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Dermatology Coding Alert

Mohs Procedure Update: Determine Medical or Cosmetic to Avoid Unnecessary Denials

You can earn as much as $550 by reporting wound closure correctly

When you report Mohs reconstruction, turn to repair, flap and graft codes to get the reimbursement your practice deserves.

Know the basics: Mohs surgery is a precise technique for treating skin cancers, such as basal cell and squamous cell carcinomas. Because Mohs surgery eliminates virtually all malignant cells with minimal damage to the surrounding skin, the dermatologist most often employs this technique to treat malignancies on the face and other cosmetically sensitive areas. Dermatologists also use Mohs procedures to remove skin cancers with ill-defined clinical margins and recurrent skin cancers.

Because Mohs surgery is more cosmetically sensitive, many patients who have the procedure require only simple closure. Sometimes, however, you may find that the dermatologist closed the wound using more complicated procedures such as intermediate (layered) or complex closure (13000 series), adjacent-tissue transfer (14000 series), or flaps and/or grafts (15000 series).

Take these steps to help you get a handle on reporting Mohs procedures and recoup full payment.

1. Know whether the procedure is medical or cosmetic.

Carriers may reject Mohs reconstructions on first submission because they assume that the dermatologist completed a cosmetic procedure. Even when the dermatologist documents that a cancer diagnosis is used in association with the reconstruction, some payers may deny claims with reconstructive flaps as cosmetic the first time around.

Solution: Document the medical necessity and Mohs procedure carefully. Make sure your documentation includes the ICD-9 codes that commonly require Mohs reconstruction, such as 172.0-172.8 (Malignant melanoma of skin), 173.4 (Other malignant neoplasm of skin; scalp and skin of neck), 173.5 (... skin of trunk, except scrotum), 173.6 (... skin of upper limb, including shoulder), 173.7 (... skin of lower limb, including hip) or 238.2 (Neoplasm of uncertain behavior; skin). If you still get denied, coding experts say, photographs of the defect may help demonstrate to the carrier why the reconstruction was a medically necessary procedure and not just a cosmetic procedure.

2. Review closure levels.

The dermatologist may perform one of many closures (simple, intermediate and complex repairs; adjacent tissue transfers; more extensive flaps; and, in extreme cases, grafts) after completing Mohs reconstruction.

Most of these repair codes vary by location. **Red flag:** Your documentation should include all details regarding location, size, depth and extent of closure. But performing many closures does not necessarily warrant increased pay.

Warning: Unfortunately, Medicare views same-operative-session excisions and re-excisions as one procedure, says **Pamela J. Biffle, CPC, CCS-P**, president of PB Healthcare Consulting and Education in Fort Worth, Texas. Therefore, if the dermatologist performs multiple same-day excisions on the same patient, he may report only one code based on the final widest excised diameter achieved at the end of the day\'s session.

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Coding example: If a surgeon excises a 0.5-cm lesion from a patient\'s cheek (11640, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less) and widens the margins to 0.8 cm after receiving a report of malignancy (11641, ... excised diameter 0.6 to 1.0 cm), you should only report the code that reflects the excision\'s final measurement, 0.8 cm in diameter, which would be 11641.

On the other hand, you may separately report a re-excision that occurs at a subsequent operative session. If the surgeon in the above example does not perform the re-excision until day four, she should report the excision with 11640 and the re-excision with 11641 appended with modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to indicate a staged procedure performed during the 10-day global of the original excision (11640), Biffle says.

One more thing: Deep defects may require the dermatologist to repair the defect in two or more stages. If the dermatologist performs a complex repair, adjacent tissue transfer, flap or graft procedure, any subsequent procedures fall within the first procedure\'s 90-day (for adjacent-tissue transfers, flaps and grafts) or 10-day (for complex and intermediate repairs) global period.

Extra: Many carriers require you to append modifier -58 to the code that describes the subsequent repair. Check your carrier\'s guidelines before appending any modifiers to make sure you\'ve met their requirements.

3. Look for multiple grafts and donor sites.

Mohs reconstruction may require the dermatologist to harvest grafts from two separate donor sites (from both upper eyelids for a graft on the nasal tip, for example) or he may perform more than one graft to repair the defect. To correctly code these situations, you should clearly state in the operative report the type of repair.

Exception: You can only report one tissue transfer code based on the size of the defect.

If the dermatologist performs a graft, the procedure notes should state whether it was a split- or full-thickness graft. You code both of these grafts by total area of the graft. Do not code the defect or the number of grafts the dermatologist performed. You must have documentation of the total area in the medical record.

Coding example: If the dermatologist performs Mohs surgery to develop a secondary defect using the z-plasty method of adjacent-tissue transfer to minimize scarring, you code the surgery with 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 [e.g., hematoxylin and eosin, toluidine blue]; first stage, fresh tissue technique, up to 5 specimens) and 17305 (... second stage, fixed or fresh tissue, up to 5 specimens).

You may report other Mohs procedure codes such as 17306 (... third stage, fixed or fresh tissue, up to 5 specimens), depending on the number of stages the surgeon deemed necessary by microscopic examination of the excised tissue, says **Patricia Tinker, CPC,** clinical practice manager in the department of dermatology at Yale University School of Medicine in New Haven, Conn.

You report the adjacent tissue repair with the appropriate 14000-series code, according to the site of the surgery and the size of the lesion, Tinker says.

Remember: If you report codes 17304-17310, your physician must be both a surgeon and a pathologist. If another physician carries only one of these responsibilities, these codes are not appropriate.

Note: Some graft codes include \"direct\" or \"primary\" closure of the donor site. If the dermatologist performs flaps or grafts, however, these are more extensive procedures than direct or primary closures, so you should report them separately.

Keep in mind: A graft is excised from a donor site, and a graft is placed in the recipient site.

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