Clinical Policy: Benign Skin Lesion Removal

Reference Number: HNCA.CP.MP.150
Effective Date: 6/04
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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Medicare NCD 250.4	Treatment of Actinic Keratosis
Medicare LCD L34233	Billing and Coding: Benign Skin Lesion Removal

Description

This policy describes the medical necessity guidelines for removal of benign skin lesions. This refers to non-cancerous growths that have become problematic depending on potential changes in their characteristics, the size, location, pressure on nearby blood vessels, nerves or organs.

Policy/Criteria

I. It is the policy of Health Net of California that removal of benign skin lesions is medically necessary, and not cosmetic, when any of the following is met and is clearly documented in the medical record:

A. The lesion is symptomatic as documented by any of the following:
   1. Intense itching; or
   2. Burning; or
   3. Irritation; or
   4. Pain; or
   5. Tenderness; or
   6. Chronic, recurrent or persistent bleeding; or
   7. Physical evidence of inflammation (e.g., purulence, oozing, edema, erythema, etc.).

B. The lesion demonstrates a significant change in color or size;

C. The lesion obstructs an orifice or clinically restricts vision;

D. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesional appearance, change in appearance and/or non-response to conventional treatment;

E. The lesion is likely to turn malignant as documented by medical peer-reviewed literature;

F. A biopsy suggests the possibility of lesional malignancy;

G. The lesion is in an anatomical region subjected to recurrent physical trauma that has in fact occurred and objective evidence of such injury or the potential for such injury is documented.

H. In addition to any indication in A-G above, wart removal is also necessary for any of the following:
   1. Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding; or
   3. Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients; or

4. Lesions are condyloma acuminate, or
5. Cervical dysplasia or pregnancy associated with genital warts.

II. It is the policy of Health Net of California that removal of benign skin lesions is not medically necessary for any of the following:
A. Lesions in sensitive anatomic locations that are non-problematic do not qualify for removal coverage on the basis of location alone; or
B. Rosacea

III. It is the policy of Health Net of California that the following treatments for the destruction of correctly diagnosed actinic keratoses, also known as solar keratoses, are medically necessary as they are considered to be premalignant lesions with a low but real possibility of malignant transformation:
A. Liquid nitrogen cryotherapy
1. Most common treatment, usually recommended for treatment of solitary lesions or small numbers of scattered lesions and/or thin, well-demarcated lesions
B. Topical drug therapy (e.g. 5-fluorouracil, Imiquimod, Diclofenac, ingenol mebutate gel) See pharmacy policy on Fluorouracil Cream
C. Any of the following treatment for multiple actinic keratoses is considered medically necessary when there is failure to adequately respond to topical 5-FU or cryosurgery:
1. Laser skin resurfacing therapy
2. Chemical peel
3. Dermabrasion

IV. It is the policy Health Net of California that photodynamic therapy (PDT) with topical aminolevulinic acid (Levulan Kerastick) and exposure to blue light is medically necessary for non-hyperkeratotic actinic keratoses. Repeat treatment may be necessary after 8 weeks.

V. It is the policy of Health Net of California that photodynamic therapy (PDT) with topical aminolevulinic acid (e.g. Ameluz, Metvixia) followed by exposure to a red light source is medically necessary when other therapies are unacceptable or considered medically less appropriate**.**

VI. It is the policy of Health Net of California that electrodessication and curettage or full-thickness excision of actinic keratoses is rarely medically necessary. However, excisional biopsy of actinic keratoses (AKS) may be considered medically necessary when the following criteria are met:
A. There is bleeding, induration, rapid growth or pain, which suggest progression to squamous cell carcinoma; and
B. The lesion does not respond to treatment.

VII. It is the policy of Health Net of California that removal of skin lesions to improve appearance is not medically necessary. Removal of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not medically necessary. In the absence of any of the above indications, removal of seborrheic keratoses, sebaceous cysts, nevi (moles) or skin tags is considered cosmetic.

Background

Benign skin lesions include seborrheic keratoses, sebaceous (epidermoid) cysts, skin tags, milia (keratin-filled cysts), nevi (moles), acquired hyperkeratosis (keratoderma), papillomas, hemangiomas and viral warts. Lesions that are suspicious for malignancy, those with changing characteristics or symptomatic lesions may warrant various procedures (e.g., excision, cryosurgery, laser ablation, etc.), and possible referral to a specialist.

Photodynamic therapy (PDT) for dermatological conditions such as pre cancer and cancer itself refers to a two step process in which a drug photosenitizer is administered to a specific area of diseased tissue then light activation is applied to activate the drug and destroy the target tissue. Two common photosensitizing agents are 5-aminolevulinic acid (5-ALA) and its methyl ester, methyl aminolevulinate (MAL).

The National Institute for Health and Care Excellence (2006) has a Guidance on ' Photodynamic therapy for non-melanoma skin tumours (including premalignant and primary non-metastatic skin lesions)' which makes the following recommendations: evidence of efficacy for photodynamic therapy for the treatment of basal cell carcinoma, Bowen's disease and actinic (solar) keratosis is adequate to support its use for these conditions, provided that the normal arrangements are in place for consent, audit and clinical governance.

The British Journal of Dermatology (McKenna et al 2008) notes that with evidence there is recommendations and clinical indications for: topical photodynamic therapy in dermatology, for thin and moderate thickness actinic keratoses, Bowen's disease and superficial basal cell carcinoma. These are rated with strength of recommendation A, and quality of evidence 1, which refers to a strong recommendation that Clinicians should follow unless a clear and compelling rationale for an alternative approach is present.

Eisen et al in the American Academy of Dermatology (2021) Guideline for the Care and Management of Actinic Keratosis it was concluded to consider strong recommendations for using ultraviolet protection, topical imiquimod, topical 5-fluorouracil, and cryosurgery. Conditional recommendations are made for the use of photodynamic therapy and diclofenac for the treatment of AK, both individually and as part of combination therapy regimens.

There is insufficient published peer-reviewed evidence to support the removal of benign skin lesions, including rosacea or vascular proliferative lesions in sensitive anatomic locations that are non-problematic. In addition, studies have noted that removal of skin lesions to improve the appearance alone, would be considered cosmetic.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Not an all inclusive list

CPT® Codes	Description
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	each additional ten lesions (List separately in addition to code for primary procedure
11300	Shaving of epidermal or dermal lesions, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301	lesion diameter 0.6 to1.0 cm
11302	lesion diameter 1.1 to 2.0 cm
11303	lesion diameter over 2.0 cm
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, genitalia; lesion diameter 0.5 cm
11306	lesion diameter 0.6 to 1.0 cm
11307	lesion diameter 1.1 to 2.0 cm
11308	lesion diameter over 2.0 cm
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311	lesion diameter 0.6 to 1.0 cm
11312	lesion diameter 1.1 to 2.0 cm
11313	lesion diameter over 2.0 cm
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 or less
11401	excised diameter 0.6 to 1.0 cm
11402	excised diameter 1.1 to 2.0 cm
11403	excised diameter 2.1 to 3.0 cm
11404	excised diameter 3.1 to 4.0 cm
11406	excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	excised diameter 0.6 to 1.0 cm
11422	excised diameter 1.1 to 2.0 cm
11423	excised diameter 2.1 to 3.0 cm
11424	excised diameter 3.1 to 4.0 cm
11426	lesion diameter over 4.0 cm
11440	Excision, other benign lesion including margins(unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less
11441	excised diameter 0.6 to 1.0 cm
11442	excised diameter 1.1 to 2.0 cm
11443	excised diameter 2.1 to 3.0 cm

CPT® Codes	Description
11444	excised diameter 3.1 to 4.0 cm
11446	excised diameter over 4.0 cm
12001-12007	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and or extremities (including hands and feet); 2.5cm or less - over 30cm
12011-12018	Superficial repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5cm or less - over 30cm
12031-12037	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less to 30.0 cm
12041-12047	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less -over 30 cm
12051-12057	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less- over 30 cm.
13100	Repair, complex, trunk; 1.1 cm to 2.5 cm
13102	each additional 5 cm or less (List separately in addition to code for primary procedure)
13120	Repair, complex, scalp, arms and/or legs:1.1.cm to 2.5 cm
13121	each additional 5 cm or less (List separately in addition to code for primary procedure)
13131	Repair, complex, forehead, cheek, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132	2.6 cm to 7.5 cm
13133	each additional 5 cm or less (List separately in addition to code for primary procedure)
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less (Code deleted in 2015)
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5cm
13152	2.6 cm to 7.5 cm
13153	each additional 5 cm or less
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	defect 10.1 sq cm to 30 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	defect 10.1 sq cm to 30 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	defect 10.1 sq cm to 30 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids nose, ears and/or lips; defect 10sq cm or less
14061	defect 10.1 sq cm to 30 sq cm

CPT® Codes	Description
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, each additional 30.0 sq cm. Or part thereof (List separately in addition to code for primary procedure)
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion
17003	second through 14 lesions, each (List separately in addition to code for first lesion)
17004	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) premalignant lesions (e.g., actinic keratoses); 15 or more lesions
17110	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
17111	15 or more lesions
54050 - 54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle)
56501 - 56515	Destruction of lesion(s), vulva
57061 - 57065	Destruction of vaginal lesion(s)
96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g.lip) by activation of photosensitive drug(s), each phototherapy exposure session
96573	Photodynamic therapy by external application of light to destroy pre-hyphenmalignant and/or malignant lesions of the skin and adjacent mucosa (e.g., lip) by activation of photosensitive drug(s), each phototherapy exposure session [red light]
96574	Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day

HCPCS Codes	Description
J3490	Unclassified drugs
J7308	Aminolevulinic acid HCL for topical administration
J7309	Methyl aminolevulinate (MAL) for topical administration,
J7345	Aminolevulinic acid hcl for topical administration,
J9190	Injection, fluorouracil, 500 mg (Use this code for Adrucil)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A63.0	Anogenital (venereal) warts
B07.0-B07.9	Viral warts
D040	Carcinoma in situ of skin [Bowen's disease, lentigo maligna]
D10.0	Benign neoplasm of lip
D17.0-D17.9	Benign lipomatous neoplasm
D18.01	Hemangioma of skin and subcutaneous tissue
D21.0-D21.9	Other benign neoplasm of connective and other soft tissue
D22	Melanocytic nevi
D23.0-D23.9	Other benign neoplasm of skin
D36	Benign neoplasm of other and unspecified sites
D37.01	Neoplasm of uncertain behavior of lip
D48.5	Neoplasm of uncertain behavior of skin
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
H02.821-H02.829	Cysts of eyelid
I78.1	Nevus, non-neoplastic
L72.0	Epidermal cyst
L72.3	Sebaceous cyst
L11.0	Acquired keratosis follicularis
L20.0-L20.9	Atopic dermatitis
L29.0-L29.9	Pruritus
L53.8-L53.9	Other specified erythematous conditions
L57.0	Actinic keratosis
L72.3	Sebaceous cyst
L82.0-L82.1	Seborrheic keratosis
L85.1	Acquired keratosis [keratoderma] palmaris et plantaris
L85.2	Keratosis punctata (palmaris et plantaris)
L98.0	Pyogenic granuloma
L98.9	Disorder of the skin and subcutaneous tissue, unspecified
Q17.0	Accessory auricle
R20.0-R20.9	Disturbances of skin sensation

Reviews, Revisions, and Approvals	Date	Approval Date
Initial Approval		6/04
Revised position on actinic keratosis		5/06

Reviews, Revisions, and Approvals	Date	Approval Date
Added PDT with topical Metvixia, followed by exposure to a red light source as medically necessary for treatment of Actinic Keratoses, when criteria is met for commercial members		9/09
Removed requirement of topical 5-FU or cryosurgery prior to photodynamic therapy with topical aminolevulinic acid (Levulan Kerastick) and exposure to blue light for non-hyperkeratotic actinic keratoses of the face and scalp		11/09
Added ingenol mebutate gel to list of topical therapies approved for treatment of Actinic keratoses. Code updates		8/13
Updates with no changes		8/14 8/15 8/16 8/17
Added CPT codes and J codes for Aminolevulinic acid gel		8/18
No changes	8/19	8/19
Removed molluscum contagiosum from I.H.4 and ICD-10 code section as this condition doesn't require excision but responds to other treatment	9/19	9/19
Added codes	10/20	10/20
No changes	10/21	10/21
Removed II. C vascular prolferative disorders as this is included in the Cosmetic and Reconstructive Surgery policy Added references	10/22	10/22
Added reference to pharmacy policy in section III.B Added Medicare NCD and LCD for Medicare members	10/23	10/23
Section IV. Removed restriction for only face and scalp for PDT with blue light	3/24	3/24

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.