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MEDICAL POLICY – 7.01.608

Mohs Micrographic Surgery

Effective Date:	**Feb. 5, 2027**	RELATED MEDICAL POLICIES:
Last Revised:	Oct. 13, 2026	Not Applicable
Replaces:	N/A	

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Introduction

Mohs micrographic surgery (MMS) is a specialized procedure used to treat certain skin cancers and other cutaneous malignancies or lesions. During the procedure, thin layers of tissue are removed and examined under a microscope one at a time until no abnormal cells remain. This technique helps preserve healthy tissue while ensuring complete removal of cancerous cells and may improve cosmetic and functional outcomes. This policy describes when MMS may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Service	Medical Necessity
Mohs micrographic surgery (MMS)	**Mohs micrographic surgery (MMS) may be considered medically necessary for treatment of an individual with any of the following skin conditions on the trunk, arms or legs (excluding pretibial surfaces, hands, feet and ankles):**

Service	Medical Necessity
	• Basal cell carcinoma or squamous cell carcinoma at high risk for recurrence due to ONE of the following features: o Area of chronic inflammation/ulceration o Area of osteomyelitis o Immunocompromised (e.g., Human Immunodeficiency Virus [HIV], organ transplant recipient, pharmacologic immunosuppression, hematologic malignancy) o Individual has genetic syndrome that predisposes to skin cancer (e.g., xeroderma pigmentosum, basal cell nevus syndrome) o Large-size lesion of 2.0 cm or greater o Poorly defined borders o Positive margins on recent excision o Prior irradiated skin o Recurrent lesion o Traumatic or burn scar **OR** • Basal cell carcinomas with any of the following aggressive histologic patterns at high risk for recurrence: o Infiltrating o Metatypical/keratotic o Micronodular o Morpheaform/fibrosing/sclerosing o Perineural **OR** • Squamous cell carcinomas with any of the following aggressive histologic patterns at high risk for recurrence: o Basosquamous o Clear cell o Infiltrating o Keratoacanthoma (KA) type: central facial o Lymphoepithelial o Pagetoid (Paget-like) o Perineural/perivascular o Poorly or undifferentiated (characterized by a high degree of nuclear polymorphism, high mitotic rate, or low degree of keratinization)

Service	Medical Necessity
	o Sarcomatoid (sarcoma-like) o Sclerosing o Single cell o Small cell o Spindle cell **OR** • Locally recurrent superficial malignant melanoma (lentigo maligna, melanoma in situ)
Other skin lesions or carcinomas	**Mohs micrographic surgery (MMS) may be considered medically necessary for treatment of an individual with ONE of the following skin lesions or carcinomas (see** Related Information**):** • Adenoid cystic carcinoma • Adnexal carcinoma • Apocrine/eccrine carcinoma • Atypical fibroxanthoma • Cutaneous leiomyosarcoma • Dermatofibrosarcoma protuberans • Extramammary Paget disease • Merkel cell carcinoma • Microcystic adnexal carcinoma • Mucinous carcinoma • Sebaceous carcinoma • Undifferentiated pleomorphic sarcoma (previously known as malignant fibrous histiocytoma)
Not medically necessary	**Mohs micrographic surgery is considered not medically necessary when the above criteria have not been met.**

Documentation Requirements
The patient's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Office visit notes that contain the relevant history and physical which includes the cell type of the skin lesion or carcinoma, the size of the lesion, and the location of the lesion or carcinoma (area of the body to be treated) along with any pertinent genetic history. **AND**

Documentation Requirements
• Results of the biopsy, including the pathology report disclosing any aggressive histologic pattern(s). **AND** • Description of the lesion- whether it is primary or recurrent and if recurrent, any previous treatments provided, and the current condition of the skin or tumor to be treated such as area of chronic inflammation/ulceration, area of osteomyelitis, poorly defined borders, positive margins on recent excision, prior irradiated skin, traumatic scar.

Coding

Note: Mohs micrographic surgery (MMS) requires one professional provider to act in two integrated but separate and distinct capacities: surgeon and pathologist. If either of these responsibilities is delegated to another professional provider who reports the services separately, the MMS codes should not be reported.

Code	Description
CPT	
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) (e.g., 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) (e.g., 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) (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)

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

Acral: refers to the "topmost" or in this case outermost parts of the body's extremities, including the palms of the hands, the soles of the feet, fingers, toes, and nail beds.

Adenoid cystic carcinoma: is a rare cancer that begins in secretory glands, which produce fluids such as saliva, tears, and sweat. It most commonly starts in the salivary glands of the head and neck. Although adenoid cystic carcinoma usually grows slowly, it can spread along nerves and recur many years later.

Adnexal carcinoma: is a rare skin cancer that develops in specialized skin structures, including hair follicles, sweat glands, and oil glands. These tumors often grow slowly but can spread deeply under skin layers and around nerves. Adnexal carcinoma usually appears as a small, firm lump or plaque on the head or neck.

Apocrine/eccrine carcinomas: are rare skin cancers that develop from sweat glands. Eccrine carcinomas arise from glands found throughout the body that help regulate temperature, while apocrine carcinomas develop from glands located in areas such as the armpits and the perianal/perineal regions. Both are forms of sweat gland carcinoma. These tumors can be locally aggressive and have high recurrence rates.

Atypical fibroxanthoma: is a rare, low-grade skin cancer that typically appears as a small red, dome-shaped bump or sore. It most often develops in older adults on sun-damaged areas such as the head, neck, ears, and scalp. Although atypical fibroxanthoma may grow rapidly, it rarely spreads to other parts of the body.

Basal cell nevus syndrome (Gorlin syndrome or Gorlin-Goltz syndrome): is a rare autosomal dominant genetic disorder that predisposes individuals to early-onset skin cancers, including multiple basal cell carcinomas. It is characterized by benign jaw cysts, skeletal and facial abnormalities, such as an enlarged head, webbing of fingers and toes, and abnormal ribs or vertebrae. There is currently no cure.

Cutaneous leiomyosarcoma: is a rare malignant soft-tissue cancer that develops from smooth muscle cells in the skin, most often from the arrector pili muscles attached to hair follicles. It

typically appears as a small, firm, and sometimes painful or tender skin nodule. Diagnosis is made by biopsy, and treatment usually involves surgical excision. This cancer occurs more often in men and most commonly affects adults ages 40 to 60. Early diagnosis and treatment help reduce the risk of metastasis and support a better prognosis, which is generally favorable because recurrence is uncommon.

Dermatofibrosarcoma protuberans (DFSP): is a rare, slow-growing skin cancer that begins in the dermis, the skin's middle layer. It usually occurs on the trunk and extremities and rarely spreads to distant areas of the body. Without treatment, it can grow deeper into nearby fat, muscle, and other tissue.

Extramammary Paget disease: is a rare, slow-growing skin cancer that typically develops in areas with many sweat glands, such as the genital or perianal skin. It often appears as a red, scaly, itchy rash and may initially be mistaken for eczema. Without treatment, it can become invasive and spread to other parts of the body.

Keratoacanthoma (KA) type: is a subtype of squamous cell carcinoma that is a fast-growing, dome-shaped skin tumor. It starts in hair follicles on sun-exposed skin, features a central core filled with dead skin cells (keratin), and typically grows for weeks before often going away on its own.

Lentigo maligna: is an early, non-invasive form of melanoma skin cancer (melanoma in situ) in which abnormal pigment-producing cells are confined to the top layer of the skin. Typically, it appears as a flat, irregularly pigmented patch. The color may vary and include shades of brown, black, tan, or pink. It usually develops on chronically sun-damaged skin, most often on the face, ears, or neck of older adults. Lentigo maligna is generally slow growing. If left untreated, it may extend into deeper layers of the skin and progress to invasive lentigo maligna melanoma.

Merkel cell carcinoma: is a rare, aggressive skin cancer that typically appears as a fast-growing, painless lump or tumor on the skin. It often develops on sun-exposed areas, such as the head, neck, or arms, and has a high risk of spreading to other parts of the body.

Microcystic adnexal carcinoma: is a rare, slow growing but locally aggressive skin cancer that develops from sweat glands and hair follicles. It most often appears on the head and neck, especially the central face, as a firm skin-colored or yellow bump or flat patch. If untreated, it can grow deeply, spread along nerves, and cause significant local damage, though it rarely spreads to distant parts of the body. Treatment typically involves Mohs micrographic surgery.

Mucinous carcinoma: is a rare cancer that starts in mucin-producing cells, which create mucin, the main component of mucus.

Nail unit: The structure at the end of the fingers and toes, including the nail plate and nail bed.

Perianal: Refers to the skin and tissues surrounding the anus.

Perineal (perineum): Refers to the area of skin and underlying tissues between the genitals (vaginal opening or scrotum) and the anus.

Perineural invasion: is the microscopic finding of cancer cells growing within, around, or through the tissues surrounding a nerve. Perineural invasion is generally associated with more aggressive tumor behavior and may indicate an increased risk of tumor spread or recurrence.

Periungual: Refers to the skin and soft tissues surrounding a fingernail or toenail.

Perivascular invasion: is the microscopic presence of cancer cells within or surrounding blood vessels or lymphatic vessels. Perivascular invasion is generally associated with more aggressive tumor behavior and may indicate an increased risk of tumor spread or recurrence.

Sebaceous carcinoma: is a rare, aggressive skin cancer that begins in the skin's oil-producing sebaceous glands. It most commonly appears as a pimple-like bump on the upper eyelid, though tumors can develop elsewhere. Mohs surgery is often used for treatment and is associated with lower recurrence and metastasis rates; however, sebaceous carcinoma remains linked to high mortality and a poor prognosis.

Squamous cell carcinoma in situ (formerly known as Bowen's disease): is an early-stage skin cancer in which abnormal squamous cells are confined to the epidermis (outermost layer of the skin) and have not invaded deeper tissues. It is diagnosed by skin biopsy and is typically treated by removal of the affected lesion.

Vermillion: The red part of the lips (it may also be referred to as lips). The name comes from the color it is associated with, a reddish orange. The vermillion lacks sweat or oil glands.

Undifferentiated pleomorphic sarcoma (previously known as malignant fibrous histiocytoma): is an aggressive cancer that develops in soft tissue or bone. It most often affects older adults and commonly occurs in the arms, legs, or abdomen. The cancer can spread quickly, recur locally despite aggressive treatment, and is associated with a poor prognosis. Prior radiation therapy is a known risk factor.

Xeroderma pigmentosum: is a rare autosomal recessive genetic disorder that impairs the body's ability to repair DNA damage caused by ultraviolet (UV) radiation. Clinical features include extreme sensitivity to sunlight and increased risk of skin cancers often beginning in childhood or early adolescence. There is currently no cure for this condition and treatment focuses on strict UV protection, regular skin surveillance, and prompt treatment of skin cancers when they occur.

Evidence Review

Description

Mohs micrographic surgery (MMS) is a specialized surgical procedure used to treat certain skin cancers and soft tissue sarcomas of the skin while preserving as much healthy tissue as possible. The surgery is performed in stages: First, a thin layer of visible tumor tissue is removed. Then, a second thin layer of tissue is removed and viewed under a microscope to identify any remaining cancer cells. If cancer cells are detected, additional thin layers are removed and examined one at a time. The process is continued until no cancer cells are seen on microscopic evaluation. By removing tissue layer by layer and confirming clear margins during the procedure, Mohs surgery maximizes cancer removal while minimizing the removal of normal tissue. In this procedure, the specially trained dermatologic Mohs surgeon serves as both the surgeon and the pathologist. In certain cases, the surgeon may reconstruct the area the same day to repair the surgical defect after tumor removal. Most Mohs surgeries are performed in an outpatient setting under local anesthesia.

Background

According to the Centers for Disease Control and Prevention, skin cancer is the most common cancer in the United States. It is most often caused by excessive exposure to ultraviolet (UV) radiation from the sun or tanning beds. The skin has two main layers: the epidermis, which is the outer layer, and the dermis, which is the inner layer. Skin cancer develops when skin cells grow out of control. The three main types of skin cancer are basal cell carcinoma, squamous cell carcinoma, and melanoma. Basal cell carcinoma is the most common type of skin cancer. Basal cell carcinomas are usually slow-growing and rarely metastasize. Squamous cell carcinoma of the skin is the second most common form of skin cancer. Most cutaneous squamous cell carcinomas are easily and successfully treated; however, if left untreated, they can become invasive, extend into deeper skin layers, spread to other parts of the body, and become life-threatening. Melanoma develops from melanocytes, the cells that produce melanin, which is the pigment that gives skin its color.[1] Lentigo maligna or melanoma in situ is an early, noninvasive skin cancer in which abnormal cells are limited to the epidermis, the skin's outermost layer. The cells have not invaded deeper tissue or spread elsewhere in the body. It usually appears as an irregular brown macule on chronically sun-damaged skin, most commonly on the head and

neck. Although it grows slowly, it can become invasive if untreated. Surgical excision is the preferred treatment.

Treatment Options and Role of Mohs Surgery

Skin cancer may be treated with several approaches, including curettage and electrodessication, standard surgical excision, radiation therapy, cryosurgery, photodynamic therapy, and laser surgery. Standard excision is recommended for low-risk lesions with 4 to 6 mm clinical margins. MMS may be especially beneficial in areas where tissue preservation is important, including the face, ears, scalp, hands, and feet. It may also be used for lesions in areas at higher risk for recurrence, such as previously irradiated skin or sites affected by chronic inflammation, osteomyelitis, or scarring, or when a tumor has a known pathology with a more aggressive growth pattern. Because Mohs surgery removes and examines tissue layer by layer until the surgical margins are cancer free, it can provide a high cure rate while minimizing removal of healthy surrounding tissue.

Summary of Evidence

For individuals who have basal cell carcinoma of the face who receive MMS versus standard excision, the evidence includes a long-term follow-up RCT. A total of 408 high-risk primary facial basal cell carcinomas —defined as lesions at least 1 cm in diameter, located on the face, or having an aggressive histologic subtype—and 204 recurrent facial basal cell carcinomas were randomly assigned to treatment with either surgical excision or MMS. Recurrence was the primary outcome. The trial found fewer recurrences among those with high-risk primary basal cell carcinoma of the face, 4.4% after MMS compared with 12.2% after surgical excision at 10 years (log-rank test $\chi^2 = 2.704$; $p = 0.100$). Among those with recurrent facial basal cell carcinoma, recurrence was 3.9% after MMS compared with 13.5% after standard excision (log-rank $\chi^2 = 5.166$; $p = 0.023$). These findings suggest that MMS is associated with fewer recurrences than standard excision in high-risk facial basal cell carcinoma. The results also underscore the importance of long-term follow-up because a substantial proportion of recurrences occurred more than five years after treatment, 56% for primary facial basal cell carcinoma and 14% for recurrent facial basal cell carcinoma.[4.] In an updated Cochrane Review, Thomson et al. (2020) evaluated 52 randomized controlled trials involving 6,690 immunocompetent adults with primary basal cell carcinoma. The review found that surgical interventions had the lowest recurrence rates overall. For high-risk facial basal cell carcinoma, Mohs micrographic surgery (MMS) was associated with slightly fewer recurrences than surgical excision at both three years (1.9% vs. 2.9%; risk ratio [RR], 0.64; 95% confidence interval [CI], 0.16

to 2.64) and five years (3.2% vs. 5.2%; RR, 0.61; 95% CI, 0.18 to 2.04).[7] The certainty of evidence was low.

Hunt et al (2022) reviewed 39 papers on squamous cell carcinoma and found no RCTs. The authors noted that available comparator studies suggest MMS may be associated with lower recurrence rates than other treatments for cutaneous squamous cell carcinoma, including standard excision. The authors noted further methodologically robust studies with comparator arms and long-term data are needed. However, they also acknowledged that such studies may be unlikely because MMS has recognized advantages, including: 100% margin assessment, reduced removal of uninvolved tissue, and histological confirmation of clearance before reconstruction.[10]

A Cochrane Review by Tzellos et al. (2014) found no RCTs evaluating surgical interventions for melanoma in situ, including lentigo maligna.[11] This absence of RCT evidence was noted despite surgery being the most widely used intervention and the recommended first-line treatment for this diagnosis. Sharma et al (2021) conducted a systematic review on the role of MMS in treating lentigo maligna and lentigo maligna melanoma. The authors noted that wide local excision has been the primary surgical approach for these diagnoses. This is largely because frozen sections used in MMS are considered suboptimal for distinguishing atypical melanocytes. The review included 27 articles and found that MMS was associated with low recurrence rates, with follow-up ranging from one month to five years. Overall recurrence rate after MMS was 1.35% Recurrence rate with classic MMS was 1.17% and MMS using rush sections provided recurrence rates of 2.4%.[13] The authors noted additional clinical trials are needed to further delineate the role of MMS compared to wide standard excision for these diagnoses. Pride et al (2022) conducted a systematic review and meta-analysis of 71 studies, including 12 comparative studies. The analysis found that recurrence was higher after wide local excision than after MMS or staged excision (odds ratio [OR], 2.5; 95% CI, 1.4-4.6) and compared with MMS alone (OR, 3.3; 95% CI, 1.8-5.9). Pooled data from comparative and noncomparative studies showed a local recurrence rate of 7% after wide local excision (95% CI, 5%-11%), 3% after staged excision (95% CI, 2%-4%), and less than 1% after MMS (95% CI, 0%-1%).[15] Williams et al (2025) conducted a systematic review and meta-analysis of 35 articles evaluating clinical outcomes for individuals with invasive melanomas treated with MMS rather than wide local excision. The review included both comparative and non-comparative evidence: sixteen studies compared MMS with wide local excision and 19 were MMS-only, non-comparative studies. The authors concluded that the available evidence was insufficient to determine whether outcomes differ when comparable invasive melanomas are treated with MMS versus wide local excision. They noted that RCTs are needed to reach a reliable conclusion.[16]

Dermatofibrosarcoma protuberans (DFSP) is a slow-growing, infiltrative soft tissue tumor that may recur locally if not completely excised. A retrospective review from the Mayo Clinic compared long-term outcomes after Mohs micrographic surgery (MMS) and wide local excision (WLE) in patients treated for DFSP. Mean follow-up was 4.8 years for MMS patients (n = 67) and 5.7 years for wide local excision patients (n = 91). Recurrence occurred in 28 wide local excision patients (30.8%; mean time to recurrence, 4.4 years) compared with 2 MMS patients (3.0%; recurrence at 1.0 and 2.6 years). Recurrence-free survival at 1, 5, 10, and 15 years was significantly higher with MMS ($p < .001$). Mean preoperative lesion size was similar between groups (5–6 cm) but mean (standard deviation) postoperative defect size was larger after wide local excision than MMS: 10.7 (4.3) cm versus 8.8 (5.5) cm ($p = .004$). Primary closure was used in 73% of MMS cases, while wide local excision more often required flaps, grafts, or other closure methods (52%). Typically, two Mohs layers were needed for margin control.[18] Overall, DFSP treatment required surgical excision with careful histologic assessment of all margins to support durable cure rates and minimize morbidity.

Atypical fibroxanthoma (AFX) is a fibrohistiocytic tumor associated with relatively high local recurrence rates but low metastatic potential. Wide local excision and Mohs micrographic surgery (MMS) are commonly used treatments, although there is no consensus on the optimal approach. Tolkachjov et al. (2018) systematically reviewed 23 studies, including 907 patients and 914 tumors, to evaluate recurrence and metastatic rates after MMS or wide local excision. Among 175 patients treated with MMS, the recurrence rate was 2.0% (95% confidence interval [CI], 0%–4.1%) and the metastatic rate was 1.9% (95% CI, 0.1%–3.8%). Among 732 patients treated with wide local excision, the recurrence rate was 8.7% (95% CI, 5%–12.3%) and the metastatic rate was 1.0% (95% CI, 0.2%–1.9%). In immunocompromised patients, no recurrences or metastases occurred in the MMS subgroup; however, 4 of 10 patients had recurrence and 1 of 10 developed metastasis in the wide local excision subgroup.[19]

Merkel cell carcinoma (MCC) is an aggressive cancer with a high recurrence rate. Current guidelines recommend wide local excision (WLE) with 1- to 2-cm margins. Mohs micrographic surgery (MMS) may offer an advantage over WLE by preserving healthy tissue while allowing assessment of 100% of surgical margins. However, Uitentuis et al. (2022) reviewed 1,108 studies, including 19 case series with 168 cases and 12 cohort studies, to evaluate surgical treatment for Merkel cell carcinoma (MCC). The authors found that the relationship between wide local excision (WLE) margins and recurrence or survival remains unclear. Although Mohs micrographic surgery (MMS) is an alternative surgical option for MCC, it is unknown whether local recurrence rates differ between MMS and WLE. Their systematic review found no significant differences in recurrence or survival by excision margin or surgical approach.[24] The authors concluded that the available evidence does not show differences in MCC recurrence or survival rates between various clinical excision margins and MMS.

Carrasquillo et al. (2022) conducted a systematic review of 40 studies: 31 evaluated patients treated with wide local excision (WLE), 3 evaluated Mohs micrographic surgery (MMS), and 6 included either WLE or MMS. In a subgroup analysis of Stage I Merkel cell carcinoma (MCC), recurrence rates were similar between approaches, with local recurrence of 6.8% for WLE versus 8.5% for MMS (p = .64) and regional recurrence of 15.2% for WLE versus 15.3% for MMS (p = .99). Overall, the WLE cases were at a more advanced stage. The analysis found that MMS was not inferior to WLE for Stage I MCC and may be a reasonable option in anatomic locations where tissue preservation is important.[25]

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this policy are listed in **Table 1**.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT06998342	MOHs Surgery and Adjuvant Short-course Hypofractionated Radiation Therapy With Structured Surveillance for Cutaneous Head & Neck Squamous Cell Carcinoma: a Phase II Pilot Study (MOHSAHRTSS-Study)	24	May 2031

NCT: National Clinical Trial.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery (AAD/ACMS/ASDSA/ASMS)

In 2012, the AAD/ACMS/ASDSA/ASMS published a report for which they consider the following relevant scenarios to this policy appropriate for Mohs micrographic surgery in the treatment of cutaneous neoplasms: Areas of the body defined as Area H: "mask areas" of face (central face, eyelids, eyebrows, nose, lips, chin, ear and periauricular skin/sulci, temple), genitalia (including perineal and perianal), hands, feet, nail units, ankles, and nipples/areola. Area M: Cheeks, forehead, scalp, neck, jawline, pretibial surface. Area L: trunk and extremities (excluding pretibial surface, hands, feet, nail units, and ankles).

- Recurrent basal cell carcinoma of any size, or unexpected positive margin on recent excision (healthy or immunocompromised patients, or patients with genetic syndromes).
    - Aggressive or Nodular pathology in area H or M.
- Recurrent squamous cell carcinoma of any size or unexpected positive margin on recent excision (healthy or immunocompromised patients, or patients with genetic syndromes).
    - Aggressive pathology in areas H and M.
    - Verrucous pathology in area H.
    - Keratoacanthoma (KA) type squamous cell carcinoma pathology (not central facial) in areas H and M.
    - In situ/Bowen in areas of H and M.
- Primary basal cell carcinoma or squamous cell carcinoma regardless of subtype, size, or depth arising in prior radiated skin, traumatic scar, area of osteomyelitis, area of chronic inflammation/ulceration, patients with genetic syndromes in areas of H and M.
- Lentigo maligna and melanoma in situ.
    - Primary lentigo maligna (healthy or immunocompromised patients) in area H.
    - Locally recurrent lentigo maligna (healthy or immunocompromised patients) in areas H, M, and L.

- Locally recurrent melanoma in situ: non-lentigo maligna (healthy or immunocompromised patients) in area H, M, and L.

- Tumor characteristics with aggressive features at high risk for recurrence:
  - 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 (characterized by a high degree of nuclear polymorphism, high mitotic rate, or low degree of keratinization), perineural/perivascular, spindle cell, Pagetoid, infiltrating, keratoacanthoma (KA) type: central facial, single cell, clear cell, lymphoepithelial, sarcomatoid, Breslow depth 2 mm or greater, Clark level IV or greater
- Less common skin cancers: adenocystic carcinoma, adnexal carcinoma, apocrine/eccrine carcinoma, atypical fibroxanthoma, dermatofibrosarcoma protuberans, extramammary Paget disease, leiomyosarcoma, undifferentiated pleomorphic sarcoma, Merkel cell carcinoma, microcystic adnexal carcinoma, mucinous carcinoma, sebaceous carcinoma.

American Academy of Dermatology

In 2018 the AAD published guidelines of care for the management of basal cell carcinoma. The authors recommend that Mohs micrographic surgery (MMS) be indicated for the treatment of high-risk basal cell carcinoma (on the basis of National Comprehensive Cancer Network [NCCN] risk stratification).

In 2018 the AAD published guidelines of care for the management of cutaneous squamous cell carcinoma. The clinical recommendation is made to support the use of MMS for high-risk cutaneous squamous cell carcinoma (on the basis of NCCN risk stratification). The authors note that a large portion of cutaneous squamous cell carcinomas are located on the head and neck, where tissue conservation is important.

In 2019 the AAD published guidelines of care for the management of primary cutaneous melanoma. The clinical recommendation is for MMS or staged excision with paraffin-embedded permanent sections be utilized for melanoma in situ (MIS) or lentigo maligna (LM) type, on the face, ears, or scalp for tissue-sparing excision and exhaustive histologic assessment of peripheral margins. And for MIS or LM type, permanent section analysis of the central MMS debulking specimen is recommended to identify and appropriately stage potential invasive cutaneous

melanoma (CM). If invasive cutaneous melanoma is identified on an MMS section intraoperatively, the tissue should be submitted for formal pathology review.

National Comprehensive Cancer Network (NCCN)

In 2026, NCCN published the following recommendations for the use of Mohs micrographic surgery (MMS):

- For low-risk basal cell carcinoma (BCC), MMS is recommended if there are positive margins from standard excision that require re-excision.
- For high-risk BCC, MMS or other forms of peripheral and deep en face margin assessment (PDEMA) are recommended as the primary surgical technique.
- MMS is also recommended when standard excision with wider surgical margins is unable to achieve negative margins in high-risk BCC.
- For low-risk cutaneous squamous cell carcinoma (cSCC), MMS or other forms of PDEMA are recommended if there are positive margins from standard excision that require re-excision.
- For high-risk/very high-risk cSCC, MMS or other forms of PDEMA are recommended.
- MMS may be considered selectively for minimally invasive (T1a) melanomas in anatomically constrained areas (i.e., face, ears, acral sites) along with other surgical methods that provide comprehensive histologic assessment. MMS is not recommended for invasive melanomas when standard clinical margins can be achieved.
- For dermatofibrosarcoma protuberans (DFSP) excision with MMS or other forms of PDEMA is recommended over wide local excision because of its tendency for irregular and frequently deep subclinical extensions.
- For Merkel cell carcinoma tumors, (N0, local Merkel cell only) that are surgically resectable, MMS and PDEMA are methods for surgical excision of the primary tumor, using margins similar to wide local excision.

Medicare National Coverage

There is no national coverage determination.

Regulatory Status

Mohs micrographic surgery is a surgical procedure and, as such, is not subject to regulation by the US Food and Drug Administration (FDA).

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History

Date	Comments
11/01/26	New policy, approved October 13, 2026, effective for dates of service on or after February 5, 2027, following 90-day provider notification. Add to Surgery section. Mohs micrographic surgery is considered medically necessary when criteria are met.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit

booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2026 Premera All Rights Reserved.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.