Dermatology

Reimbursement Policy ID: RPC.0112.2400

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 of certain dermatology procedures, including actinotherapy and 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.

The acne diagnosis codes (L70.0-L70.9, L73.0) are covered only when the patient is 18 years of age or younger (non-covered beginning on the 19th birthday), and the acne condition is infected, cystic or pustular.

The keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

All procedures discussed in this policy must be reported with the correct modifier.

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. Claims submitted for actinotherapy billed 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 our policy, there are numerous diagnoses that are appropriate indications for 96910-96913 (photochemotherapy; PUVA) including, but not limited to atopic dermatitis, lichen planus, psoriasis, and vitiligo. Photochemotherapy codes are not considered to be billable services unless one of the appropriate diagnoses is reported.

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 American Academy of Dermatology Association, laser treatment of psoriasis (96920-96922) should only 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) in order to be eligible for reimbursement. Claims submitted without a covered diagnosis will not be reimbursed.

In addition, laser treatment of psoriasis (96920-96922) should not be reported more than once in two days as there should be a minimum of 48 hours between treatments.

Lesion Removal
Medicaid will not provide coverage for excision/treatment of non-malignant dermal lesions and dermal anomalies under the following circumstances:

- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Excision/treatment of non-malignant dermal lesions and other dermal anomalies are not covered routinely. However, Medicaid will provide coverage of these anomalies if the therapy conforms with accepted treatment standards of the problem and meets one of the following conditions:

- The lesion is pre-cancerous or suspected to be cancerous by physical findings, appearance or
- changes in characteristics.
- The anomaly causes pain, irritation, or numbness that result in the functional impairment of

bodily functions or normal growth and development.
- At least two alternative methods of treatment (i.e., steroid injection, compression, silicone gel treatment, etc.) have been attempted and found ineffective.
- The anomaly is responsible for the loss of a bodily function and the treatment restores the disabled function.

Supporting documentation is required for a claim submitted for a lesion and a dermal anomaly removal or revision with diagnosis codes L91.0 and L90.5. Medicaid will not cover treatment that is considered to be experimental, investigational (i.e., chemical peels, cryosurgery, dermabrasion, punch grafts, bleomycin, interferon and verapamil injections), or done for cosmetic or emotional purposes

Keloid/Scar Conditions
Claims for these treatments must be accompanied by documentation that supports the criteria as outlined above. Medicaid will not provide coverage for excision and/or treatment of non-malignant dermal lesions, dermal anomalies and Keloid/scar conditions under the following circumstances:
- The treatment is performed for cosmetic or emotional purposes.
- The therapy is experimental or investigational.

Examples include chemical peels, cryosurgery, dermabrasion and punch grafts.

The keloid scar diagnosis L91.0 is covered only in severe cases with pain, intractable itching, or interference with range of movement.

Medicaid will provide coverage of excision and/or treatment of a Keloid scar and scar conditions and fibrosis of the skin if the therapy conforms to accepted standards of the problem and meets one of the following conditions:
- The scar causes functional impairment which interferes with daily living.
- The scar is symptomatic with a history of ulceration or inflammation that causes repeat office visits. At least two methods of treatment such as radiation (silicone gel treatment), compression, steroids and laser surgery have been tried and failed.
- There is a history of repeated infections with the scar.

Destruction Codes
Treatment must be medically indicated according to the criteria set forth in the guidelines previously stated. Certain procedures are considered cosmetic and, therefore, non-compensable.

Chemosurgery (Mohs Technique)
Procedures are compensable if medically justified and not performed for cosmetic purposes.

Skin Grafts
Providers must follow CPT guidelines when billing for skin grafts. Procedures are identified by size and location of the defect (beneficiary area) and the type of graft. Skin graft codes that pertain to subsequent (each additional square centimeter) areas must be billed in units.

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 repairs 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 when performed on the same lesion and during the same session.

Separately identifiable evaluation and management services 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 is performed.

Multiple Procedures payment reduction
The health 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. 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).
- Post-operative follow up visits

Minor Surgical Procedures
A minor surgical procedure is a procedure with a 0- or 30-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. Hospital and office E&M visits are allowed up to and including the day of surgery. Post-operative follow up visits are non-compensable. A minor surgical tray is reimbursable when minor surgery is performed in a physician's office that necessitates local anesthesia and other supplies (i.e., gauze, sterile equipment, suturing material, etc.). A minor surgical tray includes those trays necessary for suture removal, minor debridement, superficial foreign body removal, or incision and drainage of superficial abscess.

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 website 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 AmeriHealth Caritas [Plan Name] Clinical Policies.
VII. Applicable Medicaid Fee Schedule(s).
VIII. American Academy of Dermatology Association, https://www.aad.org/
IX. Applicable Physician Services Provider Manual.

Attachments

N/A

Associated Policies

RPC.0033.2400 Multiple Procedure Payment Reduction
RPC.0009.2400 Significant-Separately Identifiable Evaluation and Management service (Modifier 25)
RPC.0010.2400 Distinct Procedural Service (Modifier 59, X {EPSU})
RPC.0012.2400 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
10/2025	Reimbursement Policy Committee Approval