Name of Policy: Mohs Micrographic Surgery

Policy #: 127
Category: Surgery

Latest Review Date: June 2011
Policy Grade: Active Policy but no longer scheduled for regular literature reviews and updates.

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
Description of Procedure or Service:
Mohs micrographic surgery (MMS, Mohs chemosurgery) is a surgical method for the excision of complex or ill-defined skin cancers in such a way as to conserve maximal amounts of normal tissue while allowing for histological examination of the entire surgical margin to ensure complete removal of the skin cancer. Thin, horizontal layers of cancerous tissue are removed in a staged procedure. Each layer is microscopically examined for tumor invasion by the surgeon. The procedure is repeated until no cancer cells remain. The goal of MMS is complete tumor removal with a maximum preservation of normal tissues. The Mohs surgeon acts as a surgeon and pathologist for this procedure. The procedure is performed as outpatient and using local anesthesia.

Policy:
Moh’s micrographic surgery meets Blue Cross and Blue Shield of Alabama’s medical criteria for coverage when one or more of the following conditions are met:

- Performed in anatomic areas with high risk of recurrence of tumor with ill-defined clinical borders. These areas would include involvement of the face (around the nose, mouth, eyes and central third of the face), external ear and tragus, temple, scalp, mucosal lesions, nail bed and matrix; or
- Performed in areas of important tissue preservation, including the face, ears, hands, feet, and genitalia; or
- Performed for history of recurrent malignant lesions regardless of anatomic site, or had positive margins on previous excision; or
- Performed for history of previous irradiation therapy; or
- Performed for large size lesions (2.0 cm or greater); or
- Performed for tumors associated with high risk of metastasis including those arising in the following: Bowen’s disease, discoid lupus erythematosus, chronic osteomyelitis, lichen sclerosus et atrophicus, thermal or radiation injury, chronic sinuses and ulcers, adenoid type

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:
Over half of all cancers are skin cancers in the United States in 2002 per statistics from Cancer, the journal for clinicians. The CDC reports that more than one million cases of the most common forms of skin cancer, basal cell or squamous cell cancer will be diagnosed in 2002. The most serious form of skin cancer, malignant melanoma, was expected in over 53,000 people. Malignant melanoma causes more than 75% of all deaths from skin cancer.
The National Cancer Institute has listed the standard treatment options for skin cancer to include simple excision with frozen or permanent sectioning for margin evaluation, electrodesiccation and curettage, cryosurgery, radiation therapy, carbon dioxide laser, topical fluorouracil (5-FU), systemic retinoids, interferon alfa, and photodynamic therapy. These therapies do have usefulness in specific clinical situations with cure rates ranging from 85% to 95%. Mohs micrographic surgery has the highest 5-year cure rates for surgical treatment of 96% for primary tumors and 90% for recurrent tumors. This method is complicated and requires special training. The tumor is microscopically delineated until it is completely removed.

According to the American Academy of Dermatology Association on Guidelines of Care for Mohs Micrographic Surgery, there are multiple well-accepted surgical and non-surgical approaches for the treatment of cutaneous neoplasms and skin cancers. Certain tumors, by virtue of their characteristics, may require a more precise level of treatment. MMS offers high cure rates for malignant skin tumors with maximum preservation of surrounding normal tissue. MMS is not indicated in the treatment of all skin tumors. Data continue to accumulate supporting the efficacy of narrow surgical margins in the treatment of melanoma. MMS may prove a useful technique for certain types and locations of melanoma. MMS may be used in the treatment of several less common malignancies or tumors. These may have ill-defined clinical margins with subclinical extension that can be identified microscopically. MMS may be used alone or as an integral part of an overall treatment approach.

January 2008 Update
A January 2008 update revealed no new peer-reviewed published literature or guidelines for MMS that would alter the coverage statement of this policy.

June 2009 Update
Mosterd et al published the results of a prospective randomized controlled trial with 5 years follow-up of surgical excision versus Moh’s micrographic surgery for primary and recurrent basal-cell carcinoma of the face. A total of 612 patients were randomly assigned to either surgical excision or MMS. The primary outcome was recurrence of carcinoma diagnosed clinically by visual inspection with histological confirmation. Findings revealed that in the primary basal cell carcinoma (pBCC) 113 were lost to follow-up and there were 11 recurrences identified. Seven occurred in patients with surgical excision and four treated with MMS. In the recurrent basal cell carcinoma (rBCC), 202 were treated, 56 BCCs in 52 patients were lost to follow-up. Two BCCs recurred in two patients treated with MMS and ten BCCs recurred in ten patients. The difference in the number of recurrences between treatments was not significant for pBCC, but significantly favored MMs in rBCC. Treatment of facial rBCC with MMS leads to a significantly lower number of recurrences than treatment with surgical excision. Recurrence after surgical excision for pBCC is shown to be higher than after MMS the difference in this study is not statistically significant. When choosing between two equally effective treatments, other factors such as cost, cosmetic outcome, preference, and practical use should also be considered. The authors concluded that MMS is preferred over surgical excision for the treatment of facial rBCC, on the basis of significantly fewer recurrences after MMS than after surgical excision. However, because there was no significant difference in recurrence of pBCC between treatment groups, treatment with surgical excision is probably sufficient in most cases of pBCC.
June 2011 Update
A June 2011 update revealed no new peer reviewed published literature or guidelines for MMS that would alter the coverage statement of this policy.

Key Words:
Mohs Micrographic Surgery, MMS, skin cancer, basal cell carcinoma, squamous cell carcinoma, melanoma, malignant melanoma, chemosurgery, Mohs chemosurgery

Approved by Governing Bodies:
Not applicable

Benefit Application:
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
BellSouth/AT&T contracts: No special consideration
FEP contracts: FEP does not consider investigational if FDA approved. Will be reviewed for medical necessity.
Wal-Mart: Special benefit consideration may apply. Refer to member’s benefit plan.
Pre-certification/Pre-determination requirements: Not applicable

Note regarding use of E&M services submitted concurrently with 17311-17315: An E&M code with either modifier 25 or 59 would only be submitted if the medical records document that a separate and identifiable E&M service unrelated to the Moh’s procedure was performed during the same session.

Current Coding:
CPT codes:
Effective for dates of service on or after January 1, 2007:

17311  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) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks

17312  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) (eg, hematoxylin
and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

17313 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) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

17314 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) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

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) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)

Previous Coding:
17304 Chemosurgery (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 complete histopathologic preparation including the first routine stain (e.g., hematoxylin and eosin, toluidine blue); first stage, fresh tissue technique, up to 5 specimens (Code deleted effective January 1, 2007)

17305 ;second stage, fixed or fresh tissue, up to 5 specimens (Code deleted effective January 1, 2007)

17306 ;third stage, fixed or fresh tissue, up to 5 specimens (Code deleted effective January 1, 2007)

17307 ;additional stage(s), up to 5 specimens, each stage (Code deleted effective January 1, 2007)

17310 ;each additional specimen, after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure) (Code deleted effective January 1, 2007)
References:

Policy History:
Medical Policy Group, July 2003 (1)
Medical Policy Administration Committee, July 2003
Available for comment September 23-November 6, 2003
Medical Policy Group, January 2005
Medical Policy Group, July 2006 (1)
Medical Policy Group, January 2008 (1)
Medical Policy Group, June 2009 (1)
Medical Policy Group, June 2011 (1) Update to Key Points
Medical Policy Group, June 2012 (1): Active policy but no longer scheduled for regular literature updates.

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.