Medicare Reimbursement

The 17000 series for destruction of skin lesion codes was adopted by HCFA January 1, 1998.

Health Maintenance Organization (HMO) Reimbursement

Cryosurgery is a covered service by most HMOs. Basically, there are two formats for HMO service providers:

1. **Group Practice,** in which patients receive all care from one group practice, with only super-specialty care being referred out of the practice. Typically, physicians in this format are employed full-time by the HMO and have no fee-for-service practice. In this case, the service is covered under the standard capitation payments.
2. **Independent/Individual Practice Association (IPA),** in which the primary care practitioner acts as the "gatekeeper" for all care rendered to a given patient, requiring written referral to a specialist outside the practice (preferably a plan participant). Generally, the physician and practice association share in a "capitation" payment designed to cover all care. The association pays specialists from a "pool" and withholds a "risk incentive," a percentage of which is paid, by the formula, to the participating specialists at the end of the year, based on plan utilization.

For simple cryosurgery procedures, such as wart removal using the Histofreezer® Portable Cryosurgical System, the primary care IPA physician will often treat the patient under the standard capitation, rather than refer to a specialist who is paid out of the risk pool. In many cases, the balance of the risk incentive pool at year end is shared between the primary care physicians and specialists.

Private Insurers and Blue Shield

Most of these types of third-party insurers pay claims based on a set fee schedule by procedure code, although Blue Shield plans may use "Usual, Customary, and Reasonable" (UCR) reimbursement screens which are based on profile analyses. Plan participating physicians, receiving UCR payments directly from the insurer, are required to accept the plan-allowed amounts as payment in full. Participating physicians can usually access reimbursement information from the insurer using their provider numbers. Non-participating physicians are not required to accept UCR levels.

OraSure Technologies does not guarantee reimbursement levels or that codes will be considered when submitted.

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Histofreezer®

Portable Cryosurgical System

Getting Reimbursed for Cryosurgery

For medical professional use only

OraSure Technologies

As a service to our physicians and their staff, OraSure Technologies is pleased to provide information that we hope will assist you in billing and reimbursement for cryosurgical procedures performed using the **Histofreezer® Portable Cryosurgical System**.

Information provided is for example and comparison only. It does not represent a guarantee or assurance that services will be considered or paid.

Following is information on:

- Recommended CPT Codes
- Explanation of Reimbursement methods for:
  - Medicare
  - HMOs
  - Private Insurers

Recommended CPT Codes

For billing and reimbursement purposes, it is recommended that the following Common Procedure Terminology (CPT) codes, as provided by the American Medical Association be used. (Refer to Integumentary System-Destruction Benign or Premalignant Lesions.)

Actinic Keratosis

17000 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g. actinic keratoses); first lesion

17003 2nd through 14 lesions, each (list separately in addition to code for first lesion)
(Use 17003 in conjunction with 17000)

17004 15 or more lesions
(Do not report 17004 in conjunction with 17000-17003)

Verruca Vulgaris, Verruca Plantaris, Verruca Plana, Molluscum Contagiosum, Lentigo, Seborrheic Keratosis

17110 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions: up to 14 lesions

17111 15 or more lesions

Skin Tags (Acrochordon)

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

11201 Each additional 10 lesions

Condylomata Acuiminata, Molluscum Contagiosum

46916 Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery

46924 Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

54056 Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery

54065 Destruction of lesion(s), penis (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

56501 Destruction of lesion(s), vulva; simple (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

56515 Extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery)

It is important to note that appropriate diagnosis codes must be submitted to substantiate medical necessity for the procedure. Additionally, the appropriate modifier code must also accompany the respective CPT code to insure payment where multiple lesions or second applications may occur. Finally, adequate documentation of the procedure performed should be contained in the patient's chart to substantiate the service billed.

The following is a list of modifier codes that may be used in conjunction with CPT code submission.

Modifier	Code Usage
-50	Procedures performed on both sides of the body (mirror image) at the same operative session.
-51	Subsequent lesion or multiple procedure treated on same side of the body, same day
-76	Repeat procedure by same physician
-77	Repeat procedure by fellow physician

We recommend that offices billing these procedures for the first time direct questions to their carrier representatives.

Reporting Procedures

Reporting procedure described by codes 17000-17004 varies from carrier to carrier, and in many cases is left up to the physician to interpret. **The following examples of reporting methods are for illustration purposes only and should not be assumed to be acceptable to all carriers,** but should be applicable in most circumstances.

Following is an example of one common method for reporting the destruction of premalignant lesions when reporting these procedure to most common carriers:

Number of Lesions	Use Codes
1	17000
2	17000, and 17003-(50 or 51)
3	17000, and 17003-(50 or 51) x 2
4 through 14	17000, and 17003-(50 or 51) x 3
15 or more	17004 x 1

Representative Average Reimbursements, 2014[1]

CPT Code	Medicare/Medicaid Facility	Medicare/Medicaid Non-Facility
17000	$53.38	$75.23
17003	$2.51	$10.03
17004	$101.02	$149.38
17110	$69.85	$109.26
17111	$85.97	$129.68
11200	$74.15	$88.12
11201	$17.19	$19.34
46916	$145.44	$229.98
46924	$189.14	$542.36
54056	$112.48	$141.86
54065	$176.25	$220.67
56501	$118.57	$133.98
56515	$206.34	$230.70

[1]Payments vary from state to state. Check with your local carrier for specific reimbursement rates.