

2017 Dermatology Coding Updates

2017 Spring Current Concepts
in Dermatology Seminar
American Osteopathic College of Dermatology

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2017 CPT News

CPT Code/Modifier	Code Descriptor
Telemedicine: Appendix P	Lists current CPT codes with evidence of some payer approval for use when provided via integrative audio and video telecommunication system
*99201 - *99215	*E/M codes included in this list
Modifier 95 <i>*Check local carrier policy on coverage</i>	Indicates a service generally reported as a face-to-face service was performed via a real-time interactive audio and video telecommunication system
0419T <i>(will sunset January 2022)</i>	Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas
04120T <i>(will sunset January 2022)</i>	trunk and extremities, extensive, greater than 100 neurofibromas



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2017 Medicare Part B Premium and Deductible

- **2017 Part B premium** standard is **\$134**
 - Average is **\$109**, up from **\$104** in **2016**
- **Low Social Security cost of living** adjustment of **0.3%**.
 - "Hold harmless" provision designed to protect seniors prevented a larger increase
- **2017 Part B Deductible** is **\$183**, up from **\$166** in **2016**
 - Co-insurance remains **20%** of Medicare Physician Fee Schedule (MPFS) allowed amount
- File Medicaid claim prior to billing patient



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Medicare Beneficiary Identifier Revision

By April 2019 Medicare beneficiaries, Social Security ID numbers will be replaced with random identifiers

CMS requests provider's assistance

- Check your patient's address
- Ask the patient to update the Social Security Office directly if any changes

<https://faq.ssa.gov/ics/support/KBAAnswer.asp?questionID=3704>



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Administrative Law Judge (ALJ) and Federal Claim Appeal Increase

ALJ and Federal District Court amount in controversy increase for 2017



	Appeal Claim Total Required	
	Administrative Law Judge	Federal District Court
2016	\$150	\$1,500
2017	\$160	\$1,560

*Total may encompass a single claim or the accumulation of claims



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Medicare Drug Waste Modifier

Medicare Change Request CR 9603

JW - Drug amount discarded/not administered to any patient, Documentation must be available if requested

- Beginning January 1, 2017
- Reporting unused drug and biological portions require JW modifier to identify discarded drugs and biologicals when processing Part B claims.
- Do not use JW modifier to report Competitive Acquisition Program (CAP) drugs and biologicals.



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Medicare Drug Waste Modifier


Documentation must include

- Date and time the drug was discarded
- Amount discarded
- Reason for wastage
- Who wasted the drug

- Check local Medicare contractor for provider requirements for reporting of drug wastage

For more information see:

- **CR 9603:** www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf
- *Derm Coding Consult, Spring 2015, Billing for Drugs and Biologicals in your Practice*




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Medicare Payment Revision

Non-face-to-face prolonged E/M service

- **Must be**
 - Tied to an E/M service
 - Time spent by billing physician only
 - Not within the scope of clinical staff
 - No other CPT to report this work
- **Document**
 - Time
 - Summary of non-face-to-face work




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Prolonged E/M Service

CPT Code	Global	CMS work RVU
99358	XXX	2.10
99359	XXX	1.00



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2017 Medicare Fee Schedule Overview

- Published on 11/15/2016
- Very little impact on dermatology payments overall
- CMS estimates the CY 2017 PFS conversion factor (CF) to be **\$35.8887**, a slight increase over the 2016 CF of **\$35.8043**.



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Relative Value Units and Related Information Used in CY 2017 Final Rule

2017 CPT/HCPCS	Mod	Description	Global	2016 payment Amount \$	2017 Payment Amount \$	% Payment Difference
11100		Biopsy skin lesion	000	\$104.91	\$105.15	0.24%
11300		Shave skin lesion 0.5 cm/<	000	\$98.46	\$99.77	1.31%
11400		Exc tr-ext b9+marg 0.5 cm/<	010	\$125.32	\$126.33	0.80%
11600		Exc tr-ext mal+marg 0.5 cm/<	010	\$194.42	\$195.95	0.78%
12031		Intmd rpr s/a/t/ext 2.5 cm/<	010	\$240.60	\$241.89	0.53%
17000		Destruct premalg lesion	010	\$67.67	\$67.83	0.24%
17311		Mohs 1 stage h/n/hf/g	000	\$673.12	\$674.35	0.18%
88305		Tissue exam by pathologist	XXX	\$74.11	\$69.62	-6.45%
88305	TC	Tissue exam by pathologist	XXX	\$34.37	\$29.79	-15.39%
88305	26	Tissue exam by pathologist	XXX	\$39.74	\$39.84	0.24%
96910		Photochemotherapy with uv-b	XXX	\$72.32	\$72.14	-0.26%
96931		Rcm celulr subcelulr img skn	XXX	\$0.00	\$161.86	NA
99213		Office/outpatient visit est	XXX	\$73.40	\$73.93	0.72%

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2017 Medicare Fee Schedule - overview

- Reflectance Confocal Microscopy (RCM) 96931-96936 assigned new assigned values.
- No more Physician Quality Reporting System or EHR Meaningful Use reporting.
- Instead, MACRA Quality Payment Program (QPP) with a Merit-based Payment Improvement System (MIPS) and Alternate Payment Models (APMs).



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Two Tracks: MIPS and Advanced APMs

Here is all I know....

MIPS Options

- Test the program** – report on a limited set of data to avoid penalty only
- Partial participation** – report more data for at least 90 days to receive a small incentive
- Full participation** – report all elements for 90 days or more to receive full incentive

Advanced APM Option

- Join an Advanced APM**
 - Most receive 25% of Medicare Part B payments or see 20% of Medicare Part B patients through an advanced APM in 2017
 - Potential to earn a 5% incentive payment in 2019

Excluded from program if you:

- Are in the Medicare program for the first year
- Have less than \$30,000 in allowed charges to Medicare Part B per year
- See less than 100 Medicare Part B patients per year

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MACRA Timeline

Year	Performance Evaluation Year	Incentive
2017	2019	-
2018	2020	-
2019	2021	+/- 4%
2020	2022	+/- 5%
2021	2023	+/- 7%
2022	2024	+/- 9%

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2017 is a Transition Year — Pick Your Pace

**Test Pace:
Avoid Penalties**

**Partial Participation:
Small Incentive**

**Full Participation:
Larger Incentive**

Report ONE of the following:

- One measure in the quality performance category at least one time*
- One activity in the improvement activity category
- Five required measures making up the base score of the advancing care information (ACI) category

Report ONE of the following for 90 days:

- More than one quality measure in the quality performance category
- More than one improvement activity
- More than the five required measures in the ACI category

Report ALL of the following for 90 days:

- Six quality measures in the quality performance category
- One high-weighted improvement activity or two medium-weighted improvement activities
- Five required measures making up the base score of the ACI category.

*The AAD strongly recommends practices report more than one measure or report at least one measure over a 90-day period as an insurance policy in the event of submission issues or inaccuracies. Failure to correctly report one measure or activity in 2017 will result in a 4% penalty in 2019.

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Got questions about MACRA?

Got questions? Post them to the MACRA Readiness Community and AADA expert staff and members will find the answers.

JOIN THE DISCUSSION

<http://community.aad.org/home>

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Review of Codes with 10 and 90 Day Global Days

- Physicians in *Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island* will be expected to report post-procedure visits using CPT 99024 beginning July 1.
- North Carolina** – exempt but can volunteer
- Practices with fewer than **10 providers** are exempt.
- Codes reported annually by more than 100 practitioners and reported more than 10,000 times, or allowed charges in excess of \$10 million annually
- No penalty for not reporting, no payment for reporting**

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CMS GLOBAL SURGERY DATA COLLECTION CODE LIST

ICD-9	ICD-9 DESCRIPTION	ICD-9	ICD-9 DESCRIPTION	ICD-9	ICD-9 DESCRIPTION
90.000	Abdominal surgery	90.000	Abdominal surgery	90.000	Abdominal surgery
90.001	Abdominal surgery	90.001	Abdominal surgery	90.001	Abdominal surgery
90.002	Abdominal surgery	90.002	Abdominal surgery	90.002	Abdominal surgery
90.003	Abdominal surgery	90.003	Abdominal surgery	90.003	Abdominal surgery
90.004	Abdominal surgery	90.004	Abdominal surgery	90.004	Abdominal surgery
90.005	Abdominal surgery	90.005	Abdominal surgery	90.005	Abdominal surgery
90.006	Abdominal surgery	90.006	Abdominal surgery	90.006	Abdominal surgery
90.007	Abdominal surgery	90.007	Abdominal surgery	90.007	Abdominal surgery
90.008	Abdominal surgery	90.008	Abdominal surgery	90.008	Abdominal surgery
90.009	Abdominal surgery	90.009	Abdominal surgery	90.009	Abdominal surgery
90.010	Abdominal surgery	90.010	Abdominal surgery	90.010	Abdominal surgery
90.011	Abdominal surgery	90.011	Abdominal surgery	90.011	Abdominal surgery
90.012	Abdominal surgery	90.012	Abdominal surgery	90.012	Abdominal surgery
90.013	Abdominal surgery	90.013	Abdominal surgery	90.013	Abdominal surgery
90.014	Abdominal surgery	90.014	Abdominal surgery	90.014	Abdominal surgery
90.015	Abdominal surgery	90.015	Abdominal surgery	90.015	Abdominal surgery
90.016	Abdominal surgery	90.016	Abdominal surgery	90.016	Abdominal surgery
90.017	Abdominal surgery	90.017	Abdominal surgery	90.017	Abdominal surgery
90.018	Abdominal surgery	90.018	Abdominal surgery	90.018	Abdominal surgery
90.019	Abdominal surgery	90.019	Abdominal surgery	90.019	Abdominal surgery
90.020	Abdominal surgery	90.020	Abdominal surgery	90.020	Abdominal surgery
90.021	Abdominal surgery	90.021	Abdominal surgery	90.021	Abdominal surgery
90.022	Abdominal surgery	90.022	Abdominal surgery	90.022	Abdominal surgery
90.023	Abdominal surgery	90.023	Abdominal surgery	90.023	Abdominal surgery
90.024	Abdominal surgery	90.024	Abdominal surgery	90.024	Abdominal surgery
90.025	Abdominal surgery	90.025	Abdominal surgery	90.025	Abdominal surgery
90.026	Abdominal surgery	90.026	Abdominal surgery	90.026	Abdominal surgery
90.027	Abdominal surgery	90.027	Abdominal surgery	90.027	Abdominal surgery
90.028	Abdominal surgery	90.028	Abdominal surgery	90.028	Abdominal surgery
90.029	Abdominal surgery	90.029	Abdominal surgery	90.029	Abdominal surgery
90.030	Abdominal surgery	90.030	Abdominal surgery	90.030	Abdominal surgery
90.031	Abdominal surgery	90.031	Abdominal surgery	90.031	Abdominal surgery
90.032	Abdominal surgery	90.032	Abdominal surgery	90.032	Abdominal surgery
90.033	Abdominal surgery	90.033	Abdominal surgery	90.033	Abdominal surgery
90.034	Abdominal surgery	90.034	Abdominal surgery	90.034	Abdominal surgery
90.035	Abdominal surgery	90.035	Abdominal surgery	90.035	Abdominal surgery
90.036	Abdominal surgery	90.036	Abdominal surgery	90.036	Abdominal surgery
90.037	Abdominal surgery	90.037	Abdominal surgery	90.037	Abdominal surgery
90.038	Abdominal surgery	90.038	Abdominal surgery	90.038	Abdominal surgery
90.039	Abdominal surgery	90.039	Abdominal surgery	90.039	Abdominal surgery
90.040	Abdominal surgery	90.040	Abdominal surgery	90.040	Abdominal surgery
90.041	Abdominal surgery	90.041	Abdominal surgery	90.041	Abdominal surgery

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Review of Codes With 10 and 90 Day Global Periods

- CMS survey practitioners to gain information regarding post-op visits may occur in **mid-2017**
- CMS will collect data from Pioneer and Next Gen ACOs on the *“activities and resources involved in and around surgical events”*



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ICD 10 Updates

- Code specificity required as of October 1, 2016
- No specific dermatology code changes. However, 2017 Guideline changes may impact your practice
- Review Derm Coding Consult for more information

FALL 2016

Nothing lasts forever: ICD-10 code freeze and specificity safe harbor ends

WINTER 2016

No dermatology specific ICD-10 CM code changes for 2017



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2017 ICD-10 Guidelines

- Clinical Criteria and Code Assignment
- Excludes1
- Bilateral Conditions
- Etiology/Manifestation
- Terms – With, Use additional code
- Episode of Care
- Complications of Care




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Clinical Criteria / Code Assignment

- Diagnosis codes reported are NOT selected based on clinical criteria used to establish the diagnosis

- Physician's statement alone that the condition is present supports reporting of the ICD-10 code.




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Excludes1

- Listed with mutually exclusive codes:
 - Two conditions cannot be reported together
 - Clinically
 - Coding rule
- Clarification provided by CMS in October 2015
 - If unrelated, report both conditions



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Example

Pathology Report	ICD codes
#1 specimen from abdomen – Lentigo maligna	D03.59 Melanoma in situ of other parts of trunk
#2 specimen from back – Malignant melanoma	C43.59 Malignant melanoma of other parts of trunk
	Excludes1 <i>melanoma in situ (D03.-)</i>

?

Report both codes

Documentation must reflect separate sites within same anatomic location – per ICD grouping



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Bilateral conditions

- When available, report bilateral conditions with bilateral codes
- Even when only unilateral treatment is provided

Bilateral Condition Is:	Treatment is:	Code as:
Present bilaterally	Unilateral	Bilateral
Present bilaterally	Bilateral	Bilateral
Present unilaterally – Previously treated side is healed or no longer present	Unilateral	Unilateral – list side treated If applicable; History of code for previously treated side

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Bilateral Conditions

Patient presents with swelling and pain of both ears. On exam, manipulation of auricle causes pain and a furuncle is present at left pre-auricle area.
Gentle debridement of both ears and neomycin applied.
Assessment: otitis externa cellulitis
Rx: hydrocortisone drops.
ICD-10-CM: H60.13 Cellulitis of external ear, bilateral

Patient returns in follow-up of otitis externa cellulitis. Patient states right side is better, left still hurts.
Exam shows condition is resolved on right. Left side ear canal is red, swollen, and littered with moist, purulent debris.
RX: Continue hydrocortisone drops
Ciprofloxacin 500 mg po bid for 10 days
ICD-10-CM: H60.12 Cellulitis of left external ear

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Etiology / Manifestation

Condition with underlying etiology and manifestations


- Sequencing rules apply
 - Underlying condition or cause is listed first
 - Manifestation of this condition or cause is listed second
- Code first/Use additional code
 - Links cause or etiology to condition being treated
 - May help to show complexity of care needed

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Directional Terms - Updated

- Watch for “code first” and “use additional code” guidance
L51 – Erythema multiforme
Use additional code for adverse effect, if applicable, to identify drug
- “if applicable” was added to guidance for 2017

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Example

Combination Code

75 year-old **Type 1 diabetic** female patient presents with small raised, yellow and somewhat waxy lesions on lower part of her legs.

Final Diagnosis: Necrobiosis lipoidica diabetorum

ICD-10-CM code: E10.620 Type 1 DM with diabetic dermatitis

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Example


One Condition / Two Codes

Patient presents for follow-up of non-pressure chronic ulcer of right ankle secondary to Type 1 diabetes. Breakdown of ulcer is limited to skin. Diabetes is followed by primary care.

Final diagnosis: non-pressure ulcer, DM type 1

ICD-10-CM codes:

- E10.621 Type 1 Diabetes mellitus with foot ulcer
Use additional code to identify site of ulcer
- L97.311 Non-pressure chronic ulcer of right ankle limited to breakdown of skin
Code first any associated underlying condition


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Directional Term Updates

- With – as listed in code title or Alphabetic index
L05.01 Pilonidal cyst with abscess
- May be documented as “associated with” or “due to”
- Presumes causal relationship of linked terms

- Even in absence of documentation linking conditions
- If unrelated – Document as not related



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Example

28 year old male presents with painful, swollen lesion in the sacrococcygeal region. Review of systems is negative for fever, chills or drainage at lesion site. **No abscess** is present at this time. Patient states that he had a similar lesion in the area approximately one year ago that disappeared spontaneously.

Final Diagnosis: Pilonidal cyst

ICD-10-CM Code: L05.91 Pilonidal cyst without abscess



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Episode of Care - Clarification

- Initial care – A
 - **Each** encounter where active care is provided
- Subsequent care – D
 - Encounters occurring after active treatment is **completed**

Initial care includes

- Initial visit for the condition
- While patient is receiving active treatment for the condition
- Surgical treatment, emergency department encounter



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Documentation Should Reflect Episode

Follow up patient for second degree caustic burns on back of right hand from drain cleaner. Doing well on steroids and topical medication. No signs of infection. Continue on current medications. Dressing changed, patient to return in two days for dressing change.

ICD-10-CM Codes: T23.661D Corrosion of second degree of back of hand, right

T54.3X1D Toxic effect of corrosive alkalis and alkali-like substances, accidental



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Complications of Care

- Based on documented relationship between condition and previous care or procedure
 - Not all conditions occurring during or after procedures or treatment are considered complications
 - Documentation must reflect cause-and-effect relationship
- Complication codes may reflect episode of care
 - Active treatment – treatment of the condition described by the code



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Example

Patient returns 5 days after punch biopsy with infection at biopsy site.


ICD-10-CM Code: T81.4XXA Infection following a procedure, initial encounter



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LCD Utilization and Limitations Guidelines


- Guidelines set out by Medicare
 - Discuss the conditions affected by the policy
 - List the conditions covered under the policy
 - Describe what constitutes medical necessity
 - Describe what can cause claim payment denial
- Usually found on the first page of the LCD
 - Under Coverage Guidance



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Novitas Solutions Inc. (MAC) Local Coverage Determination (LCD): Removal of Benign Skin Lesion) (L34938)		
Policy applies to	Reasons for non-coverage	Reasons for Coverage
SKs, Skin Tags, Milia, Molluscum contagiosum, Seb. (epidermoid) cysts, Moles (nevii), Acquired hyperkeratosis (keratoderma) and Viral warts (excluding condyloma acuminatum)	Skin lesions that <i>do not pose a threat to health or function is considered cosmetic</i> and as such is not covered by the Medicare program.	Consider skin lesions as <i>medically necessary, and not cosmetic, if one or more of the following conditions is present and clearly documented</i> in the medical record: <ul style="list-style-type: none"> • Lesion has one or more of these characteristics: bleeding, intense itching, pain; • Physical evidence of inflammation, e.g., purulence, oozing, edema, erythema; • Obstructs an orifice or clinically restricts vision; • In an anatomical region subject to recurrent physical trauma and there is documentation that such trauma has in fact occurred; • Wart removals will be covered under all the above <ul style="list-style-type: none"> • In addition, if periocular wart, must be associated with chronic recurrent conjunctivitis • Evidence of spread from one body area to another, particularly immunocompromised patient




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Documentation

- Documentation in the medical record is critical in coding to ensure that every aspect of the patient condition and care is captured
- Use of the utilization and limitations guidelines can help improve your MR documentation
- Consider including words like:
 - Bleeding
 - Intense itching
 - Pain
 - Physical evidence of inflammation, e.g., purulence, oozing, edema, erythema
 - Obstructs an orifice or clinically restricts vision
 - Anatomical region subject to recurrent physical trauma



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Documentation Example 1

A 17 y/o girl has a *1.1 cm raised brown nevus on her mid back that rubs on her bra. You remove it using a shave technique.* Pathology report shows a benign compound nevus, and the lateral and underlying dermal margins are clear, confirming complete removal of the nevus.

You report:

11302 – shaving of epidermal or dermal lesion, single lesion, trunk, lesion diameter 1.1 – 2.0cm

- Complete removal of this lesion does not make this an excision.



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Documentation Example 2

82 yo female patient presents with *linear, splayed, vertical patterns of lesions on her chest.* States over time, they have increased, *get caught in neck chain, are inflamed and causing pain.* They started off light tan in color, but have progressed to becoming dark brown.

You report:

17110 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions



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Documentation Example 3

A *1.2 cm flesh-colored polypoid nodule on the upper thigh* of a 45 y/o man is *irritated by his clothing. It is removed at the base with scissors, exposing underlying fat,* and hemostasis is achieved with electrocautery. Pathology confirms a benign fibrofatty polyp.

You report:

11402 - Excision, benign lesion including margins, except skin tag, excised diameter 1.1 – 2.0 cm




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Removal of Benign Lesion LCD

The LCD, further states the following will allow coverage

- If clinical diagnosis is uncertain, particularly where malignancy is a realistic consideration based on lesional appearance (e.g. non-response to conventional treatment, or change in appearance).
- Prior biopsy suggests or is indicative of lesion malignancy or premalignancy.


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Documentation Example 4

50 yo boater has *discreet but irregular 8mm shiny red flat lesion on his back. Clinical diagnosis is probable superficial BCC and a specimen is obtained for pathology with curettage as a definitive procedure with therapeutic intent to cure.* Pathology confirms a benign diagnosis.


You report:

17110 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

- If pt presented with more than 15 lesions, you would report **17111** – Destruction of benign lesions; 15 or more lesions



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Novitas Solutions, Inc. (MAC) Local Coverage Determination (LCD): MOHS Micrographic Surgery (MMS) (L34961)		
Policy applies to	Reasons for non-coverage	Reasons for Coverage
MOHS Micrographic Surgery (MMS) CPT Codes: 17311 - 17315	Recurrent and primary AK, with focal SCC in situ; Bowenoid AK; SCC in situ (AK type) of any size in all areas in healthy or immunocompromised patients. BCC/SCC located in Area L * See AAD Appropriate Use Criteria (AUC)	<ul style="list-style-type: none"> • Requires a single physician to act in 2 separate and distinct capacities: surgeon and pathologist. • Qualifications of the physician and office/facility team. • Characteristics of the lesion (per-procedure). • Documentation of the Medical Necessity <ul style="list-style-type: none"> • If either of these responsibilities is delegated to another physician or other qualified health care professional who reports the service(s) separately, the MMS codes should not be reported • The qualifications of the performing physician must be verifiable if requested by the Contractor. <ul style="list-style-type: none"> • Providers of MOHS surgery a limited to MD or DO • The AUC provide necessary consideration of MOHS micrographic surgical treatment of a lesion.; • See LCD Documentation Requirements section


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Medicare on Mohs

- After careful review, Medicare Jurisdictions adopted coverage for Mohs in accordance with the **2012 Appropriate Use Criteria (AUC) for Mohs Micrographic Surgery** as published in **JAAD Volume 67, Issue 4, pp 531-550, October 2012**
- MMS appropriate only when:
 - Superficial (lateral) or deep margins of the cancer lesion are uncertain clinically.
 - Likelihood of surgical cure and reconstruction would be compromised without use of immediate microscopic examination of the surgical margins.
- The medical records should clearly show that MMS was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important).




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CMS MLN Matters® Number: SE1318

Guidance To Reduce Mohs Surgery Reimbursement Issues *(Applies to all Medicare carriers)*

- Documentation should support the medical necessity for Mohs procedure
- Operative notes and pathology documentation must clearly indicate:
 - That Mohs was performed using accepted MMS technique;
 - That physician acted in two integrated, but distinct, capacities as surgeon and pathologist;
 - That the location, number, and size of the lesion(s) treated;
 - That the number of stages performed; and
 - That the the number of specimens per stage.




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MLN Matters SE1318 Cont'd

Medicare Documentation Requirements

- Describe histology of the specimens taken in the first stage. Description should include:
 - Depth of invasion;
 - Pathological pattern;
 - Cell morphology; and, if present,
 - Perineural invasion or presence of scar tissue.
- Subsequent stages: note pattern and morphology of the tumor (if still seen) is as described for the first stage
 - Or, if differences are found, note the changes



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Documentation Requirements Cont'd

- ICD-10-CM/CPT code(s) submitted must be supported in the medical record
- Documentation (pre-procedure E/M note and/or post-procedure operative notes) must address
 - Why the lesion will not be (was not) managed by standard excision or destruction technique and (when applicable)
 - Why (when utilized or referred to a plastic surgeon) procedures for complex repair, adjacent tissue transfer or rearrangement, flap, or graft codes are employed.



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Documentation Requirements Cont'd

- Diagnosis is appropriate for MMS and that it is the appropriate choice for treating a particular lesion.
- The primary procedure options and repair options were discussed with the patient and clearly noted in the pre- or post- procedure documentation.
- Document why the lesion will not be (was not) managed by excision or destruction technique.
- MMS was performed using accepted MMS technique, in which the physician acts in **two integrated and distinct capacities: surgeon and pathologist** (therefore confirming that the procedure meets the definition of the CPT code(s)).



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Documentation Requirements Cont'd

- **Operative Note:** document location, number, and size of the lesion(s); number of stages performed; number of specimens per stage
- **Histology Note:**
 - **First stage:** if tumor present, depth of invasion; pathological pattern of the tumor; cell morphology; if present, note perineural invasion of scar tissue
 - **Subsequent stages:** if the tumor characteristics are the same as in the first stage, note this fact only. If the tumor characteristics are different from the first stage, describe the differences.




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Mohs Micrographic Surgery Appropriate Use Criteria

Why was it developed?

- Utilization of Mohs increased over 400% between 1995 and 2009
 - 1 in 4 skin cancers are treated with Mohs
 - Variation in use across the country
- Allows specialty to 'self-regulate' and preserve the procedure for patients/tumors where benefit felt to be greatest;
- More AUC may be forthcoming
- Oversight AUC Cmte proposed

- Collaborative effort between AAD, ASDS, ACMS, & ASMS
- Over 75 physicians involved balance of COI, practice type, geographic location
- Payer representatives invited to participate
 - First Coast
 - Noridian
- Took 13 months to complete
- Co-published in *JAAD and Dermatological Surgery*




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AAD Appropriate Use Criteria

- **270 indications**
 - BCC
 - SCC
 - Lentigo maligna
 - Other rare cancers
- **3 Areas of the Body**
 - H—M—L
 - Based on risk for recurrence and surgical difficulty

<https://www.aad.org/practice-tools/quality-care/appropriate-use-criteria>




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AAD Definition of Appropriate

An appropriate treatment modality is one in which the anticipated clinical benefit combined with clinical judgment, exceeds the possible negative consequences for a specific indication.

- Anticipated clinical benefits of MMS may include high cure rate related to total margin assessment, low rate of recurrence, small defect size, range of reconstructive possibilities, retention of functional capacity, and low morbidity and mortality.
- Negative clinical consequences of MMS may include the possible risks of an extended surgical procedure under local anesthesia, risk of incorrectly interpreted margins, and risks associated with office-based surgery.



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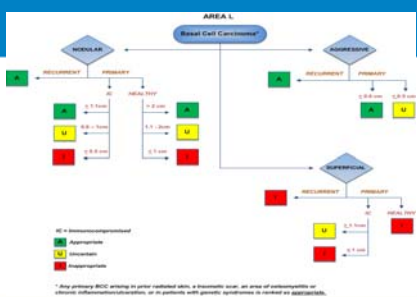
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So What is Appropriate?

- Tumors in Area H and M are generally appropriate
- Smaller tumors in Area L (trunk & extremities) may not be appropriate
- Immunocompromised patients generally appropriate
- Recurrent tumors also generally appropriate in any location



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Area H	*Face, genitalia, hands, feet, nail units, ankles, nipples/areola	*central face, eyelids, eyebrows, nose, lips
Area M	Cheeks, forehead, scalp, neck, jawline, pretibial surface	
Area L	Trunk and extremities	Excls. pretibial surfaces, hands, feet, nail units and ankles
Immunocompromised	HIV/AIDS, organ transplant, hematologic malignancy or pharmacologic suppression	
Genetic Syndromes	BC nevus syndrome, xeroderma pigmentosa, or other syndromes at high risk for skin cancer	
Healthy	no immunosuppression, no prior radiation therapy to affected area, no chronic infections and no genetic syndromes that predispose to skin cancer	
Prior Radiated Skin:	previously received therapeutic radiation in this area of the body.	
Aggressive features	Skin cancers having one or more of the following features have a higher incidence of local recurrence and regional metastasis such that minimal margin excision may not be in the beneficiary's best interest	



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Mohs Takeaway

- The physician (MD/DO) performing Mohs micrographic surgery must be specifically trained and highly skilled in MMS techniques and pathologic identification.
- If a surgeon performs an excision using Mohs surgical techniques but does not personally provide the histologic evaluation of the specimen(s), the CPT codes for MMS shall not be used.
 - Instead standard excision codes should be chosen for such medically necessary services (e.g., 11600 – 11646).
- Medicare is aware that a biopsy of the skin lesion for which Mohs surgery is planned may be necessary in order for the physician to determine the exact nature of the lesion(s) to be removed. Occasionally, that biopsy may need to be done on the same day that the Mohs surgery is planned.
 - In order to allow separate payment for a biopsy and pathology on the same day as Mohs surgery, the -59 modifier is appropriate. The 59 modifier is also appropriate when a separate skin lesion, other than the lesion for which Mohs surgery is performed, is biopsied on the same day that the Mohs surgery is performed.



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Mohs Takeway

- If a prior biopsy of the site undergoing Mohs surgery has been previously performed within the last 60 days, the surgeon should make a reasonable effort to obtain those results rather than repeating the biopsy.
- Reporting both Mohs Micrographic Surgery CPT codes 17311-17315 and Surgical Pathology CPT® 88302-88309 on tissue used for margin evaluation during Mohs surgery is inappropriate and will indicate that true Mohs surgery was not done. Such claims for Mohs surgery (17311-17315) will be denied. There are occasional clinical situations in which tissue separate from the tissue examined during Mohs surgery is appropriately submitted for subsequent formalin fixed processing and histopathologic examination. The submitted tissue is not the same tissue that was processed during the Mohs surgery. It may constitute a tissue margin beyond that evaluated with Mohs surgery or it may involve a totally unrelated tissue specimen. In such situations both the Mohs surgery and the histopathology are subject to coverage. In such cases the clinical record must clearly show the reasoning for the histopathologic specimen and interpretation.



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