

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 HMO's. 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.

The Histofreezer® Portable Cryosurgical System is a registered trademark of OraSure Technologies, Inc.

©1997, 2010 OraSure Technologies, Inc.
U.S. Patents #5738682 and #6092527 and various international patents.

Technical Assistance: 1-800-869-3538



Manufacturer:
OraSure Technologies, Inc.,
Bethlehem, PA 18015 USA.

Visit our website at:
www.histofreezer.com

CPT is a trademark of the American Medical Association (AMA). CPT codes ©2007, 2010. AMA. All rights reserved.

Item# 10155 (Rev. 01/10)

Histofreezer®

Portable Cryosurgical System

Getting Reimbursed for Cryosurgery

**For medical
professional
use only**

Presented by:

OraSure Technologies, Inc.
220 East First Street
Bethlehem, PA 18015-1360
1-800-869-3538
610-882-1820
610-814-3405 Fax
www.orasure.com
www.histofreezer.com



OraSure Technologies, Inc.

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
- HMO's
- 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).

Code recommendation for: Actinic Keratosis

- 17000** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), premalignant lesions (eg actinic keratoses); first lesion
- 17003** second 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)

Code recommendation for: Verruca Vulgaris, Verruca Plantaris, Verruca Plana, Molluscum Contagiosum, Lentigo and Seborrheic Keratosis

- 17110** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), of benign lesions other than skin tags or cutaneous vascular lesions: up to 14 lesions
- 17111** 15 or more lesions

Code recommendation for: Skin Tags (Acrochordon)

- 11200** Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
- 11201** each additional ten lesions

Code recommendation for: Condylomata Acuminata and Molluscum Contagiosum

- 46916** Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
- 46924** Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
- 54056** Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; cryosurgery
- 54065** Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
- 56501** Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)
- 56515** extensive (eg, 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	Subsequent lesion treated on both sides of the body, same day
-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.

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

No. 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	17000, and 17004-(50 or 51) X 1

REPRESENTATIVE AVERAGE REIMBURSEMENTS – YEAR 2010¹

CPT Code	Medicare/Medicaid
17000	\$73.87
17003	\$6.86
17004	\$162.28
17110	\$100.81
17111	\$120.28
11200	\$77.39
11201	\$17.64
46916	\$211.76
46924	\$464.14
54056	\$132.05
54065	\$211.49
56501	\$125.20
56515	\$215.10

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