Priority Health	BILLING POLICY No. 093
REMOVAL OF BENIGN SKIN LESIONS	
Date of origin: June 19, 2025	**Review dates: 8/2025**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards for removal of benign skin lesions.
Removal of certain benign skin lesions that don't pose a threat to health or function are considered cosmetic and as such aren't covered by Priority Health.
There may be instances in which the removal of non-malignant skin lesions is medically appropriate. In these instances, Priority Health will consider their removal as medically necessary and not cosmetic.

DEFINITIONS

Not applicable

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Billing details

An evaluation and management (E/M) service to determine a diagnosis of benign skin lesion(s) may be allowed (paid), even in the event the subsequent lesion(s) removal is determined to be cosmetic.

Priority Health won't pay for a separate E/M service on the same day as a dermatologic service unless a documented significant and separately identifiable medical service is rendered. The service must be fully and clearly documented in the patient's medical record and modifier 25 should be used.

Priority Health won't pay for a separate E/M service by the operating physician during the global period unless the service is for a medical problem unrelated to the surgical procedure. The service must be fully and clearly documented in the patient's medical record.

Frequencies

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

Coding specifics

CPT codes

CPT code	Description

11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part thereof (list separately in addition to code for primary procedure)
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
11311	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm
11312	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
11313	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm
11400	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less
11401	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm
11402	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm
11403	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm
11404	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11422	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11424	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm
11426	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm
11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less

11441	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11444	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm
11446	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses; second through 14 lesions, each (list separately in addition to code for first lesion)
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
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
17340	Cryotherapy (co2 slush, liquid n2) for acne

Revenue codes

Revenue code	Description
0360	Operating Room Services - General Classification
0361	Operating Room Services - Minor Surgery
0369	Operating Room Services - Other OR Services
0456	Emergency Room - Urgent Care
0490	Ambulatory Surgical Care - General Classification
0499	Ambulatory Surgical Care - Other Ambulatory Surgical Care
0510	Clinic - General Classification
0516	Clinic - Urgent Care Clinic
0520	Freestanding Clinic - General Classification
0761	Specialty Services - Treatment Room
0960	Professional Fees - General Classification
0969	Professional Fees - Other Professional Fee
0975	Professional Fees - Operating Room
0982	Professional Fees - Outpatient Services
0983	Professional Fees - Clinic

Modifiers

- **25**: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- **58**: Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- **59 or XS**: Distinct Procedural Service or Separate structure, a service that is distinct because it was performed on a separate organ/structure
- **57:** decision for surgery: An evaluation and management service that resulted in the initial decision to perform the surgery, may be identified by adding the modifier –57 to the appropriate level of E/M service

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list above may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

Place of service

- Office (11)
- Urgent care facility (20)
- Inpatient hospital (21)
- Outpatient hospital (22)
- Emergency room (23)
- Ambulatory surgical center (24)
- Skilled nursing facility (31)
- Nursing facility (32)
- Independent clinic (49)
- Inpatient psychiatric facility (51)
- Intermediate care facility/mentally retarded (54)

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

- Physicians must submit services with a diagnosis code to support medical necessity and must be coded to the highest level of accuracy.
- Medical records maintained by the physician must clearly document the medical necessity for lesion(s) removal if Priority Health is billed for the service.
- Surgical Procedures Lesions and Closures: Operative note(s) for surgical procedures performed in the office location may be contained in the patient's medical record for the date of service or as a separate report in the patient's chart. The operative note for the procedure performed must contain details to support the surgical procedure billed. The surgical technique used should be described in detail. Surgical procedures should include the lesion size(s) location(s) and number. Layered closures should include the length recorded in centimeters. Add together the length of multiple closures from all anatomical sites grouped together in the same code descriptor (See the American Medical Associations Physicians' Current Procedural Terminology, CPT subsection instructions for Removal of Skin Tags, Shaving of Epidermal or Dermal Lesions, Excisions - Benign Lesions, Repairs (Closures) and Destruction.).
- The decision to submit a specimen for pathological interpretation will be separate from the decision to remove or not remove the lesion. It is assumed, however, that the pathology description and tissue diagnosis will be part of the medical record if a specimen is submitted.

The type of removal is at the discretion of the treating physician and the appropriateness of the technique used will not be a factor in deciding if a lesion merits removal. However, a benign lesion excision must have medical record documentation as to why an excisional removal, other than for cosmetic purposes, was the surgical procedure of choice.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Reimbursement specifics

If one or more of the following conditions are present and clearly documented in the medical record, payment may be considered:

- The lesion has one or more of the following characteristics: bleeding, itching, pain; change in physical appearance (reddening or pigmentary change), recent enlargement, increase in number; or
- The lesion has physical evidence of inflammation, e.g., purulence, edema, erythema; or
- The lesion obstructs an orifice; or
- The lesion clinically restricts vision; or
- There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the lesion appearance; or
- A prior biopsy suggests or is indicative of lesion malignancy; or
- The lesion is in an anatomical region subject to recurrent trauma, and there is documentation of such trauma.
- Wart removals will be covered under the guidelines listed above. In addition, wart destruction will be covered when any one of the following clinical circumstances is present:
    - Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesion virus shedding
    - Warts showing evidence of spread from one body area to another, particularly in immunosuppressed patients
    - Lesions are condyloma acuminata or molluscum contagiosum
    - Cervical dysplasia or pregnancy is associated with genital warts

The payment for excision of benign lesions of skin includes payment for simple repairs. Separate payment may be made for medically necessary layered closures, adjacent tissue transfers, flaps and grafts.

REFERENCES

- Benign Skin Lesion Removal - Medical Clinical Policy Bulletins | Aetna
- BenignSkinLesionRemoval.pdf
- LCD - Removal of Benign Skin Lesions (L35498)
- Article - Billing and Coding: Removal of Benign Skin Lesions (A57044)
- Article - Billing and Coding: Removal of Benign Skin Lesions (A54602)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan

Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
August 2025	Added frequency section – effective 11/17/2025
August 2026	Reviewed, policy overview added.