DOCUMENTATION TIPS

AAD QCDR #5: 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. AAD QCDR measures are only available for reporting in DataDerm.

The DataDerm team will work with you to connect DataDerm with your EHR to extract data. To make that 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 age 18 and older, document the following in your notes:

- Current diagnosis of basal cell carcinoma or squamous cell carcinoma (to include in situ disease):
  - ICD-10 code for patient procedure during performance period (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)
- Cutaneous biopsy/ biopsies that are performed during the measurement period
  - CPT code for cutaneous biopsies (11102, 11103, 11104, 11105, 11106, 11107, 11755, 40490, 54100, 56605, 56606, 67810, 69100)
- Documentation of the date the patient was informed of their biopsy pathology results
  - Communication must occur before or equal to 14 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 are produced from excision, if applicable (11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646)

For more information, contact the American Academy of Dermatology:
WEBSITE: aad.org

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- Collect ***each time*** a biopsy is performed during the reporting period that is consistent with a cutaneous BCC or SCC (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.

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