Article - Billing and Coding: Removal of Benign Skin Lesions (A54602)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services,	A and B and HHH	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Inc.	MAC			
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

Article Information

General Information

Article ID
A54602

Article Title
Billing and Coding: Removal of Benign Skin Lesions

Article Type
Billing and Coding

Original Effective Date
10/01/2015

Revision Effective Date
05/07/2020

Revision Ending Date
N/A

Retirement Date
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CMS National Coverage Policy

N/A

Article Guidance

Article Text

Medicare does not cover cosmetic surgery or expenses incurred in connection with such surgery (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). This coding article provides documentation requirements and coding instructions for non-cosmetic removal of benign skin lesions.

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

Removal of benign skin lesions is not considered cosmetic when symptoms or signs which warrant medical intervention are present, including but not limited to:

- Bleeding
- Intense itching
- Pain
- Change in physical appearance, for example, but not limited to:
  - reddening
  - pigmentary change
  - enlargement
  - increase in the number of lesions
- Physical evidence of inflammation or infection, e.g., purulence, oozing, edema, erythema, etc.
- Lesion obstructs an orifice

- Lesion clinically restricts eye function, for example, but not limited to:
    - Lesion restricts eyelid function
    - lesion causes misdirection of eyelashes or eyelid
    - lesion restricts lacrimal puncta and interferes with tear flow;
    - lesion touches globe;
- Clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on lesion appearance
- Wart removals is not considered cosmetic when guidelines above are met or if any of the following clinical circumstances are present:
    - Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding
    - Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients or warts of recent origin in an immunocompromised patients
    - Lesions are condyloma acuminata or molluscum contagiosum

- Cervical dysplasia or pregnancy is associated with genital warts

Medicare will not pay for a separate E & M service on the same day as a minor surgical procedure unless a documented significant and separately identifiable medical service is rendered. The service must be fully and clearly documented in the patient's medical record and a modifier 25 should be used.

Medicare will not pay for a separate E & M service by the operating physician during the global period unless the service is for a medical problem unrelated to the surgical procedure. The service must be fully and clearly documented in the patient's medical record.

Coding Guidelines

For excision of benign lesions requiring more than simple closure, i.e., requiring intermediate or complex closure, report 11400-11466 in addition to appropriate intermediate (12031-12057) or complex closure (13100-13153) codes. For reconstructive closure, see 14000-14300, 15000-15261, and 15570-15770.

CPT codes 11400-11446 should be used when the excision is a full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure.

Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed. 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 most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision.

Units of service:

CPT code 11200 should be reported with one unit of service. CPT code 11201 should be reported with units equal to one for each additional group of 10 lesions or part thereof.

CPT code 17000 should be reported with one unit of service for destruction of the first lesion; CPT code 17003 should be reported with the units equal to the number of additional lesions from 2 through 14; 17004 should be reported with one unit of service, representing 15 or more lesions and should not be used with 17000 or 17003.

CPT code 17110 should be reported with one unit of service for removal of benign lesions other than skin tags or cutaneous vascular lesions, up to 14 lesions. CPT code 17111 is also reported with one unit of service representing 15 or more lesions.

Billing for cosmetic surgery:

Claims for removal of benign skin lesions performed merely for cosmetic reasons may not necessarily need to be submitted to Medicare unless the patient requests that a formal Medicare denial is issued. If a claim is filed, ICD-9 CM code V50.1 (Other plastic surgery for unacceptable cosmetic appearance) should be used in conjunction with the appropriate CPT code.

GY Modifier

The definition of the GY modifier is - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

The GY modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit

Advance Beneficiary Notice of Non-coverage (ABN) Modifier Guidelines

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or

for other reasons. Refer to CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 30, for complete instructions.

For claims submitted to the Part B MAC:

All services/procedures performed on the same day for the same beneficiary by physician/provider should be billed on the same claim.

Modifier –24 should be used when unrelated evaluation and management services, by the same physician, are reported during a postoperative global period.

Modifier – 25 should be used when separately identifiable evaluation and management services that are above and beyond the pre- and post-operative work of the procedure, by the same physician are performed on the same day as a covered minor surgical service is performed.

Evaluation and management services provided on the day, or the day before a minor surgical procedure, for the purpose of making the decision to perform the procedure, are not payable. The modifier – 57 cannot be used since the decision to perform the minor surgical procedure is considered a routine preoperative service and a visit or consultation should not be billed. (Modifier 57 is only applicable for major procedures that have a 90-day global period.)

For claims submitted to the Part A MAC:

<u>Hospital Inpatient Claims:</u>

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

- *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67*. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).*
- The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

Documentation Requirements

Medical records maintained by the physician must clearly document the medical necessity for the lesion removal(s).

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes: (41 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

CODE	DESCRIPTION
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
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

CODE	DESCRIPTION
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
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

CODE	DESCRIPTION
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
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

CPT/HCPCS Modifiers

N/A

ICD-10-CM Codes that Support Medical Necessity

N/A

ICD-10-CM Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

Claims for removal of benign skin lesions performed merely for cosmetic reasons should be submitted with ICD-10-CM code Z41.1

Group 1 Codes: (1 Code)

CODE	DESCRIPTION
Z41.1	Encounter for cosmetic surgery

Additional ICD-10 Information

N/A

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all

Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

CODE	DESCRIPTION
011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

CODE	DESCRIPTION
0360	Operating Room Services - General Classification
0361	Operating Room Services - Minor Surgery
0369	Operating Room Services - Other OR Services
0456	Emergency Room - Urgent Care
0490	Ambulatory Surgical Care - General Classification
0499	Ambulatory Surgical Care - Other Ambulatory Surgical Care
0510	Clinic - General Classification
0516	Clinic - Urgent Care Clinic
0520	Freestanding Clinic - General Classification
0761	Specialty Services - Treatment Room
0960	Professional Fees - General Classification
0969	Professional Fees - Other Professional Fee
0975	Professional Fees - Operating Room

CODE	DESCRIPTION
0982	Professional Fees - Outpatient Services
0983	Professional Fees - Clinic

Other Coding Information

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
05/07/2020	R3	This article was converted to the new Billing and Coding Article format.
01/01/2018	R2	Descriptor for CPT code 11403 has been revised.
10/01/2015	R1	The following language relating to places of service has been removed, effective for services rendered on or after 10/01/2015: CPT codes covered under this policy are paid under Part B when rendered in the following places of service: office (11), urgent care facility (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32), independent clinic (49), inpatient psychiatric facility (51) and intermediate care facility/mentally retarded (54). CPT codes 11200, 11201, 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, and 11313 are also payable when rendered in place of service home (12) and temporary lodging (16). CPT codes 17000, 17003, 17004, 17110 and 17111 are also payable in the following places of service: home (12), assisted living (13), group home (14), temporary lodging (16), and custodial care facility (33).

Associated Documents

Related Local Coverage Documents

N/A

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
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Keywords

N/A