Practice Management Center

Educational Tool on Documentation of Frozen Section Specimens during Mohs Micrographic Surgery

Background

In 2020, the Centers for Medicare and Medicaid Services (CMS) issued general requirements for documentation for Mohs surgery but did not provide specific details regarding how such documentation should be provided in a practical context. Medicare Administrative Contractors (MAC) and some private payers have adopted the guidelines.

This Educational Tool provides more detailed suggestions regarding documentation to allow members to comply with the CMS requirements. These suggestions are not meant to be exhaustive, and other means of satisfying the guidance provided by the MACs and/or private payers are possible and may be required.

> ***TIP*** *If you receive denials due to documentation deficiencies, consider creating an addendum to the operative report to address the specific payer requirements. The addendum, supported by additional information obtained from the medical record, clinical photographs, Mohs maps, and/or pathology slides, must be signed and dated,*
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> *See Medicare Instructions for amending or correcting entries in medical records at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R732PI.pdf.*

Documentation regarding indications for Mohs

Documentation of clinical / pathologic reasons for why Mohs surgery is appropriate for a particular tumor / patient should be documented. Indications for Mohs surgery may relate to a tumor's complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size, or location. The above examples are not exhaustive, and other circumstances may meet the criteria for complexity, size, or location. Criteria for the appropriate use of Mohs surgery have been developed and published.(see Mohs Surgery Appropriate Use Criteria at https://www.aad.org/member/clinical-quality/clinical-care/au/mohs-surgery.)

TIP	*Regional MACs may have Local Coverage Determinations (LCDs) for Mohs surgery, and private payers may have their own policies regarding coverage of and payment for Mohs surgery. Refer to your MAC's LCD or consult private payer policies for details regarding specific coverage indications and limitations. The Appropriate Use Criteria on Mohs Micrographic Surgery (AUC)[1] should also be taken into consideration.*

The Mohs surgeon acts as the surgeon and as the pathologist

Mohs surgery may only be performed by a physician (MD/DO) who is specifically trained and highly skilled in Mohs technique and requires the surgeon to also function as the pathologist during the procedure. The operative note should clearly state that a single physician acted as both the surgeon and pathologist. If the surgeon performing the Mohs stage does not personally serve as the pathologist, appropriate excision code(s) should be reported rather than Mohs surgery codes.

The requirement that the Mohs surgeon acts as both surgeon and pathologist does not preclude the Mohs surgeon from obtaining consultative services from another pathologist. In certain instances, it is appropriate for debulked tissue or tissue taken during Mohs stages to be sent for permanent sections or additional special stains to better characterize the tumor. [2,3] Such services can be provided, and Mohs can still be documented as performed.

Specification of size of the lesion

Preoperative tumor size and post Mohs defect size should be documented in the operative note. Historically, lesion size is based on the preoperative clinical size of the lesion (e.g. excision). However, it should be understood that tumors are often ill-defined. Non-visible, subclinical and microscopic spread of skin tumors is common and routinely results in a significantly larger histologically verified post-operative size.

Documentation regarding the number and location of specimens taken during Mohs Surgery

In the context of Mohs surgery, the term "specimen" is interpreted as the number of contiguous pieces of tissue removed during a Mohs stage. Therefore, if a single piece (specimen) of tissue is removed during a Mohs layer, it should be documented as one specimen, even if it is subsequently sectioned into multiple sections during the grossing process. If greater than one piece of tissue (discontiguous removal) is harvested during a Mohs layer because of tumor foci on separate areas of a Mohs defect, that number should be documented. The location of removal is assumed to be the same as the body site where the skin cancer is located. The exact location within the Mohs defect should be included on the Mohs map but does not explicitly need to be described in the operative note.

Histologic description when tumor is present on the first stage

When tumor is present on the first stage, the operative note should include a description of the histology. This description should include the depth of invasion and the pathologic pattern. If present, the presence of perineural invasion and/or scar tissue should be documented. While it is typical for this information to be included on the Mohs map, it is also appropriate to be documented in the operative note.

If tumor is present on subsequent stages and the histology is the same as that in stage one, this can be noted without repeating a detailed description of the tumor. If subsequent stages have different histologic findings than the first stage, these changes should be documented.

There are circumstances in Mohs surgery where tumor is not identified, but dense or perineural inflammation is present, possibly obscuring residual tumor. In these instances, documentation of dense inflammation possibly obscuring tumor is adequate to justify the need to take a second stage.

Elements of histologic description to document

- **Depth of invasion:** The operative report should document the deepest primary skin layer into which tumor has invaded (e.g. epidermis, dermis, subcutis, fascia, muscle, cartilage, bone, calvarium).

- **Pathologic pattern:** The operative report should document the overall pathologic pattern of the tumor visualized in stage one using either the tumor / subtype designation or a histologic description.
    - Basal cell carcinomas have well-recognized pathologic patterns, and morphology can be described using these terms (e.g., nodular, micronodular, infiltrating/morpheaform, etc.).
    - Squamous cell carcinoma patterns can be described using degree of differentiation (e.g., well, moderate, poor, etc). Further histologic characterization may be mentioned, if pertinent.
    - Some tumors may have a mixed pathologic pattern, which can be noted.
    - In some cases, the physician performing Mohs may choose to describe the pathologic pattern in more detail, and this is particularly useful in cases that have an unusual pathologic pattern.

- **Perineural invasion or presence of scar tissue:** If present, perineural invasion or presence of scar tissue should be documented. It should be noted that documentation should always be tailored for specific patient circumstances and procedures undertaken and may, in some cases, be appropriately more or less extensive than the above.

Guidance for Additional Mohs Documentation:

- **Number of specimens per stage:**
    - Note the number of specimens per stage

- Noting the number of blocks per specimen should be reported.

- **Histology of the first stage:**
  Specify the following parameters:
  (1) Depth of invasion (i.e., epidermis, dermis, subcutis, fascia, muscle, cartilage, bone, calvarium, etc.)
  (2) Pathologic pattern (i.e., nodular, micronodular, infiltrating/morpheaform, etc., for BCC; and as appropriate for SCC and rare tumors). When tumor is not visible but sufficient dense inflammation is present that it is concerning for tumor or perineural inflammation, note this
  (3) Perineural invasion or scar. Note only if present.

- **Histology of subsequent stages:**
  No need to specify UNLESS different from the findings in the first stage.

References

1 Appropriate Use Criteria on Mohs Micrographic Surgery AAD/ACMS/ASDSA/ASMS 2012 appropriate use criteria for Mohs micrographic surgery: A report of the American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery (ctfassets.net) JAAD 2012:67:531-550

2 American Academy of Dermatology Position Statement: PS-Pathology Consultation or Paraffin Sections Compatible with Mohs.pdf

3 CPT Assistant© On-line coding correction article, February 2014 page 10 Coding Clarification: Mohs Surgery