Coverage for Benign or Premalignant Skin Lesion Removal

Background Medicare B of Florida has developed a medical policy for these services as well as services for the removal of benign, either by shaving or excision (procedure codes 11300 through 11446); the destruction of benign facial or premalignant skin lesions in any location (procedure codes 17000 through 17002) destruction by any method of complicated benign or premalignant lesions (procedure code 17010); destruction by any method benign or premalignant lesion on any area other than face (17101 through 17105); and the destruction by any method of flat warts or molluscum contagiosum and milia (17110).

Covered Conditions and/or Diagnoses	Non-Covered Condition and/or Diagnoses	Subject to Waiver	Comments
Medicare B will consider the destruction of a benign or premalignant skin lesion medically necessary under the following circumstances: • When the patient has multiple actinic keratoses and has self-administered 2% to 5% Fluorouracil topical cream for two to four weeks and the actinic keratoses have not responded to this treatment one to two months following treatment*, or * It should be noted that the natural response to fluorouracil (Efudex) is erythema, usually followed by vesiculation, desquamation, erosion and reepithelialization. Therefore, during and immedicately following fluorouracil treatment these signs and symptoms would be considered part of the healing process and would not be considered as meeting the criteria for removal. There are contraindications for topical fluorouracil which include pregnancy, use on mucous membranes, use on mouth, and use around eyes or on nose. If after two months following treatment with fluorouracil, the actinic keratoses have not responded, they may be removed or destroyed. • When a patient presents with an actinic keratosis that has changed in size, has developed erythema, has thickened, has ulcerated, has eroded, has developed changes at the tumor margins, has become markedly hyperkeratotic, in which pain has developed and/or a cutaneous horn has developed; • When the patient presents with an actinic cheilitis (actinic keratosis of the lower lip) or an actinic keratosis on the upper lip; • When the patient presents with an actinic conjunctivae (actinic keratosis of the conjunctiva); • When the patient presents with an actinic keratosis on the nose, ear or eyelid; • When the patient presents with a actinic keratosis and has a history of one of the following: - chronic immunosuppression such as that associated with organ transplantation, particularly renal transplantation, and other disease processes such as Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and/or chronic lymphocytic leukemia or lymphoma; - treatment of psoriasis with psolaren-ultraviolet A (PUVA) therapy; - xeroderma pigmentosum, albinism, or discoid lupus erythematosus; and/or,	All other indications	Medical Necessity Yes (Refer to guidelines outlined in the Column titled "Covered Conditions and/or Diagnoses") Utilization Yes	**Coding Guidelines** CPT coding is based on the type of lesion (benign or premalignant), method of destruction or removal, and the number of lesions removed for any of the procedure codes within the following ranges: 11300-11313; 11400-11446; 17000-17002; or 17100-17110. **If a lesion is destroyed or removed for any reason or for any circumstance other than ones listed in this article, the procedure is considered medically unnecessary and is, therefore, not reimbursurable by Medicare.** **When the patient is seen in the office for purposes of prescribing fluorouracil and providing instruction on how to use this medication, the appropriate level of Evaluation and Management service may be billed.** Procedure code 17000 may only be billed once per day. Procedure code 17001 may be billed no more than two times in one day because the descriptor reads "2nd and 3rd lesion, each lesion". **It is not appropriate to use the modifier -76 (repeat procedure) with these codes.** Procedure codes 17100 through 17104 are to be billed in a similar manner. The first lesion should be billed utilizing procedure code 17100. If a second lesion is removed, it should be billed utilizing procedure code 17101. If three to fifteen lesions are removed on the same day as the first and second, procedure code 17102 may also be billed. Procedure code 17104 is used when fifteen or more lesions are removed. **It is not appropriate to bill this code with 17100, 17101, or 17102 or to bill with the modifier -76.**

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Covered Conditions and/or Diagnoses (con't)

- previous treatment of a biopsy-proven Squamous Cell Carcinoma (SCC).

- When a patient presents with an arsenical keratosis (due to arsenic exposure);
- When a patient presents with a keratosis and has a history of significant exposure to therapeutic or occupational radiation therapy (chronic radiation kertosis).
- When a patient presents with a keratosis which arises from an old scar (chronic cicatrix keratosis).

If none of the aforementioned conditions exist, Medicare B of Florida would consider the removal of an actinic keratosis as medically unnecessary and, therefore, not reimbursable by Medicare.

In addition, chemical peels of the face, even in the presence of actinic keratoses, are considered medically unnecessary in nature because the technique is used to improve the appearance of photodamaged skin, and is, therefore, not reimbursable by Medicare.

The total number of services billed utilizing procedure codes 17000, 17001, and 17002 which exceed the number that would be considered medically necessary and reasonable according to established parameters will be reviewed on a prepayment basis using the criteria above and may be denied as not medically necessary or reasonable.

Generally, the removal of benign lesions such as seborrheic keratoses, sebaceous cysts, and warts are done for cosmetic reasons, however, in rare instances it may be necessary to remove these types of lesions. Medicare B of Florida will consider the removal of these lesions as medically necessary for any of the following reasons:

- the lesion is in an area such as the neck or waist and is constantly irritated and/or is located in an anatomical location of recurrent trauma and that such trauma has in fact occurred;
- the lesion obstructs an orifice or clinically obstructs vision (this would include any lesion);
- the patient presents with condylomata acuminta (venereal warts) and/or is immunosuppressed; and/or,
- plantar warts or other lesions on the sole of the foot which impede the patient's ability to ambulate or which meet any of the aforementioned criteria.

If the aforementioned signs and symptoms are not present, further treatment would be considered medically unnecessary in nature and, therefore, not reimbursable by Medicare.

Destruction of benign or premalignant lesions that exceed utilization parameters as determined by our analysis of frequency data for beneficiaries may be reviewed for medical necessity on a prepayment basis.

Comments (con't)

Documentation Requirements:

If the patient presents with multiple actinic keratoses, the self-administration of topical 2% to 5% fluorouracil cream or solution for a period of no less than two weeks and unresponsiveness to the medication after two months should be documented. If the patient has a condition in which fluorouracil is contraindicated such as pregnancy or actinic keratosis (es) around the eyes on the nose, on the mouth, or on mucous membranes, the physician's office/progress note should reflect this. The location of the lesion(s) should be documented as well.

If the patient presents with an actinic keratosis(es) and its appearance has changed, i.e. size, erythema, thickening, ulceration, and/or erosion in the tumor or tumor margins or if the patient has developed pain within the lesion, this should be clearly documented in the physician's progress/office note to substantiate removal of the lesion.

If the patient presents with an actinic cheilitis (actinic keratosis of the lower lip) or an actinic keratosis on the ear or conjunctiva, the exact location and a description of the lesion's appearance should be documented in the physician's progress/office note.

If the patient presents with an **actinic keratosis** and has a history of chronic immunosuppression; treatment of psoriasis with PUVA therapy; xeroderma pigmentosum, discoid lupus erythematosus or albinism; and/or a previous treatment of a biopsy-proven SCC, this should clearly be documented in the physician's progress/office note. The approximate starting date and duration of radiation therapy or PUVA therapy should be documented, if applicable. In addition, the date of organ transplantation should be documented, if applicable. Any other immunosuppressive disorder should be documented with the date or approximate date of diagnosis.

Also, if the patient has had a previous biopsy-proven SCC or other skin malignancy, the location of that lesion, the date of removal, and a pathology report for the previous lesion, if available, should be documented. In addition, for the aforementioned conditions/treatments, the exact location and a description of the lesion should be documented.

For cicatrix keratoses, the location of the scar, the type of the scar, the approximate date the scar developed, and a description of the size, location and appearance of the lesion should be documented in the physicians' progress/office note.

Although not required at this time, a photograph of the lesion with an indication of the size and location would be an excellent documentation tool for the size, location, and appearance of the lesion. If the physician is not able to take a photograph or make a sketch in his/her notes regarding size, location, and appearance of the lesion, a very clear description of the lesion must be included in the progress/office note.

For those **benign lesions that are located in areas which subject the lesion to constant irritation and/or trauma** and need to be removed because of constant or frequent traumatization, the exact location and size of the lesion and type of irritation and/or trauma should be documented in the physician's progress note/office note.

In addition, to the above, the method of destruction or removal should be described in the physician's progress/office note for any type of lesion destroyed or removed.