

## **Final Comments and Responses for Mohs – DERM 010**

### **Comment #1**

It was suggested that the description for aggressive features for basal cell carcinoma (BCC) is not accurate since micronodular basal cell carcinoma is not aggressive.

### **Response #1**

Per the National Comprehensive Cancer Network (NCCN) histological subtyping of BCC as a predictor of risk of recurrence is a well-established concept. The subtypes encompassed by the term “aggressive growth pattern” including micronodular, infiltrative, sclerosing, and morpheaform (or desmoplastic) patterns are more likely to recur than the nodular and superficial BCC. Non-aggressive subtypes include the keratotic variant, infundibulocystic variant, and fibroepithelioma of Pinkus. Thus, micronodular basal cell carcinoma will remain subtyped as aggressive.

### **Comment #2**

Perineural is not a basal cell carcinoma but rather a squamous cell carcinoma.

### **Response #2**

While perineural invasion is not a common finding in BCC the incidence is increasing and there is a high risk of local recurrence. Therefore, it will remain in the list as an aggressive feature of basal cell carcinoma and also squamous cell carcinoma.

### **Comment #3**

There are too many entries in aggressive squamous cell carcinoma. Grading as intermediate or high grade should be enough for squamous cell carcinoma.

### **Response #3**

The aggressive features listed for squamous cell carcinoma are for high-risk for recurrence. They are more specific to provide guidance for a practicing clinician and are based on the collaborative work of the American Academy of Dermatology, American College of Mohs Surgery, and American Society for Dermatologic Surgery Association and the American Society for Mohs Surgery. Squamous cell carcinoma will continue with listings for aggressive features.

### **Comment #4**

Mohs surgery on the back and other areas where conserving real estate are not crucial should not be covered.

### **Response #4**

The appropriate use criteria process synthesizes evidence-based medicine, clinical practice experience, and expert judgment. The American Academy of Dermatology in collaboration with the American College of Mohs Surgery, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery has developed appropriate use criteria for 270 scenarios for which Mohs

micrographic surgery (MMS) is frequently considered based on tumor and patient characteristics. These appropriate use criteria have the potential to impact health care delivery, reimbursement policy, and physician decision making on patient selection for MMS, and aim to optimize the use of MMS for scenarios in which the expected clinical benefit is anticipated to be the greatest. In addition, recognition of those scenarios rated as uncertain facilitates an understanding of areas that would benefit from further research. Each clinical scenario identified in the 2012 Appropriate Use Criteria (AUC) document is crafted for the average patient and not the exception. Thus, the ultimate decision regarding the appropriateness of MMS should be determined by the expertise and clinical experience of the physician. The developed indications are not intended to be a comprehensive roster of the scenarios for which MMS could be considered, but are intended to represent approximately 85% of anticipated clinical scenarios. Seventy experts reviewed and approved these scenarios. While the trunk area is not indicated to be covered as often as other areas of the body per this document the intent is to provide guidance for the rational use of MMS in the practice setting.

#### **Comment #5**

It was suggested that there is one erroneous transcription from the Mohs AUC into the policy under “II. Squamous Cell Carcinoma, H. Primary SCC KA type, not central facial (immunocompromised patients), ii. Size > 0.5 cm, 2. No coverage for area L.” Rather, it should state that H, M and L are all covered for SCC KA-type in immunosuppressed patients >0.5 cm as stated in the Mohs AUC.

#### **Response #5**

Per the 2012 Appropriate Use Criteria for Mohs micrographic surgery article the primary SCC KA-type; not central facial (immunocompromised patients) is considered an appropriate use for the size greater than or equal to “0.6 cm”. The LCD will be updated to reflect this size recommendation of  $\geq 0.6$  cm.

#### **Comment #6**

Dermatofibrosarcoma protuberans and atypical fibroxanthoma are both listed as appropriate indications for Mohs surgery, yet the ICD9 and ICD10 codes for those diagnoses are missing from the draft. For ICD9: 171.0- 171.9 and for ICD10: C49.0-49.9 codes should be added.

#### **Response #6**

ICD-9 code 238.2 (Neoplasm of uncertain behavior of other and unspecified sites and tissues, skin) and ICD-10 code 49.2 (Neoplasm of unspecified behavior of bone, soft tissue, and skin) will be added for the diagnosis of Dermatofibrosarcoma protuberans. ICD-9 codes 173.0-9 (Other and unspecified malignant neoplasms of skin) and ICD-10 codes C44.0-9 (Other and unspecified malignant neoplasms of skin) are present and should be used for the diagnosis of atypical fibroxanthoma.

#### **Comment #7**

How should a basal cell carcinoma without a subtype be handled? The original biopsy is often too small to be able to definitively subtype a lesion and some pathology labs do not mention the subtype, especially if the lesion is a nodular basal cell carcinoma. It was suggested that a note be made that when the subtype of a basal cell carcinoma is not mentioned by the pathologist. Follow the rules for nodular basal cell carcinoma, the most common type of basal cell carcinoma.

#### **Response #7**

A basal cell carcinoma with no mention of a sub-type and of any size will be listed to follow the same indications as for a primary nodular basal cell carcinoma.

#### **Comments #8**

There is no mention of certain subtypes of basal cell carcinoma, including adenoid, cystic, adamantoid and fibroepithelioma of Pinkus. Similar to above, it was recommended that these be handled the same as nodular basal cell carcinoma, as they are not more aggressive than the “run of the mill” nodular basal cell carcinoma.

#### **Response #8**

The subtypes of basal cell carcinoma that include adenoid, cystic, adamantoid and fibroepithelioma of Pinkus, will be listed to follow the same indications as for a primary nodular basal cell carcinoma.

#### **Comment #9**

It was suggested that there was an erroneous value under” I. Basal Cell Carcinoma, D. Primary Nodular BCC (immunocompromised patient), iii. Size  $\geq 2$  cm.” Rather it should state that the size should be  $\geq 1.1$  cm.

#### **Response #9**

There is a gap in the size guideline between the 1 cm and 2 cm indicators listed for the I. Basal Cell Carcinoma, D. Primary Nodular BCC (immunocompromised patient). The LCD will be updated to eliminate this size gap and to read “ $\geq 1.1$  cm”.

#### **Comment #10**

This LCD draft does not provide insight into coverage for circumstances where tissue associated with Mohs Micrographic Surgery is submitted for formalin fixed processing and subsequent histopathologic examination. The American Academy of Dermatology has published a Position Statement on Appropriate Uses of Paraffin Sections in Association with Mohs Micrographic Surgery. Furthermore, a February 2014 AMA CPT Assistant article has specifically tackled these subjects which are included as an attachment to this letter. We suggest the following paragraph be inserted at the conclusion of the Mohs Surgery LCD Limitations Section:

*Reporting both Mohs Micrographic Surgery codes - 17311-17315 and Surgical Pathology codes - 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 (CPT 17311-17315) will be denied. There are occasional clinical situations in which tissue separate from the tissue examined during the 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 a situation both Mohs surgery and separate histopathology (CPT 88302-88309) are subject to coverage.*

#### **Response #10**

As defined by the American Medical Association Current Procedural Terminology (American Medical Association, Chicago, IL), Mohs Micrographic Surgery (MMS) is a technique for the removal of complex or ill-defined skin cancer with histologic examination of 100% of the surgical margins. It is a combination of surgical excision and surgical pathology that requires a single physician to act in two integrated but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another physician who reports the services separately, these codes should not be reported.

Mohs micrographic surgery is a two-step process: the tumor is removed in stages, followed by immediate histologic evaluation of the margins of the specimen(s). Further excision is performed until all margins are clear. The physician performing MMS furnishes both the surgical and pathological services, i.e., the excision and the histologic evaluation of the specimen(s).

By definition there is histological examination of 100% of surgical margins with Mohs micrographic surgery. Tissue from an unrelated tissue specimen would be a separate procedure from Mohs micrographic surgery and would not be included in CPT 17311-17315.

#### **Comment #11**

“Area M and/or L would rarely be medically necessary,” is listed 17 times under the heading: “Medicare will consider reimbursement for MMS for the following indications and anatomical locations.” We suggest that in each instance where the document reads: “...would rarely be medically necessary” the following phrase be substituted:”

- “...but may be covered on pre-payment redetermination”
- Or “ ... would rarely be medically necessary” but “can be appealed on a pre-payment basis with a patient signed Advance Beneficiary Notice (ABN).”
- Below are examples of where this suggested substitute language may be inserted: I, B, 2; I.C. ii, 2; I, D, ii, 2; I, E, I 2; I, F, ii, 2; II, A, iv, 2; II, D, ii, 2; II, E, i, 2; II, E, ii, 4, I, 1; II, E, ii, 5, ii,2; II, E, ii, 6, ii, 2; II, E, ii, 7, iii, A, 2; II, E, ii, 7, iii, C, 2; II, E, ii, 7, iv, D, 1; II, E, ii, 7, iv, H, 1; II, E, ii, 7, iv, L, 2; and II, E, ii, 7, iv, P, 1; 8, II.

#### **Response #11**

Medicare does not pre-authorize these services. In areas described in the document as “rarely medically necessary” for removal through MMS, we are indicating this would be an exception and documentation would need to support the medical necessity of the service. The medical records should clearly show that Mohs surgery was chosen because of the complexity, size and/or location of the lesion and why other approaches are not medically necessary and reasonable. 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 same 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. This information is in our documentation requirements section of the policy. Denied claims may be appealed and providers can submit documentation to support the service.

#### **Comment #12**

Under II. Squamous Cell Carcinoma, A. Recurrent SCC of any size, ii. Verrucous Pathology, 1. Area H, add areas “M and L”.

#### **Response #12**

In the document used to develop this LCD, areas M and L were not assessed or scored by the ratings panel for Recurrent SCC of any size, Verrucous Pathology. Therefore there is no data to compel adding these two areas to the policy.

#### **Comment #13**

Clarification of sequencing was requested for section “II. Squamous Cell Carcinoma” to list the category headings with capital letters instead of numbers.

#### **Response #13**

The section “II. Squamous Cell Carcinoma” already contains category headings with capital letters.

#### **Comment #14**

Clarification of sequencing was requested for major headings of “Basal or Squamous Cell Carcinoma, Lentigo Maligna and melanoma in situ, and Other less common skin cancers” to list the headings with Roman numerals.

**Response #14**

The major headings are already listed with Roman numerals.