Medicare Coverage for Mohs Surgery: Be Familiar with LCDs

Most LCDs now cover Mohs surgery for melanoma, but coverage varies. Practices need to be familiar with the requirements of their specific Medicare payor.

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In response to several Mohs surgery questions directed to DermAnswers (the DermResources e-mail advice service: DermResources.com), we recently investigated Medicare Local Coverage Determinations (LCDs; Table 1) involving Mohs. The greatest difference we noticed since our last review of Mohs LCDs is that all now allow Mohs for malignant melanoma, mostly under very limited circumstances.

Coverage Varies

The majority of the LCDs had the following indication for melanoma: "Malignant melanoma or melanoma *in-situ* (facial, auricular, genital and digital) when anatomical or technical difficulties do not allow conventional excision with appropriate margins."

Several other LCDs use the above language but without any mention of specific body sites. One simply listed malignant melanoma as an indication with no conditions. All of the policies include Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), and Basilosquamous Cell Carcinoma of the mask areas of the face, the lips, and ears as indications for Mohs. Some policies are more liberal, including the chin, mandible, and neck. In addition, each LCD includes a section for aggressive pathology of certain body areas and/or certain types of lesions, e.g. a nail unit, genitalia, a lesion ≥2 cm, positive margins on recent excision. In some LCDs "aggressive pathology" is a category of its own; in others it is included in a list of "Other Lesions."

It is important to know how your Medicare payor lists the different types of lesions, because the diagnosis codes required vary among the LCDs. For example, Noridian (contractor for AZ, MT, ND, OR, SD, UT, WA, and WY) lists "aggressive pathology" and "other skin lesions" separately. Instructions for choosing ICD9 codes for "other skin lesions" read: "...for one of the skin lesions listed under 'Other Skin Lesions'...or for lesions included in the ICD9 range 232.0-232.9, the claim must be submitted with the diagnosis code 173.8..."

A very different message appears in LCDs for several other areas: "ICD-9-CM codes 173.5, 173.6, and 173.7 should only be used when the surgery is done on the trunk, arms, or legs for one of the indications listed under Other Skin Lesions." "ICD-9-CM code 173.8 should only be used when reporting malignant neoplasms of contiguous or overlapping sites of skin whose point of origin cannot be determined."

All of the LCDs discuss performance of a biopsy and frozen section on the same day Mohs is done. Instructions are consistent:

- Performed on a lesion other than the one on which Mohs is performed. OR
- Performed on the same lesion on which Mohs was performed and a biopsy of that lesion had not been performed within the previous 60 days. OR
- There has been a biopsy performed within the

Table 1. LCDs Reviewed

Part B LCDs were in place for:

- Washington, DC
- All US possessions
- All states except:

Alabama	Arkansas	Georgia
Louisiana	Maine	Massachusetts
Mississippi	New Hampshire	Rhode Island
Tennessee	Vermont	

17313 and 17314 Utilization

Another important issue relevant to Mohs Surgery is the increase in utilization of 17313 and 17314. Billing for these codes has increased by 10 percent or more in each of the past two years. If a similar increase occurs for a third year, there will be an automatic review of the codes by Medicare's relative value update committee (RUC), with potential for reduction in reimbursements or further restrictions on these codes implemented via Local or National Coverage Determinations. Because of this potential, Brett Coldiron, MD, president of the American College of Mohs Surgery, has encouraged Mohs Surgeons to consider whether skin cancers in areas other than the face require Mohs or could be adequately treated by excision, excision with frozen sections, or destruction to prevent continued increase in the utilization of 17313 and 17314.

previous 60 days but results could not be obtained despite reasonable efforts to do so.

Advice is given to append modifier 59 to both the biopsy and the pathology reading (88331, 88332) when provided under these circumstances.

All of the LCDs stress clear and thorough documentation of medical necessity. Some even require that the number assigned to a condition in the list of "Other Skin Lesions" be documented in the record. Some LCDs state that they will closely monitor appropriate billing through the medical review process and that failure to document properly may result in denial of claims.

Some LCDs state that the record must clearly show: that Mohs was performed, with the physician performing both the surgical and pathology portions; location, number and size of lesions; number of stages performed; and number of specimens per stage. If you perform Mohs surgery in your practice, be certain you have the latest LCD from your Medicare payor. While every attempt has been made to provide accurate information here, each practice should verify the information specific to its own Medicare payor. You can search Medicare's LCD database via the "Links" page at www.Dermresources.com. ■