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Dermatology

Reimbursement Policy ID: RPC.0112.01CH

Recent review date: 07/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Policy addresses billing and/or payment for certain dermatology procedures, including actinotherapy, photochemotherapy, lesion removal and laser treatment of psoriasis.

Exceptions

Cosmetic procedures are not reimbursable.

Reimbursement Guidelines

The health plan covers actinotherapy, photochemotherapy and laser treatment of psoriasis for the treatment of certain skin conditions or cancers when such treatment is recommended by the member's physician.

All procedures discussed in this policy must be reported with the correct modifier, if applicable, including any/all anatomical modifiers for reimbursement.

Actinotherapy
Actinotherapy (ultraviolet light) (96900) may be reimbursed when submitted with a covered diagnosis code. Per this policy, certain diagnoses are appropriate indications for actinotherapy including but not limited to acne, atopic dermatitis, and psoriasis. Actinotherapy services reported without an appropriate diagnosis will be denied.

Examples of appropriate diagnosis for Actinotherapy:

- Acne (ICD-10 codes L70.0-L70.1, L70.3-L70.9, L73.0)
- Atopic dermatitis (ICD-10 codes L20.0, L20.81-L20.82, L20.84-L20.9)
- Psoriasis (ICD-10 codes L40.0-L40.1, L40.3-L40.4, L40.8-L40.9)

Photochemotherapy
According to the American Academy of Dermatology Association and the health plan policy, there are numerous diagnoses that are appropriate indications for 96910-96912 (photochemotherapy; PUVA) including but not limited to atopic dermatitis, lichen planus, psoriasis, and vitiligo. Photochemotherapy codes are not considered to be reimbursable services when reported without an appropriate diagnosis.

Examples of appropriate diagnoses for photochemotherapy:

- Atopic dermatitis (ICD-10 codes L20-L20.9)
- Lichen planus (ICD-10 codes L43-L43.9)
- Psoriasis (ICD-10 codes L40-L40.9)
- Vitiligo (ICD-10 codes L80)

Laser Treatment of Psoriasis
According to the AMA CPT Manual and the American Academy of Dermatology Association, laser treatment of psoriasis (96920-96922), and be reported with a diagnosis of psoriasis (ICD-10 codes L40.0-L40.4, L40.8-L40.9) or parapsoriasis (ICD-10 codes L41-L41.9). The health plan will not reimburse excimer laser treatment of psoriasis procedures submitted without an appropriate diagnosis or performed more than once in a two-day period.

Skin lesion(s)
Skin lesion removal is a procedure to remove growths from the skin. The procedure may be performed for several reasons, including discomfort, size, or potential for cancer. Below are the covered CPT codes for lesion removals.

- Lesion removal; malignant and pre-malignant lesion 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, 17111). Some examples of benign lesions are sebaceous cysts, skin tags, milia, nevi (moles), acquired hyperkeratosis (keratoderma), papilloma, hemangiomas, and viral warts. Removal of benign skin lesions is considered cosmetic unless accompanied by signs or symptoms that make removal medically necessary.

Excision(s)
Excisional lesion removals are categorized by type, benign (CPT 11400-11471) or malignant (CPT 11600-11646), body area (e.g., trunk, arms, legs), and size in centimeters. Excisions include margins and single layer closure using sutures, chemical cauterization, or electrocauterization. Excision codes are used to reflect “full thickness” (through dermis) removal of a lesion. Refer to the CPT Manual for instructions on correct coding (procedure codes and modifiers) of specifics such as lesion size, body area, complexity, and associated procedures such as suturing.

The health plan will reimburse the following dermatological procedures when supported in the medical record and reported with the appropriate diagnosis code(s), procedure code(s), and modifier(s).

Shaving
Removal of epidermal or dermal skin growths by shaving (CPT 11300-11313) does not require suturing. Control of bleeding by chemical or electrical cauterization is included in these codes and not separately reimbursable.

Debridement
Debridement (CPT codes 11000-11044) is a surgical excision to remove dead, damaged or contaminated skin not associated with fractures or dislocations (see CPT codes 11010-11012).

Wound repairs
Wound repairs are categorized into three types of repairs (simple, intermediate, or complex), body area (e.g., scalp, neck, extremities) and length in centimeters. Simple repairs (12001-12021) include superficial lacerations and minor repair Intermediate repairs include deeper or more complex lacerations with deep subcutaneous or layered repairs.

Biopsy
Biopsy codes (11102-11107) may be reimbursable when the procedure is performed for the specific purpose of obtaining tissue samples for diagnostic examination. The physician removes a biopsy sample of skin or subcutaneous tissue for the purpose of performing a diagnostic histopathologic study under a microscope.

Biopsies performed on separate sites or separate lesions on the same date of service may be separately reimbursable but must be reported with only one primary biopsy code regardless of how many different techniques are used.

Separately identifiable evaluation and management services reported with an appropriate modifier may be reimbursable if they are above and beyond the pre- and post-operative work of the procedure and are performed by the same physician on the same day as a covered minor surgical service.

Multiple Surgical Procedures payment reduction
The health plan reimburses multiple dermatology procedures by paying the highest valued procedure at 100% of the allowable, and 25% of the allowable for the second. No payment will be made for additional procedures after the second unless has a specific rate in their contract. Modifier 51 must be reported to receive payment for more than one procedure performed on the same date of service and by the same physician. 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. The global period for a surgical procedure considers services routinely performed by the surgeon or by members of the same group with the same specialty during the preoperative, intra-operative, and post-operative time periods. Services considered to be directly related to the pre-procedure, intra-procedure, and post-procedure work are included in the global

reimbursement and will not be paid separately. Minor surgical procedures are not separately reimbursable on the same date of service as an evaluation and management service. However, if a significant and separately identifiable evaluation and management service unrelated to the decision to perform the minor surgical procedure is documented and unrelated to the decision to perform the minor surgical procedure, an appropriate modifier is required.

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.

Please check with the health plan for any prior authorization requirements.

Definitions

Actinotherapy
A medical treatment that uses chemically active rays from the electromagnetic spectrum, such as X-rays or ultraviolet light, for therapeutic purposes. Ultraviolet light can be used to treat dermatological conditions like acne, eczema, and psoriasis, while infrared radiation can be used to treat muscle pain.

Photochemotherapy
Also known as PUVA, is a treatment that uses ultraviolet radiation and photosensitizing compounds to treat a variety of skin diseases including psoriasis, vitiligo, mycosis fungoides, alopecia areata, dyshidrotic eczema, and atopic dermatitis.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. Corresponding health plans Clinical Policies.
VII. Applicable health plans manual reference.
VIII. Commonwealth of Pennsylvania Children’s Health Insurance Program guidance.
IX. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0033.01CH Multiple Procedure Payment Reduction
RPC.0009.01CH Significant-Separately Identifiable Evaluation and Management service (Modifier 25)
RPC.0010.01CH Distinct Procedural Service (Modifier 59, X {EPSU})
RPC.0012.01CH Global Surgical Package and Split Surgery

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
07/2026	Reimbursement Policy Committee Approval
06/2026	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
06/2025	Reimbursement Policy Committee Approval