Dermatology

Policy
NHP reimburses participating providers for the provision of medically necessary dermatology services, including the diagnosis and treatment of skin disorders and disease.

Reimbursement
Providers are reimbursed according to the plan’s network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member’s benefit plan. The manner in which covered services are reimbursed is determined by the Neighborhood Health Plan Payment Policy and by the provider’s agreement with NHP. Member liability amounts may include, but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member’s benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

NHP reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Neighborhood Health Plan’s reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

MassHealth
Please refer to the MassHealth Physician Manual for a list of payable services.
Neighborhood Health Plan Reimburses

- Actinotherapy, photochemotherapy and laser therapy for inflammatory diseases of the skin.
- Mohs micrographic surgery to remove complex and/or ill-defined cancer of the skin.
- Photodynamic therapy to destroy pre-malignant and/or malignant lesions by activation of photosensitive drugs.
- Surgery to correct or repair severe disfigurement to restore physical function
- Wound repair and closures.

Neighborhood Health Plan Does Not Reimburse

- Anesthesia provided by the physician or dermatologist performing the procedure, including conscious sedation.
- Cosmetic surgery whose primary purpose is to improve, alter or enhance appearance, and that otherwise does not meet the definition of reconstructive.
- Dermatological procedures performed primarily for psychological or emotional reasons.
- Separately or additionally for the use of a device.
- Surgery to treat acne lesions.
- Surgery to remove tattoos.

Procedure Codes

Note: This list of codes may not be all-inclusive. Inclusion of a code does not imply or guarantee coverage.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Comments</th>
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<tbody>
<tr>
<td>11100</td>
<td>Biopsy, skin lesion</td>
<td>Bill with a count of one</td>
</tr>
<tr>
<td>11001</td>
<td>Biopsy, skin lesion, each additional</td>
<td>Bill on one line with a count representing the number of additional lesions biopsied</td>
</tr>
<tr>
<td>11200</td>
<td>Shaving for epidermal and dermal layers</td>
<td>Choose appropriate code by lesion size</td>
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<tr>
<td>11300-11313</td>
<td>Removal of skin tags, each additional 10 lesions</td>
<td>See above</td>
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<tr>
<td>11920-11922</td>
<td>Tatooing</td>
<td>Covered only as a component of breast reconstruction surgery</td>
</tr>
<tr>
<td>12001-12018</td>
<td>Repair superficial (simple) wound(s)</td>
<td>When multiple wounds are repaired within the same classification (simple, intermediate or complex) and the same anatomic location, measure in cm, and add the lengths, reporting single CPT code.</td>
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<tr>
<td>12031-12057</td>
<td>Intermediate wound repair, including layered closure</td>
<td>When multiple wounds are repaired within the same classification (simple, intermediate or complex) and the same anatomic location, measure in cm, and add the lengths, reporting single CPT code.</td>
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<tr>
<td>13100-</td>
<td>Repair of complex wound or lesion requiring</td>
<td>When multiple wounds are repaired within the</td>
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### Provider Payment Guidelines and Documentation

The medical record must support the medical necessity and frequency of each dermatological treatment. The medical record must clearly document the patient’s symptoms and specific physical findings that justify removal of a benign lesion.

### Related Documents

- General Coding and Billing
- Medical Policy: Gender Reassignment Surgery
- Medical Policy: Phototherapy and Photochemotherapy for Dermatologic Conditions
- Medical Policy: Reconstructive and Cosmetic Procedures
- Modifiers
- NHPNet Referral and Authorization User Guides
- Not Payable Per MassHealth Code Set
- Unlisted Code usage requirements

### References

- American Society of Plastic Surgeons (ASPS) Recommended Insurance Coverage Criteria for Third-Party Payers
- CMS LCD Article ID A54602
- Commonwealth of Massachusetts, MassHealth Provider Manual Series, Physician Manual, PHY-130, Chapter 6 (multiple years)
- National Library of Medicine, National Institute of Health, MedlinePlus Medical Encyclopedia

### Publication History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>January 20, 2010</td>
<td>Original documentation</td>
</tr>
<tr>
<td>March 2, 2010</td>
<td>Revised</td>
</tr>
<tr>
<td>November 23, 2010</td>
<td>Revised to add status column in procedure codes table. Disclaimer revised.</td>
</tr>
<tr>
<td>November 1, 2011</td>
<td>Referral, authorization and notification table updated; limitations, exceptions, procedure code table, diagnosis codes, non-coverage of MelaFind, related guidelines, and references updated</td>
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<tr>
<td>April 17, 2012</td>
<td>Annual review, Authorization Grid and Limitations updated</td>
</tr>
<tr>
<td>July 1, 2017</td>
<td>Review for update to codes and for language simplification. Addition of links to Related NHP Payment Guidelines and Medical Policies; updates to reference sources</td>
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes clinical coding criteria and claim editing logic in addition to auditing across dates of service to identify the unbundling of pre and post-operative care.