Dermatology Payment Policy

Policy

The Plan reimburses participating providers for the provision of medically necessary dermatology services including the diagnosis and treatment of diseases and conditions affecting the skin, hair and nails.

Please refer to the *Nurse Practitioner* and *Physician Assistant Payment Policies* for reimbursement information on services provided by these practitioners.

Definitions

Cosmetic service: A procedure or treatment that is performed primarily to reshape or improve the patient's appearance. Cosmetic services are not medically necessary, and are not covered by the Plan, whether intended to improve an individual's emotional well-being or to treat a mental health condition. In addition, drugs, biological, facility/hospital charges, laboratory and radiology charges, and charges for surgeons, assistant surgeons, anesthesiologists, and any other incidental services which are directly related to the cosmetic procedure are not covered.

Simple repair: Superficial wound, typically involves only epidermis, dermis, or subcutaneous tissue (no deeper involvement, e.g., fascia), and requires simple one layer closure.

Intermediate repair: Wound involving one or more deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to epidermal and dermal closure.

Complex repair: Repair of wounds requiring more than layered closure, such as scar revision, debridement, extensive undermining, stents, or retention sutures.

Reimbursement

The following procedures are reimbursed by the Plan:

- Lesion removal; malignant and pre-malignant lesions by any method; includes simple repair and local anesthesia (11600-11646, 17000-17004).
- Lesion removal; symptomatic benign lesions by any method; includes simple repair and local anesthesia (11400-11471, 17110, 17111). The following are examples of benign lesions: sebaceous cysts, skin tags, milia, nevi (moles), acquired hyperkeratosis (keratoderma), papillomas, hemangiomas, viral wars. Removal of benign skin lesions is considered cosmetic, except when there are signs or symptoms that make removal medically necessary.
- Wound repair/closure; includes local anesthesia (12001-13160).
- Intralesional corticosteroid injections (11900 and 11901).
- Laser treatment for inflammatory skin disease (96920-96922).
- Tissue transfer or rearrangement, grafts and flaps (14000-14350; 15570-15999).
- Mohs Micrographic Surgery (17311-17315).
- Photodynamic therapy (96567, J7308) for pre-malignant and/or malignant lesions, actinotherapy and photochemotherapy.
- Shaving (11300-11313).
- Biopsy of skin lesions (11102-11107):
    - When a biopsy is performed as part of a lesion removal, it is considered inherent to the overall procedure and is not reported separately. If however, a biopsy is performed on a separate date at a separate session, and subsequently the lesion is excised, the biopsy code may be reported followed by a separate removal code indicating the different dates of service with modifier 59.

The following procedures are **not** reimbursed by the Plan:

- Treatments for acne scarring, including but not limited to subcutaneous injections to raise acne scars, chemical peel, abrasion and dermabrasion.

- Treatments for active acne, including but not limited to acne surgery, cryotherapy, chemical exfoliation, and laser treatment.

Referral/notification/prior authorization requirements

PCP referral is required for consultations with a dermatologist, unless otherwise specified in the member's Evidence of Coverage (EOC).

Preauthorization is required for some dermatological procedures. The Plan identifies procedures that are typically cosmetic (see below) and periodically reviews claims for these procedures. If documentation in the medical record does not support medical necessity, the Plan will request repayment from the provider.

Unlisted dermatology procedures are subject to Medical Director Review; for additional information, see the *Unlisted Surgical Procedures Payment Policy*.

The following services require preauthorization:
- Tattoo removal as a result of radiation marking.
- Subcutaneous filling of material.
- Destruction of cutaneous vascular lesions.
- Dermabrasion (15780, 15781, 15782, 15783).

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Billing/coding guidelines

The Plan requests that all claims for outpatient professional services be submitted on a CMS-1500 claims form or HIPAA standard electronic format per industry standard guidelines.

It is not appropriate to bill the Plan for services that are not covered as if they are covered. Claims for removal of benign skin lesions performed for cosmetic reasons do not need to be submitted to the Plan unless the member requests that a formal denial is issued. In this case, use the appropriate diagnosis code, Z41.1 (Encounter for cosmetic surgery), on the claim.

Modifier 25 should be used when separately identifiable evaluation and management services that are above and beyond the pre- and post-operative work of the procedure, by the same physician are performed on the same day as a covered minor surgical service is performed.

<u>Wound repair CPT Codes</u>:
12001-12021 (simple); 12031-12057 (intermediate); 13100-13160 (complex)
When billing repair of multiple wounds, add together the lengths of those in the same classification (simple, intermediate, or complex) and from all anatomic sites that are grouped together into the same code descriptor. Report the total length. Lengths of repairs from different classifications or different anatomical sites should not be added.

<u>Excision CPT Codes (size, location needed)</u>:
11400-11471 (benign)
11600-11646 (malignant)
- Excision codes are used to reflect "full-thickness" (through dermis) removal of a lesion.
    - Note: Select a CPT code based on lesion diameter plus the most narrow margins required which equals the excised diameter. Codes are also based on body area and location (e.g., trunk/arms/legs is one (1) body area – one (1) CPT code).

    - Use modifier 59 when multiple lesions are removed in a single body area (e.g., meaning if you use the same CPT code more than once, append a modifier 59 to reflect different lesion, different site, or a different approach method in the same body area).
- Use modifier 58 for all re-excisions (e.g., didn't get all margins, patient returns).
- Select a CPT code only after the pathology report has returned as malignant lesions require different codes and reimburse at a much higher rate.
- Simple suturing CPT codes 12001-12021 (less than 0.5 cm) are bundled into excision codes.
- You can code additionally for simple (greater than .05 cm), intermediate, or complex repairs.
- Code only the most complex procedure when multiple procedures are performed on the same lesion/same day.
    - Example: If a physician removes a self-contained cyst and not an "area" of skin, code as excision vs. debridement (e.g. sebaceous cyst).

Shaving CPT Codes:
11300-11313
- Shaving = sharp removal of epidermal and dermal lesions without a full-thickness dermal excision.
- Code partial thickness removal (not through dermis) as shaving.
- Shaving codes are used when lesions are completely removed w/scalpel, scissors.
- Typically shaving does not require sutures.
- If a physician shaves off a piece of a lesion and sends to pathology, then code with biopsy codes, not shaving codes.

Debridement CPT Codes:
11000-11044
- Surgical excision of dead, devitalized, or contaminated tissue and removal of foreign matter from a wound.

Biopsy CPT Codes:
11102-11107
Definitions:
- Biopsy = removal of small tissue for microscopic examination or culture.
- Biopsies remove a "portion" of a lesion for diagnostic purposes.
- Excisional biopsy = the provider removes the "entire" lesion. This is considered a diagnostic and therapeutic procedure.
- Punch biopsy = the provider uses an instrument which punches out a cylinder of skin (e.g., deeper lesions).
- Multiple biopsies on the same lesion may only be coded as a "single lesion".
- You cannot code a biopsy and removal in the same day, only on different days.
- Modifier 59 is needed when you biopsy "one" lesion and "excise" another on the same day.
- No modifier is necessary if the biopsy and excision are performed on separate days.

Medically injected procedures:
Bill medically injected procedures (e.g., substances purchased/injected) with J HCPCS codes found in the CPT HCPCS Level II book.

Multiple procedures payment reduction:
The Plan reimburses multiple dermatology procedures by paying the highest valued procedure at 100% of the fee schedule or contracted rate, and the second through fifth procedures at 50% of the fee schedule or contracted rate. Append modifier 51 to the lesser valued service to ensure appropriate payment. Add-on codes are not subject to payment reduction.

The following services are bundled into the payment for the primary procedure performed:
- Anesthesia when provided by the surgeon or dermatologist, including conscious sedation.
- Simple closures when performed in conjunction with another procedure.
- Miscellaneous supplies (e.g., surgical trays).
- Evaluation and management services.

Minor Surgical Procedures:
A minor surgical procedure is a procedure with a 0 or 10 day global period. Dermatologic procedures with 0-day global periods include biopsies (CPT code 11102-11107), shave removals (11300–11313), and Mohs micrographic surgery (17311–17315); procedures with 10 day global periods include destructions (17000–17286), excisions (11400–11646), and repairs (12001–13153). The decision to perform a minor surgical procedure is included in the payment for the procedure and shall not be reported separately as an evaluation and management service. However, a significant and separately identifiable evaluation and management service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. If a minor surgical procedure is performed on a new patient, the same rules for reporting evaluation and management services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an evaluation and management service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles. Both the medically necessary minor surgical procedure and the evaluation and management service must be appropriately and sufficiently documented by the provider in the member's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

Refer to the *Global Surgical Payment Policy* for additional information.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	05/01/2008
Previous revision date(s):	09/01/2015 - Moved to new Plan template and updated definitions section. 07/01/2016 - Annual review.
Connection date & details:	May 2017 – Annual review. July 2018 – Annual review, no updates. July 2019 – Minor code updates. April 2024 – Under Billing/coding guidelines, added diagnosis code Z41.1 for encounters for cosmetic surgery; clarified that the decision to perform a minor surgical procedure is included in the payment for the procedure; a significant and separately identifiable evaluation and management service unrelated to the minor surgical procedure is separately reportable with modifier 25.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.