MetroPlusHealth **Policy and Procedure**

Title: Removal of Benign Skin Lesions	Division: Medical Management Department: Utilization Management
Approval Date: 3/25/2025	LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&II, Market Plus, Essential, HARP
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For the Medicare and UltraCare lines of business, MetroPlusHealth determines medical necessity based on applicable Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). https://www.cms.gov/medicare-coverage-database/search.aspx

A. POLICY DESCRIPTION: This policy describes the conditions under which MetroPlusHealth will cover treatment of removal of benign skin lesions and provider documentation requirements with coding instructions for non-cosmetic removal of benign skin lesions.

B. RESPONSIBLE PARTIES:
Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

C. DEFINITIONS:

- Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed.
- The following are examples of benign skin lesions:
  - sebaceous (epidermoid) cysts
  - skin tags
  - milia (keratin-filled cysts)
  - nevi (moles)
  - acquired hyperkeratosis (keratoderma)
  - papillomas
  - hemangiomas
  - viral warts

D. POLICY:

- MetroPlusHealth will cover benign skin lesion Excisions as defined by the Centers for Medicare & Medicaid Services (CMS). In accordance with CMS guidelines, MetroPlus does not cover cosmetic surgery or expenses incurred in connection with such surgery.
- Removal of benign skin lesions is ***not*** considered cosmetic when symptoms or signs which warrant medical intervention are present, including but not limited to

  a. The lesion has one or more of the following characteristics: bleeding, itching, pain; change in physical appearance (reddening or pigmentary change), recent enlargement, increase in number; or
  b. The lesion has physical evidence of inflammation, e.g., purulence, edema, erythema; or
  c. The lesion obstructs an orifice; or
  d. The lesion clinically restricts vision; or

e. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance; or
f. A prior biopsy suggests or is indicative of lesion malignancy or premalignancy; or
g. The lesion is in an anatomical region subject to recurrent trauma, and there is documentation of such trauma.

- Wart removals is ***not*** considered cosmetic when guidelines above are met or if any of the following clinical circumstances are present:

    a. Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding.
    b. Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients, or in locations that are likely to lead to further spread (volar aspect of hands).
    c. Lesions are condyloma acuminata or molluscum contagiosum.
    d. Cervical dysplasia or pregnancy is associated with genital warts.

- Cosmetic
    - In the absence of any of the above indications MetroPlusHealth considers the following cosmetic:

        - Removal of dermatofibromas, dermatosis papulosa nigra, pilomatrixoma, poikiloderma of Civatte (sun aging), sebaceous cysts, seborrheic keratoses, small nevi (moles), or other benign skin lesions, or needle hyfrecation for sebaceous hyperplasia.

E. Documentation requirements

a. Clinical notes submitted by the physician must clearly document the medical necessity for the lesion removal(s).
b. Each benign lesion excised should be reported separately. Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the narrowest margins required equals the excised diameter).
c. The margins refer to the narrowest margin required to adequately excise the lesion, based on the physician's judgment.
d. The measurement of lesion plus margin is made prior to excision.

F. Exclusions

a. Claims for removal of benign skin lesions performed for cosmetic reasons are not covered.
b. Benign skin lesions are frequently removed at the patient's request to improve appearance. Removal of certain benign skin lesions that do not pose a threat to health or function, are considered cosmetic and as such are not covered

G. APPLICABLE PROCEDURE CODES:

Code	Description
11200	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; UP TO AND INCLUDING 15 LESIONS
11201	REMOVAL OF SKIN TAGS, MULTIPLE FIBROCUTANEOUS TAGS, ANY AREA; EACH ADDITIONAL 10 LESIONS, OR PART THEREOF (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
11300	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.5 CM OR LESS
11301	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 0.6 TO 1.0 CM
11302	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER 1.1 TO 2.0 CM
11303	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, TRUNK, ARMS OR LEGS; LESION DIAMETER OVER 2.0 CM
11305	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.5 CM OR LESS
11306	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 0.6 TO 1.0 CM
11307	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; LESION DIAMETER 1.1 TO 2.0 CM
11308	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, SCALP, NECK, HANDS, FEET, GENITALIA; 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	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 0.6 TO 1.0 CM
11312	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; LESION DIAMETER 1.1 TO 2.0 CM

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11313	SHAVING OF EPIDERMAL OR DERMAL LESION, SINGLE LESION, FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; 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 CM OR LESS
11401	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM
11402	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 1.1 TO 2.0 CM
11403	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 2.1 TO 3.0 CM
11404	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; EXCISED DIAMETER 3.1 TO 4.0 CM
11406	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), TRUNK, ARMS OR LEGS; 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	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.6 TO 1.0 CM
11422	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 1.1 TO 2.0 CM
11423	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 2.1 TO 3.0 CM
11424	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 3.1 TO 4.0 CM
11426	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER OVER 4.0 CM

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11440	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 0.5 CM OR LESS
11441	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 0.6 TO 1.0 CM
11442	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 1.1 TO 2.0 CM
11443	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 2.1 TO 3.0 CM
11444	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER 3.1 TO 4.0 CM
11446	EXCISION, OTHER BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE; EXCISED DIAMETER OVER 4.0 CM
17000	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES); FIRST LESION
17003	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES); SECOND THROUGH 14 LESIONS, EACH (LIST SEPARATELY IN ADDITION TO CODE FOR FIRST LESION)
17004	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), PREMALIGNANT LESIONS (EG, ACTINIC KERATOSES), 15 OR MORE LESIONS
17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM
17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 TO 50.0 SQ CM
17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50.0 SQ CM
17110	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; UP TO 14 LESIONS

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17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; 15 OR MORE LESIONS
17340	CRYOTHERAPY (CO2 SLUSH, LIQUID N2) FOR ACNE

H. REFERENCES:

- Article - Billing and Coding: Removal of Benign Skin Lesions (A54602) (cms.gov)
- Benign skin lesions. Medscape.com. Published January 4, 2022. Accessed August 14 2024. https://emedicine.medscape.com/article/1294801-overview
- CMS publication 100-02; Medicare Benefit Policy Manual, Chapter 16, Section 20). including complications resulting from non-covered services (CMS publication IOM 100-02, Chapter 16, Section 180).

I. REVISION LOG:

REVISIONS	DATE
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David Ackman — Digitally signed by David Ackman Date: 2025.04.01 08:18:55 -04'00'		Sanjiv Shah MD — Digitally signed by Sanjiv Shah MD Date: 2025.04.01 09:18:05 -04'00'	
David Ackman, MD VP of Medical Directors		Sanjiv Shah, MD Chief Medical Officer	

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Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.