

Billing and Coding Guidelines for the Removal of Benign Skin Lesions LCD 35498

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 treated, multiple codes may be reported but you must follow National Correct Coding Initiative guidelines.

CPT code 11200 should be reported with one unit of service. CPT code 11201 should be reported with 1 unit for each additional group of 10 lesions.

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 should be reported with one unit of service for removal of benign lesions other than skin tags or cutaneous vascular lesions, representing 15 or more.

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.

2. The provider should use the appropriate CPT code and the diagnosis code should match the CPT code. If a provider bills a benign skin lesion CPT code, it is not correct to use a malignant diagnosis code.
3. 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 Contractor, unless the patient requests that the claim be submitted on his/her behalf.
 - b. 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 **Z41.1**.
4. 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.)
5. 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.

6. When billing the destruction of multiple other benign lesions use CPT 17110 or 17111 with a “1” in the unit box. CPT 17110 and CPT 17111 may not be reported together.

Revision History-

12/01/2017: Annual review completed 11/03/2017. No change in coverage.

03/01/2017: Added LCD **35498** to Billing & Coding Guidelines Title. No change in coverage.

12/01/2016 Annual Review completed 11/08/2016: no changes in coverage

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