numerator.



If a patient received two biopsies for melanoma that were from separate locations on the same day, but one specimen did not meet the measure and the other was an exception, then which category (i.e. Met or Exception) will this case fall under?

The measure is specified at the pathology level report; however, we do have to evaluate each specimen. We cannot give credit for a report that lacks necessary information. If there are multiple specimens, then there needs to be information about each specimen. If information is missing for some specimens, but not all, then the report will be considered incomplete and will fall into the “Not Met” category.

For a case with multiple specimens that is considered “Met”, all samples must meet the measure requirements. A case there are multiple specimen and two of them are considered “Met” and one is an “Exception”, then the whole case will fall into the “Met” category because the required quality actions were met.

Will malignant melanoma cases that are not invasive get dinged for not including documentation of the presence/absence of microsatellitosis in the path report?

Based on the Cancer Protocol, for any sample that is NOT melanoma in situ, microsatellitosis is required. Anything that is not melanoma in situ (which is excluded anyway) should have microsatellitosis documented, even if the answer is “Cannot be Determined”.

In practice, it’s possible that there are edge cases where the melanoma isn’t in situ but isn’t fully invasive. If those are rare, we can handle them manually. If they are common, we’ll have to figure out how to identify them, then ask the clinicians if microsatellitosis is required for them or not.