

Billing and Coding Guidelines

Mohs Micrographic Surgery (MMS) (**DERM – 004 L30713**)

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

Effective Date

07/16/2010

Revision Effective Date**Ending Date****AMA CPT/ADA CDT Copyright Statement**

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CMS National Coverage Policy**Title XVIII of the Social Security Act (SSA):**

Title XVIII of the Social Security Act, Section 1862 (a)(1)(A), this section allows coverage and payment for only those services considered medically reasonable and necessary.

Title XVIII of the Social Security Act, Section 1833 (e), this section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 30, Physician Services

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16, Section 120, Cosmetic Surgery

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12 Section 40-40.6, Surgeons and Global Surgery

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 60, Payment for Pathology Services

CMS Transmittal No. 434, Publication 100-04, *Medicare Claims Processing Manual*, Change Request #3458, January 14, 2005, Addition of CLIA Edits to Certain Health Care Procedure Coding System (HCPCS) Codes for Mohs Surgery.

Coding and Billing Guidelines

General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

Medicare is aware that a biopsy of the skin lesion for which Mohs' surgery is planned is necessary in order for the physician to determine the exact nature of the lesion(s) to be removed.

The National Correct Coding Initiative does not permit payment for the biopsy and the Mohs' surgery on the same lesion, in the same operative session, on the same date of service. It is NOT appropriate to report the 59 modifier (distinct procedural service) when the biopsy and Mohs' surgery is performed on the same lesion, in the same operative session, on the same date of service. The -59 modifier should be reported when a biopsy or excision of lesion is performed in situations other than stated above.

The use of CPT codes 17311-17315 is reserved for the surgeon who removes the lesion and prepares and interprets the pathology slides. The surgical pathology codes 88300-88309 and 88331-88332 and 88342 are part of the Mohs surgery and are bundled into 17311-17315. The surgeon should not append Modifier 59 to these pathology codes unless they pertain to a separate biopsy/excision that does not involve Mohs surgery.

Report the appropriate Mohs surgery code for the body location surgery performed effected, with include any applicable surgery modifiers and the appropriate quantities for the specimens mapped in the days/units field. The quantity should be entered into the days/units field as "00010" for the first stage code and the appropriate number for the additional stages. Report CPT code 17312 for additional stages with first stage code 17311. Report CPT code 17314 for additional stages with first stage codes 17313. All the surgical procedure performed in the same operative session, including repairs should be reported on the same claim.

Do not report multiple instances of 17312 on separate claim lines. These should be totaled and entered as a single item with appropriate units of service greater than one.

Do not report multiple instances of 17314 on separate claim lines. These should be totaled and entered as a single item with appropriate units of service greater than one.

For each additional (separate) lesion treated with Mohs surgery on the same day, bill each first stage as a 17311 or 17313 as appropriate, on a separate claim line with a -59 modifier. Separately identify the additional stages for these lesions by billing the 17312 or 17314 on separate claim lines with a -59 modifier, and the appropriate units of service for these lesions.

CPT code 17315 may be used to report each block after the first 5 blocks for any single stage (17315 is used as an add-on code to 17311, 17312, 17313 or 17314). Please note that this code refers to the number of blocks, not number of slides.

In order to allow separate payment for a biopsy and pathology on the same day as MMS, the -59 modifier is appropriate:

- when the lesion for which Mohs surgery is planned has not been biopsied within the previous 60 days; or

- when the surgeon cannot obtain a pathology report, with reasonable effort, from the referring physician; or
- when the biopsy is performed on a lesion that is not associated with the Mohs surgery.

If Mohs on a single site cannot be completed on the same day because the patient could not tolerate further surgery and the additional stages were completed the following day, you must start with the primary code (CPT code 17311) on day two. Computer edits will reject claims where a secondary code (e.g., CPT code 17312) is billed without the primary code (e.g., CPT code 17311) also appearing on same date of service, same claim.

For claims submitted to the carrier or Part B MAC:

Report the -59 modifier on the same line as the biopsy procedure code and the pathology procedure codes: 11100, 11101, and 88331. Do not report modifier -59 on the same detail line as the Mohs surgical procedure.

A Clinical Laboratory Improvement Act (CLIA) certification number is required on all claims submitted for Mohs surgery billed with any of the following CPT codes, 17311-17315. The CLIA number should be submitted in item 23 of the CMS 1500 claim form or the electronic equivalent.

Claims for Mohs surgery services are payable under Medicare Part B in the following places of service: office (11), inpatient hospital (21), outpatient hospital (22), ambulatory surgery center (24), independent clinic (49), federally qualified health center (50), state or local public health clinic (71) and rural health clinic (72).

Note: The facility fees for the listed procedure codes are not reimbursable with place of service 24, ambulatory surgery center (ASC) although physician fees are reimbursable.

For claims submitted to the fiscal intermediary or Part A MAC:

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-08, *Medicare Program Integrity Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*

- *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.*

Documentation Requirements

*The majority of simple skin cancers can be managed by simple excision or destruction techniques. The medical records should clearly show that Mohs surgery was chosen because of the complexity, size and/or location of the lesion.

The operative notes and pathology documentation in the patient's medical record must clearly show that Mohs micrographic surgery was performed using accepted Mohs technique, with the physician performing both the surgical and pathology services. The notes should also contain the location, number and size of the lesion(s), the number of stages performed, and the number of specimens per stage.

If reporting the -59 modifier with a skin biopsy/pathology code on the same day the Mohs surgery was performed, the physician's documentation should clearly indicate:

- That the biopsy was performed on a lesion other than the one on which Mohs surgery was performed;
- If the biopsy is of the same lesion as the Mohs lesion, that a biopsy of that lesion had not been done within the previous 60 days; or
- If there has been a recent (within 60 days) biopsy of the same lesion as the Mohs lesion, the results of that biopsy were unobtainable despite reasonable effort by the Mohs surgeon.

Documentation must be available to Medicare upon request.

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "indications and limitations of coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Denial Summary

The physician performing Mohs micrographic surgery must be specifically trained and highly skilled in MMS techniques and pathologic identification.

The following situations will result in denial of the initial surgical services or in some cases as a result of post payment review.

1. Services will be denied as not medically necessary when the "Indications and Limitation" criteria stated in DERM-004 are not met.
2. Services will be denied as not covered by Medicare when the services are determined to fall under one of the Medicare program "Exclusions", i.e., cosmetic surgery.
3. Services will be denied as inclusive when multiple lesion excision codes are reported for excision of the same lesion
4. Physician services submitted without an ICD-9 diagnosis code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.

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Note: Facility fees are now reimbursable in an ASC, but are limited so that the total facility fee is exactly offset by the site of service facility reduction in the physician payment as Mohs surgery is considered an "office-based" procedure". This means that the total reimbursement for the procedure equals that for the non-facility physician fee, but the fee is apportioned between the ASC and the physician with the above formula.

Does this LCD contain a "Least Costly Alternative" Provision?

No

Revision History Number/Explanation

*06/01/2011, corrected typo to add the word simple to the sentence "The majority of simple skin cancers can be managed by simple excision or destruction techniques."; 10/01/2010, one, replaced words "The physician performing Mohs micrographic surgery must be specifically trained and highly skilled in MMS techniques and pathologic identification."

Publication Date

*05/01/2011; 10/01/2010

Notes:

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