Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

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

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☐ No ☒
Notification Required	Yes ☐ No ☒

Applies to:

- Tufts Health Plan Senior Care Options
- Tufts Medicare Preferred HMO/PPO

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page

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, **ONE**:
        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, **One**:
    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.

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 spreading 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 codes are considered medically necessary when submitted with an appropriate ICD-10 diagnosis code:

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

Medically Necessary ICD 10 Codes

References:

1. ASPS Recommended Insurance Coverage Criteria for Third Party Payers- Skin Lesions: ASPS Recommended Insurance Coverage Criteria | ASPS. Published 2017. Accessed February 9, 2026.
2. Centers for Medicaid and Medicare. Removal of Benign Skin Lesions. Local Coverage Article. A45602. Article - Billing and Coding: Removal of Benign Skin Lesions (A54602). Accessed February 9, 2026.
3. Fania L, Didona D, Di Pietro FR, et al. Cutaneous Squamous Cell Carcinoma: From Pathophysiology to Novel Therapeutic Approaches. *Biomedicines*. 2021;9(2):171. Published 2021 Feb 9. doi:10.3390/biomedicines9020171.

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
- April 16, 2025: Reviewed by MPAC, renewed without changes effective May 16, 2025

- July 25, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed
- May 20, 2026: Reviewed by MPAC; administrative update to guideline template, renewed without changes effective July 1, 2026

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.