| Priority Health | BILLING POLICY<br>No. 040 |
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| **MOH'S MICROGRAPHIC SURGERY** | |
| **Date of origin: Oct. 7, 2024** | **Review dates: 2/2025** |

# APPLIES TO
All products

# DEFINITION
Moh's micrographic surgery (MMS) is a two-step process where the tumor is removed in stages. Removal is followed by histologic evaluation of the margins of the specimen. Further excision is performed until all margins are clear. The physician performing MMS provides both the surgical **and** pathological services.

# POLICY SPECIFIC INFORMATION
## Place of service
In line with Medicare, the qualified physician must provide services in the appropriate setting for the medical need and condition. The MMS surgery facility must meet standards of care. Standard of care equipment includes:

- Cryostats
- Staining facilities (manual and/or automated)
- Access to immunohistochemical staining

## Documentation requirements
While not an all-inclusive listing, the medical record should clearly document:

- Describe why MMS was chosen and why other approaches are not reasonable (e.g., poorly defined clinical borders, possible deep invasion)
- Location, number and size of the lesion(s)
- The number of stages performed
    - Histology documentation should include:
        - If tumor is present
        - Depth of invasion
        - Pathological pattern
        - Cell morphology
- Number of specimens per stage
- Operative and pathology notes must clearly show that MMS was performed using accepted MMS technique, with the same physician performing surgical and pathology services.
- Measurements in support of repair (i.e. adjacent tissue transfer/rearrangements)

## Coding specifics
MMS services are reported within the CPT code range 17311 – 17315. These codes should be used by the physician that removes the lesion and prepares and interprets the slides. Certain skin biopsy, excision and pathology services are bundled into the MMS service.

- If either surgery or pathologist responsibilities are delegated to another physician, MMS services (17311-17315) shouldn't be reported.
- All surgical procedures that are performed within the same operative session should be reported on the same claim.
- Multiple instances of the add on codes should be totaled and entered as a single item.

- Repairs, grafts and flaps may be separately reportable with MMS.

### Bill types

- **011x**: Hospital Inpatient (Including Medicare Part A)
- **013x**: Hospital Outpatient
- **071x**: Clinic – Rural Health
- **073x**: Clinic – Freestanding
- **085x**: Critical Access Hospital

### Revenue codes

- **036x**: Operating Room Services – General Classification
- **051x**: Clinic – General Classification
- **052x**: Freestanding Clinic – General Classification
- **0761**: Specialty Services – Treatment Room

### Modifiers

- **59**: Distinct procedural service
- **XS**: Separate structure, a service that is distinct because it was performed on a separate organ/structure
- **XU**: Unusual nonoverlapping service, the use of a service that is distinct because it doesn't overlap usual components of the main service
- **58**: Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

Get more information on modifiers in our Provider Manual.

## RESOURCES

- LCD - Mohs Micrographic Surgery (L35494) (CMS)
- Article - Billing and Coding: Mohs Micrographic Surgery (A57477) (CMS)
- Medicare NCCI Policy Manual 2024 Chapter 3 (CMS)

## DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

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## CHANGE / REVIEW HISTORY

| Date | Revisions made |
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| Feb. 13, 2025 | Added "Disclaimer" section |