Position Statement
on
Documentation of Frozen Section Specimens during
Mohs Micrographic Surgery Academy Approved Certifying Boards
(Approved by the Board of Directors: November 7, 2015)

Pursuant to MLN Matters Number SE1318:
The Centers for Medicare and Medicaid Services (CMS) have issued new guidance regarding documentation for Mohs surgery to avoid claim denials. As this guidance is general in nature, offering a plan for documentation but not providing specific details regarding how such documentation should be provided in a practical context, American Academy of Dermatology Association (AADA), American College of Mohs Surgery (ACMS), American Society for Mohs Surgery (ASMS) and American Society of Dermatologic Surgery (ASDS) have prepared the following detailed suggestions regarding documentation. These suggestions are not meant to be exhaustive, and other means of satisfying the guidance provided by CMS are possible and may be appropriate.

Please note that the MLN Matters Number SE1318 does not have an effective date. Your local Medicare Administrative Carrier (MAC), which may have adopted the guidelines, may have an implementation date. Also be aware that where necessary, you can review your Mohs slides and make an addendum to the report to satisfy these requirements so long as the additional documentation is signed and dated.

Documentation regarding indications for Mohs:
When Mohs surgery is appropriate for treatment of a particular lesion, this should be documented in the chart. Appropriate reasons include complexity (including poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (including maximum conservation of tumor-free tissue is important). The above examples in parentheses are not exhaustive, and other circumstances may meet the criteria for complexity, size or location.

If there is a current Mohs Surgery Local Coverage Determination (LCD) from your local Medicare contractor, please consult this for details regarding appropriate indications. The previously published Appropriate Use Criteria on Mohs Micrographic Surgery (AUC) should also be taken into consideration. Chart documentation may include one or more reasons for the selection of Mohs. Affirmation regarding the appropriateness of Mohs is implied, and need not be explicitly stated, when a well-accepted reason for performing Mohs is included.

Documentation regarding number and location of specimens taken during Mohs
Each stage of Mohs on a particular lesion will entail removal of one or more specimens. In many cases, a stage may require removal of only a single specimen. A primary objective of Mohs is minimization of risk of recurrence and this requires maintaining tissue orientation during harvesting, hence the preference for a single, properly oriented specimen. However, multiple specimens may be removed during a stage when a preceding stage has two or more disparate and non-continuous areas with tumor involvement. After harvesting, the specimen(s) are inked, mapped and subdivided for processing into the appropriate number of blocks needed for tissue processing.

Unless removal of more than one specimen per stage per lesion is required, the number of specimens is assumed to be one, and need not be explicitly specified. If there is a single specimen per stage, the location

of this specimen is assumed to be the previously documented location of the tumor. If more than one specimen is removed per stage per lesion, the location of the additional specimen(s) per stage should be specified. There is no stated requirement for specifying the location of the additional specimens per stage.

Specification of size of the lesion:
Either preoperative or postoperative lesion size may be included as indicators of lesion size, as the MLN SE1318 article does not specify which lesion size should be documented. If preoperative lesion size is selected, it should be understood that this is likely smaller than postoperative lesion size. In general, preoperative size is not considered highly relevant during Mohs since non-visible subclinical spread of skin tumors is common and routinely results in a significantly larger histologically verified post-operative size.

In cases when lesion borders are indistinct, other lesions are present nearby and are obscuring the borders of the lesion under treatment, or the lesion is situated within a scar or radiation field, the preoperative lesion size may be exceedingly difficult to measure accurately. In such cases, preoperative lesion size may only be roughly approximated, but it is implied that the true lesion extent may be significantly greater than what is easily visible.

Surgeon also performing pathology function:
By definition, Mohs surgery requires the surgeon to also function as the pathologist. If for a given case, excisional surgery is performed by one physician and interpretation of pathologic sections is performed by another, different physician, this two-physician procedure is not Mohs surgery, and should be reported as an excision.

A single physician's signature at the bottom of a Mohs surgery procedure note indicates that this physician and this physician alone was responsible for both the surgical and pathologic elements of Mohs surgery. Some physicians performing Mohs surgery may also wish to append a line explicitly noting that they served as both surgeon and pathologist. Note that MLN SE1318Mohs article specifies that Mohs surgery may only be performed by a physician, M.D. or D.O.

Notably, the above does not exclude additional consultative services beyond routine Mohs tissue analysis that may be required for particular cases of Mohs, with such services including formalin-fixed section analysis by a separate pathologist (Reference to Position Statement on Appropriate Uses of Paraffin Sections in Association with Mohs Micrographic Surgery and CPT Assistant© coding correction article, February 2014 page 10). Such services can be provided, and Mohs can still be said to have occurred.

Description of histology of specimens taken in the first stage:
The histologic findings in the first stage of Mohs should be described by the surgeon in the manner described below (see below: "**Histologic descriptions of the first and/or subsequent stages may include the following four elements").**

If during subsequent stages, the histology remains similar, no further documentation regarding histology is necessary. In this case, it is assumed that similar tumor remained present at the margins. If during subsequent stages, there are significant histologic findings distinct from the histologic findings described seen in the first stage, these findings may be additionally described in the operative note.

Importantly, to the extent that Mohs is designed to only check peripheral margins, and a significant proportion of tumors may be cleared in the first Mohs stage, it is possible for no tumor histology to be detected in the first stage. Additionally, there are cases in which dense inflammation may obscure residual tumor, which may not be resolvable as such, but in the estimation of the Mohs surgeon, removal of the inflammation by a subsequent layer of Mohs may be essential to ensure reasonable likelihood of tumor extirpation given a high risk of small foci of tumor hidden within the field of dense inflammation. Perineural chronic inflammation is a strong marker for neighboring perineural invasion and will often require removal of an additional stage.

Histologic description of the first and/or subsequent stages may include the following four elements

Depth of invasion:
Depth of invasion of most nonmelanoma skin cancers, which are the cancers most commonly treated by Mohs, includes epidermis and dermis, and often subcutaneous tissue. Mention of the deepest primary skin layer (i.e., epidermis, dermis, subcutis) into which tumor invaded is sufficient for description of tumor depth. In uncommon instances when tumor is deeper than subcutis, the deepest non-skin layer into which it proceeds (e.g., fascia, muscle, cartilage, bone, calvarium, etc.) should be specified.

Pathologic pattern:
Pathologic pattern of the tumor may be specified. Basal cell carcinomas have well-recognized pathologic patterns, and morphology may be described using these terms (e.g., nodular, micronodular, infiltrating/morpheaform, etc.). Similarly, for squamous cell carcinoma, patterns may be described as well, including degree of differentiation (e.g., moderate, poor, etc). Further histologic characterization may be mentioned, if pertinent. Some tumors may have a mixed pathologic pattern, including morphologic features of many or several pathologic subtypes, and if so, this may be noted. Description of pathologic pattern may be of limited relevance for describing some tumors and rare nonmelanoma skin cancers. In such cases, a brief relevant description may be provided or the lack of standard pattern may be noted. In some cases, the physician performing Mohs may choose to describe the pathologic pattern in more detail, with this particularly useful in cases of an unusual pathologic pattern.

Cell morphology:
Cell morphology in tumors treated by Mohs is rarely discussed except in routine terms (i.e., so-called "boilerplate") on dermatolopathology reports or on Mohs reports, as this is not generally relevant information for tumors treated by Mohs. Cell morphology may be briefly described even though it is of limited clinical value. Detailed specification of abnormal cell morphology is rarely clinically appropriate, and hence rarely provided.

Perineural invasion or presence of scar tissue:
Perineural invasion or presence of scar tissue may be occasionally seen during review of Mohs histology. If in the estimation of the physician performing Mohs these features are clinically significant, they may be reported in chart documentation. Only pertinent positive findings need to be noted.

In conclusion, while these general guidelines constitute the clinically relevant application of the summary guidance provided in MLN Matters SE1318 , documentation should always be tailored for the specific patient circumstances and procedures undertaken, and may in some cases be appropriately more or less extensive than the above.

Guidance for Additional Mohs Documentation:
Number of specimens per stage:

Note the number of specimens per stage, especially when this is greater than 1.
Noting the number of blocks per specimen is optional.

Histology of the first stage:

Specify the following 4 parameters:

(1) Depth of invasion (i.e., epidermis, dermis, subcutis, fascia, muscle, cartilage, bone, calvarium, etc.)

(2) Pathologic pattern (i.e., nodular, micronodular, infiltrating/morpheaform, etc., for BCC; and as appropriate for SCC and rare tumors). When tumor is poorly visible but sufficient dense inflammation that is concerning for tumor or perineural inflammation is evident that you take another stage, note this
(3) Cell morphology (i.e., of minimal clinical relevance, and usually boilerplate language)
(4) Perineural invasion or scar. Note as appropriate only if present.

Histology of subsequent stages:

No need to specify UNLESS different from the findings in the first stage.