AAD Comments on Proposed Medicare Fee Schedule for 05

The proposed rule, published on August 5, 2004, included implementation plans for provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The Academy raised concerns on: the Sustainable Growth Rate (SGR) formula, the re-pricing of clinical practice expenses for equipment, practice expense inputs for PDT, the proposed update to professional liability insurance (PLI) relative value units (RVU), corrections to Addendum B and Addendum C, the incentive payment improvements for specialty physician services in workforce shortage areas, and payment reform for covered outpatient drugs and biologicals.

Proposed Update to Professional Liability Insurance Relative Value Units

The Academy is disappointed with the proposal for the Five-Year Review of the Professional Liability Insurance (PLI) relative values. It is understood that CMS is required by statute to update this component by January 1, 2005. However, AAD urged CMS to consider this implementation “interim” until the agency has worked with physicians to ensure that the methodology for this important component of Medicare physician payment is appropriate. The proposed update includes results that are counter-intuitive. The Omnibus Budget Reconciliation Act of 1990 requires CMS to consult with physician organizations when the agency reviews all relative values at least each five years. To date, no concerted effort has been made to do so with the PLI relative values, which are very important to many specialties, which face critical decisions regarding the medical liability insurance crisis today.

Academy Authorizes Practice Expense Survey of Members

The Board of the American Academy of Dermatology Association has authorized and urges dermatologists to participate in a telephone survey the AADA is conducting to determine the practice expenses incurred by owning and operating a dermatology practice. The AADA is an organization that represents the interests of dermatologists on matters related to government policy and socio-economic issues. The AADA has contracted with DOANE Marketing Research, Inc. to conduct the telephone survey on its behalf.
Dear Derm Coding Consult Reader:

This issue includes an article on Mohs Micrographic Surgery and related services, which clarifies many of the special coding requirements. This article appeared in the July 04 issue of AMA CPTAssistant and is reprinted with AMA permission.

The Academy has contracted with Doane Marketing Research to administer a practice expense survey of members. The Practice Expense Supplemental Survey (PESS) will provide valid dermatology specific practice expense information based primarily on tax data and financial questions regarding individual physician share of practice operating costs including: rental/lease agreements, employee salaries/benefits, medical equipment/supplies as well as other administrative costs. The results of the PESS survey will be analyzed by AAD to determine whether there is advantage to AAD members in providing the survey results to CMS for use in the Practice Expense validation and update process. If you are selected, please participate!

Welcome to the Coding and Reimbursement Task Force as Derm Coding Consult’s new Editorial Advisory Board members. I wish to thank Lenore S. Kakita, MD, James D. Maberry, MD, and John A Zitelli, MD for serving on Derm Coding Consult’s Editorial Advisory Board since December 1996. Their insights and comments have ensured that it has stayed true to it’s mission of providing up-to-date information on coding and reimbursement issues. I also want to extend my best wishes to Alice Church, CCS-P, who is now with the Advocate Health System and thank her for contributions to this newsletter as well as the key role she played in the conceptualization and construction of the AAD’s 2004 Coding & Documentation Manual which has been enthusiastically received by members.

Best regards,

Norma L. Border, Editor
Now for your Medicare patients:

No hurdles

No hassles

NEW J Code
J0215
Mohs Micrographic Surgery

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Mohs surgery is a technique for the excision of skin cancer. It is a combination of surgical excision and surgical pathology. The Mohs surgery family of codes - CPT codes 17304-17310 - is unique because it includes the only CPT codes that describe procedures that involve surgery and pathology services performed together by the same surgeon or pathologist. This dual responsibility requires policies that differ from other surgical codes and has led to confusion among those unfamiliar with the use of these codes. This discussion explains the codes, the policy for their use, and the rationale for this policy so that providers, coders, and payers can all understand coding for Mohs surgery. This is an update of the Winter 1994 CPT Assistant.

General Description
Typically, Mohs surgery is an outpatient procedure usually done under local anesthesia. The basic tenet is excision followed by complete surgical margin exam by the Mohs surgeon and precise mapping of tumor containing margins so that the surgeon can re-excise positive margins. The details of the procedure require that the visible cancer be removed first (debulking) without attempting to remove a margin of normal tissue. After the bulk of the tissue is removed, the first layer or stage is excised as a thin continuous wafer of tissue, typically 1 to 3 mm thick, around the sides and base of the wound. Hemostasis is achieved, and the patient is bandaged and discharged to the waiting room.

This thin cup or saucer shaped wafer of tissue is flattened by cutting it into pieces (blocks) or making radial incisions to flatten the tissue. The smallest number of tissue blocks are created that will allow the performance of sectioning in the cryostat. The edges of the tissue are color coded with dyes that persist through histologic tissue processing. Once the wafer is cut into pieces and color-coded, a drawing or map of this tissue and its pieces is made so that it corresponds to the surgical wound. These tissue pieces, disassembled like a puzzle, are processed by frozen section pathology. Each flattened piece (or tissue block) is mounted, frozen, and sectioned horizontally. These frozen sections create an image of 100% of the surgical margin. Microscopic examination of this image allows the Mohs surgeon, who also functions as the pathologist, to identify the location of any remaining tumor. Its location as seen through the microscope is marked on the map of the surgical wound.

If the frozen sections indicate residual tumor, the patient is called back from the waiting room, reanesthetized, prepped, and draped for the next Mohs surgical stage. The Mohs surgeon, using the marked map of the wound, excises any remaining tumor as in the previous stage(s). This process of excision of remaining tumor, mapping, and histologic exam is repeated until all of the tumor is completely excised.

This Mohs method of margin exam differs significantly from traditional frozen sections used during routine surgery for margin exam. Traditional techniques use bread loaf surgical specimens, providing an image that includes a vertical cut through the tissue. This offers a view of the center of the specimen, and the lateral and deep margins, but it only samples these images every few millimeters or centimeters. This sampling technique typically examines far less than 1% of the margin. Because traditional pathology examination of surgical margins is only a sampling and may miss true positive margins, wider surgical margins are usually used for non-Mohs skin cancer surgery. Conversely, Mohs surgery using 100% examination of the margin allows excision with very narrow margins. This results in both narrower surgical margins overall, easier reconstruction of smaller operative wounds, and higher cure rates.

Coding for Mohs Surgery

17304 Chemosurgery (Mohs' micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain; first stage, fresh tissue technique, up to 5 specimens

Code 17304 is used for the first layer of Mohs surgery. Roughly 60% of Mohs cases require only a single layer. Code 17304 includes the preservice work of explanation of the procedure, informed consent, and preparation of the patient for surgery. The intraservice work includes local anesthesia, debulking of the visible tumor, excision of the first Mohs layer, color-coding of the specimens, and mapping. It also includes the pathology services of tissue preparation, microscopic examination, and mapping of positive margins. Finally, the intraservice work includes final evaluation of the tumor-free wound to determine wound management. The postservice work includes the discussion of postoperative wound management. It is important to understand these components of physician work and their relation to relative value units (RVUs) because they determine the coding and reimbursement policies.

The use of these codes is restricted to situations where one physician acts as both surgeon and pathologist. Performance of the entire procedure by one physician increases the accuracy of the technique as the risk of mapping errors is minimized. The codes are not appropriate for use when a surgeon excises tissue interpreted separately by a pathologist, even if the histologic exam is done by enface or horizontal techniques and a map is made by a pathologist for the surgeon. In those cases – something erroneously described as "modified" Mohs – the surgeon should code the appropriate excision and/or repair codes and the pathologist should report the appropriate codes for his or her service.

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Code 17304 is used for the first layer only and includes the work of excision and pathology of up to five specimens. If the tissue layer is large enough that it must be cut into six or more specimens in order to examine the entire surgical margin, then code 17310 (each additional specimen, after the first 5 specimens, fixed or fresh tissue, any stage) should be used for each additional one specimen beyond the first five included in 17304.

As the number of tissue blocks increases, the potential for false positive or false negative results rises, so efforts are made to evaluate each layer in as few blocks as possible. In certain circumstances, more than one slide may be prepared from the tissue block. The additional slides, regardless of the number of sections cut from the block, still count as a single specimen.

The work of processing and interpretation of one routine stain is included in the reimbursement for codes 17304 through 17310. This stain is usually hematoxylin and eosin, or toluidine blue. If other special stains are necessary after one routine stain, then the code for special stains may be used (88314), as well as immunoperoxidase stains (88342), or decalcification procedures (88311). Special stains are not typically used and in most practices are of low frequency.

Multiple Surgery: Modifier 51, Exempt
Under most circumstances, when two or more services are performed on the same patient at the same operative session on the same date of service, modifier 51 is appended. This identifies a secondary service associated with less physician work and practice expense than if it were a primary service and, therefore, is usually reimbursed less than the primary service. Some carriers refer to this as the multiple surgery reduction rule. The Mohs surgery family of codes is exempt from the need to append modifier 51.

For example, when two or more separate tumors are treated on the same day, CPT code 17304 is reported for the first stage of each tumor. This does not require the use of modifier 51 because code 17304 is exempt from Medicare's multiple surgery reduction rule. (CPT Appendices list codes exempt from the use of modifier 51. Appendix E lists 17304, 17305, 17306, and 17307 and; Appendix D lists 17310 as an add-on code. All Mohs codes are exempt from the use of modifier 51.)

The rationale for this policy is that for many surgical procedures some of the work of a procedure is not repeated when two or more procedures are performed. For these procedures the intraservice work is only 50% of the total work, while the other 50% represents pre- and post-service work that overlaps when multiple procedures are performed on the same patient on the same date of service. For Mohs surgery, however, greater than 80% of the work is intraservice work that does not overlap when two or more procedures are performed. The pathology portion of Mohs surgery constitutes a large portion of this total and also is not reduced with multiple procedures. The preservice and postservice work values are small because there is a zero day global period. Together there is very little overlap or reduction in work when two or more tumors are treated on the same patient on the same day. Therefore, codes 17304-17310 are exempt from the use of modifier 51.

Codes 17305-17307
17305 Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain; second stage, fixed or fresh tissue, up to 5 specimens

17306 Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain; third stage, fixed or fresh tissue, up to 5 specimens

17307 Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain, additional stage(s), up to 5 specimens, each stage

Codes 17305-17307 describe the second and subsequent stages of Mohs surgery to remove positive surgical margins. The RVUs already reflect any reduction in work done for these repeat procedures compared to code 17304 (see Appendix E, CPT 2004). No debulking procedure is done for these codes; they represent only the additional surgical work for re-excision of positive margins and the additional pathology work for interpretation of the specimens. Like code 17304, these codes are exempt from the multiple surgery reduction rule and do not require modifier 51. When four or more stages are performed in one day, code 17307 should be used with an appropriate number of units for each additional stage. For example, if a tumor was excised with a total of five layers (stages), then codes 17304, 17305, and 17306 would each be reported one time, and code 17307 would be reported with 2 units for the additional two stages.

When Mohs surgery is performed on a single tumor but is carried over to a second day, the first layer on the next day should continue with the next code in the series. For example, the second day starts with code 17305, 17306, or 17307 but not code 17304 because no debulking is
necessary. Each layer represented by 17305, 17306, or 17307 includes up to five specimens in each layer. For any individual stage that has more than five specimens, code 17310 should be used.

**Code 17310**

17310 Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathologic preparation including the first routine stain; each additional specimen, after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure)

Code 17310 is used for unusually large tumors requiring more than five tissue blocks in any layer. It is used for less than 10% of tumors excised by Mohs surgery. This code represents the incremental increase in work for both surgery and pathology for these larger tumors. Code 17310 is reported once with the appropriate number of units for each additional specimen, after the first five specimens in any stage. A specimen is defined as a piece of tissue from the layer that must be examined individually and is similar to a tissue block. That is, it represents one piece of the puzzle of the Mohs surgery map. It does not represent the number of slices of tissue from the block on the glass slides or the total number of slides.

Code 17310 is an add-on code and cannot be reported without codes 17304, 17305, 17306, or 17307. Reimbursement is typically not reduced when submitted more than once (see Appendix D, CPT 2004). When two or more tumors are treated in one day, code 17310 is reported for each piece of tissue beyond five for any one layer. It is not appropriate to add and average all pieces from all layers. For example, if the first tumor layer was divided into six pieces, and the second tumor layer had three pieces then code 173110 would be submitted once for the sixth specimen in the first tumor layer.

**General Issues: Skin Biopsy Before Mohs Surgery**

It is generally recognized that a skin biopsy and histologic diagnosis is necessary before beginning Mohs surgery. If a definitive diagnosis of the tumor is not available, the Mohs surgeon may perform a biopsy to confirm a diagnosis of skin cancer before the decision to initiate Mohs surgery. In this instance, the biopsy codes 11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion, and 11101, Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure), and frozen section surgical pathology code 88331 may be reported separately in addition to Mohs surgery. A biopsy may also be required if:

- A biopsy report is not available with reasonable effort
- A biopsy has been done more than 90 days before surgery
- The original biopsy is ambiguous

Modifier 59 should be used with the biopsy (e.g., 11100 with modifier 59) and pathology (e.g., 88331 with modifier 59) codes to document that these are separate services that are not components of Mohs surgery and that may be bundled erroneously into Mohs surgery if the modifier is not used. It is not appropriate to report a biopsy or frozen section with Mohs surgery for routinely reviewing the histopathologic features of the tumor being treated.

Code 11100 is reported for the first biopsy and code 11101 for a biopsy of second or subsequent skin cancers in different locations. Code 88331 is used for the pathology interpretation of each skin biopsy specimen. Code 88332 is used only if a single surgical specimen is cut into separate tissue blocks for separate examination and usually is not billed with Mohs surgery.

**Reconstruction**

Some wounds after Mohs surgery are allowed to heal spontaneously by secondary intention without reconstruction of the wound; and, therefore, no RVUs are included in the Mohs family of codes for surgical repair. Secondary intention is the spontaneous healing of a wound by granulation and new skin regrowth. If surgical repair is necessary, then the repair codes (simple, intermediate, complex, flaps, and grafts) should be submitted separately. If another procedure is performed on the same day as Mohs surgery, such as reconstruction, typically both procedures should be reimbursed in full since Mohs surgery, is exempt from the multiple surgery reduction rule, and the repair is performed at a separate operative session. If two Mohs surgeries are performed on the same day with both involving reconstruction, the second reconstruction procedure only is subject to the 50% multiple surgery reduction rule.

**Evaluation and Management Services**

Evaluation and management (E/M) services provided on the same day as Mohs surgery may be reported if a significant separately identifiable service is documented. A separately identifiable service may include an initial evaluation of a new patient, an initial consultation, or other E/M service, or it may include the decision to perform surgery. Modifier 57 is utilized for the E/M service to indicate the decision to perform surgery.

If an E/M service is performed with Mohs surgery alone, or when a repair code with a global period less than 90 days is done, the E/M service should be submitted with modifier 25 appended. If an E/M service is performed on the same day as a surgical reconstruction with a 90-day global period (i.e., flap or graft), the E/M service should be submitted with modifier 57 according to Medicare guidelines. A separate diagnosis for...
the E/M service and for the Mohs surgery is not required per
CPT guidelines (see modifier 25 in CPT Appendix A).

E/M services following Mohs surgery may be reported
depending on the global period of any surgical
reconstruction services done with Mohs surgery. If the
wound was allowed to heal by secondary intention and no
other service other than Mohs surgery was performed, a zero
global postoperative period applies, and any E/M services
provided after Mohs are reported without modifiers. If
reconstruction is performed with Mohs surgery, the 90-day
global period of the reconstruction applies and no E/M
service is allowable during the global period. However, an
E/M service may be reported if it is for an unrelated service,
in which case modifier 24, Unrelated evaluation and
management service by the same physician during a
postoperative period, would be appended.

Complications
Sometimes complications such as wound infection,
bleeding, hematoma, or wound dehiscence may require a
return to the operating room, (defined as a room dedicated
to the performance of surgical procedures). In this instance,
modifier 78, return to the operating room for a related
procedure during the postoperative period, would be appended
to the appropriate procedure (e.g., incision and
drainage of hematoma).

References
American Medical Association. Medicare RBRVS: The

Federal Register. Vol 64, No 211. November 2, 1999;
59410-59411.

Federal Register. Vol 64, No 211. November 2,1999; 59428.

Glossary
Block: Tissue flattened by cutting into pieces, embedded,
and frozen in mounting medium used by histotechnologists
to embed tissue for frozen sections.

Debulking: Initial removal of the bulk of the tissue prior to
the first stage.

Layer: Interchangeable with stage.

Mapping: Producing an illustration depicting color-coded
pieces drawn to correspond with the surgical wound. The
map provides orientation to the surgeon while reading the
pathology.

"Modified" Mohs: A procedure in which the surgeon submits
tissue to a pathologist who prepares slides for examination
in a manner similar to the Mohs surgeon. Do not report
codes 17304-17310 for this staged excision procedure. The
surgeon uses appropriate excision and repair codes, and the
pathologist reports pathology codes, as appropriate.

Repairs: Reported additionally as simple, intermediate,
complex, flaps and grafts.

Routine stain: A combination of hematoxylin and eosin, or
toluidine blue. Note that toluidine blue stain may be
infrequently needed as a special stain (e.g., for perineural
invasion or areas of dense inflammation) in addition to
hematoxylin and eosin.

Secondary intention: Spontaneous healing of a wound by
granulation and new skin regrowth.

Specimen: The unit of service for pathology codes.

Stage: Each layer of surgical excision including frozen
section processing of horizontal sections with pathologic
examination of margins.

Academy Authorizes Practice Expense Survey of Members
— continued from page 1

What is this study about?
The AADA advocates on behalf of the specialty of
dermatology and provides information on many issues to
government officials and policymakers. Your participation
ensures that the AADA will accurately represent you to
those who affect policy. The information that is being
collected does not exist anywhere else and therefore your
participation is important.

What type of information will be collected?
In this survey, the AADA will be collecting information
about you and your practice, including practice expenses,
hours worked, and participation in Medicare. No
information regarding income will be collected.

How will the information be used?
The AADA will use the results from the study to represent
dermatologists on issues of concern to the dermatology
community. Aggregate information obtained from the survey
will be presented to governmental policymakers for their
consideration. You may be selected as part of a statistically
controlled random sample that represents dermatologists across
the United States. Your participation is critical to ensuring that
the data are representative of dermatologists in the private
practice setting. Both members and nonmembers of the
AADA are included in the sample so the findings represent
all dermatologists in the private practice setting.

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How long will this take?
On average, the interview lasts less than 20 minutes.

What about confidentiality?
Both the AADA and DOANE Marketing Research, Inc. will ensure the confidentiality of your data. Any information that would permit identification of a participant or individual dermatology practice will be treated as strictly confidential and will not be disclosed to anyone outside of DOANE Marketing Research. All individual survey responses will remain anonymous to both the AADA staff and any other party who might be asked to consider the survey results. Therefore, there will be no risk of any personally recognizable expense data being attributed to you.

How will the information be collected and who will collect it?
The data will be collected during a telephone interview with a trained interviewer from DOANE Marketing Research, Inc., an independent survey and research organization.

The type of information the survey is seeking is listed in the survey worksheet. If you have been selected, DOANE Marketing Research, Inc. will contact you by phone to conduct the survey within the next few weeks. Your effective participation is critical to the success of this effort. If you have any questions or concerns about participation in this survey, please contact Norma Border, Sr. Manager, Health Policy & Practice at 847 240 1814.

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