AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Cutaneous Melanoma

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: **Melanoma** is a malignant neoplasm arising from melanocytes, most commonly in the skin (**cutaneous melanoma**) but also in the uveal tract and mucosal surfaces.[1] Cutaneous melanoma develops through **ultraviolet-induced DNA damage** with **activation of the MAPK/ERK and PI3K/AKT** pathways; a **BRAF V600** mutation is present in roughly **50%** of cutaneous tumors and determines eligibility for targeted therapy.[2] Four histologic subtypes are recognized: **superficial spreading** (most common), **nodular** (most aggressive, disproportionately lethal), **lentigo maligna**, and **acral lentiginous**.[2] In the Medicare population melanoma is predominantly a disease of older adults — the mean age at diagnosis is **65** and **65.7%** of cases occur between ages **55 and 84**.[3] Almost **90%** of cases are attributable to ultraviolet exposure.[4]

ICD-10 Codes:

Invasive cutaneous melanoma is reported with the **C43** series, subdivided by anatomic site and laterality to the 5th–6th character — for example **C43.4** (scalp and neck), **C43.62** (left upper limb), and **C43.72** (left lower limb). **C43.9** (melanoma of skin, unspecified) should be reserved for genuinely undocumentable sites. Melanoma in situ (Stage 0) is reported with the **D03** series and does not map to any HCC. Confirmed distant metastases are coded at each site in addition to the primary: **C78.0-** (lung), **C78.7** (liver), **C79.31** (brain), **C79.51** (bone). **Z85.820** (personal history of melanoma) is used only after treatment is complete and the patient is in documented remission.[5]

Prevalence: An estimated **100,640** new invasive melanomas and **99,700** new in-situ melanomas were projected in the United States in 2024, with about **8,510 deaths**.[6] The rate of new invasive cases is **22.3 per 100,000 per year**, and incidence rose roughly **1.1%** per year over 2014–2023.[7,8] Mortality fell about 2.2% per year, and approximately **2.2%** of Americans will be diagnosed in their lifetime.[9,10] Melanoma of the skin represents **5.3%** of all new cancer cases in the U.S.[7]

CLINICAL PEARL - RECOGNITION GAPS IN OLDER ADULTS

The classic **ABCDE** rule (Asymmetry, Border, Color, Diameter >6 mm, Evolution) was derived from superficial spreading melanoma and is **less reliable in older adults**, who more often present with nodular, amelanotic, or ulcerated tumors on the head, neck, and scalp that do not meet classic criteria.[11] AAVBC supports dermoscopy, as recommended in all skin-cancer practice guidelines, to raise detection sensitivity. Patients aged 80 and older present with significantly thicker tumors (median Breslow 0.80 mm)[12] and far worse 2-year survival once distant metastases are present (10.9% vs. 34.8% in patients under 40).[7] Because no Medicare-covered standalone screening benefit exists, and the **USPSTF** assigned visual skin-cancer screening an 'I' (insufficient evidence) rating in 2023, primary care remains the default setting for detection. However, the **American Cancer Society (ACS)** and **American Academy of Dermatology (AAD)** recommend that adults aged **40 and older** undergo a professional skin examination annually as part of routine cancer-related care — a position AAVBC supports. Early detection depends on the primary care total-body skin examination at the annual wellness visit and at problem-oriented encounters.[3]

HCC/RAF V28 Mapping

ICD-10 CODES	HCC (V28)	RAF (CNA)	DOCUMENTATION ANCHOR
C43.0–C43.9	**HCC 23** Prostate/ Breast/and Other Cancers and Tumors (includes invasive cutaneous melanoma)	0.186	Active malignancy documented; **site and laterality** specified; treatment or surveillance status noted
C78.0-, C78.7, C79.31	**HCC 17** Cancer Metastatic to Lung/Liver/Brain/ and Other Organs	4.209	Each metastatic site confirmed by imaging or pathology; code **in addition to** primary **C43.x**
C79.51, C79.89	**HCC 18** Cancer Metastatic to Bone/Other and Unspecified Metastatic Cancer	2.341	**Bone and other/unspecified secondary sites**; code separately in addition to **C43.x**
D03.0–D03.9 Melanoma in situ (Stage 0)	**HCC 23** Prostate/ Breast/and Other Cancers and Tumors	0.186	**Noninvasive**, confined to epidermis; confirm Stage 0 from the pathology report
Z85.820 Personal history of melanoma	**No HCC**		**ONLY after treatment complete** and patient in documented remission; premature use forfeits HCC documentation

ABBREVIATIONS: HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; ICD-10 = International Classification of Diseases, 10th Revision; V28 = 2024 CMS-HCC Model. RAF values are CNA-segment coefficients from the 2024 CMS-HCC model; ICD-10 to HCC assignments per the 2026 Final Mappings. CNA values are illustrative of clinical complexity and are not plan payment *RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Risk-Adjusted Care Resources per Patient/Year[14,15]

Risk-adjusted care resource allocation — MA base rate (~$10,402.34) × RAF coefficient

Invasive Cutaneous Melanoma	Metastatic to Lung/ Liver/Brain	Metastatic to Bone/ Other
$1,935	**$43,783**	**~$24,352**
HCC 23 · RAF 0.186	HCC 17 · RAF 4.209	HCC 18 · RAF 2.341

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance (Adult and Geriatric)

SERVICE/ TOUCHPOINT	COVERAGE	FREQUENCY	PCP ACTION
Annual Wellness Visit (G0438/G0439)[16]	Part B, no copay; skin assessment incorporated into the personalized prevention plan	Annually	Perform a focused **total-body skin exam**; document findings and any suspicious lesion
Problem-oriented E/M visit (99202–99215)[13]	Part B, standard copay; code to the presenting complaint	As needed	Add a brief **skin check** of exposed areas; document medical necessity for any workup
Complete physical skin exam (CPT-II 2029F)[17]	Quality-tracking code; no separate payment	Each melanoma-related encounter	Record **full-skin** and **lymph-node exam**; note scalp, soles, interdigital and covered areas
Dermoscopy (trained PCP)[10]	Bundled into the E/M encounter	At lesion identification	Raises sensitivity from **76% to 92%** and specificity from **75% to 95%** vs. naked eye[10]
Dermatology referral for surveillance[18]	Specialist visit, standard copay	Per dermatologist	Refer personal history of melanoma, **≥5 atypical nevi**, genetic predisposition, or immunosuppression

ABBREVIATIONS: AWV = Annual Wellness Visit; CPT-II = Current Procedural Terminology Category II; E/M = Evaluation and Management; PCP = primary care physician; USPSTF = US Preventive Services Task Force. No standalone Medicare melanoma-screening benefit exists (USPSTF "I" rating, 2023)[11]

CLINICAL PEARL

Dermoscopy raises melanoma detection sensitivity from 76% to 92% and specificity from 75% to 95% versus the naked eye — a substantial diagnostic gain. AAVBC supports its routine use at lesion identification, as recommended in all skin-cancer practice guidelines.[10]

Subtle Early Signs in Older Adults (>65)

SIGN/PATTERN	WHY IT MATTERS IN OLDER ADULTS	PCP CUE
EFG mnemonic — Elevated, Firm, Growing >1 month[10]	Documents **nodular melanoma**, often symmetric and uniform in color, yet small and rapidly lethal	Teach and apply **EFG** alongside **ABCDE** for any raised, firm, enlarging lesion
Amelanotic (non-pigmented) lesion[18]	Lacks the pigment that triggers concern; commonly missed on scalp and face of older patients(amelanotic)	Maintain **high suspicion for pink, red, or skin-colored lesions** that change or bleed
"Ugly duckling" sign[18]	A mole that looks different from a patient's other moles warrants evaluation regardless of **ABCDE**	Compare **each lesion** against the patient's overall nevus pattern; biopsy outliers
Head/neck and scalp location[19]	Most common high-risk sites in older men; routinely under-examined	Part the hair and examine the **scalp**; enlist a partner/caregiver for **monthly home checks**
Ulcerated, bleeding, or non-healing lesion[20]	Marker of thicker, higher-stage disease at presentation in older adults with worse prognosis	Any bleeding or non-healing pigmented lesion warrants **same-week** evaluation

ABBREVIATIONS: EFG = Elevated, Firm, Growing; ABCDE = Asymmetry, Border, Color, Diameter, Evolution

Geriatric Risk Factors

RISK FACTOR	RELATIVE RISK/ SIGNAL	PCP RELEVANCE
≥5 atypical (dysplastic) nevi	**RR 10.49** (95% CI 5.05–21.76)[18]	**Strongest surveillance signal**; refer for dermatology monitoring
Personal history of melanoma	**RR 8.40** (8.04–8.78)[18]	**Lifelong annual skin exam**; teach monthly self-examination
101–120 total body nevi	**RR 6.89** (4.63–10.25)[18]	**Higher nevus count raises baseline risk**; document total-body exam
Kidney transplant recipient	**RR 3.60** (3.10–4.10)[18]	**Immunosuppression accelerates risk**; coordinate dermatology surveillance
Immunosuppression (any cause)	**HR 1.70** (1.30–2.23) for mortality[21]	**Dermatology visits** independently **improved survival** in this group
Fitzpatrick type I vs. IV	**RR 2.09** (1.67–2.58)[18]	**Fair skin/sunburn history**; reinforce sun-protection counseling

RISK FACTOR	RELATIVE RISK/ SIGNAL	PCP RELEVANCE
Age ≥80 vs. 70 years	**Relative excess risk 2.378** (p <0.001)[12]	**Older age** independently **worsens outcome**; do not defer exams
Smoking (older adults)	Independent risk factor in patients ≥60[22]	Underemphasized in standard guidelines; **document tobacco history**
≥5 blistering sunburns (ages 15-20)	**~80%** increased risk[6]	A single blistering sunburn in childhood/ adolescence also carries lasting risk; ask about sunburn history, not just current sun exposure
First-degree relative with melanoma	**HR 1.74** (95% CI 1.45-2.09), ~74% increased risk[23]	Ask about family history at intake; consider earlier/more frequent surveillance
Indoor tanning before age 35	**RR 1.75** (95% CI 1.35-2.26), 75% increased risk[24]	Ask about tanning bed history, especially in patients now in their 50s-70s who tanned when young

ABBREVIATIONS: RR = relative risk; HR = hazard ratio; CI = confidence interval

Diagnostic Thresholds (AJCC 8th Edition)

ELEMENT	THRESHOLD/DEFINITION	CLINICAL CONSEQUENCE
Breslow thickness[25]	Measured to the nearest **0.1 mm**; single most important primary-tumor prognostic factor	Determines **surgical margins**, SLNB candidacy, and adjuvant-therapy eligibility
Ulceration status[25]	Present or absent — a **required** synoptic element	Upstages the T category and worsens prognosis at any thickness
T1 substaging (AJCC 8th ed.)[25]	**T1a <0.8 mm without ulceration; T1b <0.8 mm with ulceration or 0.8–1.0 mm**	**SLNB recommended at ≥0.8 mm or with ulceration** (T1b and above); confirms nodal stage
Stage-specific survival[26]	5-yr melanoma-specific survival **98.4% (I), 82.5% (II), 66.4% (III), 14.4% (IV)**	**Early detection is decisive**; AJCC 8th ed. improved stage III discrimination (C-index 0.65 → 0.70)

ELEMENT	THRESHOLD/DEFINITION	CLINICAL CONSEQUENCE
Stage IIC vs. IIIA paradox[27]	5-yr recurrence-free survival **26.5%** (IIC) vs. **56.0%** (IIIA), p=0.002	Thick node-negative disease can **behave worse** than thin node-positive disease
M1d designation[25]	New AJCC 8th-ed category for **CNS metastases**	Brain metastasis **(C79.31)** changes trajectory; prompts **urgent neuro workup**. Machine-learning adjuncts further refine TNM discrimination (C-index 0.89–0.92)

ABBREVIATIONS: AJCC = American Joint Committee on Cancer; SLNB = sentinel lymph node biopsy; TNM = Tumor, Node, Metastasis; CNS = central nervous system

Clues to Dig Deeper

CLUE	WHAT TO LOOK FOR	NEXT STEP
A lesion the patient says is new or changing[18]	About **one-third** of melanomas arise de novo; patient-reported change is a high-yield signal	Examine, photograph, and refer for biopsy if **EFG** or **ABCDE** features are present
New lump in neck, axilla, or groin[17]	**Palpable node** in a draining basin of a known melanoma	Imaging and biopsy to evaluate for **regional recurrence**; coordinate surgical oncology
New symptoms during checkpoint-inhibitor therapy[17]	**New** rash, diarrhea, dyspnea, chest pain, visual change, severe fatigue, or joint pain	Treat as possible **immune-related adverse event**; contact oncology promptly
Persistent cough, bone pain, headache, or weight loss[18]	In a patient with **melanoma history**, suggests distant metastasis	Expedited **cross-sectional ± brain imaging** and oncology re-referral
Scalp or sole lesion in an older adult[18]	**High-risk**, under-examined sites; amelanotic and nodular tumors common	Part hair/inspect soles; low threshold for dermatology referral

ABBREVIATIONS: EFG = Elevated, Firm, Growing; ABCDE = Asymmetry, Border, Color, Diameter, Evolution; irAE = immune-related adverse event

Common Oversights

COMMON OVERSIGHT	CLINICAL CONSEQUENCE	MITIGATION
Relying on ABCDE alone in older adults[18]	Misses nodular and amelanotic melanoma, which are **over-represented after age 65**	Apply **EFG** and the **ugly-duckling sign** alongside **ABCDE** in older adults
Spot-check instead of total-body exam[18]	**Lesions** on scalp, soles, interdigital spaces, and covered areas **go undetected**	Perform a **systematic exam** with the patient undressed and gowned
Superficial shave biopsy of a suspected melanoma[28]	**42.9%** positive deep-margin rate and **7.7%** upstaging; underestimates Breslow thickness	Use **excisional biopsy with 1–3 mm margins** when melanoma is suspected
Inadequate surgical margins in older patients[29]	Margins **<10 mm** are more common with age **(OR 1.04/yr, p=0.038)** and triple local recurrence **(HR 3.00)**	Maintain standard margins in fit older adults; **do not under-treat by age alone**
Missing immune-related adverse events between oncology visits[30]	Myocarditis carries a **25–50%** fatality rate; delayed recognition causes preventable harm	Review symptoms and check **TSH/LFTs/BMP** at **every PCP encounter** during ICI
Deferring SLNB or treatment on chronologic age alone[31]	Fit older adults are under-treated; standard performance tools miss frailty (**90%** of KPS 80–100 are pre-frail/frail)	Screen with **G8** (≤14 abnormal) and assess function, not age
Missing nailbed (subungual) melanoma[18,62]	Misdiagnosed as subungual hematoma, onychomycosis, or trauma in up to **~15-20%** of cases initially; delayed diagnosis worsens prognosis	Biopsy any persistent nail-bed pigmentation, dystrophy, or non-healing lesion; look for **Hutchinson's sign** (pigment extending onto adjacent nail fold)

ABBREVIATIONS: OR = odds ratio; HR = hazard ratio; SLNB = sentinel lymph node biopsy; ICI = immune checkpoint inhibitor; TSH = thyroid-stimulating hormone; LFT = liver function test; BMP = basic metabolic panel; KPS = Karnofsky Performance Status; G8 = Geriatric 8 screening tool

CLINICAL PEARL

Superficial shave biopsy of a suspected melanoma carries a **42.9%** positive deep-margin rate and **7.7%** upstaging rate, and underestimates Breslow thickness — the single measurement that drives staging and treatment. Use **excisional biopsy with 1-3 mm margins** whenever melanoma is suspected.[29]

Key Differentials in Elderly

DIFFERENTIAL	DISTINGUISHING FEATURES	WHEN TO BIOPSY/REFER
Seborrheic keratosis[32]	"Stuck-on," waxy, well-demarcated; uniform on dermoscopy	**Biopsy if pigment network**, rapid change, or diagnostic uncertainty
Benign/dysplastic nevus[10]	Symmetric, stable; dysplastic nevi may mimic early melanoma	**Excisional biopsy** if ugly-duckling, evolving, or **≥5** atypical nevi
Pigmented basal cell carcinoma[33]	Pearly border, telangiectasia, central ulceration	**Biopsy**; distinguish from melanoma histologically
Solar lentigo/lentigo maligna[10]	Flat tan-brown macule on sun-damaged skin; lentigo maligna is in situ melanoma	**Dermoscopy and biopsy** of any enlarging or color-variegated facial macule
Subungual hematoma[10]	Sharp proximal margin that migrates distally; history of trauma	If no clear trauma or no distal migration, refer to **exclude subungual melanoma**
Pyogenic granuloma/ angioma[34]	**Rapidly growing** red papule that bleeds — mimics amelanotic melanoma	Biopsy rapidly growing amelanotic lesions; **do not assume benign**

ABBREVIATIONS: BCC = basal cell carcinoma; in situ = confined to the epidermis (Stage 0)

Comorbidity Screening

COMORBIDITY	INTERACTION WITH MELANOMA CARE	PCP ACTION
Cardiovascular disease	CV mortality in melanoma patients rose **7.1%** per year (2005–2020); ICI myocarditis fatality **25–50%**[30,35]	**Optimize CV risk factors**; evaluate any new cardiac symptom during ICI urgently
Chronic kidney disease	AKI risk elevated in older ICI recipients **(RR 1.09, 95% CI 1.05–1.13)**; affects contrast imaging[36]	Monitor **renal function** at **baseline and serially**; adjust supportive medications
Immunosuppression/transplant	Worse outcomes **(HR 1.70 for mortality)**; ICI risks allograft rejection[21]	Coordinate **transplant + oncology before ICI**; dermatology visits improve survival

COMORBIDITY	INTERACTION WITH MELANOMA CARE	PCP ACTION
Cognitive impairment/ dementia	Impairs follow-up adherence, self-examination, and symptom reporting[37]	**Involve caregivers**; include cognitive screening in geriatric assessment
Polypharmacy (≥5 medications)	**BRAF/MEK inhibitors are CYP3A4 substrates** with meaningful interaction potential[38]	Reconcile medications; review CYP3A4 interactions **before and during** targeted therapy
Frailty	G8 ≤14 predicted higher irAE hospitalization **(54% vs. 29%, p=0.02)**, not more severe irAEs[39]	**Screen with G8**; refer abnormal scores for comprehensive geriatric assessment(CGA)

ABBREVIATIONS: CV = cardiovascular; AKI = acute kidney injury; ICI = immune checkpoint inhibitor; RR = relative risk; HR = hazard ratio; CYP3A4 = cytochrome P450 3A4; irAE = immune-related adverse event; G8 = Geriatric 8 screening tool

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

- New seizure, focal neurologic deficit, or altered mental status in a patient with known melanoma suggests **brain metastasis (C79.31)** — immediate transfer
- New chest pain, dyspnea, or arrhythmia during checkpoint-inhibitor therapy may signal **immune-mediated myocarditis (25-50% fatality)** — **hold ICI**, urgent cardiology
- **Grade 4 irAEs** (fulminant hepatitis, severe colitis with instability, myasthenic crisis, Stevens-Johnson syndrome) require immediate care and **high-dose corticosteroids**

⚠ RED FLAG — URGENT (24-72 HOURS)

- Rapidly enlarging, ulcerated, or bleeding pigmented lesion — especially on the head/ neck of an older adult
- New palpable lymphadenopathy in a draining nodal basin
- **Grade 3 irAEs**: Symptomatic hepatitis (**AST/ALT >5x ULN**), colitis (**≥7 stools/day over baseline**), pneumonitis limiting ADLs — **contact oncology for ICI hold** and immunosuppression
- New subcutaneous nodules or satellite/in-transit lesions warrant surgical oncology evaluation
- Shave biopsy showing a **positive deep margin** needs prompt re-excision

AAVBC PERSPECTIVE

AAVBC encourages primary care providers to recognize that melanoma is not reliably identified by the **ABCDE criteria** alone, and that two subtypes consistently evade detection through standard visual pattern recognition. **Nodular melanoma** is fast-growing, often symmetric, and frequently pink or red rather than pigmented. **Amelanotic melanoma** lacks pigmentation entirely and may resemble a scar, dermatitis, or basal cell carcinoma, a presentation that routinely delays biopsy. In elderly patients, lesions are more often thicker, ulcerated, or nodular at presentation, and disproportionately affect the head and neck.

AAVBC supports awareness that the ABCDE criteria describe surface appearance only and do not capture **Breslow thickness**, which is the defining prognostic variable in melanoma and the determinant of every downstream treatment decision. The **Ugly Duckling sign** (any lesion that looks different from all others on that patient) warrants clinical suspicion regardless of whether ABCDE criteria are met. This helps ensure the **right lesions** are identified and biopsied at the **right time**.

3 MEAT DOCUMENTATION ESSENTIALS

MEAT documentation ensures each melanoma encounter accurately reflects the patient's clinical status. For PCPs, the central question at every visit is straightforward: is the melanoma **active** (under treatment, surveillance, or watchful waiting → **C43.x**) or in **documented remission** (→ **Z85.820**)? Patients on adjuvant immunotherapy, under surveillance imaging, or in watchful waiting all have active malignancy and are **not** in remission.

*Case vignette: A male patient, 72, completed wide local excision of a 1.4 mm ulcerated melanoma of the left upper back **(C43.59)** and is six months into adjuvant pembrolizumab. At a routine visit he reports three loose stools daily and mild fatigue. The PCP documents active melanoma on adjuvant therapy, checks TSH and LFTs, recognizes possible grade 2 immune-mediated colitis, and contacts oncology the same day — capturing both the clinical reality and the active-disease code the record requires.*

MONITOR: "Full-skin and lymph-node exam (CPT-II 2029F): excision scar left upper back healed, no local recurrence, no palpable adenopathy. Checkpoint-inhibitor labs: TSH/free T4 pending, LFTs pending, BMP and glucose within prior baseline. Symptom review: **3 loose stools/day** (baseline 1/day), mild fatigue, no fever or blood in stool. Pathology carried forward: **1.4 mm** Breslow thickness, ulcerated, left upper back (**C43.59**)."

EVALUATE: "New-onset diarrhea (3 stools/day above baseline) and mild fatigue at 6 months into adjuvant pembrolizumab — consistent with **Grade 2 immune-mediated colitis** per CTCAE. No signs of recurrence: no new lymphadenopathy, no subcutaneous nodules, no change in excision site. Fatigue and GI symptoms reviewed against differential (infectious, thyroid dysfunction) pending labs."

ASSESS: "Active melanoma on adjuvant systemic therapy (**C43.59**) — not in remission. Suspected **Grade 2 immune-mediated colitis** related to pembrolizumab; oncology contacted same day for management guidance. No confirmed metastatic sites. Geriatric assessment: G8 score pending/documented per protocol; if **≤14**, comprehensive geriatric assessment triggered."

TREAT: "Adjuvant pembrolizumab continued pending oncology input; **same-day contact with oncology** regarding Grade 2 colitis. Plan per oncology: possible ICI hold, symptomatic management, consider corticosteroids if symptoms progress. Medication reconciliation completed. Patient educated on colitis warning signs (blood in stool, worsening frequency, fever) and instructed to report immediately. Follow-up scheduled to reassess symptoms and review pending labs"

Clinical Documentation Elements

- **Anatomic site and laterality** to the most specific ICD-10 subcode (e.g., **C43.72** for left lower limb, not **C43.9**)
- Breslow thickness (to 0.1 mm), ulceration status, mitotic activity, and AJCC stage from the synoptic pathology report
- Explicit **active-vs-remission** statement at every encounter, with the basis (on therapy, under surveillance, or treatment complete)
- Each **confirmed metastatic site** coded separately in addition to the primary **C43.x**, with the imaging or pathology that confirms it
- BRAF mutation status when known — documented for treatment planning; it does not change HCC mapping
- Geriatric assessment for patients ≥65 (G8 score, function, cognition, nutrition, polypharmacy) and any irAE monitoring performed

Reframing Common Documentation Shortcuts

DOCUMENTATION SHORTCUT	WHY IT FALLS SHORT	ACCURATE REFRAME
"History of melanoma" while on adjuvant ICI	**Z85.820** signals remission and forfeits HCC documentation during active treatment	"Active melanoma — patient on adjuvant immunotherapy" → **C43.x** with site/laterality
"Melanoma of skin" (C43.9)	Unspecified site	Specify the **site and laterality** (e.g., **C43.4** scalp/neck) supported by the exam note
"Metastatic melanoma" with no site codes	Omits HCC 17/18; the metastatic categories carry far higher coefficients than HCC 23	**Code each confirmed site (C78.0-, C78.7, C79.31, C79.51)** in addition to C43.x
"Stable, doing well" during surveillance	Does **not** convey that active malignancy is still being monitored	Document active surveillance with the schedule and exam findings → **C43.x**
"Skin checked, normal"	Does **not** establish that a systematic total-body exam occurred	"Total-body skin and lymph-node exam performed, including scalp and soles; no new lesions" (CPT-II 2029F)

DOCUMENTATION SHORTCUT	WHY IT FALLS SHORT	ACCURATE REFRAME

ABBREVIATIONS: ICI = immune checkpoint inhibitor; PPV = positive predictive value; HCC = Hierarchical Condition Category; CPT-II = Current Procedural Terminology Category II

DOCUMENTATION REMINDER IS COMPREHENSIVE CODING

Accurate documentation of clinical complexity means the record reflects what is actually happening with the patient. A patient receiving ongoing immunotherapy and monitored every **3-6 weeks** is not "history of melanoma." Name the **active disease, the site, and every confirmed metastasis**.

4 TREATMENT AND REFERRAL QUICK GUIDE

Melanoma treatment is stage-dependent and follows the **AJCC 8th-edition staging system**, with regimens guided by **NCCN Melanoma: Cutaneous (v2.2026)** and the **ASCO systemic-therapy and irAE guideline updates**.[17,25,40,41]

The PCP's role centers on **detection and biopsy decisions**, **total-body skin examination**, **irAE co-management**, **geriatric assessment**, and the **active-vs-history coding decision**. Specialists retain ownership of systemic-regimen selection, **sentinel lymph node biopsy (SLNB)**, and radiation planning.

Therapy Escalation Criteria

TRIGGER	THRESHOLD/FINDING	ESCALATION STEP
Biopsy-confirmed melanoma[17]	Any invasive cutaneous melanoma on pathology	Refer to surgical/ dermatologic oncology for **wide local excision**
Breslow ≥0.8 mm or ulceration (T1b+)[17]	Meets **SLNB** criteria	Refer for **SLNB** discussion; shared decision in frail older adults
Resected Stage IIB–III[18]	**High recurrence risk** after excision	Refer to medical oncology for **adjuvant anti-PD-1** consideration
Metastatic/unresectable disease[17]	Distant or unresectable spread	Oncology-led systemic therapy; code each metastatic site with **C43.x**

TRIGGER	THRESHOLD/FINDING	ESCALATION STEP
Suspected grade 3–4 irAE[17,41]	Symptomatic hepatitis **(AST/ALT >5× ULN)**, colitis **≥6 stools/day**, pneumonitis limiting ADLs	Hold ICI, contact oncology; high-dose corticosteroids per ASCO protocol

ABBREVIATIONS: SLNB = sentinel lymph node biopsy; anti-PD-1 = anti–programmed cell death protein 1; irAE = immune-related adverse event; ULN = upper limit of normal; ADL = activity of daily living; ICI = immune checkpoint inhibitor

NCCN/ASCO-Aligned Treatment by Stage and Patient Profile

STAGE/PROFILE	GUIDELINE-ALIGNED APPROACH*	GERIATRIC CONSIDERATION
Stage 0 (in situ, D03.x)[17]	Wide local excision with **0.5–1 cm** margins; no systemic therapy	Surveillance every **6–12** months; no HCC documentation for in situ disease
Stage I–II (localized, C43.x)[17]	WLE with margins by Breslow thickness **(≤1.0 mm → 1 cm; >1.0–2.0 → 1–2 cm; >2.0 mm → 2 cm)**; SLNB if **≥0.8 mm** or ulcerated	Maintain standard margins in fit older adults; **SLNB is a shared decision in frailty**
Stage IIB–III (resected, C43.x)[42]	Adjuvant **anti-PD-1** (pembrolizumab or nivolumab) up to 1 year; **dabrafenib + trametinib** alternative for BRAF V600E/K	**ICI ≥75 linked to shorter DFS and more skin/renal/bowel toxicity** (n=456); closer monitoring
Stage IV (metastatic, C43.x + C78.x/C79.x)[43]	First-line **nivolumab + ipilimumab** preferred; **nivolumab + relatlimab** (LAG-3) lower toxicity; anti-PD-1 monotherapy for frail patients	ADOREG **(n=8,213)**: anti-PD-1 monotherapy in **≥75** gave non-inferior PFS/MSS with lower toxicity
BRAF V600-mutant, high-volume symptomatic[17]	**BRAF/MEK inhibitors** (encorafenib+binimetinib, dabrafenib+trametinib, vemurafenib+cobimetinib) for rapid response; ICI otherwise preferred for OS	**Review CYP3A4 interactions**; ECG monitoring with vemurafenib in older adults

STAGE/PROFILE	GUIDELINE-ALIGNED APPROACH*	GERIATRIC CONSIDERATION
Second-line/refractory[17]	TIL therapy, nivolumab/relatlimab, ipilimumab, or cytotoxic chemotherapy (temozolomide, carboplatin/paclitaxel)	**Weigh toxicity against function and goals of care**; single-agent ICI ≥80 shows meaningful activity with manageable toxicity

ABBREVIATIONS: WLE = wide local excision; SLNB = sentinel lymph node biopsy; anti-PD-1 = anti–programmed cell death protein 1; LAG-3 = lymphocyte-activation gene 3; BRAF/MEK = B-Raf/MAPK-ERK kinase; TIL = tumor-infiltrating lymphocyte; DFS = disease-free survival; PFS = progression-free survival; MSS = melanoma-specific survival; OS = overall survival; DFS/PFS/MSS/OS are study endpoints. *Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions

CLINICAL PEARL

Function, not chronologic age, should guide treatment decisions. Two patients of the same age can present very differently, one physically active with no functional limitations, the other frail with polypharmacy and cognitive impairment. Standard performance tools often miss this distinction. Screen with the **G8** (8 items, **under 5 minutes**, score **≤14** abnormal) and assess function before deferring **SLNB** or systemic therapy.

Non-Pharmacologic Care and Prevention

INTERVENTION	EVIDENCE/RATIONALE	PCP ROLE
Total-body skin self-examination	Only **14%** of US melanoma patients examine all body parts; partner-assisted training raised detection from **0% to 81%**[44,45]	Teach **monthly SSE** with a partner; supply printed/digital body maps
Daily broad-spectrum sunscreen (SPF ≥30)	Reduced invasive melanoma vs. discretionary use **(HR 0.27, 95% CI 0.08–0.97)** at 10 years[46]	**Counsel application to face, ears, scalp, neck, hands**; consider spray formulations for arthritis
Sun-protective clothing and wide-brimmed hats[18]	**Recommended by ASCO, AAD, and NCCN**; practical for limited dexterity	Often **more feasible** than reapplying sunscreen for older adults with limited dexterity
UV avoidance during peak hours (10 AM–2 PM)[18]	Endorsed across major guidelines	Counsel on **timing of gardening, walking, and outdoor activity**

INTERVENTION	EVIDENCE/RATIONALE	PCP ROLE
Geriatric assessment and supportive care	**GAP70+** reduced grade **3–5 toxicity** from **71% to 51% (RR 0.74)** without compromising survival[47]	Address **nutrition, function, polypharmacy, and social support** before/during therapy

ABBREVIATIONS: SSE = skin self-examination; SPF = sun protection factor; UV = ultraviolet; HR = hazard ratio; RR = relative risk; CI = confidence interval; AAD = American Academy of Dermatology

Medication Safety and Key Interactions

AGENT/CLASS*	KEY INTERACTION/RISK	PCP ACTION
Pembrolizumab; nivolumab (anti-PD-1)	Immune-related adverse events: thyroiditis, colitis, hepatitis, pneumonitis, **myocarditis (25–50% fatality)**[30]	**Monitor TSH/LFTs/BMP and symptoms each visit**; urgent oncology contact for grade 3–4
Nivolumab + ipilimumab	Higher irAE burden; frailty raises irAE hospitalization **(54% vs. 29%)**[39]	Reserve combination for **fitter patients**; intensify monitoring in older adults
Nivolumab + relatlimab (LAG-3)	Lower toxicity than nivolumab+ipilimumab[17]	Reasonable option where **toxicity tolerance is limited; monitor irAEs**
Dabrafenib + trametinib (BRAF/MEK)	**CYP3A4** substrate/inducer — interacts with warfarin, statins, digoxin, strong inhibitors/inducers; pyrexia, QTc[48]	**Reconcile medications**; monitor INR; review antiepileptics/antibiotics
Vemurafenib + cobimetinib (BRAF/MEK)	QTc prolongation additive with antiarrhythmics, antipsychotics, fluoroquinolones[49]	**Baseline and periodic ECG**; avoid concurrent QTc-prolonging agents
Systemic corticosteroids (irAE management)	Required for **grade 3–4 irAE**; do not withhold for fear of attenuating ICI efficacy[41]	**Initiate per ASCO irAE protocol**; coordinate with oncology

ABBREVIATIONS: anti-PD-1 = anti–programmed cell death protein 1; LAG-3 = lymphocyte-activation gene 3; BRAF/MEK = B-Raf/MAPK-ERK kinase; CYP3A4 = cytochrome P450 3A4; irAE = immune-related adverse event; ICI = immune checkpoint inhibitor; INR = international normalized ratio; QTc = corrected QT interval; ECG = electrocardiogram; FDA = US Food and Drug Administration
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

REFERRAL	TRIGGER	TIMEFRAME
Surgical/dermatologic oncology[18]	Biopsy-confirmed invasive melanoma for wide excision ± SLNB	Within **1–2 weeks**
Medical oncology[18]	Resected Stage IIB+ or metastatic disease for systemic therapy	**Promptly** after staging
Dermatology (surveillance)[18]	Personal history, **≥5** atypical nevi, genetic predisposition, immunosuppression	Per dermatologist schedule
Cardiology[39]	Any new cardiac symptom or troponin elevation during ICI (possible myocarditis)	**Same day — emergency**
Geriatric oncology/ assessment[50]	**G8 ≤14** in a patient ≥65 before systemic therapy	**Before** treatment decisions
Emergency department[17]	New seizure/focal deficit (brain metastasis) or grade 4 irAE	**Immediate**

ABBREVIATIONS: SLNB = sentinel lymph node biopsy; ICI = immune checkpoint inhibitor; irAE = immune-related adverse event; G8 = Geriatric 8 screening tool

Follow-Up Timing

STAGE/SETTING	PCP FOLLOW-UP CADENCE	IMAGING/MONITORING
Stage 0 (in situ)[17]	History + skin exam at least **annually**	**No routine imaging**; watch the excision scar
Stage IA–IIA[17]	Skin + node exam every **6–12 months × 5 years**, then **annually**	Imaging **only** for symptoms; teach **SSE**
Stage IIB–IV (NED)[17]	Every **3–6 months × 2 years**, then every **3–12 months × 3 years**, then **annually**	Cross-sectional ± brain imaging **q3–12 months × 2 years** (category 2B)
During checkpoint-inhibitor therapy[17]	Symptom review and exam at **each PCP visit**	TSH/free T4, LFTs, CMP, glucose every **3–6 weeks**
During BRAF/MEK therapy[17]	**Per oncology**; PCP reviews interactions	CBC/LFTs baseline then monthly

ABBREVIATIONS: NED = no evidence of disease; SSE = skin self-examination; TSH = thyroid-stimulating hormone; LFT = liver function test; BMP = basic metabolic panel; CBC = complete blood count; category 2B = NCCN consensus level

Comorbidity Management - Primary Care Role

DOMAIN	PRIMARY CARE ROLE	DOCUMENTATION TIE-IN
Cardiovascular risk[35]	Optimize BP, lipids; evaluate ICI cardiac symptoms **urgently**	Document **CV comorbidities and ICI monitoring**
Renal function[51]	Baseline and serial monitoring; **adjust supportive drugs**	Record **creatinine trend** during therapy
Cognition/function[50]	**Screen cognition**; involve caregivers in surveillance	Document G8 and **functional status ≥65**
Polypharmacy[38]	Reconcile medications; review **CYP3A4 interactions**	**List concurrent medications and interaction checks**
Mood/coping[37]	Screen for **depression/anxiety**; connect to support	Document **psychosocial assessment and referrals**; screen at intervals

ABBREVIATIONS: BP = blood pressure; ICI = immune checkpoint inhibitor; CV = cardiovascular; CYP3A4 = cytochrome P450 3A4; G8 = Geriatric 8 screening tool

Cost-Smart Options

BRAND (EST. COST)	GENERIC (EST. COST)	EST. SAVINGS	COST-SMART RATIONALE
Pembrolizumab (Keytruda) IV, 200 mg q3wk ($11,564/dose)[52]	Nivolumab (Opdivo) IV, comparable monotherapy dosing (**~$15,700/mo** real-world drug cost)[53]	Roughly comparable	Both NCCN category 1 monotherapy; real-world monthly drug costs are similar — choose per formulary
Pembrolizumab q3wk, 200 mg/dose ($11,564)[52]	Pembrolizumab extended-interval q6wk, 400 mg/dose (**$23,591**, same monthly cost)[52]	~$0 drug cost	Q6wk halves infusion visits for stable patients
Ipilimumab-containing regimens (nivolumab + ipilimumab or ipilimumab monotherapy) (~$70,051/mo drug cost, real-world claims data)[53]	Pembrolizumab or nivolumab monotherapy (**~$15,700/mo**)[53]	~$54,000/mo	Real-world data confirm pembrolizumab/nivolumab monotherapy as preferred first-line over ipilimumab-containing regimens on both cost and toxicity grounds

BRAND (EST. COST)	GENERIC (EST. COST)	EST. SAVINGS	COST-SMART RATIONALE
Dabrafenib + trametinib (Tafinlar $16,451/mo + Mekinist $19,528/mo ≈ $35,979/mo)[54,55]	Encorafenib + binimetinib (Braftovi **$16,013/mo** + Mektovi **$16,653/mo** ≈ **$32,666/mo**)[56,57]	**~$3,300/mo**	All BRAF/MEK doublets are NCCN category 1; encorafenib/binimetinib carries a modest cost edge, but selection should follow toxicity profile (pyrexia with dab/tram vs. photosensitivity/ocular effects with enco/bini)

ABBREVIATIONS: ICI = immune checkpoint inhibitor; NCCN = National Comprehensive Cancer Network

Patient Education and Adherence

- **Confirm and document malignancy status** — **active** or **remission** — annually and at every melanoma-related encounter. Active status includes patients on adjuvant immunotherapy, under surveillance imaging, or in watchful waiting, all reported with **C43.x** rather than **Z85.820**
- **Document anatomic site and laterality** to the most specific subcode available, carrying forward Breslow thickness, ulceration, and AJCC stage from the synoptic pathology report. Specific coding (e.g., **C43.72** for left lower limb) supports diagnostic accuracy that unspecified codes undermine
- For metastatic disease, **list and confirm each site annually**: lung, liver, and brain map to **HCC 17**; bone and other/unspecified secondary sites map to **HCC 18**. Each site is coded in addition to the primary **C43.x** and must be supported by imaging or pathology
- **Document the geriatric assessment for patients ≥65** (function, cognition, nutrition, polypharmacy), immune-related adverse-event monitoring performed during therapy, and **BRAF status** when known. BRAF status guides treatment selection but does not affect HCC mapping

DOCUMENTATION REMINDER - PATIENT EDUCATION

Document the education you deliver. A note such as "**Total-body skin and lymph-node exam performed**; **SSE and sun-protection counseling provided**; **ICI warning symptoms reviewed**" (**CPT-II 2029F**) records both the care delivered and the active-surveillance status that supports **C43.x** documentation.

Quality Metrics Tie-In

MEASURE	PROGRAM	APPLICABILITY TO MELANOMA
Complete Physical Skin Exam (CPT-II 2029F; MIPS #137)[58]	**Denominator:** all patients regardless of age with a current diagnosis of melanoma or a history of melanoma, with a qualifying visit during the performance period **Numerator:** patient's information entered at least once within a 12-month period into a recall system that includes a target date for the next complete physical skin exam AND a process to follow up with patients who missed or did not schedule that appointment **Exclusions:** documented system reason for not entering patient information (e.g., melanoma being managed by another provider)	MIPS #137 is the most directly applicable melanoma measure in the MIPS inventory — it operationalizes the CPT-II 2029F documentation into a structured recall workflow. Document a full skin exam at each melanoma-related visit using 2029F; enter the patient into the practice recall system annually to satisfy MIPS #137
Care for Older Adults (HEDIS COA)	**Denominator:** MA/SNP enrollees ≥66, continuously enrolled **Numerator:** all 4 sub-measures documented annually — functional status assessment, medication review **Exclusions:** hospice, ESRD	For older adults navigating systemic melanoma therapies (e.g., ipilimumab, nivolumab), functional assessments (ADLs/IADLs) track therapy tolerance, and medication reviews are critical to screen for severe immune-mediated adverse events
Transitions of Care (HEDIS TRC; MIPS #46 for sub-measure 4)[59]	**Denominator:** enrollees ≥18 with inpatient discharge. **Numerator:** 4 sub-measures within 30 days of discharge — (1) notification of inpatient admission (2) receipt of discharge information (3) patient engagement after discharge (4) medication reconciliation post-discharge **Exclusions:** hospice	MIPS #46 covers sub-measure 4 (medication reconciliation) only; sub-measures 1–3 are HEDIS/plan-level. Melanoma patients are frequently admitted for major surgical resections (lymph node dissections) or severe **Immune Checkpoint Inhibitor (ICI) toxicities** (e.g., immune-mediated pneumonitis, colitis, or myocarditis)

MEASURE	PROGRAM	APPLICABILITY TO MELANOMA
Controlling High Blood Pressure (HEDIS CBP; MIPS #236)[60]	**Denominator:** patients 18-85 with hypertension (≥2 outpatient visits with HTN diagnosis in MP or year prior) **Numerator:** most recent BP <140/90 mmHg during MP **Exclusions:** ESRD, hospice, palliative care, pregnancy	**Therapy-Induced Hypertension:** First-line targeted oral therapies for BRAF-mutated melanoma (such as **dabrafenib/trametinib** or **encorafenib/binimetinib**) commonly induce or severely exacerbate systemic arterial hypertension
Melanoma Reporting (MIPS #397)[61]	**Denominator:** patients ≥18 with primary malignant cutaneous melanoma (C43.x) covered by pathology reports for biopsies or excisions; melanoma in situ does not qualify **Numerator:** pathology report includes pT category, thickness, ulceration and mitotic rate, peripheral and deep margin status, and presence or absence of microsatellitosis for invasive tumors **Exclusions:** documented medical reason for not including required elements (e.g., insufficient tissue, negative biopsy); melanoma in situ cases	Applies to pathology and dermatologic surgery rather than the PCP directly; PCP role is to verify the synoptic report is on file before proceeding with staging workup and oncology referral. An incomplete pathology report delays AJCC 9th edition staging and sentinel lymph node biopsy decision-making

ABBREVIATIONS: AJCC = American Joint Committee on Cancer; BRAF = B-Raf proto-oncogene; COA = Care for Older Adults; CPT-II = Current Procedural Terminology Category II; ESRD = end-stage renal disease; HEDIS = Healthcare Effectiveness Data and Information Set; ICI = immune checkpoint inhibitor; MA = Medicare Advantage; MEK = mitogen-activated protein kinase; MIPS = Merit-based Incentive Payment System; MP = measurement period; PCP = primary care physician; TRC = Transitions of Care

AAVBC PERSPECTIVE

AAVBC encourages primary care providers to perform and document a **systematic total-body skin examination (TBSE)** at every annual visit for high-risk patients, defined as those with more than **50 moles**, a prior **atypical nevus**, or a **family history of melanoma**. A systematic examination requires full undressing and inspection of all body surfaces, including the scalp, soles of the feet, the space between toes, anogenital skin, and skin beneath the breasts - areas where melanoma is frequently located and where reactive spot-checks will not reach. Lesions identified through systematic PCP surveillance are measurably thinner at detection than those found otherwise, and **Breslow thickness** at diagnosis is the single most important determinant of prognosis and surgical planning.

AAVBC supports asking patients to identify new, changing, or unusual lesions before the

examination begins, and encourages **excisional biopsy** technique when biopsy is indicated, to ensure full lesion depth is captured for accurate staging. Reactive, complaint-driven skin assessment is not a substitute for systematic surveillance in this population. **This helps ensure the right patients receive the right examination and the right intervention at the earliest possible stage.**

QUALITY OUTCOME

Melanoma detected at **Stage 0 or I** carries a substantially higher 5-year survival than **Stage IV** disease. Early detection depends on consistent screening at every primary care encounter. A documented **total-body skin exam**, prompt **biopsy decision**, and timely **irAE recognition** represent the highest-leverage quality actions available for this condition.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

CODE	USE WHEN	HCC (V28)/ RAF (CNA)	SPECIFICITY NOTE
C43.x (e.g., C43.4, C43.62)	Active invasive cutaneous melanoma — including adjuvant ICI, active surveillance, watchful waiting	HCC 23/0.186	Specify **site and laterality**; avoid **C43.9**
D03.x	Melanoma in situ (Stage 0) confirmed by pathology	-	Noninvasive; do not use for invasive lesions
C78.0-, C78.7, C79.31	Confirmed lung, liver, or brain metastasis	HCC 17/4.209	Code each site in addition to **C43.x**; imaging or pathology required
C79.51, C79.89	Confirmed bone or other/ unspecified secondary site	HCC 18/2.341	**Bone maps to HCC 18, not HCC 17**; code separately in addition to **C43.x**
Z85.820	Treatment complete AND patient in documented remission AND routine surveillance only	-	Premature use during active treatment forfeits HCC documentation

CODE	USE WHEN	HCC (V28)/ RAF (CNA)	SPECIFICITY NOTE

ABBREVIATIONS: HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; CNA = Community Non-Dual Eligible, Aged; PPV = positive predictive value; ICI = immune checkpoint inhibitor; V28 = 2024 CMS-HCC Model. RAF values are CNA-segment coefficients; mappings per the 2026 Final ICD-10-CM to CMS-HCC Mappings

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

Annual Clinical Review and Confirmation

- At least once per year, and at each melanoma-related encounter, confirm and document whether the malignancy is **active** or in **remission**. Active status includes patients on adjuvant immunotherapy, under surveillance imaging, or in watchful waiting — all reported with **C43.x**, not **Z85.820**
- Re-document the anatomic site and laterality to the most specific subcode, carrying forward Breslow thickness, ulceration, and AJCC stage from the synoptic pathology report. Specific coding (e.g., **C43.72** for left lower limb) supports the accuracy that unspecified codes undermine — melanoma ICD codes carry only **58% PPV** when used alone
- For metastatic disease, list and confirm each site every year: lung, liver, and brain map to **HCC 17** (RAF **4.209**); bone and other/unspecified secondary sites map to **HCC 18** (RAF **2.341**). Coefficients are the CNA-segment values from the **2024 CMS-HCC model** applied at **100% weight** for CY 2026. Each site is coded in addition to the primary **C43.x** and must be supported by imaging or pathology
- Document the geriatric assessment for patients **≥65** (G8 score, function, cognition, nutrition, polypharmacy), the immune-related adverse-event monitoring performed during therapy, and **BRAF status** when known. BRAF status guides treatment but does not change HCC mapping

Good Documentation - EHR Tips

EHR TIP	WHAT TO DOCUMENT	WHY IT HELPS
Active-vs-history hard stop	A required field at each melanoma visit: active **(C43.x)** vs. remission **(Z85.820)**; default to active if uncertain	Prevents the single most impactful coding error in melanoma
Site + laterality picklist	Structured anatomic site and side feeding the **C43.x** subcode	Reduces reliance on **C43.9** and improves code PPV
Metastatic-site checklist	Prompts for lung/liver/brain (HCC 17) and bone/other (HCC 18) with confirmation source	Documents the markedly higher metastatic coefficients accurately

EHR TIP	WHAT TO DOCUMENT	WHY IT HELPS
ICI monitoring SmartPhrase	TSH/free T4, LFTs, BMP, glucose, and symptom review during therapy	Supports **timely irAE recognition** and documents active care
Skin-exam template (CPT-II 2029F)	Total-body skin and lymph-node exam, including scalp and soles	Records the systematic exam and the quality-tracking code

ABBREVIATIONS: EHR = electronic health record; ICI = immune checkpoint inhibitor; irAE = immune-related adverse event; TSH = thyroid-stimulating hormone; LFT = liver function test; BMP = basic metabolic panel; CPT-II = Current Procedural Terminology Category II; PPV = positive predictive value

Brief Case Examples

SUCCESS - Active Disease Named, Complexity Represented, Toxicity Caught Early

Patient: Female patient, 74, with a resected 1.8 mm ulcerated melanoma of the left lower leg **(C43.72)**, six months into adjuvant pembrolizumab.

Documentation: PCP records active melanoma on adjuvant immunotherapy **(C43.72)**, a total-body skin and lymph-node exam (CPT-II 2029F), TSH/LFTs/BMP, a G8 score of 13 prompting geriatric assessment, and BRAF status.

Outcome: Active disease and clinical complexity are accurately represented; a grade 2 thyroiditis is caught early and co-managed with oncology without interrupting therapy.

Coding integrity: C43.72 (HCC 23) maintained throughout active treatment; **Z85.820** deferred until remission is documented.

PITFALL - Premature History Coding and Omitted Metastasis

Documentation as written: "History of melanoma, doing well" → **Z85.820**, recorded while the patient is mid-course on adjuvant nivolumab with surveillance imaging scheduled.

Consequence: Active malignancy is mis-stated as remission; HCC 23 is forfeited and the record no longer reflects the patient's clinical reality or monitoring burden.

Compounding error: A confirmed lung metastasis is described narratively but **C78.01** is never coded, omitting HCC 17 (RAF 4.209).

Fix: Code active disease as **C43.x** with site/laterality plus **C78.01** for the lung metastasis; reserve **Z85.820** for documented remission after treatment completion.

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