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Comments and Responses Regarding Draft Local Coverage Determination: Removal of Benign Skin Lesions

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Removal of Benign Skin Lesions LCD. The official notice period for the final LCD begins on October 1, 2008, and the final determination will become effective on November 15, 2008.

Comment:

Representatives of the American Academy of Dermatology objected to the statement below from the Supplemental Instructions Article (SIA) which provides coding guidance:

“If a benign skin lesion excision was performed, report the applicable CPT code, even if final pathology demonstrates a malignant or carcinoma in situ diagnosis for the lesion removed. The final pathology does not change the CPT code of the procedure performed.”

This statement conflicts with the accepted Dermatology Guidelines, which have taken the position that the final pathology **determines** the appropriate CPT code to report, and that when the diagnosis is not certain, providers should hold the claim pending the final pathology report. This approach offers the best assurance of correct coding, and discourages abuse.

This position is also consistent with that of the AMA-CPT Workgroup that revised the descriptors for the Excision- benign and malignant lesion CPT codes to include margins.

Consider the converse situation which was more prevalent among surgeons prior to the redefinition of excisions to include margins. Some surgeons would “approach” a lesion as if it were malignant, i.e. with a little larger margin to “do a malignant excision”, and then would report a malignant excision regardless of the fact that final pathology was benign. This has great abuse potential that increases inversely with the clinical diagnostic skills of the surgeon.

Medicare should pay for the care the patient needs, and that is best determined by the final pathology. When a skin lesion is excised and final pathology confirms a malignant lesion or carcinoma in situ, only malignant excision codes should be reported, based on the excised diameter. When a skin lesion is excised, even with concern for possible malignancy, but the final pathology confirms a benign lesion, or lesion of uncertain behavior, only benign lesion excision codes should be reported, also based on excised diameter. Such a policy is more consistent with the intent of CPT, and should be basic to any LCD Guidelines related to excision of skin lesions.

As this LCD comes up for comment in the various CAC meetings, we offer the Carriers replacement language for the paragraph in question. Please consider the following for your consideration to Draft Article A47397, Removal of Benign Skin Lesion Supplemental Instructions:

"Claims for excision of skin lesions should represent the work actually performed, in order to assure that Medicare pays only for the procedure the patient needs. When a skin lesion is excised, even with concern for possible malignancy, and the final pathology confirms a benign lesion, or lesion of uncertain behavior, the Excision-Benign lesion codes should be reported, based on the excised diameter. If a final pathology report confirms that a malignant lesion or carcinoma in situ has been excised, the Excision-Malignant lesion codes are appropriate."

Response:

The contractor respectfully disagrees with this suggestion. The result of a pathology report does not change what was actually performed at the time of the excision. The excision of a malignant skin lesion requires a deeper margin than a benign lesion and may also require immediate re excision if a frozen section is performed at the time of the original excision.

The provider should report what was actually performed at the time of surgery; however, the contractor will accept either method of billing.

CPT Assistant

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Integumentary, 11400-11446, 11600-11646 (Q&A)

Question

When a lesion is removed that turns out to be a neoplasm of uncertain morphology (eg, melanoma vs dysplastic nevi), is it correct to use excision of benign neoplasm rather than excision of malignant neoplasm?

AMA Comment

"Uncertain behavior" identifies tissue that is beginning to exhibit neoplastic behavior but cannot yet be categorized as benign or malignant. Additional or further testing is required. To ensure correct coding, the removal of the neoplasm should be coded after receiving the pathology report.

When the morphology of a lesion is ambiguous, choosing the correct CPT procedure code relates to the manner in which the lesion was approached rather than the final pathologic diagnosis, since the CPT code should reflect the knowledge, skill, time, and effort that the physician invested in the excision of the lesion. Therefore, an ambiguous but low suspicion lesion might be excised with minimal surrounding grossly normal skin/soft tissue margins, as for a benign lesion (codes 11400-11446), whereas an ambiguous but moderate-to-high suspicion lesion would be excised with moderate to wide surrounding grossly normal skin/soft tissue margins, as for a malignant lesion (codes 11600-11646). Thus, the CPT code that best describes the procedure as performed should be chosen.

Comment:

The dermatology representative from NY had this additional comment (also raised at the NY CAC meeting):

The NY State Society of Dermatology would like to see removal of warts added to the list of conditions that are covered without qualification, that is, on the basis of diagnosis alone (and that are not symptomatic), because these are contagious to other individuals and other body areas. The same consideration is afforded to removal of molluscum contagiosum lesions, which are also viral in etiology and contagious.

Response:

The LCD does allow for excision of warts if there is evidence of spread to other body areas. The incidence of spread is higher for condyloma acuminata or molluscum contagiosum than for the common wart (verruca vulgaris), plantar wart (verruca plantaris), and flat wart (verruca plana) where treatment should be tempered by the observation that a majority of warts in normal individuals resolve spontaneously within 1 to 2 years.

Indications

8. Wart removals will be covered under guidelines (1-7) above. In addition, wart destruction will be covered when 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 warts of recent origin in an immunocompromised patient.*
 - c. Lesions are condyloma acuminata or molluscum contagiosum*
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Comment:

The dermatology CAC member stated that language in the LCD and SIA needs to be brought up to date with the changes in the CPT descriptor changes (AMA CPT coding changes – CPT book for 2003). ICD-9 codes are selected by measuring diameter of lesion plus margins.

Response:

This comment is contained in the limitation section which describes the code selection based on the apparent lesion plus that margin required for complete excision.

LIMITATIONS SECTION

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.

Comment:

A CAC member stated the if benign lesions are removed, the final pathology of the lesion determines the CPT code to report.

Response:

See comment and response #1

Comment:

A commenter stated that is common for physicians to describe seborrheic keratoses as "irritated" and are therefore removing them. Since "inflammation" is a different idea and it would be therefore incorrect to code this condition as 702.11, we are trying to anticipate the impact of the LCD on these claims.

- Will it be the intent of this LCD to cover the removal of "irritated" seborrheic keratosis?
- If yes, how would we convey that idea to UGS?

Would this fall into this indication: "The lesion is in an anatomical region subject to recurrent physical trauma, and there is documentation that such trauma has, in fact, occurred"?

Response:

Since the definition of "irritated" includes, "inflamed or made raw, as a part of the body", the contractor recommends using the inflamed diagnosis for the irritated lesion.

in•flam•ma•tion (in"flm-macshmn) [L. *inflammatio*; *inflammare* to set on fire] a localized protective response elicited by injury or destruction of tissues, which serves to destroy, dilute, or wall off (sequester) both the injurious agent and the injured tissue. It is characterized in the acute form by the classical signs of pain (*dolor*), heat (*calor*), redness (*rubor*), swelling (*tumor*), and loss of function (*functio laesa*). Histologically, it involves a complex series of events, including dilatation of arterioles, capillaries, and venules, with increased permeability and blood flow; exudation of fluids, including plasma proteins; and leukocytic migration into the inflammatory focus.

ir·ri·tat·ed [**ir-i-tey-tid**]-adjective

1. *angered, provoked, or annoyed.*
 2. *inflamed or made raw, as a part of the body.*
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Comment:

A commenter noted, in the medical necessity reasoning for removal of the lesions such as a sebaceous cyst it says if the cyst is in an area that is easily traumatized, enlarging, or runs the chance of infection it will be covered. When you look at diagnosis codes and sebaceous cyst (706.2) and lipomas (214.8) need a secondary code from the approved list there are no codes for enlargement, easily traumatized and more often what we see is that we will have to drain an infected cyst and then some time later excise it. What codes to we use? If there are no secondary codes with the claim be rejected?

Response:

The contractor will add V58.77 (Aftercare following surgery of the skin and subcutaneous tissue) to our list of secondary codes to cover the situation where a sebaceous cyst has required I&D and now is presented for definitive excision.

In the majority of cases where the lesion is enlarging or easily traumatized, the overlying complaint is pain and this should be listed as the secondary diagnosis. In some cases, the concern of malignancy may exist for an enlarging lesion and this is also an accepted indication.