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 amount 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.
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.

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 curettage), premalignant lesions (e.g., actinic keratoses), first lesion
  - 17003: 2nd through 14 lesions, each (list separately in addition to code for first lesion)
  - 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 curettage), 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 Acuminata, Molluscum Contagiosum**
  - 46916: Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpeti vesicle), simple; cryosurgery
  - 46924: Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpeti vesicle), extensive (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, 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, chemosurgery)

- **Skin Tags (Acrochordon)**
  - 11200: Removal of skin tags, multiple fibrocutaneous tags, any area, up to and including 15 lesions
  - 11201: Each additional 10 lesions

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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 ensure 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
  - 56: Repeat procedure by same physician
  - 57: Repeat procedure by fellow physician

**Representative Average Reimbursements, 2014**

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