HEALTH PLANS
UNIVERSITY OF UTAH

Medical Policy

Benign Skin Lesion Removal

Policy MP-011

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.

Description:

A skin lesion is a nonspecific term that refers to any change in the skin surface; it may be benign, malignant or premalignant. Skin lesions may have color (pigment), be raised, flat, large, small, fluid filled or exhibit other characteristics. Common examples of benign skin lesions may include moles (nevi), sebaceous cysts, seborrheic keratoses, skin tags (acrochordon), calluses, corns or warts.

The treatment of benign skin lesions consists of destruction or removal by any of a wide variety of techniques. The removal of a skin lesion can range from a simple biopsy, scraping or shaving of the lesion, to a radical excision that may heal on its own, be closed with sutures (stitches) or require reconstructive techniques involving skin grafts or flaps. Laser, cautery or liquid nitrogen may also be used to remove benign skin lesions. When it is uncertain as to whether or not a lesion is cancerous, excision and laboratory (microscopic) examination is usually necessary.

Policy Statement and Criteria

1. Commercial Plans

U of U Health Plans covers the removal of lipomas, seborrheic keratoses, melanocytic nevi, acrochordons/skin tags, fibromas, warts and dermatofibromas in adults when found to be medically necessary based upon documentation of a functional* problem.

Some benign skin conditions present predominantly in children such as congenital hemangiomas, port wine stains and other vascular lesions may only be covered under specific conditions identified in policies specific to those conditions.

Specific lesions not shown to have a covered functional* problem are denied based upon the reconstructive and cosmetic limitations present in the plan certificate of coverage.

*Functional impairment is defined as pain of such a magnitude or location of the lesion(s) that it impairs an individual's ability to perform their activities of daily living (ADL), limit mobility or otherwise prevent normal function of a body part.

2. **Medicaid Plans**
   Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

3. **Medicare Plans**
   Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicare policies and coverage, please visit their search website at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

Clinical Rationale

Acquired nevi (moles) can appear anywhere on the skin. They are usually brown in color, but can be skin colored or pink, light tan to brown, or blue-black. Moles may be flat or raised and can be various sizes and shapes. Most appear during the first 20 years of a person's life, although some may not appear until later in life. Sun exposure increases the number of moles. The majority of moles are benign. However, moles that raise suspicion of malignancy are those that change in size, shape or color, and those that bleed, itch, or become painful. Atypical moles (dysplastic nevi) have an increased risk of developing into melanoma. Atypical moles are larger than average (greater than 6 mm) and irregular in shape. They tend to have uneven color with dark brown centers and lighter, sometimes reddish, uneven borders or black dots at edge. The most common methods of removal include shaving and excision.

Congenital melanocytic nevi occur in approximately 1 % of newborns and are usually classified according to their size. Giant congenital melanocytic nevi are most simply defined as melanocytic nevi that are greater than 20 cm in largest dimension; whereas small congenital nevi are defined as melanocytic nevi less than 1.5 cm in largest dimension. Giant congenital melanocytic nevi are associated with an increased risk of the development of melanoma, and are therefore surgically removed. However, small congenital nevi do not need to be removed as the risk of malignant transformation is thought to be small or none. The management of intermediate sized congenital nevi is controversial, as the risk of malignant transformation and the lifetime melanoma risk in patients with intermediate sized congenital nevi is not known.

A skin tag (acrochordon) is a benign, soft, moveable, skin-colored growth that hangs from the surface of the skin on a thin piece of tissue called a stalk. The prevalence of skin tags increases with age. They appear most often in skin folds of the neck, armpits, trunk, beneath the breasts or in the genital region. They are painless, but may become painful if thrombosed or if irritated. They may become irritated if

they occur in an area where clothing or jewelry rubs against them. Skin tags may be removed by excision, cryosurgery, or electrosurgery.

Bowen's disease (squamous cell carcinoma in situ) is a pre-malignant lesion, often due to arsenic exposure, that may give rise to squamous cell carcinoma. Lesions predominantly affect the elderly, and consist of persistent, erythematous, scaly plaques with well-defined margins. Treatment options include excision, cryotherapy, curettage and cautery, and topical 5-fluorouracil.

Lentigo maligna (Hutchinson's Freckle) is a pre-malignant lesion that may give rise to lentigo maligna melanoma. These lesions are pigmented macules, often greater than 1 cm in diameter with an irregular border, occurring mainly on sun-exposed areas. Lesions characteristically have brown, black, red, and white areas and become more irregularly pigmented over time. Risk of conversion to melanoma by age 75 is estimated at 1 to 2 %. Patients should undergo regular follow-up examinations for signs of conversion to melanoma. Because conversion to melanoma is usually relatively slow, the decision to excise lentigo maligna should be based on several factors, including the size and location of the lesion, which determines the complexity of the procedure required, and the patient's life expectancy and comorbidities.

A systematic review (Loo et al, 2014) studied the effects of treatments for warts (non-genital). Seventeen studies were found that met the inclusion criteria. Warts are caused by the human papillomavirus (HPV), of which there are over 100 types. They are most common at sites of trauma, such as the hands and feet, and probably result from inoculation of virus into minimally damaged areas of epithelium. Warts on the feet can be acquired from walking barefoot in areas where other people walk barefoot. One observational study (146 adolescents) found that the prevalence of warts on the feet was 27% in those that used a communal shower room and 1.3% in those that used the locker room. Warts on the hand are also an occupational risk for butchers and meat handlers. One cross-sectional survey (1086 people) found that the prevalence of warts on the hand was 33% in abattoir workers, 34% in retail butchers, 20% in engineering fitters, and 15% in office workers. Immunosuppression is another important risk factor. One observational study in immunosuppressed renal transplant recipients found that, at 5 years or longer after transplantation, 90% had warts. The rate of resolution is highly variable and probably depends on several factors, including host immunity, age, HPV type, and site of infection. One cohort study (1000 children in long-stay accommodation) found that two-thirds of warts resolved without treatment within a 2-year period.

An UpToDate review on “Neurofibromatosis type 1 (NF1): Management and prognosis” (Korf, 2015) states that “Cutaneous and subcutaneous neurofibromas are not removed unless there is a specific need for removal (e.g., pain, bleeding, interference with function, disfigurement). Referral to dermatology is advised for patients with severe pruritus”.

Ovejero and colleagues (2016) stated that cutaneous skeletal hypophosphatemia syndrome (CSHS), caused by somatic RAS mutations, features excess fibroblast growth factor-23 (FGF23) and skeletal dysplasia. In this study, records from 56 individuals were reviewed and demonstrated fractures, scoliosis, and non-congenital hypophosphatemia that in some cases were resolved. Phosphate and calcitriol, but not skin lesion removal, were effective at controlling hypophosphatemia. No skeletal malignancies were found; 5 CSHS subjects underwent prospective data collection at clinical research centers. A review of the literature identified 45 reports that included a total of 51 additional patients, in whom the findings were compatible with CSHS. Data on nevi subtypes, bone histology, mineral and skeletal disorders, abnormalities in other tissues, and response to treatment of hypophosphatemia were analyzed. Fractures, limb deformities, and scoliosis affected most CSHS subjects. Hypophosphatemia was not present at birth. Histology revealed severe osteomalacia but no other abnormalities. Skeletal

dysplasia was reported in all anatomical compartments, though less frequently in the spine; there was no clear correlation between the location of nevi and the skeletal lesions. Phosphate and calcitriol supplementation was the most effective therapy for rickets. Convincing data that nevi removal improved blood phosphate levels was lacking. An age-dependent improvement in mineral abnormalities was observed. A spectrum of extra-osseous/extra-cutaneous manifestations that included both benign and malignant neoplasms was present in many subjects, though osteosarcoma remains un-reported.

Applicable Coding

CPT Codes

Covered codes if criteria are met:

11200-11201 Removal of skin tags, multiple fibrocutaneous tags, any area

11300-11313 Shaving of epidermal or dermal lesions

11400-11446 Excision, benign lesions

17000-17004 Destruction, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses)

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

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)

HCPCS Codes

No applicable codes

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