

# Dermatology Payment Policy

## Policy

This policy applies to evaluation and management and surgical services performed in an office setting pursuant to the diagnosis and treatment of skin disorders and disease. A procedure or treatment that is performed primarily to reshape or improve the patient's appearance is considered cosmetic and is excluded from coverage in the member's Evidence of Coverage (EOC).

The Plan will reimburse for dermatological services when performed by a physician, PCP, nurse practitioner, or a physician assistant who is participating through a contracted entity within their legal scope of practice. The credentialed nurse practitioner or physician assistant services must be rendered in collaboration with or under the supervision of a physician.

The Plan covers:

1. Office visits and consultations for the evaluation and diagnosis of conditions affecting the skin, and
2. The medically necessary treatment of conditions affecting the skin.

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

## 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, 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).
- 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).

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

## Billing/coding guidelines

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

Wound repair CPT Codes:

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.

Excision CPT Codes (size, location needed):

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.
- You can code an evaluation and management office visit (99211-99215) with a biopsy if the patient presents with signs/symptoms/abnormality requiring an evaluation (e.g., the documentation of HPI elements = history of the present illness, physical examination, and medical decision-making).
- If the determination to biopsy was made at a previous visit (e.g., you already charged an evaluation and management CPT code), then note that the follow up visit for the biopsy

service only would not warrant charging additionally for an evaluation and management service on the second visit.

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.

The Plan does not reimburse an evaluation and management service on the same day that a dermatology procedure is performed, unless a significant and separately identifiable service was provided and clearly documented in the medical record. If the evaluation and management service provided is for the purpose of deciding that a dermatological procedure is to be performed, it may be reported separately. Append modifier 25 to the appropriate evaluation and management code to indicate the patient's condition required a significant, separately identifiable service unrelated to the procedure performed.

- Example - benign lesion removal:  
If a lesion is diagnosed as an asymptomatic (i.e., without symptoms) benign (i.e., non-malignant) lesion, and the lesion is removed at the time of the office visit or consult, then only the office visit or consultation to diagnose the lesion is reimbursed. The plan member is responsible for an office visit copayment and all charges related to removal of the asymptomatic benign lesion. If the lesion is diagnosed as a symptomatic benign lesion, the office visit and the removal of the lesion are reimbursed. The member is responsible for an office visit copayment.

Dermatology procedures have a global period (generally 0, 10, or 90 days); during this time, services provided in follow-up to the dermatology procedure include evaluation and management services and are not separately reimbursable. 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.

*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.*