Clinical Policy Title: Indications for Mohs micrographic surgery

Clinical Policy Number: CCP.1056

Effective Date: March 1, 2014
Initial Review Date: September 18, 2013
Most Recent Review Date: November 5, 2019
Next Review Date: March 2021

ABOUT THIS POLICY: Select Health of South Carolina has developed clinical policies to assist with making coverage determinations. Select Health of South Carolina’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Select Health of South Carolina when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state and federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Select Health of South Carolina’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Select Health of South Carolina’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Select Health of South Carolina will update its clinical policies as necessary. Select Health of South Carolina’s clinical policies are not guarantees of payment.

Coverage policy

Mohs micrographic surgery is considered clinically proven and, therefore, medically necessary when any of the following criteria involving indications and anatomic locations are met. Please see the Appendix for relevant conventions and definitions.

Basal cell carcinoma

- Recurrent basal cell carcinoma of any size or unexpected positive margin on recent excision (found in healthy or immunocompromised patients, or patients with genetic syndrome[s]).
  - Aggressive pathology.
    - Areas H, M, and/or L (defined in Appendix, below).
  - Nodular pathology.
    - Areas H, M, and/or L.
  - Superficial pathology.
    - Areas H and M only.
    - No coverage for area L.
- Primary aggressive basal cell carcinoma.
  - Size ≤ 0.5 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Size ≥ 0.6 cm.

Policy contains:
- Basal cell carcinoma.
- Malignant melanoma.
- Mohs micrographic surgery.
- Squamous cell carcinoma.
- Areas H, M, and L.
- Primary nodular basal cell carcinoma (healthy patients).
  - Size ≤ 0.5 cm – 1 cm.
    - Areas H and M only.
    - No coverage for area L.
  - Size 1.1 cm – 2 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Size ≥ 2 cm.
    - Areas H, M, and L.
- Primary nodular basal cell carcinoma (immunocompromised patients).
  - Size ≤ 0.5 cm.
    - Areas H and M only.
    - No coverage for area L.
  - Size 0.6 cm – 1 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Size ≥ 2 cm.
    - Areas H, M, and L.
- Primary superficial basal cell carcinoma (healthy patients).
  - Size ≤ 0.5 cm.
    - Area H.
    - Area M may be considered for coverage on redetermination.
    - No coverage for area L.
  - Size ≥ 0.6 cm.
    - Areas H and M.
    - No coverage for area L.
- Primary superficial basal cell carcinoma (immunocompromised patients).
  - Size ≤ 1.0 cm.
    - Areas H and M.
    - No coverage for area L.
  - Size > 1.0 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.

Squamous cell carcinoma.
- Recurrent squamous cell carcinoma of any size or unexpected positive margin on recent excision.
  - Aggressive pathology.
    - Areas H, M, and L.
  - Verrucous pathology.
- Area H.
  - Keratoacanthoma, not central facial.
    - Areas H, M, and L.
  - In situ squamous cell carcinoma (Bowen disease).
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Actinic keratosis with focal squamous cell carcinoma in situ; Bowenoid actinic keratosis; or squamous cell carcinoma in situ, actinic keratosis type.
    - Not covered.
  - Without aggressive histologic features, < 2 mm depth without other defining features, Clark level ≤ III.
    - Areas H, M, and L.
- Primary aggressive squamous cell carcinoma (healthy patients).
  - All sizes.
    - Areas H, M, and L.
- Primary aggressive squamous cell carcinoma (immunocompromised patients).
  - All sizes.
    - Areas H, M, and L.
- Primary squamous cell carcinoma without aggressive histologic features, < 2 mm depth without other defining features, Clark level ≤ III (healthy patients).
  - Size ≤ 1.0 cm.
    - Areas H and M.
    - No coverage for area L.
  - Size 1.1 cm – 2 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Size > 2 cm.
    - Areas H, M, and L.
- Primary squamous cell carcinoma without aggressive histologic features, < 2 mm depth without other defining features, Clark level ≤ III (immunocompromised patients).
  - Size ≤ 1.0 cm.
    - Areas H and M.
    - Area L may be covered on redetermination.
  - Size ≥ 1.1 cm.
    - Areas H, M, and L.
- Primary verrucous squamous cell carcinoma (healthy or immunocompromised patients).
  - All sizes.
    - Area H only.
    - No coverage for areas M and L, as this type of tumor in these areas is extremely rare. The rare occurrence may be covered on redetermination.
- Primary squamous cell carcinoma keratoacanthoma type, not central facial (healthy patients).
- **Primary squamous cell carcinoma keratoacanthoma type, not central facial (immunocompromised patients).**
  - **Size ≤ 1.0 cm.**
    - Areas H and M.
    - No coverage for area L.
  - **Size ≥ 1.1 cm.**
    - Areas H, M, and L.
- **Primary in situ squamous cell carcinoma (Bowen disease) (healthy patients).**
  - **Size ≤ 1.0 cm.**
    - Areas H and M.
    - No coverage for area L.
  - **Size 1.1 cm – 2 cm.**
    - Areas H and M.
    - Area L may be covered on redetermination.
  - **Size > 2 cm.**
    - Areas H, M, and L.
- **Primary in situ squamous cell carcinoma (Bowen disease) (immunocompromised patients).**
  - **Size ≤ 0.5 cm.**
    - Areas H and M.
    - No coverage for area L.
  - **Size 0.6 cm – 1 cm.**
    - Areas H and M.
    - Area L may be covered on redetermination.
  - **Size ≥ 1.1 cm.**
    - Areas H, M, and L.
- **Primary actinic keratosis with focal squamous cell carcinoma in situ; Bowenoid actinic keratosis; squamous cell carcinoma in situ, actinic keratosis type (healthy or immunocompromised patients)**
  - **Any size.**
    - Not covered.

**Basal cell or squamous cell carcinoma**
- **Primary basal cell carcinoma or squamous cell carcinoma, regardless of subtype, size, or depth arising in any of the following:**
  - Skin area that was previously irradiated.
  - Traumatic scar.
- Area of osteomyelitis.
- Area of chronic inflammation or ulceration.
- Patients with genetic syndromes predisposing to skin cancer.

- Areas H, M, and L (applies to all of the above).

**Lentigo maligna and melanoma in situ**

- Primary lentigo maligna (healthy or immunocompromised patients).
  - Areas H and M.
  - Area L may be covered on redetermination.
- Locally recurrent lentigo maligna (healthy or immunocompromised patients).
  - Areas H, M, and L.
- Primary melanoma in situ; non-lentigo maligna (healthy or immunocompromised patients).
  - Areas H and M.
  - Area L may be covered on redetermination.
- Locally recurrent melanoma in situ; non-lentigo maligna (healthy or immunocompromised patients).
  - Areas H, M, and L.

**Other less common skin cancers**

- Adenocystic carcinoma.
  - Areas H, M, and L.
- Adnexal carcinoma.
  - Areas H, M, and L.
- Apocrine/eccrine carcinoma.
  - Areas H, M, and L.
- Angiosarcoma.
  - Areas H, M, and L, subject to records review for medical necessity.
- Atypical fibroxanthoma.
  - Areas H, M, and L.
- Bowenoid papulosis.
  - Not covered.
- Dermatofibrosarcoma protuberans.
  - Areas H, M, and L.
- Desmoplastic trichoepithelioma.
  - Areas H and M subject to medical records review for medical necessity.
  - Area L not covered.
- Extramammary Paget disease.
  - Areas H, M, and L.
- Leiomyosarcoma.
  - Areas H, M, and L.
- Malignant fibrous histiocytoma.
Areas H, M, and L.

- Merkel cell carcinoma.
  - Areas H and M.
  - Area L may be covered on redetermination.

- Microcystic adnexal carcinoma.
  - Areas H, M, and L.

- Mucinous carcinoma.
  - Areas H, M, and L.

- Sebaceous carcinoma.
  - Areas H, M, and L.

- Rare, biopsy-proven malignancies not otherwise specified.
  - Areas H, M, and L — will be looked at for medical necessity on a prepay basis or may be covered on redetermination.


Limitations:

See above for limitations.

Alternative covered services:

Each case must be individualized when considering other treatment options. Depending on the type, extent, size, and location of non-melanoma skin cancers, other treatment options include:

- Electrodesiccation and curettage.
- Excisional surgery.
- Radiation therapy.
- Topical creams.
- Chemotherapy.
- Cryosurgery.
- Photodynamic therapy.
- Laser surgery.

Background

In the U.S., 5.4 million new cases of non-melanoma skin cancers in 3.3 million people were diagnosed in 2012 (Skin Cancer Foundation, 2019b), along with 91,270 cases of melanoma in 2018 (Noone, 2018). The number of non-melanoma skin cancers has increased 77% from 1994 to 2014 (Skin Cancer Foundation, 2019b).
The number of Mohs surgeries performed on tumors each year in the United States is at least 876,000 (Asgari, 2012). Mohs micrographic surgery use has increased 400% from 1995 to 2009, and one fourth of skin cancers are treated using this procedure (Ad Hoc Task Force, 2012).

Mohs micrographic surgery is named after the physician who developed the original technique. Frederic Mohs was a practicing physician in Wisconsin the 1930s who discovered a new way to treat skin cancer tumors. Mohs micrographic surgery is a precise tissue-sparing surgical technique for removing and treating selected malignant neoplasms of the skin. Mohs micrographic surgery is perhaps the most effective treatment for basal cell carcinoma and squamous cell carcinoma, and improvements in identifying cancerous cells have made the technique more effective in treating melanoma (Skin Cancer Foundation, 2019a).

The majority of simple skin cancers can be managed by excision or destruction techniques. The medical record should clearly show that Mohs micrographic surgery was chosen because of the complexity (e.g., poorly defined clinical borders, possible deep invasion, and prior irradiation), size, or location (e.g., when maximum conservation of tumor-free tissue is important). Mohs micrographic surgery is usually an outpatient procedure done under local anesthesia (with or without sedation).

Mohs differs from other types of skin cancer surgery, in that the cancer is removed by layers. Margins of each layer are examined until the tissue is completely cancer-free (described as “clear margins”). This minimizes the amount of healthy tissue that is removed, and eliminates far more cancerous tissue than traditional excisions. Because the Mohs surgeon has received specialized training in both surgery and pathology, the ability to remove only the cancerous tissue is enhanced (American College of Mohs Surgery, 2017).

The procedure is performed on an ambulatory basis. After a local anesthetic is administered, the surgeon scrapes the portion of skin with the most evident cancer. Downward and crosswise incisions are made, and the surgeon draws a map of the area and excised tissue. While the patient waits, specimens are frozen, cut, transferred to slides, and examined — a process that often lasts 30 to 60 minutes. If any tumor remains, more anesthesia is given, the process is repeated (removing tissue only from the cancerous area), and new slides are prepared and analyzed. While the surgery can be completed in just one such stage, it typically takes two or three stages (Harvard Medical School, 2006).

If stitches are made, they typically are removed in less than one week. If the surgeon decides to allow the excision area to close on its own, it typically takes about a month to heal. Skin grafts and skin flaps may be used instead of stitches (Harvard Medical School, 2006).

A complications registry has been developed by the American College of Mohs Surgery. Four major types of complications and one minor type are included: death, bleeding requiring additional intervention, functional loss attributable to surgery, hospitalization for an operative complication, and surgical site infection (Council, 2016).
Searches

Select Health of South Carolina searched PubMed and the databases listed below:

- U.K. National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality.
- The Centers for Medicare & Medicaid Services.
- Cochrane Library.

We conducted searches on September 6, 2019. Search terms were: “basal cell carcinoma,” “squamous cell carcinoma” and “Mohs micrographic.”

We included the following types of articles:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined, transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and thus are rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews**.
- **Economic analyses**, such as cost-effectiveness analysis, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

Guidelines have been developed by the American Academy of Dermatology to recommend when Mohs micrographic surgery is appropriate or not (Ad Hoc Task Force, 2012). The guidelines present 270 scenarios based on patient condition; of these, 200 (74.1%) are considered appropriate, 24 (8.9%) uncertain, and 46 (17%) inappropriate (see the table below):

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Condition</th>
<th>Appropriate</th>
<th>Uncertain</th>
<th>Inappropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>Basal cell carcinoma</td>
<td>53</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>143</td>
<td>Squamous cell carcinoma</td>
<td>102</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>12</td>
<td>Lentigo maligna+ melanoma</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>46</td>
<td>Rare cutaneous malignancies</td>
<td>35</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>270</td>
<td>Total</td>
<td>200</td>
<td>24</td>
<td>46</td>
</tr>
</tbody>
</table>

Other guidelines, such as those from the United Kingdom and Scotland, recommend that Mohs micrographic surgery be considered for squamous cell carcinoma (Morton, 2014; Scottish Intercollegiate Guidelines Network, 2014). A 2016 guideline recommended Mohs for high-risk basal cell carcinoma; aggressive recurrent squamous cell carcinoma; cancers of the ear, lips, and middle of the face; and dermatofibrosarcoma protuberans (Cernea, 2016).
In 2019, a Canadian panel of experts conducted a systematic review and concluded Mohs micrographic surgery was the treatment of choice for primary basal cell carcinomas of the face that are greater than 1 centimeter, have aggressive histology, or are located on area H of the face. No conclusions could be drawn for other skin cancers (Murray, 2019).

A total of 195,768 melanomas were diagnosed from 2003 through 2009 from 17 state and metropolitan cancer registries. Utilization of Mohs micrographic surgery for invasive melanoma and melanoma in situ increased by 60% from 2003 to 2008. Of all lesions treated by surgical excision in this time period, 3.5% (6,872) were excised by Mohs micrographic surgery. Use of Mohs micrographic surgery for melanoma appears to be increasing (Viola, 2015).

Little data exists comparing outcomes of Mohs micrographic surgery to other surgical procedures for certain cancers. For example, a Cochrane review of persons treated for basal cell carcinoma, either with Mohs micrographic surgery or surgical excision, was unable to locate any randomized controlled trials that met criteria for such a comparison (Narayanan, 2014). A systematic review of 40 studies, 29 of them randomized controlled trials, revealed that the “gold standard” for treating basal cell carcinoma was Mohs micrographic surgery (Clark, 2014).

Most efficacy studies of Mohs micrographic surgery focused on recurrence rates, and these have been favorable to Mohs micrographic surgery. One review that compared five types of treatment for basal cell carcinoma observed that the five-year recurrence rate for Mohs micrographic surgery (1%) is well below those for surgical excision (10.1%), electrodessication and curettage (7.7%), radiation therapy (8.7%), and cryotherapy (7.5%) (Tierney, 2009). Another study observed 166 patients with basal cell carcinoma, half treated with Mohs micrographic surgery and half with standard surgery. Two people in the Mohs group had recurrence within five years, compared with 10 people from the standard surgery group, a significant difference at \( P = 0.015 \) (Mosterd, 2008).

A systematic review of 21 studies, each with at least 30 subjects, addressed recurrences, cure, complications, cosmesis, and quality of life. The authors recommended Mohs for all recurrent basal cell carcinomas of the face, and for primary cases that are greater than one centimeter, have aggressive histology, or are located on area H of the face. Recommendations were not made for skin cancers other than basal cell (Murray, 2019).

Another study observed 408 patients with primary basal cell carcinoma and another 204 with a basal cell carcinoma recurrence. All subjects underwent either Mohs micrographic surgery or standard surgery, and 10-year recurrence rates after surgery were measured. The 10-year recurrence rates were 4.4% after Mohs micrographic surgery and 12.2% after surgery, not significant at \( P = 0.10 \). Ten-year rates for recurrent cases were 3.9% for Mohs micrographic surgery and 13.5% for surgery, significant at \( P = 0.023 \). A substantial proportion of recurrences occurred later than five years post-treatment (van Loo, 2014).
A comparison of Mohs micrographic surgery and wide local excision for treating melanoma in situ (n = 662) found similar five-year survival rates (92% for Mohs micrographic surgery, 94% for wide local excision, P = 0.28). Persons with Mohs micrographic surgery had lower total and five-year recurrence rates (1.8% versus 5.7%, and 1.1% versus 4.1%). The differences were of borderline significance at P = 0.07 (Nosrati, 2017).

A systematic review of 118 observational studies of treatments for squamous cell carcinoma analyzed local recurrence rates. The rate after Mohs micrographic surgery (10 studies, 3%), was lower than for standard surgical excision (12 studies, 5.4%), external radiography (seven studies, 6.4%), and photodynamic therapy (eight studies, 26.4%). The lower rate for Mohs micrographic surgery differed significantly only with photodynamic therapy. The five-year cure rate for Mohs micrographic surgery was 97.4% (a range of 95.7% – 98.8%), with most studies tracked for five years after surgery (Lansbury, 2013).

A comparison of 23 non-randomized studies of patients treated by Mohs micrographic surgery or wide local excision for dermatofibrosarcoma protuberans showed a lower recurrence rate after Mohs micrographic surgery (1.11%) than after wide local excision (6.32%); mean follow-up was 68 months (Foroozan, 2012). A review of five meta-analyses and 38 studies showed, despite a lack of strong data, that Mohs micrographic surgery had lower recurrence rates than other treatments for dermatofibrosarcoma protuberans (Pallure, 2013).

A review of 20,821 patients at 23 medical centers who underwent Mohs micrographic surgery showed that 149 patients, or 0.72%, had an adverse event. Almost all of these were infections, dehiscence/necrosis, or bleeding/hematoma (Alam, 2013).

A recent review of 882 Mohs micrographic surgery cases suggested that the 17% of melanoma in situ cases that require margins > 5 mm can be treated effectively using Mohs micrographic surgery (Stigall, 2016).

One literature review determined that Mohs micrographic surgery not only had superior outcomes (cure rates while optimizing tissue preservation) for high-risk cases of basal cell carcinoma, but also was the most cost-effective of any studied option (Kauvar, 2015). This conclusion was consistent with an earlier study, which found Mohs to be efficacious, equal to the cost of excision with permanent sections, 12% less costly than office-based excision with frozen sections, and 27% less costly than excision with frozen sections in an ambulatory surgical center (Tierney, 2009).

A systematic review and meta-analysis of patients with the rare, dermally based tumor atypical fibroxanthoma compared treatments with Mohs micrographic surgery (n = 188) and with wide local excision (n = 783). Recurrence in the Mohs group was lower (6.6% versus 11.3%), and not significant at P = 0.12). Average months to recurrence were similar, at 14.2 months versus 13.3 months (Phan, 2019).
A systematic review of 446 procedures for basal cell carcinoma of the vulva, with no underlying vulvar disease, revealed that, over time, 21 cases treated surgically had recurrent cancer, compared with zero for those treated with Mohs micrographic surgery (Renati, 2019).

Policy updates:

In September 2019, two guidelines/other and two peer-reviewed references were added to this policy, and one guideline/other and two peer-reviewed references were removed.

References

Professional society guidelines/other:


**Peer-reviewed references:**


**Centers for Medicare & Medicaid Services National Coverage Determinations:**

No National Coverage Determinations identified as of the writing of this policy.

**Local Coverage Determinations:**

Mohs Micrographic Surgery (L33436, L33689, L34195, L34961, L35494, L35702, L35704).

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>17311</td>
<td>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) (e.g., 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</td>
<td></td>
</tr>
<tr>
<td>17312</td>
<td>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) (e.g., 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)</td>
<td>Add-on code</td>
</tr>
<tr>
<td>17313</td>
<td>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) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks</td>
<td></td>
</tr>
<tr>
<td>17314</td>
<td>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) (e.g., hematoxylin and eosin, toluidine blue)</td>
<td>Add-on code</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>17315</td>
<td>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) (e.g., 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)</td>
<td>Add-on code</td>
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>C00.0-C00.9</td>
<td>Malignant neoplasm of lip</td>
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</tr>
<tr>
<td>C43.0-C43.9</td>
<td>Malignant melanoma of skin</td>
<td></td>
</tr>
<tr>
<td>C44.00-C44.99</td>
<td>Other and unspecified malignant neoplasm of skin</td>
<td></td>
</tr>
<tr>
<td>C4A.0-C4A.9</td>
<td>Merkel cell carcinoma</td>
<td></td>
</tr>
<tr>
<td>D03.0-D03.9</td>
<td>Melanoma in situ</td>
<td></td>
</tr>
<tr>
<td>D04.0-D04.9</td>
<td>Carcinoma in situ of skin</td>
<td></td>
</tr>
<tr>
<td>D07.1</td>
<td>Carcinoma in situ of vulva</td>
<td></td>
</tr>
<tr>
<td>D07.4</td>
<td>Carcinoma in situ of penis</td>
<td></td>
</tr>
<tr>
<td>D07.61</td>
<td>Carcinoma in situ of scrotum</td>
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<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
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</tbody>
</table>

**Appendix**

This Appendix outlines the conventions used in American Dermatological Association coverage criteria used by Centers for Medicare & Medicaid Services, Local Coverage Determination L35702.

**Definitions:**

**Area H:** Mask areas of the face (central face, eyelids [including inner/outer canthi], eyebrows, nose, lips [cutaneous/mucosal/vermillion], chin, ear and periauricular skin/sulci, temple), genitalia (including perineal and perianal areas), hands, feet, nail units, ankles, nipples/areola.

**Area M:** Cheeks, forehead, scalp, neck, jawline, pretibial surface.

**Area L:** Trunk and extremities (excluding pretibial surfaces, hands, feet, nail units and ankles).

**Immunocompromised:** a patient with HIV/AIDS, organ transplant, hematologic malignancy or pharmacologic suppression.
**Genetic Syndromes:** basal cell nevus syndrome, xeroderma pigmentosa, or other syndromes at high risk for skin cancer.

**Healthy:** no immunosuppression, no prior radiation therapy to affected area, no chronic infections and no genetic syndromes that predispose to skin cancer.

**Prior Radiated Skin:** patient has previously received therapeutic radiation in this area of the body.

**Aggressive features:**

- **For Basal Cell Carcinoma**
  - Morpheaform, fibrosing, sclerosing
  - Infiltrating
  - Perineural
  - Metatypical/keratotic
  - Micronodular

- **For Squamous Cell Carcinoma**
  - Sclerosing
  - Basosquamous excluding keratotic basal cell carcinoma
  - Small cell
  - Poorly or undifferentiated, i.e. high degree of polymorphism, high mitotic rate and/or low degree of keratinization
  - Perineural or perivascular
  - Spindle cell
  - Pagetoid
  - Infiltrating
  - Keratoacanthoma (KA) type: central facial
  - Single Cell
  - Clear Cell
  - Lymphoepithelial
  - Sarcomatoid
  - Breslow depth below 2mm or greater
  - Clark level IV or greater

**Tissue Block:** A block is the plate that tissue is placed upon, coated with embedding medium, frozen, and then placed into the microtome for cutting. Thus, a block is a plate with tissue and mounting medium on it. How many tissue pieces go onto the plate (block) does not matter. The technician, with possible input from the physician, decides how many tissue pieces from a given excision stage would fit on one tissue plate (block). For example, a specimen may be butterflied and put on one block (tissue
plate), or the same specimen could be bisected and both tissue pieces put on one plate (block). It is still one block.

Another example: one may take a subsequent Mohs excision stage as three separate, non-contiguous pieces (specimens). Each of the tissue pieces is considered as a separate tissue specimen; however, depending upon their size and the technician’s proficiency, all three pieces could be placed upon one plate (one block), or two pieces on one plate and one on another plate (2 blocks), or each of the three tissue pieces (specimens) could be placed on individual plates (3 blocks).

The block is the billing unit, not the tissue piece.