Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Removal of Benign Skin Lesions for Tufts Senior Care Options and Tufts Medicare Preferred

Effective: January 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care Plan – A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 888-609-0692
☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Benign skin lesions are a common skin condition that may be the result of an injury or damage to the skin. Skin lesions may present as sebaceous cysts, skin tags, moles, hemangiomas, viral warts, etc. Removal of these skin lesions can be performed with multiple techniques such as excision, laser ablation, or cryosurgery. Removal of skin lesions without documentation of clinical impact is considered cosmetic in nature and is non-covered.

Clinical Guideline Coverage Criteria

The removal of benign skin lesions may be reasonable and medically necessary when documentation confirms **ONE** of the following signs or symptoms:

1. The lesion presents with one of the following:
    a. Bleeding; **or**
    b. Intense Itching; **or**
    c. Pain; **or**

d. Change in physical experience:
    i. Reddening; **or**
    ii. Pigmentary change; **or**
    iii. Enlargement; **or**
    iv. Increase in the number of lesions
2. The lesion has physical evidence of inflammation (purulence, edema, erythema, etc.) ; **or**
3. The lesion obstructs an orifice; **or**
4. The lesion clinically restricts vision;
    a. Lesion restricts eyelid function; **or**
    b. Lesion causes misdirection of eyelashes or eyelid; **or**
    c. Lesion restricts lacrimal puncta and interferes with tar flow; **or**
    d. Lesion touches globe; **or**
    e. Lesion clinically restricts eye function; **or**

Removal of warts may be considered reasonable and medically necessary when documentation confirms **ONE** of the following signs or symptoms:

1. Periocular warts associated with chronic recurrent conjunctivitis secondary to lesion virus shedding; **or**
2. Warts showing evidence of spread from one body area to another; **or**
3. Lesions are condyloma acuminata or molluscum contagium; **or**
4. Cervical dysplasia or pregnancy associated with genital warts

Limitations

The Plan considers the removal of benign skin lesions and warts as noncovered and not medically necessary when removal is for cosmetic purposes only

Codes

The following code(s) are associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
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
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

List of Covered ICD-10 Codes

References:

1. ASPS Recommended Insurance Coverage Criteria for Third Party Payers- Skin Lesions: http://www.plasticsurgery.org/Documents/medical-professionals/health-policy/insurance/Skin-Lesions.pdf
2. Centers for Medicaid and Medicare. Removal of Benign Skin Lesions. Local Coverage Article. A45602. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54602&ver=17&keyword=17000&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1
3. Feldman SR, Fleischer AB Jr. Progression of actinic keratosis to squamous cell carcinoma revisited: clinical and

treatment implications. Cutis. 201; 87(4):201-207

Approval And Revision History

September 19, 2024: Service reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee effective January 1, 2025

Subsequent endorsement date(s) and changes made:

- October 17, 2024: Reviewed by the Medical Policy Approval Committee (MPAC) effective January 1, 2025

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.