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Dermatology Coding Alert

Mohs Procedures: 17311-17315 Means Dermatologist Must Wear 2 Hats

Is the physician also acting as the pathologist? If not, consider excision codes instead.

The Mohs codes (17311-17315) probably show up frequently on your claims forms. But are you certain they're appropriate each time?

Scenario: A patient presents with a confirmed diagnosis of primary squamous cell carcinoma on the vermilion border of the lower lip. To preserve the integrity of the healthy skin surrounding the neoplasm, the dermatologist decides to excise the lesion in layers.

The practice does not possess the clinical pathology equipment necessary to biopsy each excised layer, but they do have arrangements with a nearby hospital that allows for single-session excision and pathology. After the dermatologist removes tissue, it is taken to the hospital where pathology freezes and examines the section. The dermatologist receives a call within 10 minutes notifying him if the tissue sample is malignant. The dermatologist begins with a 1.8-cm excision, and proceeds with two more stages of lesion excision (comprising margins of 2.1 cm and 2.4 cm) before the hospital's pathologist is able to report no further sign of cancer. He then repairs the 2.4-cm defect using two advancement flaps.

Your challenge: Did the dermatologist in this scenario perform Mohs micrographic surgery? How should you accurately code his work?

Wear 2 Hats to Report Mohs

Even though the dermatologist painstakingly removed the malignant lesion layer-bylayer, you cannot report his work using Mohs chemosurgery codes (17311-17315, 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 histopathologic preparation including routine stain[s] [e.g., hematoxylin and eosin, toluidine blue ...]).

Reason: To report Mohs, the physician needs to work as both a surgeon and a pathologist. In this case, the pathological analysis was outsourced to a hospital.

What to look for: To report Mohs surgery appropriately, you need to verify that the dermatologist not only removed the lesion (one layer may be enough, notes **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas) but also prepared sequential slides and rendered a diagnosisto each one completed at that stage. Because Mohs involves frozen section pathology, you will also likely see documentation that the dermatologist immediately freezes the tissue samples after excising.

Report Same-Session Excisions Only Once

So if Mohs codes are not appropriate, how can you code for multiple same-session excisions? Unfortunately, under CPT® guidelines, you can only report one procedure to represent the dermatologist's work. Medicare views same-operative-session excisions and re-excisions as one procedure.

CPT® states, "Use only one code to report the additional excision or re-excision(s) based on the final widest excised diameter required for complete tumor removal at the same operative session." In this case, the widest margin is 2.4 cm, which should point you to 11643 (Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm).

Alternative: If a re-excision occurs at a subsequent operative session, however, you may report it using modifier 58 (Staged or related procedure or service by the same physician during the postoperative period).

For example, if the dermatologist in this scenario had to wait three days for the pathology report and a follow-up operative session, you could report the first 1.8-cm excision using 11642 (... excised diameter 1.1 to 2.0 cm), and 11643-58 (... excised diameter 2.1 to 3.0) for the separate-session 2.1-cm excision.

Global tip: You'll only append modifier 58 to the second procedure if it occurs during the first procedure's global period. The date of the second procedure resets the global period. You should expect 100 percent reimbursement for procedures you file with modifier 58. Make sure you deserve the reimbursement before you append the 58, advises **Elisabeth Janeway, CCP, CPC, CCS-P,** president of Carolina Healthcare Consultants in Winston-Salem, N.C.

Code Repair Based on Defect Size

In the above case, the dermatologist performs both the excision and the repair.

But what if a dermatologist encounters a patient for reconstruction after the patient has received Mohs from another physician?

Regardless of whether the reconstructive surgeon is new to the case or is the same person who performed the Mohs, report separate reconstruction codes for flaps or grafts.

In this scenario, the dermatologist uses two advancement flaps to repair a 2.4-cm excision. Remember: Even though he uses two flaps, there is only one defect site and therefore only one applicable code, 14060 (Adjacent tissue transfer or rearrangement, eyelids, nose, ears, and/or lips; defect 10 sq cm or less).

Look out: You may face challenges in repair approval because some carriers will initially classify as cosmetic a closure following a multi-step excision. To make your case for medical necessity, be sure to link the cancer diagnosis to your reconstruction code. In this case, you would use 140.1 (Malignant neoplasm of lip; lower lip, vermilion border) to report the squamous cell carcinoma.

Coming soon: Once ICD-10 is implemented, the above diagnosis code will change. Starting Oct. 1, 2013, you will instead report C00.1 (Malignant neoplasm of external lower lip).

Good idea: Even with this diagnosis, you may wish to submit photographic evidence of the defect to the carrier to further support the reconstructive rather than purely cosmetic nature of the surgery.