

Coding and Billing Guidelines

Article Title

DERM-008 Removal of Benign Skin Lesions

Article Effective Date

07/01/2009

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CMS Regulations:

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Coding Information

CPT/HCPCS Codes

See LCD DERM-008

Coding Information

1. Use the CPT code that best describes the procedure, the location and the size of the lesion. If there are multiple lesions, multiple codes from 11300 through 11446 or 17106 through 17111 may be used, but National Correct Coding Initiative guidelines apply for all submitted codes. 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 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.

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.

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.

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.

3. The provider should use the appropriate CPT code and the ICD-9 code should match the CPT code. If a provider bills a benign skin lesion CPT code, it is not correct to use a malignant ICD-9 code.
4. If a beneficiary wishes to have one or more benign asymptomatic lesions removed that pose no threat to health or function, and for cosmetic purposes:
 - a. The physician should explain to the patient, in advance, that Medicare will not cover cosmetic cutaneous surgery and that the beneficiary will be liable for the cost of the service. Charges should be clearly stated. A claim for cosmetic services does not need to be submitted to the Medicare carrier, unless the patient requests that the claim be submitted on his/her behalf.
 - b. For DOS on or after 01/01/2002, when the patient requests the claim for cosmetic services be submitted on his/her behalf, the services should be reported with modifier GY (items or services statutorily excluded or does not meet the definition of any Medicare benefit) **and** diagnosis code **V50.1**. The diagnosis code V50.1 should be placed in the first position in item 21 on the CMS 1500 claim form or the equivalent diagnosis code field for electronic claims.
 - c. In this situation an ABN for the cosmetic services should not be signed by the beneficiary, the provider may choose to have a Notice of Exclusion from Medicare Benefits (NEMB) signed. (See <http://www.cms.gov/BNI/> or CMS Pub. 100-4 Ch. 30 §§90-90.5)
5. Evaluation and management services provided on the day, or the day before a dermatological 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 dermatological 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.)
6. An E&M service reported on the same day as a dermatological surgery is subject to the Medicare global surgery rules and will only be payable if a significant and separately identifiable medical service is rendered and clearly documented in the patient's medical record. A modifier-25 should be appended to the appropriate visit code to indicate the patient's condition required a significant, separately identifiable visit service in addition to the procedure that was performed.

Removal of benign lesions is elective surgery and generally pre-scheduled. It is inappropriate to report an E&M service with a 25 modifier on the same date of service as these surgeries for the usual pre/post-operative care associated with these surgeries.
7. When billing the destruction of multiple other benign lesions use CPT 17110 or 17111 with a “1” in the unit box (e.g. “0010”). 17111 is included in 17110, and these codes may not be reported together.

For claims submitted to the fiscal intermediary:

HOSPITAL INPATIENT CLAIMS:

- 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.

Procedure Codes

See LCD DERM-008

Diagnosis Codes

See LCD DERM-008

Other Information

Documentation Requirements

See LCD DERM-008

Denial Summary

The following situations will result in the denial of the initial lesion removal services or in some cases as a result of a postpayment review.

1. Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Physicians' Services submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completion will be denied as unprocessable.

2. Title XVIII of the Social Security Act section 1862 (a)(10). This section excludes expenses for or in connection with cosmetic surgery.

Benign skin lesion removal for reasons other than those given in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the DERM-008 LCD are considered to be

cosmetic and will be denied as non-covered. These reasons include, but are not limited to, emotional distress, “makeup trapping” and asymptomatic lesions in any anatomic location. A non-coverage ABN notice is NOT necessary because the reason for denial is based upon Medicare Program exclusion.

Removal of benign lesions that are not problematic, irrespective of their location will be denied as non-covered.

Cutting or removal of asymptomatic corns and calluses (ICD-9 codes 700) of the hands and feet may be considered to be routine foot care services and are usually not covered (See FT-001).

3. E&M services reported with a 25 modifier for the usual pre/post-operative care associated with these surgeries will be denied as non-covered.

Sources

CMS Pub.100-2 Ch.16 §120

Notes

An asterisk (*) indicates a revision to that section of the article.

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Revision History/Number/Explanation

06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

07/01/2009, one, new LCD this policy replaces all other WPS Medicare LCDs on this topic including DERM-008 and DERM-508, effective 08/16/2009;