

## New Codes for Hyperhidrosis

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are to be coded as 64999, a “miscellaneous” code.

“You all know what the dreaded –99 on the end of a code means. That means it cannot be submitted electronically. It has to be submitted manually and will be subject to individual medical review—a pain in the you-know-what. But that is the proper way today to code for the hands and feet,” Dr. Pariser said, adding that it will take payers some time to get used to the new Botox codes.

In the meantime, he advised contacting regional payers to find out how they want bills for hyperhidrosis therapy to be submitted. Some insurers will request the former code 64640 (“destruction by neurolytic agent”) or the subcutaneous injection code 90782, even though these are now incorrect.

Reimbursement dollars under the new codes are such that, in Dr. Pariser’s office, the injections have become a procedure that is done by physician extenders. “They’re the ones who can spend the time and effort to do this at a reimbursement that’s more reasonable for them than me, frankly,” he said.

The CPT code for the cost of the Botox medication is J0585. He advised checking to be sure both the payer and the office billing system are capable of accepting triple digits in the units code.

Sometimes, physicians who have coded for the standard 100 U of Botox typically needed to treat two axillae have been paid for 10 U or even 1. One solution is to code for 99 U on one line and 1 U on another line.

Alternatively, because reimbursement for Botox injections for hyperhidrosis remains hit or miss, Dr. Pariser suggested writing a prescription for the Botox and having the patient fill it at a pharmacy.

“The specialty pharmacy will send it directly to you and a regular pharmacy will give it to the patient to bring in. Let the pharmacy take the hit if there’s going to be any problem about denial of the drug. You don’t want to get stuck with having done a treatment later deemed not medically necessary. Not only do you not get reimbursed for what you did, but you’ve also lost a vial of Botox into somebody’s armpits without any reimbursement,” he commented.

Dr. Pariser said he has found it quite helpful to have proactive general conversations with health plan medical directors in order to streamline the reimbursement process. The goal is to set up a preauthorization procedure.

He said he explains to the medical director that patients with hyperhidrosis have been shown to have the worst Dermatology Life Quality Index scores of any

skin disease patients, including those with severe psoriasis or acne.

He also offers to provide recent practice guidelines and treatment algorithms (J. Am. Acad. Dermatol. 2004;51:274-86), so the medical director will better understand the justification for specific therapies—for example, that the standard of care for axillary disease is now topical aluminum chloride as first-line therapy, and if it’s ineffective or poorly tolerated, then Botox is the next option.

A standardized letter of medical necessity is also useful. It should include a brief assessment of the patient’s disease severity as well as documentation of prior therapies that failed to help.

“I always like to include an anecdote about the patient. For example, I had a patient who was a policeman who could not hold his pistol on the firing range because his hands were so sweaty, and a computer operator who shocked out a keyboard due to sweating. True stories are very helpful. Medical directors are people, too, sometimes,” he quipped.

Dr. Pariser contrasted the spotty reimbursement for Botox injections for hyperhidrosis and the almost reflexive coverage of endoscopic transthoracic sympathectomy—often with no preauthorization or

requirement for documentation that other therapies have been tried—even though the surgery costs \$15,000-\$20,000 and has a 40%-60% rate of long-term complications, including compensatory hyperhidrosis and Horner’s syndrome.

By far the most cost-effective method of treating patients with palmar and/or plan-

tar hyperhidrosis is tap water iontophoresis. “The cost of a Fischer MD-1a machine is around \$700; that’s about the cost of one botulinum injection,” he noted.

The CPT code for iontophoresis

is 97033. One unit of treatment is defined as 15 minutes. Standard protocols now call for 20-minute therapy sessions to each area. Thus, a physician treating two hands or both feet would bill for two treatment units, while a session involving treatment of all four extremities would warrant billing for four units, he said.

Several brands of botulinum toxin type A are marketed in the United States, but only Botox is approved by the Food and Drug Administration for hyperhidrosis. Dr. Pariser is a consultant for Allergan, which markets Botox and sponsored the hyperhidrosis session at the Hawaii meeting. The Skin Disease Education Foundation and this news organization are wholly owned subsidiaries of Elsevier. ■



**‘Let the pharmacy take the hit if there’s going to be any problem about denial of the drug.’**

DR. PARISER

## Knowledge of Fusiform, Z-Plasty Aids New Mohs Surgeons

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SAN DIEGO — Some closures may be too complex for inexperienced Mohs surgeons, but even novices can successfully close most of their cases if they have an understanding of how skin flaps move and a willingness to see the possibilities in the two simple skin movements—the fusiform and the z-plasty—that underlie all flap closures, Dr. Kenneth G. Gross said at a meeting sponsored by the American Society for Mohs Surgery.

It helps to think of flap movement as occurring in two dimensions.

“The majority of skin flaps can be explained simply by exploring what makes a fusiform work,” Dr. Gross said.

Fusiform flaps generally have 30-degree angles at their tips, based on principles of plane geometry, but the skin is not a flat plane, and whether a lesion will close with 30-degree angles depends on the anatomic location.

“The purpose of making 30-degree angles at the ends of the fusiform is to allow closure without a standing cone,” said Dr. Gross, a dermatologic surgeon in private practice in San Diego.

The fusiform consists of three components: the central defect to be closed (depicted as a circle) and two Burow’s triangles.

The short axis of the defect usually forms the short axis of the fusiform. The surgeon uses the Burow’s triangles at each end of the fusiform to bring the defect to 30-degree angles or to the angles necessary to close the wound without creating a standing cone at the ends of the excision.

The Burow’s triangles also can be rotated at the ends of the fusiform as needed to achieve the best cosmetic

result. “The Burow’s triangle can even be rotated 90 degrees,” Dr. Gross pointed out. “You should do whatever type of Burow’s triangle is needed to make the best possible closure.”

If the location of the defect prevents the use of a Burow’s triangle at one or both ends of the fusiform, the surgeon can offset the Burow’s triangles, Dr. Gross explained.

“This will result in the creation of what we call an advancement or a rotation flap. If the Burow’s triangle is offset to two sides, the result will be a bilateral flap, such as the bilateral advancement or the A to T flap,” he commented.

“If the surgeon is in doubt about how to close a wound, he or she may start by drawing a fusiform and then [assessing] whether the fusiform lies in the relaxed skin tension lines and whether it causes distortion of surrounding important anatomic structures,” Dr. Gross advised.

If the fusiform does interfere with important anatomy, the surgeon must decide where to offset

the Burow’s triangles at one or both ends of the fusiform—thereby creating an advancement or rotation flap that doesn’t interfere with important anatomy or degrade the cosmetic result.

He noted that about 90% of his Mohs closures are variations of rotation flaps.

Although rotation flaps are generally larger than other types of flaps, Dr. Gross believes that they yield better cosmetic results than transposition flaps because the resulting scar lines can usually be placed in junctions between anatomic units.

Transposition flaps are based primarily on z-plasty movement.

“If you understand the movement of a z-plasty, you will understand how all transposition flaps move and why they

move the way they do,” Dr. Gross said at the meeting.

Think of a z-plasty as two Burow’s triangles sharing a common side, called the central limb. When planning a z-plasty, think about using imaginary skin hooks to pull the central limb longer, Dr. Gross said.

While the central limb lengthens and rotates, there is concomitant shortening of tissue approximately 90 degrees from the axis of the central limb.

The amount of central limb lengthening, and the amount of rotation and shortening in the other axis, is determined by the total of both angles of the Burow’s triangles in the z-plasty.

“You can combine 45-degree and 90-degree angles in the same z-plasty, and in fact the Burow’s triangles of transposition flaps never have the same-sized angles,” Dr. Gross said.

This is the reason some surgeons don’t recognize the z-plasties that lie at the heart of all transposition flaps: They are accustomed to seeing z-plasties in textbooks that are drawn with equal angles.

As long as there is sufficient tissue in the opposite direction to allow for shortening without disrupting the surrounding anatomy, as well as enough skin laxity, the surgeon can use whatever size z-plasty angles are needed to produce the amount of central limb lengthening that will close the defect.

The three transposition flaps most often discussed and used by dermatologic surgeons are the Limberg, Webster, and Dufourmentel flaps.

The only difference among them is the total angle of the z-plasties used to create the flaps. The larger the sum of the total angles of the z-plasty of the transposition flap, the greater the lengthening and degree of rotation of the central limb and the greater the shortening of tissue in the opposite axis.

These actions result in the movement of tissue into the defect known as a transposition flap closure. Overall, the amount of tissue that is “wasted” is similar in both a z-plasty and a rotation flap, Dr. Gross said. ■