

Part B Insider (Multispecialty) Coding Alert

DERMATOLOGY: New Moh's Codes Could Spell Body-Part Bias--And Denials

Make sure your carrier revises its local coverage determinations

Sometimes more specific codes aren't a good thing.

CPT 2007 replaces the old Moh's microsurgery codes with five new codes, which break the procedure down into two anatomical areas: one for head, neck, hands, feet and genitalia--and one for trunk, arms and legs.

Some coders worry that this new division could lead to carriers and payors discriminating between the two body areas. - Any time they divide a code into body parts I am suspicious,- says **Christine Liles**, insurance supervisor with **Knoxville Dermatology Group** in Knoxville, TN. -It leads me to believe that they will be making it harder to get Moh's paid on one body part over the other.-

Check with your carriers: Your carriers may need to revise their local coverage determinations (LCDs) right away, worries Wendy Weisel, a coder with the Department of Dermatology at the University of Virginia Health Systems.

For example: Trailblazers will only cover Moh's for the legs, arms or trunk if the patient's diagnosis meets specific criteria. Trailblazers and other carriers also require you to use ICD-9 code 173.8, for -other malignant neoplasm- of an unspecified area. But for Moh's in the legs, arms or trunk, the correct ICD-9 code should be more specific, such as 173.7, for foot or leg, or 173.6 for arm or hand.

You should make sure your carrier is accepting the most accurate diagnosis codes for the region of the body where youre performing Moh-s, Weisel warns. Otherwise, you could be coding incorrectly. -Moh's is dermatology's high-dollar ticket,- and a major source for many practices, she notes. So you can't afford any denials or delays in payment.

No more separate stages: Also, the old Moh's surgery codes divided the add-on codes into second stage, third stage and each additional stage. But the new codes simply include one add-on code for each additional stage after the first.

This appears to mean that for a patient who needs three or four stages, you should bill multiple units of the -additional stage- code, says Weisel. -I have always had difficulty at one time or another when billing units to insurance companies. You have to watch your claim like a hawk to make sure they reimburse you correctly,- she frets. Or if you bill the add-on code multiple times, you may face duplicate denials.

Usually, Weisel will bill one to three stages of Moh-s, but she sometimes bills up to nine or 10 stages in one session. Having separate codes for the first few stages was a big help in getting paid, she says.

But Liles welcomes the change because it will simplify Moh's coding. -It never made much sense that they had different codes for the different stages since they were basically the same procedure,- she says. Instead of needing five or more codes to bill for a single session, she-II only need three at most.

For example: The physician performs Moh's on the face with three stages and five blocks in one stage. Using the old codes, you only bill 17304, 17305, 17306 and 17310. With the new codes, you only bill 17311, 17312, 17315, says Liles.

More code changes:



- You can now distinguish between destruction of premalignant or benign lesions. The new update revises the descriptors for 17000 and 17004 to make them only apply to premalignant lesions, and now 17110 is only for benign lesions other than skin tags or cutaneous vascular proliferative lesions.
- There are new codes for forehead flap with preservation of vascular pedicle (15731), cryosurgical excision of fibroadenoma using ultrasound guidance (19105), and excision of a cyst, fibroadenoma, or other tumor from aberrant breast tissue (19120).
- CPT 2007 deletes abdominoplasty code 15831 and adds two new codes for excision of excessive skin and subcutaneous tissue from the abdomen, 15830 and 15847.
- The new descriptor for breast reconstruction code 19361 clarifies that it doesn't include prosthetic implants, if any.