Benign Skin Lesion Removal

Number: 0633

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB*

Aetna considers removal of acquired or small (less than 1.5 cm) congenital nevi (moles), cutaneous and subcutaneous neurofibromas, dermatofibromas, acrochordon (skin tags), pilomatrixomata (slow-growing hard mass underneath the skin that arises from hair follicle matrix cells), sebaceous cysts (pillar and epidermoid cysts), seborrheic keratoses (also known as basal cell papillomas, senile warts or brown warts), and or other benign skin lesions medically necessary if any of the following criteria is met:

- Biopsy suggests or is indicative of pre-malignancy (e.g., dysplasia) or malignancy; or
- Due to its anatomic location, the lesion has been subject to recurrent trauma/irritation (e.g., bra line, waist band, etc.); or
- Lesion appears to be pre-malignant (e.g., actinic keratoses (see CPB 0567 - Actinic Keratoses Treatment ../500_599/0567.html)), Bowen's disease, dysplastic lesions, dysplastic nevus syndrome, large congenital melanocytic nevi, lentigo maligna, or leukoplakia) or malignant* (due to coloration, change in appearance or size, etc. (see note below) especially in a person with

Policy History

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Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes
personal or family history of melanoma); or
- Skin lesions are causing symptoms (e.g., bleeding, burning, intense itching, or irritation); or
- The lesion has evidence of inflammation (e.g., edema, erythema, or purulence); or
- The lesion is infectious (e.g., warts (verruca vulgaris)); or
- The lesion restricts vision or obstructs a body orifice.

In the absence of any of the above indications, removal of seborrheic keratoses, sebaceous cysts, small nevi (moles), dermatofibromas, pilomatrixoma, or other benign skin lesions is considered cosmetic.

*Note: Clinical suspicion of malignancy, is indicated by any of the following:

- Asymmetry – one half of the mole or lesion does not match the other;
- Border – the edges of a mole or lesion are irregular, ragged, blurred;
- Color – 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;
- Diameter – the mole or lesion is larger than six millimeters across (about ¼ inch or the size of a pencil eraser); or
- Evolving – the mole is changing in size (enlarging), shape or color.

**Background**

A skin lesion is a nonspecific term that refers to any change in the skin surface; it may be benign, malignant or premalignant. Skin lesions may have color (pigment), be raised, flat, large, small, fluid filled or exhibit other characteristics. Common examples of benign skin lesions may include moles (nevii), sebaceous cysts, seborrheic keratoses, skin tags (acrochordon), callouses, corns or warts.

The treatment of benign skin lesions consists of destruction or
removal by any of a wide variety of techniques. The removal of a skin lesion can range from a simple biopsy, scraping or shaving of the lesion, to a radical excision that may heal on its own, be closed with sutures (stitches) or require reconstructive techniques involving skin grafts or flaps. Laser, cautery or liquid nitrogen may also be used to remove benign skin lesions. When it is uncertain as to whether or not a lesion is cancerous, excision and laboratory (microscopic) examination is usually necessary.

Seborrheic keratoses are non-cancerous growths of the outer layer of skin. They are usually brown, but can vary in color from beige to black, and vary in size from a fraction of an inch to more than an inch in diameter. They may occur singly or in clusters on the surface of the skin. They typically have a wart-like texture with a waxy appearance, and have the appearance of being glued or stuck on to skin. Seborrheic keratoses are most often found on the chest or back, although, they can also be found almost anywhere on the body. These become more common with age, and most elderly patients develop one or more of these lesions. Seborrheic keratoses can get irritated by clothing rubbing against them, and their removal may be medically necessary if they itch, get irritated, or bleed easily. Although seborrheic keratoses are non-cancerous, they may be difficult to distinguish from skin cancer if they turn black. Seborrheic keratoses may be removed by cryosurgery, curettage, or electrosurgery.

Acquired nevi (moles) can appear anywhere on the skin. They are usually brown in color, but can be skin colored or pink, light tan to brown, or blue-black. Moles may be flat or raised and can be various sizes and shapes. Most appear during the first 20 years of a person's life, although some may not appear until later in life. Sun exposure increases the number of moles. The majority of moles are benign. However, moles that raise suspicion of malignancy are those that change in size, shape or color, and those that bleed, itch, or become painful. Atypical moles (dysplastic nevi) have an increased risk of developing into melanoma. Atypical moles are larger than average (greater
than 6 mm) and irregular in shape. They tend to have uneven color with dark brown centers and lighter, sometimes reddish, uneven borders or black dots at edge. The most common methods of removal include shaving and excision.

Congenital melanocytic nevi occur in approximately 1% of newborns and are usually classified according to their size. Giant congenital melanocytic nevi are most simply defined as melanocytic nevi that are greater than 20 cm in largest dimension; whereas small congenital nevi are defined as melanocytic nevi less than 1.5 cm in largest dimension. Giant congenital melanocytic nevi are associated with an increased risk of the development of melanoma, and are therefore surgically removed. However, small congenital nevi do not need to be removed as the risk of malignant transformation is thought to be small or none. The management of intermediate sized congenital nevi is controversial, as the risk of malignant transformation and the lifetime melanoma risk in patients with intermediate sized congenital nevi is not known.

A sebaceous (keratinous) cyst is a slow-growing, benign cyst that contains follicular, keratinous, and sebaceous material. The sebaceous cyst is firm, globular, movable, and non-tender. These cysts seldom cause discomfort unless the cyst ruptures or becomes infected. Ranging in size, sebaceous cysts are usually found on the scalp, face, ears, and genitals. They are formed when the release of sebum from the sebaceous glands in the skin is blocked. Unless they become infected and painful or large, sebaceous cysts do not require medical attention or treatment, and usually go away on their own. Infected cysts can be incised and drained, or the entire cyst may be surgically removed.

A skin tag (arochordon) is a benign, soft, moveable, skin-colored growth that hangs from the surface of the skin on a thin piece of tissue called a stalk. The prevalence of skin tags increases with age. They appear most often in skin folds of the neck, armpits, trunk, beneath the breasts or in the genital region. They are painless, but may become painful if thrombosed or if
irritated. They may become irritated if they occur in an area where clothing or jewelry rubs against them. Skin tags may be removed by excision, cryosurgery, or electrosurgery.

Actinic keratoses are the most common type of premalignant skin lesions, occurring in sun-exposed areas that may give rise to squamous cell carcinomas. They are thought to be caused by years of exposure to the sun. The lesions are scaly sandpaper-like patches, varying in color from skin-colored to reddish-brown or yellowish-black. Lesions may be single or multiple. They are usually painless but may be slightly tender. Actinic keratoses are discussed in [CPB 0567 - Actinic Keratoses Treatment](../500_599/0567.html).

Bowen's disease (squamous cell carcinoma in situ) is a premalignant lesion, often due to arsenic exposure, that may give rise to squamous cell carcinoma. Lesions predominantly affect the elderly, and consist of persistent, erythematous, scaly plaques with well-defined margins. Treatment options include excision, cryotherapy, curettage and cautery, and topical 5-fluorouracil.

Lentigo maligna (Hutchinson's Freckle) is a premalignant lesion that may give rise to lentigo maligna melanoma. These lesions are pigmented macules, often greater than 1 cm in diameter with an irregular border, occurring mainly on sun-exposed areas. Lesions characteristically have brown, black, red, and white areas and become more irregularly pigmented over time. Risk of conversion to melanoma by age 75 is estimated at 1 to 2%. Patients should undergo regular follow-up examinations for signs of conversion to melanoma. Because conversion to melanoma is usually relatively slow, the decision to excise lentigo maligna should be based on several factors, including the size and location of the lesion, which determines the complexity of the procedure required, and the patient's life expectancy and comorbidities.

A hemangioma is a benign tumor consisting chiefly of dilated or newly formed blood vessels. A port wine stain is a reddish
purple superficial hemangioma of the skin commonly occurring as a birthmark.

Pirouzmanesh and colleagues (2003) noted that pilomatrixoma, also known as calcifying epithelioma of Malherbe, is a benign skin neoplasm that arises from hair follicle matrix cells. Pilomatrixoma is a common skin neoplasm in the pediatric population that is often mis-diagnosed as other skin conditions. This study reviewed an 11-year experience at a tertiary children's hospital, examining the cause, clinical and histopathological presentation, management, and treatment outcomes of pilomatrixoma. A review of the pathology database at Children's Hospital Los Angeles revealed 346 pilomatrixomas excised from 336 patients between 1991 and 2001. The hospital charts, pathology records, and plastic surgery clinic charts were reviewed with respect to variables such as sex, age at the time of presentation, clinical and histopathological presentation, pre-operative diagnosis, management, recurrence, and treatment outcome. The main presenting symptom was a hard, subcutaneous, slowly growing mass. The pre-operative diagnosis was accurate and consistent with the pathological diagnosis of pilomatrixoma in only 100 cases (28.9 %). This entity should be considered with other benign or malignant conditions in the clinical differential diagnosis of solitary firm skin nodules, especially those on the head, neck, or upper limbs. The diagnosis can generally be made with a clinical examination. Imaging studies are not required unless symptoms or the location of the lesion warrants such diagnostic assessments. The treatment of choice is surgical excision, and the recurrence rate is low.

Roche et al (2010) stated that a pilomatricoma, also known as pilomatrixoma or calcifying epithelioma of Malherbe, is a benign skin tumor arising from the hair follicle matrix. This tumor is common in children and young adults, especially in the head and neck region. However, pilomatricomas are frequently mis-diagnosed or not recognized. The history is typical of a slowly enlarging mass, irregularly contoured; it is fixed to the skin but slides freely over the, underlying tissues, often with a
discoloration that varies from red to purple-bluish. Ultrasound examination, magnetic resonance imaging, and fine-needle aspiration can be helpful if the diagnosis is uncertain. Spontaneous regression has never been observed and malignant degeneration is very rare. Surgical excision with clear margins is the treatment of choice, otherwise recurrence may occur due to incomplete resection.

Guinot-Moya et al (2011) determined the incidence and clinical features of patients diagnosed with pilomatrixoma. A retrospective analysis was made of 205 cases of pilomatrixoma diagnosed according to clinical and histological criteria, with an evaluation of the incidence, patient age at presentation, gender, lesion location and size, single or multiple presentation, differential diagnosis, histopathological and clinical findings and relapses. Pilomatrixoma was seen to account for 1.04 % of all benign skin lesions. It tended to present in pediatric patients -- almost 50 % corresponding to individuals under 20 years of age -- with a slight male predilection (107/98). Approximately 75 % of all cases presented as single lesions measuring less than 15 mm in diameter. Multiple presentations were seen in 2.43 % of cases. The most frequent locations were the head and orofacial zones (particularly the parotid region), with over 50 % of all cases, followed by the upper (23.9 %) and lower limbs (12.7 %). Only 1 relapse was documented following simple lesion excision. The authors concluded that the frequency of pilomatrixomas was 1.04 % of all benign skin lesions -- the lesions being predominantly located in the maxillofacial area. Due to the benign features of this disorder, simple removal of the lesion is considered to be the treatment of choice, and is associated with a very low relapse rate.

Porokeratosis is a disorder of keratinization characterized by one or more atrophic macules or patches surrounded by a distinctive hyperkeratotic ridge-like border called a cornoid lamella (Spencer, 2011; Spencer, 2012). The coronoid lamella is a thin column of closely stacked, parakeratotic cells extending through the stratum corneum with a thin or absent granular layer. Multiple clinical variants of porokeratosis exist. The most
commonly described variants include: disseminated superficial actinic porokeratosis (DSAP), disseminated superficial porokeratosis (DSP), classic porokeratosis of Mibelli, linear porokeratosis, porokeratosis plantaris palmaris et disseminata, and punctate porokeratosis. The diagnosis of porokeratosis often can be made based solely on clinical examination (Spencer, 2011; Spencer, 2012). The clinical appearance of an atrophic macule or patch with a well-defined, raised, hyperkeratotic ridge suggests this disorder. Biopsies are typically performed when the appearance of the lesion is not classic or when there is concern for malignant transformation. Malignant transformation has occurred in patients with all major variants of porokeratosis with the exception of punctate porokeratosis. It is estimated to occur in 7.5 to 11 percent of patients, with an average period to cancer onset of 36 years (Spencer, 2011; Spencer, 2012). Linear porokeratosis and giant porokeratosis (a manifestation of porokeratosis of Mibelli) are the variants most susceptible to malignant transformation, while this occurrence in DSAP is rare. Although removal of lesions via surgical or destructive methods is an option for the prevention of malignant transformation in lesions of porokeratosis, the need to do so is questionable (Spencer, 2011; Spencer, 2012). Factors such as the estimated risk for malignancy for specific lesion types and the risk for significant cosmetic or functional defects following removal must be considered. The removal of the lesions with the greatest risk for malignancy (linear porokeratosis or large porokeratosis of Mibelli) often would result in an unfavorable amount of scarring. Moreover, the large number of lesions and low risk for malignancy in individual lesions of DSAP or DSP suggest that the benefit of lesion removal for the prevention of malignancy in these variants is likely to be minima (Spencer, 2011; Spencer, 2012). The ability to clinically follow lesions of porokeratosis for signs or symptoms of malignancy and the high likelihood of successful treatment of malignancy once it develops support clinical surveillance as an acceptable method of management, and thus, most patients with porokeratosis are followed clinically (Spencer, 2011; Spencer, 2012). Lesions suggestive of malignancy require excision, whereby micrographic surgery
offers a precise way of separating the tumor from its porokeratotic background (Sertznig, et al., 2012). Although nonexcisional destructive methods (e.g., laser, cryotherapy) has been used to remove isolated porokeratosis lesions, there are no studies showing the value of prophylactic non-excisional surgical treatment in reducing the incidence of malignancy in cases of porokeratosis (Sertznig, et al., 2012). If the decision is made to excise or destroy a lesion for prophylactic purposes, doing so in an urgent manner is not necessary, as the period between lesion development and malignancy often spans decades. After removal, clinical follow-up still should be performed yearly to evaluate these patients for the development of new or recurrent lesions (Spencer, 2011; Spencer, 2012).

Cutaneous and Subcutaneous Neurofibromas:

An UpToDate review on “Neurofibromatosis type 1 (NF1): Management and prognosis” (Korf, 2015) states that “Cutaneous and subcutaneous neurofibromas are not removed unless there is a specific need for removal (e.g., pain, bleeding, interference with function, disfigurement). Referral to dermatology is advised for patients with severe pruritus”.

Appendix

Pre-Malignant Skin Lesions (not an all-inclusive list):

- Actinic keratosis
- Lentigo maligna
- Leukoplakia
- Squamous cell carcinoma in-situ (Bowen's disease)

Skin Lesions That Do Not Qualify as Pre-Malignant (not an all-inclusive list):

- Acrochordons (skin tags)
- Cherry angioma
- Dermatofibroma
- Hemangioma (superficial or deep)
- Neurofibroma
- Nevus flammeus (port-wine stain)
- Nevus simplex
- Pyogenic granuloma
- Seborrheic keratosis
- Telangiectasia
- Verruca vulgaris (warts)

### CPT Codes / HCPCS Codes / ICD-10 Codes

*Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":*

#### Pre-Malignant Lesions:

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CPT codes not covered for indications listed in the CPB:
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<td>0420T</td>
<td>Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); trunk and extremities, extensive, greater than 100 neurofibroma</td>
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**ICD-10 codes covered if selection criteria are met:**

- **A63.0** Anogenital (venereal) warts
- **B07.0 - B07.9** Viral warts [*note - report 17110-17111 per AMA CPT guidelines*]
- **B08.1** Molluscum contagiosum
- **D04.0 - D04.9** Carcinoma in situ of skin [Bowen's disease, lentigo maligna]
- **D17.0 - D17.39** Benign lipomatous neoplasm of skin and subcutaneous tissue
- **D18.00 - D18.09** Hemangioma [superficial or deep]
- **D22.0 - D22.9** Melanocytic nevi
- **D23.0 - D23.9** Other benign neoplasm of skin
- **D36.10 - D36.9** Benign neoplasm of other and unspecified sites [neurofibroma]
- **I78.1** Nevus, non-neoplastic [nevus simplex, telangiectasia, cherry angioma]
- **L72.0** Epidermal cyst
- **L72.3** Sebaceous cyst
- **L82.0 - L82.1** Seborrheic keratosis
- **L91.0 - L91.9** Hypertrophic scar [acrochordons, skin tags]
- **L98.0** Pyogenic granuloma
The above policy is based on the following references:


AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0633
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There are no amendments for Pennsylvania Medicaid.

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