

Dermatology

Policy

Mass General Brigham Health Plan 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 Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. 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.

Mass General Brigham Health Plan 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.

Provider Payment Guidelines

Mass General Brigham 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 or MyCare Family: Please refer to the MassHealth Physician Manual for a list of payable services.

- *Commercial: Entire policy applies.*
- *Medicare Advantage: Entire policy applies.*

Mass General Brigham 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.

Mass General Brigham 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.

Code	Descriptor	Comments
11102	Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion	Bill one unit

Provider Payment Guidelines

Code	Descriptor	Comments
11103	Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)	Bill on one line with a count representing the number of additional lesions biopsied
11104	Punch biopsy of skin (including simple closure, when performed); single lesion	Bill one unit
11105	Punch biopsy of skin (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	Bill on one line with a count representing the number of additional lesions biopsied
11106	Incisional biopsy of skin (e.g., wedge) (including simple closure, when performed); single lesion	Bill one unit
11107	Incisional biopsy of skin (e.g., wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)	Bill on one line with a count representing the number of additional lesions biopsied
11200	Removal of skin tags, up to 15	Bill with a count of one for up to 15 skin tags removed
11201	Removal of skin tags, each additional 10	List separately in addition to code for primary procedure, with a count of 1 for each 10 additional skin tags removed
11300-11313	Shaving for epidermal and dermal layers, trunk arms or legs	Choose appropriate code by lesion size and by location on body
11920-11922	Tattooing	Covered only as a component of breast reconstruction surgery
12001-12018	Repair superficial (simple) wound(s)	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.

Provider Payment Guidelines

Code	Descriptor	Comments
12031-12057	Intermediate wound repair, including layered closure	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.
13100-13153	Repair of complex wound or lesion requiring more than layered closure	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.

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 Affirming Procedures](#)

[Modifiers](#)

[Mass General Brigham Health Plan Referral and Authorization Guide](#)

[Medical Policy Phototherapy and Photochemotherapy for Dermatologic Conditions](#)

[Medical Policy Reconstructive and Cosmetic Procedures](#)

[Unlisted Code Requirement](#)

References

[CMS Local Coverage Article, Billing and Coding: Removal of Benign Skin Lesions \(A54602\)](#)

[MassHealth Provider Manual Series, Physician Manual, PHY-164, Subchapter 6](#)

National Library of Medicine, National Institute of Health, MedlinePlus Medical Encyclopedia

Provider Payment Guidelines

Publication History

Topic: Dermatology	Owner: Network Management
January 20, 2010	<i>Original documentation</i>
March 2, 2010	<i>Revised</i>
November 23, 2010	<i>Revised to add status column in procedure codes table. Disclaimer revised.</i>
November 1, 2011	<i>Referral, authorization and notification table updated; limitations, exceptions, procedure code table, diagnosis codes, non-coverage of MelaFind, related guidelines, and references updated</i>
April 17, 2012	<i>Annual review, Authorization Grid and Limitations updated</i>
July 1, 2017	<i>Review for update to codes and for language simplification. Addition of links to Related Mass General Brigham Health Plan Payment Guidelines and Medical Policies; updates to reference sources</i>
April 24, 2018	<i>Document review; corrections to code narrative transpositions</i>
January 01, 2019	<i>Document restructure; codes, code descriptor and references updated. Added: 11102,11103,11104, 11105,11106 and 11107. Removed 11100 and 11101</i>
January 01, 2023	<i>Document rebrand; added Medicare Advantage; added reference links</i>

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. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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