

## I. General orientation of user to the data entry screen

### Procedures are entered in relation to the lesion being treated.

For example, if you treat the same patient on the same day for a 1) basal cell carcinoma on their nose, 2) a squamous cell carcinoma on their back and 3) a wart on their toe you would enter the procedural data for each lesion in its own distinct entry screen.

For example :

First data entry screen: If you performed 3 stages of Mohs surgery and a rhombic flap on the nose, then these 2 procedures (Mohs and flap) and all relevant data (see below) would be logged in association with the BCC of the nose. Once all data related to treatment of this first lesion (see details below) had been entered it would be saved and a second data entry screen opened to enter data on the second lesion.

Second data entry screen: The excision and complex repair for the SCC would be logged in association with the back lesion. This would be saved as an individual entry even though it occurred on the same patient, same day. Next open a third data entry screen for the third lesion.

Third data entry screen: The laser destruction of the wart would be logged in association with the toe lesion. This would be saved as the third individual entry for this patient thereby completing entry of all procedures performed on the same patient, same day.

## II. Manual fields clarification

### Lesion ID

To ensure that case log reports assign credit for all procedures entered, we ask that when completing a data entry screen that the following lesion naming convention be used:

Enter the patient's initials followed by a lesions number consisting of at least 2 digits:

For example, if patient Joseph Patrick Smith had 3 lesions the first Lesion ID entered should be JPS01, the second JPS02 and the third JPS03.

### Fellow Role Definitions

**Fellow Surgeon:** Scrubbed in and performed majority of the procedure.

**Assistant:** Scrubbed in and assisted other fellow or attending who performed majority of the procedure.

### CPT Code

Direct enter or use the search function to use the CPT code that best represents the procedure performed on the lesion for which data is being entered.

### **III. Use of Mohs codes**

When Mohs codes are entered for any Lesion ID then the following must be entered in the data entry screen:

#### Mohs codes

Use the appropriate site-specific CPT code for each stage of Mohs surgery.

For example, if lesion JPS01 on the nose was treated with 3 stages of Mohs surgery then enter 17311, 17312 and 17312. If JPS01 was on the trunk then 3 stages of Mohs surgery should be entered as 17313, 17314 and 17314.

#### Mohs Defect Disposition

All Lesions IDs for which a Mohs code is entered must be accompanied by a code entry for **only one** of the following:

- 1) CPT code for the repair procedure (If a flap code is used the user will be required to designate the type of flap as well).
- 2) The case log code for second intention
- 3) The case log code for referral to another repair physician

#### Post Mohs Defect Size

Select from the list the most appropriate range of dimension that encompasses the **greatest diameter** of the Mohs defect at the completion of the final stage of Mohs surgery. This is also referred to as the "final defect" size.

#### Complex Mohs Case

Check this box if the lesion is one or more of the following:

- 1) Histologically aggressive tumor
- 2) Large tumor (entire cosmetic unit, scalp tumors > 5 cm)
- 3) Tumor located in peri-auricular, orbital, anal sites; intranasal and

nail bed

- 4) Tumor other than BCC or SCC
- 5) Tumor involving bone
- 6) Tumor requiring > than four stages
- 7) Multiply recurrent tumor
- 8) Tumor requiring a multidisciplinary team surgical approach
- 9) Patient requiring special intraoperative management

Recurrent Lesion designation

Check this box if the lesion has recurred following previous attempts to treat.