Priority Health

MEDICAL POLICY
No. 91456-R19

SKIN CONDITIONS

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Date of Origin: August 28, 2002

Status: Current

Summary of Changes

- Changes:
  - Reordered according to alphabetical order
- Clarification
  - I.B.11.a - Directed members to consult benefit documents for applicable pharmacy coverage for treatment of rosacea.
- Addition:
  - I.B.6.b - Home phototherapy (UVB) Treatment for vitiligo is experimental, investigational and/or not medically necessary.
  - I.B.11 – Broad light band therapy for the treatment of rosacea is cosmetic.

I. POLICY/CRITERIA

A. Coverage for the following skin conditions associated with the listed codes and all subgroups within these major coding groups is limited to office visits and prescription drug therapy only. Other therapies and treatments are not covered.

L57.3	Poikiloderma of Civatte
L63.0 – L63.9	Alopecia areata
L64.0 – L64.9	Androgenic alopecia
L65.0 – L65.9	Other nonscarring hair loss
L66.0 – L66.9	Cicatricial alopecia [scarring hair loss]
L70.0 - L70.9	Acne
L71.1 - L71.9	Rosacea
L73.0	Acne keloid
L81.0 – L81.9	Other disorders of pigmentation
L84	Corns and callosities
L85.1	Acquired keratosis [keratoderma] palmaris et plantaris
L95.8	Other vasculitis limited to the skin
L95.9	Vasculitis limited to the skin, unspecified
L98.8	Other specified disorders of the skin and subcutaneous tissue
L98.9	Disorder of the skin and subcutaneous tissue, unspecified

B. Treatment of Skin Conditions

1. **Cosmetic Skin Conditions:** Treatment of cosmetic skin conditions (including but not limited to those listed above) is not medically necessary. Priority Health defines cosmetic as any condition which if left untreated will result in no adverse medical outcome.
2. **Acne Surgery** (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules) is not medically necessary.
3. **Alopecia**:
    a. Treatment of alopecia (or baldness) including drugs, prosthetics, ointments and surgical transplantation are considered cosmetic in nature and not medically necessary.
    b. Treatment or services to prevent hair loss (e.g., cooling therapy or devices during chemotherapy) are considered cosmetic and not covered.
4. **Chemical Peel**: Medium and deep chemical peels for actinic keratoses and other pre-malignant skin lesions are a covered benefit when patients have 15 or more lesions, such that it becomes impractical to treat each lesion individually, AND they have failed to adequately respond to treatment with topical 5-fluorouracil (5-FU).
    a. Chemical peels are not covered for the treatment of non-malignant (simple) lesions.
    b. Chemical peels are not covered for active acne, acne scarring, skin wrinkling, or other cosmetic purposes.
5. **Facial Dermabrasion**
    a. Dermabrasion for the removal of superficial basal cell carcinomas and pre-cancerous actinic keratoses using the conventional method of controlled surgical scraping (dermaplaning) or carbon dioxide (CO2) laser is medically necessary when conventional methods of removal such as cryotherapy, curettage, excision, and 5-FU (Efudex) are impractical due to the number and distribution of the lesions.
    b. Dermabrasion is not medically necessary for conditions including, but not limited to:
        i. Removal of acne scars because its use for these indications is considered cosmetic.
        ii. For use in treating active acne because dermabrasion has been shown to increase inflammation associated with active acne.
6. Home phototherapy (UVB)
    a. Treatment for psoriasis is covered under the Durable Medical Equipment (DME) benefit when all of the following apply*:
        i. Ordered and managed by a dermatologist.

1. Treatment for severe disabling psoriasis must be ordered and managed by a dermatologist for consideration to be made.

ii. Patient is unable to travel for treatment.
iii. Severe disabling psoriasis (>10% of body) unresponsive to conventional treatment (see list from Treatment of Psoriasis).
iv. Additional consideration for home therapy may be made if the treatment has been continuous, long term (> 1 year in duration), and has been shown to be effective for the member and is expected to continue long term.

b. Treatment for vitiligo is experimental and investigational and/or not medically necessary.
c. Medicaid members: Home phototherapy is not a covered benefit for Medicaid.

7. **Keloid formation:** Removal is medically necessary when at least one of the following are met:
   a. Formation is due to complications arising from a medically necessary service when the treatment of the complication itself is medically necessary (e.g., major surgery such as organ transplantation and the development of a lesion secondary to host vs. graft syndrome.
   b. Excision of lesion and restoration of body form following an accidental injury.
   c. Keloid is a result of neoplastic surgery (e.g., hypertrophic keloid scar formation due to radiation therapy to a specific body part).
   d. Keloid formation secondary to burns scars
   e. Lesion is suspicious of a malignancy.
   f. Lesion causes infection, bleeding, and inflammation at site.
   g. Removal for formations due to body piercings, tattoos are not medically necessary.
8. **Labial Hypertrophy:** Excision of excessive skin and subcutaneous tissue for hypertrophy of the labia is not a covered benefit.
9. **PUVA and UVB Therapy**:
   a. Phototherapy and photochemotherapy is medically necessary when there has been a failure, intolerance, or contraindication to treatment using conventional medical management for ANY of the following medical conditions:
      i. Atopic dermatitis (atopic eczema)
      ii. Chronic plaque psoriasis

iii. Connective tissue diseases involving the skin (e.g., cutaneous graft vs. host disease [GVHD], localized scleroderma, lupus erythematosus)
iv. Cutaneous T-cell lymphoma (CTCL), including mycosis fungoides (MF)
v. Grover's disease (transient and persistent acantholytic dermatosis)
vi. Lichen planus
vii. Photo dermatoses (e.g., polymorphic light eruption, actinic prurigo, chronic actinic dermatitis)
viii. Pityriasis

b. PUVA and UVB therapy to treat hair loss (Alopecia Areata) is a cosmetic treatment and is not medically necessary.

10. **Treatment of Psoriasis**

a. **Phototherapy (UVB) treatment for psoriasis** is a covered benefit when ***all*** of the following apply:
i. Ordered and managed by a dermatologist.
ii. Severe disabling psoriasis (>10% of body) unresponsive to conventional treatment (see list below).
iii. Conventional treatment may be divided into the following six categories:
1. Systemic Treatment may include the following:
a. 6-Thioguanine (not FDA approved for the treatment of plaque psoriasis)
b. Antibiotics
c. Azathioprine (Imuran)
d. Biologic Response Modifiers
e. Cyclosporine
f. Hydroxyurea (Hydrea)
g. Methotrexate
h. Mycophenolate mofetil
i. Retinoids
j. Sulfasalazine
k. Tacrolimus
2. Topical treatments may include:
a. Anthralin or tazarotene
b. Bath Solutions
c. Calcipotriene
d. Coal Tar
e. Corticosteroids
f. Moisturizers
g. Retinoids
h. Salicylic Acid
i. Topical Immodulators (TIMs)
3. Combination Therapy

a. Photochemotherapy
b. Phototherapy + topicals (tar, calcipotriene, retinoids)
c. Retinoids + UV
d. Biologics + UV, Biologics + Systemics

4. Intralesional injections of steroids: Intralesional injections of steroids are reserved for local lesions that have been resistant to topical applications.
5. Laser Therapy: Laser therapy has been used to treat localized lesions of plaque psoriasis that have been unresponsive to conventional treatment methods.
    a. Excimer laser
    b. Pulsed dye laser (PDL)

    * See I.B.3.d for additional criteria

6. Light Therapy include the following:
    a. Sunlight
    b. Ultraviolet B (UVB) Phototherapy
    c. Psoralen and Ultraviolet A Phototherapy (PUVA)
    d. Light Therapy combined with other therapies

b. Home tanning beds are not a covered benefit.
c. Laser therapy for psoriasis: The use of excimer laser therapy (i.e., 308 nanometers [nm]) or the flash lamp-pumped pulsed dye laser (FLPDL) for the treatment of adult patients is medically necessary when all of the following criteria are met
    i. Treatment is for localized, symptomatic psoriasis of the hands, feet, knees, elbows, scalp or face.
    ii. Patients with chronic, stable, localized, mild to moderate plaque psoriasis.
    iii. Those with < 10 % body surface area (BSA) involvement of plaque psoriasis and some or all of these lesions have proven refractory to at least a two-month trial conservative treatment of topical agents and/or non-laser phototherapy.
    iv. Conventional treatment with at least three of the below defined treatments for psoriasis have failed:
        1. Topical treatments
        2. Light therapy
        3. Systemic treatment
        4. Combination treatment
        5. Intralesional injections of steroids
    v. Lesions have previously been shown to be responsive to UVB treatment.
    vi. Members in the following categories would be exclude from consideration for laser treatment:

1. Anyone with a history of photosensitivity
2. Anyone with a history of keloid formation
3. Persons < 18 years of age*
4. Pregnant/lactating
5. Psoriasis that responds to standard therapies
6. Those with ≥ 10 % body surface area involvement of plaque-type psoriasis
7. Those with other types of psoriasis

*Individual consideration will be given to requests for excimer or FLPDL laser therapy for members 12-17 years old. Such requests must meet the same criteria as for adult patients as stated above. In addition, detailed clinical information must be supplied as to prior treatments and response, the rationale for the request, and specific treatment plans and goals for such pediatric members.

11. **Rosacea**
    a. Antibiotic treatments – Limitations may apply. Please check benefit plan descriptions and formularies for details on which specific medications are covered if any. The medications may not be covered for members without pharmacy benefit plans; in addition, some pharmacy benefit plans may exclude or limit coverage of some or all of these medications.
    b. Retinoids are covered with limitations.
    c. Surgical treatment is not covered.
    d. Broad band light therapy is considered cosmetic and not medically necessary.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

Home phototherapy units over $1,000 require authorization for commercial products. Not a covered benefit for Medicaid.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***

- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. DESCRIPTION

The skin is composed of an outer layer – the epidermis, and a thicker inner layer – the dermis. The epidermis contains keratinocytes, melanocytes, and Merkel's cell disks (touch-sensitive cells). The dermis is made up of connective tissue, which contains protein, collagen, and elastic fibers. It also contains blood and lymph vessels, sensory receptors, related nerves (those that sense heat and cold, texture, pressure and trauma), and sebaceous and sweat glands. There is a subcutaneous layer of fatty tissue immediately below the dermis. Fibers from the dermis attach the skin to the subcutaneous layer and the underlying tissues and organs also connect to the subcutaneous layer.

Phototherapy involves exposure to type A ultraviolet (UVA) radiation or type B ultraviolet (UVB) phototherapy or a combination UVA/UVB phototherapy. Photochemotherapy include administration of psoralens (P) and exposure to type A ultraviolet (UVA) radiation, known as PUVA photochemotherapy, and combinations of P/UVA/UVB.

Home phototherapy (UVB) for treatment of vitiligo is not supported by adequate safety and efficacy data at this time. According to the International Vitiligo Task Force home phototherapy demonstrated better compliance, similar repigmentation outcomes, similar frequency of adverse effects and lower time investment, but significantly less patient satisfaction than in office-treatment. (Seneschal et al., 2023). Optimal dosing of UVB administration and patient selection is a challenge

for this indication. The Vitiligo Working Group (Mohammad et al., 2017) states that "There are no consistent guidelines regarding the administration of narrowband ultraviolet B phototherapy to patients with vitiligo." A systematic review by Ashraf and colleagues (2022) included 3 studies totaling 195 participants. The publications included were randomized controlled trials comparing home-based phototherapy with institution-based phototherapy or placebo/no phototherapy for vitiligo. The primary outcome was treatment effectiveness. Findings on effectiveness were contradictory across studies with variable rates of repigmentation. There was no significant difference in repigmentation rates between the groups, although adherence to treatment schedules was found to be significantly better in home-based groups. Adverse effects were significantly higher in home-based groups. No long-term data were reported on maintenance of treatment benefits. The authors concluded that due to the significantly higher rates of adverse events in home-based UVB groups, it is difficult to recommend home phototherapy in clinical practice and larger randomized controlled trials are needed to evaluate this treatment modality.

Psoriasis is a chronic inflammatory skin disease that can begin at any age. There are multiple clinical subtypes of psoriasis. The most common form of psoriasis is chronic plaque psoriasis, other major subtypes include guttate psoriasis, pustular psoriasis, and erythrodermic psoriasis. Conventional treatment may be divided into the following six categories: Topical treatments, light therapy, systemic treatment, combination therapy, intralesional injections of steroids, and laser therapy.

Dermabrasion is a surgical skin procedure in which a specialized handheld instrument is used remove the surface of the epidermis of the skin (the stratum corneum) with the purpose of improving skin contour. The procedure may be used for treating large areas when lesions are too large to treat effectively with topical preparations.

Chemical peel is a common facial skin resurfacing procedure using a controlled induction of caustic substances to the skin in order to induce injury. Light or superficial chemical peels cause injury only to the epidermis. Medium-depth peels injure the epidermis and papillary dermis while deep chemical peels induce the greatest degree of injury, extending into the reticular dermis.

Rosacea is a chronic disorder involving inflammation of the cheeks, nose, chin, forehead, or eyelids. It may cause redness, prominent blood vessels, swelling, or skin eruptions similar to acne. The cause of rosacea is unknown. The treatment is aimed at the control of redness, inflammation, and skin eruptions. Rosacea is not medically dangerous. It is not curable, but usually is controllable with treatment. It may be persistent and chronic. Complications of Rosacea include permanent changes in appearance, psychological damage, and loss of self-esteem. Long-term treatment (5 to 8 weeks or more) with oral antibiotics such as tetracycline may control skin eruptions. Oral medications similar to vitamin A (isoretinol or Accutane) are a stronger alternative. The treatment of skin eruptions may also

include long-term treatment with topical (applied to a localized area of the skin) antibiotics such as metronidazole. In severe cases, laser surgery may help reduce the redness. Surgical reduction of enlarged nose tissue may also improve the patient's appearance.

V. CODING INFORMATION

A. Not Covered Diagnosis

Evaluation & Management codes for new or established patients are covered when billed with the following diagnosis codes. Treatment of these conditions is not covered:

ICD-10 Codes*:*

L57.3	Poikiloderma of Civatte
L63.0 - L63.9	Alopecia areata
L64.0 - L64.9	Androgenic alopecia
L65.0 - L65.9	Other nonscarring hair loss
L66.0 - L66.9	Cicatricial alopecia [scarring hair loss]
L70.0 - L70.9	Acne L71.1 - L71.9 Rosacea
L73.0	Acne keloid
L81.0 - L81.9	Other disorders of pigmentation
L84	Corns and callosities
L95.8	Other vasculitis limited to the skin
L95.9	Vasculitis limited to the skin, unspecified
L98.8	Other specified disorders of the skin and subcutaneous tissue
L98.9	Disorder of the skin and subcutaneous tissue, unspecified

B. Treatment of skin conditions

1. PUVA and UVB Treatment

ICD-10 Codes*: These diagnoses support medical necessity of the procedures listed below:*

B36.0	Pityriasis versicolor
C84.00 - C84.09	Mycosis fungoides
C84.10 - C84.19	Sezary disease
D89.810 - D89.813	Graft-versus-host disease
L11.1	Transient acantholytic dermatosis *[Grover]*
L20.0 - L20.9	Atopic dermatitis
L28.0 - L28.2	Lichen simplex chronicus and prurigo
L29.0 - L29.9	Pruritus ani
L30.5	Pityriasis alba
L40.0 – L40.9	Psoriasis
L41.0 – L41.9	Parapsoriasis
L42	Pityriasis rosea
L43.0 - L43.9	Lichen planus
L44.0 - L44.9	Other papulosquamous disorders
L45	Papulosquamous disorders in diseases classified elsewhere
L56.0 - L56.9	Other acute skin changes due to ultraviolet radiation

L66.1	Lichen planopilaris
L80	Vitiligo
L90.0	Lichen sclerosus et atrophicus
L94.0	Localized scleroderma [morphea]
L94.1	Linear scleroderma
L94.3	Sclerodactyly
L94.5	Poikiloderma vascular atrophicans
L98.1	Factitial dermatitis
T86.00 - T86.09	Complications of bone marrow transplant

CPT/HCPCS Codes:

96900	Actinotherapy (ultraviolet light)
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photo responsive dermatoses requiring at least four to eight hours of care under direct supervision of the physician (includes application of medication and dressings)

2. Home Phototherapy

ICD-10 Codes: *These diagnoses may support medical necessity of the devices listed below:*

L40.0 - L40.4	Psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified
L41.0 - L41.9	Parapsoriasis

CPT/HCPCS Codes:

Prior Authorization required for these devices.
(Not covered for Priority Health Medicaid)

E0691	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less
E0692	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel
E0693	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel
E0694	Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection

3. Photodynamic Therapy

ICD-10 Codes: *This diagnosis supports medical necessity of the CPT/HCPCS codes listed below:*

L57.0	Actinic keratosis

CPT/HCPCS Codes:

96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
96574	Debridement of premalignant hyperkeratotic lesion(s) (i.e., targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
J7308	Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7345	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg

4. Laser Therapy
ICD-10 Codes: *These diagnoses support medical necessity of the procedures listed below:*

L40.0 - L40.4	Psoriasis
L40.8	Other psoriasis
L40.9	Psoriasis, unspecified

CPT/HCPCS Codes:

96920	Excimer laser treatment for psoriasis; total area less than 250 sq cm
96921	Excimer laser treatment for psoriasis; 250 sq cm to 500 sq cm
96922	Excimer laser treatment for psoriasis; over 500 sq cm

5. Facial Dermabrasion
ICD-10 Codes: *The following procedures are covered for theses diagnoses only:*

C44.00 - C44.99	Other and unspecified malignant neoplasm of skin
D48.5	Neoplasm of uncertain behavior of skin
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
L57.0	Actinic keratosis

CPT/HCPCS Codes:

15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face

6. Chemical Peel
ICD-10 Codes: *The following procedures are covered only for the diagnoses below:*

C44.00 - C44.99	Other and unspecified malignant neoplasm of skin
D48.5	Neoplasm of uncertain behavior of skin

D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
L57.0	Actinic keratosis

CPT/HCPCS Codes:

15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal

7. Not Covered Conditions

ICD-10 Codes*: Services billed with these diagnoses are not covered.*

L57.3	Poikiloderma of Civatte
L63.0 – L63.9	Alopecia areata
L64.0 – L64.9	Androgenic alopecia
L65.0 – L65.9	Other nonscarring hair loss
L66.0 – L66.9	Cicatricial alopecia [scarring hair loss]
L70.0 - L70.9	Acne
L71.1 - L71.9	Rosacea
L73.0	Acne keloid
L81.0 – L81.9	Other disorders of pigmentation
L95.8	Other vasculitis limited to the skin
L95.9	Vasculitis limited to the skin, unspecified
L98.8	Other specified disorders of the skin and subcutaneous tissue
L98.9	Disorder of the skin and subcutaneous tissue, unspecified

CPT/HCPCS Codes:

Evaluation & Management codes for new or established patients are allowed when billed with the diagnoses above.

Treatment services NOT COVERED for the diagnoses above include but are not limited to:

- Medicine services including injections
- Medication used in treatment except that which is subject to pharmacy coverage
- Minor or major surgical procedures including but not limited to:

10040	Acne surgery (e.g., marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site, (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional four lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal

15793	Chemical peel, nonfacial; dermal
17106	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); less than 10 sq. cm
17107	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); 10.0 to 50.0 sq. cm
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq. cm
17340	Cryotherapy (CO2 slush, liquid N2) for acne
17360	Chemical exfoliation for acne (e.g., acne paste, acid)

8. Treatment of Labial Hypertrophy – Not Covered

ICD-10 Codes*: Services billed with this diagnosis are not covered.*

N90.60	Unspecified hypertrophy of vulva
N90.61	Childhood asymmetric labium majus enlargement
N90.69	Other specified hypertrophy of vulva

CPT/HCPCS Codes:

15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
56620	Vulvectomy simple; partial

9. Other Not Covered

CPT/HCPCS Codes:

E1399	Durable medical equipment, miscellaneous *(Explanatory notes must accompany claims billed with unlisted codes.)* Not covered when billed for scalp cooling device
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
17380	Electrolysis epilation, each 30 minutes
0700T	Molecular fluorescent imaging of suspicious nevus; first lesion
0701T	Molecular fluorescent imaging of suspicious nevus; each additional lesion (List separately in addition to code for primary procedure)
96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)

96935 Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)
96936 Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)

10. Other benign conditions*: Coverage may be subject to nonstandard cost sharing or may be excluded. See plan documents.*
Removal of skin tags

11200 Removal of skin tags, multiple fibro cutaneous tags, any area; up to and including 15 lesions
11201 Removal of skin tags, multiple fibro cutaneous tags, any area; each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)

Seborrheic Keratosis
ICD-10 Diagnosis:
L82.0 Inflamed seborrheic keratosis
L82.1 Other seborrheic keratosis

Professional or facility treatment services for the diagnoses above include but are not limited to:
- Anesthesia
- Minor or major surgical procedures
- Not covered for Medicaid

Vitiligo
ICD-10 Diagnosis:
L80 Vitiligo

Professional or facility treatment services for the diagnoses above include but are not limited to:
- Anesthesia
- Medical procedures and services
- Limitations do not include treatments mentioned elsewhere in this policy

Treatment of Lipoma

ICD-10 Diagnosis:
D17.0 Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
D17.1 Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk
D17.20 0 D17.24 Benign lipomatous neoplasm of skin and subcutaneous tissue of limb
D17.30 – D17.39 Benign lipomatous neoplasm of skin and subcutaneous tissue of other and unspecified sites
D 17.9 Benign lipomatous neoplasm, unspecified

Professional or facility treatment services for the diagnoses above include but are not limited to:

- Anesthesia
- Minor or major surgical procedures

C. Suspicious Lesions:
From Principles of CPT Coding: "When an excised lesion is a neoplasm of uncertain morphology (i.e. benign vs. malignant), choosing the correct CPT code relates to the manner in which the lesion was approached rather than the final pathologic diagnosis, since the CPT code should reflect the knowledge, skill, time, and effort that the physician invested in the excision of the lesion. Therefore, an ambiguous but low-suspicion lesion might be excised with minimal surrounding grossly normal skin/soft tissue margins, as for benign lesion codes. An ambiguous but moderate-to high-suspicion lesion would be excised with moderate to wide surrounding grossly normal skin/soft tissue margins as for malignant lesions codes."

VI. REFERENCES

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