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Clinical Guideline

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Treatment and Removal of Benign Skin Lesions

Summary

The integumentary system is comprised of the skin, hair, and nails. The skin is divided into two layers: the dermis and epidermis; diseases of these protective outer layers are among the most common conditions worldwide. Lesions of the skin can be either benign (non-malignant), pre-malignant (potential for evolving into malignancy), or malignant (cancerous). Such lesions arise from congenital malformations or are acquired, often due to extensive UV exposure or underlying illness. Diagnosis is primarily through history, clinical exam, and the appearance of the lesion(s). While the vast majority of benign lesions require no intervention, some cases may necessitate intervention due to bothersome symptoms, for definitive diagnosis, or for exclusion of malignant features. The treatment of these benign lesions can consist of simple biopsy up to radical excision or destruction, where lasers, electrosurgery, or liquid nitrogen may also be utilized.

Definitions

"Skin Lesions" is a nonspecific term that refers to any change in the skin surface that may be benign, premalignant or malignant.

"Benign Skin Lesions" are those with minimal risk of malignant transformation and commonly require no intervention in a majority of individuals. Includes, but not limited to, the following:

- Acne

- Acquired or small (<1.5cm) congenital nevi
- Acrochordons (skin tags)
- Cherry angioma
- Dermatofibroma
- Epidermoid cysts ("sebaceous" cysts, epidermal inclusion cysts)
- Hemangioma (superficial or deep)
- Keloids
- Lipoma
- Neurofibroma (cutaneous or subcutaneous)
- Nevus flammeus (port-wine stain)
- Nevus simplex
- Pyogenic granuloma
- Pilomatrixomata
- Seborrheic keratosis
- Telangiectasia
- Verruca vulgaris (common warts)

"Premalignant Skin Lesions" are lesions that are benign in their current form but have varying potential for malignant transformation. Includes, but not limited to, the following:

- **"Actinic Keratosis"** appear as a rough, scaly patch. Commonly seen after long-term UV exposure. There is a risk of malignant transformation if untreated.
- **"Lentigo Maligna"** is essentially a melanoma in situ, meaning that it contains malignant cells but without any invasive growth. Can progress to invasive melanoma. Occurs primarily in elderly individuals with UV exposure and is often found on face and neck.
- **"Leukoplakia"** are predominantly white patches of thickened skin, often in the oral region. There is a significant risk of malignant transformation. Associate with alcohol and tobacco usage.
- **"Squamous Cell Carcinoma In-Situ (Bowen's Disease)"** appears as a flat, red, scaly growth. Common in elderly individuals and is considered a pre-malignant form of squamous cell carcinoma found in the outermost layer of skin.

"ABCDE" is a model for clinical suspicion. Lesions meeting any of these criteria are considered suspicious for malignancy and may require intervention:

- **A**symmetry: one half of the mole or lesion appears different from the other half;
- **B**order: the edges of a mole or lesion are irregular, ragged, blurred;

- **C**olor: the color of the lesion is variable and lacks uniformity; the color is not the same all over and may include shades of brown or black or sometimes have patches of pink, red, white or blue;
- **D**iameter: the mole of lesion is greater than 6mm across;
- **E**volution: the size, shape, or color has undergone change

"Reconstructive" refers to a procedure to restore normal human anatomy/appearance/physiology after trauma, accidental injury, disease, or congenital defect.

"Cosmetic" refers to a procedure done to enhance or alter human anatomy/appearance in a non-natural form or to repair a "defect" that is within the normal variation of anatomical form. Cosmetic surgery does not include reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part or reconstructive surgery due to a congenital disease or anomaly of a covered child that has resulted in a functional defect.

Treatment Options:

- **"Laser Surgery"** refers to the use of laser technology to destroy lesions (e.g. pulsed carbon dioxide (CO2) laser, erbium yttrium aluminium garnet (YAG) laser, 755 nm alexandrite laser, and 532 nm diode laser, etc.).
- **"Electrosurgery"** refers to the use of electric current to remove or destroy lesions; can be associated with electrocautery to stop bleeding (e.g. Bovie device).
- **"Cryosurgery**" refers to the use of liquid nitrogen (or argon) to freeze (destroy) a lesion.
- **"Surgical Curettement or Excision"** refers to the use of a surgical instrument (e.g. scalpel) to remove lesions.
- **"Topical Therapy"** refers to the use of topical agents (e.g. 5-fluorouracil) to destroy certain lesions.

Removal and biopsy preserve tissue (i.e., sent for pathological analysis) while **destructive techniques** destroy the lesion.

"Mole Mapping/Total Body Photography (TBP) and Dermatoscopy/Dermoscopy" refer to visual or digital aids used by dermatologists. Examples include total body imaging, skin surface microscopy, digital epiluminescence microscopy (DELM), epiluminescence microscopy (ELM), and incidence light microscopy.

"Pterygium" is a benign growth of the eye.

Clinical Indications and Coverage

Pathologic Interpretation

Decision for submission to pathologic interpretation is at the discretion of the treating clinician and is independent of the decision to remove or not to remove a benign lesion, however documentation must be provided explaining the necessity for such testing, assuming the general criteria above are met. The pathological report of such lesions must be included in the medical record.

Choice of Surgical Procedure

The chosen surgical procedure (e.g., electrosurgery, cryosurgery, excisional removal) is independent of the decision to remove or not to remove a benign lesion, and is at the discretion of the treating clinician, assuming the general criteria above are met. However, documentation regarding the necessity for excision of a benign lesion must be clearly defined in the medical record.

Removal/Destruction of a Suspected Benign Skin Lesion

Removal/destruction of a suspected benign skin lesion (as defined in "*Definitions*" above) is medically necessary and covered when **ALL** of the following criteria are met:

A. Removal is expected to reasonably improve the impairment; ***and***
B. There is clear documentation of medical necessity containing written description of the surgically treated lesion with respect to location, physical characteristics, and rationale for intervention. This must include a specific diagnosis and documentation of size changes via patient history, medical record, or in-office measurement; ***and***
C. Any one of the following criteria are met and documented in the medical record:
    a. Prior biopsy suggests premalignancy or malignancy; ***or***
    b. There is recurrent trauma/irritation due to lesion location (e.g. bra line, waistband); ***or***
    c. The lesion clinically appears to be pre-malignant (e.g. actinic keratoses, large congenital nevi, Bowen's disease, dysplastic lesions, lentigo maligna, leukoplakia) or malignant (due to ABCDE criteria, or associated symptoms, especially in patients with personal/family history of melanoma); ***or***
        i. **Note**: In cases where the diagnosis is uncertain, biopsy or removal may be more appropriate than destruction.
    d. The lesion is persistently symptomatic (e.g., bleeding, burning, itching, pain); ***or***
    e. The lesion shows evidence of inflammation (e.g., edema, erythema, purulence); ***or***
    f. The lesion is infectious (verruca vulgaris) (especially in immunocompromised patients); ***or***
    g. The lesion restricts vision (e.g., restricts eyelid function, misdirects eyelashes/eyelids, interferes with tear ducts, or touches globe), or obstructs a body orifice.

Other Conditions

1. **Pterygium**: Removal is covered in cases of increased growth towards center of cornea and/or when the lesion results in functional deficit (visual impairment, discomfort, irritation)
2. **Wart removal** is considered medically necessary when one of the following criteria are met:
    a. Periocular warts associated with chronic recurrent conjunctivitis thought to be secondary to lesion viral shedding; ***or***
    b. Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients or warts of recent origin in an immunocompromised patients; ***or***
    c. Lesions consistent with molluscum contagiosum in a symptomatic or immunocompromised patient or after a trial and failure of over the counter measure; *or*
    d. Lesions consistent with condyloma acuminata (genital warts); ***or***
    e. Pain, irritation, or infection directly associated with wart(s).
3. **Scar removal** is considered medically necessary if one of the following criteria are met:
    a. The lesion interferes with normal bodily function; ***or***
    b. The lesion causes pain or irritation; ***or***
    c. Removal is for restorative intent to correct functional impairment.
4. **Tattoos**: Tattoo application is medically necessary when it is a component of a medically necessary treatment such as radiation therapy or as part of a covered breast reconstruction.

Coverage Exclusions

Any lesion or condition not meeting the criteria discussed above is **NOT** covered.

The shaving and/or excision of benign hyperkeratotic lesions (calluses) is considered not medically necessary and is not covered.

Procedures performed for psychological reasons or for emotional distress are considered not medically necessary and are not covered.

Cosmetic services are considered not medically necessary and are not covered. These services include:

- Procedures performed only to improve physical appearance such as in acne scars, uneven pigmentation, and/or photoaging (wrinkles)
- Tattoo removal
- Laser skin resurfacing
- Chemical peels, except in rare cases when the following criteria are met:

    - Medium or deep chemical peel (i.e., dermal peel) may be considered medically necessary for actinic keratosis (>15 lesions) when individual treatment would be ineffective and/or time-consuming **AND** when topical retinoids, topical chemotherapeutic agents, and cryotherapy have failed; ***or***
    - Chemical peels are considered medically necessary for active acne when first line treatments have failed to demonstrate improvement
- Light and laser therapy (including intense pulsed light therapy) except in rare cases for Erythematotelangiectatic Rosacea when the following criteria are met:
    - Documented failure of trial of pharmacologic therapy, defined as documented adherence to 2 or more topical and/or oral therapies for a minimum of 6 months; ***and***
    - Treatment is to improve functional impairment (such as recurrent infections, persistent bleeding or burning symptoms, etc).
- Dermabrasion, in most cases may be medically necessary for actinic keratosis or in cases of other pre-malignant and localized non-melanoma malignant lesions (e.g. Basal cell carcinoma or carcinoma in situ)
- Ultrasonographic evaluation of photoaging and rejuvenation techniques

The following approaches are considered **experimental and investigational** and are not covered:

- Computerized Total Body Photography (TBP) systems (e.g., MelaFind, MoleMapCD, MoleMate, MoleSafe)
- Conventional total body photography (TBP) and dermoscopy
- Confocal Scanning Laser Microscopy
- Electrical impedance device
- High-resolution ultrasonography
- Multi-photon laser scanning microscopy (also known as multi-photon fluorescence microscopy or multi-photon excitation microscopy)
- Multi-spectral image analysis
- Optical coherence tomography
- Spectroscopy
- Visual image analysis

Rallan D, Harland CC.[37] Found that computer-assisted diagnosis of pigmented lesions was at best equivalent to human diagnosis and that other optical imaging techniques had yet to demonstrate a proven role in diagnosis, treatment, and monitoring of existing disease. Others have echoed these findings (Marchesini R, Bono A, Bartoli C, et al.[27]).

Applicable Billing Codes

CPT/HCPCS Codes covered if criteria are met:	
Code	Description
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 - 17111	Destruction, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular lesions
54050 - 54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle)
56501 - 56515	Destruction of lesion(s), vulva
57061, 57062, 57063, 57064, 57065	Destruction of vaginal lesion(s)
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve
64790	Excision of neurofibroma or neurolemmoma; major peripheral nerve
64792	Excision of neurofibroma or neurolemmoma; extensive (including malignant type)
64520	Excision or transposition of pterygium; without graft
64526	Excision or transposition of pterygium; with graft
ICD-10 codes covered if criteria are met:	
Code	Description
A63.0	Anogenital (venereal) warts
B07.0 - B07.9	Viral Warts [e.g., Verruca vulgaris]
B08.1	Molluscum contagiosum

D03.0 - D03.9	Melanoma in situ [lentigo maligna]
D04 - D04.9	Squamous cell carcinoma in-situ (Skin)
D17.0 - D17.39	Lipoma
D18.00 - D18.09	Hemangioma [superficial or deep]
D22.0 - D22.9	Nevi
D23.0 - D23.9, D28.0, D29.0, and D29.4	Dermatofibroma and Benign skin Lesions
D48.5	Neoplasm of uncertain behavior of skin
I78.1	Telangiectasia
K13.21	Leukoplakia of oral mucosa, including tongue
L57.0	Actinic keratosis
L72.0	Epidermal cyst
L72.3	Sebaceous cyst
L70 - L70.9	Acne
L91.0 - L91.9	Hypertrophic disorders of skin
L82.0 - L82.1	Seborrheic keratosis
L98.0	Pyogenic granuloma
Q82.5	Congenital non-neoplastic nevus
Q85.00 - Q85.09	Neurofibroma

CPT/HCPCS codes not covered:	
Code	Description
0400T - 0401T	Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia

0419T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibroma
0420T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibroma
11055	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions
11057	Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions
15788	Chemical peel, facial; epidermal
15792	Chemical peel, nonfacial; epidermal
17360	Chemical exfoliation for acne
96904	Whole body integumentary photography, for monitoring of high-risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or family history of melanoma
96931, 96932, 96933, 96934, 96935, 96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin

References

1. American Academy of Dermatology. Clinical Guidelines. https://www.aad.org/practice-tools/quality-care/clinical-guidelines. (Accessed February 6, 2017)
2. Alster T, Zaulyanov L. Laser scar revision: a review. Dermatol Surg. 2007; 33(2):131-140
3. Alster T. Laser scar revision: comparison study of 585-nm pulsed dye laser with and without intralesional corticosteroids. Dermatol Surg. 2003; 29(1):25-29
4. Andrews MD. Cryosurgery for common skin conditions. Am Fam Physician. 2004 May 15;69(10):2365-72.
5. Argenziano (1998 Arch Dematol), Bafounta (2001 Arch Dermatol), Carli (2004 J Am Acad Dermatol.
6. Argenziano G, Soyer HP. Dermoscopy of pigmented skin lesions--a valuable tool for early diagnosis of melanoma. Lancet Oncol 2001; 2:443.
7. Argenziano G, Zalaudek I, Hofmann-Wellenhof R, et al. Total body skin examination for skin cancer screening in patients with focused symptoms. J Am Acad Dermatol. 2011 Jul 12.

8. Banik R, Lubach D. Skin tags: localization and frequencies according to sex and age. Dermatologica 1987; 174:180.
9. CGS Administrators LLC. Available at: http://www.cms.gov/mcd/index_local_alpha.asp?from=alphalmrp&letter=P&num_on_page=25&page_num=1. Accessed on February 7, 2016. Medicare Coverage Documents - Removal of Benign Skin Lesions - A54602.
10. Dixon AJ, Anderson SJ, Mazzurco JD, Steinman HK. Novel photodynamic therapy does not prevent new skin cancers--randomized controlled trial. Dermatol Surg. 2014 Apr;40(4):412-9.
11. Foley P, Merlin K, Cumming S, et al. A comparison of cryotherapy and imiquimod for treatment of actinic keratoses: lesion clearance, safety, and skin quality outcomes. J Drugs Dermatol. 2011 Dec;10(12):1432-8.
12. Gachon J, Beaulieu P, Sei JF, et al. First prospective study of the recognition process of melanoma in dermatological practice. Arch Dermatol 2005; 141:434.
13. Goldstein BG. Overview of benign lesions of the skin. In: UpToDate, Dellavalle RP (Ed), UpToDate, Waltham, MA. (Accessed on February 7, 2017).
14. Hafner C, Vogt T. Seborrheic keratosis. J Dtsch Dermatol Ges 2008; 6:664.
15. Higgins JC, Maher MH, Douglas MS. Diagnosing Common Benign Skin Tumors. American Family Physician. 2015 Oct 1;92(7):601-607.
16. Hultman CS, Edkins RE, Wu C, et al. Prospective, before-after cohort study to assess the efficacy of laser therapy on hypertrophic burn scars. Ann Plast Surg. 2013; 70(5):521-526.
17. Jacob CI, Dover JS, Kaminer MS. Acne scarring: a classification system and review of treatment options. J Am Acad Dermatol 2001; 45:109.
18. Kim YK, Kim DY, Lee SJ, et al. Therapeutic efficacy of long-pulsed 755-nm alexandrite laser for seborrheic keratoses. J Eur Acad Dermatol Venereol 2014; 28:1007.
19. Lanigan SW, Robinson TW. Cryotherapy for dermatofibromas. Clin Exp Dermatol 1987; 12:121.
20. Lanssens S, Ongenae K. Dermatologic lesions and risk for cancer. Acta Clin Belg. 2011; 66(3):177-185.
21. Lee HE, Yang CH, Chen CH, et al. Comparison of the surgical outcomes of punch incision and elliptical excision in treating epidermal inclusion cysts: a prospective, randomized study. Dermatol Surg 2006; 32:520.
22. Leventhal D, Furr M, Reiter D. Treatment of keloids and hypertrophic scars: a meta-analysis and review of the literature. Arch Facial Plast Surg. 2006; 8(6):362-368.
23. Levy LL, Zeichner JA. Management of acne scarring, part II: a comparative review of non-laser-based, minimally invasive approaches. Am J Clin Dermatol 2012; 13:331.
24. Luba M, Bangs SA. Common benign skin tumors. http://www.aafp.org/afp/2003/0215/p729.pdf. February 2003, Vol 67, N4. (Accessed February 5, 2017).

25. Liu W, Hill D, Gibbs AF, et al. What features do patients notice that help to distinguish between benign pigmented lesions and melanomas?: the ABCD(E) rule versus the seven-point checklist. Melanoma Res 2005; 15:549.
26. Maier LE, Dahl MV Management of rosacea. In: UpToDate, Tsae H (Ed), UpToDate, Waltham, MA. (Accessed on February 7, 2017).
27. Marchesini R, Bono A, Bartoli C, et al. Optical imaging and automated melanoma detection: Questions and answers. Melanoma Res. 2002;12(3):279-286.
28. Marghoob AA. Dermoscopic evaluation of skin lesions. In: UpToDate, Tsae H (Ed), UpToDate, Waltham, MA. (Accessed on February 7, 2017).
29. Marghoob AA, Swindle LD, Moricz CZ, et al. Instruments and new technologies for the in vivo diagnosis of melanoma. J Am Acad Dermatol 2003; 49:777.
30. Matteucci P, Pinder R, Magdum A, et al. Accuracy in skin lesion diagnosis and the exclusion of malignancy. J Plast Reconstr Aesthet Surg. 2011 Jul 6.
31. Mentzel T. Cutaneous mesenchymal tumours: an update. Pathology 2014; 46:149.
32. Myhre-Jensen O. A consecutive 7-year series of 1331 benign soft tissue tumours. Clinicopathologic data. Comparison with sarcomas. Acta Orthop Scand 1981;52:287-93.
33. Nguyen T, Zuniga R. Skin conditions: Benign nodular skin lesions. FP Essent. 2013;407:24-30.
34. Pariser RJ. Benign neoplasms of the skin. Med Clin North Am 1998;82:1285-307.
35. Pelle MT, Crawford GH, James WD. Rosacea: II. Therapy. J Am Acad Dermatol 2004; 51:499.
36. Plunkett A, Merlin K, Gill D, Zuo Y, Jolley D, Marks R. The frequency of common nonmalignant skin conditions in adults in central Victoria, Australia. Int J Dermatol 1999;38:901-8.
37. Rallan D, Harland CC. Skin imaging: Is it clinically useful? Clin Exp Dermatol. 2004;29(5):453-459.
38. Requena L, Sangueza OP. Cutaneous vascular proliferation. Part II. Hyperplasias and benign neoplasms. J Am Acad Dermatol 1997;37:887-919.
39. Rivera AE. Acne scarring: a review and current treatment modalities. J Am Acad Dermatol 2008; 59:659.
40. Scott MA. Benign cutaneous neoplasms. Prim Care 1989;16:645-63.
41. Thompson SC, Jolley D, Marks R. Reduction of solar keratoses by regular sunscreen use. N Engl J Med 1993; 329:1147.
42. Wat H, Wu DC, Rao J, et al. Application of intense pulsed light in the treatment of dermatologic disease: A systematic review. Dermatol Surg. 2014;40.
43. Weedon, David (2010). Weedon's Skin Pathology (3rd ed.). Elsevier. ISBN 978-0-7020-3485-5.
44. Wilkin J, Dahl M, Detmar M, et al. Standard classification of rosacea: Report of the National Rosacea Society Expert Committee on the Classification and Staging of Rosacea. J Am Acad Dermatol 2002; 46:584.

45. Wolfram D, Tzankov A, Pülzl P, Piza-Katzer H. Hypertrophic scars and keloids - a review of their pathophysiology, risk factors, and therapeutic management. Dermatol Surg. 2009; 35(2):171-181.
46. Zimmerman EE, Crawford P. Cutaneous cryosurgery. Am Fam Physician. 2012 Dec 15;86(12):1118-24.
47. Zuber TJ. Minimal excision technique for epidermoid (sebaceous) cysts. Am Fam Physician 2002; 65:1409-12.

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